Affinity Health Services
Senior Community Management and Consulting Services

Schizophrenia MDS Coding- CMS I6000 Audit

Affinity Health Services
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Office of Inspector General(OIG) Schizophrenia Findings

From 2015 – 2019, the number of long-stay residents who were coded in MDS item I6000 (Schizophrenia (e.g., Schizoaffective and Schizophreniform Disorders)) jumped by 35 percent, according to the November 2022 report *Long-Term Trends of Psychotropic Drug Use in Nursing Homes* from the Office of Inspector General (OIG).

This report assessed long-stay residents aged 65 and older who were Medicare beneficiaries from 2011 – 2019.

"Additionally, the number of residents reported in the MDS as having schizophrenia but lacking a corresponding schizophrenia diagnosis in Medicare claims and encounter data increased by 194 percent," says the OIG.

In other words, there was a significant increase in residents with no indication that mental health providers or other clinicians provided these residents with care or services related to managing the schizophrenia diagnosis coded on the MDS.

I6000 Schizophrenia

The increase in schizophrenia diagnoses “coincides” with the 2015 addition of the Percent of Long-Stay Residents Who Received an Antipsychotic Medication into the Five-Star Quality Rating System’s quality measure (QM) domain, notes the OIG.

Schizophrenia, Tourette’s syndrome (I5350), and Huntington’s disease (I5250) are the only diagnoses that allow residents who meet the numerator criteria to be excluded from this measure.

In 2019, more than three-quarters of the residents with MDS-reported schizophrenia but no related encounter data had a claim for an antipsychotic drug but qualified for exclusion from the long-stay antipsychotic drug use QM.

I6000 Schizophrenia

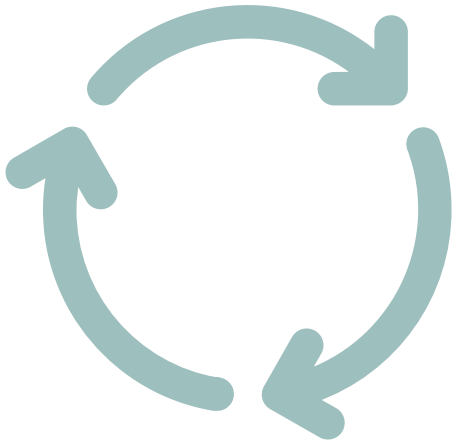
The bottom line

More long-stay residents are coded as having a schizophrenia diagnoses in MDS item I6000.

Greater than 75 percent of the residents who meet these first two criteria receive an antipsychotic medication but are excluded from public reporting in the long-stay antipsychotic medication use QM.

More long-stay residents who have a schizophrenia diagnosis coded on the MDS don't receive support or management services for schizophrenia from other clinicians who bill Medicare.

CMS Updates Related to Schizophrenia

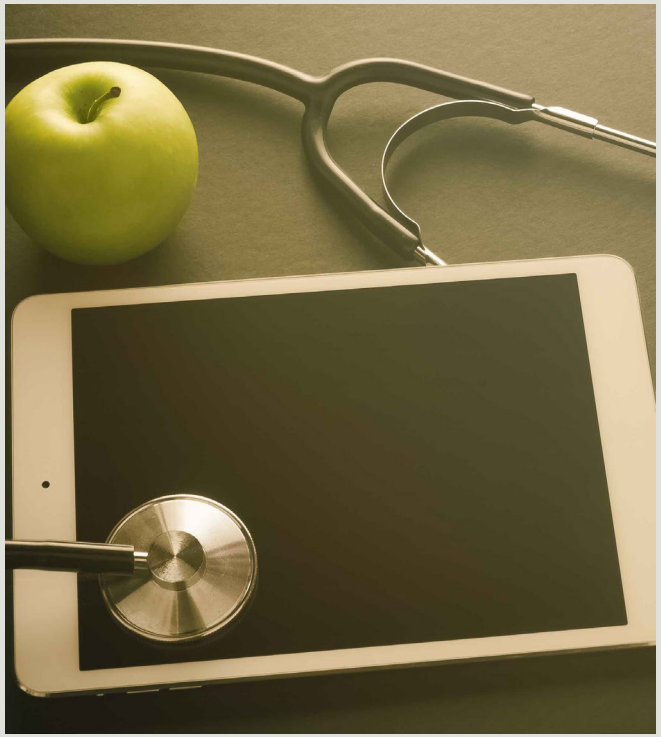


Based on the OIG report and the reported findings multiple changes have occurred over the last several months that have a direct impact to long-term care.

