September 2024 EQRS Stakeholder Meeting

Today's focus:

Forms CMS 2728 and 2746 Updates

September 2024 EQRS Stakeholder Meeting

Monthly EQRS (End Stage Renal Disease (ESRD) Quality Reporting System) Stakeholder Meetings are hosted to educate and inform End Stage Renal Disease Quality Incentive Program (ESRD QIP) stakeholders regarding EQRS status, upgrades, and enhancements.

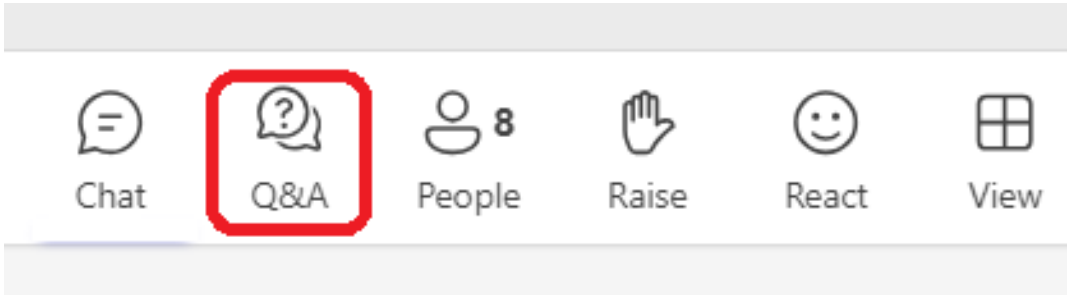
Today's meeting is focused on preparing dialysis and transplant facilities for the release of the new versions of the CMS 2728 and 2746

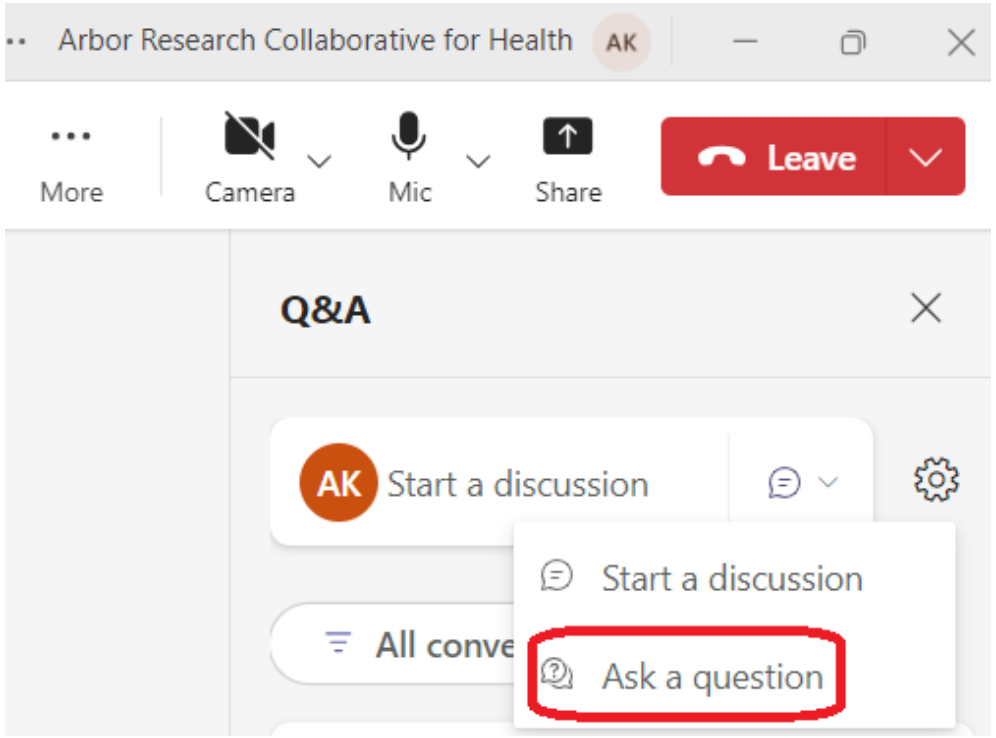
Agenda

Topic	Speaker
Welcome and Agenda	**Alissa Kapke, MS**
Important Information about New CMS forms versions	**Tricia Phulchand, BSN, RN**
CMS 2728 Overview	**Tricia Phulchand, BSN, RN**
Live Q&A about CMS 2728	**Alissa Kapke, MS** **Tricia Phulchand, BSN, RN**
CMS 2746 Overview	**Tricia Phulchand, BSN, RN**
Important Dates & Deadlines	**Alissa Kapke, MS**
Upcoming QIP & EQRS Events	**Alissa Kapke, MS**
Live Q&A	**Alissa Kapke, MS** **Tricia Phulchand, BSN, RN**

Submitting Questions

- Click on Q&A at top of your screen to submit a question





- Under Q&A, select Ask a question.
- Type your question in box on right hand side of your screen.

Please note that some questions may require additional research.
Any unanswered questions can be submitted to
QualityNet Question and Answer Tool

What Do I Need to Know?

Important Information

- The new versions of the Forms CMS 2728 and 2746 will go live in EQRS on **October 1, 2024**
- Any form created in EQRS and **SAVED** before that date (**September 30th or earlier**) will be the old form version
- Any form created in EQRS **ON** or **AFTER October 1st** will be the new form version

Important Information for:
DaVita and Fresenius Medical Care (FMC) Facilities

- DaVita Facilities
  - Form CMS 2728 is batched into EQRS
    - Please wait before initiating these forms on your own
    - Please reach out to your corporate entity for guidance

- FMC Facilities
  - Forms CMS 2728 and 2746 are batched into EQRS
    - Please wait before initiating these forms on your own
    - Please reach out to your corporate entity for guidance

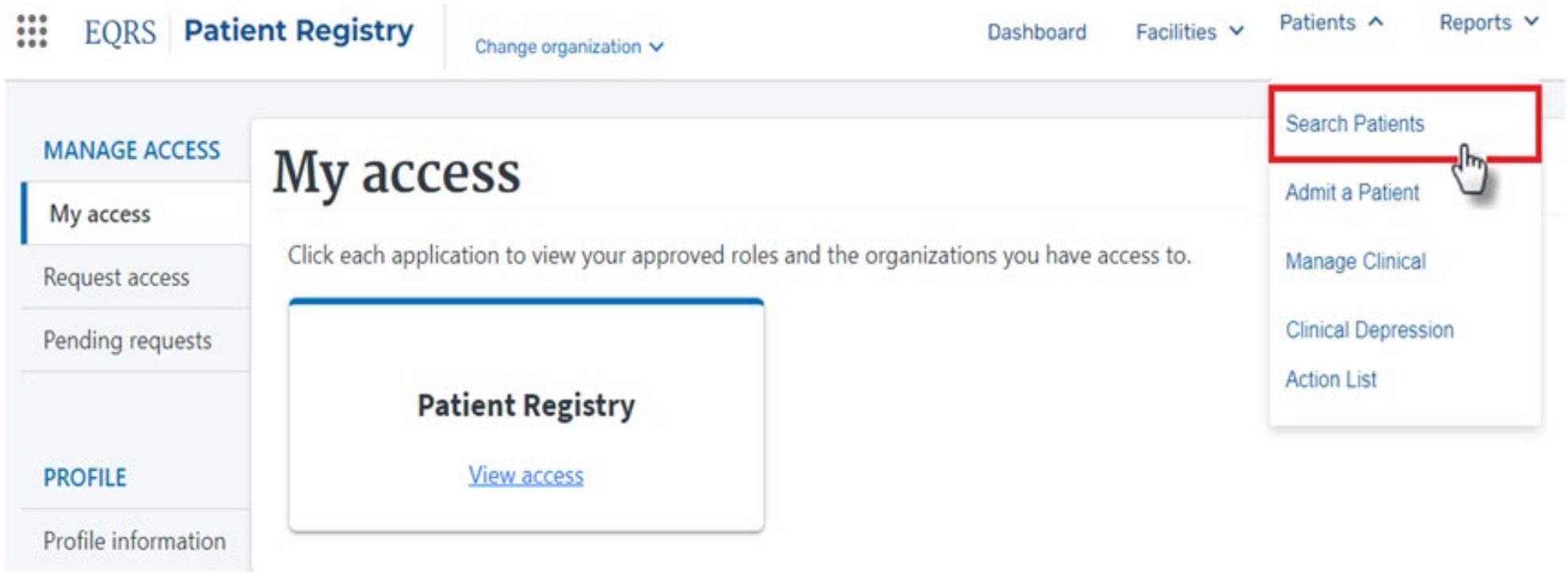
Form CMS-2728 Overview

Updated CMS 2728 (Version 2023)

