ESRD Conditions of Coverage (CfCs)
Frequently Asked Questions by Registered Dietitians (RDs)

Information provided by CRN is not intended to establish or replace policies and procedures provided by dialysis providers to their facilities. Please check with your dialysis facility management before implementing any information provided here.

General

Q: Where do I obtain a Participation Certificate for attending the CRN September 18, 2008 webinar?
A: Please contact Denise Dilley at denise.dilley@kidney.org. A certificate of participation will be sent via email.

Q: Where can I find the National Kidney Foundation KDOQI nutrition guidelines mentioned during the webinar?
A: The NKF KDOQI Nutrition guidelines were published as a Supplement 2 of the American Journal of Diseases, Volume 35, Number 6, June 2000. They can be accessed at http://www.kidney.org/professionals/KDOQI/guidelines_updates/doqi_nut.html (accessed 11-02-08).

Q: Are Registered Dietitians required to be CPR certified?
A: No. CPR certification applies only to those that provide direct patient care, such as nurses and patient care technicians. These staff members must have current basic CPR certification per final rule §494.60.

Q: Are Registered Dietitians required to wear gloves at all times in the treatment area or only during put on & take off times?
A: No. According to the interpretive guidance at V113, "Hand hygiene is required after every direct contact with a patient and between patient contacts, even if the contact is casual. ***Gloves are not necessary for casual social contact with a patient, for example, staff members may touch the patient's shoulder, take his/her arm, or shake hands without wearing gloves.*** However, gloves should always be worn anytime contact with blood or body fluids is anticipated."

Q: For the diabetes self-management section, are dietitians required to complete "foot checks"?
A: The CfC does not address foot checks or who should perform them. Refer to the facility policy for guidance on who is assigned to do foot checks on patients with diabetes if they are done at the dialysis facility.

RD Qualifications

Q: What are the specific qualifications for RDs?
A: Dietitians working in dialysis must have evidence of registration with the Commission on Dietetic Registration, the credentialing agency for the American Dietetic Association (ADA) and must meet the applicable scope of practice board and licensure requirements of the state in which they are employed. Dietitians must also have a minimum of one year's professional work

experience in clinical nutrition as a registered dietitian AFTER successful completion of the registration exam. Experience in clinical nutrition as an intern (prior to registration) would not count toward this requirement, nor would foodservice experience after registration as a dietitian meet this requirement

Q: Is there a grandfathering clause for RDs hired prior to October 14, 2008 who do not meet the one year clinical experience (post registration) as of October 14?
A: No. There is a grandfathering clause only for social workers that have been working since 1975. The work experience of RDs working in facilities as of October 14, 2008 will count toward this experience requirement, whether that experience was gained before or after registration. This means that an RD who was hired in dialysis prior to registration but, as of October 14, 2008, had more than a year's clinical experience as an RD would meet this qualification.

Q: What are the specific qualifications for DTRs?
A: The final rule does not address the potential role for dietetic technicians. The rule requires a dietitian to contribute on the dialysis facility interdisciplinary team (IDT), perform patient assessments, and participate in patient care planning and the Quality Assessment and Performance Improvement (QAPI) program. A Dietetic Technician, Registered, may work UNDER RD SUPERVISION, but it is the RD who must perform the tasks outlined by the Conditions of Coverage. Refer to the updated Standards of Practice and Standards of Professional Performance in the September 2008 Journal of the American Dietetic Association for more information on competency and the description of supervision as it relates to RDs and DTRs.

Nutrition Care Plans/Assessments

Q: The Measures Assessment Tool (MAT) states an albumin goal of 4.0 mg/dL. How was this selected?
A: The summary of the KDOQI Nutrition guideline states: "A predialysis or stabilized serum albumin equal to or greater than the lower limit of the normal range (approximately 4.0 g/dL for the bromcresol green method or BCG) is the outcome goal." Therefore, CMS set 4.0 g/dL as the intended target. Several research studies have reported significantly elevated risks of death and hospitalization with albumin < 4.0 g/dL. The Nutrition Guideline states: "...hypoalbuminemia is highly predictive of future mortality risk when present at the time of initiation of chronic dialysis as well as during the course of maintenance dialysis (MD)." The guideline also states that other factors besides nutrition, such as inflammation or acute or chronic stress, can contribute to hypoalbuminemia.

