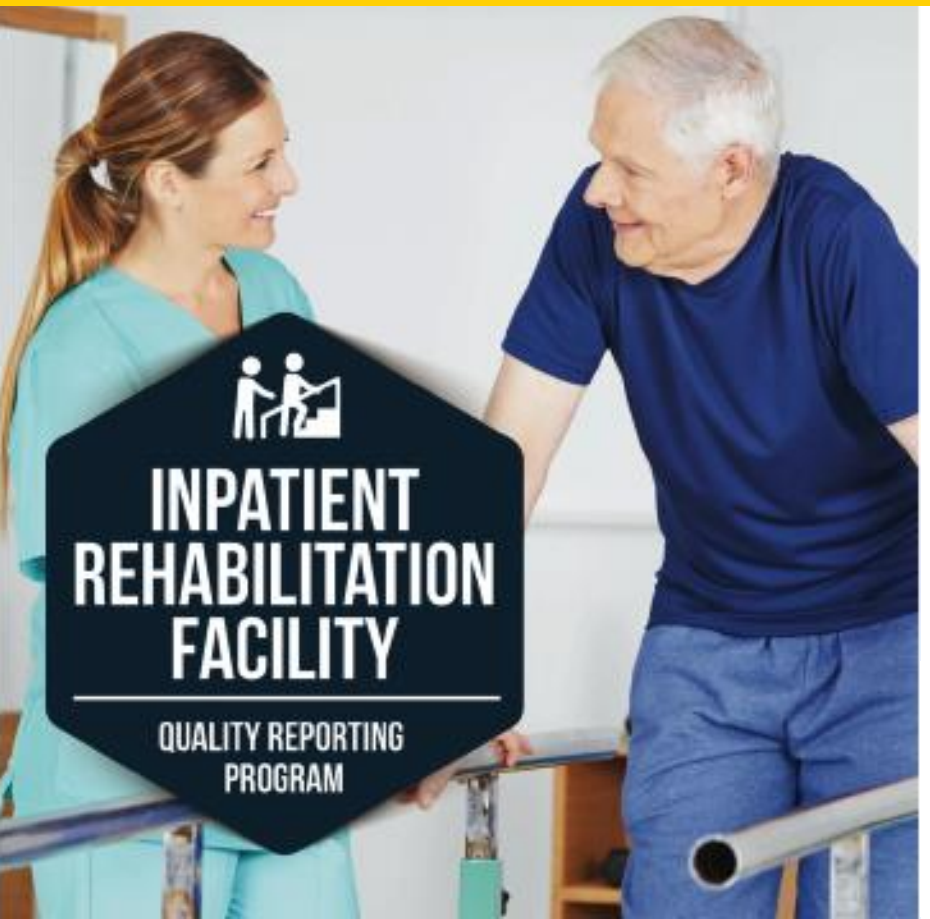
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Inpatient Rehabilitation Facility

Quality Reporting Program Provider Training



Section N: Medications (Drug Regimen Review)

Terry Kahlert Eng, RTI International

August 15, 2019

Acronyms in This Presentation

- CMS – Centers for Medicare & Medicaid Services
- DVT – Deep Vein Thrombosis
- DOAC – Direct Oral Anticoagulant
- DRR – Drug Regimen Review
- HHA – Home Health Agency
- IMPACT – Improving Medicare Post-Acute Care Transformation
- INR – International Normalized Ratio
- IRF – Inpatient Rehabilitation Facility

Acronyms in This Presentation (cont.)

