**Discharge Criteria & Documentation Reference Guide**

Must submit a completed Provider Disenrollment Form #6 and

* Documentation that informs the plan of the ‘Who was involved?’ ‘When did it happen?’ ‘Where did it happen?’ ‘What Happened?’
* Details are important. You need to paint a picture.
* If a report was filed with the police, please include a copy of the report.

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| **Ref #** | **Discharging for:** | **Documentation** | **Good documentation:** | **Bad documentation**  |
| 1 | **Fraudulent behavior** under a health plan contract | Describe the event. | On 6/6/16 checked in for her scheduled appointment at 8 a.m. * The PHC ID card presented was for Jackie Smith.
* Jackie Smith is a known patient, receptionist Mary Clark requested a photo ID.
* Patient could not provide a photo ID.
* When questioned, patient admitted Jackie Smith, her cousin “lent” her, her PHC ID Card.
 | I think the member maybe lending her id card to a relative…. |
| 2 | **Fraudulently receiving and/or altering prescriptions**, theft of prescriptions pads or photocopying prescriptions. | Describe the event. | On 6/6/16 Walgreens contacted our office to verify a prescription for mbr John Smith. Per Walgreens: * John Smith presented a prescription on 6/5/2016 for Vicodin 125 mg for 8 pills per day.
* Our records indicate the prescription was for 3 pills per day.
* Attached is the fax received from Walgreens showing w/8 pills per day, our chart notes from 6/5/2016 indicating Vicodin 125 mg 3 pills per day.
 | I believe the member took my prescription paid. I saw him on 6/6/16 and not cannot locate the prescription pad. |
| 3 | **Physically abusive behavior** exhibited to a provider or office personnel  | Describe the event. | * 6/16/16 8:30 a.m. John Smith checked into our reception desk for his appointment. His appointment was scheduled for 7:30 a.m. When informed that he missed his appointment and Dr. Jones was not able to see him today, John Smith called receptionist Joan Miller a “B\*@#th” and attempted to stab her hand with his pen.
* Police were called and an incident report was filed.
* If the police were called, include a copy of the incident report.
 | Joan Smith check into the receptionist desk late for her appointment and when told jammed a pen in the pencil box.  |
|  4 | **Threatening Behavior** exhibited in the course of needing or receiving care | Describe the event. | 6/16/16 8:30 a.m. John Smith check into our reception desk for his appointment. * He was seen by Dr. Jan Tree. Dr. Tree to discuss the results of the member’s blood test.
* Dr. Tree questioned the member as to why the member’s prescribed pain medication was not showing in his system.
* The mbr stood up and told Dr. Tree it was none of her business.
* Aggressively he backed Dr. Tree into a corner while jabbing her in the chest with his index finger and demanding a prescription.
* John Smith is 6 ft. 5 in. and Dr. Tree is 5 ft. 3 in.
 | Dr. Tree saw John Smith today and when Jason didn’t get a refill on his medication stood up abruptly and left the room.  |
| 8 | **Notice of a member’s** **intent to initiate or** **pursue legal action**. | Copy of the Notice or chart notes. | A copy of the notice and or charts indicating the member’s intent to pursue legal action.Note: This excludes state fair hearings or appeals. | Submitted the Provider Discharge form only. No other documentation.  |
| 9 | **Failure to follow recommended treatment.**  | Describe the event. | Parent of a child is a Christian Scientist who doesn’t believe in using modern medical treatments. Child is diagnosed with severe asthma and parent refuses to use medications. Child’s life is at risk from not using medications. | Doctor recommended that the patient quit smoking. The patient refused. |
| 10 | **Deterioration in the doctor/patient relationship**  | Describe the event. | Patient said she has never had a C-section and said her abdominal scar was for an ovarian cyst. Medical records show that patient had multiple prior C-sections. Lying about this information put patient at risk of serious complications and leads provider to not know what to believe when the patient says something.  | Parent refuses to vaccinate her children. Doctor spends great deal of time going over the reasons to vaccinate. Patient thanks the doctor for the explanation, but still declines. Doctor has **no** office-wide policy on excluding patients without vaccinations from the practice. |
| 11 | **Discharged from the practice before the member became PHC eligible**. | Copy of the Notice. | A copy of the letter notifying member of the discharge from the practice.***Providers must notify PHC within sixty (60) days of the member’s initial assignment.***  | Submitted form only. |
| 12 | **Disruptive or verbally inappropriate behavior to PCP, office staff or other patients**  | Describe the event. | Jane Doe check in for her appointment at 10 a.m. She was informed by reception staff Joe Smith that Dr. Wilson was running 20 minutes late and to please have a seat in the waiting area until she was called.* Jane said in a loud voice that she did not want to “f@#King wait 20 minutes, especially since she had to wait 3 weeks for the appointment and she didn’t want to sit in the “f@#king” waiting room with all the infected <racial slur>.
* If she was <race> she wouldn’t have to wait and get everything free. This is a “F@#Kin” joke.
* Reception staff Joe Smith informed member to keep her voice down and refrain from using racial slurs. It was not acceptable behavior and if she could just please have a seat or come back in 20 mins. All patients are treated fairly and the same.
* Member voiced raised her voice again and yelled at Joe-shut up, you “f@#kin” idiot, don’t tell me to calm down. I say what I want when I want. I’ll show you what inappropriate behavior is, when I wrap that phone upside your head.

**Note:** Requires documentation of counseling and corrective action by the provider has been ineffective.  | Patient didn’t want to wait 20 mins and called the receptionist an idiot and insulted other patients.  |
| 13 | **Missed Appointments*** Three (3) or more missed appointments within six (6) months

or * Four (4) or more missed appointments within twelve (12) months
 | Documentation of verbal and written notice(s) | Letters and/or documentation of the provider’s good faith effort must be dated in the qualifying time frames:* 3 missed appointments w/in prior 6 months or
* 4 or more missed appointments w/in the last 12 months.

Provider must provide documentation of warnings issued to the member. Warning documentation must be dated after the member’s first missed appointment. Acceptable documentation includes:* Dates and times of the member’s missed appointments and one of the following:
	+ 2 written warnings or documentation-copies of the letters sent to the member.

Or* + Documentation of the date the member was advised of the verbal warning (copy of patent notes) and a copy of one written warning.

**Exceptions:** Missed appointments due to an inpatient hospital stay or appointments cancelled 24 hours in advance are not considered missed appointments. | * Submitted documentation of warnings dated two years ago.
* Documentation of issued prior to the member’s first missed appointment.
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