Discharging Patients:

CMS Rules Regarding Appropriate Discharges, EQRS Reporting, and Expectations for Readmission

The Network has become aware of facilities utilizing the Lost to Follow-Up status in EQRS as a means of discharging non-adherent patients, which is incorrect. Additionally, and equally incorrect, are facility refusals to readmit patients who have been out of the facility over 30 days. ***Non-adherence alone, is not a recognized, sanctioned reason for involuntary discharge.*** Until there is a legitimate handoff to another provider, the patient officially withdraws from treatment or deceases, the patient remains your facility's responsibility for care.

Use the following tables for EQRS data submission/input guidance.

EQRS Admit/Discharge Reasons

ADMIT REASONS: Required within 5 business days of first treatment	
NEW ESRD PATIENT	Initial 2728 required • ESRD patient has first chronic outpatient dialysis in the U.S. Includes: o Puerto Rico, Guam, Mariana Islands, American Samoa, U.S. Virgin Islands and District of Columbia • Treatments outside the U.S. and territories are not tracked in EQRS.
TRANSFER IN	Patient transferring into your facility from another dialysis facility in the U.S.
RESTART	• Submit **Re-Entitlement 2728** if > 1 year since stopping dialysis. • Patient restarting dialysis. • Discharge reason was: Discontinue, Recover Function, Other, Lost to Follow-up.
DIALYSIS AFTER TRANSPLANT FAILED	• Submit Re-Entitlement 2728 if > 3 years since receiving kidney transplant. • Kidney transplant failed; patient restarting chronic outpatient dialysis.
DIALYSIS IN SUPPORT OF TRANSPLANT	• Use this admit reason only for patients that require **temporary** dialysis after receiving a kidney transplant. • If a patient's transplanted kidney is still functioning, do not admit them to your facility. If the transplant fails, admit them as **Dialysis after Transplant Failed.**

DISCHARGE REASONS: Required within 5 business days of discharge	
If a patient dies within 30 days of discharge for one of the following discharge reasons, your facility is responsible for completing the 2746 form: • Discontinue • Transfer to non-dialysis facility • Other • Regain Function	
INVOLUNTARY DISCHARGE	Per Conditions for Coverage (CfC), all Involuntary Discharges **MUST** be reported to the Network (Patient Services Department).
LOST TO FOLLOW-UP	Used when unable to locate the patient. Facility **MUST** follow the CfC and **contact the Network** for assistance **before selecting this option.**
TRANSFER • Dialysis Facility • Hospital • Long Term Care Facility (LTC) • Hospice • Nursing Home • Rehabilitation Center	• **Dialysis Facility:** Patient transferred to CMS-certified dialysis facility in the U.S. • **Hospital:** Use if the patient is hospitalized >30 days but may return (CMS CfC expect patient will be readmitted to your facility upon discharge from a hospital. Requires you hold a chair).
OTHER	• Patient is IN PRISON and is receiving treatment in prison, **OR** • Patient is OUT OF COUNTRY for > 30 days.
DISCONTINUE	• Patient/family wishes to permanently stop dialysis treatment.
DEATH	• Patient died while a patient at your facility. Submit 2746 form within 14 days.
TRANSPLANT IN U.S.	• Patient received kidney transplant in the U.S.
TRANSPLANT OUT OF U.S.	• Patient received kidney transplant in another country.
RECOVER FUNCTION	• Patient recovered NATIVE kidney function and no longer requires dialysis (Does not apply to transplanted kidney).
ACUTE	• Acute patients should not be in EQRS. Use this discharge reason for **acute patients only**.

Lost to Follow- Up

*****Facilities MUST contact the Network before updating EQRS with a Lost to Follow-Up status.*****

The only time use of "Lost to Follow Up" can be used in EQRS is when the patient cannot be located and there has been an inability to contact the patient for over 30 days. In these cases the following should occur:

- Request a welfare check by authorities
- Request intervention from emergency contacts
- Determine if the patient has been hospitalized, incarcerated or left the country (Refer to the table for guidance on how to document these events in EQRS)

Should the patient be found, the facility must reaccept the patient. The original chair assignment does not have to be provided. If a chair is unavailable, the facility must assist in securing treatment at another location until space becomes available.

