Medicare Insider

Note from the instructor: Use of swing beds during the COVID-19 public health emergency

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There have been many unique blanket waivers and regulatory flexibilities implemented by the Trump Administration and CMS over the past few months while hospitals, providers, and suppliers struggle to contain the spread of 2019 Novel Coronavirus Disease (COVID-19). These waivers, many of which are retroactive to March 1, 2020, will remain in effect through the end of the public health emergency (PHE).

Skilled nursing facility (SNF) waivers

In addition to the 1135 waiver authority, Section 1812(f) of the Social Security Act authorizes the Secretary to provide coverage for a SNF stay in the absence of a three-day acute care qualifying hospital stay. Typically, the patient must have been an inpatient in an acute care hospital for a minimum of three consecutive days (three midnights) within 30 days prior to a SNF or swing bed admission. Types of hospitals that are appropriate for consideration of a preceding inpatient hospitalization include an acute care prospective payment system (PPS) hospital or a critical access hospital (CAH); an inpatient psychiatric or rehabilitation hospital; or a long-term acute care hospital.

For certain beneficiaries who exhausted their SNF benefits, this waiver also authorizes renewed SNF coverage without first having to start and complete a 60-day "wellness period" (i.e., the 60-day period of non-inpatient status that is normally required in order to end the current benefit period and renew SNF benefits). This waiver will apply only for those beneficiaries who have been delayed or prevented by the COVID-19 emergency from commencing or completing the 60-day "wellness period" that would have occurred under normal circumstances.

Swing bed waivers

Through the usual CMS certification and licensure, certain rural hospitals and CAHs may use their beds for either acute care or post-hospital SNF care. These beds are referred to as "swing beds" and are intended to increase Medicare beneficiaries' access to post-acute SNF care in their own communities.

A rural hospital can be authorized to provide swing bed services when it is located in a defined rural area, has less than 100 licensed beds, is a Medicare participating provider, has not had swing bed approval terminated within two years prior to application resubmission, and has not had a 24-hour nursing waiver granted.

Under normal circumstances, a CAH may maintain no more than 25 acute care inpatient beds. A CAH with Medicare swing bed approval may use any of its inpatient beds for either inpatient or SNF-level of care services. During the current PHE, the Secretary has waived 42 *CFR* §485.610(b) and (e) and 42 *CFR* §485.620. This permits a CAH to operate outside of a defined rural area to allow for temporary surge site locations, off-site locations, and CAHs without walls. This waiver also allows a CAH to operate more than the usual 25 beds maximum limitation and treat inpatients beyond the usual length of stay limitation of 96 hours upon admission (i.e., good faith certification). Under this waiver, a CAH may also increase its capacity of swing beds to assist community SNFs in the prevention of spreading COVID-19.

Usually, an approved hospital or CAH does not have to locate its swing beds in a special section of the facility unless the hospital's or CAH's policy or physical plant requires it. During the PHE, swing beds may be located in a temporary surge site. A hospital or CAH can also enter into a contractual agreement with a SNF to be a facility without walls and operate as a temporary expansion site for SNF care in the hospital or CAH. Under this arrangement, the SNF will bill Medicare for the services and the SNF pays the hospital. This type of arrangement is normally part of a SNF's emergency preparedness plan to facilitate the exchange of patients and information during natural disasters and other emergencies. However, swing bed services in a hospital or CAH cannot be provided in rehabilitation or psychiatric distinct part units, intensive care-type units, or newborn beds, even during the PHE.

All of the documentation requirements remain in effect during the PHE and must support admission to a SNF level of care, including acute care discharge orders and related discharge summary, admission orders to swing bed status in the same or different hospital or CAH, and progress notes supporting the medical necessity of the SNF level of care. In addition, the hospital or CAH must have a discharge planning process that focuses on patient goals and treatment preferences. If the hospital or CAH is unable to find placement for the patient in a SNF, documentation should support

the swing bed length of stay, as well as communication and placements efforts of the facility.

If a hospital or CAH has not obtained swing bed approval in normal circumstances or under the PHE, or if it has been unable to enter into an arrangement with a SNF, a physician must certify that the continued inpatient stay is medically necessary and the hospital will continue to be paid under its usual payment system (IPPS or cost) until a SNF bed is available.

Expansion of swing bed services

On May 15, CMS updated its guidance, Hospitals: CMS Flexibilities to Fight COVID-19, that allows any Medicare-enrolled hospital (except psychiatric and long-term care hospitals) to offer swing bed services to patients who do not require acute care but do meet the SNF level of care criteria. Under the 1135 waiver, CMS is waiving the requirements at 42 *CFR* §482.58, to allow hospitals to establish SNF swing beds payable under the SNF PPS to provide additional options for hospitals with patients who no longer require acute care but are unable to find placement in a SNF.

