Swing Bed Programs
Documentation to Support Sustainable Reimbursement

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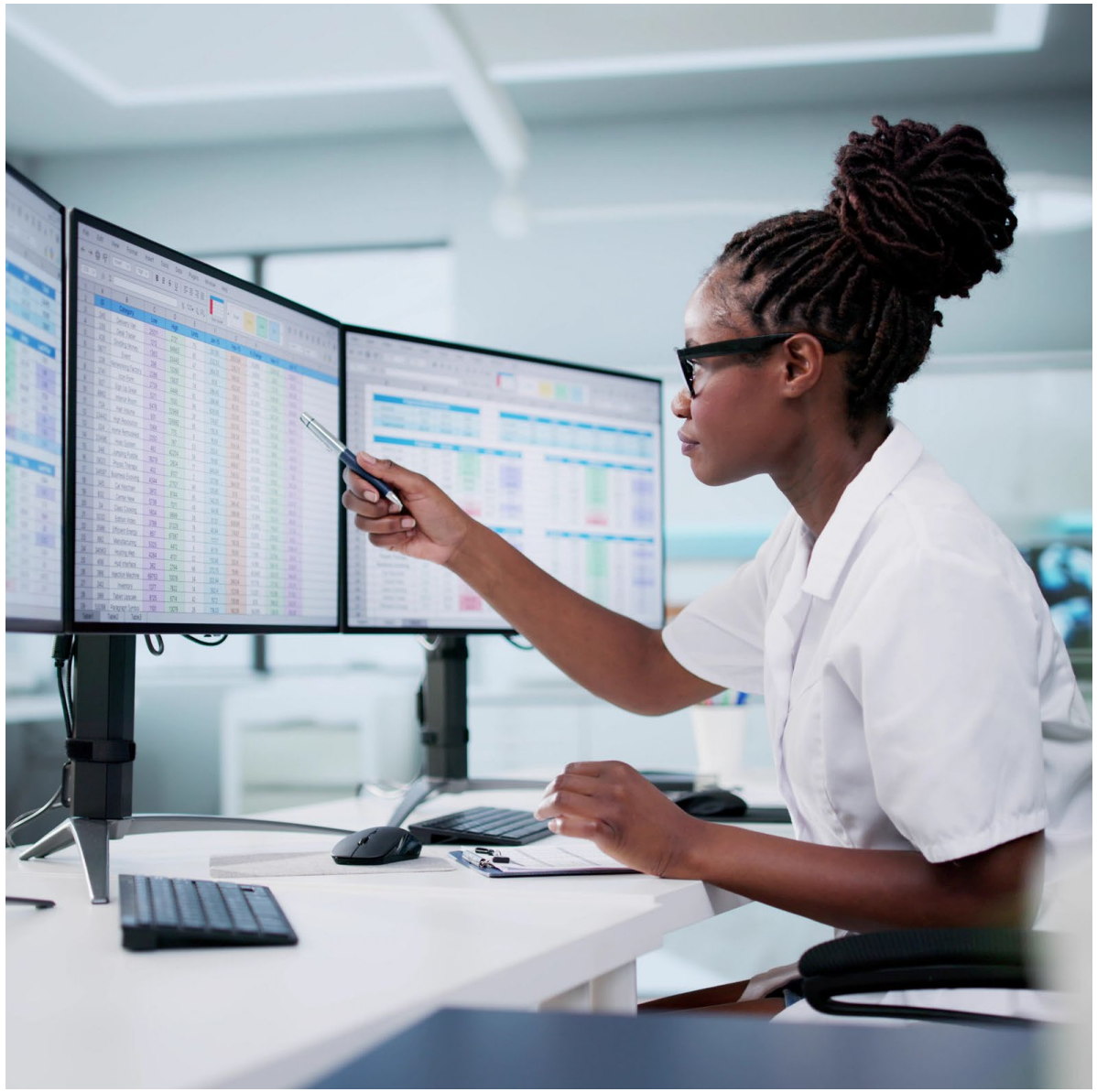
forvis mazars

Agenda

Overview of Key Requirements & Best Practices for:

1. Documentation
2. Billing
3. Coding
4. Compliance

Focus on Critical Access Hospitals (CAHs) & Rural Facilities



Documentation Requirements for Swing Bed Admission

Three-Day Qualifying Stay:
Minimum three consecutive days of medically necessary inpatient stay

Timely Admission:
Must occur within 30 days of hospital discharge

Required Documentation:

- Physician’s status change order from acute to swing bed
- Discharge summary from acute stay
- Swing bed nursing admission physical & progress notes
- Skilled nursing care plan
- Swing bed physician history & physical documentation & progress notes
- Discharge summary from swing bed stay

