V-TAGS & INTERPRETIVE GUIDANCE REGARDING TRANSPLANT

CMS End Stage Renal Disease (ESRD) Program Interim Final Version Interpretive Guidance Version 1.1

TAG NUMBER	REGULATION	INTERPRETIVE GUIDANCE
V458	(7) Be informed about all treatment modalities and settings, including but not limited to, transplantation, home dialysis modalities (home hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis), and in-facility hemodialysis. The patient has the right to receive resource information for dialysis modalities not offered by the facility, including information about alternative scheduling options for working patients;	Documentation in patient records must demonstrate that facility staff provide unbiased education to patients/designees about transplantation and all dialysis treatment options (modalities and settings) offered for kidney failure, whether or not those options are offered at the current dialysis facility. This includes alternate scheduling options for in-center hemodialysis patients who attend school or are working. Patients who work or attend school should be encouraged to continue doing so and facilities should recommend the most appropriate modality and setting for their dialysis. Examples of how facilities may meet this requirement include developing a resource information packet for patients or providing patients an existing resource list of facilities that offer alternate schedules or home dialysis treatment options can be found at Medicare's Dialysis Facility Compare, and Home Dialysis Central. The requirements for assessment of patients for home dialysis and transplantation are addressed at V512 and V513 and at V553 and V554 respectively under the Condition for Patient plan of care.
V510	(7) Evaluation of psychosocial needs by a social worker.	The evaluation of psychosocial needs must be conducted by a qualified social worker as defined by these regulations at V691. Examples of psychosocial parameters to be addressed by the qualified social worker include, but are not limited to: • Cognitive status and capacity to understand; • Ability to meet basic needs; • Ability to follow the treatment prescription; • Mental health history, capacities, and needs for counseling; • Substance abuse history, if any; • Current ability to cope with and adjust to dialysis; • Expectations for the future and living with kidney failure and treatment; • Educational and employment status, concerns, and goals; • Home environment including current living situation;

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		• Legal issues (e.g., court appointed guardian, advance directive status, and health care proxy) • Need for advocacy with traditional (nursing home) and non-traditional housing (e.g., homeless shelters, group homes); • Financial capabilities and resources; • Access to available community resources; and • Eligibility for Federal, State, or local resources. Other members of the IDT may contribute to portions of the comprehensive assessment which correlate with the psychosocial evaluation (e.g., patient preferences for modality and self-care at V512, evaluation for transplant referral at V513, family/support systems at V514, and evaluation for referral to rehabilitation services at V515). Requirements for the plan of care for psychosocial status are at V552.
V513	(10) Evaluation of suitability for a transplantation referral, based on criteria developed by the prospective transplantation center and its surgeon(s). If the patient is not suitable for transplantation referral, the basis for nonreferral must be documented in the patient's medical record.	The IDT comprehensive assessment must demonstrate that each patient is evaluated for suitability for transplantation referral, using selection/exclusion criteria provided by the transplant center. The regulations for transplant programs require written selection criteria to be developed and provided upon request to patients and dialysis facilities. Selection criteria vary among transplant centers; if the dialysis facility refers patients to multiple transplant centers, the dialysis facility should have the selection criteria for each center on file and available to patients; patient are also free to select a transplant center other than the ones normally utilized by the dialysis facility for referrals. If the assessment finds a patient is not suitable for transplantation, the reason for the non-referral should be documented as part of the comprehensive assessment. The requirements for plan of care for transplant status are at V554.
V554	(ii) Transplantation status. When the patient is a transplant referral candidate, the interdisciplinary team must develop plans for pursuing transplantation. The	The patient's plan of care must reflect the information from the interdisciplinary team's evaluation of the patient's suitability for transplantation referral, required under the Condition for Patient assessment at V513.

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	patient's plan of care must include documentation of the– (A) Plan for transplantation, if the patient accepts the transplantation referral; (B) Patient's decision, if the patient is a transplantation referral candidate but declines the transplantation referral; or(C) Reason(s) for the patient's non referral as a transplantation candidate as documented in accordance with § 494.80(a)(10).	The patient record must show evidence that the patient was informed about transplantation as an option, living and deceased kidney donation, area transplant center(s) and each transplant facility's selection criteria. Each patient's record must reflect the IDT's determination about the patient's suitability and whether the patient accepted or declined referral for transplantation and reason for non referral. If a patient was determined as suitable for transplantation referral, the IDT must document making the referral and providing applicable information to the transplant center as appropriate or when requested. Documentation in patient records should agree with the patient's understanding of their status as a transplant candidate. Patients may independently contact a transplant center for an appointment for more information and evaluation. If this is the case, the IDT should be aware of the self-referral. A patient's insurance coverage and a transplant center's selection criteria may dictate which transplant center(s) the patient can access.
V561	(c) Standard: Transplantation referral tracking. The interdisciplinary team must— (1) Track the results of each kidney transplant center referral; (2) Monitor the status of any facility patients who are on the transplant wait list; and (3) Communicate with the transplant center regarding patient transplant status at least annually, and when there is a change in transplant candidate status.	Requiring the facility to track patients' transplant referrals and their status on the transplant wait list is intended to enhance the communication and coordination between the transplant center and the dialysis facility so that patients do not get "lost" along the way in the transplant referral, work up and waiting period. Tracking completion of the tests and evaluations required for a transplant work up and waiting list active status is primarily the responsibility of the patient in partnership with the transplant center. However, by communicating and coordinating activities with the transplant center, the dialysis facility IDT may be able to adjust their plan of care to facilitate the patient's transplantation goal. This communication should be systematic and documented. A "change in status" refers to a medical or psychosocial event that could either temporarily or permanently change a transplant patient's status. The "change" could either enhance or limit a dialysis patient's opportunities to receive a transplant. Examples of "change" events are cardiac events, weight loss, cessation of smoking, or identification of a new potential living organ donor. The transplant center should be notified at the time of any change in status.

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		The facility's patient transplant referral/waiting list status tracking may be centralized, but must also be documented in each referred patient's medical record.
V562	(d) Standard: Patient education and training. The patient care plan must include, as applicable, education and training for patients and family members or caregivers or both, in aspects of the dialysis experience, dialysis management, infection prevention and personal care, home dialysis and self-care, quality of life, rehabilitation, transplantation, and the benefits and risks of various vascular access types.	The dialysis facility must provide patients and their family members/caregivers with education and training in these listed areas, at a minimum. The IDT must have the skills and expertise needed to educate dialysis patients in these subjects, and to provide this education in a manner understood by the patient and family/caregiver. Patients/designees must receive education regarding the types, risks, benefits and care of their vascular access, personal hygiene related to dialysis access, infection prevention, dietary and fluid management, etc. The patient's medical record must demonstrate the provision of patient education and training in all of the listed subject areas. There may be a single form or section of the medical record for information on patient education or it may be located in various parts of the record, such as the progress notes of the members of the IDT.
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Excerpted from the CMS ESRD Surveyor Training Interpretive Guidance (version 1.1) available at www.cms.gov/Medicare/ProviderEnrollment-and-Certification/GuidanceforLawsAndRegulations/Dialysis.html

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