- CMS updated the Resident Assessment Instrument(RAI) Manual was updated for MDS section I6000 with additional guidance to the RNAC's.
- CMS updated the State Operational Manual Appendix PP
- CMS Updated the Critical Elements Pathways
- CMS released QSO -23-05-NH Updates to the Nursing Home Care Compare Website and Five Star Quality Rating System: Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding

MDS Section I Active Diagnosis

Active Diagnosis



ACTIVE DIAGNOSES

Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

CMS Actions

Two key sets of guidance:

- The *Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual*, and
- Appendix PP, "Guidance to Surveyors for Long-Term Care Facilities," of the *State Operations Manual*.

Steps that nurse assessment coordinators (NACs) can take to navigate the new requirements for schizophrenia diagnoses include the following:

- **Check the medical record for supporting diagnostic information before coding I6000**
  - In situations where practitioners have potentially misdiagnosed residents with a condition for which there is a lack of appropriate diagnostic information in the medical record, such as for a mental disorder, the corresponding diagnosis in Section I should not be coded, and a referral by the facility and/or the survey team to the State Medical Boards or Boards of Nursing may be necessary.

MDS 3.0 RAI User's Manual (v1.17.1R) Errata (v2) Effective July 15, 2022

I: Active Diagnoses in the Last 7 Days Chapter 3 Section I-12

In situations where practitioners have potentially misdiagnosed residents with a condition for which there is a lack of appropriate diagnostic information in the medical record, such as for a mental disorder, the corresponding diagnosis in Section I should not be coded, and a referral by the facility and/or the survey team to the State Medical Boards or Boards of Nursing may be necessary.

I: Active Diagnoses in the Last 7 Days (cont.)

4. *The resident was admitted without a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident's medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards.*

Coding: *Schizophrenia item (I6000), would* ***not be checked.***

Rationale: *Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, in accordance with professional standards (§483.21(b)(3)(i)), of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for the time period required.*

MDS 3.0 RAI User's Manual (v1.17.1R) Errata (v2) Effective July 15, 2022

MDS

Need to modify prior MDS assessments

The July 2022 errata doesn't require RNACs to go back and audit I6000 coding on previously submitted MDS assessments, confirmed CMS officials at the Aug. 4, 2022, Skilled Nursing Facility/Long-Term Care Open Door Forum (SNF/LTC ODF).

However, if a RNAC identifies an I6000 coding error in the course of completing an MDS—or if the interdisciplinary team identifies an improper schizophrenia diagnosis during, for example, a QAPI review—the RNAC will need to submit a modification to correct any prior MDS assessments with inaccurate I6000 coding.

QSO-23-05-nh Nursing Home Compare Update:1/18/2023

Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding

In 2008, CMS added the Five-Star Quality Rating System to the CMS Nursing Home Compare website.

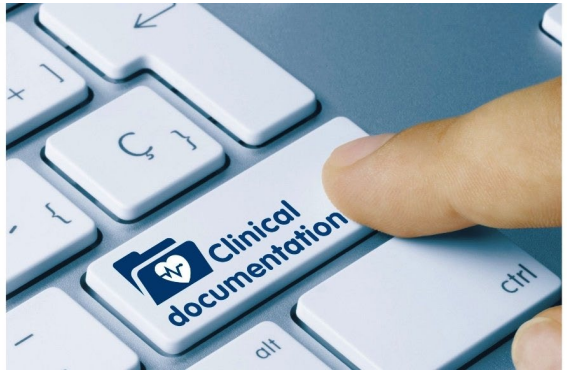
The rating system comprises three rating domains: health inspections, staffing, and quality measures (QMs).

One of the QMs reported on Nursing Home Care Compare and included in the star rating calculation is the percentage of long-stay residents who are receiving antipsychotic drugs.

This measure excludes residents with diagnoses of schizophrenia, Huntington's disease, or Tourette syndrome.

https://www.cms.gov/files/document/qso-23-05-nh.pdf

CMS – Background



"CMS is concerned that some nursing homes have erroneously coded residents as having schizophrenia, which can mask the facilities' true rate of antipsychotic medication use. Therefore, CMS will conduct offsite audits of schizophrenia coding and, based upon the results, adjust the quality measure star ratings for facilities whose audit reveals inaccurate coding."

CMS – Background

In 2016, CMS launched focused schizophrenia onsite surveys to specifically address the issue of erroneous coding of schizophrenia in nursing homes.

These surveys identified facilities with patterns of erroneous coding of residents with a diagnosis of schizophrenia.

To increase focus on this issue, CMS will begin conducting offsite audits to assess the accuracy of Minimum Data Set (MDS) data.