Billing Guidelines for CAHs

Reimbursement: Paid at 101% of reasonable cost

Revenue Codes: Include nursing, rehab, lab, drugs, & supplies

Bill Types: Use types 181–188 depending on claim nature

Occurrence Code 70: Required to document qualifying hospital stay dates

Frequency: Monthly or upon discharge, transfer, or drop below skilled level

Billing Guidelines for PPS Hospitals

Subject to SNF PPS (PDPM) & MDS 3.0 Submission

Must Follow SNF Consolidated Billing Rules

Compliance & Risk Mitigation

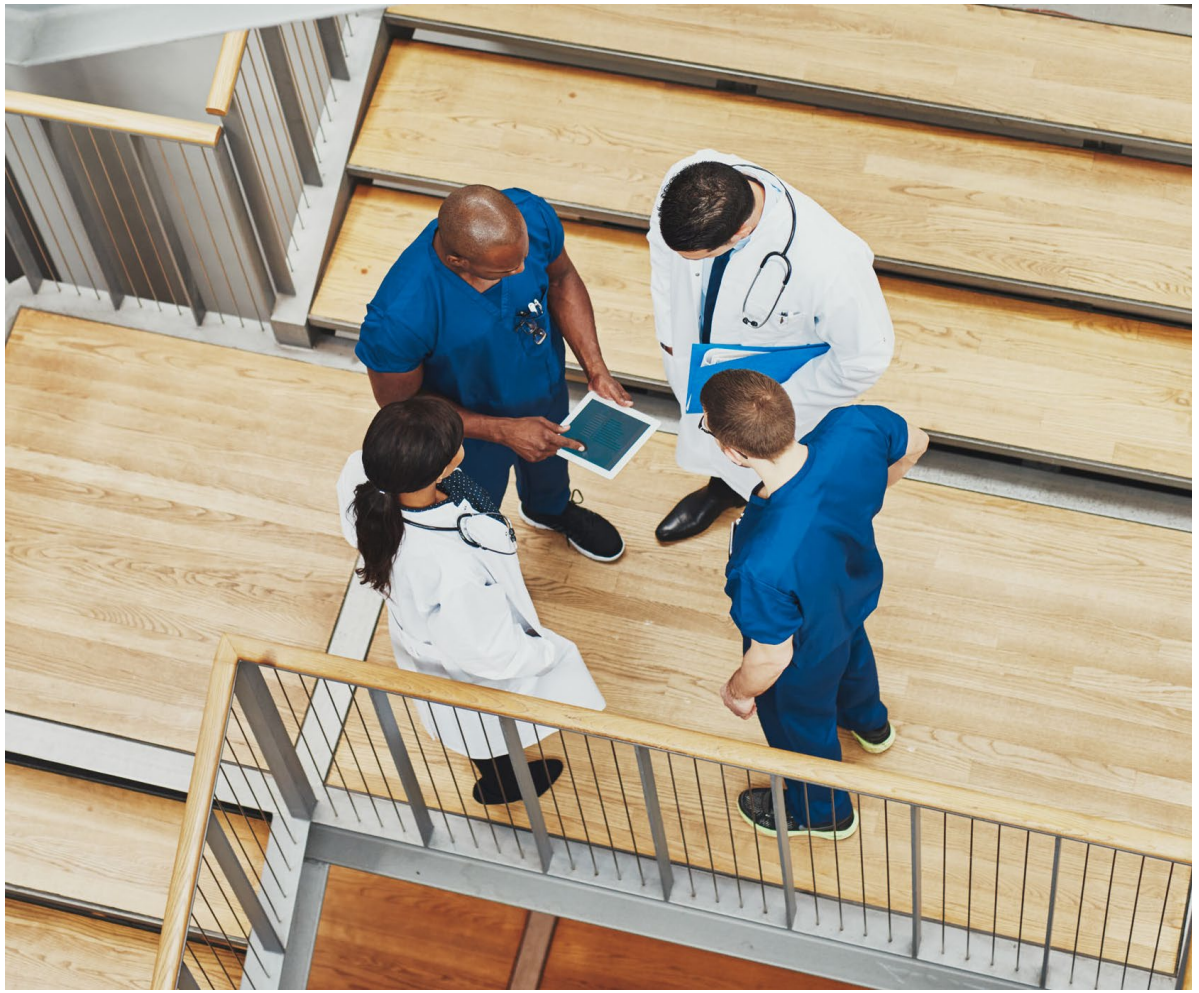
Train staff on swing bed transitions & documentation standards.

Conduct monthly self-audits to help ensure compliance.

Use internal checklists to verify eligibility & documentation completeness.

Avoid common pitfalls:

- Missing the three-day rule
- Incorrect place of service
- Inadequate progress notes



