SECTION N: MEDICATIONS

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

N2001: Drug Regimen Review

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*

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 affects the patient's health, safety and quality of life.
- Drug regimen review is intended to improve patient safety in IRFs by identifying and addressing potential and actual clinically significant medication issues at the time of patient 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 close to the actual time of admission as possible, to identify any potential or actual clinically significant medication issues.
   - Medical record sources include medical records received from facilities where the patient received health care, 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.

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.

SECTION N: MEDICATIONS

Coding Instructions

Complete at the time of admission.

- Code 0. No - No issues found during review, if a drug regimen review was conducted upon admission and no potential or actual clinically significant issues were identified.

  Example:

  – Patient's acute care hospital discharge medication orders match the IRF 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 clinician determines there are no potential or actual clinically significant medication issues.

- Code 1. Yes - Issues found during review, if a drug regimen review was conducted upon admission and potential or actual clinically significant issues were identified.

  Examples:

  – Patient's acute care hospital discharge medication orders do not match the IRF admission medication orders, and the clinician determines this is a potential or actual clinically significant medication issue.

  – Patient's medication(s) are not working 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.

DEFINITIONS

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

- Potential or actual clinically significant medication issues 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 (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)
- Any of these issues listed above 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 drug regimen review items.

  - 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.

- Code 9. NA- 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 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 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 that she was taking for her current medical conditions. The pharmacist reviewed and confirmed the medication orders as appropriate for the patient. As a result of this collected and communicated information, the RN 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 IRF physician's admission medication orders, collaborated with the IRF pharmacist, and interviewed the patient. The RN determined there were no potential or actual clinically significant medication issues.

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. 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 INR was below 1.0. The RN questioned the INR level listed on the admitting physician's order, based on the IRF's established INR therapeutic parameters of 2.5-3.5 which prompted the RN 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 RN reviewed and compared the patient's discharge healthcare records from the acute care hospital with the IRF physician's admission medication orders. The RN identified a discrepancy between the physician's ordered INR level (1.0) for this patient and the IRF's standard therapeutic range (2.5 – 3.5). The RN considered this to be a potential clinically significant medication issue because the admitting IRF physician's order was to hold the anticoagulation medication for an INR of 1.0, which is below the IRF'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 ☐

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**

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 clinician in a timeframe that reduces the risk for medication errors and patient harm.
- A critical time and opportunity for identifying potential and actual clinically significant medication issues occurs when the patient is admitted to the IRF.

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

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 signification 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 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.

Medical record sources include medical records received from facilities where the patient received health care, 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

Complete at the time of admission; and if N2001 Drug Regimen Review was coded 1. Yes – Issues found during review.

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.

- Code 0. No, if **all** identified potential or actual clinically significant medication issues were **not** addressed **by midnight of the next calendar day**.

  Examples:

  - Clinician did not communicate all identified clinically significant medication issues to the physician (or physician-designee) until after midnight of the next calendar day.
  - Clinician communicated all identified clinically significant medication issues to the physician (or physician-designee) by midnight of the next calendar day, but the clinician did not receive a response from the physician (or physician-designee) to communicate prescribed/ recommended actions until after midnight of the next calendar day.
  - Clinician 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 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:

  - Clinician communicated every identified clinically significant medication issue 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.

- Clinician contacted the physician (or physician-designee) regarding all identified medication issues; and the physician (or physician-designee) communicated to the clinician that no actions were necessary regarding the reported issues. All communications took place before midnight of the next calendar day.

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.
- 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 clinician to monitor the medication issue over the weekend and call if the problem persists.
- Examples of **by midnight of the next calendar day**:
  - A clinically significant medication issue is identified at 10:00am on 9/12/2017. The physician (or physician-designee) prescribed/recommended action is completed on or before 11:59pm on 9/13/2017.
  - A clinically significant medication issue is identified at 11:00pm on 9/12/2017. The physician (or physician-designee) prescribed/recommended action is completed on or before 11:59pm on 9/13/2017.
- A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.

Example

1. 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 the patient was on a seven-day course of antibiotics and the patient had 3 remaining days of this treatment plan. The IRF pharmacist reviewing the discharge records from the acute care facility and the IRF 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 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 three days, starting that day. However, the first INR laboratory test did not occur 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: The IRF staff 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.