Alternative Options to Manage Chronic No-Show Patients

Discharge for non-adherence alone is unacceptable, as patients have the right to accept and reject treatment options. Patients do, however, have responsibility for the decisions they make and should be included in the planning of their care to facilitate informed decision-making.

In instances where "no-show" behaviors are pervasive the facility may, with agreement of the prescribing physician, consider giving the patient notice that the "privilege" of a regular outpatient appointment time is being suspended and the patient will have to contact the unit for further treatment times. The time would be determined by vacant chairs that become available, for example, when another patient is hospitalized, absent or dialyzing elsewhere. Under this approach, if the patient demonstrates adherence with regular treatment, a regular on-going time can be offered when available.

If the patient is in emergent need of dialysis when no chair is available, the patient would be directed to the Emergency Room for acute services, as is routine in ESRD care.

Patients that miss treatment for prolonged periods of time and present with no complications should be reevaluated for residual function and appropriateness of an ongoing chronic treatment schedule. Patients who show for treatment after a prolonged absence should be assessed by the Registered Nurse, Medical Director or Attending Nephrologist prior to initiating treatment. **The patient should only be referred to the hospital if the clinical assessment conducted indicates that the patient needs medical attention that cannot be provided in the outpatient dialysis setting.** (This represents a change from previous Network recommendations.) If the patient is deemed stable per the clinical assessment, the patient should be provided with dialysis at that time, per the doctor's orders.

In the event you have a patient gone from your clinic at least 30 days who has had no apparent symptomatology and has not declared an intent to withdraw from treatment, and the facility has done due diligence to affect change in the patient, there may be a route by which the patient can be discharged. ******This step will require Network involvement and direction.****** As the last facility of record, you would be expected to readmit were the patient to change their mind in the future or have a change of situation.

Non-Adherent Home Dialysis Patients

Non-adherence in the home patient typically includes situations in which the patient is not completing all prescribed treatments; there is a lack of treatment documentation (manual and/or electronic); monthly scheduled clinic visits are not being attended. The attending physician may determine, after reasonable steps* have been taken to try to change patient adherence, that the patient is no longer appropriate for independent care. Involuntary discharge is NOT an appropriate action. These situations should be viewed as a modality change in which the patient would be transitioned back to in-center treatment.

*Reasonable steps include:

- Ruling out underlying barriers preventing the patient from completing their treatments, such as pain or depression, equipment issues, life changing events, support system changes, need for retraining or review of rights and responsibilities
- Patient education, care plan meetings, behavior meetings

- Flagging of patient as “unstable” for care planning
- Patient notification of risk for movement back to in-center program
- Are cancelled visits being rescheduled?
- Involvement of family/care partners

Transitioning the patient should include assisting the patient in identifying and securing an in-center placement of their choice. If this cannot be accomplished, the fallback would be placement at the home program’s backup facility. ***Anticipate strong resistance from the patient***, including refusal of in-center treatment. This is a common reaction which typically ends with the patient accepting in-center treatment when they are unable to sustain the stalemate.

Discontinuation of Treatment

If a patient or responsible surrogate, expresses a clear desire to discontinue treatment, it is appropriate to discharge the patient and document the reason in EQRS as “Discontinued”. In these situations, ensure the following is done:

- Refer the patient to hospice
- Ensure the patient understands that they may lose Medicare benefits if they are only eligible through the ESRD program
- Provide education and resources regarding end of life
- Provide all the above both verbally and in writing (send via certified mail/trackable method)

Do you need additional assistance?

Facilities should always follow their internal policies and procedures, consult with leadership when determining actions to take in addressing patient discharges, and document ALL steps taken during this process as part of the patient’s medical record. The Network should also be consulted.

The Patient Services Department is available for case consultations on any patient situations that you may be struggling with or about which you need additional guidance. We can provide you with recommendations, interventions and resources and will help you understand the Conditions for Coverage as it applies to each situation.

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