I. **Policy Summary**

Patient discharge from UCR Health may occur when, in a care provider's professional judgment:

A. the patient/provider therapeutic relationship no longer can effectively exist
B. a patient’s behavior is a safety concern
C. the patient is non-compliant with: UCR Health “Patient Rights and Responsibilities,” recommended medical treatment, payment or Medication Management Agreement (Attachment A)

In general, patient discharge is a measure of last resort.

UCR Health may not discharge a patient from care due to an adverse change in the patient’s health status, or because of the patient’s utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his/her special needs unless this behavior seriously impairs the providers ability to furnish services to either this or other patients.

II. **Definitions**

Not Applicable

III. **Policy Text**

A. It is the policy of UCR Health to maintain cooperative and trusting provider-patient relationships. When a provider-patient relationship is no longer proceeding in a mutually productive manner, it is the policy of UCR Health to terminate the provider-patient relationship within the bounds of applicable state and federal laws, rules, and regulations.

B. Behaviors which may indicate discharge may include, but are not limited to:

1. Habitual non-compliance with UCR Health practice guidelines and/or a treatment plan.
2. Abusive, threatening, hostile or destructive behavior in person, on the phone, emails, or other contacts that may impact the delivery of care to this or other patients (refer to Managing Threatening, Hostile, Abusive Encounters Policy and Procedure).
3. Documented altering or forgery of prescriptions.
4. Narcotics abuse, violation of the Medication Management Agreement, or drug seeking behavior.
5. Theft or fraud.
6. Other behavior which has caused or creates the potential to cause a breakdown in the provider/patient relationship.
7. The patient moves out of the designated service area.
8. Failure to pay for services.

IV. **Responsibilities**

   **Attending Faculty Provider**

V. **Procedure**

   A. The termination process must be initiated by an attending/faculty provider. Staff or residents may give input into the process but it remains up to the discretion of an attending/faculty provider to make the final decision. If a provider declines to treat an established patient with the intent to permanently terminate the relationship, a termination letter must be sent.

   B. The Compliance and Privacy Director should be notified prior to the termination notice being sent to the patient.

   C. The termination letter includes reasonable notice to the patient, (except in extreme circumstances involving threats of violence), affording the patient an opportunity to find other medical care:

      - A minimum of 30 days from receipt of the notice.
      - Forty five (45) day notice period for patients with Medicaid coverage as required by state law.

   D. Letter is signed by an attending/faculty provider. Refer to Termination for Non-Payment (Attachment B) Termination for Non-Compliance (Attachment C)

   E. The medical record documentation supports the decision for termination and the letter to the patient must include documented reason for the dismissal.

   F. The letter will be delivered certified mail with delivery confirmation requested. Copies of the letter will be placed in the patient’s medical record and with the Compliance Office.

   G. Regardless of which provider or department initiated the discharge, the patient is discharged from the entire practice.

   H. Discharged patients may submit a written appeal to the Compliance and Privacy Director if they feel there are facts or conditions that were not known at the time the discharge decision was made. The patient will be notified, in writing, of the review decision, which is final.
VI. Forms /Attachments
Attachment A – Medication Management Agreement
Attachment B – Termination for Non-Payment Letter
Attachment C – Termination for Non-Compliance

VII. Related Information
CFR 438.56 Disenrollment: Requirements and limitations.

VIII. Revision History
New 3/2016

Approval(s):

Compliance Committee (07/19/2016)
Attachment A

UCR Health

MEDICATION MANAGEMENT AGREEMENT

This Agreement between _________________ (patient) and the UCR Health Pain Management Physicians is for the purpose of establishing
an understanding between the doctor and patient on clear conditions for their pain management program, which may include the prescriptions and
use of pain controlling medications prescribed by the doctors for the patient. The doctor and patient understand that this Agreement is an essential
factor in maintaining the trust and confidence necessary in a doctor/patient relationship.

As Consultants in Pain Management, we will recommend and/or initiate therapy for your chronic pain condition. This may include performing procedures
and formulating an optimal medication regimen. A reduction in the intensity of your pain and an improvement in your quality of life are the goals of this
program. An agreement between the UCR Pain Management Physicians and your primary care physician may be necessary prior to initiating opioid
medications.

I agree to and accept the following conditions for my pain management program, which may include medication prescriptions by my UCR Health
Pain Management doctor:

1. Opioids may cause drowsiness. I understand that they are strong medications for pain relief and I have been informed of the risks and side
   effects involved with taking them. Overdose of this medication may cause death by stopping my breathing. This can be reversed by
   emergency personnel if they know I have taken opioid painkillers. It is suggested that I wear medical alert bracelet or necklace that
   contains this information.

2. I realize that it is my responsibility to keep others and myself safe, including the safety of my driving or the operation of machinery.
   If there are any questions of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity
   until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side-effects to resolve.

3. I realize that all medications have potential side-effects. I understand, accept, and agree that there may be unknown risks associated
   with the long term use of controlled substances and that my physician will advise me as knowledge and training advances and will make
   appropriate treatment changes.

4. I understand if I am pregnant or become pregnant while taking these opioid medications, my child would be physically dependent on the
   opioids, and withdrawal can be life-threatening for a baby. If a female of childbearing age, I certify that I am not pregnant and I will use
   appropriate contraceptive measures during the course of treatment with opioids.