N2005: Medication Intervention

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**

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 clinician in a timeframe that reduces the risk for medication errors and patient harm.
- Potential or actual clinically significant medication issues can occur throughout the patient stay.
- Every time a clinically significant medication issue is identified throughout the patient stay, the clinically significant medication issue must be communicated to a physician (or physician-designee), and the physician (or physician-designee) prescribed/recommended actions must be completed by the clinician in a timeframe that reduces the risk for medication errors and patient harm.

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.
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 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.

   Medical record sources include medical records received from facilities where the patient received health care, 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.

SECTION N: MEDICATIONS

Coding Instructions

Complete at the time of discharge.

- Code 0, No, if the facility did not contact 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).

  Examples:

  - At admission or at any time during the patient's stay, the clinician(s) 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 clinician(s) 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 clinician(s) 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 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 clinician(s) communicated every 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 clinician(s) contacted the physician/physician-designee regarding all identified potential or actual clinically significant medication issues; and the physician/physician-designee communicated to the clinician(s) that no actions were necessary regarding the reported issues. All communications took place before midnight of the next calendar day.

- 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.

SECTION N: MEDICATIONS

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 appropriate steps 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**:
  - Physician (or physician-designee) writes an order instructing the clinician to monitor the medication issue over the weekend and call if the problem persists.
- Examples of **by midnight of the next calendar day**:
  - A clinically significant medication issue is identified at 10:00am on 9/12/2017. The physician (or physician-designee) prescribed/recommended action is completed on or before 11:59pm on 9/13/2017.
  - A clinically significant medication issue is identified at 11:00pm on 9/12/2017. The physician (or physician-designee) prescribed/recommended action is completed on or before 11:59pm on 9/13/2017.
- 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 IRF, the discharging licensed clinician reviewed Ms. T's medical records, which included admission through her entire stay at the IRF, and noted that a clinically significant medication issue was documented during the admission assessment. 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. 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.

   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 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 item includes all potential or actual clinically significant medication issues identified at admission or at any time throughout the patient's stay. When reviewing Ms. T's medical record at discharge, the nurse found that a clinically significant medication issue was identified during the admission drug regimen review, but the facility did not communicate with the physician **and** complete prescribed actions by midnight of the next calendar day. Although no other potential or actual clinically significant medication issues were identified during the remainder of the resident's stay, the facility did not communicate with the physician and complete prescribed/recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified during the patient's stay.

2. A discharge medication list was completed for Mr. C one day prior to discharge from the IRF; however, on the day of discharge, the dose of one of his medications was adjusted by the IRF physician. The licensed clinician reviewing the patient's medical records noted this discrepancy between the discharge medication list and the most recent MAR. The clinician used clinical judgement to determine that the issue was a potential clinically significant medication issue and contacted the IRF physician. The discharge medication list was immediately updated to reflect the current medication dose. Note that for items N2001 and N2003, no clinically significant medication issues were identified at admission.

   Coding: N2005, Medication Intervention, would be coded as 1, Yes.
   (Note: N2001, Drug Regimen Review, would have been coded 0. No - No Issues found during review. N2003, Medication Follow-up, would have been skipped.)

   Rationale: All clinically significant medication issues identified at admission or at any time throughout the patient stay (admission through discharge) were resolved by midnight of the next calendar day. In this scenario, an issue was identified at discharge only and the licensed clinician used clinical judgement to determine that the issue was a potential clinically significant mediation issue. The IRF clinicians' two-way communications resulted in the identified medication issue being addressed immediately.

3. 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 for a scheduled procedure. However, this medication had not been restarted 48 hours post-procedure and the IRF RN determined that the physician needed urgent notification. The day after the notification occurred, the IRF 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 (admission through discharge) were communicated and addressed by midnight of the next calendar day, and there were no additional clinically significant medication issues identified during the remainder of the IRF stay.

   Coding: N2005, Medication Intervention, would be coded as 1, Yes. The facility did contact 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).

(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 error was identified as a clinically significant medication issue at admission, it was resolved by midnight of the next day. Further, the drug regimen review conducted at discharge included the entire patient stay (admission through discharge). During the patient's stay a second clinically significant medication issue was identified. The identified clinically significant medication issues identified at admission and during the stay were communicated to the physician and resolved through completion of prescribed/recommended actions by midnight of the next calendar day.

SECTION N: MEDICATIONS

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