Thank you for joining Stroudwater's 2nd Annual Swing Bed Bootcamp on October 16, 2025. Below you will find the swing bed related questions generated during the bootcamp, with answers from our team of swing bed experts! If you have additional questions, do not hesitate to reach out. Lindsay Corcoran (lcorcoran@stroudwater.com)

Documentation

- **Are there specific guidelines for the timeframe in completing a baseline and a comprehensive care plan? Both a comprehensive and baseline care plan needs to be completed?**
    - ANSWER: A baseline care plan must be developed within 48 hours of a patient's admission to ensure essential care and services are provided promptly while the full assessment is being completed. A comprehensive care plan must be completed within 7 days after completion of the comprehensive assessment and must reflect measurable goals, interventions, and timeframes that address the patient's identified medical, nursing, and psychosocial needs. Both the comprehensive and baseline care plans are not required - Facilities may complete a comprehensive care plan instead of the baseline care plan. In this circumstance, the completion of the comprehensive care plan will not override the RAI process, and must be completed and implemented within 48 hours of admission and comply with the requirements for a comprehensive care plan at §483.21(b), with the exception of the requirement at (b)(2)(i) requiring the completion of the comprehensive care plan within 7 days of completion of the comprehensive assessment. If a comprehensive care plan is completed in lieu of the baseline care plan, a written summary of the comprehensive care plan must be provided to the resident and resident representative, if applicable, and in a language that the resident/representative can understand.
    - **Please note that CAHs are not required to meet these timeframes.
    - REFERENCE: Medicare State Operations Manual – Appendix PP
- **We are a CAH and have EPIC as our EHR. Do we need a special physician signed certification form on admission OR is our EHR order sufficient.**
    - ANSWER: For Critical Access Hospitals (CAHs), a physician-signed certification of Swing Bed services is required, but this certification does not have to be on a separate form if all required elements are clearly documented and authenticated within the electronic health record (EHR). If your EPIC admission order includes the physician's signature (electronic or written) and meets CMS requirements—specifically identifying that Swing Bed (skilled nursing) services are ordered, the need for daily skilled care, and that the care must is medically necessary—then a separate certification form is not required. The EHR order serves as the certification if it is complete, dated, and signed by the physician.
    - REFERENCE**:** Medicare Benefit Policy Manual – Chapter 8
- **Are you able to provide a template for the IDT documentation?**
    - ANSWER: See separate document.

- **Many referrals we receive are for stroke patient that need speech therapy, OT and PT. However, we only have PT. Do we need referring hospital to send referral with only PT need listed?**
    - ANSWER: Yes, if your facility can only provide physical therapy (PT), the referral documentation and physician certification should specifically reflect PT as the skilled need. CMS requires that Swing Bed admissions are based on an identified daily skilled need that your hospital can provide. If the referral lists additional services such as speech or occupational therapy that your facility cannot provide, the referring hospital should revise or clarify the referral and discharge summary to reflect only the skilled services that will be furnished at your site. This ensures compliance with 42 CFR §409.31 and §485.645(d)(2) — which require Swing Bed care to meet medical necessity and skilled service criteria — and prevents any suggestion of unmet care needs after transfer.
    - REFERENCE**:** Medicare Benefit Policy Manual – Chapter 8
- **Can independent nurse practitioner write admission orders?**
    - ANSWER: Yes, an independent NP may write admission orders for swing bed patients if permitted under state scope of practice laws and the hospital's medical staff bylaws and policies. The regulatory requirements in Appendix W allow an NP or PA to admit and care for a Swing Bed patient. However, the regulations also require that the physician review and sign records of all inpatients cared for by both NPs and PAs. And the NP or PA cannot complete the certification if employed by the facility.
    - REFERENCE: CMS State Operations Manual - Appendix W
- **We are in Iowa. Can an advanced practice provider write the admission orders?**
    - ANSWER: Iowa law grants independent practice authority to nurse practitioners, meaning they may write swing bed admission orders. But like the above the certification for swing bed services must be done by a physician, and a physician must review and sign records.
    - REFERENCE: CMS State Operations Manual - Appendix W, Medicare Benefit Policy Manual – Chapter 8

