



Quality
Insights

Renal Network 4

1586 Sumneytown Pike #1470
Kulpsville, PA 19443
1-610-265-2418
1-800-548-9205 (patients only)
www.qirn4.org

Involuntary Discharge & Involuntary Transfer Packet

This packet contains vital information pertaining to both the Involuntary Discharge and Involuntary Transfer process as outlined in the Centers for Medicare & Medicaid Services ESRD Facilities Conditions for Coverage.

<http://cms.gov/Center/Special-Topic/End-Stage-Renal-Disease-ESRD-Center.html?redirect=/center/esrd.asp>

- The Network AND State Survey Agency must be notified by phone or in writing 30 days prior to an involuntary discharge or involuntary transfer.
- This entire packet must be completed for all Involuntary Discharges and all Involuntary Transfers then **fax** the completed packet to the QIRN4 office prior to the involuntary discharge or involuntary transfer.
- This packet must also be completed in its entirety for all cases of immediate and severe threat then **fax** the completed packet to the QIRN4 office WITHIN 24 hours of the discharge.
- Retain a copy of this completed packet in the patient's medical record.

For interpretative guidance on the CMS ESRD facilities Conditions for Coverage visit the CMS website at: <http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/downloads/esrdfinalrule0415.pdf>

All information must be completed in full and faxed to QIRN4 prior to the patient's discharge from the facility.

Fax all information to:
Quality Insights Renal Network 4
Attention: Patient Services Department
Fax: (610) 783 - 0374

IMPORTANT

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

The End Stage Renal Disease Network for Pennsylvania and Delaware



§ 494.70 and § 494.180 Conditions for Coverage
Involuntary Discharge and Transfer Policies and Procedures

No facility takes lightly the involuntary discharge/transfer of a patient. Challenging patient situations are often the result of unresolved issues involving both the patient and staff.

The Conditions for Coverage are clear about the facility's responsibility to ensure that staff have and use appropriate skills to manage challenging patient situations in the dialysis clinic. The Conditions also state the parameters for implementing an involuntary discharge/transfer.

Please note: Non-compliance is not an acceptable reason for an involuntary discharge/transfer.

In the unlikely event that your facility is faced with making a decision about involuntarily discharging/transferring a patient, you must comply with the CMS directives and make sure all your efforts are documented in the patient's medical record. You must complete and document:

1. Initial problem assessment and plan of care addressing interventions and goals;
2. Documentation of interventions over a period of time;
3. Documentation of patient's response to interventions;
4. If a behavior contract is appropriate then reassessment after contract implemented;
5. If discharge is for nonpayment, documentation showing assistance provided to link patient with potential payment sources and the outcome of those referrals;
6. Discharge notification letter sent to patient (**30 days prior**);
7. Contact Quality Insights Renal Network 4 Patient Services at (610) 265-2418 extension: 2831 regarding the issuance of the 30 day notice;
8. Discharge order signed by attending physician and medical director;
SEND COPY OF DISCHARGE LETTER AND ALL MEDICAL RECORDS RELATED TO THE INVOLUNTARY DISCHARGE/TRANSFER TO QIRN4 FOR REVIEW.
9. Facility responsibility at time of discharge:
 - a. Every effort must be made to transfer patient to another out-patient facility. Documentation must show such efforts were extensive and all avenues were pursued;
 - b. If no out-patient facility will accept patient, facility must provide patient with acute care resources and advise patient about the medical ramifications of not receiving dialysis when ordered by a physician, i.e. fluid overload, congestive heart failure, death; and
 - c. Facility must notify the State Survey Agency of the involuntary discharge / transfer 30 days prior to the discharge / transfer.

Pennsylvania Department of Health, Delaware Department of Health,
Telephone: 1-877-724-3258 Telephone: 302-283-7220

10. In the case of an immediate severe threat to the health and safety of others, the facility may utilize an abbreviated involuntary discharge / transfer procedure.



Involuntary Discharge / Transfer Checklist for Dialysis Facilities

If you have made the decision to either Involuntarily Discharge or Involuntarily Transfer a patient then you **MUST** complete the attached forms to ensure compliance with the Conditions for Coverage.

