Quality Reporting Program Provider Training

Section N: Medications

Terry Kahlert Eng, RTI International

August 29, 2018

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  - LTCH Quality Reporting Training page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/LTCH-Quality-Reporting/LTCH-Quality-Reporting-Training.html
  - IRF Quality Reporting Training page: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting/IRF-Quality-Reporting-Training.html
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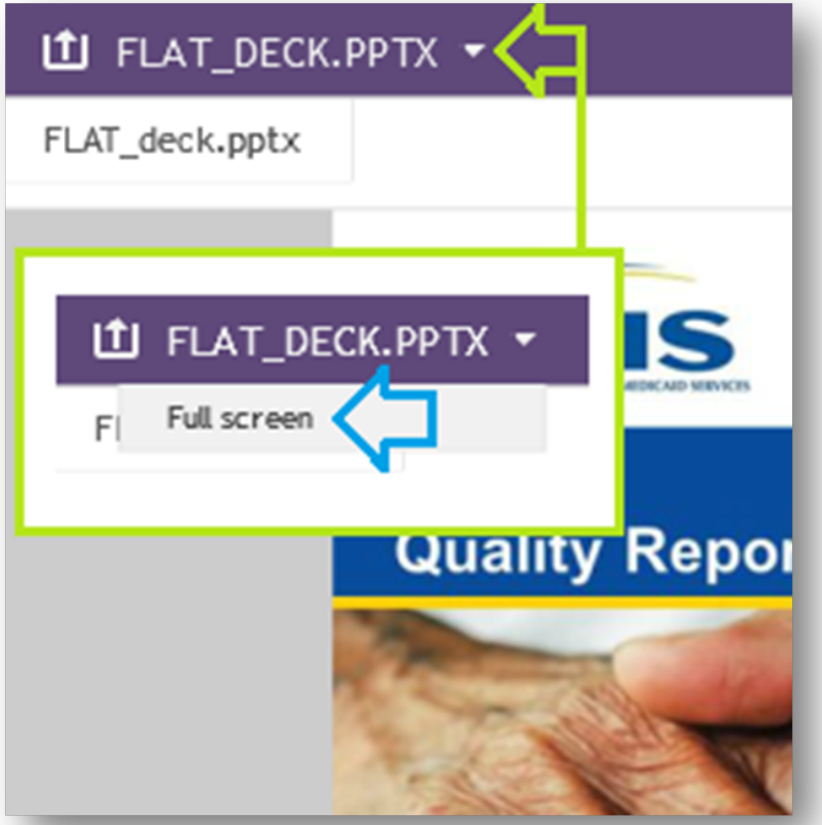

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- When prompted with a question, review the options offered and select your answer by clicking the on-screen circle next to your selection
- Once you select your answer, it will automatically be submitted for you
- Following a brief pause, the presenter will review the correct responses and rationale for each question

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B. Two people

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Today's Presenter

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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

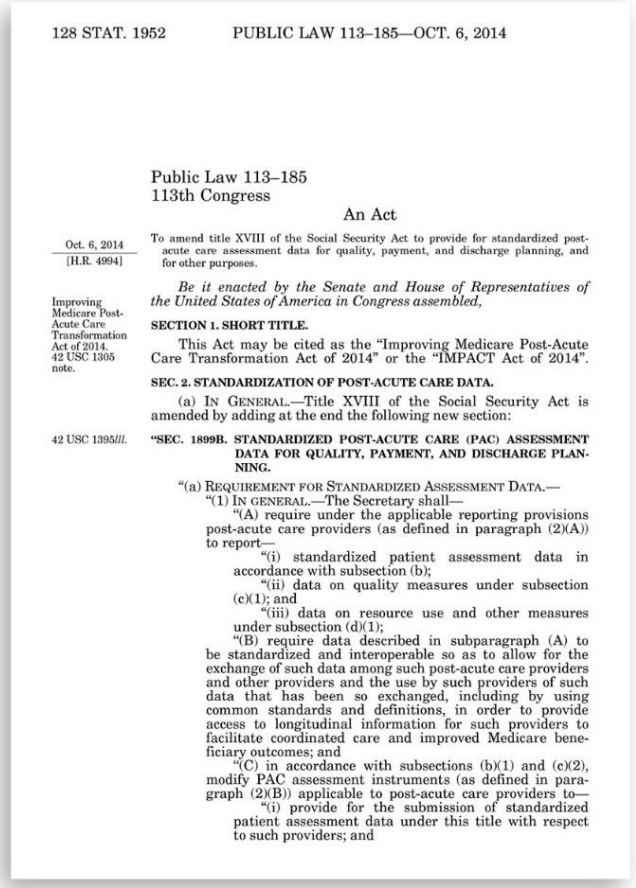
Objectives

1. State the intent of Section N
2. Articulate the purpose of the new items and coding options
3. Apply coding instructions to accurately code practice scenarios
4. 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



128 STAT. 1952 PUBLIC LAW 113–185—OCT. 6, 2014

Public Law 113–185
113th Congress

An Act

Oct. 6, 2014
[H.R. 4994]

To amend title XVIII of the Social Security Act to provide for standardized post-acute care assessment data for quality, payment, and discharge planning, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Improving Medicare Post-Acute Care Transformation Act of 2014. 42 USC 1305 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Improving Medicare Post-Acute Care Transformation Act of 2014" or the "IMPACT Act of 2014".

