Quality Reporting Program Provider Training

Section N: Medications

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Acronyms in This Presentation

- Centers for Medicare & Medicaid Services (CMS)
- Drug Regimen Review (DRR)
- Improving Medicare Post-Acute Care Transformation Act (IMPACT Act)
- Inpatient Rehabilitation Facility (IRF)
- Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI)
- International Normalized Ratio (INR)

Acronyms in This Presentation (cont.)

- Long-Term Care Hospital (LTCH)
- LTCH Continuity Assessment Record and Evaluation (LTCH CARE) Data Set
- Medication Administration Record (MAR)
- Post-Acute Care (PAC)
- Registered Nurse (RN)
- Total Parenteral Nutrition (TPN)

Overview

- Define the new Section N: Medications
- Explain the intent of Section N
- Explain new items added to the Long-Term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set v4.00 and Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) v2.0
- Discuss coding instructions for items
- Provide practice coding scenarios
- Explain how the Drug Regimen Review (DRR) quality measure is calculated

Objectives

- State the intent of Section N
- Articulate the purpose of the new items and coding options
- Apply coding instructions to accurately code practice scenarios and the case study
- Describe the new DRR quality measure

Section N: Medications

New Section in LTCH CARE Data Set v4.00 and IRF-PAI v2.0

Drug Regimen Review Conducted With Follow-Up for Identified Issues

- DRR is an assessment-based, cross-setting process quality measure adopted to meet the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act domain of medication reconciliation
- Data collection begins:
  - July 1, 2018, for Long Term Care Hospitals (LTCHs)
  - October 1, 2018, for Inpatient Rehabilitation Facilities (IRFs)

New Items

- N2001. Drug Regimen Review and N2003. Medication Follow-Up have been added to the **Admission Assessment**

N2001. Drug Regimen Review	
Enter Code ☐	**Did a complete drug regimen review identify potential clinically significant medication issues?** 0. **No - No issues found during review** → *Skip to O0100, Special Treatments, Procedures, and Programs* 1. **Yes - Issues found during review** → *Continue to N2003, Medication Follow-up* 9. **NA - Patient is not taking any medications** → *Skip to O0100, Special Treatments, Procedures, and Programs*
N2003. Medication Follow-up	
Enter Code ☐	**Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/ recommended actions in response to the identified potential clinically significant medication issues?** 0. **No** 1. **Yes**

New Items (cont.)

- N2005. Medication Intervention has been added to the:
  - **Discharge Assessment** for IRFs
  - **Planned Discharge, Unplanned Discharge, and Expired Assessments** for LTCHs

N2005. Medication Intervention	
Enter Code ☐	**Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?** 0. **No** 1. **Yes** 9. **NA - There were no potential clinically significant medication issues identified since admission or patient is not taking any medications**

Section N: Medications

Definitions

Drug Regimen Review (DRR)

- The DRR in post-acute care (PAC) is generally considered to include:

Medication Reconciliation	• A review of all medications a patient is currently using
Drug Regimen Review	• A review of the drug regimen to identify and, if possible, prevent clinically significant medication issues

What Does the DRR Include?

- The DRR includes all medications:
  - Prescribed and over-the-counter
    - Including nutritional supplements, vitamins, and homeopathic and herbal products
  - Administered by any route
    - Including oral, topical, inhalant, injection, sublingual, parenteral, and by infusion
- Includes total parenteral nutrition (TPN) and oxygen

Potential or Actual Clinically Significant Medication Issues

Clinically Significant Medication Issue

- A potential or actual issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest

Potential or Actual Clinically Significant Medication Issues (cont. 1)

- Potential or actual clinically significant medication issues may include, but are not limited to:
  - Medication prescribed despite medication allergy noted in the patient's medical record
  - Adverse reactions to medications
  - Ineffective drug therapy

Potential or Actual Clinically Significant Medication Issues (cont. 2)

- Drug interactions
  - Serious drug-drug, drug-food, and drug-disease interactions
- Duplicate therapy
  - For example, generic name and brand name-equivalent drugs are co-prescribed

Potential or Actual Clinically Significant Medication Issues (cont. 3)

