Frequently Asked Questions:

[On-demand webinar] Drug Regimen Reviews: Yes, there are two DRRs!

On Tuesday, Dec. 4, 2018, SimpleLTC and Briggs Healthcare offered a free webinar, featuring nationally recognized MDS expert Mary Madison, which covered the two Drug Regimen Reviews skilled nursing are now responsible for completing. In this FAQ document, Mary Madison has covered all the specific questions asked by attendees during the webinar.

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1. **Do the new DRR requirements include changes to medication dosage due to effectiveness?**

   It will always come back to the definition of potential/actual clinically significant medication issues or irregularities, depending on which DRR you're asking about. If in doubt, please conduct the review and consult/notify the physician for recommendations. Don't forget to document everything involving that consultation.

2. **How is it possible to do all these reviews on every resident, especially MCRA, in the time specified by law?**

   Your facility is required to do the DRRs for the SNF QRP for traditional Medicare Part A stays, so you do not encode N2001, N2003 & N2005 on MDSs for Medicare Advantage/Alternative plans. It would be good practice to do the DRR for all skilled residents, regardless of pay source since no MDS coding is required other than for traditional Medicare Part A.

   I encourage your facility to train several clinicians to conduct these DRRs, looking for potential/actual clinically significant medication issues as one person simply cannot do them all! Have several backups ready to step in when you have multiple admissions on a given day or when clinicians who usually do the review are out. This is good clinical practice and protects the resident, the facility, and the nurse from harm or even worse, litigation.

3. **How many areas of care does the F756 impact?**

   Please reference the provided handouts and the presentation slides. CMS-20082 will help identify these areas as will the excerpted F756 verbiage from the SOM (Appendix PP).

4. **When dispensing medication, is the pharmacy review of meds included in the initial review on admission? If so, does the pharmacy need to submit documentation to the facility whether there is a clinically significant medication issue noted?**

   To properly answer that question, you need to consider all the requirements for the F756 DRR, including review of resident's medical record. If your pharmacist reviews the medical record on admission in order to dispense meds, you've answered that question. The pharmacist needs to report and document any irregularities. Please reference presentation slides #30, #36 and #38.

5. **Is there a specific CMS form for DRR?**

   No, CMS does not specify any given form for DRR. Found in this CMS statement:

   "CMS does not impose specific documentation procedures on nursing homes in completing the Resident Assessment Instrument (RAI). CMS does not provide guidance on who can complete the DRR nor on documentation practice. Each facility delivers resident care according to its unique characteristics and standards (e.g., resident population). Thus, each facility self-determines its policies and procedures for resident documentation practices and who may complete the assessments in compliance with State and Federal requirements. Data in the MDS should be consistent with information reported in the resident's medical record."

6. **How do we get the clinic doctors to comply with the documentation requirements of the DRR?**

   Great question. You may have to be resourceful in order to meet this requirement. This is more than just a Federal regulation and quality measure. The resident's well-being and sometimes continued existence could depend on this DRR. Physicians direct the care of residents and Medical Directors are responsible for the care provided in the facility they serve. Work with physicians to educate and ensure compliance. Tap your Medical Director as needed to help you do this. Keep trying and document any and all efforts to obtain compliance.

7. **Where can pharmacy forms be found for the medication regimen review?**

   Links to Briggs Healthcare's documentation resources can be found on slide 48 of the presentation handout.

8. **When a resident is picked up in the 30-day window, should the nurse review the meds with the MD at that time?**

   If the resident is picked back up for PPS, another 5-day PPS assessment is required so please do a DRR at that time as it is considered the start (in this case re-start) of the PPS stay. You need to answer N2001 and potentially N2003 (depending on your answer to N2001) with each/every 5-day PPS assessment.

9. **Can an LPN/LVN complete the DRR?**

   Please check with your state Board of Nursing for any applicable state requirements/rulings. Another good resource is your state's RAI Coordinator since individual is the CMS "interpreter" of the RAI Process. You can find that here.

10. **Can an NP document that GDR is clinically contraindicated for antipsychotics or does it need to be done by a primary physician?**

    Great question. The regs in F756 speak to attending physician/prescribing practitioner. In many states, an NP can prescribe medications. F756 does not specify primary care physician. CMS also states that practitioners may perform physician-delegated tasks act within the regulatory requirements and within the scope of practice as defined by State law.

11. **Does the drug review for the pharmacist include residents who are staying for respite care?**

    It certainly can. On page 470 of Appendix PP - beneath F756 - CMS says that your facility policies/procedures address DRRs for residents with anticipated lengths of stay less than 30 days - which would include your respite residents.

    As a fellow clinician, I recommend that you refer these short-stay/respite residents to the pharmacist for review at or shortly after the time of admission so their regimen can be assessed by the pharmacist. It could prevent a clinically significant medication issue while the resident is receiving care or provide valuable information to the caregiver upon discharge.

12. **Referring to slide 14, is it possible that something from the list of issues is identified but not clinically significant?**

    Yes, that is possible. It's all in the definition of clinically significant medication issue. I encourage you to review that definition on slide 13.

13. How often do you have to do a DRR QRP?

As often as needed during the PPS stay. CMS says each resident's medication usage is evaluated upon admission and on an ongoing basis, and that risks and problems are identified and acted upon. It would make sense to conduct a DRR if/when new medications are ordered, the resident's status changes, an infection is present, etc.

14. If a pharmacist is willing to do the drug regimen review, can requirements be met if he/she doesn't have access to the most recent history or physical/clinical progress notes?

The pharmacist needs to access medical record documents and transfer materials to properly conduct the DRR, just like any other clinician would. Without access to those references, a proper DRR cannot be conducted. It would be like trying to read a book without any light. Make sure that whomever conducts the DRR has access to the documents needed!

15. If an issue during the look-back period is identified by the MDSC during the MDS review, what should he/she do?

I would recommend that the MDSC follow the facility's policy re: the SNF QRP DRR. The MDSC should report what was found to the person(s) specified in the facility policy immediately, so the physician can be contacted for recommendations to be followed and completed. The N2001 - N2005 items are not specific to the function of the MDSC, but if the MDSC is one of the clinicians specified in the facility's policy, he/she should go ahead and contact the physician/designee.

16. Would it be considered an omission of meds if the floor nurse's chart states that a medication is unavailable when a resident arrives, and when should it be reported to the physician?

It depends. If the omission of meds is a potential or actual clinically significant (refer to the definition), then it must be reported/reviewed by the AP with completion of recommended/prescribed actions by midnight of the next calendar day. If the omission does not meet the clinically significant medication issue definition, nothing further is needed.