Swing Bed Review

Kerry Dunning, MHA, MSH, CPAR, RAC-CT
Kerry Dunning LLC
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What is Swing Bed Compliance?

- Comply with CoPs
- Conform to Federal/State laws and regulations
- Complete Medicare required paperwork
- Admit patients appropriate to a post-acute, skilled level of care
- Use RAI and MDS
- Meet medical necessity documentation requirements
- Be compliant with billing and coding regulations specific to skilled services

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Swing Bed Regulatory Requirements

- Medicare requirements include:
  - Verification of days available for skilled nursing care
  - 3 night qualifying stay
  - MSP
  - Physician Certification
  - Practical Matter
  - Physician Orders/H&P
  - Physician sign/date Therapy POC
  - Medical Necessity Documentation and Daily Documentation
  - ADLs
  - Beneficiary Notices
  - Validation Report

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Swing Bed Regulatory Requirements

- What is skilled care?
  - It is not ACUTE
- Determination for skilled services:
  - If the inherent complexity of the service is such that it can only be performed safely and/or effectively under the general supervision of skilled nursing or skilled rehabilitation personnel
  - Your question if it is therapy: why are they in a swing bed? Could it be done in Outpatient Therapy or Home Health?
    - Nursing documentation is key
    - Diagnosis and LOS

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Admissions Process

- Does the patient meet your Admissions Criteria?
- Who gets MSP and what is the double check?
- If patients are coming from another hospital what is the verification of the 3 midnight stay?
- Who makes sure all the signatures are on patient rights?
- What is the process for the patient's care plan and discharge planning?
- Is the nursing admission assessment completed within and 24 hours of admission and what is the swing bed policy on completion?

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CMS and Skilled 2018

- CMs released a comprehensive revision of federal nursing facility regulations for 2018 (over 700 pages total in new rules and explanations)
- A new provision that an initial care plan be developed and implemented within 48 hours
  - Must involve patient and patient representative in those decisions
  - SNF: team must include CNA and Nutrition Services
- Person-Centered care emphasis added, especially in care planning process
  - Must know more "about the patient as a person" including their preferences

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Skilled and Medications

- New regs talk more about antipsychotics and psychotropic meds
  - Nursing homes surveyed on "unnecessary meds"
- DRR x 2
  - DRR coded in Section N is completely separate from the regulatory requirement that all nursing homes have a pharmacist conduct a monthly review of each resident's medications as detailed in F757 (Drug Regimen Review) in Appendix PP of the *State Operations Manual*
  - The new DRR "intent" is to show whether the provider conducted a DRR at admission (start of a Part A stay), throughout the stay to discharge AND that there was significant discussion about med issues with the physician. There must be a reported response from the physician (in person, phone, voice mail, fax, etc.) and it must show ACTION to the reported issue by midnight of the next calendar day

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MDS has major changes

- MDS Sections A, C, GG, I, J, M, N, O
  - Section GG
    - This is changing the "skilled" way of showing improvement = functional gain
    - ***THIS IS PAC – LTACH, IRF, SNF AND HH GETTING GRADED ON SAME STANDARDS LOOKING FOR BEST OUTCOMES AT DISCHARGE and $$***
  - Section GG
    - 46 new questions
    - Added " not attempted due to environmental limitations"