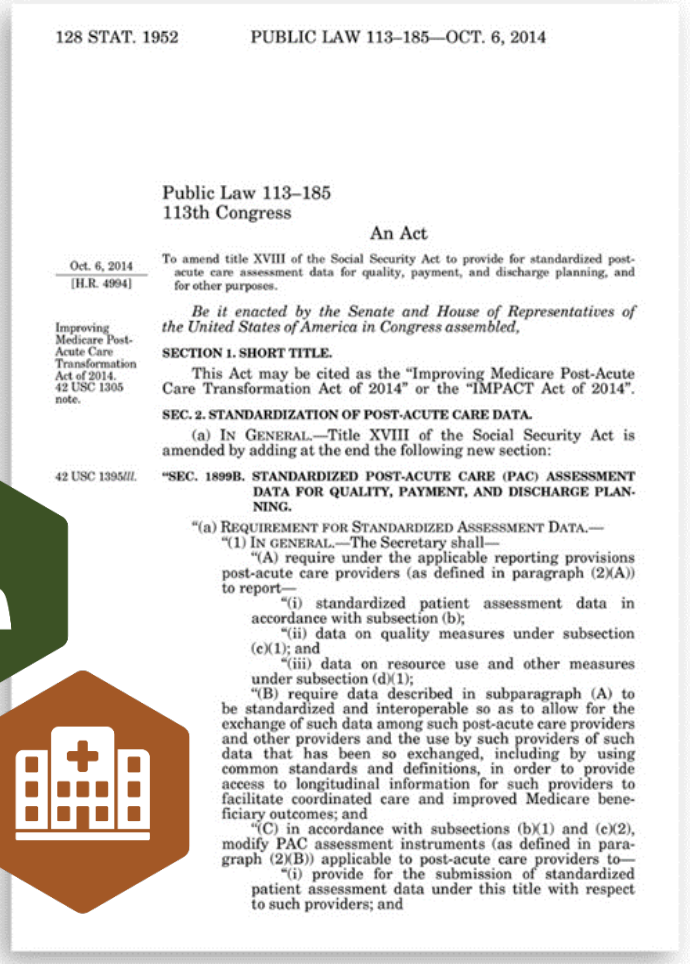
- IRF-PAI – Inpatient Rehabilitation Facility-Patient Assessment Instrument
- LTCH – Long-Term Care Hospital
- MAR – Medication Administration Record
- PAC – Post-Acute Care
- PRN – As Needed
- RN – Registered Nurse
- SNF – Skilled Nursing Facility

Objectives

- State the intent of Section N.
- Articulate the purpose of the Drug Regimen Review (DRR) items and coding options.
- Apply coding instructions to accurately code practice scenarios and the case study.
- Describe the DRR quality measure.

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.



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 1395*lll*.

"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 Quality Measure Across Post-Acute Care (PAC) Settings

This measure has been uniformly applied across PAC settings.

Home Health Agencies (HHAs)

- Introduced: January 1, 2010
- Revised: January 1, 2017

Long-Term Care Hospitals (LTCHs)

- July 1, 2018

Skilled Nursing Facilities (SNFs)

- October 1, 2018

Inpatient Rehabilitation Facilities (IRFs)

- October 1, 2018

N2001. Drug Regimen Review and N2003. Medication Follow-up

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**

N2005. Medication Intervention

Discharge Assessment

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**

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM

Section N

Definitions

Drug Regimen Review (DRR)

The DRR in post-acute care 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.

Note: The DRR also includes total parenteral nutrition 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 a 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

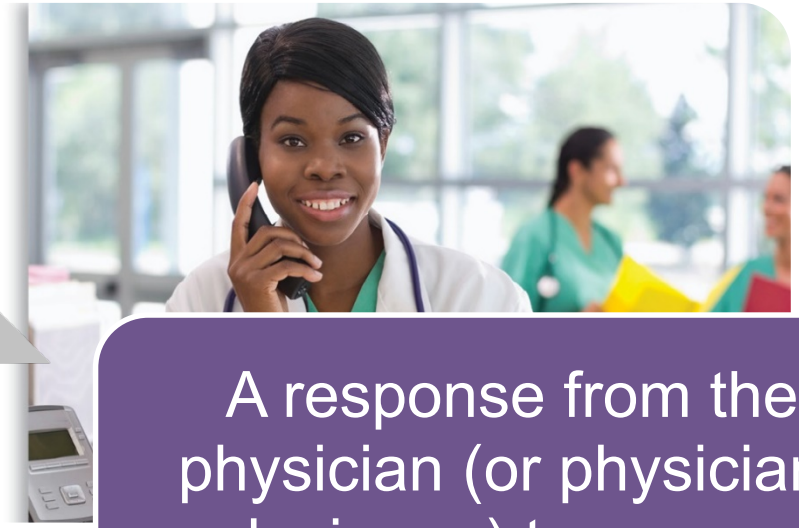
- Any of these issues must reach a level of clinical significance that warrants physician/physician-designee communication and completion of prescribed/recommended actions by midnight of the next calendar day, at the latest.
- Any circumstance that does not require this immediate attention is not considered 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 Inpatient Rehabilitation Facility-Patient Assessment Instrument (IRF-PAI) Manual.

