Involuntary Discharge Packet

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

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  ☐ 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: ____________________

☐ Cannot meet documented medical needs

☐ Ongoing disruptive and abusive behavior

☐ Immediate severe threat to health and safety of others

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.

<table>
<thead>
<tr>
<th>State</th>
<th>Contact Information</th>
<th>Telephone</th>
</tr>
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| 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 | 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  
2nd 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.*