- Wrong patient, drug, dose, route, and time errors
- Omissions (drugs missing from a prescribed regimen)
- Nonadherence (purposeful or accidental)

Potential or Actual Clinically Significant Medication Issues (cont. 4)

- Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the DRR items
- Examples of potential or actual clinically significant medication issues can be found in Section N of the Quality Reporting Program (QRP) Manual

Contact With Physician (or Physician-Designee)

- Communication to the physician (or physician-designee) to convey an identified potential or actual clinically significant medication issue(s); **AND**
- A response from the physician (or physician-designee) to convey prescribed/recommended actions in response to the medication issue(s)

Contact With Physician (or Physician-Designee) (cont. 1)

- Examples of communication methods:
  - In-person
  - Telephone
  - Voicemail
  - Electronic means
  - Fax
  - Any other means that appropriately conveys the message of patient status

Contact With Physician (or Physician-Designee) (cont. 2)

- Communication can be:
  - **Directly** to/from the physician (or physician-designee); OR
  - **Indirectly** through the physician's office staff on behalf of the physician (or physician-designee), in accordance with the legal scope of practice

How is Physician-Designee Defined?

- The role of physician-designee is defined by Federal and State licensure regulations
- Please refer to these regulations to determine which clinicians are licensed to act as physician-designees

Medication Follow-Up

Medication Follow-Up

- The process of contacting a physician (or physician-designee) to communicate the identified medication issue and addressing all physician- (or physician-designee)-prescribed/recommended actions by midnight of the next calendar day at the latest

Section N: Medications

Coding Guidance

Data Sources/Resources for Coding the Items

- Medical Record
  - Within the electronic health record/electronic medical record, and/or paper medical records as transferred from the acute care hospital
- Medication List
  - For example, medication administration record (MAR), home medication list
- Clinical Communication Notes
  - Including pharmacy, nursing, physician (or physician-designee), and other applicable clinical notes

Data Sources/Resources for Coding the Items (cont.)

- Acute Care Hospital Discharge Summary and Discharge Instructions
- Discussions, including with:
  - The acute care hospital
  - Other staff and clinicians responsible for completing the drug regimen review
  - Patient and patient family/significant other

Medical Records Data Reflect Coding DRR Items

- Data in the LTCH CARE Data Set/IRF-PAI should be consistent with information reported in the patient's medical record

Who Can Code DRR Items?

- The Centers for Medicare & Medicaid Services (CMS) does not provide guidance on who can or cannot code the DRR items
- Please refer to facility, Federal, and State policies and procedures to determine which LTCH or IRF staff members may complete a DRR
- Each facility determines their policies and procedures for completing the assessments
- Each facility provides patient care according to their unique characteristics and standards (for example, patient population)

N2001, N2003, N2005. Drug Regimen Review Conducted With Follow-Up for Identified Issues

Admission Assessment

- N2001
  - Identifies if a drug regimen review was conducted upon admission, and if the clinician identified any potential or actual clinically significant medication issues

- N2003
  - Identifies if the facility contacted a physician (or physician-designee) and completed all physician- (or physician-designee)-prescribed/ recommended actions by midnight of the next calendar day in response to all potential or actual clinically significant medication issues identified upon admission

Discharge Assessment (For LTCH: Planned or Unplanned, Expired)

- N2005
  - Identifies if the facility contacted a physician (or physician-designee) and completed all physician- (or physician-designee)-prescribed/ recommended actions by midnight of the next calendar day each time potential or actual clinically significant medication issues were identified throughout the stay

N2001: Drug Regimen Review (Admission)

0. **No - No issues found during review**
1. **Yes - Issues found during review**
9. **NA - Patient is not taking any medication**

Section N	Medications
N2001. Drug Regimen Review	
Enter Code ☐	**Did a complete drug regimen review identify potential clinically significant medication issues?** 0. **No - No issues found during review** → *Skip to O0100, Special Treatments, Procedures, and Programs* 1. **Yes - Issues found during review** → *Continue to N2003, Medication Follow-up* 9. **NA - Patient is not taking any medications** → *Skip to O0100, Special Treatments, Procedures, and Programs*