Specifically, CMS will examine the facility's evidence for appropriate documenting, assessing, and coding a diagnosis of schizophrenia on the MDS for residents in a facility.

CMS – Background

Earlier this year, CMS conducted pilot audits to test the effectiveness of the MDS audit process.

During these pilot audits, CMS found several issues related to the inaccurate MDS coding of residents with a diagnosis of schizophrenia.

Examples

- There was an absence of comprehensive psychiatric evaluations and behavior documentation.
- Many residents had only sporadic behaviors noted in their medical records, and these behaviors were related to dementia, rather than schizophrenia.

CMS – Moving Forward

- CMS will conduct these audits and, based upon the results, adjust the quality measure star ratings for facilities whose audits reveal inaccurate MDS coding.
- This action supports CMS's goal to reduce the use of unnecessary antipsychotics and improve the accuracy of the quality measure and the five-star rating system.

Audit Details

Facilities selected for an audit will receive a letter explaining the purpose of the audit, the process that will be utilized, and instructions for providing supporting documentation.

During the audit process, facilities will have the opportunity to ask questions and seek any clarification needed.

Additionally, at the conclusion of the audit, the facility will have the opportunity to discuss the audit results with CMS

Audit Impact

Facilities that have coding inaccuracies identified through the schizophrenia MDS audit will have their QM ratings adjusted as follows:

- The Overall QM and long stay QM ratings will be downgraded to one star for six months (this drops the facility's overall star rating by one star).
- The short stay QM rating will be suppressed for six months.
- The long stay antipsychotic QM will be suppressed for 12 months.

Opportunity to Forego the Audit

CMS plans to offer facilities the opportunity to forego the audit by admitting they have errors and committing to correct the issue.

This will reduce the burden of conducting audits for CMS and nursing homes, and allow CMS to audit more facilities.

To incentivize this admission and to promote improvement, for facilities that admit miscoding after being notified by CMS that the facility will be audited, but prior to the start of the audit, CMS will consider a lesser action related to their star ratings than those listed above, such as suppression of the QM ratings (rather than downgrade).

CMS Monitoring

FOR ALL FACILITIES WHERE PATTERNS OF CODING INACCURACIES WERE IDENTIFIED, EITHER THROUGH AN AUDIT OR THROUGH A FACILITY'S ADMISSION. CMS WILL MONTOR EACH AUDITED FACILITY'S DATA TO IDENTIFY IF THE INFORMATION INDICATES THEY HAVE ADDRESSED THE IDENTIFIED ISSUES, AND IF ANY DOWNGRADES OR SUPPRESSIONS THAT ARE APPLIED SHOULD BE LIFTED.

ALSO, A FOLLOW-UP AUDIT MAY BE CONDUCTED TO CONFIRM THE ISSUE IS CORRECTED.

CMS Letter

Addressed to the administrator

Subject: Schizophrenia Minimum Data Set (MDS) Audit

Audit Contractor :Myers and Stauffer LC

Description: CMS and their contractor are conducing an audit to assess the accuracy of MDS Data. Specifically, this audit will examine the process for appropriately assessing and coding a diagnosis of schizophrenia in the MDS for residents of your long-term care facility.

Instructions

Web Portal access (forms must be completed and submitted within two business days of the delivery date of the certified letter. (date on the certified mail tracking)

Checklist for all requested documents

Detailed instructions for document submission via a secure web portal

After the document submission you are instructed to contact the CMS auditor to schedule your entrance conference

Auditors will need access to the electronic health record.

Attachment A- Facility Survey

Name, Position start date, Phone number, Email For the below Listed positions:

- Administrator
- MDS contact
- Director of Nursing
- Medical director
- Facility Liaison

Attachment A- Facility Survey

Electronic Health Record (HER) system details

- Are all medical record available electronically or will a portion need to be uploaded into the secure web portal?

Facility Bed Size and current Census

Does your facility utilize an in-house psychiatric provider?

- Has there been a recent change in providers?

☐ Completed copy of the Facility Survey (Attachment A)

☐ Completed and signed copy of the Attestation Form (Attachment C)

Note: Attachment C is an attestation of the accuracy of the information submitted. It must be completed by the facility's administrator or their designee who has the authority to officially represent the facility. If no attestation of inaccuracy is provided, the audit will proceed. If Minimum Data Set (MDS) coding inaccuracies are identified during the audit or your facility fails to submit the required documentation, there will be a downgrade of your facility's Five Star Quality Measure Ratings. In the case of attestation of inaccuracy prior to the start of the audit that includes immediate resolution of the self-identified issues, CMS will consider lesser action related to your star ratings.

