

## SECTION N: MEDICATIONS

### N0415. High-Risk Drug Classes: Use and Indication

**Intent:** The intent of the item in this section is to record whether the patient is taking any medications in specified drug classes and whether the patient-specific indication was noted for the prescribed medications.

N0415. High-Risk Drug Classes: Use and Indication		
1. Is taking Check if the patient is taking any medications by pharmacological classification, not how it is used, in the following classes	1. Is taking	2. Indication noted
2. Indication noted If column 1 is checked, check if there is an indication noted for all medications in the drug class	Check all that apply ↓	Check all that apply ↓
A. Antipsychotic		
E. Anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>
F. Antibiotic	<input type="checkbox"/>	<input type="checkbox"/>
H. Opioid	<input type="checkbox"/>	<input type="checkbox"/>
I. Antiplatelet	<input type="checkbox"/>	<input type="checkbox"/>
J. Hypoglycemic (including insulin)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	

### Item Rationale

- Medications are an integral part of the care provided to patients of LTCHs. They are administered to try to achieve various outcomes, such as curing an illness, diagnosing a disease or condition, arresting or slowing a disease's progress, reducing or eliminating symptoms, or preventing a disease or symptom.
- Patients taking medications in these medication categories and drug classes are at risk for side effects that can adversely affect health, safety, and quality of life.

#### DEFINITION

##### INDICATION

The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the patient's condition and therapeutic goals.

### Steps for Assessment

*Complete only if A0250 = 01 Admission, A0250 = 10 Planned Discharge, or A0250 = 11 Unplanned Discharge.*

*Complete based on assessments that occur within the 4-day admission assessment time period or the 3-day discharge assessment time period.*

- Determine whether the patient is taking any prescribed medications in any of the drug classes (Column 1). Include all medications that are part of a patient's current reconciled drug

regimen, even if it was not taken during the 4-day admission assessment or 3-day discharge assessment time period.

- Sources include medical records received from facilities where the patient received healthcare, the patient's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.
  - Discussions (including with the acute care hospital, other staff and clinicians, the patient, and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.
2. If Column 1 is checked (patient is taking medication in drug classification), review patient documentation to determine if there is a documented patient-specific indication noted for all medications in the drug class (Column 2).

## Coding Tips

- Code medications according to the medication's therapeutic category and/or drug classification, regardless of why the patient is taking it.
- CMS does not specify a source for identifying the therapeutic category and/or pharmacological classification.
- Include any of these medications used by any route in any setting (e.g., at LTCH, in a hospital emergency room, at physician office or clinic) while a patient of the setting that is also part of a patient's current reconciled drug regimen, even if it was not taken during the 4-day admission assessment or 3-day discharge assessment time period.
- Medications that have more than one therapeutic category and/or drug classification should be coded in **all** categories/classifications assigned to the medication, regardless of how it is being used. For example, prochlorperazine is dually classified as an antipsychotic and an antiemetic. Therefore, in this section, it would be coded as an antipsychotic, regardless of how it is used.
- Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E, Anticoagulant.
- Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0415E, Anticoagulant.
- Do not include flushes to keep an IV access patent in N0415E, Anticoagulant.
- Count long-acting medications, such as fluphenazine decanoate or haloperidol decanoate, that are given every few weeks or monthly **only** if they are part of the patient's current reconciled drug regimen, even if it was not taken during the 4-day admission assessment or 3-day discharge assessment time period.
- A transdermal patch is designed to release medication over a period of time (typically 3–5 days); therefore, transdermal patches would be considered long-acting medications for the purpose of coding the LCDS, and are counted if they are part of the patient's current reconciled drug regimen, even if it was not taken during the 4-day admission assessment or 3-day discharge assessment time period.

- Combination medications should be coded in all categories/drug classes that constitute the combination. For example, if the patient receives a single tablet that combines an opioid and an antiplatelet, then both opioid and antiplatelet categories should be coded, regardless of why the medication is being used.
- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). Therefore, they should not be counted as medications (e.g., melatonin, chamomile, valerian root).
- CMS does not provide an exhaustive list of examples for determining the source for the documented patient-specific indication.
- At discharge, N0415 considers medications included in the patient's prescribed drug regimen at discharge, and not what is expected to occur after discharge.