SEC. 2. STANDARDIZATION OF POST-ACUTE CARE DATA.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

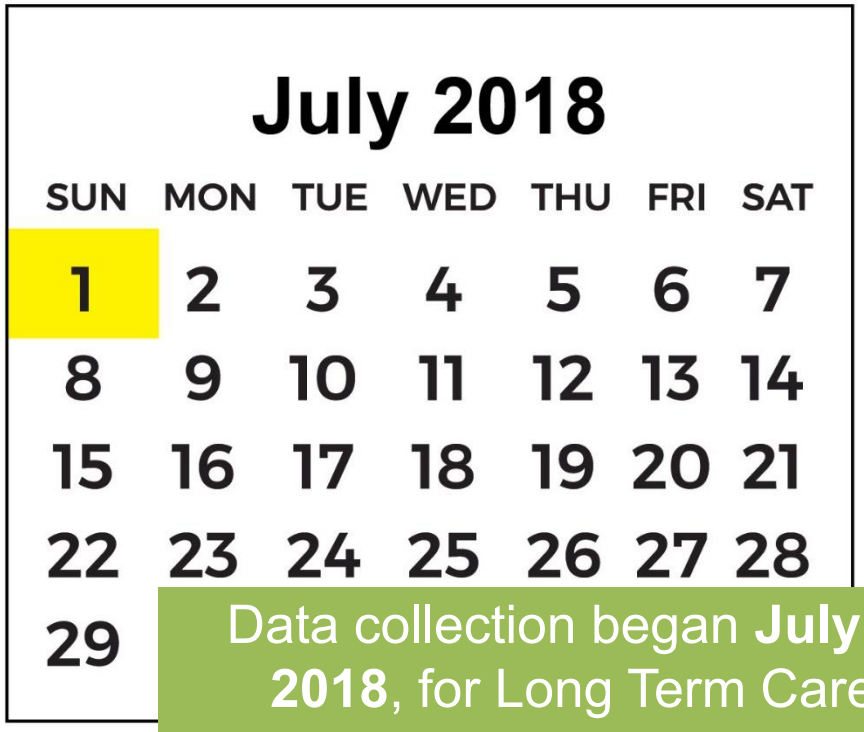
42 USC 1395lll.

"SEC. 1899B. STANDARDIZED POST-ACUTE CARE (PAC) ASSESSMENT DATA FOR QUALITY, PAYMENT, AND DISCHARGE PLANNING.

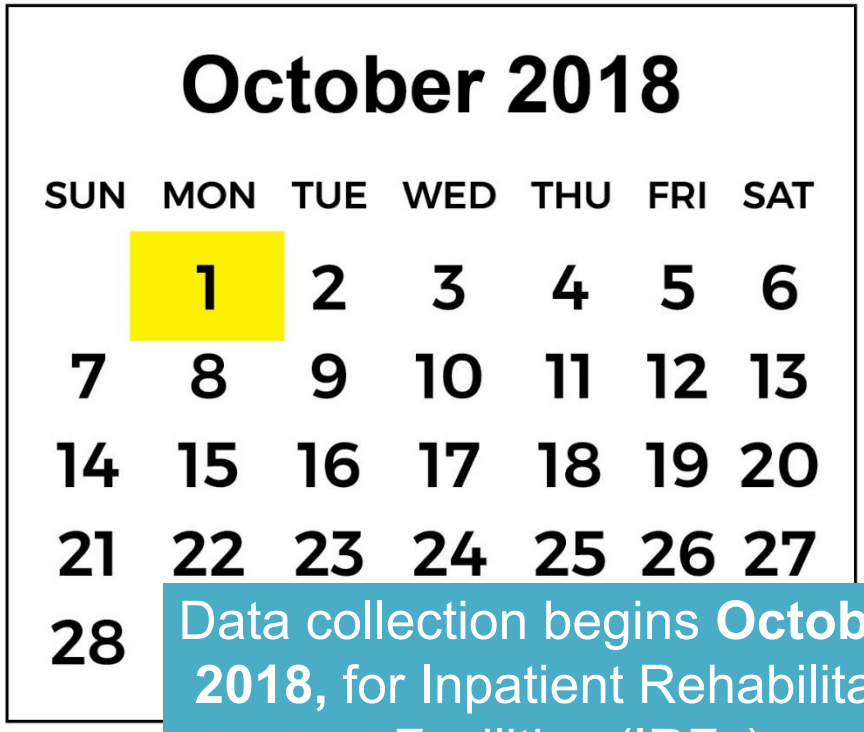
"(a) REQUIREMENT FOR STANDARDIZED ASSESSMENT DATA.—
"(1) IN GENERAL.—The Secretary shall—
"(A) require under the applicable reporting provisions post-acute care providers (as defined in paragraph (2)(A)) to report—
"(i) standardized patient assessment data in accordance with subsection (b);
"(ii) data on quality measures under subsection (c)(1); and
"(iii) data on resource use and other measures under subsection (d)(1);
"(B) require data described in subparagraph (A) to be standardized and interoperable so as to allow for the exchange of such data among such post-acute care providers and other providers and the use by such providers of such data that has been so exchanged, including by using common standards and definitions, in order to provide access to longitudinal information for such providers to facilitate coordinated care and improved Medicare beneficiary outcomes; and
"(C) in accordance with subsections (b)(1) and (c)(2), modify PAC assessment instruments (as defined in paragraph (2)(B)) applicable to post-acute care providers to—
"(i) provide for the submission of standardized patient assessment data under this title with respect to such providers; and