☐ Completed copy of the Web Portal Registration (Attachment F)

☐ Scheduled entrance conference with Christy Caines (CMSQMAudits@mslc.com)

☐ **Electronic Health Record** - Auditor access of the system will be granted by the facility within **two business days** after the completion of the entrance conference. Supporting documentation that the auditor will need access to includes, but is not limited to:

a. MDS assessments at the time of admission, the first assessment that was completed with the resident being coded for a schizophrenia diagnosis, and the most recently completed MDS assessment
b. Behavioral health records, including practitioner(s) assessments pertaining to the diagnosis of schizophrenia
c. Medication administration records, progress notes (i.e., gradual dose reduction attempts, etc.), and medication orders pertaining to antipsychotic medication use, if prescribed
d. Other associated information related to the resident's schizophrenia diagnosis and antipsychotic medication use, if prescribed

Attachment B- Requested Supporting Documentation Checklist

Attachment C- Attestation Form

ATTESTATION FORM

Schizophrenia Minimum Data Set (MDS) Accuracy

☐ I attest that, all facility-supporting documentation (i.e., MDS assessments and other medical records-related information) is accurate to the best of my knowledge and belief.

OR

☐ I have personal knowledge that some facility-supporting documentation, referenced in Attachment B, is **not** accurate.

a. Please describe the inaccurate information and the circumstances that make the information inaccurate; and
b. State the specific actions the facility will take to correct the inaccurate information or make the information complete.
Please respond in the space below. If you require more space, attach another sheet(s) of paper.

If no attestation of inaccuracy is provided, the audit will proceed. If during the audit inaccuracies are identified, there will be a downgrade of your facility's Five Star Quality Measure (QM) Ratings. In the case of attestation of inaccuracy prior to the start of the audit that includes immediate resolution of the self-identified issues, CMS will consider lesser action related to your star ratings.

Attachment D- Web Portal User Account Request

Due: 2nd business day after delivery date o the certified letter

Guidance on completing the web portal registration form (Attachment F- Myers and Stauffer secure portal)

Guidance on where the completed form sent (email address)