CMS recognizes that meeting the albumin goal may be a challenge for some patients. When patients do not meet targets, the expectation is that there will be a review of the reasons why the indicator may be below target and a plan developed to address that.

The care should be based on the patient assessment and *individualized* to that patient. For example, if a patient's current albumin using the BCG method is 3.5 mg/dL, the plan of care would include **several methods** to help increase this patient's likelihood of reaching the goal of 4.0. Was education provided regarding high quality protein sources and how much extra protein to eat? Were high protein supplements recommended? Was inflammation considered as a potential cause, and addressed, and treated if identified? Was stress/depression considered as a potential cause, and identified and treated if present? What other ideas did the interdisciplinary team have to help the patient reach the goal of 4.0 g/dL?

Q: What is a reference weight?
A: There is no specific "reference" weight in the final interpretive guidelines. For patient assessment, one may use the current professionally accepted clinical standards for assessing

weights. The final MAT refers to % usual weight and % standard weight when addressing outcome goals in the plan of care.

Q: How is weight loss calculated in one month?
A: The regulations state that albumin, body weight and trends in body weight be measured monthly. It is up to the individual facility to define a level of weight loss which should be recognized and addressed in the plan of care, and how weight loss (or gain) will be tracked. Significant changes in body weight, to below accepted targets, might trigger a comprehensive patient assessment due to instability if accompanied by poor nutritional status, in addition to unmanaged anemia and inadequate dialysis.

Q: Are some using Estimated Dry Weight?
A: The MAT recommends using professionally accepted clinical practice standards. Refer to the NKF *KDOQI Clinical Practice Guidelines for Nutrition in Chronic Renal Failure*. American Journal of Kidney Disease Vol 35, No 6, Supple 2, June 2000, page S19. (OR http://www.kidney.org/professionals/KDOQI/guidelines_updates/nut_a10.html)

Q: Is there a definition of what is considered "stable"?
A: The regulations provide the following minimum criteria for defining unstable conditions:
- Extended or frequent hospitalizations;
- Marked deterioration in health status;
- Significant change in psychosocial needs; or
- Concurrent poor nutritional status, unmanaged anemia and inadequate dialysis.

Per the interpretive guidelines (IGs), the interdisciplinary team (IDT) has the flexibility to use its professional judgment to further define unstable based on their patient population.

Q: Regarding failure to thrive with loss of body weight AND low albumin, does this mean a decrease in albumin level for the month with a weight loss (>5%), or any low albumin (below goal) with a weight loss (>5%)?
A: It is up to the individual facility to define this. Review the KDOQI Clinical Practice Guidelines for Nutrition Care in Chronic Renal Failure as referenced above for further direction.

Q: Is the RD still required to chart monthly on all patients regardless of stability status?
A: Federal regulations have never required monthly documentation. However, state licensing rules for ESRD may have such stipulations or individual dialysis facilities may have policies that set documentation frequency.

Under the CfCs, the monthly care plan documentation is only for those patients who meet the criteria for unstable. The preamble to the CfCs states, "While we are requiring stable patients to be comprehensively reassessed at least annually, we recognize that appropriate monitoring of patients may require ongoing assessments in various areas. We expect that patients would be monitored on an ongoing basis and expect progress notes would be entered in the patient's medical record as needed. The IDT has the flexibility to use its professional judgment regarding on-going monitoring methods as appropriate for their patients." Federal Register Vo 73, No. 73, April 15, 2008, page 20399. In this statement "ongoing assessments" means ongoing monitoring and review of status.