In order to qualify for this waiver, hospitals must:

- Not use SNF swing beds for acute inpatient care
- Comply with all other hospital and SNF *Conditions of Participation* to the extent not waived
- Be consistent with the state's emergency preparedness or pandemic plan.

To add swing bed services during the PHE, hospitals and CAHs must call their Medicare Administrative Contractor (MAC) enrollment hotline and must attest to CMS that:

- The hospital or CAH has made a good faith effort to exhaust all other options
- There are no SNFs within the hospital's or CAH's catchment area that under normal circumstances would have accepted SNF transfers, but are currently not willing to accept or able to take patients because of the COVID-19 PHE
- The hospital or CAH meets all waiver eligibility requirements
- The hospital or CAH has a plan to discharge patients as soon as practicable, when a SNF bed becomes available, or when the PHE ends, whichever is earlier

In addition, if a CAH wishes to increase its number of swing beds beyond the usual 25 bed inpatient limitation, the CAH must make a formal request to their MAC through the enrollment hotline.

Billing and payment for swing bed services during the PHE

Swing bed services are billed on Type of Bill (TOB) 018X, regardless of whether the services are provided by a hospital or CAH. If the services are provided under the 1135 waiver, condition code DR must also be reported on the claim. This includes when the three-day acute care qualifying stay is waived prior to admission to the swing bed or in a CAH with approved swing beds and the 25-bed limitation is exceeded.

The National Uniform Billing Committee defines condition code DR (disaster related) to be "used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster." The DR condition code is used only for institutional billing on the CMS-1450/UB-04 form or in the 837I electronic format. Effective August 31, 2009, use of condition code DR is mandatory for any claim for which Medicare payment is conditioned directly or indirectly on the presence of a "formal waiver."

Under the various 1135 waivers, payment for swing bed services remains the same. Medicare will pay for these services under the SNF PPS for hospitals providing swing bed services under the waiver (excluding CAHs). The SNF PPS covers all beneficiary-provided services under a Part A covered SNF stay, except some separately-payable Part B services. In order for a hospital to be paid under the swing bed waiver, the hospital must complete the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) through a free software application called jRAVEN.

For CAHs, their swing bed services are exempt from the SNF PPS, and Medicare instead pays them based on 101% of the reasonable cost of the services or a per-diem rate. CAHs are not required to complete the MDS RAI regardless of whether the CAH is licensed for swing beds or is expanding its swing bed capacity under the PHE.

Since announcement of the waiver that allows hospitals to provide swing bed services outside of the usual licensure and certification requirements, hospitals who do not have experience in swing bed billing and SNF PPS payment have raised many questions about how to provide, document, and bill for the SNF level of care provided under the PHE.

On May 20, 2020 CMS released *Special Edition MLN Matters 20018* to provide additional clarification. Hospitals that

have attested to their MAC under the waiver may want to hold swing bed claims for a review to ensure that the services are documented and billed correctly the first time.

Practitioner visits to swing bed patients

One of the other areas that causes confusion for hospitals and CAHs that bill for professional services related to swing bed services is that even though the bed "swings" between an acute care bed and a skilled bed, the appropriate SNF professional CPT codes must be billed when practitioners provide services to swing bed patients. There must be good communication between the hospital or CAH and the practitioner, since many times the patient remains in the same room or bed for both acute care and swing bed services.

In a recent RAC audit, physicians and non-physician practitioners (NPP) billed for inpatient hospital care (99221-99223, 99231-99233, and 99238-99239) in error, as those claims should have been billed as SNF care.

A physician or NPP should report the most appropriate initial nursing facility care evaluation and management (E/M) CPT code (99304-99306) or subsequent nursing facility care code (99307-99310), even if the E/M service is provided prior to the initial federally mandated visit. The E/M discharge day management visit (99315-99316, 99318) should be reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date.

To allow for flexibility for physician visits to swing bed patients, CMS is waiving the requirement in 42 *CFR* §483.30 for physicians and NPPs to perform in-person visits for SNF patients and allow visits to be conducted via telehealth or other remote communication options. However, the nursing facility E/M codes are not approved for audio-only visits at this time.

Under the waiver, physicians may also delegate any required visit to a nurse practitioner, physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the state, and performing within the state's scope of practice laws. Under this waiver, the delegated task must continue to be under the supervision requirements of the physician.

Note: The COVID-19 Public Health Emergency has required an active and frequently changing response from regulatory authorities and Congress. This guidance is up to date as of May 26, 2020. Please monitor the CMS current emergencies page as well as the COVID-19 stakeholder call transcripts page and the MLN Connects page for the most current information, as well as operational and implementation guidance.