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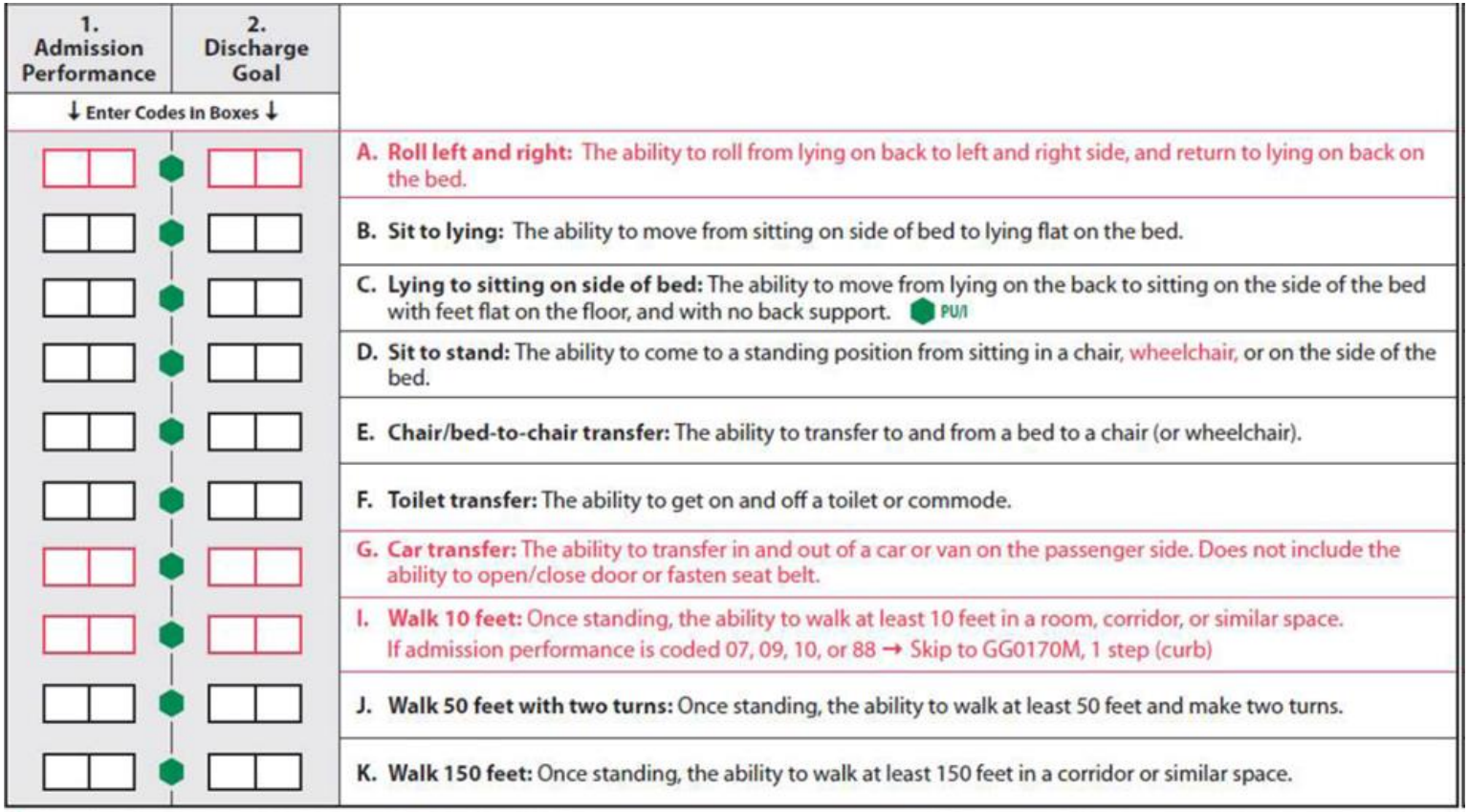
GG0170 Mobility



1. Admission Performance	2. Discharge Goal	
↓ Enter Codes In Boxes ↓		
		A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
		B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
		C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support. PU/I
		D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
		E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
		F. **Toilet transfer:** The ability to get on and off a toilet or commode.
		G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
		I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
		J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
		K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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Role of IDT

- The RAI helps Swing Bed staff look at patients holistically—as individuals for whom quality of life and quality of care are mutually significant and necessary. **Interdisciplinary use of the RAI promotes this emphasis on quality of care and quality of life.**
- Importance? OIG Report: SNFs often fail to meet Care Planning and Discharge Planning Requirements (2013)
- An interdisciplinary team that includes at least the attending physician and a registered nurse with responsibility for the beneficiary must prepare the care plan. SSA, § 1819(b)(2)(B), 42 U.S.C. 1395i–3(b)(2)(B).
- OIG says discharge planning be conducted by an IDT including a physician
- IDT can include SWB Coordinator, Therapy, Social Services, Dietary, Medicare Nurse/DON, etc.