Entrance Conference call

Entrance conference form

Request for read only access to the EHR

Facility uploads due relatively quickly

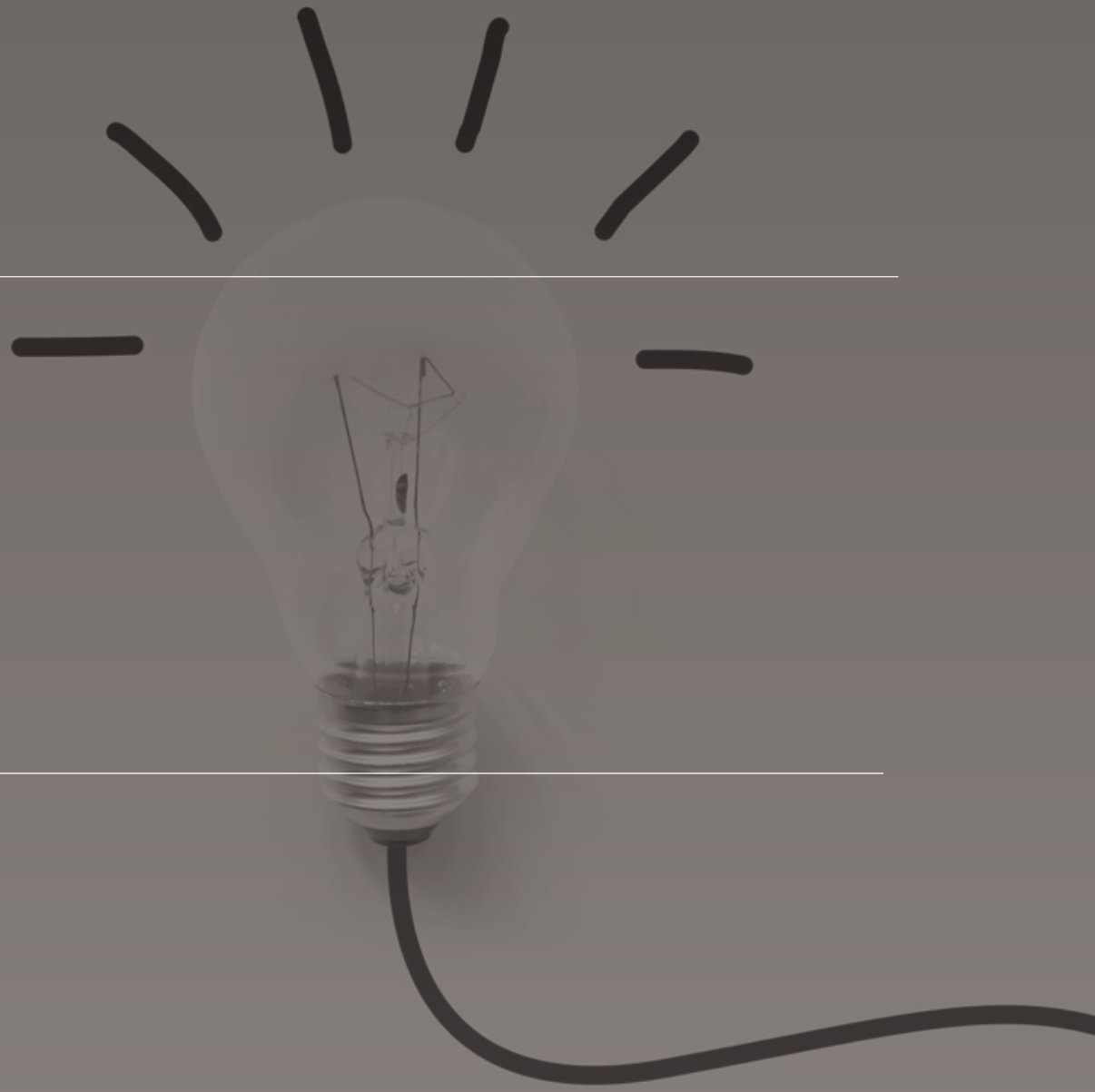
Document request form

- Focus on residents' who did not have schizophrenia diagnosis upon admission, that received the diagnosis after admission to the facility.
- Medical evaluation at the time of the diagnosis
- 3 MDS's
  - Admission MDS, Most recent MDS and MDS with the first schizophrenia diagnosis listed.

Supporting Documentation

- Physician progress notes upon admission, most recent MD and Psy, and progress notes prior to the date of the MDS with the schizophrenia diagnosis
- Medication list 7-day lookback
- Progress notes
- MAR/ TAR/ Orders
- Behavioral documentation, notes, tracking
- Use of Antipsychotic medication and diagnosis

Findings



Diagnosis: 16000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)

- The diagnosis of schizophrenia was not noted anywhere in the medical record(s); however, it was listed on the electronic health record diagnosis list and subsequently inaccurately coded on the MDS.
- The diagnosis was present upon admission per the facility-submitted documentation; however, the diagnosis was not coded on the admission MDS assessment(s).
- The Resident Assessment Instrument Manual was not followed regarding the requirement for the diagnos1s to be coded on the MDS, including a progress note signed by the physician in the last 60 days, and documentation of an active problem in the last seven days of the assessment reference date.

Diagnostic Process:

- The reviewed medical record(s) lacked sufficient documentation of behaviors indicative of a schizophrenia diagnosis, in the six months prior to the diagnosis.
- The reviewed medical record(s) did not contain documentation of a comprehensive medical and psychiatric evaluation, completed by a physician that meets professional standards of practice, at the time of the initial diagnosis of schizophrenia.

Antipsychotic Medication Use - Clinical Indications, Monitoring, and Gradual Dose Reductions (GDR):

- Clinical indications for the use of antipsychotic medications were lacking in the medical record(s) of the sampled resident(s).
- Documentation of monitoring for adverse drug reactions was lacking in the reviewed medical record(s).
- The reviewed medical record(s) lacked documentation to indicate that GDRs were recommended and attempted, as appropriate.
- The sampled resident(s) were receiving antipsychotic medications; however, these medications were not appropriately coded on the MDS.
- Documentation of monitoring for target behaviors was lacking in the reviewed medical record(s).

Action

CMS expects that all issues identified during this audit be corrected immediately. This pertains to all sampled residents, other residents within the facility currently impacted by the identified issues, and residents that may be impacted in the future.

As a result of this audit, your facility's Five Star Quality Measure (QM) Ratings will be adjusted as follows:

- Your Overall QM and Long-stay (LS) QM ratings will be downgraded to one star for six months. (Note: This will reduce your overall star rating by one star.)
- Your Short-stay QM rating will be suppressed for six months.
- Your LS Antipsychotic QM will be suppressed for 12 months.

Your facility's data will be monitored to identify if the information indicates that you have addressed the identified issues and determine if any downgrades and suppressions that are applied will be lifted. Also, a follow-up audit may be conducted at the discretion of CMS.