Q: Does having access to an RD mean that the RD will actually see every patient each month and document that interaction?
A: See above. The patient needs to be monitored frequently enough so the RD can alert the IDT if the patient's nutritional status is potentially affecting the patient's stability. If the facility provides training and support to home dialysis patients, the RD must be available as needed to

provide consultation for those home patients. According to V592, for a home dialysis patient: "The required minimum frequency of contacts may be defined by facility policy, but must meet the individual needs of each patient in accordance with their plan of care."

Q: What is the required frequency of new assessments? Please clarify the timing of documents.
A:
1) Assessments for new patients must be completed within the latter of 30 days or 13 hemodialysis sessions beginning with the first hemodialysis session in the facility. For peritoneal dialysis (PD) or hemodialysis (HD) patients treated more frequently, the timeline for completion is 30 days excluding any hospitalization days.
2) Follow up comprehensive assessment must occur within 3 months of the initial assessment.
3) Each patient's annual comprehensive re-assessment is due 12 months after the 3-month reassessment or 15 months after the patient's admission to the facility.
4) *Unstable patients are required to be reassessed monthly*. If the unstable condition is triggered by another discipline, the RD is required to review his/her assessment parameters to determine whether nutritional status was affected (i.e. did the patient's recent CVA affect ability to eat and therefore alter nutritional status?). The IGs state that "participation of some team members around some changes that do not impact their specialty may be limited but patient status, whether changed or unchanged, should clearly be reflected in the new assessment".

Q: Does the same assessment documentation form need to be used for both the initial and 3-month assessment?
A: The regulations do not stipulate the form to be used. However, the initial assessment, the 3-month and annual reassessments are intended to be comprehensive and have all components to reflect congruence with other disciplines represented on the IDT.

Q: Is the 3-month reassessment on the regular form or do we need to revise it?
A: See above.

Q: If a patient has a significant psychosocial change, but stable from a nutritional standpoint, do we have to complete the full reassessment or just document that the patient is stable from a nutritional standpoint?
A: The RD would be expected to participate in the reassessment of any unstable patient. The IGs state that "participation of some team members around some changes that do not impact their specialty may be limited but patient status, whether changed or unchanged, should clearly be reflected in the new assessment".

Q: Do we need to do our own individual nutrition assessment in addition to the CIPA form?
A: The regulations do not stipulate the form to be used. A sample Comprehensive Interdisciplinary Assessment (CIPA) form is available at http://www.kidney.org/professionals/CRN/. This was developed by a consortium of volunteers including representatives of NKF professional councils and American Nephrology Nurses' Association (ANNA). Dialysis providers may adopt this form or develop their own forms to collect and document the required IDT assessments. The IGs state: "The assessment may be incorporated into one document or composed of sections developed by each team member, but must address the specific criteria as outlined in V502-515. Electronic or paper formats may be used."

Q: Is it required to have one interdisciplinary document or can it be individual assessment tools by the different disciplines as long as it is documented discussion/ team approach?
A: See above

Q: The plan of care in the CIPA - does this need to be developed by the team as a whole or would this include individual team members' plans of care and compiled towards the end of the CIPA?
A: The assessment leads to the development of the interdisciplinary patient plan of care; it may be part of the same form or another format. See §494.90. According to the IGs, the IDT must develop a written, individualized, comprehensive plan of care that specifies services needed as identified in the CIPA process. According to V541: "The written patient plan of care must be individualized for the patient, built on the comprehensive assessment as outlined at V502-515 under the Condition for Patient assessment, and include at minimum: problem(s) identified at assessment/reassessment, measurable goals/outcomes, planned interventions for achieving the goals, timetables and reassessment date(s). Review of the plan of care, treatment records, progress notes, laboratory reports, etc. should demonstrate implementation of the plan of care… Professionally-accepted clinical practice standards, guidelines and CMS Clinical Performance Measures (CPM) must be used to derive the measurable and expected outcomes."

Q: If a patient transfers within your organization and there is not a change of caregiver does the CIPA have to be redone?
A: The IG's state "If the comprehensive patient assessment and plan of care for an experienced dialysis patient transferring from one dialysis facility to another is received with the patient in transfer, the receiving facility's IDT must conduct a reassessment within 3 months of the patient's admission to the new facility". This would also apply to transient patients staying longer than 30 days.