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Daily Documentation

- Daily Documentation is required to reflect the skilled services being provided.
  - Objective measures of the current level of assistance required for functional tasks
  - A description of the skilled services provided
  - Assessment of the patient's response to the services.
  - Progress towards the treatment goals
  - Documentation of any treatment variations with the associated rationale
  - Accurate documentation of treatment time in minutes, to be recorded on the MDS

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ADL Accuracy

- ADLs require review for accuracy of documentation
- All documentation of functional level and assist should be reviewed including ADL records, nursing progress notes, and therapy evals and progress notes
- ADL inservices for both the nursing assistants and professional nurses should be routine

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Swing Bed Regulatory Requirements

- Skilled Therapy
  - Be directly and specifically related to an active treatment plan, designed by the **physician** after consultation with a qualified therapist
  - Be of a **level of complexity**, or the patient's condition such that the judgment, knowledge and skills of a qualified therapist are required
  - Be provided with an expectation that the condition of the patient **will improve** in a reasonable and predictable period of time, or the services must be required to establish a safe and effective maintenance program
  - Be **reasonable and necessary** under accepted standards of clinical practice, in terms of the amount, frequency and duration of the services

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Things to Know

1. How are your coders aware of primary services used in skilled nursing?
2. When is the 3-midnight rule still in play?
3. Do you allow LOAs?
4. What services should not occur in a swing bed?
5. When are swing bed claims submitted?
6. How are you tracking outcomes? Trends? Cost?

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Survey and Audit

- **This is the beginning of 2 years of distinct changes**
- CMS released the revised v1.16 of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual
- New SWB MDS for PPS sites (and CAH training) is 1.16.1
- The SNF QRP Measure Calculations and Reporting User's Manual will soon be updated to include the new/modified and revised assessment-based SNF QRP QMs that implement on Oct. 1
- CMS is discontinuing public reporting of Percent of Residents or Patients With Pressure Ulcers That Are New or Worsened (Short Stay) and replacing it with Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury by October 2020
- The only new MDS-based SNF QRP QM without a clear start date for public reporting is Drug Regimen Review Conducted With Follow-Up for Identified Issues – Post-Acute Care SNF QRP

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Who's Watching?

- CERT-- Comprehensive Error Rate Testing
- ZPICs-- Zone Program Integrity Contractor
- MAC-- Medicare Administrative Contractor (FI)
- GAO-- Government Accountability Office
- RA – RAC Auditors
- OIG – Office of Inspector General

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Why is This Important?

- One MAC recently reported that out of 508 errors identified in a CERT audit of certain Medicare claims, the contractor found that:
  - 311 errors were due to "insufficient documentation."
    - Notably, a majority of the errors in this category were because the medical record "did not contain a valid physician's signature" or because a diagnostic test performed "did not contain a valid physician's order" or an identification of the provider who rendered the service
  - 132 errors were due to "lack of medical necessity" based on the medical documentation submitted

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Audits – Noridian and Therapy

- Findings of the 100 claims reviewed through February 2016 are as follows:
  - 54 claims were accepted
  - 35 claims received correction for the following reasons:
    - RUG level adjusted due to incorrect therapy minutes
    - No therapy orders
    - Occurrence code 50 (ARD)
    - Occurrence span code 70 (3 day stay)
- 6 claims were partially denied for the following reasons:
  - Incorrect therapy minutes/use of E-stim minutes toward total therapy minutes
  - Late certification/recertification
- 5 claims were denied in full for the following reasons:
  - Untimely certification/recertification
  - No qualifying hospital stay
  - No skilled care
  - Incorrect billing