N2001 Steps for Assessment

1. Complete a drug regimen review upon admission or as close to the actual time of admission as possible to identify any clinically significant medication issues
2. Review the medical record sources to determine if a drug regimen review was conducted upon admission

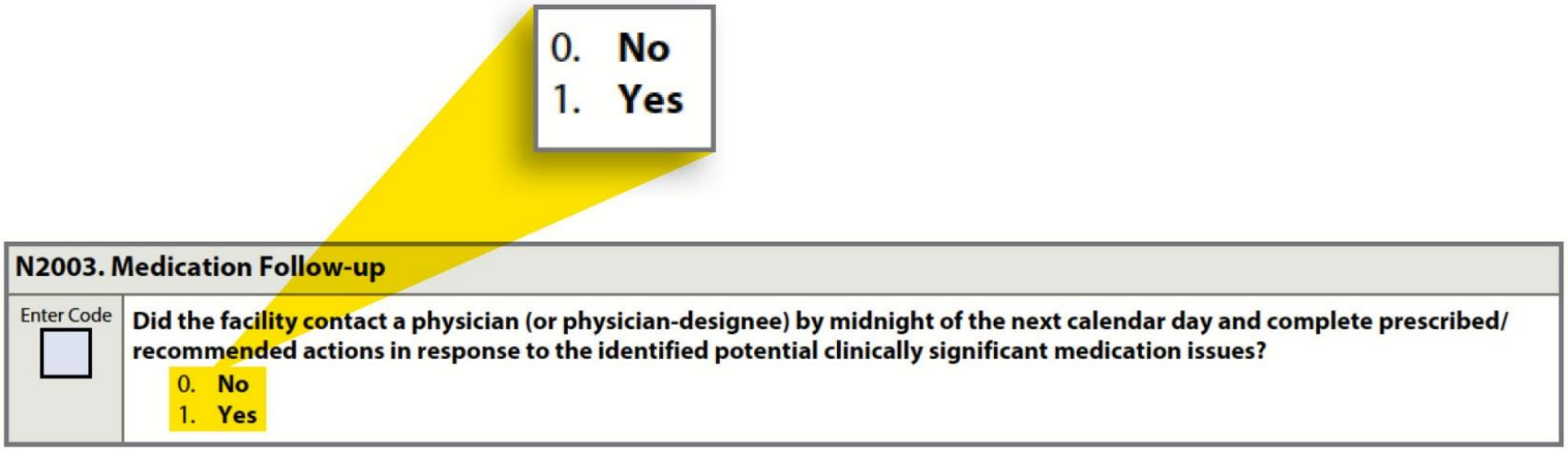
N2001 Coding Instructions

IRF and LTCH: Completed only at admission

(LTCH: A0250 = 01 Admission)

- Code **0, No – No issues found during review,** if a drug regimen review was conducted upon admission and no potential or actual clinically significant medication issues were identified
- Code **1, Yes – Issues found during review,** if a drug regimen review was conducted upon admission and potential or actual clinically significant medication issues were identified
- Code **9, N/A – Patient is not taking any medications,** if the patient was not taking any medications a drug regimen review was conducted upon admission and, per data sources/resources reviewed, there were no medications prescribed for the patient and the patient was not taking any medications at the time of the assessment

N2003: Medication Follow-Up (Admission)



N2003 Steps for Assessment

1. Determine whether the following criteria were met for all potential and actual clinically significant medication issues that were identified upon admission:
   - Two-way communication between the clinician(s) and the physician (or physician-designee) was completed by midnight of the next calendar day; AND
   - All physician- (or physician-designee-) prescribed/recommended actions were completed by midnight of the next calendar day