Two-Way Communication With Physician (or Physician-Designee)

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

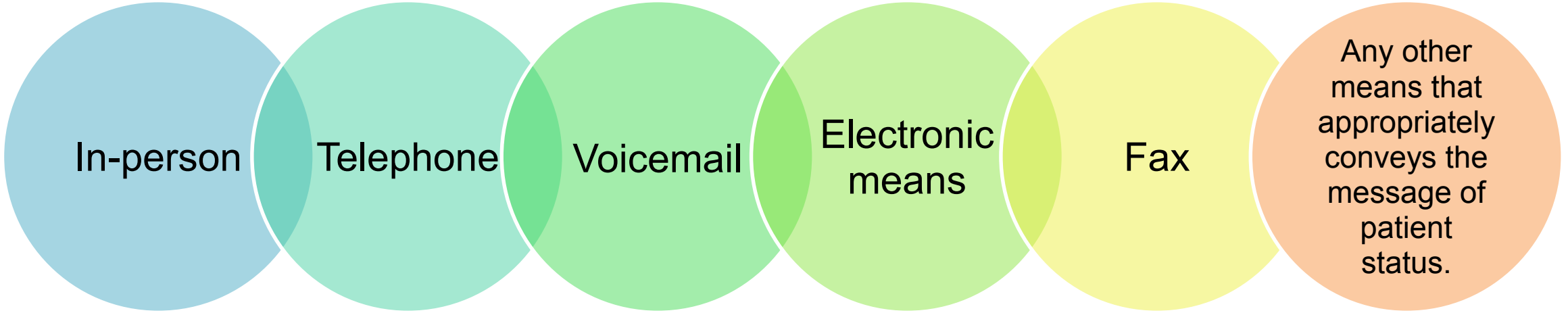
and



A response from the physician (or physician-designee) to convey prescribed/recommended actions in response to the medication issue(s).

Two-Way Communication 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

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 Lists/Records

- For example, medication administration record, 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's family/significant other.

Documentation in the Medical Record

Data reported on the IRF-PAI should be supported by information documented in the patient's medical record.

Who Can Complete a DRR?

- CMS does not provide guidance on who can or cannot complete a DRR or code the DRR items.
- Please refer to facility, Federal, and State policies and procedures to determine which IRF staff members may complete a DRR.
- Each facility determines its policies and procedures for completing the assessments.
- Each facility provides patient care according to its unique characteristics and standards (e.g., 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

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

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*

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM

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.

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 IRF nurse reviewed and compared the acute care hospital discharge medication orders and the IRF 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.

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM

Q1 N2001: 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

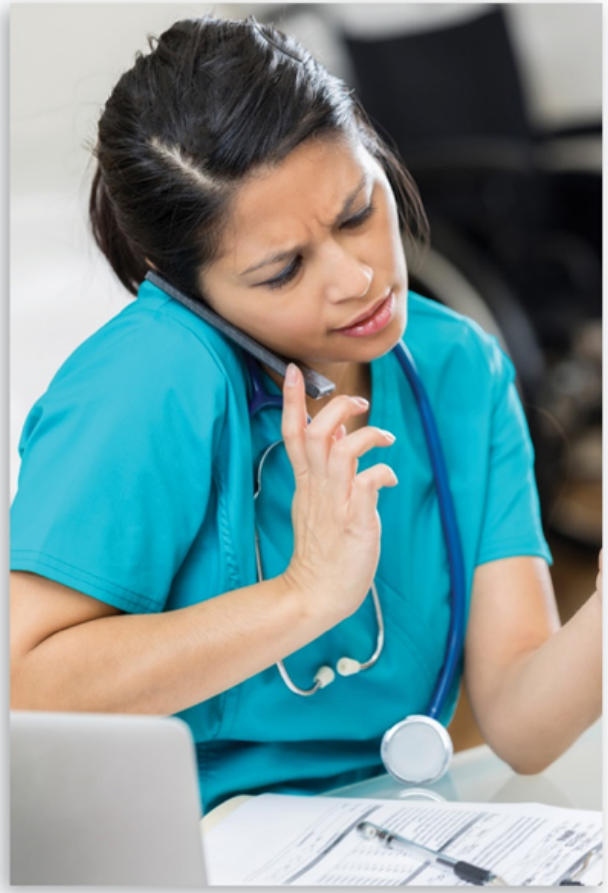
- Mr. C was admitted to an IRF after undergoing mitral valve replacement cardiac surgery.
- The acute care hospital discharge information indicated that Mr. C had a mechanical mitral heart valve and was to continue receiving anticoagulant medication.