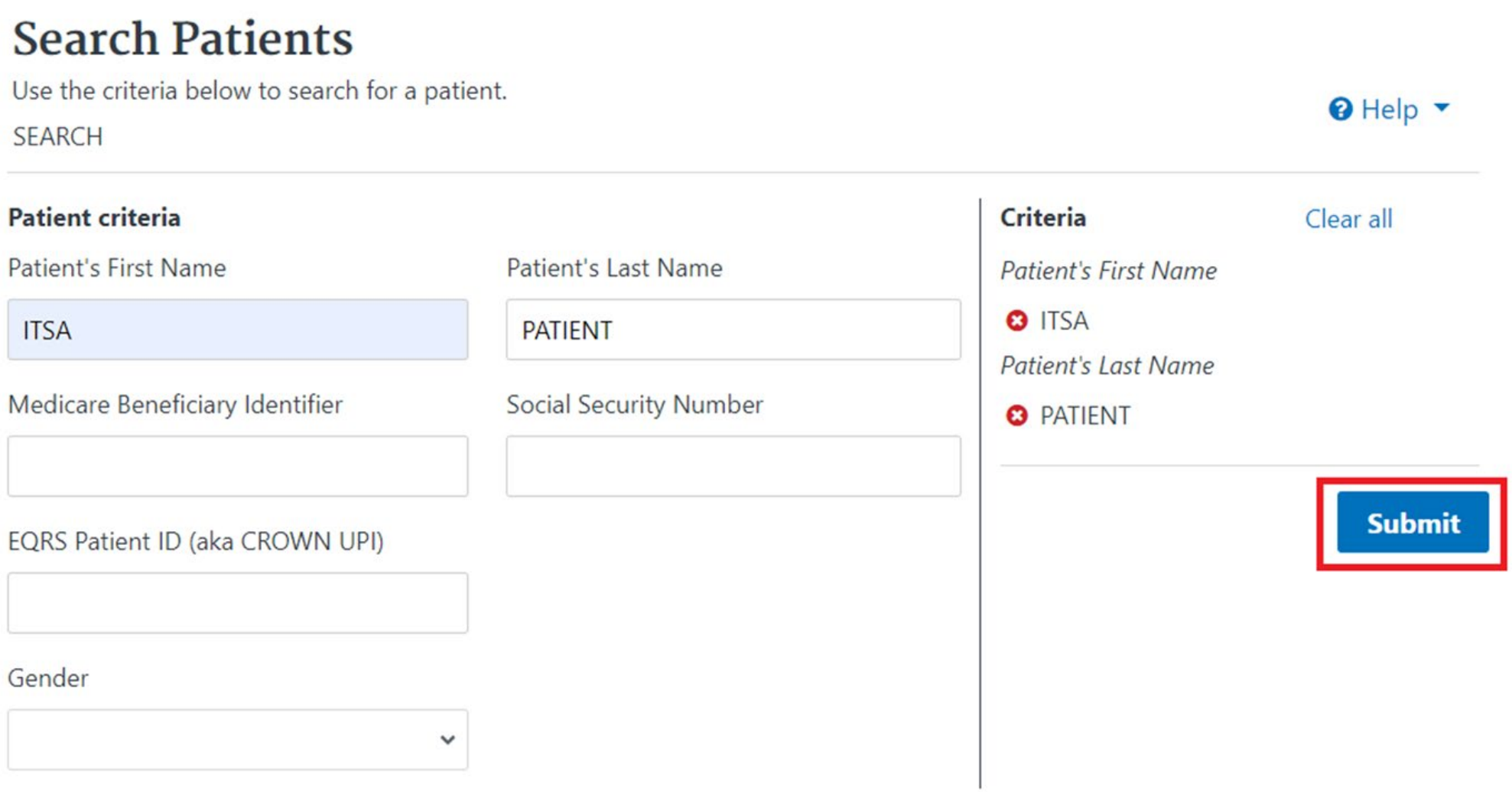
- On November 30, 2023, the Centers for Medicare & Medicaid Services (CMS) approved the version 2023 Form CMS-2728 updates
- The updated form with instructions can be found: https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms2728.pdf
- Due dates have not changed
  - Form CMS 2728 is still due within 45 days of the patient's admission to the facility

Navigating to Form CMS-2728

Click Search Patients



Enter Search Criteria



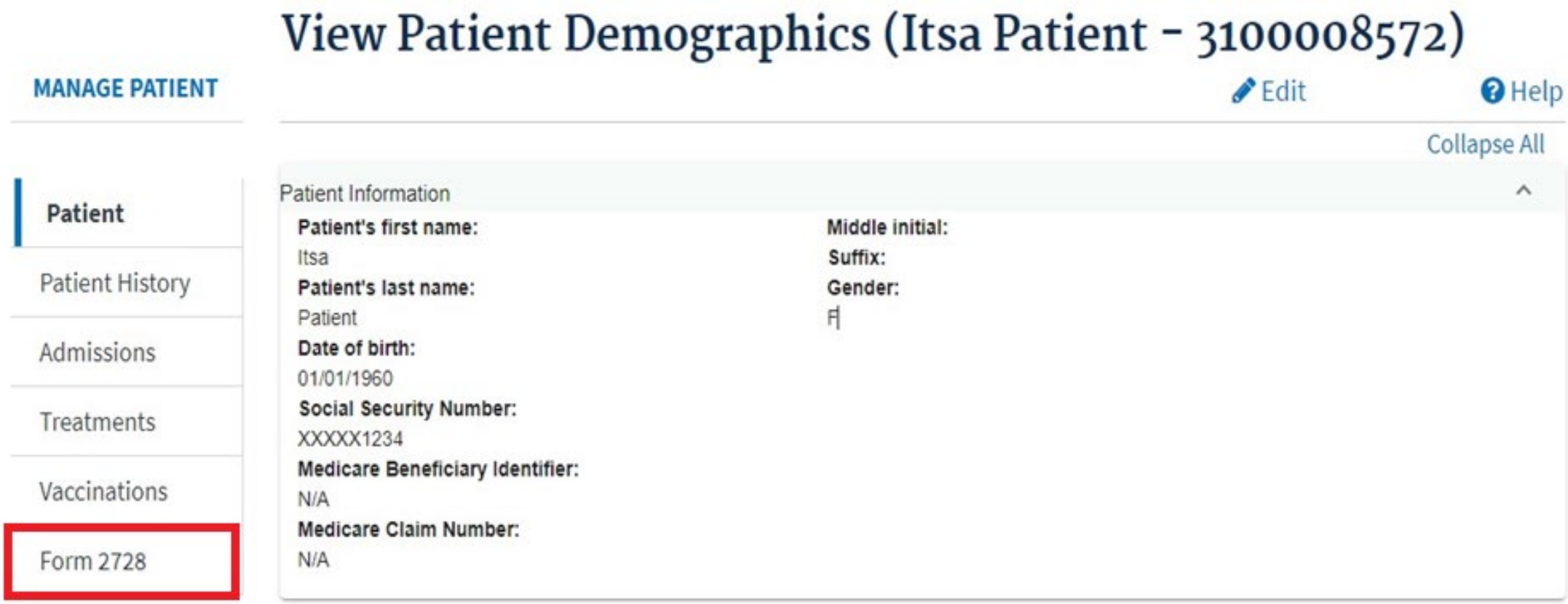
Click EQRS Patient ID

Search Patient Results

Back to Search

EQRS Patient ID (aka CROWN UPI)	First Name	Middle Initial	Last Name	Gender	Date of Birth	Date of Death	Social Security Number	Medicare Beneficiary Identifier
3100008572	ITSA		PATIENT	F	01/01/1960		XXXXX1234	N/A

Click Form 2728



Add Initial 2728

Eligible 2728 Forms	Admit Date	Admit Facility	Due Date	Add 2728
Initial Dialysis	07/08/2024	ABC DIALYSIS	08/22/2024	Add Initial 2728

Existing 2728 Forms	Status	Admit Facility	Due Date	Date Submitted

No Form 2728s exist for this patient.

Section A. Complete for All ESRD Patients

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0046

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT
MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS *Check one:* ☐ Initial ☐ Re-entitlement ☐ Supplemental

1. Name *(Last, First, Middle Initial)*

2. Medicare Beneficiary Identifier or Social Security Number

3. Date of Birth *(mm/dd/yyyy)*

4. Patient Mailing Address *(Include City, State and Zip)*

5. Phone Number *(including area code)*

6. Sex ☐ Male ☐ Female

7. Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino (Complete Item 9)

8. Country/Area of Origin or Ancestry

Old Version of 2728

New Version of 2728

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0046
Expires: 11/30/2026

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT
Medicare entitlement and/or patient registration

A. Complete for all ESRD patients.
Select one: ◯ Initial ◯ Re-entitlement ◯ Supplemental

1. Last name | First name | Middle initial

2. Medicare Number (if available)

3. Social Security Number

4. Date of birth (mm/dd/yyyy)

5. Patient mailing address (include city, state and ZIP Code)

6. Phone number (including area code)

7. Alternate phone number (including area code)

8. Sex assigned at birth, on your original birth certificate
◯ Male ◯ Female

9. How do you currently describe yourself
◯ Male ◯ Female ◯ Transgender male ◯ Transgender female ◯ None of these

10. Ethnicity*
◯ Not Hispanic or Latino ◯ Hispanic or Latino

11. Country/area of origin or ancestry

#9 is an optional field

Section A. Complete for All ESRD Patients

Old Version of 2728

9. Race *(Check all that apply)*
- ☐ White
- ☐ Black or African American
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander*
- ☐ Other