Physician Documentation for Swing Bed Patients

Physician Documentation for Swing Bed Patients

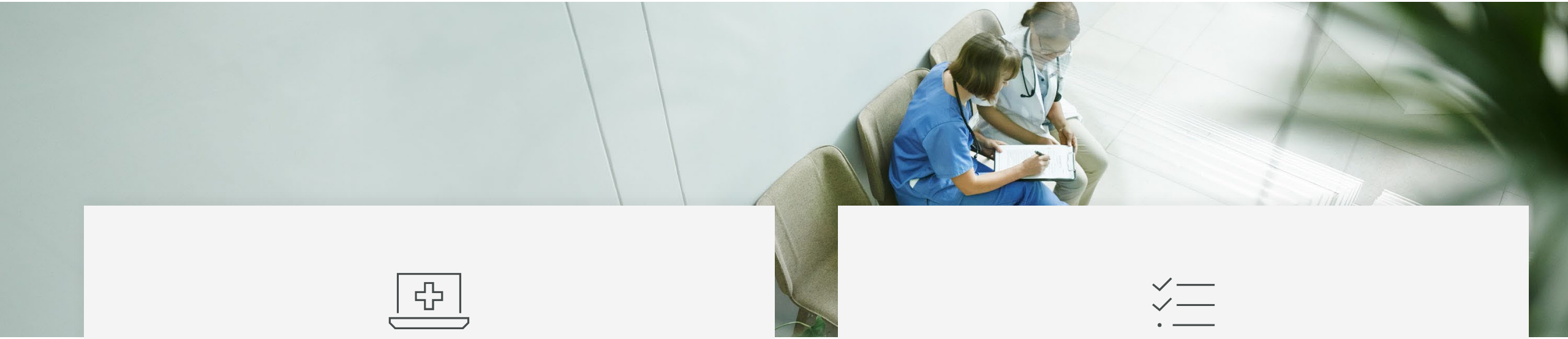
Overview

Overview of required documentation for swing bed patient management

Helps ensure compliance with CMS guidelines & supports sustainable reimbursement

Includes admission, care planning, progress notes, & discharge documentation

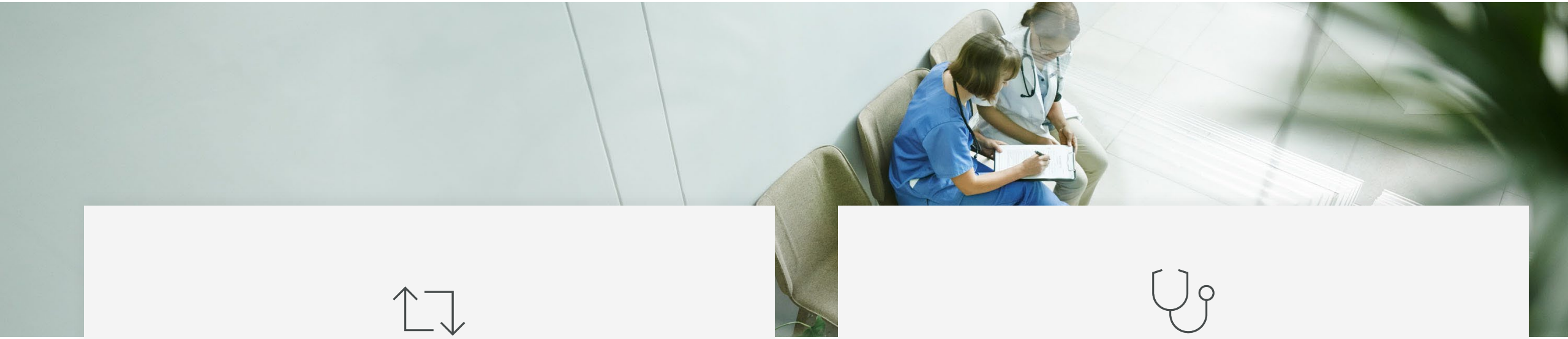
Discharge Documentation From Acute Care



Discharge Summary
Details diagnosis, treatment,
& reason for swing bed transition

Discharge Orders
Indicate end of acute care
& need for skilled services

Swing Bed Admission Orders



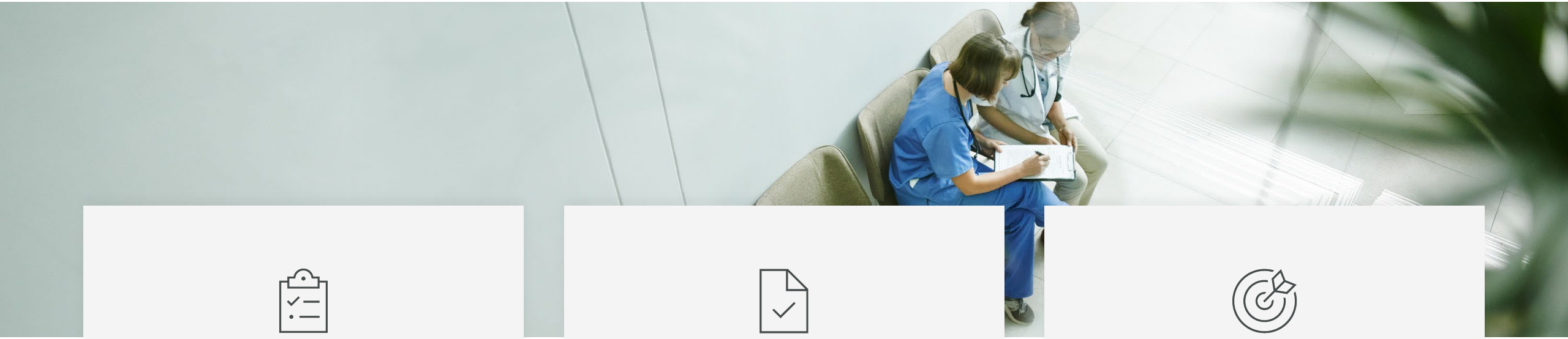
Status Change Order
Document transition from acute to swing bed status