CMS State Operations Manual, Appendix PP (REV.208, 10-21-2022)

- The Centers for Medicare & Medicaid Services has several F-tags related to schizophrenia, behavioral health, assessment process, standards of practice and psychotropic drugs
  - F658 Comprehensive Care Plans- Services Provided Meet Professional Standards
  - F740 Behavioral Health Services
  - F758 Free from Unnecessary Psychotropic Medications

F 658 Comprehensive Care Plans

483.21(b)(3) Comprehensive Care Plans, requires that services that are provided or arranged for by the facility must- (i) meet professional standards of quality.

Note: **“CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia)which would then exclude the resident from the long-stay antipsychotic quality measure.”**

Guidance:

For these situations, determine if non-compliance exists related to the practitioner not adhering to professional standards of quality for assessing and diagnosing a resident.

This practice may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing

F740 Behavioral Health Services

483.40

Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders

F 740 Behavioral Health Services cont.

Schizophrenia

Schizophrenia is a serious mental disorder that may interfere with a person's ability to think clearly, manage emotions, make decisions and relate to others.

It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40.

Schizophrenia must be diagnosed by a qualified practitioner, using evidence-based criteria and professional standards, such as the Diagnostic and Statistical Manual of Mental Disorders - Fifth edition (DSM-5), and documented in the resident's medical record.

Symptoms of Schizophrenia include delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), grossly disorganized or catatonic behavior, and diminished expression or initiative.

- Delusions refer to false beliefs that don't change even when the person who holds them is presented with new ideas or facts.
- Hallucinations include a person hearing voices, seeing things, or smelling things others can't perceive.

F 758 Free from Unnecessary Psychotropic Medications

483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

- (i) Anti-psychotic;
- (ii) Anti-depressant;
- (iii) Anti-anxiety; and
- (iv) Hypnotic

F 758 Free from Unnecessary Psychotropic Medications

- §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--
  - §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record
  - §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs
  - §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record

INTENT: (*F757)* §483.45(d) Unnecessary drugs and *(F758) §*483.45(c)(3) and (e)Psychotropic Drugs

The intent of *these* requirements is that:

Each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being;

The facility implements gradual dose reductions (GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and

PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited

For concerns related to psychotropic medications only, including the unnecessary medication requirements, surveyors should assess compliance with §§483.45(c) and (e), F758.

The regulations associated with medication management include consideration of:

Indication and clinical need for medication;

Dose (including duplicate therapy);

Duration;

Adequate monitoring for efficacy and adverse consequences; and

Preventing, identifying, and responding to adverse consequences.

With regard to psychotropic medications, the regulations additionally require:

Giving psychotropic medications only when necessary to treat a specific diagnosed and documented condition;

Implementing GDR and other non-pharmacologic interventions for residents who receive psychotropic medications, unless contraindicated; and

Limiting the timeframe for PRN psychotropic medications, which **are not** antipsychotic medications, to 14 days, unless a longer timeframe is deemed appropriate by the attending physician or the prescribing practitioner.

Limiting PRN psychotropic medications, which **are** antipsychotic medications, to 14 days and not entering a new order without first evaluating the resident.

Medication Management

F758 Psychotropic Drugs

Indication for Use

The resident's medical record must show documentation of adequate indications for a medication's use and the diagnosed condition for which a medication is prescribed.

An evaluation of the resident by the IDT helps to identify his/her needs, goals, comorbid conditions, and prognosis to determine factors (including medications and new or worsening medical conditions) that are affecting signs, symptoms, and test results. This evaluation process is important when selecting initial medications and/or non-pharmacological approaches and when deciding whether to modify or discontinue a current medication.

Evaluation

An appropriately detailed evaluation of mental, physical, psychosocial, and functional status, including comorbid conditions and pertinent psychiatric symptoms and diagnoses and a description of resident complaints, symptoms, and signs (including the onset, scope, frequency, intensity, precipitating factors, and other important features);

Each resident's goals and preferences;

Allergies to medications and foods and potential for medication interactions;

A history of prior and current medications and non-pharmacological interventions (including therapeutic effectiveness and any adverse consequences);

Recognition of the need for end-of-life or palliative care; and

The basis for declining care, medication, and treatment and the identification of pertinent alternatives.

Documentation of indications of distress, delirium, or other changes in functional status.

Circumstances that warrant evaluation of the resident and medication(s) include:

- Admission or re-admission;
- A clinically significant change in condition/status;
- A new, persistent, or recurrent clinically significant symptom or problem;
- A worsening of an existing problem or condition;
- An unexplained decline in function or cognition;
- A new medication order or renewal of orders; and
- An irregularity identified in the pharmacist's medication regimen review. See F756 for guidance related to the medication regimen review.
- Orders for PRN psychotropic and/or antipsychotic medications which are not prescribed to treat a diagnosed specific condition or do not meet the PRN requirements for psychotropic and antipsychotic medications.