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AUDIT TYPE	AUDIT TIPS
DOCUMENTATION: • **SNF Level of Care Supported** • **Medical Necessity Evident** • **Skills of a Nurse and/or Therapist Required**	1. Physician Cert/Recert 2. Hospital Discharge Summary Supports SNF Medical Necessity 3. Nursing and Therapy Documentation Reflects Daily Skilled Need
CODING: • **Pertinent Medical Diagnoses Support Continued Skilled Care after Hospital Discharge** • **Pertinent Medical and Treatment Diagnosis Support Therapy Involvement in SNF** • **Local Coverage Determinations followed**	1. MDS/Nursing Should Identify Admitting Medical Diagnosis 2. Therapy Must Identify Medical Diagnoses and Treatment Diagnoses to support Therapy Interventions 3. Therapists must follow Local Coverage Determinations when Coding Therapy Interventions
TRIPLE CHECK: Necessary Team Members Attendance: • **Business Office Manager** • **MDS Coordinator** • **Therapy Manager** • **DON**	1. Schedule a set meeting day and time 2. Mandate meeting and attendance compliance 3. Check diagnostic codes, RUG levels, UB-04, MDS 4. Develop Plan of Correction for Identified Risks


Q&A

Resources

- http://www.npuap.org/wp-content/uploads/2016/11/Margaret-Goldberg-Microclimate-presentation-final.pdf
- CMS Post-Acute Care Quality Initiative website
- https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/Proposed-MDS-30-V1160-Change-Table.pdf
- Information on the IMPACT Act of 2014 can be found at:
- http://www.gpo.gov/fdsys/pkg/BILLS-113hr4994enr/pdf/BILLS-113hr4994enr.pdf
- https://www.govtrack.us/congress/bills/113/hr4994
- For SNF Quality Reporting Program comments or questions: SNFQualityQuestions@cms.hhs.gov
- SNF QRP Table for Reporting Assessment-Based Measures for the FY 2020 SNF QRP APU [PDF, 122KB]
- Final MDS 3.0 Data Set Version 1.16.0 - Effective October 1, 2018.pdf [PDF, 1MB]
- Final MDS 3.0 Data Set Version 1.16.0 Change Table - Effective October 1, 2018.pdf [PDF, 317KB]
- Final Specifications for SNF QRP Quality Measures and Standardized Resident Assessment Data Elements-Effective October 1 2018.pdf [PDF, 593KB]
- SNF QM User's Manual V1.0 FINAL 5-22-17 [PDF, 394KB]
- SNF QRP Measure Specifications_October 2016.pdf [PDF, 138KB]
- 2016_07_20_mspb_pac_ltch_irf_snf_measure_specs [PDF, 822KB]
- SNF Function Quality Measures TEP Summary Report August 2016 [PDF, 2MB]

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Kerry Dunning, MHA, MSH, CPAR, RAC-CT

Kerry has over 30 years in the health care industry, and over 25 specifically working in post-acute. She worked for national rehabilitation chains in varied roles and in hospital leadership positions. Kerry has experience with start-up units/facilities, programs beginning Medicare services, ongoing management of hospital business office operations, IRF units, skilled facility operations, and in 100-day turn around programs centered on cost reduction, cost avoidance and revenue enhancement.

As a consultant, Kerry has worked with swing beds (CAH and PPS), skilled nursing units, freestanding and hospital-owned long term care facilities. She has served as an educator for hospital and LTC associations, hospital associations and for CAH associations in the areas of corporate compliance, Medicare compliance, medical necessity documentation, therapy services, and coding/billing. She is the primary SNF/Swing Bed consultant for multiple rural health state associations and a presenter at other state and rural health associations annually.

Her international work includes projects in Russia (training and starting the first nursing home services), China (teaching graduate students on western post-acute services and training on western inpatient rehabilitation); volunteering with an orphanage in Bolivia; teaching on outpatient surgery (National Health Services, England); Home Health (European Health Conference, Spain); presentations on Chinese Health in a Poster Session and a Free Theme Session at the 36th World Hospital Congress (Brazil); and study projects in Italy, Cuba, and Canada.

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