## Examples

1. The documentation for the patient reflects that they are taking (at admission) edoxaban and glipizide. The documentation indicates the patient has type 2 diabetes and is taking the glipizide to control high blood sugar. There is no indication documented for the edoxaban.

**Coding:** Medications in N0415, High-Risk Drug Classes: Use and Indication would be coded as follows: Column 1 (Is taking) **would be checked** for **E. Anticoagulant** and **J. Hypoglycemic** and Column 2 (Indication noted) **would be checked** only for **J. Hypoglycemic**.

**Rationale:** Column 2 would not be checked for E. Anticoagulant because there was no indication documented for the edoxaban.

2. At discharge, the patient's documentation indicates they are taking oxycodone for pain. Tramadol is also listed but there is no indication documented for the tramadol.

**Coding:** Medications in N0415, High-Risk Drug Classes: Use and Indication would be coded as follows: Column 1 (Is taking) **would be checked** for **H. Opioid** and Column 2 (Indication noted) **would not be checked** for **H. Opioid**.

**Rationale:** Column 1, H. Opioid is checked because the patient is taking oxycodone and tramadol, both medications in that class. However, **all** medications in the class need the indication to be documented to check Column 2.

## N2001. Drug Regimen Review

**Intent:** The intent of the Drug Regimen Review data elements is to document that an LTCH provider conducted a drug regimen review upon patient admission and whether clinically significant medication issues were addressed in a timely manner when identified throughout the patient stay.

N2001. Drug Regimen Review	
Enter Code	Did a complete drug regimen review identify potential clinically significant medication issues?
<input type="checkbox"/>	0. No - No issues found during review → Skip to 00110, Special Treatments, Procedures, and Programs
<input type="checkbox"/>	1. Yes - Issues found during review → Continue to N2003, Medication Follow-up
<input type="checkbox"/>	9. Not applicable - Patient is not taking any medications → Skip to 00110, Special Treatments, Procedures, and Programs

### Item Rationale

- Potential and actual patient medication errors are prevalent among post-acute care (PAC) settings and often occur during transitions in care.
- Medication errors can lead to medication-related adverse reactions, emergency department visits, and re-hospitalizations, and affect the patient's health, safety, and quality of life.
- Drug regimen review is intended to improve patient safety in LTCHs by identifying and addressing potential and actual clinically significant medication issues at the time of patient's admission and throughout the patient stay.

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

### DEFINITIONS

#### DRUG REGIMEN REVIEW

The drug regimen review in post-acute care is generally considered to include medication reconciliation, a review of all medications a patient is currently using, and review of the drug regimen to identify, and if possible, prevent potential clinically significant medication issues.

Note: The drug regimen review includes all medications, prescribed and over the counter (OTC) (including nutritional supplements, vitamins, and homeopathic and herbal products), administered by any route (for example, oral, topical, inhalant, injection, sublingual, parenteral, and by infusion). The drug regimen review also includes total parenteral nutrition (TPN) and oxygen.

#### ADVERSE DRUG REACTION

Any unexpected, unintended, undesired, or excessive response to a drug that: requires discontinuing the drug (therapeutic or diagnostic), requires changing the drug therapy, requires modifying the dose (except for minor dosage adjustments), necessitates admission to a hospital, prolongs stay in a healthcare facility, necessitates supportive treatment, significantly complicates diagnosis, negatively affects prognosis, or results in temporary or permanent harm, disability, or death.