Print Name of Enrolled/Principal Tribe _____

10. Is patient applying for ESRD Medicare coverage?
☐ Yes ☐ No

11. Current Medical Coverage *(Check all that apply)*
☐ Medicaid ☐ Medicare ☐ Employer Group Health Insurance
☐ VA ☐ Medicare Advantage ☐ Other ☐ None

12. Height
INCHES _____ OR
CENTIMETERS _____

13. Dry Weight
POUNDS _____ OR
KILOGRAMS _____

14. Primary Cause of Renal Failure *(Use code from back of form)*

15. Employment Status *(6 mos prior and current status)*

Prior	Current	
☐	☐	Unemployed
☐	☐	Employed Full Time
☐	☐	Employed Part Time
☐	☐	Homemaker
☐	☐	Retired due to Age/Preference
☐	☐	Retired (Disability)
☐	☐	Medical Leave of Absence
☐	☐	Student

New Version of 2728

12. Race* ☐ Multiracial (check all that apply)
- ☐ American Indian/Alaska Native
- ☐ Asian
  - ☐ Asian Indian ☐ Japanese ☐ Chinese ☐ Korean ☐ Filipino ☐ Vietnamese ☐ Guamanian or Chamorro ☐ Other Asian
- ☐ Black or African American
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
  - ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Samoan
- ☐ White
- ☐ Other if unable to identify with any of these six race categories

Print name of enrolled/principal tribe: _____

13. Is patient applying for ESRD Medicare coverage? ..... ○ Yes ○ No

14. Current medical coverage (check all that apply)
☐ Employer group health insurance ☐ Medicare ☐ Medicaid ☐ Veterans Administration ☐ Medicare Advantage ☐ Other
☐ None

15. Height: inches _____ **OR** centimeters _____

16. Dry weight: pounds _____ **OR** kilograms _____

17. Primary cause of renal failure (use code at end of form)

18. Occupation status (6 months prior and current status)

Prior	Current		Prior	Current	
○	○	Unemployed	○	○	Retired (disability)
○	○	Employed full time	○	○	Medical leave of absence
○	○	Employed part time	○	○	Student
○	○	Homemaker	○	○	Volunteer
○	○	Retired due to age/preference			

International Classification of Diseases (ICD)-10 Codes

- Three additional ICD-10 codes were added to the List of Primary Causes of Renal Disease:
  - **E11.21** Type 2 diabetes mellitus with diabetic nephropathy
  - **I120.0** Hypertensive chronic kidney disease with stage 5 chronic kidney disease or end stage renal disease
  - **U07.1** COVID-19

Section A. Co-morbid Conditions

Old Version of 2728

16. Co-Morbid Conditions
(Check all that apply currently and/or during last 10 years)
*See instructions

- a. ☐ Congestive heart failure
- b. ☐ Atherosclerotic heart disease ASHD
- c. ☐ Other cardiac disease
- d. ☐ Cerebrovascular disease, CVA, TIA*
- e. ☐ Peripheral vascular disease*
- f. ☐ History of hypertension
- g. ☐ Amputation
- h. ☐ Diabetes, currently on insulin
- i. ☐ Diabetes, on oral medications
- j. ☐ Diabetes, without medications
- k. ☐ Diabetic retinopathy
- l. ☐ Chronic obstructive pulmonary disease
- m. ☐ Tobacco use (current smoker)
- n. ☐ Malignant neoplasm, Cancer
- o. ☐ Toxic nephropathy
- p. ☐ Alcohol dependence
- q. ☐ Drug dependence*
- r. ☐ Inability to ambulate
- s. ☐ Inability to transfer
- t. ☐ Needs assistance with daily activities
- u. ☐ Institutionalized
  - ☐ 1. Assisted Living
  - ☐ 2. Nursing Home
  - ☐ 3. Other Institution
- v. ☐ Non-renal congenital abnormality
- w. ☐ None

New Version of 2728

19. Co-morbid conditions (check all that apply currently and/or during last 10 years)

- ☐ a. Congestive heart failure
- ☐ b. Atherosclerotic heart disease ASHD
- ☐ c. Other cardiac disease
- ☐ d. Cerebrovascular disease, CVA, TIA*
- ☐ e. Peripheral vascular disease*
- ☐ f. History of hypertension
- ☐ g. Amputation
- ☐ h. Diabetes
  - ☐ Currently on insulin
  - ☐ Currently use other injectable
  - ☐ On oral medications
  - ☐ Without medications
- ☐ i. Diabetic retinopathy
- ☐ j. Chronic obstructive pulmonary disease
- ☐ k. Tobacco use (current smoker)
- ☐ l. Malignant neoplasm, cancer
- ☐ m. Toxic nephropathy
- ☐ n. Alcohol dependence
- ☐ o. Drug dependence*
- ☐ p. Inability to ambulate*
- ☐ q. Inability to transfer*
- ☐ r. Needs assistance with daily activities*
- ☐ s. Alternate housing arrangement:
  - ☐ Assisted living
  - ☐ Nursing home
  - ☐ Other institution
- ☐ t. Non-renal congenital abnormality
- ☐ u. None (no comorbidities)
- ☐ v. Protein calorie malnutrition
- ☐ w. Morbid obesity
- ☐ x. Endocrine metabolic disorders
- ☐ y. Intestinal obstruction/perforation
- ☐ z. Chronic pancreatitis
- ☐ aa. Inflammatory bowel disease
- ☐ bb. Bone/joint/muscle infections/ necrosis
- ☐ cc. Dementia
- ☐ dd. Major depressive disorder
- ☐ ee. Myasthenia gravis
- ☐ ff. Guillain-Barre syndrome
- ☐ gg. Inflammatory neuropathy
- ☐ hh. Parkinson's disease
- ☐ ii. Huntington's disease
- ☐ jj. Seizure disorders and convulsions
- ☐ kk. Interstitial lung disease
- ☐ ll. Partial-thickness dermis wounds
- ☐ mm. Complications of specified implanted device or graft
- ☐ nn. Artificial openings for feeding or elimination

Consider for Pediatric Patients:

- ☐ oo. Chronic lung disease (including dependency on CPAP and ventilators)
- ☐ pp. Vision impairment
- ☐ qq. Feeding tube dependence
- ☐ rr. Failure to thrive/feeding disorders
- ☐ ss. Congenital anomalies requiring subspecialty intervention (cardiac, orthopedic, colorectal)
- ☐ tt. Congenital bladder/urinary tract anomalies
- ☐ uu. Non-kidney solid organ
- ☐ vv. Stem cell transplant
- ☐ ww. Neurocognitive impairment
- ☐ xx. Global developmental delay
- ☐ yy. Cerebral palsy
- ☐ zz. Seizure disorder

Section A. Prior to ESRD Therapy

Old Version of 2728

17. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months

b. Was patient under care of a nephrologist? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months

c. Was patient under care of kidney dietitian? ☐ Yes ☐ No ☐ Unknown If Yes, answer: ☐ <6 months ☐ 6-12 months ☐ >12 months

d. What access was used on first outpatient dialysis: ☐ AVF ☐ Graft ☐ Catheter ☐ Other

If not AVF, then: Is maturing AVF present? ☐ Yes ☐ No

Is maturing graft present? ☐ Yes ☐ No

New Version of 2728

20. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent? ◯ Yes ◯ No ◯ Unknown

If yes, answer: ◯ <6 months ◯ 6-12 months ◯ >12 months

b. Was patient under routine care of a nephrologist? ◯ Yes ◯ No ◯ Unknown

If yes, answer: ◯ <6 months ◯ 6-12 months ◯ >12 months

c. Was patient under routine care of kidney dietitian? ◯ Yes ◯ No ◯ Unknown

If yes, answer: ◯ <6 months ◯ 6-12 months ◯ >12 months

d. What access was used on first outpatient dialysis:

◯ AVF ◯ Graft ◯ PD catheter ◯ Central venous catheter ◯ Other

If not AVF, then: Is maturing AVF present? ◯ Yes ◯ No

Is graft present? ◯ Yes ◯ No

Was one lumen of the central venous catheter used and one needle placed in a AVF or graft? ◯ Yes ◯ No

Is PD catheter present? ◯ Yes ◯ No

e. Was patient diagnosed with an acute kidney injury in the last 12 months? ◯ Yes ◯ No ◯ Unknown

If yes, was dialysis required? ◯ Yes ◯ No

f. Does the patient indicate they received and understood options for a home dialysis modality? ◯ Yes ◯ No

g. Does the patient indicate they received and understood options for a kidney transplant? ◯ Yes ◯ No

For living donor transplant ◯ Yes ◯ No

h. Does the patient indicate they received and understood the option of not starting dialysis at all, also called active medical management without dialysis? ◯ Yes ◯ No

Section A. Laboratory Values

Old Version of 2728

18. Laboratory Values Within 45 Days Prior to the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a.1. Serum Albumin (g/dl)	___.___		d. HbA1c	___ ___.___%	
a.2. Serum Albumin Lower Limit	___.___		e. Lipid Profile TC	___ ___ ___	
a.3. Lab Method Used (BCG or BCP)			LDL	___ ___ ___	
b. Serum Creatinine (mg/dl)	___ ___.___		HDL	___ ___	
c. Hemoglobin (g/dl)	___ ___.___		TG	___ ___ ___ ___	

New Version of 2728

21. Laboratory values within 45 days prior to the most recent ESRD episode. If not available within 30 days of admission to the dialysis facility for ESRD treatment, admission laboratory values may be used. (HbA1c and LDL within 1 Year of most recent ESRD episode).