Medicare Criteria

- **Does the 3-midnight rule only apply to traditional Medicare patients? Several advantage plans tell me no 3-midnight rule is needed, and they say patients can actually go from home straight to a SNF facility. I know that is the Medicare rule but do these advantage plans go against these rules?**
    - ANSWER: The 3-day qualifying stay rule applies to Traditional Medicare. When it comes to other payers, they can either follow Medicare guidelines or have their own criteria, which in the case of many Medicare Advantage plans they waive the 3-midnight acute qualifying stay.
    - REFERENCE: CMS Swing Bed Services, Medicare Benefit Policy Manual – Chapter 8
- **When my CAH swing bed patient has a change in medical status, requiring the transition to inpatient for more complex treatment, do they need to remain in IP status for 3 midnights before transitioning back to swing bed?**

  - ANSWER: They do not need to meet the 3-day qualifying stay again, they do however need to return to the swing bed with the 30-day window and under the same treatment condition as the first swing bed stay.
  - REFERENCE: Medicare Benefit Policy Manual – Chapter 8
- **How does this influence scheduled surgeries, (multiple trauma patient) when in the swing bed program. Upon return does patient then need another 3 midnight before transition back into swing bed program?**
  - ANSWER: They do not need to meet the 3-day qualifying stay again, they do however need to return to the swing bed with the 30-day window and under the same treatment condition as the first swing bed stay.
  - REFERENCE: Medicare Benefit Policy Manual – Chapter 8
- **If a patient needs therapy 3 days per week but it is not available in the home health setting, they cannot get to an outpatient therapy. They can benefit from skilled services 5 days per week for therapy and this can be justified to reduce the risk of falls or rehospitalization. Should we utilize this justification in our documentation? "Skilled PT services are not available at a frequency necessary to improve, prevent, or slow decline in the HH setting. Patient will benefit from skilled PT services 5 days per week to ensure the goals noted below are realized…**
  - ANSWER: Yes, this is an acceptable justification for skilled care and would fall under a "Practical Matter" – I would also incorporate the risk to the patient and that rehab services as a practical matter can provided effectively only in a swing bed setting.
  - REFERENCE: Medicare Benefit Policy Manual – Chapter 8

Rules & Regulations

- **Patients ask if they can have day passes on the weekend. Are day passes, for swing bed patients, only for physician appointments?**
  - ANSWER: Patients can grant an outside pass or short leave of absence outside of physician appointments – they may attend a special religious service, holiday meal, family occasion, go on a car ride, or for a trial visit home. I would however ask since patients are leaving frequently and on weekends – are they still receiving daily skilled services? Can the services that they are receiving only be furnished on an inpatient basis?
  - REFERENCE: Medicare Benefit Policy Manual – Chapter 8

Swing Bed / Skilled Services

- **Can behavioral health services be provided to patients in swing bed?**
  - ANSWER: Perhaps, this may fall under observation and assessment which are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures, until the patient's condition is essentially stabilized. Chapter 8 of the Medicare Benefit Policy states" Skilled observation and assessment may also be required for patients whose primary condition and needs are psychiatric in nature or for patients who, in addition to their physical problems, have a secondary psychiatric diagnosis. These patients may exhibit acute psychological symptoms such as depression, anxiety or agitation, which require skilled observation and