- 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

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



Data collection began **July 1, 2018**, for Long Term Care Hospitals (LTCHs)



Data collection begins **October 1, 2018,** for Inpatient Rehabilitation Facilities (IRFs)

New Items: N2001 and N2003

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 Item: N2005

IRFs: Added to the Discharge Assessment

LTCHs: Added to the Planned Discharge, Unplanned Discharge and Expired Assessments

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/physician-designee communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest

Examples of Potential or Actual Clinically Significant Medication Issues

Medication prescribed despite medication allergy noted in the patient's medical record

Adverse reactions to medications

Ineffective drug therapy

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

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

- Any of these issues must reach a level of clinical significance that warrants notification of the physician/physician-designee for orders or recommendations—by midnight of the next calendar day, at the latest
- 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)

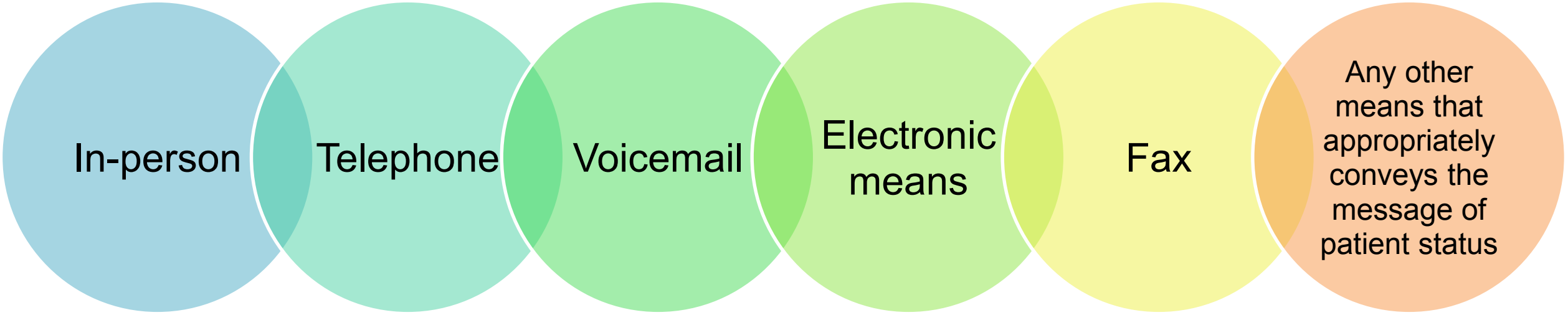
Communication to the physician (or physician-designee) to convey an identified potential or actual clinically significant medication issue(s)

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.)

Examples of communication methods



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 and Practice Coding Scenarios

Data Sources/Resources for Conducting the DRR

Medical Record

- Within the electronic health 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

Acute Care Hospital Discharge Summary and Discharge Instructions

Discussions, including with

- The acute care hospital
- Other staff and clinicians responsible for completing the DRR
- Patient and patient family/significant other

Documentation in the Medical Record

- Data in the LTCH CARE Data Set/IRF-PAI should be supported by information documented 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)

Complete only at 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

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, NA – Patient is not taking any medications	If 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

A dash is a valid response for this item. CMS expects dash use to be a rare occurrence.

N2001 Skip Patterns

Code 0, No – No issues found during review

Skip to O0100. Special Treatments, Procedures, and Programs

Code 1, Yes – Issues found during review

Continue to N2003. Medication Follow-up

Code 9, NA – Patient is not taking any medications

Skip to O0100. Special Treatments, Procedures, and Programs

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?

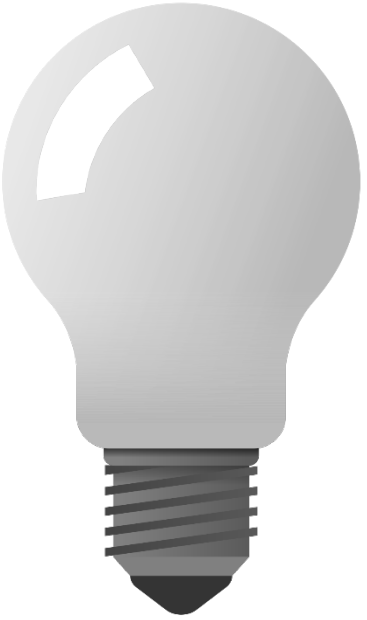
Did a complete drug regimen review identify potential clinically significant medication issues?