◯ Prior lab values ◯ Admission lab values

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a. Serum albumin g/dl	___.___		e. Hemoglobin g/dl	___.___	
b. Serum albumin lower limit	___.___		f. HbA1c	___.___	
c. Lab method used (BCG/BCP)	___.___		g. LDL	___.___	
d. Serum creatinine mg/dl	___.___		h. Cystatin C	___.___	

Section A. Laboratory Values – Prior lab values vs. Admission lab values

- Prior Lab Values
  - Laboratory values obtained within 45 days prior to date regular chronic dialysis began (#34).
- Admission Lab Values
  - Laboratory values drawn within 15 days prior to or 15 days after the Date Patient Started Chronic Dialysis at Current Facility (#35).
    - Please note that EQRS will display a warning if the lab date entered is outside of this range.

Section A: New Questions Added

New Questions - OPTIONAL
22. Does the patient have living will or medical/physician order for life sustaining treatment?
23. Are you currently concerned about where you will live over the next 90 days? (No longer applicable)
24. (a) Do you have caregiver support to assist with your daily care? (b) With home dialysis/kidney transplant? (c) Does the caregiver live with you?
25. Do you have access to reliable transportation? (No longer applicable)
26. (a) Do you understand health literature in English? (b) Do you need a different way other than written documents to learn about your health? (c) Do you need a translator to understand health information?
27. Do you find it hard to pay for the very basics like housing, medical care, electricity, and heating? (No longer applicable)
28. Within the past 12 months, has the food you bought not lasted and you didn't have money to get more? (No longer applicable)
29. Has anyone, including family and friends, threatened you with harm or physically hurt you in the last 12 months? (No longer applicable)

Section A. New Questions Added

(22) Does the patient have living will or Medical/Physician order for life sustaining treatment?
(23) Are you currently concerned about where you will live over the next 90 days?
(24) a. Do you have caregiver support to assist with your daily care? b. Do you have caregiver support to assist with home dialysis/kidney transplant? c. Does the caregiver live with you?
(25) Do you have access to reliable transportation?
(26a) Do you understand health literature in English? (26b) Do you need a different way other than written documents to learn about your health? (26c) Do you need a translator to understand health information?
(27) Do you find it hard to pay for the very basics like housing, medical care, electricity, and heating?
(28) Within the past 12 months, has the food you bought not lasted and you didn't have money to get more?
(29) Has anyone, including family and friends, threatened you with harm or physically hurt you in the last 12 months?

Section B.

Old Version of 2728

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT	
19. Name of Dialysis Facility	20. Medicare Provider Number *(for item 19)*
21. Primary Dialysis Setting ☐ Home ☐ Dialysis Facility ☐ SNF/Long Term Care Facility	22. Primary Type of Dialysis ☐ Hemodialysis (Sessions per week____/hours per session____) ☐ CAPD ☐ CCPD ☐ Other
23. Date Regular Chronic Dialysis Began *(mm/dd/yyyy)*	24. Date Patient Started Chronic Dialysis at Current Facility *(mm/dd/yyyy)*
25. Has patient been informed of kidney transplant options? ☐ Yes ☐ No	26. If patient NOT informed of transplant options, please check all that apply: ☐ Patient declined information ☐ Patient is not eligible medically ☐ Patient has not been assessed ☐ Other

New Version of 2728

B. Complete for all ESRD patients in dialysis treatment

30. Name of dialysis facility

31. CMS Certification Number (CCN) (for item 30)

32. Primary dialysis setting (select one)
◯ Home ◯ In-center ◯ SNF/LTC*

33. Primary type of dialysis (select one)
◯ Hemodialysis (sessions per week____/minutes per session____) ◯ CAPD ◯ CCPD ◯ Other

34. Date regular chronic dialysis began (mm/dd/yyyy)

35. Date patient started chronic dialysis at current facility (mm/dd/yyyy)*

36. Does the patient understand kidney transplant options at the time of admission?* ..... ◯ Yes ◯ No
◯ N/A (if patient answered yes to question 20(g)

37. If patient NOT informed of transplant options (or does not understand transplant options) please check all that apply:
☐ Patient found information overwhelming* ☐ Patient declined information ☐ Cognitive impairment*
☐ Patient has not been assessed at this time ☐ Patient has an absolute contraindication* ☐ Other

38. Has the patient been connected to a transplant center with a referral?* ..... ◯ Yes ◯ No
Date of referral (mm/dd/yyyy): _____
Name of transplant center: _____

39. Does the patient understand home dialysis options at the time of admission?* ..... ◯ Yes ◯ No
◯ N/A (if patient answered yes to question 20(f)

40. If patient NOT informed of home dialysis options (or does not understand home dialysis options) please check all that apply:
☐ Patient found information overwhelming* ☐ Patient declined information ☐ Cognitive impairment*
☐ Patient has not been assessed at this time ☐ Patient has an absolute contraindication* ☐ Other

Section C.

Old Version of 2728

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS		
27. Date of Transplant *(mm/dd/yyyy)*	28. Name of Transplant Hospital	29. Medicare Provider Number for Item 28
Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.		
30. Enter Date *(mm/dd/yyyy)*	31. Name of Preparation Hospital	32. Medicare Provider number for Item 31
33. Current Status of Transplant *(if functioning, skip items 36 and 37)* ☐ Functioning ☐ Non-Functioning	34. Type of Donor: ☐ Deceased ☐ Living Related ☐ Living Unrelated	
35. If Non-Functioning, Date of Return to Regular Dialysis *(mm/dd/yyyy)*	36. Current Dialysis Treatment Site ☐ Home ☐ Dialysis Facility ☐ SNF/Long Term Care Facility	

New Version of 2728

C. Complete for all kidney transplant patients	
41. Date of transplant (mm/dd/yyyy)	
42. Name of transplant hospital	43. CMS Certification Number (CCN) (for item 42)
Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.	
44. Enter date (mm/dd/yyyy)	
45. Name of preparation hospital	46. CMS Certification Number (CCN) (for item 45)
47. Current status of transplant (if functioning, skip items 49 and 50) ◯ Functioning ◯ Non-functioning	
48. Type of transplant: ◯ Deceased donor ◯ Living related ◯ Living unrelated ◯ Multi-organ ◯ Paired exchange	
49. If non-functioning, date of return to regular dialysis (mm/dd/yyyy)	
50. Current dialysis setting ◯ Home ◯ In-center ◯ SNF/LTC* ◯ Transitional care unit*	

Section D.

Old Version of 2728

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)			
37. Name of Training Provider		38. Medicare Provider Number of Training Provider (for Item 37)	
39. Date Training Began *(mm/dd/yyyy)*		40. Type of Training ☐ Hemodialysis a. ☐ Home b. ☐ In Center ☐ CAPD ☐ CCPD ☐ Other	
41. This Patient is Expected to Complete *(or has completed)* Training and will Self-dialyze on a Regular Basis. ☐ Yes ☐ No		42. Date When Patient Completed, or is Expected to Complete, Training *(mm/dd/yyyy)*	
I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.			
43. Printed Name and Signature of Physician personally familiar with the patient's training			44. UPIN or NPI of Physician in Item 43
a.) Printed Name	b.) Signature	c.) Date *(mm/dd/yyyy)*	

New Version of 2728

D. Complete for all ESRD self-dialysis training patients (Medicare applicants only)	
51. Name of training provider	
52. CMS Certification Number (CCN) of training provider (for item 51)	53. Date training began (mm/dd/yyyy)
54. Type of training ☐ Hemodialysis: (select one) a. ◯ Home b. ◯ In-center ☐ CAPD ☐ CCPD ☐ Other	
55. This patient is expected to complete (or has completed) training and will self-dialyze on a regular basis. ..... ◯ Yes ◯ No	
56. Date when patient completed, or is expected to complete, training (mm/dd/yyyy)	
I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.	
57. Printed name and signature of physician personally familiar with the patient's training	
a. Printed name	
b. Signature	c. Date (mm/dd/yyyy)
58. NPI of physician (for item 57)	

Section E.

Old Version of 2728

E. PHYSICIAN IDENTIFICATION		
45. Attending Physician *(Print)*	46. Physician's Phone No. *(include Area Code)*	47. UPIN or NPI of Physician in Item 45
PHYSICIAN ATTESTATION *I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.*		
48. Attending Physician's Signature of Attestation *(Same as Item 45)*		49. Date *(mm/dd/yyyy)*
50. Physician Recertification Signature		51. Date *(mm/dd/yyyy)*
52. Remarks		

New Version of 2728

E. Physician Identification	
59. Attending physician (print)	
60. Physician's phone number (include area code)	61. NPI of physician
Physician attestation I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.	
62. Attending physician's signature of attestation (same as item 59)	63. Date (mm/dd/yyyy)
64. Physician recertification signature	65. Date (mm/dd/yyyy)
66. Remarks	

Section F.