assessment such as observing for indications of suicidal or hostile behavior. However, these conditions often require considerably more specialized, sophisticated nursing techniques and physician attention than is available in most participating SNFs. (SNFs that are primarily engaged in treating psychiatric disorders are precluded by law from participating in Medicare.) Therefore, these cases must be carefully documented.
    - REFERENCE: Medicare Benefit Policy Manual – Chapter 8
- **Will there be any discussion regarding progress versus maintenance versus decline in meeting requirements for skilled care?**
    - ANSWER: Maintenance Therapy - Therapy services in connection with a maintenance program are considered skilled when they are so inherently complex that they can be safely and effectively performed only by, or under the supervision of, a qualified therapist. (See 42CFR §409.32) If all other requirements for coverage under the SNF benefit are met, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of a safe and effective maintenance program. **Such a maintenance program to maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program.** When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services do not constitute a covered level of care.
    - REFERENCE: Medicare Benefit Policy Manual – Chapter 8
- **How does skilling someone for education work?**
    - ANSWER: Teaching and training activities, which require skilled nursing or skilled rehabilitation personnel to teach a patient how to manage their treatment regimen, would constitute skilled services. Some examples are:
        - Teaching self-administration of injectable medications or a complex range of medications;
        - Teaching a newly diagnosed diabetic to administer insulin injections, to prepare and follow a diabetic diet, and to observe foot-care precautions;
        - Teaching self-administration of medical gases to a patient;
        - Gait training and teaching of prosthesis care for a patient who has had a recent leg amputation;
        - Teaching patients how to care for a recent colostomy or ileostomy;
        - Teaching patients how to perform self-catheterization and self-administration of gastrostomy feedings;
        - Teaching patients how to care for and maintain central venous lines, such as Hickman catheters;
        - Teaching patients the use and care of braces, splints and orthotics, and any associated skin care; and

        - Teaching patients the proper care of any specialized dressings or skin treatments.

      The documentation must thoroughly describe all efforts that have been made to educate the patient/caregiver, and their responses to the training. The medical record should also describe the reason for the failure of any educational attempts, if applicable.
    - REFERENCE: Medicare Benefit Policy Manual – Chapter 8
- **What are ways that you can incorporate respiratory therapy more in a skilled patient?**
    - ANSWER: Here is how the CMS Resident Assessment Manual 3.0 (used by SNFs and PPS swing beds) defines RT services: Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.
    - REFERENCE: LTC Facility RAI 3.0 Manual
- **Have you discussed what procedures, and outpatient visits a CAH SB patient can and cannot do? We have been told no visits with audiology. Is there a list, if so, can we get it?**
    - ANSWER: CAHs are subject to the hospital bundling requirements at section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m), and therefore, all services provided to a CAH swing-bed patient must be included on the CAH swing-bed bill (subject to the exceptions at 42 CFR § 411.15(m)(3)). The exceptions include Physician/APP professional services. Generally, there are several procedures/outpatient services a CAH swing bed patient can receive – the bigger question is whether the service is bundled on the swing bed claim or separately billed.
    - REFERENCE: Medicare Claims Processing Manual – Chapter 3
- **If patient needs to have surgery while in the swing bed program, does that require a discharge, change of swing bed status to Inpatient or OBS?**
    - ANSWER: 40.3.5.2 - Leave of Absence (Rev. 4001, Issued: 03-16-18, Effective: 06-19-18, Implementation: 06-19-18) **A leave of absence for the purposes of this instruction is a situation where the patient is absent, but not discharged, for reasons other than admission to a hospital, other SNF, or nonparticipating portion of the same institution.** If the absence exceeds 30 consecutive days, the 3-day prior stay and 30-day transfer requirements, as appropriate, must again be met to establish re-entitlement to SNF benefits. Leave of absence (LOA) days are shown on the bill with revenue code 018X and LOA days as units. However, charges for LOA days are shown as zero on the bill, and the SNF cannot bill the beneficiary for them except as specified in Chapter 1 of this manual at §30.1.1.1. Occurrence span code 74 is used to report the LOA from and

through dates. Providers should review the RAI manual to clarify situations where an LOA is not appropriate, for example observation stays in a hospital lasting greater than 24 hours.
    - REFERENCE: Medicare Claims Processing Manual – Chapter 6

