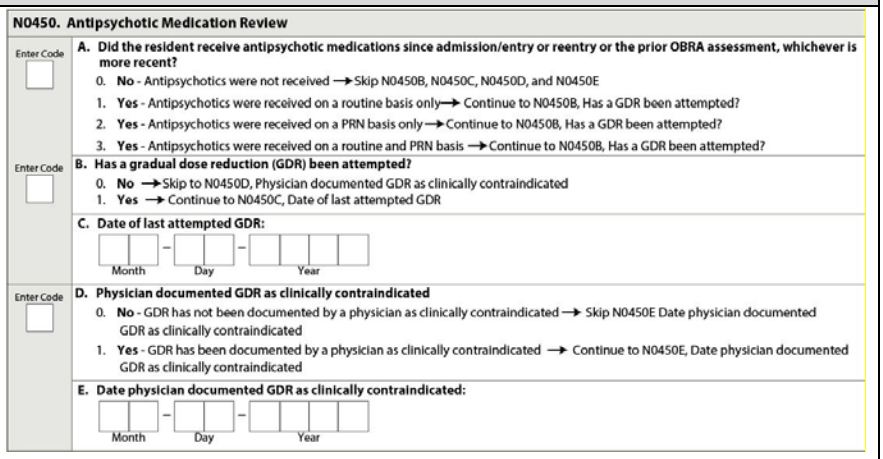
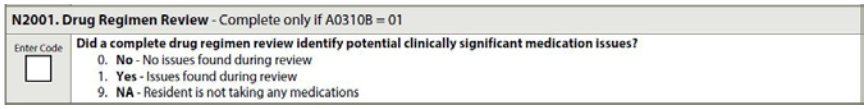
Track Changes
from Chapter 3 Section N v1.15
to Chapter 3 Section N v1.16

Chapter	Section	Page	Change
3	N0450	N-11	 Updated graphic
3	N0450A	N-12	Code 0, no: if antipsychotics were not received: Skip N0450B, N0450C, N0450D and N0450E. ~~to O0100, Special Treatments, Procedures, and Programs.~~
3	N0450D	N-14	Code 0, no: if a GDR has not been documented by a physician as clinically contraindicated. Skip N0450E Date physician documented GDR as clinically contraindicated. ~~to O0100, Special Treatments, Procedures, and Programs.~~
3	N2001–N2005	N-15–N-24	Page length changed due to revised content.
3	N2001	N-15–N-18	## N2001: Drug Regimen Review Intent: The intent of the drug regimen review items is to document whether a drug regimen review was conducted upon the resident's admission (start of Skilled Nursing Facility [SNF] Prospective Payment System [PPS] stay) and throughout the resident's stay (through Part A PPS discharge) and whether any clinically significant medication issues identified were addressed in a timely manner. 

Item Rationale

Health-related Quality of Life

- Potential and actual resident medication adverse consequences and errors are prevalent in health care settings and often occur during transitions in care.
- Adverse consequences related to medications may result in serious harm or death, emergency department visits, and rehospitalizations and affect the resident's health, safety, and quality of life.
- Drug regimen review is intended to improve resident safety by identifying and addressing potential and actual clinically significant medication issues at the time of a resident's admission (start of SNF PPS stay) and throughout the resident's stay (through Part A PPS discharge).

DEFINITIONS

DRUG REGIMEN REVIEW

A drug regimen review includes medication reconciliation, a review of all medications a resident is currently using, and a review of the drug regimen to identify, and if possible, prevent potential clinically significant medication adverse consequences.

The drug regimen review includes all medications, prescribed and over the counter (OTC), nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. It also includes total parenteral nutrition (TPN) and oxygen.

Planning for Care

- Drug regimen review is an important component of the overall management and monitoring of a resident's medication regimen.
- Prevention and timely identification of potential and actual medication-related adverse consequences reduces the resident's risk for harm and improves quality of life.
- Educate staff in proper medication administration techniques and adverse effects of medications, as well as to be observant for these adverse effects.

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			• Implement a system to ensure that each resident's medication usage is evaluated upon admission and on an ongoing basis and that risks and problems are identified and acted upon. **Steps for Assessment** Complete if A0310B = 01. 1. Complete a drug regimen review upon admission (start of SNF PPS stay) or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues. 2. Review medical record documentation to determine whether a drug regimen review was conducted upon admission (start of SNF PPS stay), or as 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 resident received health care, the resident'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 resident, and the resident's family/significant other) may supplement and/or clarify the information gleaned from the resident's medical records. 3. 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. • 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 coprescribed). • Wrong resident, drug, dose, route, and time errors.