- Medical record sources include medical records received from facilities where the patient received healthcare, the patient's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.
3. Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the patient, and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.
  4. Potential or actual clinically significant medication issues may include, but are not limited to:
    - Medication prescribed despite documented medication allergy or prior adverse reaction.
    - Excessive or inadequate dose.
    - Adverse reactions to medication (such as a rash).
    - Ineffective drug therapy (such as an analgesic that does not reduce pain).
    - Side effects (such as potential bleeding from an anticoagulant).
    - Drug interactions (such as serious drug-drug, drug-food, and drug-disease interactions).
    - Duplicate therapy (such as generic-name and brand-name equivalent drugs that are both prescribed).
    - Wrong patient, drug, dose, route, and time errors.
    - Medication dose, frequency, route, or duration not consistent with patient's condition, manufacturer's instructions, or applicable standards of practice.
    - Use of a medication without evidence of adequate indication for use.
    - Omissions (medications missing from a prescribed regimen).
    - Nonadherence (purposeful or accidental).
    - Any of the circumstances listed above must reach a level of clinical significance that warrants notification of the physician (or 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 drug regimen review items.

## Coding Instructions

*Complete only if A0250 = 01 Admission. Complete based on an assessment that occurs within the 4-day admission assessment time period.*

- **Code 0, No – No issues found during review,** if a drug regimen review was conducted upon admission and based on the assessing clinician's professional judgment, no potential or actual clinically significant issues were identified.

### Example

- Patient's acute care hospital discharge medication orders match the LTCH admission medication orders, patient's medications are consistent with patient's medical conditions, and patient exhibits no signs/symptoms of an adverse reaction caused by medication(s). As such, the facility determines there are no potential or actual clinically significant medication issues.

- **Code 1, Yes – Issues found during review,** if a drug regimen review is conducted upon admission and based on assessing clinician's professional judgment, potential or actual clinically significant medication issues are identified.

### Examples

- Patient's acute care hospital discharge medication orders do not match the LTCH admission medication orders, and the clinician determines this is a potential or actual clinically significant medication issue.
- Patient's medication(s) are ineffective for the diagnoses/symptoms for which they are prescribed, and the clinician determines this is a potential or actual clinically significant medication issue.
- Patient exhibits signs/symptoms of an adverse reaction that the clinician suspects are likely related to an ordered medication, and the clinician determines this is a potential or actual clinically significant medication issue.
- Patient takes multiple non-prescribed medications (OTCs, herbal and homeopathic products) that could interact with prescribed medications, and the clinician determines this is a potential or actual clinically significant medication issue.
- Patient's medication order includes medications known to have adverse interactions, and the clinician determines this is a potential or actual clinically significant medication issue.

## DEFINITION

### POTENTIAL (OR ACTUAL) CLINICALLY SIGNIFICANT MEDICATION ISSUE

A clinically significant medication issue is 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).

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 drug regimen review items.

- **Code 9, Not applicable – Patient is not taking any medications,** if a drug regimen review was conducted at the time of the patient's admission and, per data sources/resources reviewed, there were no medications prescribed for the patient and the patient was not taking any medications, by any route, at the time of the assessment.

## Coding Tips

- A dash (-) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.
- The drug regimen review includes all medications, prescribed and OTC (including nutritional supplements, vitamins, and herbal and homeopathic products), administered by any route (for example, oral, topical, inhalant, injection, sublingual, parenteral, and by infusion). The drug regimen review also includes total parenteral nutrition (TPN) and oxygen.

## Examples

1. The admitting LTCH nurse reviewed and compared the acute care hospital discharge medication orders and the LTCH physician's admission medication orders for the patient. The nurse interviewed the patient, who confirmed the medications that they were taking for their current medical conditions. The nurse found no discrepancies between the acute care hospital discharge medications and the admitting physician's medication orders. After the nurse contacted the pharmacy to request the medication, the pharmacist reviewed and confirmed the medication orders as appropriate for the patient. As a result of this collected and communicated information, the nurse determined that there were no identified potential or actual clinically significant medication issues.

**Coding:** N2001, Drug Regimen Review, would be **coded 0, No - No issues found during review.**

**Rationale:** The admitting nurse reviewed and compared the patient's discharge medication records from the acute care hospital with the LTCH physician's admission medication orders, collaborated with the LTCH pharmacist, and interviewed the patient. The nurse determined there were no potential or actual clinically significant medication issues.