Remember: The Network requires this documentation for **ALL** Involuntary Discharges and **ALL** Involuntary Transfers. Be aware that your submitted documentation is the only paper evidence of the situation for the Network’s review. This information must be completed and faxed to the QIRN4 office **30 DAYS PRIOR** to discharge or transfer OR within **24 hours** of an immediate discharge or transfer.

Demographic Information

Patient Name: _____ Date of Birth: ____ / ____ / ____

Facility Provider Number: _____ *(Tip: this is the facility’s six digit Medicare provider number. If you are a DE facility your provider number will begin with 08. If you are a PA facility your provider number will begin with 39).*

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 / Transfer Information

Date of Last Treatment: ____ / ____ / ____ Date Facility Notified Network: ____ / ____ / ____

Date Facility Notified the State Survey Agency: ____ / ____ / ____

Date patient was notified of Discharge / Transfer: ____ / ____ / ____

Date of Anticipated Discharge / Transfer: ____ / ____ / ____



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Part I: Reason for Discharge

- Non-Payment for ordered services
- Facility ceases to operate*
- 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 aforementioned reasons for discharge. If the discharge is due to the physician terminating the relationship with the patient, this is considered an invalid reason for discharge per the CMS Conditions for Coverage:* Comment: _____

*For facility closures, complete only one packet and attach a list of ALL the patients who are being discharged and their disposition. Skip Parts II and IV.

Please provide a brief description of the incident(s) leading up and including the incident that necessitated the involuntary discharge (Please attach all pertinent documentation): **NOTE: Even with attached documentation this section must be completed.**

Part II: Mental Health Assessment

*Not required for a facility closure

Mental Health Problem/Diagnosis Reported: Yes No

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



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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?)

**For facility closure attach a copy of your census with the disposition of each patient.*

- Admitted to another Outpatient Facility: Medicare provider # of the admitting facility _____
- Patient in Correctional Facility
- Patient Date of Death _____
- Patient Date of Transplant _____ Medicare provider # of the transplant center _____
- Not Admitted to another Outpatient Facility – Hospital Acute _____
- Other – Comment _____



Part IV: Required Documentation*

**Not required for a facility closure*

	Date Sent to QIRN4 office:
<input type="checkbox"/> Patient discharge letter or transfer notice	/ /
<input type="checkbox"/> A copy of the Facility's discharge/transfer policy and procedure	/ /
<input type="checkbox"/> A copy of the Facility's patient rights and patient responsibilities	/ /
<input type="checkbox"/> Medical Director signed approval of the patient discharge/transfer order	/ /
<input type="checkbox"/> Attending Physician signed approval of the patient discharge/transfer order	/ /
<input type="checkbox"/> Copy of the patient assessment, plan of care and reassessment(s)	/ /
<input type="checkbox"/> Documentation of ongoing problem(s) and ALL efforts to resolve problem(s)	/ /
<input type="checkbox"/> Documentation of facility's inability to meet patient's medical need(s) (if applicable)	/ /
<input type="checkbox"/> Documentation of ALL efforts to locate another facility for the patient	/ /
<input type="checkbox"/> Documentation that State Survey Agency was notified of the discharge/transfer	/ /
<input type="checkbox"/> Police Report (if applicable)	/ /
<input type="checkbox"/> Other:	/ /

Part V: State Survey Agency Contact Information

Pennsylvania	Pennsylvania Department of Health Health and Welfare Bldg. 8th Floor West 625 Forster Street Harrisburg, PA 17120	1-800-254-5164 or 1-877-724-3258
Delaware	Delaware Department of Health 258 Chapman Road, Suite 101 Newark, DE 19702	1-800-942-7373 or 1-302-283-7220

**QIRN4 strongly encourages that each facility call and confirm that all of their
faxed documents have been received at QIRN4.**

Phone (610) 265-2418 ext 2831 or ext 2830

The End Stage Renal Disease Network for Pennsylvania and Delaware