N2003 Coding Instructions

IRF and LTCH: Completed only at admission

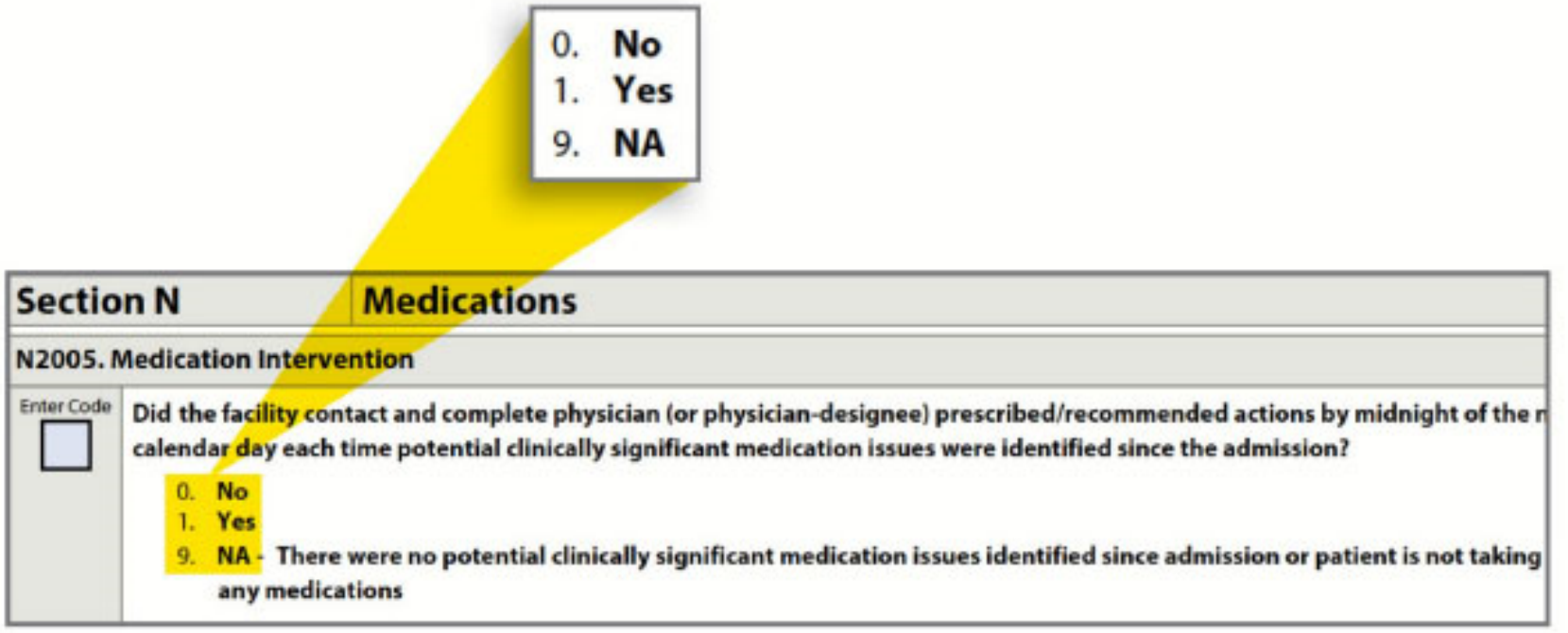
(LTCH: A0250 = 01 Admission)

- Code **0, No,** if **all** identified potential or actual clinically significant medication issues were **not** completed **by midnight of the next calendar day**
- Code **1, Yes,** if the two-way communication AND completion of the prescribed/recommended actions occurred by midnight of the next calendar day after the potential clinically significant medication issue was identified

N2001 and N2003 Coding When DRR is Not Completed

- If the drug regimen review was not completed upon admission, then N2001 and N2003 are coded with a dash (–)
- A dash value is a valid response for this item; however, CMS expects dash use to be a rare occurrence

N2005: Medication Intervention (Discharge)



N2005 Steps for Assessment

1. Review the patient's medical documentation and identify **all** potential and actual clinically significant medication issues that were identified upon admission and throughout the patient's stay

N2005 Steps for Assessment (cont.)

