Demystifying Form 2728

By Adam Weinstein

Although nephrologists complete the "End Stage Renal Disease (ESRD) Medical Evidence Report Medicare Entitlement and/or Patient Registration" form (form 2728) 138,000 times per year, the form is underappreciated and surprisingly important (1). Form 2728 was born in 1973 out of necessity. The form is, primarily, a nephrologist's attestation to the Centers for Medicare & Medicaid Services (CMS) that a patient is eligible to receive the ESRD Medicare benefits, irrespective of age and based solely on his or her diagnosis (2). However, form 2728 is also a critical point of data collection for understanding the population of patients requiring kidney replacement therapy.

Aside from the expected patient demographics, form 2728 collects various diagnostic and care information, for example, primary and secondary diagnoses leading to ESRD status (boxes 14 and 16), aspects of pre-dialysis chronic kidney disease (CKD) care (box 17), and incident laboratory data (box 18) (3). These data, it turns out, are the most impactful.

CMS, the US Renal Data System (USRDS), and, under a CMS contract, the University of Michigan Kidney Epidemiology and Cost Center (UM-KECC) are the prime users of 2728 data. CMS uses the data to administer the ESRD program, for example, determining a patient's first day of dialysis. USRDS uses the data to evaluate and publish patient trends in its annual report. UM-KECC employs 2728 data in a wide variety of metrics to which both medical directors and dialysis facilities are held accountable. It is this last use case that is often underappreciated. For example, UM-KECC uses comorbidity data collected in box 16 for risk-adjusted metrics included in the Quality Incentive Program (QIP), 5-star program, and related dialysis quality metrics (4).

Form 2728 has several limitations of which nephrologists should be aware. First, the list of selectable comorbidities (box 16) and primary causes of renal failure (box 14) are chosen by CMS and are the only choices available. Second, after initial submission, there is only a 5-day window to update a patient's 2728 data (5). Third, CMS has no specific processes to gather feedback for the form. Suggested changes in data elements or processes must go through standard CMS advocacy pathways.

All of this means that the 2728 data may not easily capture the full complexity or intensity of a patient's illness. And the initial data selected persist over the entire duration of a patient's kidney replacement care, irrespective of disease progression. Given this, nephrologists and their care teams have an enormous opportunity to ensure that patients' form 2728 data are comprehensive, timely, and accurate (6, 7). Engaging the right processes and people to create a precise clinical picture of our incident dialysis patients is critical. To be sure, this effort is challenging, but form 2728 is our tool for painting that picture. ■

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Accepting New Patients Undergoing Long-Term Dialysis with a History of Disruptive or Maladaptive Behaviors
Leaving Labels Behind

By Darren C. Schmidt

Nephrology care requires a long-term collaboration among the patient, his or her nephrologist, and the many other essential members of the healthcare team. However, in some situations, circumstances evolve to where it is in the best interest of all parties (including the patient) for a change in provider and/or facility. If an individual has a history of disruptive or maladaptive behaviors, the potential new provider or medical director is confronted with the dilemma of whether to accept the patient (1). There are a number of factors to weigh in making this decision (Table 1), running the gamut from ethical principles and obligations to practical concerns about quality metrics and reimbursement rates. The phrase "problem patient" is pejorative and is to be avoided. When one uses that phrase, often what he or she is referencing is troublesome physician-patient interactions or patient behaviors. The label, problem patient, however, can cause serious damage to an individual and prevent him or her from accessing necessary medical care.

If a patient has a documented history of disruptive or maladaptive behavior(s), it may be helpful to first take inventory of what is occurring with some degree of perspective and emotional detachment (2). Whether functioning as a clinical provider or a medical director, answering some key questions can be helpful in assessing whether to assume care for a patient with this type of history. Who, if anyone, do these behaviors put at risk? Could the behavior be a manifestation of a medical condition (Table 2)? Could these behaviors arise from problematic interactions where both the patient and others involved in his or her care (e.g., the provider, nurses, or dialysis unit staff) are playing a role, and could this dynamic be adjusted for a better outcome? Would the change in environment brought about by the patient joining your practice or dialysis facility potentially lead to the resolution of these issues? Unfortunately, it may not be possible to fully answer these types of questions with the information available at the time a decision needs to be made.

Dialysis facilities should have codes of contact that are shared with patients on admission to the unit and generally at specified intervals thereafter. However, it can be helpful to review these documents with a patient when troublesome behaviors occur. There are some patient behaviors, such as threats or violence toward other patients or healthcare workers, where rigid boundaries must be enforced. The diversity of legal statutes, institutional policies, and cultural practices makes it impossible to offer uniform guidance on how to proceed. Providers are encouraged to consult with their risk managers and other legal resources in specific instances.

In the vast majority of cases, it is in no one's interest, and is particularly unfortunate for the patient, if care devolves into frequent emergency department visits and emergent dialysis. Furthermore, even beyond ethical concerns, medical abandonment can put a provider in legal jeopardy when suitable alternative care has not been found. If the nephrology community has a collaborative approach, where providers and facilities in the area share an understanding that even challenging patients will ultimately need to receive care, then open and honest communication among the healthcare professionals can go a long way to building a foundation for successful transitions of care. ■

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