Monitoring of Psychotropic Medications

Diagnoses alone do not necessarily warrant the use of an antipsychotic medication. Antipsychotic medications may be indicated if:

- behavioral symptoms present a danger to the resident or others;
- expressions or indications of distress that are significant distress to the resident;
- if not clinically contraindicated, multiple non-pharmacological approaches have been attempted, but did not relieve the symptoms which are presenting a danger or significant distress;
- GDR was attempted, but clinical symptoms returned

If antipsychotic medications are prescribed, documentation must clearly show the indication for the antipsychotic medication, the multiple attempts to implement care-planned, non-pharmacological approaches, and ongoing evaluation of the effectiveness of these interventions.

Psychotropic Medications and Antipsychotic Medications (F758 Only Guidance)

The regulations and guidance concerning psychotropic medications are not intended to supplant the judgment of a physician or prescribing practitioner in consultation with facility staff, the resident and his/her representatives and in accordance with appropriate standards of practice.

Rather, the regulations and guidance are intended to ensure psychotropic medications are used only when the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s).

Concerns related to inappropriate prescribing of psychotropic medications may require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.

Psychotropic Medications

- Failure to present to the attending physician or prescribing practitioner the need to attempt GDR in the absence of identified and documented clinical contraindications; or
- Use of psychotropic medication(s) without documentation of the need for the medication(s) to treat a specific diagnosed condition; or
- PRN psychotropic medication ordered for longer than 14 days, without a documented rationale for continued use; or
- Failure to implement person-centered, non-pharmacological approaches in the attempt to reduce or discontinue a psychotropic medication *(§§483.40(a)(2) and 483.45(e)(2))*; or
- Administering a new PRN antipsychotic medication for which the resident had a previous PRN order (for 14 days) but the medical record does not show that the attending physician or prescribing practitioner evaluated the resident for the appropriateness of the new order for the medication.

Key Components of Noncompliance

- [ ] Does the resident have psychosocial, behavioral, mental, or physical adverse consequences that may be related to a medication? *Evaluate if the resident experienced psychosocial harm related to a side effect(s) of a medication(s):*
  - Anorexia/unplanned weight changes, edema;
  - Decline in physical functioning (e.g., mobility or activities of daily living (ADLs));
  - Rash, pruritus;
  - Bleeding or bruising, spontaneous or unexplained;
  - Respiratory changes;
  - Bowel dysfunction (e.g., cramping abdominal pain);
  - Urinary retention, incontinence;
  - Dehydration or swallowing difficulty;
  - Falls, dizziness, or headaches;
  - Muscle/nonspecific pain or unexplained abnormal movement;
  - Psychomotor agitation (restlessness, pacing, hand wringing);
  - Psychomotor retardation (slowed speech, thinking, movement);
  - Subdued, sedated, lethargic, or withdrawn;
  - Insomnia or sleep disturbances;
  - Mental status changes;
  - Behavioral changes or unusual behavior patterns; or
  - Depression, apathy or mood disturbance.

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review **Critical Element Pathway**

*11. Do the practitioner's diagnostic practices meet professional standards? **NOTE**: CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which would then exclude the resident from the long-stay antipsychotic quality measure.*
If No, cite F658

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Right to be Informed and Participate F552, F553, Notification of Change F580, Chemical Restraints F605, Choices (CA), *Activities (CA)*, Social Services F745, Admission Orders F635, Professional Standards F658, Pain (CA), General Pathway (CA) for Diabetic Management, Dementia Care (CA), ADLs (CA), Urinary Incontinence (CA), Behavioral-Emotional Status (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), Physician Services F710, F711, Pharmacy Services F755, *Medical Director F841, Antibiotic Stewardship Program (Infection Control Task)*, *QAPI/QAA* (Task).

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review **Critical Element Pathway**

Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway

Critical Elements Decisions:

1. For the **Medication Regimen Review (MRR)**:

   A. Did the licensed pharmacist:
   - Conduct an MRR, at least monthly, that included a review of the resident's medical record;
   - Conduct an MRR more frequently, as needed; and
   - Report irregularities to the attending physician, medical director, and the DON?

   B. Did the attending physician document:
   - Review of identified irregularity(ies);
   - The action, if any, taken;
   - A rationale if no action is taken?

   C. Has the facility developed and implemented MRR policies and procedures?
   - Do they address, at a minimum:
     - Time frames for steps in the MRR process;
     - Steps the pharmacist must take when an irregularity requires urgent action.

