



Quality
Insights

Renal Network 5

Involuntary Discharge Packet

For interpretative guidance on the CMS ESRD facilities Conditions for Coverage visit our website at <http://www.esrdnet5.org>

This packet contains vital information pertaining to the Involuntary Discharge Process as outlined in the Centers for Medicare & Medicaid Services ESRD Facilities Conditions for Coverage. Please read carefully.

- The Network must be notified by phone or in writing **30 days prior** to the discharge.
- This entire packet must be completed on all involuntary discharges and sent to the Network office **prior to** the discharge.
- Completed packets for documented cases of immediate and severe threat must be sent **within 48 hours** of the discharge.

All information on pages 3-5 must be completed in full and faxed to:

**Quality Insights Renal Network 5
Renee Bova-Collis LCSW
Fax: (804) 320-5918
Office: (804) 320-0004, extension 2705**

Do not send this information by email due to HIPAA requirements.

§ 494.180 Condition: Governance

(f) Standard: Involuntary Discharge and Transfer Policies and Procedures

The governing body must ensure that all staff follows the facility's patient discharge and transfer policies and procedures. The medical director ensures that no patient is discharged or transferred from the facility unless:

- (1) The patient or payer no longer reimburses the facility for the ordered services;
- (2) The facility ceases to operate;
- (3) The transfer is necessary for the patient's welfare because the facility can no longer meet the patient's documented medical needs; or
- (4) The facility has reassessed the patient and determined that the patient's behavior is disruptive and abusive to the extent that the delivery of care to the patient or the ability of the facility to operate effectively is seriously impaired, in which case the medical director ensures that the patient's interdisciplinary team:
 - (i) Documents the reassessments, ongoing problem(s), and efforts to resolve the problem(s), and enters this documentation into the patient's medical record;
 - (ii) Provides the patient and **ESRD Network 5** with a **30-day** notice of the planned discharge;
 - (iii) Obtains a written physician's order that must be signed by both the medical director and the patient's attending physician concurring with the patient's discharge or transfer from the facility;
 - (iv) Contacts another facility, **attempts to place the patient there, and documents that effort;** and
 - (v) Notifies the State survey agency of the involuntary transfer or discharge.
- (5) In the case of immediate severe threats to the health and safety of others, the facility may utilize an abbreviated involuntary discharge procedure.

Involuntary Discharge Checklist for Dialysis Facilities

If you have made the decision to involuntarily discharge a patient, complete the attached information to ensure compliance with the Conditions for Coverage. **Remember:** The Network requires this documentation for all involuntary discharges. Be aware that your submitted documentation is the only paper evidence of the situation for the Network review. **This information is to be completed and faxed to the Network PRIOR to discharge or within 48 hours of an immediate discharge.**

Demographic Information

Patient Name _____ Date of Birth _____

First Date of Dialysis _____ Gender _____ Race _____

Insurance Provider _____

Facility Provider Number: _____ *(Tip: this is the facility's six digit Medicare provider number. If you are an AL facility your provider number will begin with 01, if you are a MS facility your provider number will begin with 25, if you are a TN facility your provider number will begin with 44).*

Name and title of person completing this form (**please print**): _____

Facility telephone number _____ Facility Fax Number _____

Name of Facility Medical Director _____

Name of Patient's Attending Physician _____

Name of Facility Administrator _____

Involuntary Discharge Information

Date of Last Treatment _____ Date Facility Notified Network _____

Date Facility Notified the State Survey Agency _____

Date patient was notified of Discharge _____ Date of Anticipated Discharge _____

Part I: Reason for Discharge

- Non-Payment for services ordered
- Cannot meet documented medical needs
- Ongoing disruptive and abusive behavior
- Immediate severe threat to health and safety of others

Other - *note: CMS Conditions for Coverage only allows the listed reasons for discharge. If the discharge is due to the physician terminating the relationship with the patient, include documentation of the facility's efforts to place the patient with another physician and/or at another facility.* Comment: _____

Please provide a brief description of the incident(s) leading to the involuntary discharge (Please attach all pertinent documentation):

*****NOTE: Even with attached documentation, this section must be completed.*****

Part II: Mental Health Assessment

Mental Health Problem/Diagnosis Reported: Yes No

If yes, provide explanation and/or diagnosis (attach physician documentation)

Chemical Dependency/Abuse Reported: Yes No

If yes, provide explanation and/or diagnosis (attach documentation)

Cognitive Deficit Reported: Yes No

If yes, provide explanation and/or diagnosis (attach physician documentation)

Part III: Patient's Disposition

(Where will the patient dialyze immediately after discharge):

- Unknown
- Admitted to another Outpatient Facility
- Patient in Correctional Facility
- Patient Died
- Patient Transplanted
- Not Admitted to another Outpatient Facility – Other – Comment _____
- No Outpatient Facility Accepts – Hospital Acute
- No Outpatient Facility Accepts – Other – Comment _____

Part IV: Required Documentation

- Patient discharge letter or transfer notice
- Police Report (*if applicable*)
- Facility's discharge and transfer policy/procedure
- Facility's patient rights and responsibilities document
- Documentation of facility's inability to meet patient's medical need (*if applicable*)
- Copies of patient's interdisciplinary reassessments
- Documentation of ongoing problem and efforts to resolve
- Medical Director and attending Physician's signed order
- Documentation of efforts to relocate patient
- Documentation of facility notifying State Survey Agency of discharge
- Other: _____

Part V: State Survey Agency Contact Information

Facilities are required to notify their state survey agency(s) of involuntary discharges.

Maryland	Maryland Office Of Health Care Quality Bland Bryant Bldg 55 Wade Ave Catonsville, MD 21228 AND Maryland Commission on Kidney Disease 4201 Patterson Avenue, Room #310 Baltimore, MD 21215	1-800-492-6005 1-866-253-8461
Virginia	Virginia Department Of Health 9960 Mayland Drive Suite #401 Henrico, VA 23233 A written summary is required.	1-800-955-1819 Fax: 804-527-4503
West Virginia	Office Of Health Facility Licensure and Certification 408 Leon Sullivan Way Charleston, WV 25301-1713	1-304-558-0050
District of Columbia	DC Department Of Health Health Care Facilities Division 899 North Capital Street NE 2 nd Floor Washington, DC 20002	1-202-724-8800

Part VI: CROWNWeb Entry

When reporting an involuntary discharge in CROWNWeb, please remember to report the “discharge reason” as “Involuntary.” Do not list the reason as “Discontinue,” “Other,” or “Transfer.” Even if you know the patient was accepted at another facility, and you have submitted an involuntary discharge packet to the Network, you still report the discharge reason as “Involuntary.”

Developed by Alliant Quality Kidney Collaborative and adapted and revised with permission.