2. Determine if both criteria were met for **all** potential and actual clinically significant medication issues that were identified upon admission or at any time throughout the patient's stay (admission through discharge):
   - Two-way communication between the clinician(s) and the physician (or physician-designee) was completed by midnight of the next calendar day; AND
   - All physician- (or physician-designee)-prescribed/recommended actions were completed by midnight of the next calendar day

N2005 Coding Instructions

IRF and LTCH: Completed only at discharge

(LTCH: A0250 = 10 Planned discharge, 11 Unplanned discharge, or 12 Expired)

- Code **0, No,** if **all** clinically significant medication issues identified upon admission or at any time throughout the patient stay (admission through discharge) were **not** addressed **by midnight of the next calendar day**
- Code **1, Yes,** if **all** clinically significant medication issues identified upon admission or at any time throughout the patient stay (admission through discharge) **were** addressed **by midnight of the next calendar day**

N2005 Coding Instructions (cont.)

IRF and LTCH: Completed only at discharge

(LTCH: A0250 = 10 Planned discharge, 11 Unplanned discharge, or 12 Expired)

- Code **9, N/A – Not applicable,** if there were no potential or actual clinically significant medication issues identified upon admission or throughout the patient stay, or the patient was not taking any medications at the time of admission or throughout the stay

N2005 Coding Clarification

- **N2005 asks** if all clinically significant medication issues:
  - Were identified **upon admission or at any time throughout the patient stay (admission through discharge);** and
  - Whether the facility **contacted** the physician/physician designee **and completed** prescribed/recommended actions by midnight of the next calendar day each time clinically significant medication issues were identified
- **"Throughout the stay" includes admission through and up to the time of the patient's discharge**

N2005 Coding Clarification (cont.)

- **<u>Throughout the stay</u> includes up to the time of the patient's discharge**
  - Drug regimen review is conducted **upon admission**; and
  - Clinicians complete actions recommended by a physician (or physician designee) during a timely follow-up, which are completed each time potential or actual clinically significant medication issues are identified **throughout the stay**

Provider Question and Answer

Question: If a provider coded item N2003 as **0, No,** on the Admission Assessment indicating that the required follow-up action did not take place, is there a way for the facility to code N2005 as **1, Yes?**

Answer: If N2003 is coded as **0, No,** then in accordance with the DRR measure requirements, item N2005 (which includes admission and throughout the patient stay), must also be coded **0, No**

Rationale: Follow-up for ALL identified potential or actual clinically significant medication issues was not completed by midnight of the next calendar day throughout the stay

Section N: Medications

Practice Scenarios

N2001 Practice Coding Scenario 1

- The admitting PAC nurse reviewed and compared the acute care hospital discharge medication orders and the PAC physician's admission medication orders for Ms. W
- The nurse interviewed Ms. W, who confirmed the medications she was taking for her current medical conditions. Upon the nurse's request, the pharmacist reviewed and confirmed the medication orders as appropriate for the patient
- As a result of this collected and communicated information, the registered nurse (RN) determined that there were no identified potential or actual clinically significant medication issues

How would you code N2001 on the Admission Assessment?

Did a complete drug regimen review identify potential clinically significant medication issues?

A. **0, No** – No issues found during review

B. **1, Yes** – Issues found during review

C. **9, NA** – Patient is not taking any medications

D. Enter a **dash (–)**

N2001 Practice Coding Scenario 2

- Mr. C was admitted to PAC after undergoing mitral valve replacement
- The acute care hospital discharge information indicated that Mr. C had a mechanical mitral heart valve and was to continue receiving anticoagulant medication

N2001 Practice Coding Scenario 2 (cont. 1)

- While completing a review and comparison of the patient's discharge healthcare records from the acute care hospital with the PAC physician's admission medication orders, an RN noted that the admitting physician ordered the patient's anticoagulation medication to be held if the international normalized ratio (INR) was below 1.0
- However the physician's admission note indicated that the desired therapeutic INR parameters for Mr. C was 2.5 to 3.5

N2001 Practice Coding Scenario 2 (cont. 2)

- The RN questioned the INR level listed on the admitting physician's order, based on the therapeutic parameters of 2.5 to 3.5 documented in the physician's admission note
- This prompted the RN to call the physician immediately to address the issue

How would you code N2001 on the Admission Assessment?

Did a complete drug regimen review identify potential clinically significant medication issues?