2. The patient was admitted to an LTCH after undergoing cardiac surgery for mitral valve replacement. The acute care hospital discharge information indicated that the patient had a mechanical mitral heart valve and was to continue receiving anticoagulant medication. While completing a review and comparison of the patient's discharge healthcare records from the acute care hospital with the LTCH physician's admission medication orders and admission note, the nurse noted that the admitting physician had 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 the patient were 2.5–3.5. The nurse questioned the INR level listed on the admitting physician's order, based on the LTCH's established INR therapeutic parameters of 2.5–3.5 documented in the physician's admission note, which prompted the nurse to call the physician immediately to address the issue.

**Coding:** N2001, Drug Regimen Review, would be **coded 1, Yes - Issues found during review.**

**Rationale:** The admitting nurse reviewed and compared the patient's discharge healthcare records from the acute care hospital with the LTCH physician's admission medication orders and admission note. The nurse identified a discrepancy between the physician's ordered therapeutic INR level (1.0) for this patient and the LTCH's standard therapeutic range (2.5–3.5) for the patient in the admission note and the physician's order to hold anticoagulation medication for an INR level of 1.0. The nurse considered this discrepancy to be a potential clinically significant medication issue because the admitting LTCH physician's order was to hold the anticoagulation medication for an INR of 1.0, which is below the LTCH's established therapeutic INR parameters (2.5–3.5), which could lead to potential clotting issues.



## N2003. Medication Follow-up

N2003. Medication Follow-up	
Enter Code <input type="checkbox"/>	<p>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?</p> <p>0. No 1. Yes</p>

### Item Rationale

- Integral to the process of safe medication administration practice is timely communication with a physician (or physician-designee) when a potential or actual clinically significant medication issue has been identified.
- Physician (or physician-designee) prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the facility by midnight of the next calendar day at the latest to reduce patient harm.

### DEFINITION

#### 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.

### Steps for Assessment

*This item is completed if A0250 = 01 Admission and one or more potential or actual clinically significant medication issues were identified during the admission drug regimen review (N2001 = 1).*

1. Complete a drug regimen review upon admission or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues. Determine if the following criteria were met for all potential and actual clinically significant medication issues that were identified during the admission drug regimen review:
  - Two-way communication between the facility 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.

Medical record sources include medical records received from facilities where the patient received healthcare, the most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.

Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the patient, and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.

## Coding Instructions

- **Code 0, No,** if the facility did not contact the physician and complete prescribed/ recommended actions in response to each identified potential or actual clinically significant medication issue **by midnight of the next calendar day.**

### Examples

- Facility did not communicate all identified clinically significant medication issues to the physician (or physician-designee) until after midnight of the next calendar day.
  - Facility communicated all identified clinically significant medication issues to the physician (or physician-designee) by midnight of the next calendar day, but the facility did not receive a response from the physician (or physician-designee) to communicate prescribed/ recommended actions until after midnight of the next calendar day.
  - Facility did not complete all physician (or physician-designee) prescribed/ recommended actions for all identified clinically significant medication issues until after midnight of the next calendar day (even if all but one medication issue was addressed before midnight of the next calendar day).
- **Code 1, Yes,** if the facility contacted the physician AND completed the prescribed/recommended actions **by midnight of the next calendar day** after each potential or actual clinically significant medication issue was identified.

### Examples

- Facility communicated all identified clinically significant medication issues to the physician (or physician-designee), and all physician (or physician-designee) prescribed/recommended actions for all identified medication issues were completed by midnight of the next calendar day.
- Facility contacted the physician (or physician-designee) regarding all identified medication issues; and the physician (or physician-designee) communicated to the facility that no actions were necessary regarding the reported issues. All communications took place before midnight of the next calendar day.

### DEFINITION

#### CONTACT WITH PHYSICIAN (OR PHYSICIAN-DESIGNEE)

- Communication to the physician (or physician-designee) to convey an identified potential or actual clinically significant medication issue, AND a response from the physician (or physician-designee) to convey prescribed/ recommended actions in response to the medication issue.
- Communication can be in person, by telephone, voicemail, electronic means, facsimile, or any other means that appropriately conveys the message of patient status.
- Communication can be directly to/from the physician (or physician-designee), or indirectly through physician's office staff on behalf of the physician (or physician-designee), in accordance with the legal scope of practice.