Old Version of 2728

F. OBTAIN SIGNATURE FROM PATIENT	
I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.	
53. Signature of Patient *(Signature by mark must be witnessed.)*	54. Date *(mm/dd/yyyy)*

New Version of 2728

F. Obtain signature from patient	
I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.	
67. Signature of patient (signature by mark must be witnessed.)	68. Date (mm/dd/yyyy)
If patient unable to sign/mark: (select one) ☐ Lost to follow-up ☐ Moved out of the United States and territories ☐ Expired date (mm/dd/yyyy)	

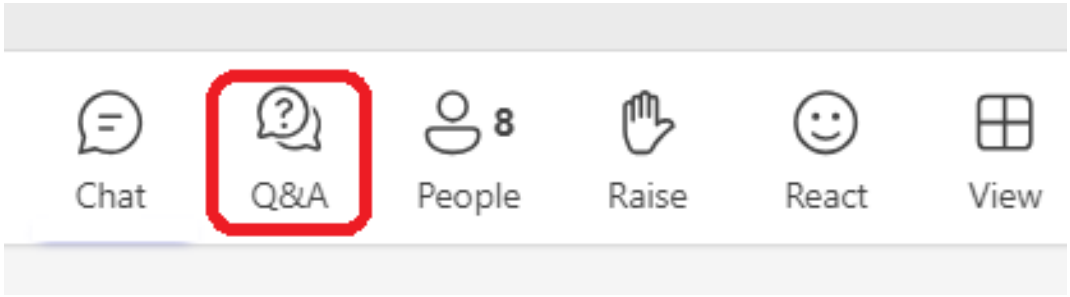
Section F.

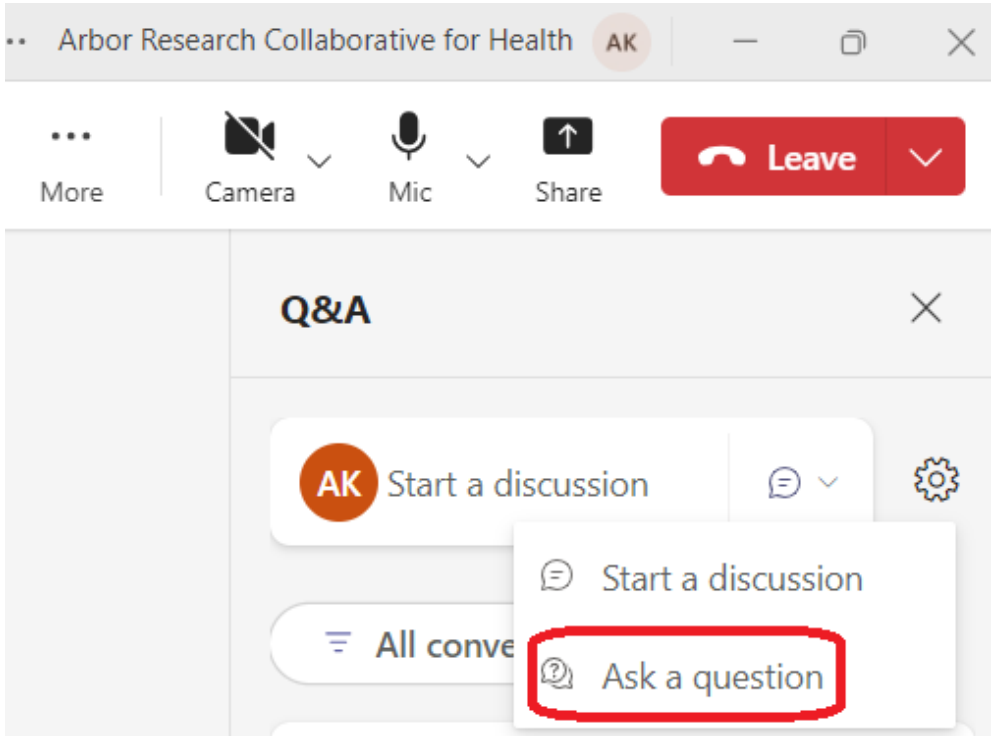
Patient Unable to Sign Reason	Circumstances for selecting an option
***Lost to follow-up**	Select this option **AFTER** several attempts to reach the patient have been made without success. These include but are not limited to: • Calling the patient's home and cell phone • Calling the patient's next of kin or alternate emergency contacts • Sending certified letter to the patient's home • Requesting a well-visit from local police department • Checking local hospitals.
Moved out of the United States and territories	Select this option if the patient has left the country, this may occur in cases when patients from other countries visit short term and then return to their homelands. (Yes, you are responsible for completing 2728s on foreign visitors – if no other 2728 form exists for those visitors)
Expired date	Select this option if the patient has passed away before signing the form. Please note that you will need to enter the patient's Date of Death on the form.

*** Please consult your local ESRD Network before selecting Lost to follow-up**

Submitting Questions

- Click on Q&A at top of your screen to submit a question





- Under Q&A, select Ask a question.
- Type your question in box on right hand side of your screen.

Please note that some questions may require additional research.
Any unanswered questions can be submitted to
QualityNet Question and Answer Tool

Form CMS-2746 Overview

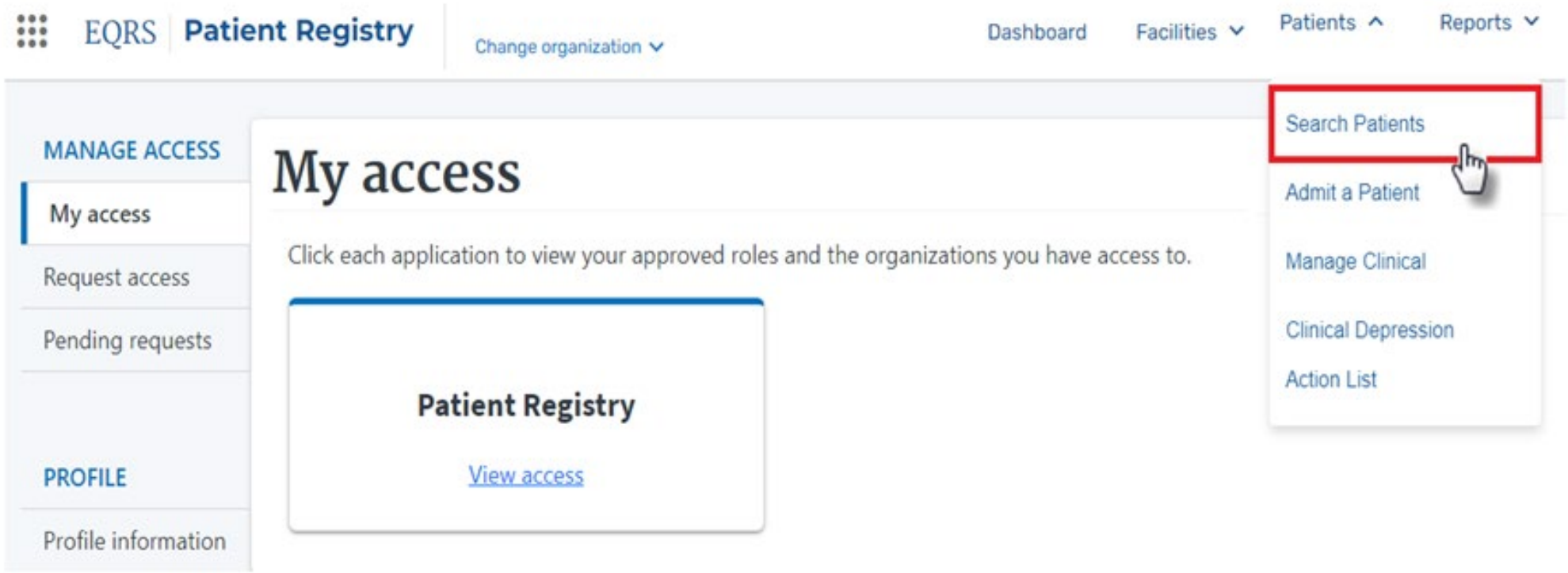
Updated CMS 2746

- The updated form with instructions can be found: https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms2746.pdf