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 IRF 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 were 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.



Q2

N2001: 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

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** addressed **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.

Examples of "By Midnight of the Next Calendar Day"

Example 1

- A clinically significant medication issue is identified at 10 a.m. on May 1.
- The physician's (or physician-designee's) prescribed/ recommended action is completed on or before 11:59 p.m. on May 2.

Example 2

- A clinically significant medication issue is identified at 11 p.m. on May 1.
- The physician's (or physician-designee's) prescribed/ recommended action is completed on or before 11:59 p.m. on May 2.

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 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.

Provider Q&A #1

Question: If a physician orders medications on admission, and the pharmacist contacts the physician and resolves the question/potential issue on the same day, 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: 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, then this scenario did not require two-way communication with facility staff (because the physician-designee identified and resolved the medication issue). Since no two-way communication was warranted, this is not considered a clinically significant medication issue for the purposes of completing N2001.

In this scenario, N2001 would be coded 0, No (no issues found during review) and N2003 would be skipped.

Provider Q&A #3

Question: Is there a specific timeframe that the admission drug regimen review must be completed for N2001 and N2003?

Answer: IRFs would follow best practices by conducting the drug regimen review as soon after the patient's admission as possible. DRR items N2001 and N2003 would be completed upon admission or as close to the actual time of admission as possible. Any clinically significant medication issues identified during the drug regimen review or at any other time throughout the patient's stay must be addressed by midnight of the next calendar day.

Each facility delivers patient care according to its unique characteristics and standards (e.g., patient population). Thus, each facility determines its policies and procedures for documenting medication issues and the processes used to notify the physician. Examples of two-way communication with a physician or physician designee include in person, telephone, voicemail, electronic means, fax, or any other means that appropriately conveys the patient's status.

Provider Q&A #4

Question: What are some examples of a clinically significant medication issue?

Answer: Potential or actual clinically significant medication issues may include, but are not limited to:

- Medication prescribed despite medication allergy documented in the patient's medical record.
- Adverse reactions to medications.
- Ineffective drug therapy.
- Drug interactions.
- Duplicate therapy.
- Wrong patient, drug, dose, route, and time errors.
- Omissions (drugs missing from a prescribed regimen).
- Nonadherence (purposeful or accidental).
- Use of a medication without evidence of adequate indication for use.
- Presence of medical condition that may warrant medication therapy.

N2003 Practice Coding Scenario 3

- Mr. B was admitted to the IRF following a hip fracture and with an active diagnosis of pneumonia and atrial fibrillation.
- The acute care facility medication record indicated that Mr. B was on a 7-day course of antibiotics and he had 3 remaining days of this treatment plan.
- The IRF pharmacist reviewed the discharge records from the acute care facility and the IRF admission medication orders.

N2003 Practice Coding Scenario 3 (cont. 1)

- The pharmacist noted that Mr. B had an order for an anticoagulant medication that required INR monitoring as well as the antibiotic.
- On the date of admission, the IRF pharmacist contacted the IRF 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 IRF 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 first INR laboratory test did not occur that day and instead occurred after midnight of the next calendar day—meaning the IRF physician's recommended actions were not completed by midnight of the next calendar day.

Q3 N2001: 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 (–).

Q4

N2003: 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. K was transferred from an acute care hospital to an IRF with discharge paperwork.
- Her medical records indicate that she is on a direct oral anticoagulant (DOAC) for atrial fibrillation as well as aspirin and a P2Y12 inhibitor (e.g., clopidogrel) for recent cardiac stent placement.

N2003 Practice Coding Scenario 4 (cont. 1)

- The admitting physician recalls recent guidelines suggesting that triple therapy with a DOAC, aspirin, and P2Y12 inhibitor is not recommended due to excess risk of bleeding.
- The admitting physician immediately calls and speaks with the patient's cardiologist, who agrees with the recommendations and discontinues the aspirin, retaining the P2Y12 inhibitor and low dose DOAC, in accordance with recent guidelines.

Q5 N2001: 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 (–).

Q6

N2003: 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 5

- Mr. D is in severe pain on admission to an IRF following his recent surgery for spinal stenosis.
- He is scheduled to receive two tablets of extra-strength acetaminophen every 6 hours.
- In addition, other as needed (PRN) pain medications are ordered, including ibuprofen and hydrocodone-acetaminophen.