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			• Medication dose, frequency, route, or duration not consistent with resident's condition, manufacturer's instructions, or applicable standards of practice. • Use of a medication without evidence of adequate indication for use. • Presence of a medical condition that may warrant medication therapy (e.g., a resident with primary hypertension does not have an antihypertensive medication prescribed). • Omissions (medications missing from a prescribed regimen). • Nonadherence (purposeful or accidental). 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 (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest. "Clinically significant" means effects, results, or consequences that materially affect or are likely to affect an individual's mental, physical, or psychosocial well-being, either positively, by preventing a condition or reducing a risk, or negatively, by exacerbating, causing, or contributing to a symptom, illness, or decline in status. 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

Code 0, No: if no clinically significant medication issues were identified during the drug regimen review.

Code 1, Yes: if one or more clinically significant medication issues were identified during the drug regimen review.

Code 9, NA: if the resident was not taking any medications at the time of the drug regimen review.

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 over the counter (OTC), including nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. The drug regimen review also includes total parenteral nutrition (TPN) and oxygen.

Examples

1. The admitting nurse reviewed and compared the acute care hospital discharge medication orders and the physician's admission medication orders for Ms. D. The nurse interviewed Ms. D, who confirmed the medications she was taking for her 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 Ms. D. As a result of this collected and communicated information, the nurse determined that there were no potential or actual clinically significant medication issues.

   Coding: N2001 would be coded 0, No—No issues found during review.

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

2. Mr. H was admitted to the nursing facility after undergoing cardiac surgery for mitral valve replacement. The acute care hospital discharge information indicated that Mr. H had a

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			mechanical mitral heart valve and was to continue receiving anticoagulant medication. While completing a review and comparison of Mr. H's discharge records from the hospital with the physician's admission medication orders and admission note, the nurse noted that the admitting physician had ordered Mr. H'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. H was 2.5–3.5. The nurse questioned the INR level listed on the admitting physician's order, based on the 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 would be coded 1, Yes—Issues found during review. Rationale: The admitting nurse reviewed and compared Mr. H's discharge health care records from the acute care hospital with the nursing facility physician's admission medication orders and admission note. The nurse identified a discrepancy between the physician's documented therapeutic INR level (2.5–3.5) for Mr. H 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 that could lead to potential clotting issues for Mr. H.
3	N2003	N-18–N-21	N2003: Medication Follow-up **N2003. Medication Follow-up** - Complete only if N2001 =1 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** DEFINITION MEDICATION FOLLOW-UP The process of contacting a physician to communicate an identified medication issue and completing all physician-prescribed/recommended actions

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			by midnight of the next calendar day at the latest. **Health-related Quality of Life** • Integral to the process of safe medication administration practice is timely communication with a physician when a potential or actual clinically significant medication issue has been identified. • Physician-prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm. **Planning for Care** • When a potential or actual clinically significant medication issue is identified, prompt communication with the physician and implementation of prescribed actions is necessary to protect the health and safety of the resident. **Steps for Assessment** This item is completed if one or more potential or actual clinically significant medication issues were identified during the admission drug regimen review (N2001 = 1). 1. Review the resident's medical record to determine whether the following criteria were met for any potential or actual clinically significant medication issues that were identified upon admission: • Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND • All physician-prescribed/-recommended actions were completed by midnight of the next calendar day. Medical record sources include medical records received from facilities where the resident received health care, the resident'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 resident, and the resident's family/significant other) may supplement and/or clarify the information gleaned from the resident'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*.

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.

Coding Tips

- If the physician prescribes/recommends an action that 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 the appropriate steps to comply with the prescribed/recommended action.
  - Example of a *physician-recommended action that would take longer than midnight of the next calendar day to complete*:
    - The physician writes an order instructing the clinician to monitor the medication issue over the next three 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 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.
    - A clinically significant medication issue is identified at 11:00 PM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.

DEFINITION

CONTACT WITH PHYSICIAN

- Communication with the physician to convey an identified potential or actual clinically significant medication issue, *and* a response from the physician to convey prescribed/recommended actions in response to the medication issue.
- Communication can be in person, by telephone, voice mail, electronic means, facsimile, or any other means that appropriately conveys the resident's status.

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			• A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence. **Examples** 1. Mr. P was admitted to the nursing facility with active diagnoses of pneumonia and atrial fibrillation. The acute care facility medication record indicated that Mr. P was on a seven-day course of antibiotics and had three remaining days of this treatment plan. The nurse reviewing the discharge records from the acute care facility and the nursing facility admission medication orders noted that Mr. P had an order for an anticoagulant medication that required INR monitoring, as well as the antibiotic. On the date of admission, the nurse contacted the physician responsible for Mr. P and communicated a concern about a potential increase in Mr. P's INR with this combination of medications that could place him at greater risk for bleeding. The physician provided orders for laboratory testing so that Mr. P's INR levels would be monitored over the next three 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 would be coded 0, No. 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. Ms. S was admitted to the facility from an acute care hospital. During the admitting nurse's review of Ms. S's hospital discharge records, it was noted that Ms. S had been prescribed metformin. However, laboratory tests at admission indicated that Ms. S had a serum creatinine of 2.4, consistent with renal insufficiency. The admitting nurse contacted the physician to ask whether this medication would be contraindicated with Ms. S's current serum creatinine level. Three hours after Ms. S's admission to the facility, the physician provided orders to discontinue the metformin and start Ms. S on a short-acting sulfonylurea for ongoing diabetes management. These medication changes were implemented within the hour. Coding: N2003 would be coded 1, Yes.

