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FROM: Director
Survey and Certification Group
Center for Medicaid and State Operations

SUBJECT: Nursing Home That Has No Arrangement to Provide Dialysis Services
To Its Residents

TO: Associate Regional Administrators, DMSO
State Survey Agency Directors

Purpose

The purpose of this memorandum is to provide further guidance regarding changes in the Balanced Budget Refinement Act of 1999 regarding nursing home residents who are receiving end stage renal disease (ESRD) services. Some states have erroneously cited a SNF for not having an arrangement with an ESRD facility when the SNF neither provides nor bills Medicare for dialysis services.

Background

The Balanced Budget Refinement Act of 1999 amended the Social Security Act (the Act) to, among other things, eliminate the previous obligation of a SNF to furnish directly or indirectly institutional dialysis to its residents. Further, the SNF prospective payment system (PPS) regulations allow the SNF the option to furnish institutional dialysis or to make arrangements for the dialysis. If the SNF chooses not to provide dialysis, the resident can obtain dialysis services from an outside supplier which provides the services and bills Medicare directly for them under Part B. The ambulance service which transports the residents to and from the ESRD facility to the SNF may also bill Medicare directly for its service. Therefore, there is no longer a basis to cite the SNF under 42 CFR 483.75 (h) or section 1861 (w)(1) of the Act for not having an arrangement for the dialysis services. This is because the arrangement that a facility must have in place under 1861 (w)(1) concerns only services for which the SNF is paid. Consequently, if the SNF chooses to provide the dialysis services itself under an arrangement and bills for these services through the SNF, the guidance at 42 CFR 483.75 (h) is still applicable.

However, you can still cite nursing home deficiencies for dialysis problems related to a resident who received dialysis services while being a resident in a nursing home.

Guidance & Example

For example, a resident at XYZ Nursing Home was admitted to the SNF with a diagnosis of, among other things, chronic renal failure and required ongoing dialysis treatments three days a week at an ESRD facility. Review of the resident's plan of care revealed that it addressed neither hemodialysis nor the diagnosis of renal failure. The nurse manager verified that the SNF was unfamiliar with the care of the resident receiving dialysis, and did not plan to address the resident as having end-stage renal disease and the need for dialysis treatments. Further, the SNF had not received information from the ESRD facility or other sources regarding the care of the resident with renal disease. The facility lacked policies and procedures for the staff to use to develop care plans related to the assessment and care of conditions related to end state renal disease. In addition, the nurse manager verified that the ESRD facility sent no written documentation following the resident's dialysis to indicate if there were other problems that the facility should be aware of and monitor. There has been no training of SNF personnel on emergencies for the particular resident including hypotension, hemorrhage from dislodging of the catheter, symptoms of sepsis or other needs of the dialysis resident.

In the absence of a requirement for an agreement between the facility and the dialysis unit, the facility must maintain the responsibility of managing the care the resident requires based upon the comprehensive assessment, care plan, physicians orders and resident care policies and be provided qualified staff. The following regulatory tags, although not all inclusive, might be used to cite the problems of the lack of management and coordination of dialysis care, and the lack of staff understanding of the provision of such care:

F309 - 483.25 Quality of care: Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. In addition, in the area of quality of care, there is also a specific regulatory cite, F325 483.25(i)(1) which addresses the maintenance of acceptable parameters of nutritional status;

F279 – 483.20(k) Comprehensive care plans: The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.25;

F281 - 483.20(k)(3)(i): The services provided or arranged by the facility must meet professional standards of quality and be provided by qualified persons in accordance with each resident's written plan of care;

F501 - 483.75(i): Medical Director:

(2) The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility;

F521 483.75 (2)(o)(i)(ii): Quality Assessment and assurance. The Quality Assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies; and

In addition, the requirements at 483.40 - Physician's Services, 483.65 - Infection Control might also be used to address specific issues.

Effective Date: This policy clarification is effective immediately.

Training: This policy should be shared with all survey and certification staff, their managers, legal counsel and the State/Regional office training coordinator. We are making changes to the State Operations Manual to reflect this policy.

/s/

Steven A. Pelovitz