## Coding Tips

- If the physician (or physician-designee) prescribed/recommended action will take longer than midnight of the next calendar day to complete, then Code 1, Yes, should still be entered, as long as if by midnight of the next calendar day the facility has taken whatever actions are possible to comply with the prescribed/recommended action.
- Example of a physician (or physician-designee) recommended action that would take longer than midnight of the next calendar day to complete:
  - Physician (or physician-designee) writes an order instructing the facility to monitor the medication issue over the next 3 days and call if the problem persists.
- Examples of by midnight of the next calendar day:
  - A clinically significant medication issue is identified at 10:00 am on September 12. The physician (or physician-designee) prescribed/recommended action is completed on or before 11:59 pm on September 13.
  - A clinically significant medication issue is identified at 11:00 pm on September 12. The physician (or physician-designee) prescribed/recommended action is completed on or before 11:59 pm on September 13.
- A dash (-) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.

## Examples

1. The patient was admitted to the LTCH with active diagnoses of pneumonia and atrial fibrillation. The acute care facility medication record indicated that the patient was on a 7-day course of antibiotics and had 3 remaining days of this treatment plan. The LTCH pharmacist reviewing the discharge records from the acute care facility and the LTCH admission medication orders noted that the patient had an order for an anticoagulant medication that required INR monitoring as well as the antibiotic. On the date of admission, the LTCH pharmacist contacted the LTCH physician responsible for the patient and communicated a concern about a potential increase in the patient's INR with this combination of medications that could place them at greater risk for bleeding. The LTCH 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.

**Coding:** N2003, Medication Follow-up, would be **coded 0, No**.

*(Note: N2001, Drug Regimen Review, would have been coded 1, Yes - Issues found during review.)*

**Rationale:** A potential clinically significant medication issue was identified during the drug regimen review; the staff did contact the physician before midnight of the next calendar day, but did not complete, to the extent possible, the physician-prescribed actions related to the INR laboratory test until after midnight of the next calendar day.

2. The patient was admitted to an LTCH from an acute care hospital. During the admitting nurse's review of the patient's hospital discharge records it was noted that the patient had

been prescribed metformin. However, laboratory tests at admission indicated the patient had a serum creatinine of 2.4, consistent with renal insufficiency. The LTCH admitting nurse contacted the LTCH physician-designee to ask whether this medication would be contraindicated with the patient's current serum creatinine level. Three hours after the patient's admission to the LTCH, the LTCH 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.

**Coding:** N2003, Medication Follow-up, would be **coded 1, Yes**.

*(Note: N2001, Drug Regimen Review, would have been coded 1, Yes - Issues found during review.)*

**Rationale:** The physician communication occurred, and the nurse completed the physician-designee-prescribed actions by midnight of the next calendar day. In this case, medication had been ordered that was contraindicated for the patient's current condition. The LTCH facilities' two-way communications resulted in discontinuing the contraindicated medication and replacing with an appropriate medication.

## N2005. Medication Intervention

N2005. Medication Intervention	
Enter Code <input type="text"/>	<p>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?</p> <p>0. No 1. Yes 9. Not applicable – There were no potential clinically significant medication issues identified since admission or patient is not taking any medications</p>

### Item Rationale

- Integral to the process of safe medication administration practice is timely communication with a physician (or physician-designee) when a potential or actual clinically significant medication issue has been identified.
- Physician (or physician-designee) prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the facility by midnight of the next calendar day at the latest to reduce patient harm.
- Potential or actual clinically significant medication issues can occur throughout the patient's stay.

### Steps for Assessment

*Complete only if A0250 = 10 Planned Discharge, A0250 = 11 Unplanned Discharge, or A0250 = 12 Expired*

1. Review the patient's medical record to determine whether any potential and actual clinically significant medication issues were identified upon admission and throughout the patient's stay.
2. Determine if the following criteria were met for all potential and actual clinically significant medication issues that were identified upon admission or at any time during the patient's stay:
  - Two-way communication between the facility and the physician (or physician-designee) was completed by midnight of the next calendar day; AND
  - All actions prescribed or recommended by the physician (or physician-designee) were completed by midnight of the next calendar day.