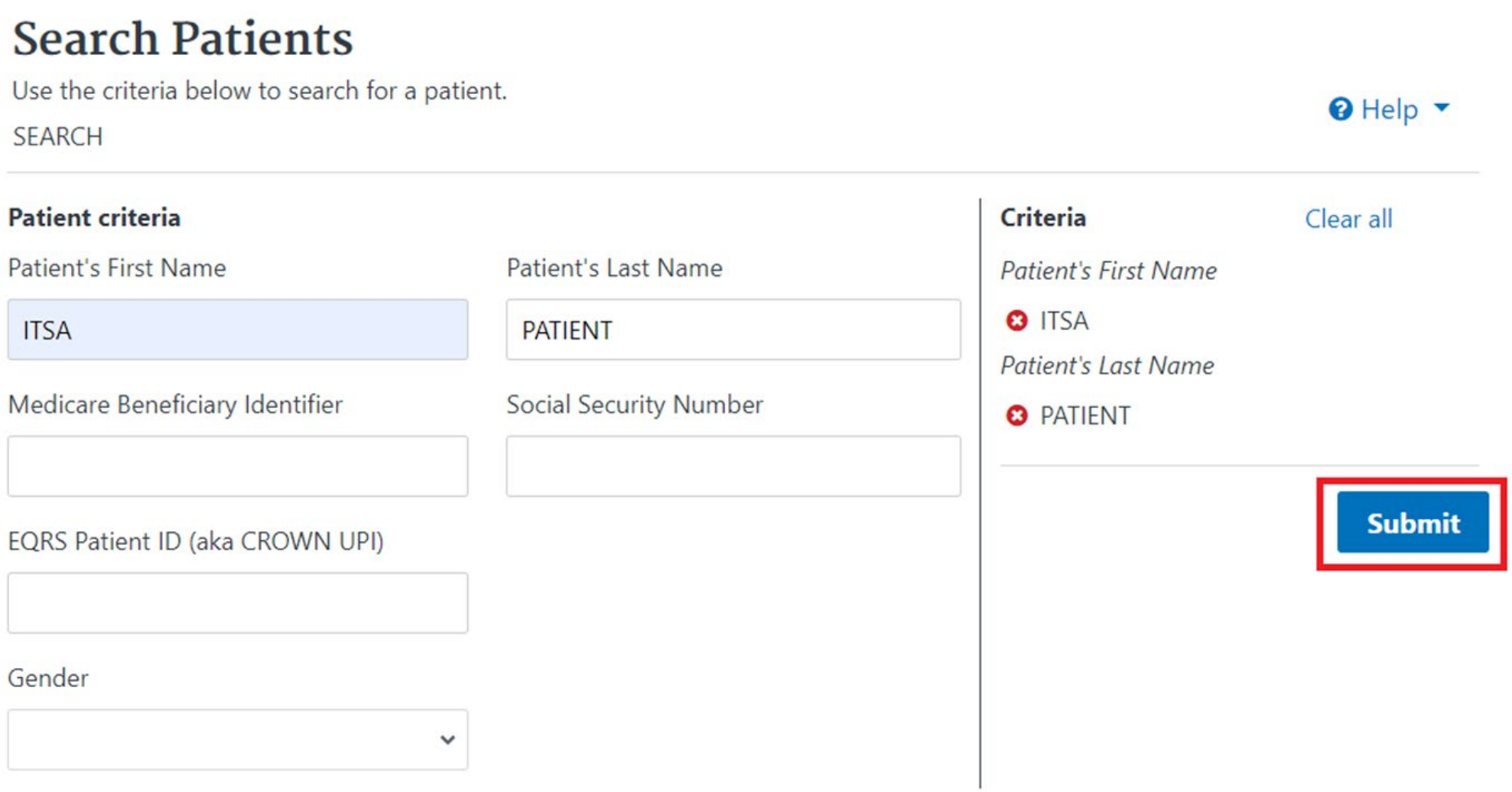
- Due dates have not changed
  - Form CMS-2746 is still due within 14 days of the patient's date of death

Navigating to Form CMS-2746

Click Search Patients



Enter Search Criteria



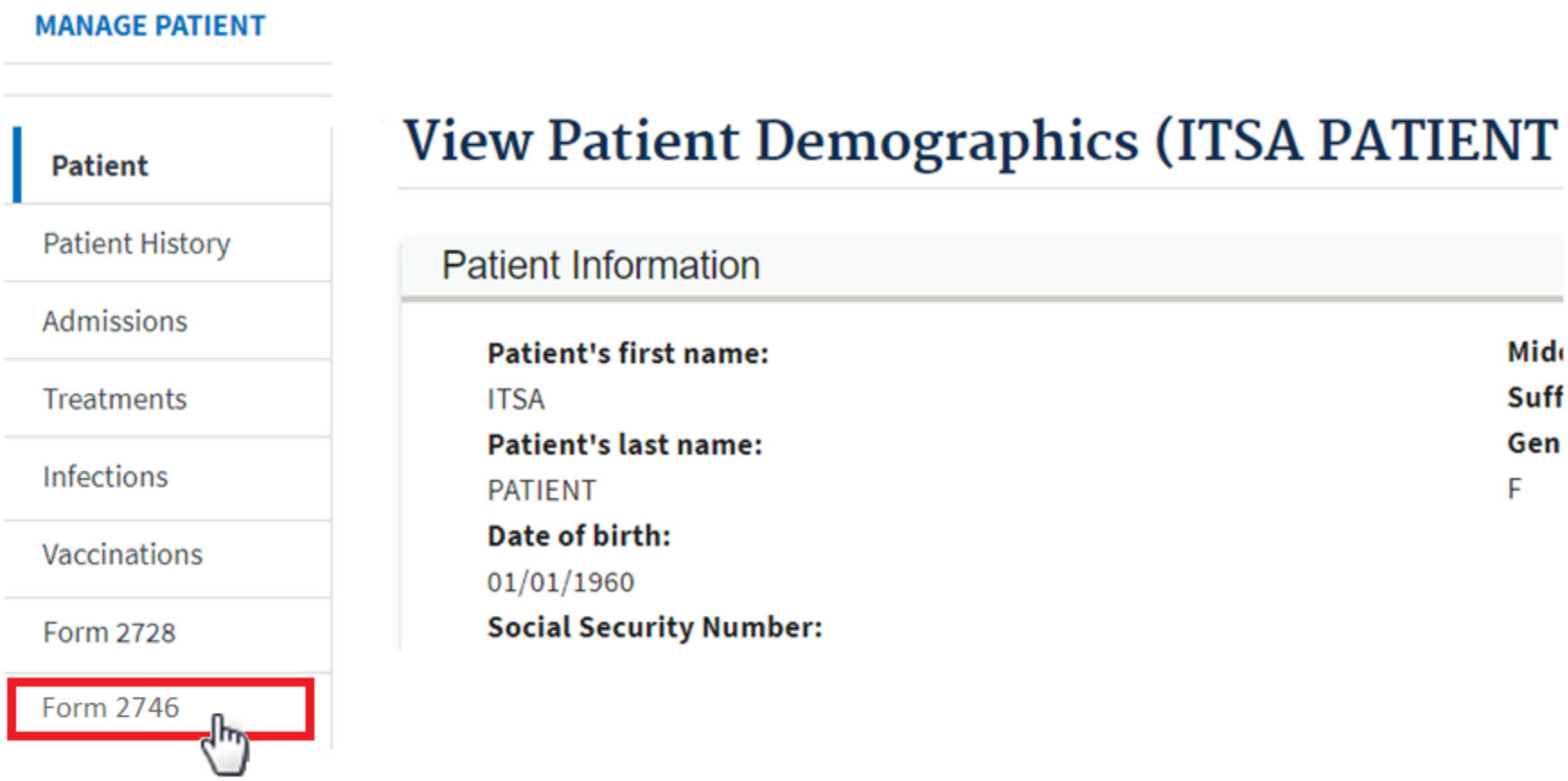
Click EQRS Patient ID

Search Patient Results

Back to Search

EQRS Patient ID (aka CROWN UPI)	First Name	Middle Initial	Last Name	Gender	Date of Birth	Date of Death	Social Security Number	Medicare Beneficiary Identifier
3100008572	ITSA		PATIENT	F	01/01/1960		XXXXX1234	N/A

Click Form 2746



ESRD Death Notification

ESRD DEATH NOTIFICATION
END STAGE RENAL DISEASE MEDICAL INFORMATION SYSTEM

1. Patient's Last Name	First	MI	2. Patient's Sex a. ☐ Male b. ☐ Female
3. Date of Birth ___ ___ / ___ ___ / ___ ___ ___ ___ Month Day Year	4. Medicare Beneficiary Identifier or Social Security Number		
5. Patient's State of Residence	6. Place of Death a. ☐ Hospital c. ☐ Home e. ☐ Other b. ☐ Dialysis Unit d. ☐ Nursing Home f. ☐ Unknown		7. Date of Death ___ ___ / ___ ___ / ___ ___ ___ ___ Month Day Year
8. Modality at Time of Death a. ☐ Incenter Hemodialysis b. ☐ Home Hemodialysis c. ☐ CAPD d. ☐ CCPD e. ☐ Transplant f. ☐ Other			