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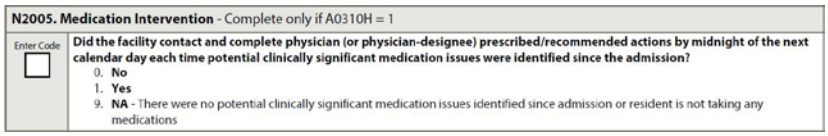
			Rationale: A potential clinically significant medication issue was identified during the drug regimen review; the physician communication occurred, and the nurse completed the physician-prescribed actions, by midnight of the next calendar day.
3	N2005	N-21–N-23	

N2005: Medication Intervention

Item Rationale

Health-related Quality of Life

- Integral to the process of safe medication administration practice is timely communication with a physician when a potential or actual clinically significant medication issue has been identified.
- Physician-prescribed/-recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.
- Potential or actual clinically significant medication issues can occur throughout the resident's stay.

Planning for Care

- Every time a potential or actual clinically significant medication issue is identified throughout the resident's stay, it must be communicated to a physician, and the physician-prescribed/-recommended actions must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.

Steps for Assessment

The observation period for this item is from the date of admission (start of SNF PPS stay) through discharge (Part A PPS discharge).

1. Review the resident's medical record to determine whether the following criteria were met for any potential and actual clinically significant medication issues that were identified upon admission or at any time during the resident's stay:

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			• Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND • All physician-prescribed/-recommended actions were completed by midnight of the next calendar day. Medical record sources include medical records received from facilities where the resident received health care, the resident'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 resident, and the resident's family/significant other) may supplement and/or clarify the information gleaned from the resident's medical records. **Coding Instructions** • Code 0, No: if the facility did not contact 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 since admission (start of SNF PPS stay). • Code 1, Yes: if the facility contacted the physician *and* completed prescribed/ recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since admission (start of SNF PPS stay). • Code 9, NA: if there were no potential or actual clinically significant medication issues identified at admission or throughout the resident's stay or the resident was not taking any medications at admission or at any time throughout the stay. **Coding Tips** • If the physician prescribes an action that 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 clinician has taken the appropriate steps to comply with the recommended action. o Example of a *physician-recommended action that would take longer than midnight of the next calendar day to complete*:

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- The physician writes an order instructing the clinician to monitor the medication issue over the next three days and call if the problem persists.

o Examples of *by midnight of the next calendar day*:

- A clinically significant medication issue is identified at 10:00 AM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM on 9/13/2017.
- A clinically significant medication issue is identified at 11:00 PM on 9/12/2017. The physician-prescribed/-recommended action is completed on or before 11:59 PM 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 the end of the resident's Part A PPS stay, the discharging nurse reviewed Ms. T's medical records, from the time of admission (start of SNF PPS stay) through her entire Part A PPS stay (Part A PPS discharge) and noted that a clinically significant medication issue was documented during the admission assessment. Ms. T's medical records indicated that a nurse had attempted to contact the assigned physician several times about the clinically significant medication issue. After midnight of the second calendar day, the physician communicated to the nurse, via telephone, orders for changes to Ms. T's medications to address the clinically significant medication issue. The nurse implemented the physician's orders. 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 would be coded 0, No—the facility did not contact 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 since the resident's admission (start of SNF PPS stay).

   Rationale: Coding of this item includes all potential or actual clinically significant medication issues identified at any time during the resident's stay. When reviewing Ms. T's medical record at discharge, the nurse found that a clinically significant medication issue was identified

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			during the admission (start of SNF PPS stay) 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 resident's SNF PPS stay. 2. At discharge, the nurse completing a review of Ms. K's medical records found that two clinically significant medication issues had been identified during the resident's stay. During the admission drug regimen review, the admitting nurse had identified a clinically significant medication issue, contacted the physician, and implemented new orders provided by the physician on the same day. Another potentially significant medication issue was identified on day 12 of Ms. K's stay; the nurse communicated with the physician and carried out the orders within one hour of identifying the potential issue. Both medication issues identified during Ms. K's stay were communicated to the physician and resolved by midnight of the next calendar day after identification. There were no other clinically significant medication issues identified during Ms. K's stay. Coding: N2005 would be coded as 1, Yes—*all* potential or actual clinically significant medication issues identified at any time during the resident'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. Rationale: While a medication error was identified as a clinically significant medication issue at admission, it was resolved by midnight of the next day. During Ms. K's stay, an additional clinically significant medication issue was identified; it too was resolved by midnight of the following 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.