Q: Does CIPA need to be completed on TRANSIENT patients who may not stay beyond 30 days?
A: See above. If the transient patient does not stay beyond 30 days, a CIPA is not required even if he/she did not come with a current IDT assessment and plan of care. However, if the patient is expected to stay more than 30 days, the IDT would need to do a CIPA and plan of care within 30 days or 13 HD treatments. The timeline for completing the CIPA and plan of care for those PD or HD patients doing more frequent treatments is 30 days excluding hospitalization days.

Q: What forms are required in the case of a patient starting on HD and then transferring to PD within a month of their first HD treatment? Would this require two CIPAs or one plus a follow-up?
A: The IGs state: "Patients returning to dialysis from a failed transplant or changing modalities are also considered "new" patients. Based on this statement, this would require another initial CIPA. If the change occurs within the first 30 days, the IDT would complete one CIPA, with the plan being to accommodate the change in modality. The team would then need to monitor and address the change in the plan of care as the modality changes, and the 3 month reassessment would reflect the PD modality.

Q: What about patients who change from one modality to another (PD to HD for example)?
A: See above

Q: What if a patient switches to another unit within the same hospital system? Are they treated the same as any other transfer?
A: Yes. The IGs state" "If the comprehensive patient assessment and plan of care for an experienced dialysis patient transferring from one dialysis facility to another is received with the patient in transfer, the receiving facility's IDT must conduct a reassessment within 3 months of the patient's admission to the new facility." If a patient transfers, and the new admitting facility

does not receive a current IDT assessment and plan of care, that facility must complete the CIPA and plan of care within 30 days or 13 HD treatments. The timeline for completing the CIPA and plan of care for those PD or HD patients doing more frequent treatments is 30 days excluding hospitalization days.

Q: Where do we get sample forms?
A: A sample CIPA is posted in the National Kidney Foundation website at http://www.kidney.org/professionals/CRN/. One may use all of it or incorporate portions of it into their own forms. As mentioned earlier, this sample CIPA was developed for educational purposes and does not represent a mandated form. CMS does not provide any sample forms and leaves it up to the discretion of the facility to design their own forms to meet the criteria.

Q: How can RDs apply ADA's Nutrition Care Process (NCP) in the CIPA?
A: The CIPA represents the first step in the NCP—the assessment. CIPA templates, and the policies and procedures about how to use them, will have to be developed at the unit, regional or corporate level. The CIPA created by the NKF and the ANNA does not use ADA's standardized language (SL) of the NCP, and that may be unavoidable since it is interdisciplinary. But it will help the care team to assess patients and to identify problems that require attention.

There is an opportunity to apply the NCP and its major tool, the SL, for the plan of care that follows the CIPA. The second step in NCP, diagnosis, connects the assessment in the CIPA to services (see SL for the intervention quadrant of the NCP) and outcomes (refer to the monitoring and evaluation terms for the NCP).

ADA members can find more information about the NCP and SL on the ADA web page (www.eatright.org). Follow the links from the "Nutrition Care Process" menu button on the left edge of the ADA home page.

Q: Is it mandatory to use the NCP and SL?
A: No. Essentially ADA cannot mandate the application of the NCP or the specific terms in the SL. ADA members can access a well-written discussion of this question among FAQs on the NCP pages of ADA's web site (go to http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/home_13910_ENU_HTML.htm.

However, there are many advantages to using SL. These include describing what dietitians do in standard terms which in turn will support quality improvement audits and research projects to define clearly:

1. How dietitians assess patients (assessment terms);
2. What problems or diagnoses we treat (diagnosis terms);
3. What services we provide to patients with particular diagnoses (intervention terms) and,
4. What outcomes our patients/clients enjoy (monitoring and evaluation terms).

The mandates in the Conditions for Coverage (CfC) are for a CIPA and for a plan of care developed for each individual patient. Neither the Centers for Medicare & Medicaid Services (CMS), the NKF (National Kidney Foundation) nor the ADA mandate the application of the NCP or its SL.