Admission Orders
Include skilled services, medications, & therapy needs

History & Physical (H&P)

Current H&P must reflect patient's condition at swing bed admission

Skilled Nursing Care Plan & Progress Notes

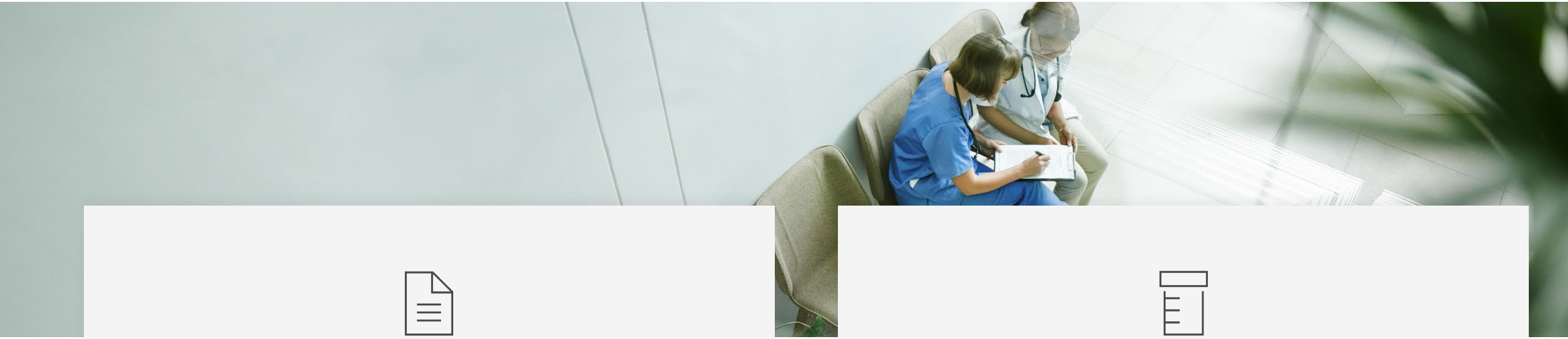


Individualized Care Plan
Goals, interventions, & expected outcomes

Physician must review & sign care plan

Progress Notes
Reflect skilled need & patient response to treatment

Discharge Planning From Swing Bed



Discharge Summary
Required at end of swing bed stay

Follow-Up Orders
Include referrals, medications, & care instructions

Therapy Documentation for Swing Bed Patients