Medical record sources include medical records received from facilities where the patient received healthcare, the patient's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.

Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the patient, and the patient's family/significant other) may supplement and/or clarify the information gathered from the patient's medical records.

## 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 a potential or actual clinically significant medication issue was identified at admission or at any time throughout the patient stay (admission through discharge).

### Examples

- At admission or at any time during the patient's stay, the facility did not communicate all identified potential or actual clinically significant medication issues to the physician until after midnight of the next calendar day.
  - At admission or at any time during the patient's stay, the facility communicated to the physician/physician designee all identified potential or actual clinically significant medication issues, but the physician/physician designee did not respond until after midnight of the next calendar day.
  - At admission or at any time during the patient's stay, the facility did not complete all physician/physician designee prescribed/recommended actions for every identified potential or actual clinically significant medication issue by midnight of the next calendar day (even if only one issue was not addressed until after midnight of the next calendar day and all other issues were addressed by midnight of the next calendar day).
- **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 potential or actual clinically significant medication issues were identified at admission or at any time throughout the patient stay (admission through discharge).

### Examples

- At admission and at any time throughout the patient stay, the facility communicated each identified clinically significant medication issue to the physician/physician-designee; and all physician/physician-designee prescribed/recommended actions for the identified issues were addressed by midnight of the next calendar day.
  - At admission and at any time throughout the patient stay, the facility contacted the physician/physician-designee regarding all identified potential or actual clinically significant medication issues; and the physician/physician-designee communicated to the facility that no actions were necessary regarding the reported issues. All communications took place before midnight of the next calendar day.
- **Code 9, 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, by any route, at admission or throughout the stay.

## Coding Tips

- If the physician (or physician-designee) prescribed/recommended action will take longer than midnight of the next calendar day to complete, then code 1, Yes, should still be

entered, if by midnight of the next calendar day, the facility has taken whatever actions are possible to comply with the recommended action.

- Example of a physician (or physician-designee) recommended action that would take longer than midnight of the next calendar day to complete:
  - The physician (or physician-designee) writes an order instructing the facility to monitor the medication issue over the next 3 days and call if the problem persists.
- Examples of “by midnight of the next calendar day”:
  - A clinically significant medication issue is identified at 10:00 am on September 12. The physician (or physician-designee) prescribed/recommended action is completed on or before 11:59 pm on September 13.
  - A clinically significant medication issue is identified at 11:00 pm on September 12. The physician (or physician-designee) prescribed/recommended action is completed on or before 11:59 pm on September 13.
- A dash (-) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.

## Examples

1. At discharge from the LTCH, the discharging licensed clinician reviewed the patient’s medical records, which included from the time of admission through their entire stay at the LTCH and noted that a clinically significant medication issue was documented during the admission assessment. At admission, the patient was taking two antibiotics – an antibiotic prescribed during a recent acute care hospital stay that the LTCH physician had included in the patient’s LTCH medication orders, and a second antibiotic prescribed by the LTCH physician upon admission that is known for drug-induced nephrotoxicity. The patient has renal disease. The patient’s medical records further indicated that an LTCH nurse had attempted to contact the assigned LTCH physician several times about this clinically significant medication issue. After midnight of the second calendar day, the LTCH physician communicated to the nurse, via telephone, orders for changes to the patient’s medications to address the clinically significant medication issue. The nurse implemented the physician’s orders. Upon further review of the patient’s medical records, the discharging nurse determined that no additional clinically significant medication issues had been recorded throughout the remainder of the patient’s stay.

**Coding:** N2005, Medication Intervention, would be **coded 0, No**. The facility did not contact the physician (or physician-designee) and complete prescribed/recommended actions by midnight of the next calendar day each time potential or actual clinically significant medication issues were identified at admission or at any time throughout the patient stay (admission through discharge).

