

Network of New England

Do you have a question about ESRD Conditions for Coverage?

1. Do the Conditions specify what qualifies as “emergency” drugs? **No—the Medical director should define those for each facility. These should include medications needed to respond to an allergic reaction to any medications normally administered in the course of dialysis treatment; review the drug inserts for commonly used medications to determine a minimum list.**
2. Is there an ACLS requirement in order to administer emergency medications? If so, should we have emergency drugs available when non-ACLS RN’s in charge of facility/patients? **An ACLS prepared staff person is not routinely expected to be present in the facility at all times. If the facility is using a “traditional” defibrillator (rather than an AED), a person qualified to operate that device must be present at all times patients are being treated. See the answer to question #1 for more information about emergency medication expectations.**
3. What are the medical director’s responsibilities regarding the initial prescription review when it is written by the referring nephrologists? **There is no requirement for a routine review of other physician’s orders; part of the QAPI plan should include methods to identify any concerns with orders, which would then need to be reviewed.**
4. Catheter infection in MAT = % catheters infected – should it be infections per/1000 patient day? **Review of the MAT did not find the referenced comment. The MAT refers to “per use-life of accesses” and sets goals of <1% for fistula and <10% for graft. The reference to catheters is to reduce the use of cuffed catheters >90 days to less than 10%.**
5. With new assessment/care plan paradigm and eliminations of S.T. care plan, are “quarterly/bi-annual notes” still required? **There was no regulation dictating frequency of progress notes, and the new regulations do not define a specific frequency for progress notes either. Your facility policy may include this requirement, or a state licensing rule.**

- A. How is it determined when an unstable patient becomes stable again? This is determined by the IDT by resolution of the issue(s) that caused the patient to be unstable.
- B. Unstable patient repeated comprehensive review/assessment – how to focus on problem making patient “unstable”, and not spend and/or waste time on stable assessment issues. Can we review the stable issues and document simply “reviewed and unchanged?” You will need to completely reassess unstable patients, with the goal being to identify all possible contributing factors to the patient being unstable. How you document the review is up to your facility and the forms/ systems you develop to make documentation as easy and time efficient as possible.
- C. Do “unstable” patients need both the assessment and POC monthly? Reassess on all or just area of instability? Unstable patients are required to be completely reassessed monthly, with the POC implemented within 15 days post completion of the assessment.
- D. Once patient’s has been identified as “unstable” monthly “note”, by full team fulfills requirement until problem on care plan has been resolved? Question is a little unclear: a monthly “note” may not fulfill the requirement for a full IDT reassessment. Unstable patients require full IDT reassessment of all required areas; not just reassessment of the problem area.
- E. If a patient is deemed unstable, does a complete multidisciplinary assessment need to be done if there are no new psychosocial issues? In other words, is that “monthly unstable” assessment need to be the same as our initial annual reassessment? Yes, the monthly unstable reassessment would need to be the same as the annual reassessment.
- F. If a patient is deemed unstable and being reviewed monthly by the IDT, will this preclude the monthly nurse’s note or MSW note? When disciplines enter progress notes is dependent on facility policy and on documentation necessary to demonstrate implementation of the POC.
- G. If a patient is always an outlier – as documented since arrival at the unit and has not ever gotten to the level of stable, how long does the monthly care plan need to be done? If the areas are in the monthly progress note (albumin, bone) adequacy does that cover as the care plan or does it have to be a separate document? As long as

- the patient remains unstable, a monthly IDT assessment and POC is required. CMS would encourage facilities to critically evaluate their classification of patients as stable or unstable, and to consider adopting the minimum list of elements in the regulations that define an “unstable” patient.
- H. Does the monthly/annual reassessment have to be the same form as the initial (i.e. the initial nutrition form is very comprehensive – would a flow note, that addresses the required criteria, be acceptable? CMS is not dictating any format for the assessment or reassessment; you must be able to demonstrate that a comprehensive IDT reassessment is done for any unstable patient.
 - I. How can 3 months possibly be a good sample to use as evidence to show quality of care? Eventually, will it be a larger sample?-CROWN WEB The initial plan is to model the CPM data on the previous model which was for 3 months of hemodialysis data and 6 months for peritoneal data. In time, you can expect this sample size to be increased.
 - J. Do we need to use the comprehensive assessment monthly for unstable patients or can we use the monthly assessment? See above comments
 - K. A patient is considered unstable if there are concurrent problems with, adequacy, nutrition and anemia. Does this mean if only one area is problematic then the patient is not necessarily “unstable”? Yes
- 6. Request sample template policies for involuntary DC, QAPI program, etc. Policies that are across the board. CMS does not have template policies; perhaps the Network can help with this request?
 - 7. Has the long-term care plan been replaced by another form? No—there is no requirement for a form to document providing the choice of modalities of treatment to patients. However, there are requirements under the Conditions for Coverage for Patient Rights, Patient Assessment and Plan of Care to ensure patients are given choices of modalities, including the requirement that information from transplant centers be used to determine whether a patient is a candidate for transplantation. Transplant centers are required to develop and make available to dialysis facilities on request their selection criteria.

8. Is a patient fall still a trigger for a care plan? [Not unless your policy or a state rule requires it.](#)

9. If a patient has not shown up at the dialysis clinic for 30 days can that patient be discharged involuntarily? [Non-compliance is not a reason for involuntary discharge. You could notify the patient that his treatment slot would be reassigned to another patient, and that s/he would need to call the facility to schedule treatment when s/he decides to return for treatment.](#)