Therapy Documentation for Swing Bed Patients

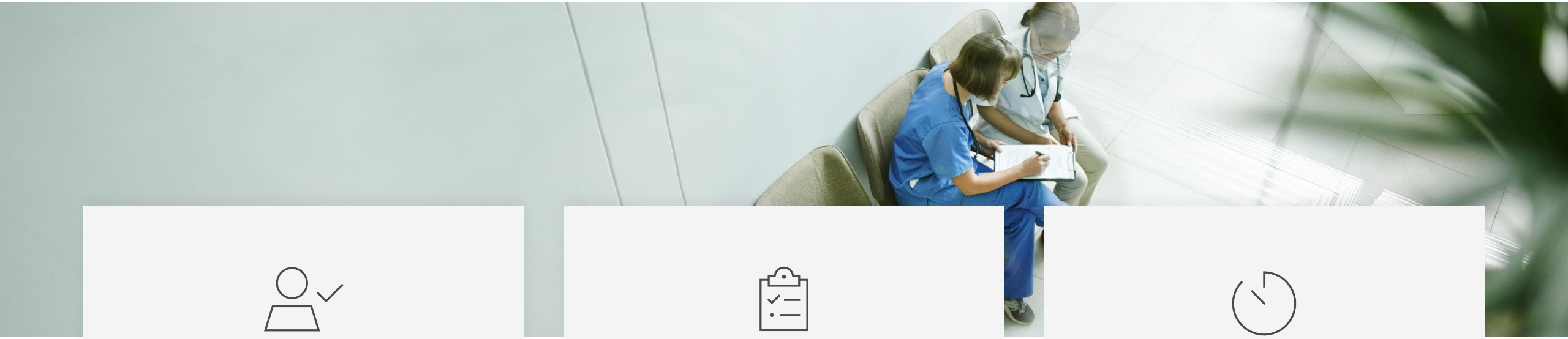
Overview

Overview of therapy documentation requirements

Importance of supporting skilled need & medical necessity

Therapist's role in interdisciplinary care planning

Initial Evaluation

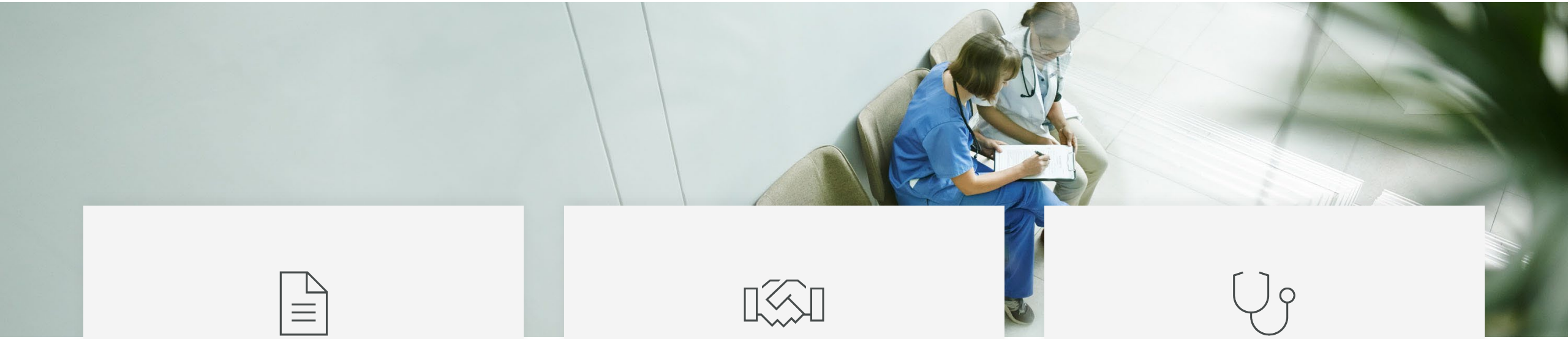


Functional Assessment
Mobility, ADLs, transfers, gait, balance, strength

Justification for skilled therapy services

Measurable, time-bound, patient-specific goals

Plan of Care

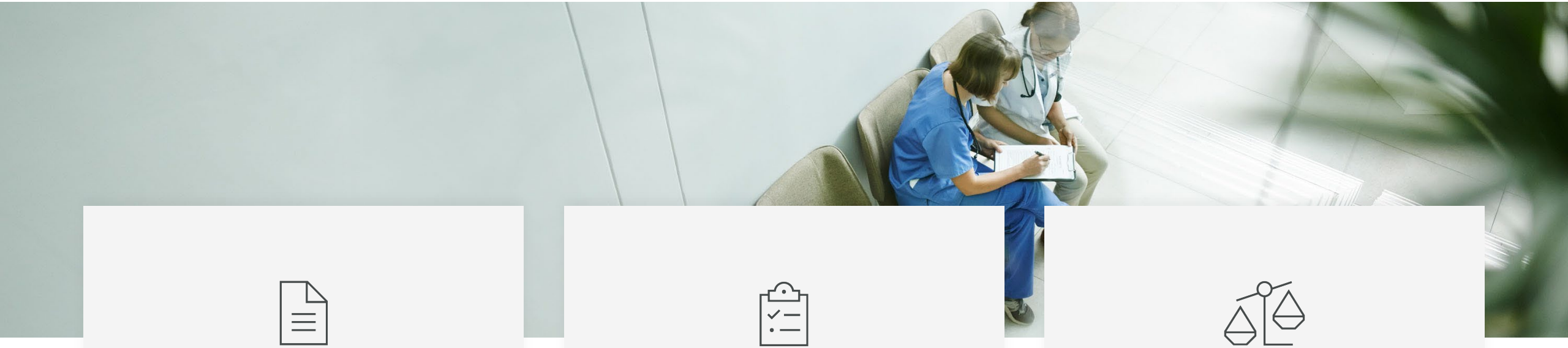


Intervention Plan
Type, frequency, duration of therapy

Coordination with interdisciplinary team (IDT)

