GUIDE TO COMPLETING THE INVOLUNTARY DISCHARGE (IVD) PROCESS

This document contains vital information pertaining to the Involuntary Discharge (IVD) process as outlined in the Centers for Medicare & Medicaid Services End Stage Renal Disease (ESRD) Facilities Conditions for Coverage. Please read carefully and refer to the document General Guidelines for the Involuntary Discharge Process before completing this document.

A dialysis facility MUST:

➢ Notify the ESRD Network at least 30 days prior to the discharge.
➢ Complete this entire packet on all involuntary discharges prior to the discharge and submit to the appropriate ESRD Network:
   o In cases of immediate and severe threat, submit the completed packet within 48 hours of the incident/discharge.
   o In cases of non-payment of fees, ongoing and disruptive behavior, facility ceases to operate, and/or facility can no longer meet patient’s medical need, submit the completed packet within the first two (2) business days after you have given (or mailed) a patient your facility’s 30-day-notice of discharge letter. Example: If the patient’s discharge letter has the date of May 15, you should submit the completed packet to the Network within two (2) business days of May 15.
➢ Retain a copy of this completed packet in the patient’s medical record.
§ 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 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.  
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 facility 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 the local ESRD Network 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 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 discharge or transfer.  

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

Involuntary Discharge Checklist for Dialysis Facilities

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<tr>
<td>Alabama, Mississippi, Tennessee</td>
<td>Texas</td>
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<tr>
<td>(601) 936-9260</td>
<td>(972) 503-3215</td>
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TO AVOID A SECURITY INCIDENT, DO NOT EMAIL THIS INFORMATION TO THE ESRD NETWORK. MAIL or FAX ONLY.
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 ESRD Network requires this documentation for all involuntary discharges. Be aware that your submitted documentation is the only paper evidence of the situation. *This information is to be completed and faxed to the Network PRIOR to discharge or within 48 hours of an immediate discharge.*

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**Demographic Information**

Patient Name ___________________________ Date of Birth __________

First Date of Dialysis___________ Gender________________ Race________________

Insurance Provider ____________________________________________

Facility Provider Number: ______________________

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 ____________ *(Attach copy of incident form.)*

Date patient was notified of Discharge ____________ Date of Anticipated Discharge ____________

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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 above 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.

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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)

____________________________________________________________________________________

____________________________________________________________________________________

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Part III: PATIENT’S DISPOSITION

(Where will the patient dialyze immediately after discharge?)

☐ 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 ____________________________
☐ Unknown

Part IV: REQUIRED DOCUMENTATION

Date Sent to Network office:

☐ 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 Medical Director approval / / 
☐ Documentation of facility’s inability to meet patient’s medical need (if applicable) / / 
☐ Copies of patient’s interdisciplinary reassessments (if applicable) / / 
☐ 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: ____________________________ / / 

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Part V: 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.” If you have submitted an involuntary discharge packet to the Network, you should still report the discharge reason as “Involuntary” even if you know that a patient was accepted at another dialysis facility.

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# Part V: STATE SURVEY AGENCY CONTACT INFORMATION

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<thead>
<tr>
<th>State</th>
<th>Agency Name</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>Division of Health Care Facilities</td>
<td>334-206-5075</td>
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<tr>
<td></td>
<td>Al. Dept. of Public Health</td>
<td>Fax: 334-206-5088</td>
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<tr>
<td></td>
<td>201 Monroe St., Ste. 600</td>
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<td></td>
<td>Montgomery, AL 36104</td>
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<tr>
<td>Mississippi</td>
<td>Health Facilities Licensure</td>
<td>800-227-7308</td>
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<td></td>
<td>MS State Dept. of Health</td>
<td>Fax: 601-364-5050</td>
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<tr>
<td></td>
<td>P.O. Box 1700</td>
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<td>Jackson, MS 39215</td>
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<td>Tennessee</td>
<td>Division of Health Care Facilities</td>
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<tr>
<td></td>
<td>TN Dept. of Health</td>
<td>East TN: 865-594-9396</td>
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<tr>
<td></td>
<td>Cordell Hull Building, 1&lt;sup&gt;st&lt;/sup&gt;</td>
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<td>Floor 425 5&lt;sup&gt;th&lt;/sup&gt; Avenue North</td>
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<td></td>
<td>Nashville, TN 37247</td>
<td>Fax: 865-594-5739</td>
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<td>West TN: 731-984-9684</td>
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<td>Fax: 731-512-0063</td>
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<td>Texas</td>
<td>TX Department of State Health</td>
<td>888-973-0022</td>
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<td>Services Regulatory Licensing Unit</td>
<td>Fax: 512-834-4514</td>
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