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 (–)**

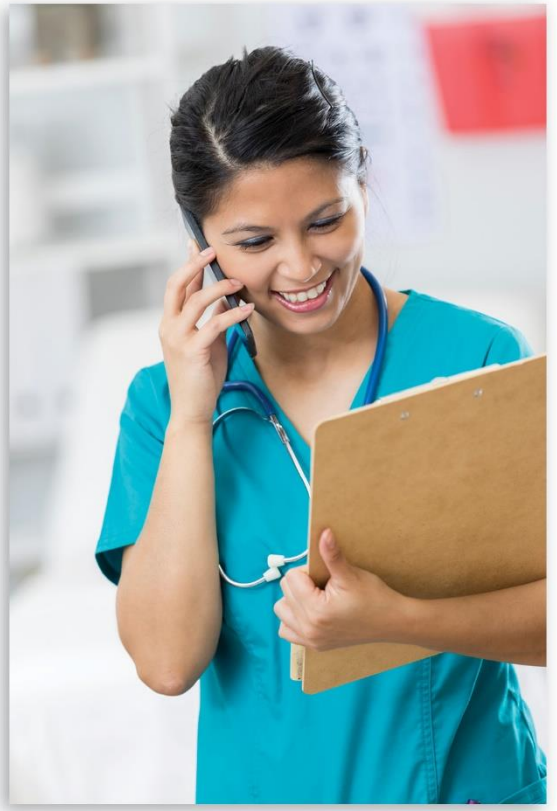


N2001 Practice Coding Scenario 2

- 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

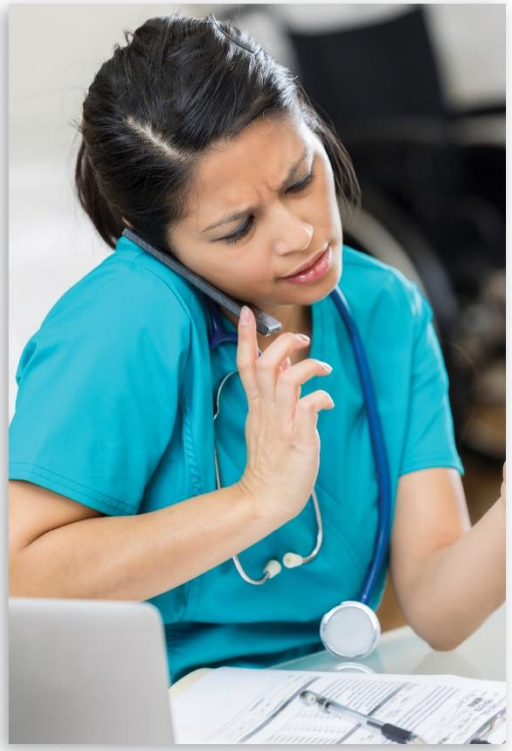
N2001 Practice Coding Scenario 2 (cont. 1)

- 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?

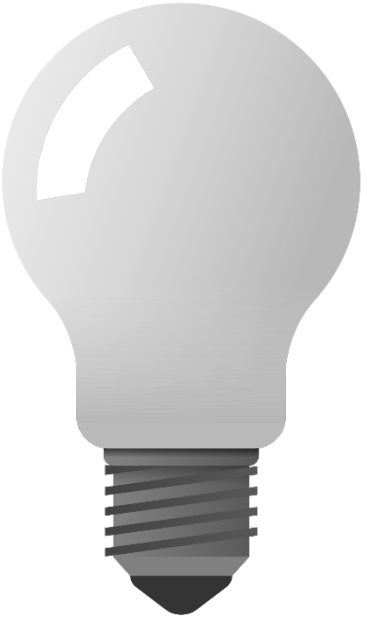
Did a complete drug regimen review identify potential clinically significant medication issues?

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: Medication Follow-Up (Admission)

Complete only at Admission

0. No
1. Yes

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

N2003 Steps for Assessment

- 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

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

A **dash** is a valid response for this item. CMS expects dash use to be a rare occurrence.

Examples of "By Midnight of the Next Calendar Day"

Example 1

- A clinically significant medication issue is identified at 10:00 a.m. on 9/12/2018
- The physician's (or physician-designee's) prescribed/ recommended action is completed on or before 11:59 p.m. on 9/13/2018

Example 2

- A clinically significant medication issue is identified at 11:00 p.m. on 9/12/2018
- The physician's (or physician-designee's) prescribed/ recommended action is completed on or before 11:59 p.m. on 9/13/2018

Coding Tips

If the physician (or physician-designee) recommends an action that will take longer than midnight of the next calendar day to complete, then Code **1, Yes** should still be entered as long as by midnight of the next calendar day the clinician has taken the necessary measures to comply with the recommended action

Coding Tips (cont. 1)

If the physician (or physician-designee) recommends an action that will take longer than midnight of the next calendar day to complete, then Code **1, Yes** should still be entered as long as by midnight of the next calendar day the clinician has taken the necessary measures to comply with the recommended action

Example

Physician writes an order instructing the clinician to monitor the medication issue over the weekend and to call if the problem persists

Coding Tips (cont. 2)

If the physician (or physician-designee) communicates that **no actions** are necessary regarding the reported issues, then Code **1, Yes** should still be entered as long as all communications took place before midnight of the next calendar day

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

Provider Q&A #1

Question: If a physician orders medications on admission, and the pharmacist contacts the physician to resolve the question/potential issue, is this still considered an issue?