N2003 Practice Coding Scenario 5 (cont. 1)

- A drug regimen review is completed later that afternoon which identifies that the patient is scheduled to receive the maximum dose of acetaminophen for a 24-hour period, but also has orders for hydrocodone-acetaminophen PRN, which could potentially result in an acetaminophen overdose.

N2003 Practice Coding Scenario 5 (cont. 2)

- The clinician completing the drug regimen review contacts the IRF physician, who states she will review the medications later today and make necessary changes.
- Following the facility's protocol, the clinician documents the conversation with the IRF physician.
- However, the physician forgets to change the order that day.
- Two days later, the physician is paged to assess Mr. D for ongoing pain and, on review of his current medication list, sees that she did not discontinue hydrocodone-acetaminophen. She immediately discontinues this medication and initiates an alternative PRN medication that does not contain acetaminophen.

Q7 N2001: 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 (–).

Q8

N2003: 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

Complete only at Discharge

0. No
1. Yes
9. NA

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 r 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 record 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 the facility did not contact the physician (or physician-designee) and complete prescribed/recommended actions by midnight of the next calendar day each time clinically significant medication issues were identified at admission or at any time throughout the patient stay (admission through discharge).
Code **1, Yes**	If the facility contacted the physician (or physician-designee) and completed prescribed/recommended actions by midnight of the next calendar day each time clinically significant medication issues were identified at admission or at any time throughout the patient stay (admission through discharge).
Code **9, NA – Not applicable**	If there were no potential or actual clinically significant medication issues identified at admission nor throughout the patient's stay, or the patient was not taking any medications at admission or throughout the stay.

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 #5

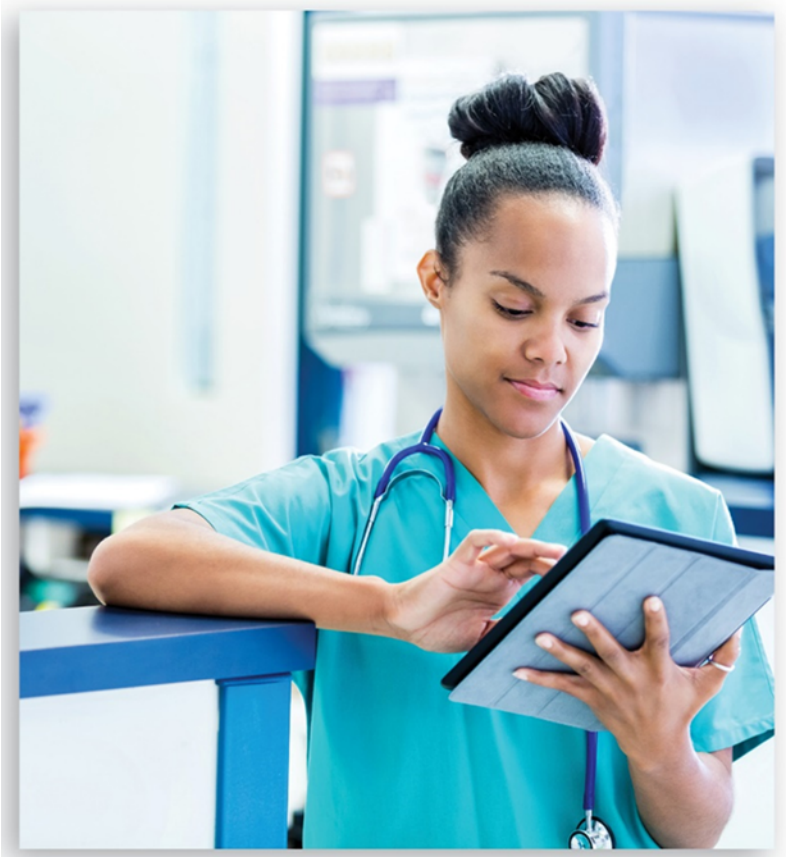
Question: If a provider coded item N2003 as **0, No,** on the Admission Assessment indicating that the required follow-up action did not take place, is there a way for the facility to code N2005 as **1, Yes?**

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 6

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



N2005 Practice Coding Scenario 6 (cont. 1)

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

N2005 Practice Coding Scenario 6 (cont. 2)

- After midnight of the second calendar day, the IRF 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.