Physician orders required for therapy services

Daily Treatment Notes

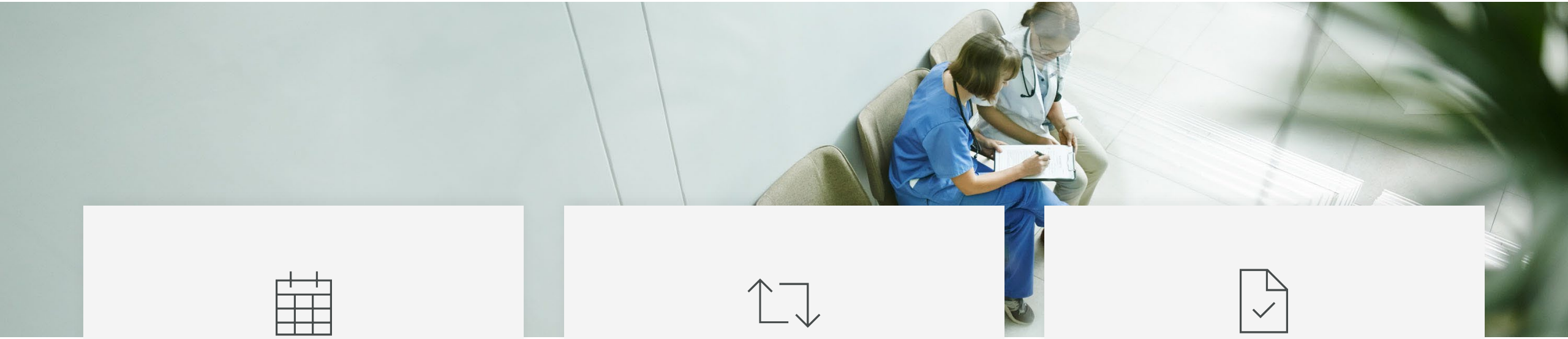


Detail skilled interventions provided, *e.g.*, gait training

Document patient response & progress

Reflect therapist's clinical judgment & care adjustments

Progress Reports & Discharge Summary



Weekly/biweekly updates on progress toward goals

Reassessment & goal updates

Final functional status & recommendations at discharge

Compliance & Best Practices

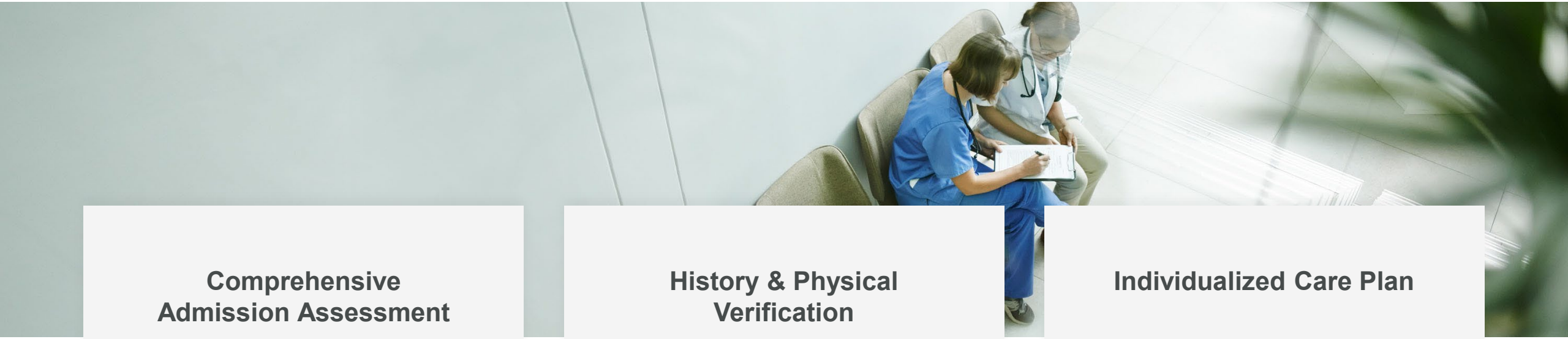
Use objective measures & avoid vague language

Support skilled need with clear documentation

Participate in IDT meetings & discharge planning

Nursing Documentation for Swing Bed Patients

Admission Documentation



Comprehensive Admission Assessment

Nurses perform thorough physical, cognitive, psychosocial, & functional evaluations to guide patient care

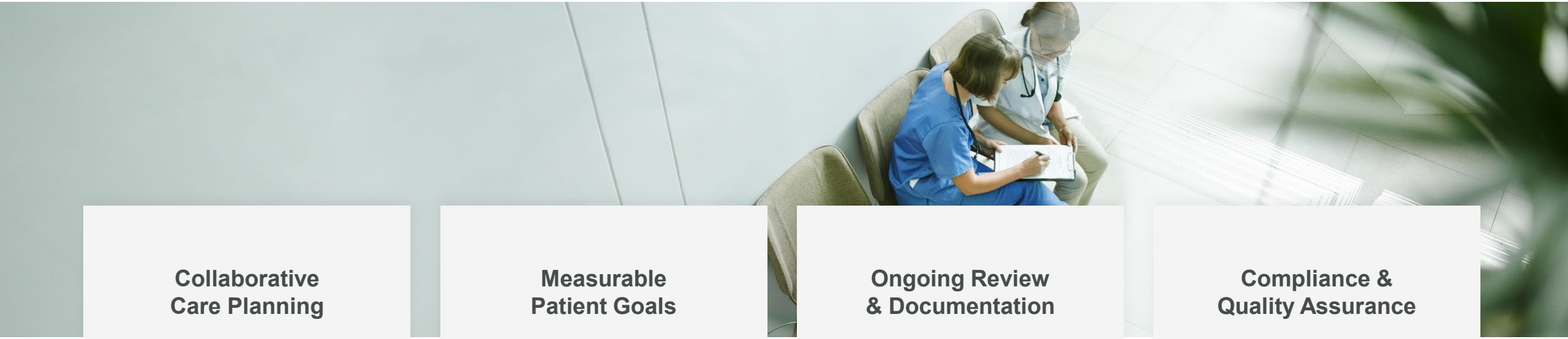
History & Physical Verification

Nurses verify & update the History & Physical to reflect the patient's current condition upon admission

Individualized Care Plan

Care plans are tailored to patient needs with measurable goals to support skilled nursing & collaboration

Skilled Nursing Care Plan



Collaborative Care Planning

Skilled nursing care plans are developed collaboratively with the interdisciplinary team to address patient needs comprehensively

Measurable Patient Goals

Care plans include specific, time-bound objectives such as wound healing, medication management, & improving mobility