Answer: If the issue was determined to be clinically significant, then the issue identified by the pharmacist and communicated to the physician and resolved by midnight of the next calendar day meets the requirements for coding N2001 **1, Yes,** Issues Found During Review, and N2003 **1, Yes,** Medication Follow-Up, on the admission assessment.

Provider Q&A #2

Question: If a facility-based physician-designee performed the drug regimen review, identified a medication issue, and addressed it without needing to communicate with another physician/physician designee, how should N2001 and N2003 be coded?

Answer: In this scenario, the physician-designee identified and resolved a medication issue and therefore it did not require two-way communication with facility staff.

The definition of a clinically significant medication issue requires the identification of a medication issue that warrants contacting a physician or physician designee (i.e., two-way communication) in a timely manner and addressing all physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day at the latest. If no clinically significant medication issues were identified then N2001 would be coded **0, No** and N2003 would be skipped.

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?

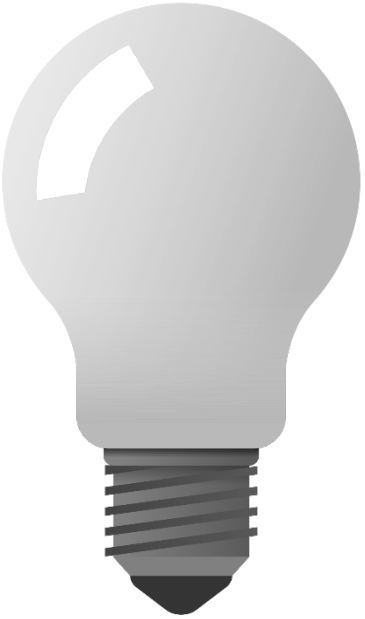
Did a complete drug regimen review identify potential clinically significant medication issues?

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

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

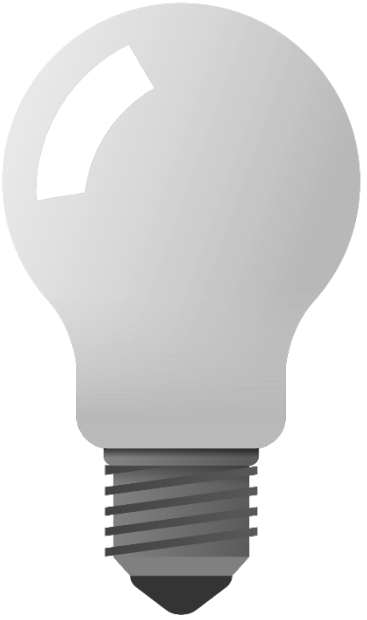
C. **9, NA** – Patient is not taking any medications

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?

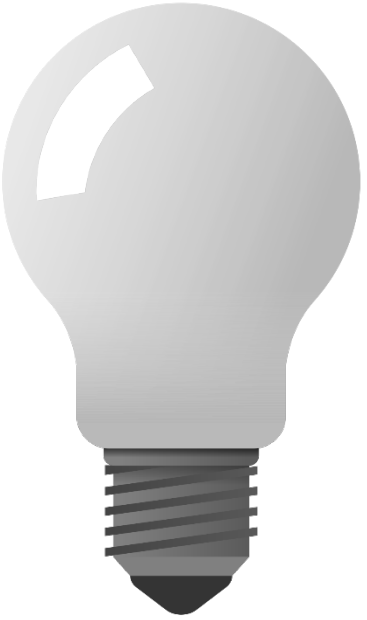
Did a complete drug regimen review identify potential clinically significant medication issues?

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

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

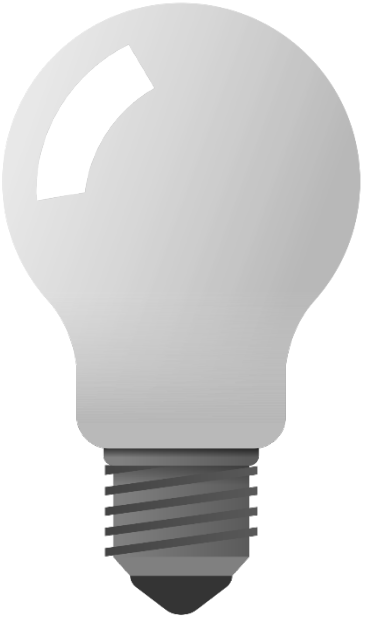
C. **9, NA** – Patient is not taking any medications

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: Medication Intervention (Discharge)

