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Swing beds and the MDS

by Reta Underwood, ADC

Unique in their own way, “swing beds” provide the patient, physician, and rural communities another avenue of care and an opportunity to further stabilize acute physical situations without having to travel great distances to access Medicare Part A skilled long-term care benefits. However, due to the complexity of the Prospective Payment System (PPS), OBRA regulations, and acute versus long-term care and rehabilitation, many misunderstandings between swing beds and skilled nursing facilities have developed over the years. Let's take a look at the basic swing bed hospital nomenclature.

What is a swing bed? Swing bed hospitals are located in rural areas and must have 99 or less acute-care beds. The swing beds are used in the same manner as a Medicare skilled nursing facility.

What type of patient uses a swing bed? Medicare eligibility rules are applied to swing bed placement. The patient must have Medicare Part A insurance and have had a medically necessary three-day hospital stay, receive Part A care within 30 days of the qualifying hospital stay, Part A care needed for a condition which was treated during the qualifying hospital stay, and receive a skilled level of care—either skilled nursing or skilled rehabilitation.

Why do swing bed hospitals use the SB-MDS? Swing bed hospitals use the SB-MDS for Medicare Prospective Payment System (PPS) for payment-only reasons.

What is the most obvious difference of the SB-MDS compared to the MDS v2.0? The SB-MDS contains 45 PPS calculation questions. Questions 1-16 are resident demographic in nature with questions 17–45 providing the necessary clinical data for RUG-53 calculation.

Are there any documentation pitfalls with the SB-MDS? Yes, just like the traditional MDS v2.0, the SB-MDS requires all care providers to know its terminology and definitions. Then these staff members must apply it to their documentation in the medical record. This is a daunting and difficult task. Often the patient doesn't change beds, only payment classification. If staff are not provided with systems and tools to assist them in Medicare and SB-MDS documentation, providers risk inaccurate assessment that will result in an inaccurate RUG-53 calculation. These types of errors usually result in loss of revenue.

What documentation minimums assist with these pitfalls? There are some must haves!

- An ADL form that allows all shifts to document. Because the SB-MDS looks at the patient in a 24-hour scenario, it is important to capture patient differences from day, evening, and night.
- Skilled nurse charting formatted so that its focus is on the patient's skilled nursing need. This will assist in eliminating the unnecessary minutia and allows staff to concentrate, be thorough, and concise when documenting.
- Skilled therapy service logs that track provided patient days and minutes.
- A standardized physician certification form.

Which items on the SB-MDS are often missed or inaccurately assessed? The most frequent inaccuracy used on the SB-MDS is Question 10 Assessment Reference Date (ARD). It is often not “set” to maximize the PPS RUG-53 system calculation, resulting in many hospitals shortchanging swing bed reimbursement.

Are there any skilled services that the SB-MDS captures that SB hospitals do not often provide? Yes, Question 39 Nursing Rehabilitation/Restorative Care. This is often not provided due to the short length of stay or not having a formalized program in place.

What staff misconceptions have you encountered relating to the SB-MDS? The misconception of more paperwork! In reality, it isn't any more paperwork, but it does require changing the focus from “acute” to “stabilized” and implementing a formatted documentation system to assist staff.

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