Old Version of 2746

New Version of 2746

#6 is an optional field

ESRD DEATH NOTIFICATION
End Stage Renal Disease Medical Information System

1. Last name	First name	Middle initial
2. Medicare Number (if available)	3. Social Security Number	4. Date of birth (mm/dd/yyyy)
5. Sex assigned at birth, on original birth certificate (select one) ◯ Male ◯ Female		
6. Gender identity (select one) ◯ Male ◯ Female ◯ Transgender male ◯ Transgender female ◯ None of these		
7. Patient's State of residence (2-letter abbreviation)	8. Date of death (mm/dd/yyyy)	
9. Place of death (select one) ◯ Hospital ◯ Home ◯ Other ◯ Dialysis unit ◯ Nursing home ◯ Unknown		
10. Modality at time of death (select one) ◯ Incenter hemodialysis ◯ Home hemodialysis ◯ CAPD ◯ CCPD ◯ Transplant ◯ Other		

ESRD Death Notification

9. Provider Name and Address *(Street)*	10. Provider Number
Provider Address *(City/State)*	
11. Causes of Death (enter codes from list on back of form) a. Primary Cause: ___ ___ ___ b. Were there secondary causes? ☐ No ☐ Yes, specify: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ c. If cause is other (98) please specify: _____	

Old Version of 2746

New Version of 2746

11. Name of dialysis facility/transplant center	12. CMS Certification Number (CCN) for item 11 (6 digits)
13. Address of dialysis facility/transplant center (street address, city, state, ZIP Code)	
14. Causes of death (enter codes from list on form) Primary cause of death: _____ Secondary causes of death (list up to 4): _____ _____ _____ _____ ☐ No secondary If cause of death is other (98) specify here: _____	

ESRD Death Notification: Causes of Death

CARDIAC
23 Myocardial infarction, acute
25 Pericarditis, incl. Cardiac tamponade
26 Atherosclerotic heart disease
27 Cardiomyopathy
28 Cardiac arrhythmia
29 Cardiac arrest, cause unknown
30 Valvular heart disease
31 Pulmonary edema due to exogenous fluid
32 Congestive Heart Failure

VASCULAR
35 Pulmonary embolus
36 Cerebrovascular accident including intracranial hemorrhage
37 Ischemic brain damage/Anoxic encephalopathy
38 Hemorrhage from transplant site
39 Hemorrhage from vascular access
40 Hemorrhage from dialysis circuit
41 Hemorrhage from ruptured vascular aneurysm
42 Hemorrhage from surgery (not 38, 39, or 41)
43 Other hemorrhage (not 38-42, 72)
44 Mesenteric infarction/ischemic bowel

INFECTION
33 Septicemia due to internal vascular access
34 Septicemia due to vascular access catheter
45 Peritoneal access infectious complication, bacterial
46 Peritoneal access infectious complication, fungal
47 Peritonitis (complication of peritoneal dialysis)
48 Central nervous system infection (brain abscess, meningitis, encephalitis, etc.)
51 Septicemia due to peripheral vascular disease, gangrene
52 Septicemia, other
61 Cardiac infection (endocarditis)
62 Pulmonary infection (pneumonia, influenza)
63 Abdominal infection (peritonitis (not comp of PD), perforated bowel, diverticular disease, gallbladder)
70 Genito-urinary infection (urinary tract infection, pyelonephritis, renal abscess)

LIVER DISEASE
64 Hepatitis B
71 Hepatitis C
65 Other viral hepatitis
66 Liver-drug toxicity
67 Cirrhosis
68 Polycystic liver disease
69 Liver failure, cause unknown or other

GASTRO-INTESTINAL
72 Gastro-intestinal hemorrhage
73 Pancreatitis
75 Perforation of peptic ulcer
76 Perforation of bowel (not 75)

METABOLIC
24 Hyperkalemia
77 Hypokalemia
78 Hypernatremia
79 Hyponatremia
100 Hypoglycemia
101 Hyperglycemia
102 Diabetic coma
95 Acidosis

ENDOCRINE
96 Adrenal insufficiency
97 Hypothyroidism
103 Hyperthyroidism

OTHER
80 Bone marrow depression
81 Cachexia/failure to thrive
82 Malignant disease, patient ever on immunosuppressive therapy
83 Malignant disease (not 82)
84 Dementia, incl. dialysis dementia, Alzheimer's
85 Seizures
87 Chronic obstructive lung disease (COPD)
88 Complications of surgery
89 Air embolism
104 Withdrawal from dialysis/uremia
90 Accident related to treatment
91 Accident unrelated to treatment
92 Suicide
93 Drug overdose (street drugs)
94 Drug overdose (not 92 or 93)
98 Other cause of death
99 Unknown

Old Version of 2746

Cardiac
23 Myocardial infarction, acute
25 Pericarditis, incl. cardiac tamponade
26 Atherosclerotic heart disease
27 Cardiomyopathy
28 Cardiac arrhythmia
29 Cardiac arrest, cause unknown
30 Valvular heart disease
31 Pulmonary edema due to exogenous fluid
32 Congestive Heart Failure

Vascular
35 Pulmonary embolus
36 Cerebrovascular accident including intracranial hemorrhage
37 Ischemic brain damage/anoxic encephalopathy
38 Hemorrhage from transplant site
39 Hemorrhage from vascular access
40 Hemorrhage from dialysis circuit
41 Hemorrhage from ruptured vascular aneurysm
42 Hemorrhage from surgery (not 38, 39, or 41)
43 Other hemorrhage (not 38-42, 72)
44 Mesenteric infarction/ischemic bowel

Infection
33 Septicemia due to internal vascular access
34 Septicemia due to vascular access catheter
45 Peritoneal access infectious complication, bacterial
46 Peritoneal access infectious complication, fungal
47 Peritonitis (complication of peritoneal dialysis)
48 Central nervous system infection (brain abscess, meningitis, encephalitis, etc.)
51 Septicemia due to peripheral vascular disease, gangrene
52 Septicemia, other
61 Cardiac infection (endocarditis)
62 Pulmonary infection (pneumonia, influenza)
63 Abdominal infection (peritonitis (not comp of PD), perforated bowel, diverticular disease, gallbladder)
70 Genito-urinary infection (urinary tract infection, pyelonephritis, renal abscess)

Liver Disease
64 Hepatitis B
71 Hepatitis C
65 Other viral hepatitis
66 Liver-drug toxicity
67 Cirrhosis
68 Polycystic liver disease
69 Liver failure, cause unknown or other

Gastro-Intestinal
72 Gastro-intestinal hemorrhage
73 Pancreatitis
75 Perforation of peptic ulcer
76 Perforation of bowel (not 75)

Metabolic
24 Hyperkalemia
77 Hypokalemia
78 Hypernatremia
79 Hyponatremia
100 Hypoglycemia
101 Hyperglycemia
102 Diabetic coma
95 Acidosis

Endocrine
96 Adrenal insufficiency
97 Hypothyroidism
103 Hyperthyroidism

Other
80 Bone marrow depression
81 Cachexia/failure to thrive
82 Malignant disease, patient ever on immunosuppressive therapy
83 Malignant disease (not 82)
84 Dementia, incl. dialysis dementia, Alzheimer's
85 Seizures
87 Chronic obstructive lung disease (COPD)
88 Complications of surgery
89 Air embolism
90 Accident related to treatment
91 Accident unrelated to treatment
92 Suicide
93 Drug overdose (street drugs)
94 Drug overdose (not 92 or 93)
98 Other cause of death
99 Unknown
104 Withdrawal from dialysis/uremia
105 COVID-19
106 Severe adverse medication reaction

New Version of 2746

ESRD Death Notification

12. Renal replacement therapy discontinued prior to death: ☐ Yes ☐ No

If yes, check one of the following:

a. ☐ Following HD and/or PD access failure
b. ☐ Following transplant failure
c. ☐ Following chronic failure to thrive
d. ☐ Following acute medical complication
e. ☐ Other
f. Date of last dialysis treatment ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

13. Was discontinuation of renal replacement therapy after patient/family request to stop dialysis?

☐ Yes ☐ No
☐ Unknown ☐ Not Applicable

Old Version of 2746

New Version of 2746

15. Renal replacement therapy discontinued prior to death ..... ○ Yes ○ No

If yes, select one of the following:

○ Following HD and/or PD access failure ○ Following transplant failure ○ Following chronic failure to thrive
○ Following acute medical complication ○ Other

Date of last dialysis treatment: _____

16. Was discontinuation of renal replacement therapy after patient/family request to stop dialysis? ..... ○ Yes ○ No ○ Unknown ○ Not applicable

☐ **If yes,** check here if related to hospice care.