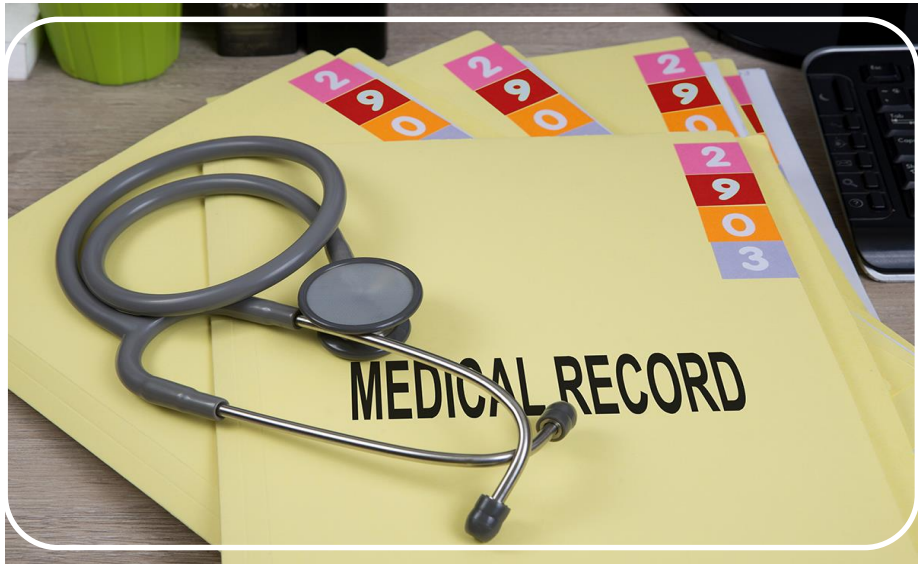
0. No
1. Yes
9. NA

IRF: Discharge Assessment

LTCH: Planned Discharge, Unplanned Discharge, and Expired Assessments

Section N	Medications
N2005. Medication Intervention	
Enter Code ☐	Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the n 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

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

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**
Code **9, NA – 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

A dash is a valid response for this item. CMS expects dash use to be a rare occurrence.

N2005 Coding Clarification

- **<u>Throughout the stay</u> includes admission through and 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 Q&A #3

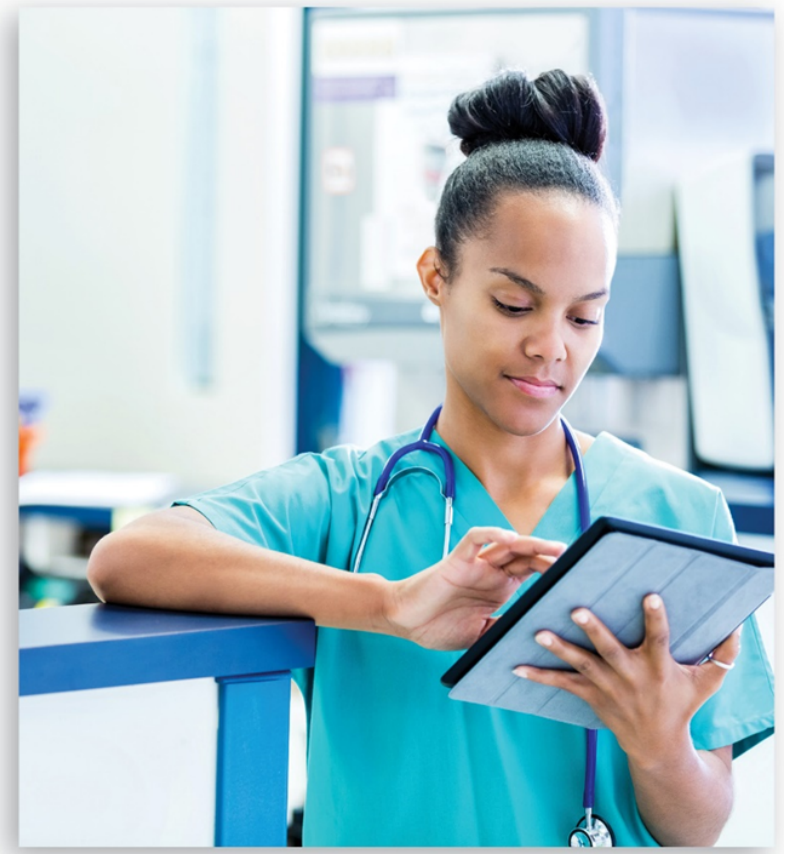
Question: If a provider coded item N2003 as **0, No,** on the Admission Assessment indicating that the required follow-up action did not take place, is there a way for the facility to code N2005 as **1, Yes?**

Answer: If N2003 is coded as **0, No,** then N2005 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.

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?

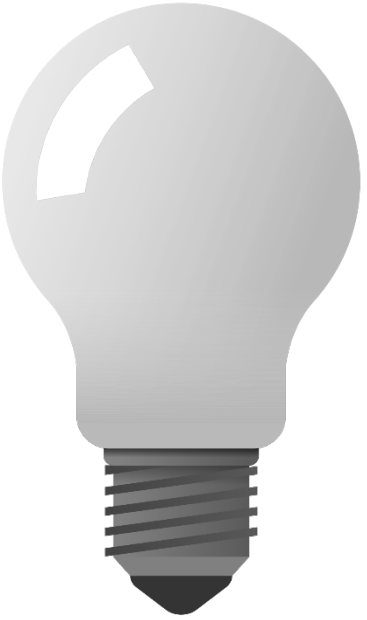
Did a complete drug regimen review identify potential clinically significant medication issues?