*(Note: N2001, Drug Regimen Review, would have been coded 1, Yes - Issues found during review. N2003, Medication Follow-up, would have been coded 0, No. The facility did not contact the physician (or physician-designee) and complete prescribed/recommended actions by midnight of the next calendar day.)*

**Rationale:** Coding of this assessment item includes all potential or actual clinically significant medication issues identified at admission or at any time throughout the patient stay that were or were not communicated to the physician (or physician-designee), with prescribed/recommended actions completed by midnight of the next calendar day. In this scenario, although no potential or actual clinically significant medication issues were identified by the nurse during the remainder of the stay, notification of the medication issue identified at admission, despite repeated communication attempts by the nurse, was not addressed by the physician by midnight of the next calendar day.

2. At discharge, the licensed clinician completing a review of the patient's medical records found that three clinically significant medication issues had been identified during the patient's stay. The patient's record included an order to hold the medication they were receiving for deep vein thrombosis prophylaxis for a scheduled procedure. However, this medication had not been restarted 48 hours post-procedure and the LTCH nurse determined that the physician needed urgent notification. The day after the notification occurred, the LTCH physician provided an order to resume the medication, which was carried out by the nursing staff within the hour. In addition, during the admission drug regimen review, the admitting nurse had identified that a clinically significant medication issue had occurred during the admission assessment period and the physician had been contacted. The nurse implemented new orders provided by the physician on the same day. Another potentially significant medication issue was identified on day 12 of the patient's stay; the nurse communicated with the physician and completed the orders within one hour of identifying the potential issue. All medication issues identified during the patient's stay (admission through discharge) were communicated to the physician and prescribed/recommended actions completed by midnight of the next calendar day after identification. There were no other clinically significant medication issues identified during the remainder of the patient's stay.

**Coding:** N2005, Medication Intervention, would be **coded as 1, Yes**, all potential or actual clinically significant medication issues identified at any time during the patient's stay (admission through discharge) were communicated to the physician and prescribed/recommended actions were completed by midnight of the next calendar day after each issue was identified.

*(Note: N2001, Drug Regimen Review, would have been coded 1, Yes - Issues found during review. N2003, Medication Follow-up, would have been coded 1, Yes. The facility contacted a physician by midnight of the next calendar day and completed prescribed recommended actions in response to the identified potential clinically significant medication issue.)*

**Rationale:** While a medication issue was identified as a clinically significant medication issue at admission, it was resolved by midnight of the next day. During the patient's stay, additional clinically significant medication issues were identified; all were resolved by midnight of the next calendar day. Each time a clinically significant medication issue was identified (at admission and during the stay), it was communicated to the physician and resolved through completion of prescribed/recommended actions by midnight of the next calendar day after identification.



## Additional Coding Scenarios

### N2001 – Drug Regimen Review (Admission), N2003 – Medication Follow-up (Admission), and N2005 – Medication Intervention (Discharge) scenarios

#### *Scenario 1*

The patient was admitted to an LTCH and their healthcare records were transferred from the discharging acute care hospital. The LTCH 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. Within an hour, the LTCH physician telephones the acute care hospital and speaks to the discharging clinician, who confirms that the patient should be prescribed this medication due to their history of diabetes. The LTCH 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.

#### AT ADMISSION

- **N2001 Coding:** N2001, Drug Regimen Review would be **coded 1, Yes - Issues found during review.**
- **N2001 Rationale:** During the drug regimen review, the LTCH physician identified a potential clinically significant medication issue (discrepancy in medication lists) that warranted notification and communication with the physician/physician-designee for recommendations/orders before midnight of the next calendar day.
- **N2003 Coding:** N2003, Medication Follow-up would be **coded 1, Yes.**
- **N2003 Rationale:** The identified clinically significant medication issue was resolved by midnight of the next calendar day. In this case, before midnight of the next calendar day, the LTCH physician followed up with the acute care discharging clinician (physician-designee) to resolve the discrepancy and the LTCH physician ordered the needed medication.