Q9 N2001: Did a complete drug regimen review identify potential clinically significant medication issues?

Admission Assessment

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 (–).

Q 10

N2003: 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?

Admission Assessment

A. 0, No.

B. 1, Yes.

C. Enter a dash (–).

Q 11

N2005: 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?

Discharge Assessment

A. 0, No.

B. 1, Yes.

C. 9, NA.

D. Enter a dash (–).

N2005 Practice Coding Scenario 7

- Mr. H is admitted to the IRF and his healthcare records are transferred from the discharging acute care hospital.
- The IRF physician notices that the most recent medication administration record (MAR) from the acute care hospital indicates that the patient was receiving long-acting insulin.
- However, the final discharge medication list sent with the patient does not include this medication.

N2005 Practice Coding Scenario 7 (cont. 1)

- Within an hour, the IRF physician telephones the acute care hospital and speaks to the discharging clinician, who confirms that the patient should be prescribed this medication due to his history of diabetes.
- The IRF physician orders the long-acting insulin immediately after the telephone call with the acute care discharging clinician.
- No other potential clinically significant medication issues were identified during the remainder of the patient's stay.

Q 12

N2001: Did a complete drug regimen review identify potential clinically significant medication issues?

Admission Assessment

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 (–).

Q 13

N2003: 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?

Admission Assessment

A. 0, No.

B. 1, Yes.

C. Enter a dash (–).

Q 14

N2005: 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?

Discharge Assessment

A. 0, No.

B. 1, Yes.

C. 9, NA.

D. Enter a dash (–).

N2005 Practice Coding Scenario 8

- Mr. P is admitted to an IRF with a recent history of a traumatic brain injury.
- A drug regimen review is completed by pharmacy and identifies that the patient is on deep vein thrombosis (DVT) prophylaxis and is on two different antipsychotic medications, one prescribed during the patient's recent acute care hospitalization and another one newly prescribed by the admitting IRF physician.

N2005 Practice Coding Scenario 8 (cont. 1)

- The pharmacist contacts the IRF physician and leaves a message providing notification of the potential duplicative drug therapy upon discovery of the issue.
- The following morning, the IRF physician discontinues one of the antipsychotic medications and notifies the nursing staff who discontinue the medication from the MAR.
- A couple of weeks later, Mr. P has a planned bedside procedure and the patient's DVT prophylaxis is held.

N2005 Practice Coding Scenario 8 (cont. 2)

- The following day, the IRF physician noted that this medication should have been restarted earlier that morning and the order was immediately placed.
- This information was then communicated to the nursing staff and the medication was administered.
- No additional clinically significant issues were identified during the rest of the IRF stay.

Q15 N2001: Did a complete drug regimen review identify potential clinically significant medication issues?

Admission Assessment

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 (–).

Q 16

N2003: 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?

Admission Assessment

A. 0, No.

B. 1, Yes.

C. Enter a dash (–).

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM

Q 17

N2005: 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?

Discharge Assessment

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 (or physician-designee) 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 both of the following criteria are met:

1. **The facility conducted a drug regimen review on admission which resulted in one of the following three scenarios:**
   - **1.1** No potential or actual clinically significant medication issues were found during the review (N2001 = [0]); or
   - **1.2** Potential or actual clinically significant medication issues were found during the review (N2001 = [1]) and a physician (or physician-designee) was contacted and prescribed/recommended actions were completed by midnight of the next calendar day (N2003 = [1]); or
   - **1.3** The patient was not taking any medications (N2001 = [9]).
2. **Appropriate follow-up occurred each time a potential or actual clinically significant medication issue was identified during the stay (N2005 = [1]); or no potential or actual clinically significant medications issues were identified since admission or patient was not taking any medications (N2005 = [9]).**

=

Denominator

Patient stays during the reporting period.

INPATIENT REHABILITATION FACILITY QUALITY REPORTING PROGRAM

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

Summary

- The DRR is an assessment-based, cross-setting process quality measure adopted to meet the requirements of the IMPACT Act domain of medication reconciliation.

- The DRR measure includes the following items:
  - N2001. Drug Regimen Review.
  - N2003. Medication Follow-Up.
  - N2005. Medication Intervention.

Summary (cont.)

- This measure assesses whether a drug regimen review was conducted 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.

Record Your Action Plan Ideas


Join at
slido.com
#Econometrica
Questions?