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 (–)**



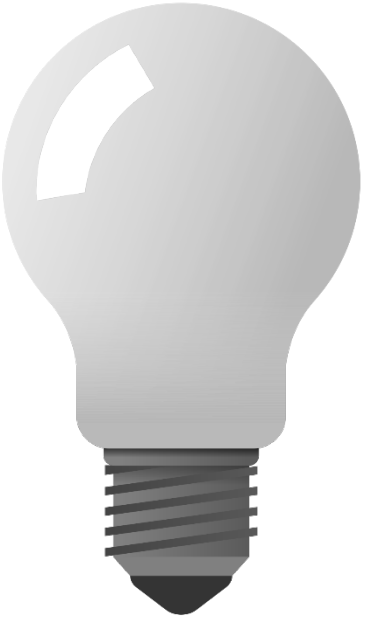
How would you code N2003 on the Admission Assessment?

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**

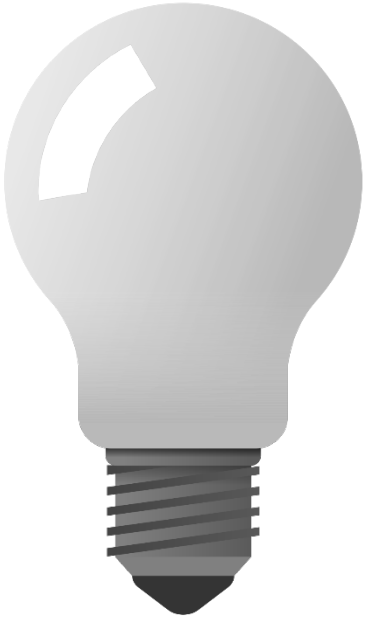
B. **1, Yes**

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, NA**

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
- 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?

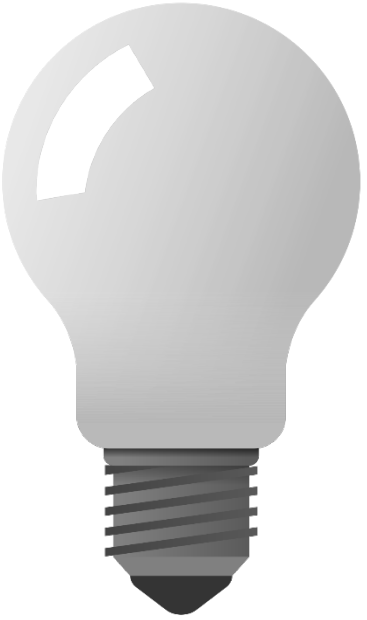
Did a complete drug regimen review identify potential clinically significant medication issues?

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

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

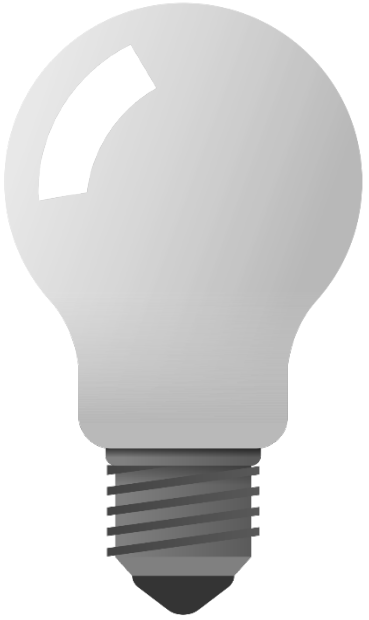
C. **9, NA** – Patient is not taking any medications

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?

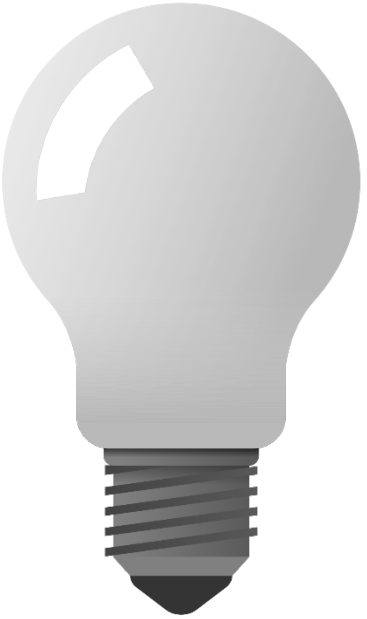
Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