   If No to any of the above, cite F756

Documentation

Psychiatric Evaluations

Behavior documentation and tracking

All psychotropic drug orders must have documentation of diagnosed condition

Documentation of comprehensive assessment process

Gradual dose reduction recommendations and follow-up

Ongoing resident condition monitoring

- Target behaviors
- Non-pharmacological interventions attempted and response
- Identification of potential triggers and solutions

Schizophrenia Diagnosis DSM-5 Diagnosis Criteria

Schizophrenia is a serious mental illness that deeply affects people. Because a correct schizophrenia diagnosis can improve someone's quality of life, it's important that it be made as soon as possible after the symptoms of schizophrenia appear.

Currently, no tests can provide a schizophrenia diagnosis. To determine whether someone has the disorder, doctors follow established criteria for a schizophrenia diagnosis

Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* is the authority on mental illness. Created and published by the American Psychiatric Association, this comprehensive manual describes all known mental disorders, among them schizophrenia.

Mental health professionals use the *DSM-5* when determining what someone is experiencing. Doctors use the information and analyze:

- diagnostic features and symptoms
- level of impairment
- duration of symptoms
- other conditions that share symptoms

Age

While it’s not part of the diagnostic criteria, they do consider someone’s age.

The typical age of schizophrenia diagnosis is between late adolescence and the mid-30s.

This varies, though, with peak ages ranging from the early- to mid-20s for males and late-20s for females.

While it’s rare, schizophrenia can be diagnosed as early as childhood and as late as the 40s

Symptoms and Features

Professionals use specific diagnostic features in the *DSM-5* to help determine whether someone meets the criteria for schizophrenia. The *DSM-5* delineates five main criteria. Paraphrased:

A. Two or more of:

- Delusions
- Hallucinations
- Disorganized speech (such as speaking incoherently, losing track of thoughts)
- Disorganized or catatonic behavior
- Negative symptoms

B. Level of functioning has declined
C. The symptoms in Criterion A have persisted for at least 6 months
D. Schizoaffective disorder, major depression, and bipolar disorder have been ruled out
E. Substance use/abuse has been ruled out as a cause

Symptoms and Features

In order for someone to be diagnosed with schizophrenia, he must experience a group of these symptoms and features. One or two are not enough.

To receive a schizophrenia diagnosis, someone can have any of the symptoms and features, but he must have the following:

The symptoms must impair one's life and get in the way of her ability to work (or go to/participate in school), have positive relationships (or any relationships at all), and practice self-care. The problems in these areas must be new, a decline in the previous status

At least two symptoms from Criteria A

One of those two must be delusions, hallucinations, or disorganized speech.

These must have been present for at least one month. Symptoms must be present some of the time for six consecutive months

Compliance Steps

Policy and Procedure

- Diagnosis of Schizophrenia- evaluations and evidence-based Criteria
- Adequate documentation
- IDT team evaluations
- Direct care giver monitoring and documenting on behaviors
- MDS coding reflects proper diagnosis

Compliance Steps

Develop an audit process to identify all residents with the diagnosis of schizophrenia to determine if we have:

Psychiatric evaluation

Documentation

Behavior monitoring and tracking.

Psychotropic drug use

Individualized, person-centered care plan

Focused Audit

- Diagnosis is I6000
- Date of diagnosis
- Supporting documentation present for DX
- Comprehensive psych evaluation
- Persistent behaviors documented x6 months before medication started
- Behavior monitoring with target behaviors
- Antipsychotic medication coded correctly on MDS N0410A
- Care plan addressing diagnosis, with target behaviors and individualized interventions
- Care plan/ progress notes addressed medication dose reductions

References and Resources

- Centers for Medicare & Medicaid Services. Updates to the Nursing Home Care Compare Website and Five Star Quality Rating System: Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding, and Posting Citations Under Dispute, QSO-23-05-NH, January 18, 2023: https://www.cms.gov/files/document/qso-23-05-nh.pdf
- Centers for Medicare & Medicaid Services. State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 208, 10-21-22): https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf
- Centers for Medicare & Medicaid Services. Unnecessary Medications, Psychotropic Medications, and Medication Regimen Review Critical Element Pathway, CMS 20082 10/2022: https://www.cms.gov/files/zip/ce-pathways.zip
- Centers for Medicare & Medicaid Services. Adverse Drug Event Trigger Tool: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/Adverse-Drug-Event-Trigger-Tool.pdf
- The Minimum Data Set 3.0 Resident Assessment Instrument Manual (page 2 of the Errata (v2) effective July 15, 2022). https://www.cms.gov/files/document/mds30raimanualv1171rerratav2july152022.pdf

Thank you for your attention and the opportunity to conduct this presentation

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