A. **0, No** – No issues found during review

B. **1, Yes** – Issues found during review

C. **9, NA** – Patient is not taking any medications

D. Enter a **dash (–)**

N2003 Practice Coding Scenario 3

- Mr. B was admitted to PAC with an active diagnosis of pneumonia and atrial fibrillation
- The acute care facility medication record indicated that the patient was on a 7-day course of antibiotics and the patient had 3 remaining days of this treatment plan
- The PAC pharmacist reviewing the discharge records from the acute care facility and the PAC admission medication orders noted that the patient had an order for an anticoagulant medication that required INR monitoring as well as the antibiotic

N2003 Practice Coding Scenario 3 (cont. 1)

- On the date of admission, the PAC pharmacist contacted the PAC physician caring for Mr. B and communicated a concern about a potential increase in the patient's INR with this combination of medications, which placed the patient at greater risk for bleeding
- The PAC physician provided orders for laboratory testing so that the patient's INR levels would be monitored over the next 3 days, starting that day
- However, the nurse did not request the first INR laboratory test until after midnight of the next calendar day

How would you code N2001 on the Admission Assessment?

Did a complete drug regimen review identify potential clinically significant medication issues?

A. **0, No** – No issues found during review

B. **1, Yes** – Issues found during review

C. **9, NA** – Patient is not taking any medications

D. Enter a **dash (–)**

How would you code N2003 on the Admission Assessment?

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

A. 0, No

B. 1, Yes

C. Enter a **dash (–)**

N2003 Practice Coding Scenario 4

- Ms. S was admitted to PAC from an acute care hospital
- During the admitting nurse's review of the patient's acute care facility discharge records, it was noted that the patient had been prescribed metformin
- However, admission labs indicated the patient had a serum creatinine of 2.4, consistent with renal insufficiency

N2003 Practice Coding Scenario 4 (cont. 1)

- The PAC admitting nurse contacted the PAC physician-designee to ask if this drug would be contraindicated with the patient's current serum creatinine level
- Three hours after the patient's admission to PAC, the PAC physician-designee provided orders to discontinue the metformin and start the patient on a short-acting sulfonylurea for ongoing diabetes management. These medication changes were implemented within the hour

How would you code N2001 on the Admission Assessment?

Did a complete drug regimen review identify potential clinically significant medication issues?

A. **0, No** – No issues found during review

B. **1, Yes** – Issues found during review

C. **9, NA** – Patient is not taking any medications

D. Enter a **dash (–)**

How would you code N2003 on the Admission Assessment?

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

A. 0, No

B. 1, Yes

C. Enter a **dash (–)**

N2005 Practice Coding Scenario 5

- At discharge from PAC, the discharging licensed clinician reviewed Ms. T's medical records, which included admission through her entire stay at the PAC
- The clinician noted that a clinically significant medication issue was documented during the admission assessment

N2005 Practice Coding Scenario 5 (cont. 1)

- At admission, Ms. T was taking two antibiotics—an antibiotic prescribed during a recent acute care hospital stay that the PAC physician had included in her PAC medication orders, and a second antibiotic prescribed by the physician upon admission that is known for drug-induced nephrotoxicity. Ms. T has renal disease
- Ms. T's medical records further indicated that a PAC nurse had attempted to contact the assigned PAC physician several times about this clinically significant medication issue

N2005 Practice Coding Scenario 5 (cont. 2)

- **After** midnight of the second calendar day, the PAC physician communicated to the nurse via a telephone order to administer a newly prescribed antibiotic in addition to the previously prescribed antibiotic. The nurse implemented the physician's order
- Upon further review of Ms. T's medical records, the discharging nurse determined that no additional clinically significant medication issues had been recorded throughout the remainder of Ms. T's stay

How would you code N2001 on the Admission Assessment?

Did a complete drug regimen review identify potential clinically significant medication issues?

A. **0, No** – No issues found during review

B. **1, Yes** – Issues found during review

C. **9, NA** – Patient is not taking any medications

D. Enter a **dash (–)**

How would you code N2003 on the Admission Assessment?

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

A. 0, No

B. 1, Yes

C. Enter a **dash (–)**

How would you code N2005 on the Discharge Assessment?