A. **0, No**

B. **1, Yes**

C. **9, NA**

D. Enter a **dash (–)**



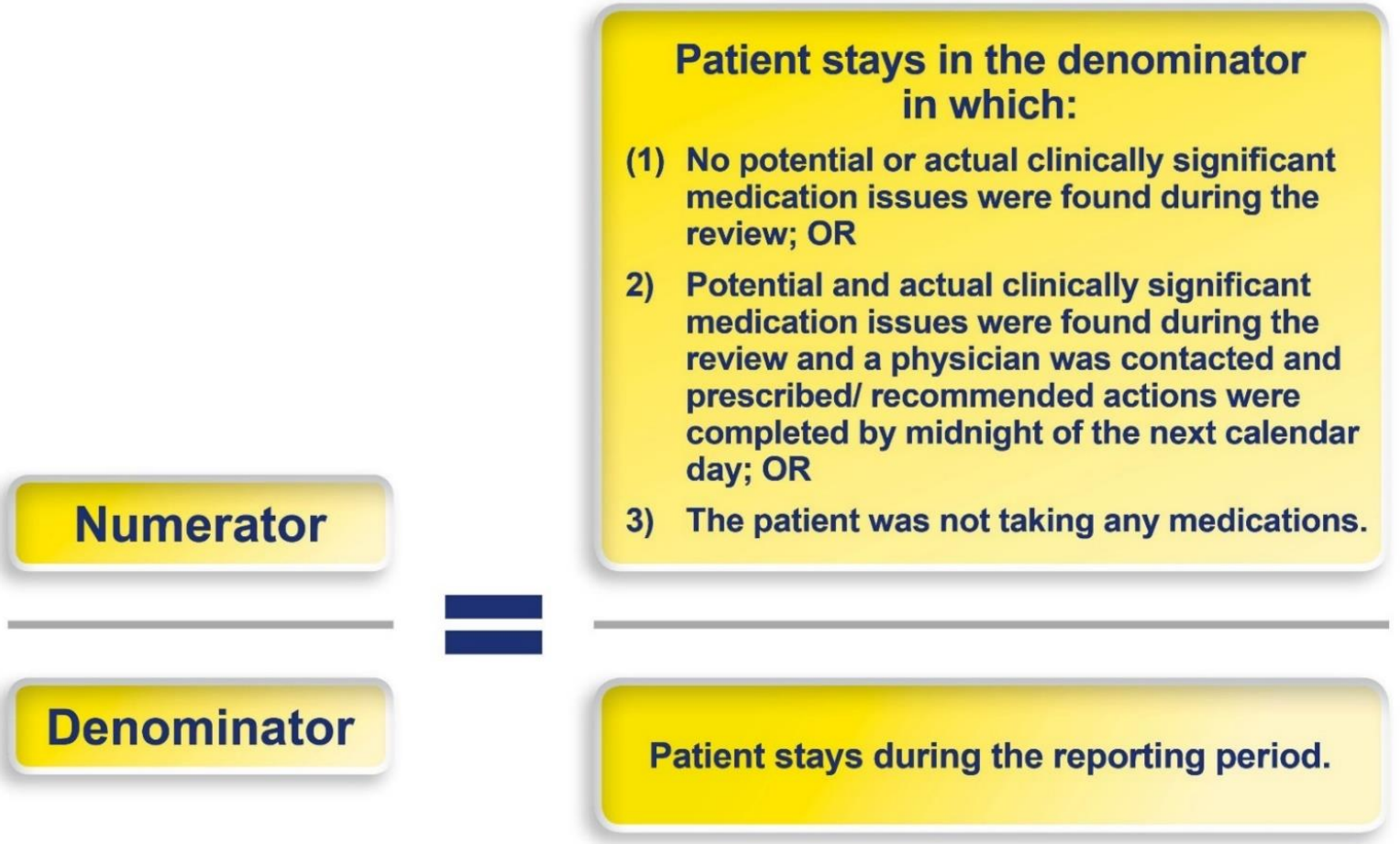
Drug Regimen Review Conducted With Follow-Up for Identified Issues Quality Measure

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)



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

FY 2019 IRF and LTCH Rule Updates

- The final rules removed the following measures from the IRF QRP and LTCH QRP:
  - IRF and LTCH
    - National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure (NQF #1716) beginning with the FY 2020 IRF and LTCH QRPs.
      - Beginning October 1, 2018, IRFs and LTCHs will no longer be required to submit data on this measure for the purposes of the IRF and LTCH QRPs.
    - Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short Stay) (NQF #0680) beginning with the FY 2021 IRF and LTCH QRPs.
      - Beginning October 1, 2018, IRFs/LTCHs should enter any of the valid codes or a dash (–) for O0250A, O0250B, and O0250C until the next IRF-PAI and LTCH CARE Data Set is released.
  - LTCH-only
    - National Healthcare Safety Network (NHSN) Ventilator-Associated Event (VAE) Outcome Measure beginning with the FY 2020 LTCH QRP.
      - Beginning October 1, 2018, LTCHs will no longer be required to submit data on this measure for the purposes of the LTCH QRP.

FY 2019 IRF and LTCH Rule Updates (cont.)

- Further, CMS finalized the following:
  - An update to expand the methods by which IRFs and LTCHs are notified of noncompliance with the requirements of the IRF and LTCH QRPs for a program year and how CMS will notify IRFs and LTCHs of a reconsideration decision.
  - IRF-only: To display data on the four assessment-based functional outcome measures in CY 2020.
- For more information, refer to the final rules:
  - FY 2019 IRF PPS final rule: https://www.gpo.gov/fdsys/pkg/FR-2018-08-06/pdf/2018-16517.pdf
  - FY 2019 IPPS/LTCH PPS final rule: https://www.gpo.gov/fdsys/pkg/FR-2018-08-17/pdf/2018-16766.pdf


Questions?