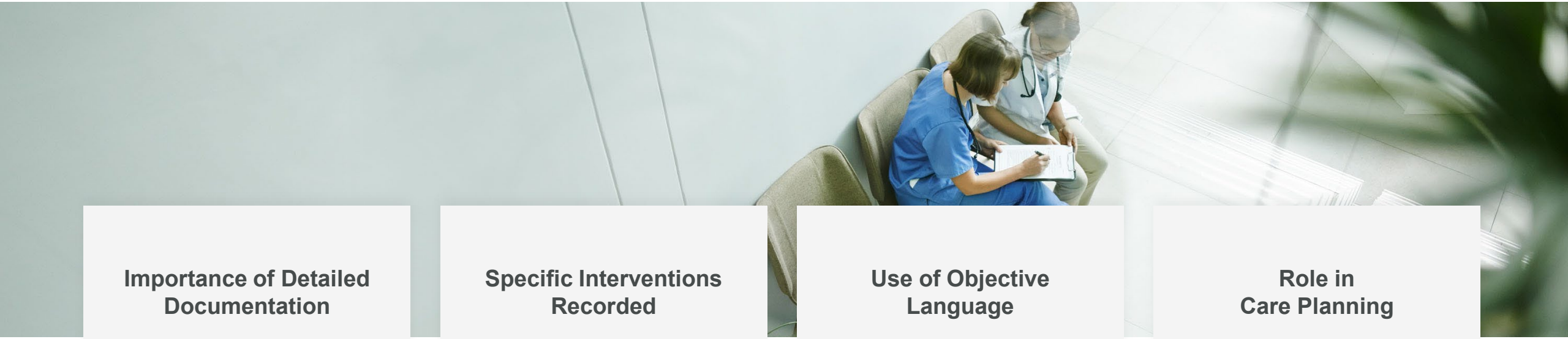
Ongoing Review & Documentation

Regular updates & documentation help ensure the care plan reflects patient progress & changes in condition

Compliance & Quality Assurance

The care plan supports reimbursement & quality assurance by demonstrating medical necessity & skilled nursing services

Daily Skilled Nursing Notes



Importance of Detailed Documentation

Detailed nursing notes document skilled services & patient responses, supporting medical necessity & claim approvals

Specific Interventions Recorded

Notes must include specifics such as wound care, IV therapy, catheter management, & medication administration

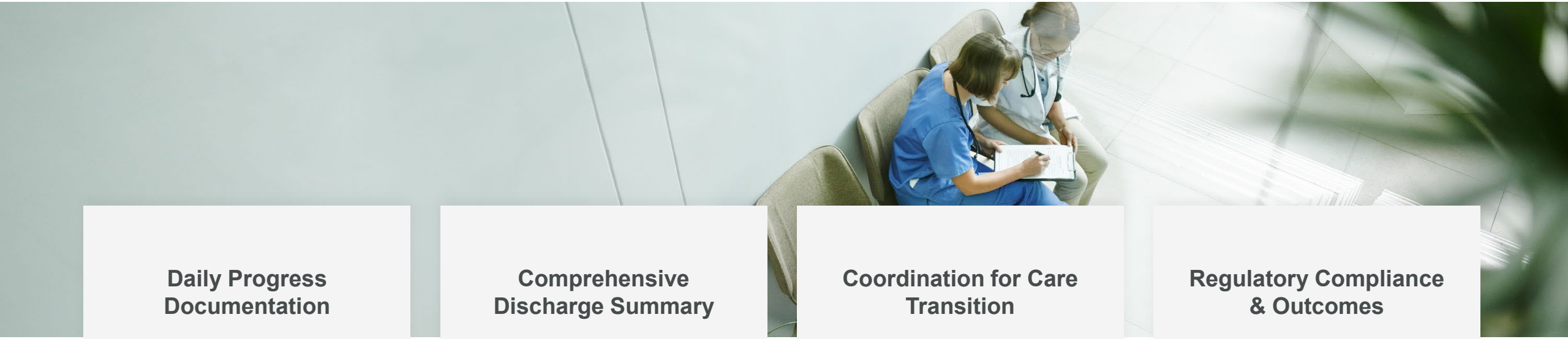
Use of Objective Language

Avoid vague terms; use objective measures to describe patient condition & tolerance to interventions

Role in Care Planning

Nursing notes guide interdisciplinary care plans & treatment decisions through comprehensive documentation

Progress Notes & Discharge Planning



Daily Progress Documentation

Nurses document daily progress notes showing skilled needs & patient advancement toward care goals with objective data

Comprehensive Discharge Summary

Discharge summaries outline final patient status, services provided, outcomes, & patient education on medications & care