ESRD Death Notification

14. If deceased ever received a transplant:	15.Was patient receiving Hospice care prior to death?
a. Date of most recent transplant ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year) ☐ Unknown b. Type of transplant received ☐ Living Related ☐ Living Unrelated ☐ Deceased ☐ Unknown c. Was graft functioning (patient not on dialysis) at time of death? ☐ Yes ☐ No ☐ Unknown d. Did transplant patient resume chronic maintenance dialysis prior to death? ☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

16. Name of Physician *(Please print complete name)*	17. Signature of Person Completing this Form	Date

Old Version of 2746

New Version of 2746

17. Did the patient ever receive a transplant prior to death? ..... ○ Yes ○ No ○ Unknown
If yes, date of most recent transplant (mm/dd/yyyy): _____
Type of transplant received (select one):
○ Deceased donor ○ Living related ○ Living unrelated ○ Multi-organ ○ Paired exchange
Was transplant graft functioning (patient not on dialysis) at time of death? ..... ○ Yes ○ No ○ Unknown
Did transplant patient resume chronic maintenance dialysis prior to death? ..... ○ Yes ○ No ○ Unknown
Did the transplant patient experience a short-term course (acute) of dialysis prior to death? ..... ○ Yes ○ No ○ Unknown

18. Was patient receiving palliative care/hospice care? ..... ○ Yes ○ No ○ Unknown

19. Name of attending physician (print complete name)

20. Name of person submitting the form	21. Date (mm/dd/yyyy)

Coming Soon

Upcoming New Features, Events & Deadlines

- CMS Form 2728 and 2746 updates (Oct. 1)
- New Medical Personnel Module
- Clinical data submission deadlines
- Depression screening deadlines
- ICH CAHPS attestation submission deadline
- Facility Commitment to Health Equity attestation submission deadline
- NHSN data submission deadlines

Updates to Forms CMS 2728 and 2746

- New form versions will be available in EQRS on October 1, 2024
- To access the new forms
  - CMS 2728
  - CMS 2746

EQRS Clinical Data Submission Deadlines

Data Submission Schedule for 2024 EQRS Clinical Data	
Reporting Month	**Data Submission Deadline**
July 2024	September 30, 2024, at 11:59 p.m. PT
August 2024	October 31, 2024, at 11:59 p.m. PT
September 2024	December 2, 2024, at 11:59 p.m. PT
October 2024	December 31, 2024, at 11:59 p.m. PT
November 2024	February 3, 2025, at 11:59 p.m. PT
December 2024	March 3, 2025, at 11:59 p.m. PT

Note: For additional information on the ESRD QIP measures, refer to the Calendar Year (CY) 2024 ESRD QIP Technical Measure Specifications.

EQRS Depression Screening and Follow-Up Submission Deadline

EQRS Submission Schedule for 2024 Depression Screening and Follow-Up Assessments	
Assessment Period	**Data Submission Deadline**
January 1 – December 31, 2024	March 3, 2025, at 11:59 p.m. PT

Note: For additional information on the Clinical Depression Screening and Follow Up measure, refer to the CY 2024 ESRD QIP Technical Measure Specifications.

ICH CAHPS Attestation Submission Deadline

EQRS Submission Schedule for 2024 In-Center Hemodialysis Consumer Assessment of Healthcare Providers and Systems (ICH CAHPS) Attestation	
Attestation Year	**Data Submission Deadline**
January 1 – December 31, 2024	March 3, 2025, at 11:59 p.m. PT

Note: For additional information on the ICH CAHPS Survey measure, refer to the CY 2024 ESRD QIP Technical Measure Specifications.

Facility Commitment to Health Equity Attestation Submission Deadline

EQRS Submission Schedule for Facility Commitment to Health Equity Attestation	
Attestation Year	**Data Submission Deadline**
January 1 – December 31, 2024	March 3, 2025, at 11:59 p.m. PT

Note: For additional information on the Facility Commitment to Health Equity measure, refer to the CY 2024 ESRD QIP Technical Measure Specifications.

NHSN ESRD Data Submission Deadlines

Data Submission Schedule for 2024 NHSN ESRD Data: Dialysis Events, Bloodstream Infections, and COVID-19 Vaccination Coverage Among Healthcare Personnel		
Quarter	**2024 Reporting Months**	**Data Submission Deadline**
1	January-March	July 1, 2024, at 11:59 p.m. PT
2	April-June	September 30, 2024, at 11:59 p.m. PT
3	July-September	December 31, 2024, at 11:59 p.m. PT
4	October-December	March 31, 2025, at 11:59 p.m. PT

Facilities must submit NHSN data by the established deadlines. Not meeting the required reporting deadlines puts your facility at risk for an ESRD QIP payment reduction.

Note: For additional information on the NHSN measures, refer to the CY 2024 ESRD QIP Technical Measure Specifications.

EQRS Data Reporting: Additional Information

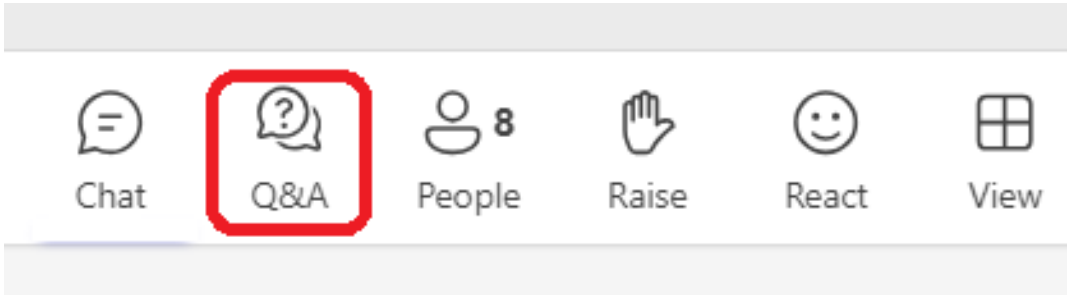
EQRS data submission deadlines are listed on MyCROWNWeb.org: EQRS deadlines for CY 2024 Data

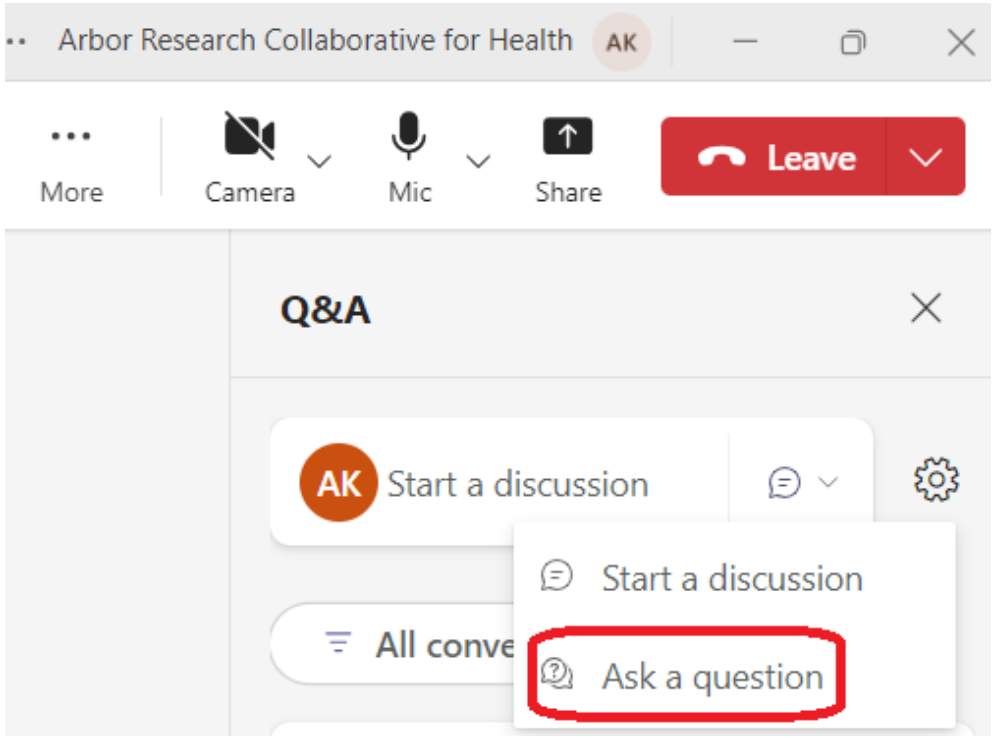
Additional information on EQRS data reporting requirements is available on MyCROWNWeb.org:

- EQRS Data Submission Stopwatch
- EQRS Data Management Guidelines
- ESRD QIP Successful Reporting Guide

Submitting Questions

- Click on Q&A at top of your screen to submit a question





- Under Q&A, select Ask a question.
- Type your question in box on right hand side of your screen.

Please note that some questions may require additional research.
Any unanswered questions can be submitted to
QualityNet Question and Answer Tool

Submitting Questions

For additional help, contact:

- **QualityNet Help Desk**
  - **Email**
    - qnetsupport-esrd@cms.hhs.gov
  - **Online Ticket submission**
    - https://cmsqualitysupport.servicenowservices.com/ccsq_support_central
  - **Phone**
    - 1-(866)-288-8912

Upcoming ESRD QIP & EQRS Events

Save the Dates!

All Events are Scheduled to begin at 2PM ET	
EQRS Monthly Stakeholder Meeting -EQRS basics, new medical personnel module, updating facility contacts	Oct. 15
ESRD QIP Quarterly Stakeholder Meeting -Topics to be determined	Oct. 22
EQRS Monthly Stakeholder Meeting -Topics to be determined	Nov. 19

Event Slides and Recordings

Recordings and slides from all ESRD QIP and EQRS events are all posted shortly after the events at: https://mycrownweb.org/events/

Post-Event Evaluation

Please complete a short post-event evaluation by clicking on the link in the Chat box. Your feedback will help improve future events.