Quality Insights
Renal Network 4

610.265.2418
Fax 610.783.0374
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. https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/ESRDfinalrule0415.pdf

- 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 **faxed** to the QIRN4 office prior to the involuntary discharge or involuntary transfer.
- This packet must be completed in its entirety for all cases of immediate and severe threat then **faxed** to the QIRN4 office WITHIN 24 hours of the discharge.
- Retain a copy of this completed packet in the patient's medical record.

For interpretive guidance on the CMS ESRD facilities Conditions for Coverage visit the CMS website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/esrdpgmguidance.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

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IMPORTANT

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

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 facility. The Conditions for Coverage also states the parameters needed before implementing an involuntary discharge/transfer.

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

In the event that your facility is faced with making a decision about involuntarily discharging/transferring a patient, your responsibilities for the patient continues until your patient is permanently accepted and receiving treatment at another outpatient dialysis facility. Monthly documentation must be submitted to Quality Insights Renal Network 4 that shows that efforts to locate another outpatient facility are being actively pursued.

In the case of an immediate severe threat to the health and safety of others, you may utilize an abbreviated involuntary discharge / transfer procedure. After everyone at your facility is safe please contact both your State Department of Health and Quality Insights Renal Network 4 Patient Services Department.

Facility responsibility at time of discharge:

a. Facility and doctor remain responsible providers for patient until such time patient is permanently accepted and is receiving treatment at another outpatient dialysis facility. Monthly documentation must be submitted to QIRN4 that shows that efforts to locate another outpatient facility are actively being pursued;
b. Facility provider must advise patient about the medical ramifications of not receiving outpatient dialysis i.e. fluid overload, congestive heart failure, death; and
c. Facility must notify Quality Insights Renal Network 4 and their specific State Survey Agency of the involuntary discharge / transfer 30 days prior to the discharge / transfer date.

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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 the completed discharge paperwork for **ALL** Involuntary Discharges and Involuntary Transfers be completed and submitted by fax to the Quality Insights Renal Network 4 office **30 DAYS PRIOR** to the discharge/transfer date of the patient from the facility. In the case of an immediate discharge/transfer due to severe and imminent threat, the completed discharge paperwork must be faxed to the Quality Insights Renal Network 4 office within **24 hours** of the immediate discharge of the patient from the facility.

Demographic Information

Patient Name: _____ Date of Birth: _____

Facility Provider Number: _____ *(Tip: this is your facility's six digit Medicare provider number. In DE this number will begin with 08. In PA this number will begin with 39 or 73).*

Name and title of person completing this form: _____

Facility telephone number: _____ Facility Fax Number: _____

Name of Facility Medical Director: _____

Name of Patient's Attending Physician: _____

Name of Facility Administrator: _____

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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: _____

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: 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 to and including the incident that necessitated the involuntary discharge (Please attach all pertinent documentation): **NOTE: Even with attached documentation this section must be completed.**

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Part II: Required Documentation*

*Not required for a facility closure

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

Part III: 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)

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)

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Part IV: Patient's Disposition

(Where will the patient be treated 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 _____ Name of the transplant center _____
❑ Not Admitted to another Outpatient Facility – Name of Hospital Treating Patient_____
❑ Other – Comment:

Part V: State Survey Agency Contact Information

Pennsylvania	Pennsylvania Department of Health 555 Walnut Street, 7th Floor, Forum Place Suite 701 Harrisburg, PA 17101	1-717-783-1379
Delaware	Delaware Department of Health 261 Chapman Road, Suite 200 Newark, DE 19702	1-302-283-7220

QIRN4 strongly encourages each facility to call in a report of their IVD / IVT to their state DOH office and confirm that all of the documents faxed by the facility have been received by QIRN4.
Fax (610) 783-0374 Phone (610) 265-2418 ext 2831 or 1-800-548-9205