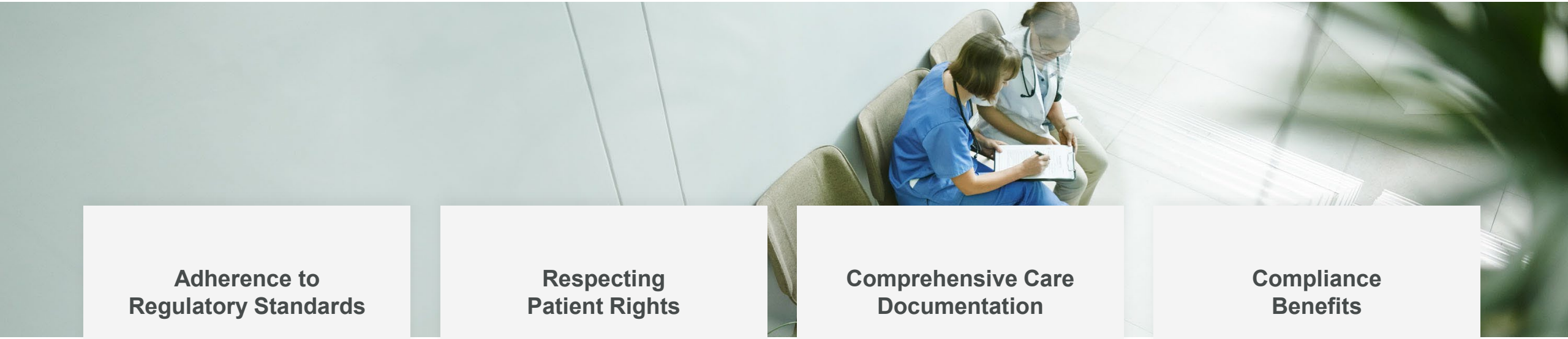
Coordination for Care Transition

Effective discharge planning requires coordination with case management & therapy to ensure smooth patient transitions

Regulatory Compliance & Outcomes

Proper documentation supports patient outcomes & CMS compliance & facilitates appropriate reimbursement for care provided

Regulatory Compliance



Adherence to Regulatory Standards

Nursing documentation must comply with CMS & governing bodies to deliver legal & ethical care

Respecting Patient Rights

Notes must reflect patient autonomy, informed consent, & measures to prevent abuse or neglect

Comprehensive Care Documentation

Documentation should cover assessments, care planning, referrals, & discharge plans to meet conditions of participation

Compliance Benefits

Maintaining compliance helps protect facilities from penalties & supports certification for skilled nursing services

Swing Bed Coordinator Documentation for Swing Bed Patients

Swing Bed Coordinator Documentation for Swing Bed Patients

Objectives

1

Understand documentation needs at each phase of the swing bed patient journey.

2

Identify best practices to support compliance & prevent denials.

3

Equip coordinators with tools to streamline workflows & improve outcomes.

Pre-Admission Documentation

Required Elements:

- Pre-admission assessment tool (clinical status, goals, discharge plan)
- Face sheet, H&P, physician progress notes
- MAR, surgical/procedure reports
- Therapy assessments & progress notes
- Vital signs, I&O, nursing notes (last 48 hrs.)
- Medication reconciliation plan
- Referral source communication summary

Best Practice:

Develop internal checklists & standard templates

Admission Documentation

Required Elements:

- Status change order by physician
- Discharge summary from acute stay
- Swing bed admission physical
- Admission care plan
- History & skilled nursing needs
- Medication reconciliation
- Initial therapy evaluations

Coordinator Role:

- Notify interdisciplinary team
- Assign admitting nurse
- Prepare patient engagement board

Continued Stay Documentation

Required Elements:

- Daily skilled nursing & therapy notes
- Updated care plans & progress notes
- Interdisciplinary team meeting documentation
- Medication reviews & updates
- Patient education logs
- Functional assessments (mobility, ADLs)

Compliance Focus:

- Ensure documentation supports skilled need
- Track quality metrics & patient satisfaction

Discharge Documentation

Required Elements:

- Final progress notes & discharge summary
- Medication reconciliation
- Therapy discharge evaluations
- Patient education & instructions
- Transfer documentation (if applicable)
- Notification to referring provider/facility

Best Practice:

Include discharge planning in IDT meetings early

Best Practices for Coordinators

Conduct monthly self-audits

Train staff on swing bed transitions

Use standardized documentation templates

Maintain survey readiness

Collaborate with billing & compliance teams

Common Pitfalls & Audit Risks

Common Documentation Pitfalls in Swing Bed Programs

- Missed or incomplete three-day qualifying stay
- Inadequate progress notes
- Incorrect place of service (POS) coding
- Missing or vague skilled need justification
- Poor medication reconciliation
- Lack of interdisciplinary team (IDT) documentation
- Incomplete discharge planning
- Failure to document functional progress
- Missing occurrence code 70 or status change orders
- No self-audit or quality review process

Implementing the Transforming Episode Accountability Model (TEAM)

Skilled Nursing Facility Three-Day Rule Waiver

- CMS will allow acute care hospitals that participate in TEAM to discharge patients without a three-day hospital stay to a qualified skilled nursing facility (SNF) or swing bed provider, including a CAH.
- The patient must meet the eligibility criteria for TEAM and have a qualifying outpatient procedure or hospital inpatient stay prior to admission to the SNF.
- The admission date to the SNF must happen no later than 30 days after the hospital or outpatient department discharges the patient.
- CMS will pay for services when the SNF claim meets certain payment criteria, including submitting the claim with the required TEAM demonstration code A9.

9/16/2025

Key Takeaways

- **Train Staff on Standards**
- **Conduct Monthly Self-Audits**
- **Use Internal Checklists**
- **Avoid Common Pitfalls**
- **Support Skilled Needs With Clear Documentation**

Watch On Demand

Swing Bed Programs: Understanding the Basics

Swing Bed Programs: Navigating the Pre-Admission Process

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