#### AT DISCHARGE

- **N2005 Coding:** N2005, Medication Intervention would be **coded 1, Yes.**
- **N2005 Rationale:** The only clinically significant medication issue identified at admission was resolved by midnight of the next calendar day and no other potential medically significant medication issues were identified during the remainder of the patient's stay

#### *Scenario 2*

The patient is admitted to an LTCH 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 LTCH physician. The pharmacist contacts the LTCH physician and leaves a message providing notification of the potential duplicative drug therapy upon discovery of the issue. The

following morning, the LTCH physician discontinues one of the antipsychotic medications and notifies the nursing staff, who discontinued the medication from the MAR.

A couple of weeks later, the patient has a planned bedside procedure and their DVT prophylaxis is held. The following day, the LTCH 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 LTCH stay.

#### AT ADMISSION

- **N2001 Coding:** N2001, Drug Regimen Review would be **coded 1, Yes - Issues found during review.**
- **N2001 Rationale:** During the drug regimen review, the pharmacist identified a potential clinically significant medication issue (duplicative drug therapy) that warranted notification and communication with the physician/physician-designee for recommendations/orders before midnight of the next calendar day.
- **N2003 Coding:** N2003, Medication Follow-up would be **coded 1, Yes.**
- **N2003 Rationale:** The identified clinically significant medication issue was resolved by midnight of the next calendar day. In this case, the pharmacist identified a potentially clinically significant medication issue, followed up with the LTCH physician regarding duplicative drug therapy; and the physician resolved the issue by discontinuing one of the medications and notifying the nursing staff by midnight of the next calendar day.

#### AT DISCHARGE

- **N2005 Coding:** N2005, Medication Intervention would be **coded as 1, Yes.**
- **N2005 Rationale:** All clinically significant medication issues identified at admission and throughout the patient stay (admission through discharge) were resolved by midnight of the next calendar day.

#### N2001 – Drug Regimen Review (Admission) and N2003 – Medication Follow-up (Admission) scenarios

##### *Scenario 3*

The patient was transferred from an acute care hospital to an LTCH with discharge paperwork. The patient's medical records indicate that they are 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. 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. The cardiologist discontinues the aspirin and changes the patient to a P2Y12 inhibitor and low dose DOAC alone in accordance with recent guidelines.

- **N2001 Coding:** N2001, Drug Regimen Review would be **coded 1, Yes - Issues found during review.**

- **N2001 Rationale:** Using clinical judgment during the drug regimen review, the physician identified a potential clinically significant medication issue (a medication contraindication with risk for excess bleeding).
- **N2003 Coding:** N2003, Medication Follow-up would be **coded 1, Yes**.
- **N2003 Rationale:** The identified clinically significant medication issue was resolved by midnight of the next calendar day. In this case, before midnight of the next calendar day, the admitting physician contacted the patient's cardiologist regarding the medication contraindication, and the medication orders were changed.

#### *Scenario 4*

The patient is in severe pain on admission to an LTCH following their recent surgery for spinal stenosis. The patient 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. 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 is also ordered for hydrocodone-acetaminophen PRN, which could potentially result in an acetaminophen overdose. The clinician completing the drug regimen review contacts the LTCH physician, who states he will review the medications later today and make necessary changes. Following the facility's protocol, the clinician documents the conversation with the LTCH physician. However, the physician forgets to change the order that day. Two days later, the physician is paged to assess the patient for ongoing pain and on review of the patient's current medication list sees that hydrocodone-acetaminophen was not discontinued. The physician immediately discontinues this medication and initiates an alternative PRN medication that does not contain acetaminophen.

- **N2001 Coding:** N2001, Drug Regimen Review would be **coded 1, Yes - Issues found during review**.
- **N2001 Rationale:** During the drug regimen review, using clinical judgment, the clinician identified a potential clinically significant medication issue (potential for acetaminophen overdose) that warranted notification and communication with the physician/physician-designee for recommendations/orders before midnight of the next calendar day.
- **N2003 Coding:** N2003, Medication Follow-up would be **coded 0, No**.
- **N2003 Rationale:** The identified clinically significant medication issue (potential for acetaminophen overdose) was not resolved by midnight of the next calendar day.