Frequently Asked Questions:

[On-demand webinar] Psychotropic Medication: Achieving a successful survey

On Tuesday, Dec. 11, 2018, SimpleLTC and TeamHealth offered a free webinar, featuring industry experts Dr. Robert Figlerski and Ms. Elizabeth Borntrager MSN, PMHNP-BC, which covered managing psychotropic medication as it continues to be a significant focus of CMS guidance and DOH surveys. In this FAQ document, our speakers covered all the specific questions asked by attendees during the webinar.

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1. **Is there a database to identify appropriate diagnosis for medication types?**

   No, there is not. CMS states that the diagnosis should be appropriate for the medication given through the FDA approval process or by general standard of care. Make sure you understand the difference between the CMS guidelines and 5-Star Rating regarding specific diagnosis for antipsychotics.

2. **Does a GDR make sense for a SNF with an average stay of 20 days?**

   It depends on what medication it is. If it is an antidepressant, then it is not necessary. However, if an antipsychotic or anxiolytic is introduced during the resident's hospital stay, it may be necessary. It depends on if the patient was on the medicine prior to his/her hospital admission and if the medication was for a pre-existing diagnosis.

3. **Does Medicare pay for behavioral health services provided by outside providers in connection with requirements to provide behavioral health services for SNF residents not on Med A?**

   Yes, Medicare covers outside providers treating SNF residents. Providers can bill Medicare directly.

4. **Is agitation acceptable for behavior monitoring?**

   Absolutely. Agitation comes in many forms, so specifying which kind is important. Is it verbal aggression? Is it resistance to ADL care? Is it threatening? Agitation can be a symptom of multiple psychiatric disorders.

5. **With proper documentation, can a PRN psychotropic order be renewed after a 60-day extension?**

   Routine medication can be written on an ongoing basis. PRN psychotropics can be written for longer than 14 days if the time frame and diagnosis are listed. 60 days was used as an example, but it can be any time frame. It depends on if the provider feels it is appropriate. However, it's important to note that PRN antipsychotics can **only** be given for 14 days and require a face-to-face evaluation to be continued – no exceptions.

6. **For coding purposes, is Melatonin considered a hypnotic or an OTC natural sleep aid?**

   It can be coded as an OTC, but it may need GDR like a hypnotic.

7. **If psychosis lasts longer than 6 months, the resident may have Schizophrenia especially if they have intermittent paranoid delusions or hallucinations. Is it safe to ask Psychiatrists or MDs to re-classify the resident to a more specific diagnosis as Paranoid Schizophrenia or Schizoaffective?**

   To clarify, Psychosis is a symptom of schizophrenia. In terms of the appropriateness to ask for a re-classification, it is alright to ask if the provider feels the patient meets criteria for schizophrenia. Usually, schizophrenia is diagnosed prior to the existence of dementia. However, there are some open-ended classifications like "schizophrenia spectrum disorder" that may be appropriate. It should always be in a dialogue with the prescriber.

8. **Are there specific examples of behaviors associated with dementia that are acceptable for pharmacological intervention?**

   Any that cause psychological distress or functional impairment. If a resident is anxious, pacing, and won't allow staff to change her, that's a functional impairment. If the staff says she won't calm down, that is causing psychological distress. It all depends on the situation presented.

9. **Do hospice clients fall under the same rules for PRN psych meds?**

   My understanding is that they do.

10. In the case GDR is attempted or justified and the resident doesn't agree to gradually reducing or stopping medication, does the resident have right to continue medication based on resident request?

That is very case specific. CMS does not allow residents to dictate care, but it does want residents to be a part of their treatment. A good example is if you have a resident receiving a high dose Xanax and does not want it reduced, but it is not clinically appropriate for them to continue. Then it should be reduced. However, if a patient is a good historian and can offer coherent reasoning for why something should not be reduced, that should be taken into consideration.

11. If a patient is on Depakote for mood, is a Depakote level required?

The standard of care for Depakote is that Depakote levels are obtained. There are instances where this is not done because the patient might be on an extremely low dose for years or the patient cannot tolerate lab work and the patient's family understands the risk. In general, Depakote levels should be recorded.

12. Is Namenda now classified as a psychotropic?

Namenda falls under the broad CMS definition of psychotropic, which is any medication that works on the brain other than an opiate medication. However, it is not clinically recommended to reduce doses of Namenda unless the person is near end of life, unable to tolerate it, or has had an adverse reaction.

13. Can you please explain the face-to-face from the treating physician for new orders?

The face to face is required for renewal of PRN antipsychotics after 14 days. If I start someone on PRN Haldol, that can only last for 14 days. If I want it to go longer than that, I must see the patient in 14 days and write a new order.

14. If Benadryl is used for sleep, is it considered a hypnotic?

It can be considered that. I've seen it classified as one when given for sleep.