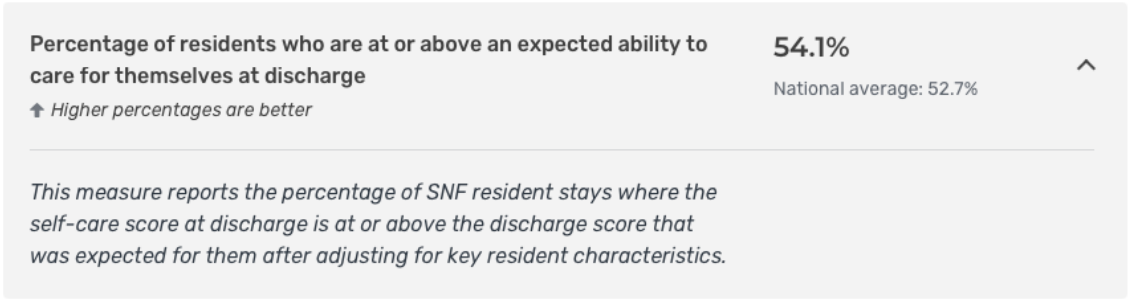
Dental Services

- **Does the 24hr dental services mean making a patient appointment, or does the CAH need to have a dentist on call 24/7?**
- **Is a dental contract/agreement required? Or the policy/procedure of how a dental emergency/routine care is addressed sufficient?**
- **Do swing bed require to have a dentist agreement in place/contract. We did in the past and it was ended recently. I noticed on list servs that auditors had requested it from a swing bed recently. I understand the emergent care; we would need to provide this for the patient.**
    - ANSWER: §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities: A facility— §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.
    - There must be policies & procedures in place regarding dental services, outline the process to provide or obtain routine or emergency dental services for swing bed patients. Outside dental resources must have an agreement in place.
    - REFERENCE: Medicare State Operations Manual – Appendix PP

Quality and Clinical Outcomes

- **What options (software) are available to rural PPS hospitals to complete the assessments and submit to iQies since the change on October 1?**
    - ANSWER: The October 1 change for iQIES submission was rolled back. Please email me if you have heard differently.
- **Where can I find state and national statistics for therapy improvement (GG codes)?**

- ANSWER: For SNFs and Rural PPS hospitals – Nursing Home Compare – you would look at "short-stay quality measures"



  - REFERENCE: CMS Data, Nursing Home Compare
- **How do we get started in participating the Swing Bed quality reporting program?**
  - ANSWER: Email Lindsay Corcoran @ lcorcoran@stroudwater.com – you must be a Critical Access Hospital.
- **How are you capturing readmissions when many times discharged swing patients come from other facilities and may not come back to this facility as a readmission, but go back to their local hospital?**
  - ANSWER: For the Stroudwater Swing Bed Quality Reporting Program – readmissions are captured via a post-discharge 30-day follow up call to the patient – asking is there was a return to acute for same or new condition.
  - For SNF/PPS Hospitals – Readmission data comes from claims data
    - REFERENCE: Technical User Guide

Billing

- **We are looking for some guidance for billing when a swing bed care turns to end of life situation. If we don't have hospice available but patient is expected to decline. Can we maintain swing bed status and how should that be documented and billed?**
  - ANSWER: Palliative or end-of-life care by itself is not automatically a skilled service under Medicare, however a patient receiving palliative care may still qualify for swing bed if they also meet skilled care criteria based on nursing or therapy needs that require skilled-level services. Documentation and billing would follow Medicare guidelines for skilled services.
  - REFERENCE: Medicare Benefit Policy Manual – Chapter 8
- **If a patient is admitted for SWB and needs a procedure is the CAH responsible for the bill of the procedure?**
  - ANSWER: CAHs are subject to the hospital bundling requirements at section 1862(a)(14) of the Social Security Act and 42 CFR § 411.15(m), and therefore, all services provided to a CAH swing-bed patient must be included on the CAH swing-bed bill (subject to the exceptions at 42 CFR § 411.15(m)(3)). The exceptions include Physician/APP professional services. Generally, there are several procedures/outpatient services a CAH swing bed patient can receive – the bigger question is whether the service is bundled on the swing bed claim or separately billed.
  - REFERENCE: Medicare Claims Processing Manual – Chapter 3

Program Design

- **How can you possibly respond to a bed request within 4 hours when we need prior authorizations from insurance companies? That process alone can take days.**
    - ANSWER: We generally use this timeframe for traditional Medicare – understanding that prior authorizations from commercial plans can quite long. I would suggest assessing process for those prior authorizations and is there any part of the workflow that can be improved on to make the process quicker?