5. I understand I must contact my pain physician before taking Benzodiazepines (drugs like Valium or Ativan), sedatives or muscle relaxants
   (drugs like Soma, Xanax or Norflex) and antihistamines (drugs like Benadryl). I understand that the combined use of the above drugs
   and opioids, as well as alcohol and opioid, may produce profound sedation, respiratory depression, blood pressure drop and even death.
   I will not use recreational drugs while on opioids. If consumed the consequences will be termination from the program.

6. In particular, I understand that opioids and sedatives could cause physical dependence. If I suddenly stop or decrease the medication,
   I would have withdrawal symptoms (nausea, vomiting, diarrhea, shivers, chills) that may occur within 24-48 hours of the last dose.
   I agree that continued refill of opioid medications may be contingent upon compliance with the program in general as well as other chronic
   pain treatment modalities recommended by my doctor.

7. I will keep all scheduled appointments in the pain clinic. I will bring in medication bottles to each visit. Noncompliance such as frequent
   cancellation of appointments may result in termination of my doctor.

8. I understand that the main treatment goal is to improve my ability to function and/or work and/or reduce pain. In consideration of the
   goal and the fact that I may receive potent medication to help me reach that goal I agree to help myself by following better health habits,
   exercise, weight control, and avoiding the use of tobacco. I must also comply with the treatment plan as prescribed by my doctor.
   I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

9. I agree to comply fully with all aspects of my treatment program which may include behavioral medicine and physical therapy. Failure to
   do so may lead to discontinuation of your medication and referral to an outside physician.

10. Refills of controlled substance medication: 1) will be made only during the office hours of 9 am to 3 pm, Monday through Friday.
    2) will not be made at night on holidays or weekends. 2) will not be made if I "run out early" or "lose a prescription" or "spill or
        misplace my medication." I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.
        3) will not be made as an "emergency," such as on Friday afternoon because I suddenly realize I will "run out tomorrow." I will call at least
            48 hours ahead if I need assistance with a controlled substance medication prescription. 4) If your medications are stolen and you
        complete a police report regarding the theft, an exception may be made. A copy of the report will be required to be filed in the chart and
        upon immediate notice to the office at least the police report number needs to be provided in order to consider a second script.
        *Repeated offenders will not have exceptions.

All documentation must indicate the specific date and time of entry and a signature complete with identifying credential, title or classification.

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11. I agree that I will use my medication at a rate no greater than the prescribed rate unless it is discussed directly with my UCR Health Pain Physician.

12. I will not use any illegal controlled substance (cocaine, heroin, etc).

13. I will not share, sell, or trade my medication for money, goods or services.

14. I will discontinue all previously used pain medication, unless told to continue them.

15. I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by the UCR Health Pain Management Physicians.

16. I understand that once my pain management is optimized, refill of my medication will be transferred to my primary care physician. If I do not have a primary care physician at the time, I will have 1-3 months to find a doctor that will take over my care and prescribe my medications.

17. I understand that this medication regimen will be continued for a definitive time period as determined by my doctor. My case will be reviewed at the end of that period. If there is no evidence that I am improving or that progress is being made to improve my function or quality of life, the regimen will be tapered to my pre-trial medications and my care will be referred back to my primary care physician.

18. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to the prescribing of my pain medication and I authorize the doctor and my pharmacy to cooperate fully with any city, state, or federal law enforcement agency, including the California Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize the doctor to provide a copy of this Agreement to my pharmacy, other healthcare providers, and any Emergency Department upon request.

19. I understand that random urine testing may be employed to monitor effectiveness and compliance of my medication regimen.

20. I understand that if a random urine test is ordered, and I do not complete the test, my medication MAY NOT be refilled at my next appointment.

My UCR Health Pain Management physician and I agree that this contract is essential to my doctors’ ability to treat my pain effectively and that my failure to comply with the agreement may result in the withdrawal of all prescribed medication by my doctor and termination of the doctor/patient relationship.

I have read the above agreement and understand the rules regarding prescribing and use of opioid medication. I also agree to testing and detoxification if necessary.

We understand that emergencies can occur and under some circumstances, exceptions to these guidelines may be made. Emergencies will be considered on an individual basis.

If at any time you are concerned about your medication or side effect of your medication, you may call the UCR Health Pain Management number 951.827.7962. A physician or nurse will return your message.

I agree to use __________________________________________ telephone number ______________ for all my pain medication. If I change pharmacy for any reason, I agree to notify the doctor at the time I received a prescription, and advise my new pharmacy of my prior pharmacy’s address and telephone number.

This agreement is entered into on this ________day of __________, ________.

Patient Signature ___________________ Doctor’s Signature ___________________ Witness’ Signature ___________________
Dear Patient,

While it has been our pleasure treating you, it has come to our attention that your account with UCR Health is in arrears, and though you have been previously notified of this issue, there has been no resolution. As a result, we must terminate the patient/physician relationship due to your lack of compliance with UCR Health’s financial protocols.

We will be available to continue treatment for the next 30 days, but encourage to seek the regular care of another physician as soon as possible. We will be happy for forward your medical records with your written authorization.

We regret the need to terminate this relationship over this matter and wish you success in the treatment of your future healthcare needs.

Sincerely,

cc: Compliance Department
Dear Patient,

Over the course of treatment with UCR Health there have been frequent incidents where you have not followed the recommend course of care. Although it is your right to reject your physician’s recommendations, we believe the effects of you non-compliance do not meet accepted medical practice standards.

We will be available to continue treatment for the next 30 days, but encourage to seek the regular care of another physician as soon as possible. We will be happy for forward your medical records with your written authorization.

We regret the need to terminate this relationship over this matter and wish you success in the treatment of your future healthcare needs.

Sincerely,

cc: Compliance Department