Did the facility contact and complete physician- (or physician-designee)-prescribed/ recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

A. 0, No

B. 1, Yes

C. 9, N/A

D. Enter a **dash (–)**

N2005 Practice Coding Scenario 6

- At discharge, the licensed clinician completing a review of Ms. K's medical records identified and noted two clinically significant medication issues during the patient's stay
- The patient's record included an order to hold the medication Ms. K was receiving for deep vein thrombosis prophylaxis
- Based on the patient's clinical status, the PAC RN determined that the physician needed urgent notification

N2005 Practice Coding Scenario 6 (cont. 1)

- The day after the observed symptoms were identified and physician notification occurred, the PAC physician provided an order to resume the medication, which was carried out by the nursing staff within the hour
- In addition, a licensed clinician identified a clinically significant medication issue had occurred during the admission assessment period and the physician had been contacted on the same day

N2005 Practice Coding Scenario 6 (cont. 2)

- Both medication issues identified during the patient's stay were communicated and addressed by midnight of the next calendar day
- There were no additional clinically significant medication issues identified during the remainder of the PAC stay

How would you code N2001 on the Admission Assessment?

Did a complete drug regimen review identify potential clinically significant medication issues?

A. **0, No** – No issues found during review

B. **1, Yes** – Issues found during review

C. **9, NA** – Patient is not taking any medications

D. Enter a **dash (–)**

How would you code N2003 on the Admission Assessment?

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

A. 0, No

B. 1, Yes

C. Enter a **dash (–)**

How would you code N2005 on the Discharge Assessment?

Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

A. 0, No

B. 1, Yes

C. 9, N/A

D. Enter a **dash (–)**

Drug Regimen Review Conducted With Follow-Up for Identified Issues Quality Measure

Drug Regimen Review Conducted With Follow-Up for Identified Issues

Quality Measure Description:

- Reports the percentage of patient stays in which:
  - A drug regimen review was conducted at the time of admission; and
  - Timely follow-up with a physician occurred each time potential and actual clinically significant medication issues were identified throughout the patient's stay

Drug Regimen Review Conducted With Follow-Up for Identified Issues (cont. 1)

Numerator

Patient stays in the denominator in which:

(1) No potential or actual clinically significant medication issues were found during the review; OR

2) Potential and actual clinically significant medication issues were found during the review and a physician was contacted and prescribed/ recommended actions were completed by midnight of the next calendar day; OR

3) The patient was not taking any medications.

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Denominator

Patient stays during the reporting period.

Drug Regimen Review Conducted With Follow-Up for Identified Issues (cont. 2)

- **Denominator Exclusions**
  - This measure has no denominator exclusions
- **Risk Adjustment**
  - This measure is not risk-adjusted or -stratified

Drug Regimen Review Conducted With Follow-Up for Identified Issues (cont. 3)

- **Items Included in the Quality Measure:**
  - N2001. Drug Regimen Review
  - N2003. Medication Follow-Up
  - N2005. Medication Intervention
- If a dash is entered for any of these three items:
  - The patient stay will not be included in the numerator count
  - The patient stay will be included in the denominator count

Summary

- Section N is **new** to the LTCH CARE Data Set v4.00 and IRF-PAI v2.0 and includes the following items:
  - N2001. Drug Regimen Review
  - N2003. Medication Follow-Up
  - N2005. Medication Intervention
- This measure assesses whether providers conducted a drug regimen review upon the patient's admission and throughout the patient's stay and whether any potential or actual clinically significant medication issues identified were addressed in a timely manner

Action Plan

- Determine the appropriate healthcare personnel who will collect and enter DRR information into the medical record
- Identify staff who will need to be trained to code the DRR items

Action Plan (cont. 1)

- Develop processes and protocols used for tracking clinical data collection, tracking documentation, and coding DRR items
- Identify where the DRR data will be located to facilitate comprehensive use and support of DRR clinical coding accuracy

Action Plan (cont. 2)

- Review Section N intent, rationale, and steps for assessment
- Review the steps for evaluation and coding tips for Section N
- Practice coding a variety of scenarios with staff


Questions?