Quality

Measure Tip Sheet

Percent of Long-Stay Resident Who Received an Antipsychotic Medication

AHCA

AMERICAN HEALTH CARE ASSOCIATION

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 15,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers, and homes for individuals with intellectual and development disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day. For more information, please visit www.ahcancal.org.

For over a decade, the Centers for Medicare and Medicaid Services (CMS) has focused on the reduction of the unnecessary use of antipsychotic medication. As part of this focus, CMS publishes the percentage of long-stay residents receiving antipsychotics and includes this information in the Five Star Quality Rating System.

In 2021, the Office of Inspector General (OIG) reported that the use of the Minimum Data Set (MDS) for reporting the number of long-stay residents receiving antipsychotic medications may not accurately reflect the number of residents who are prescribed antipsychotic medications. This lead to the creation of the first hybrid quality measure introduced by the CMS in 2025 and implemented in the Five-Star Quality Rating System January 2026. CMS notes this will more accurately capture antipsychotic prescribing that falls within the nursing home stay.

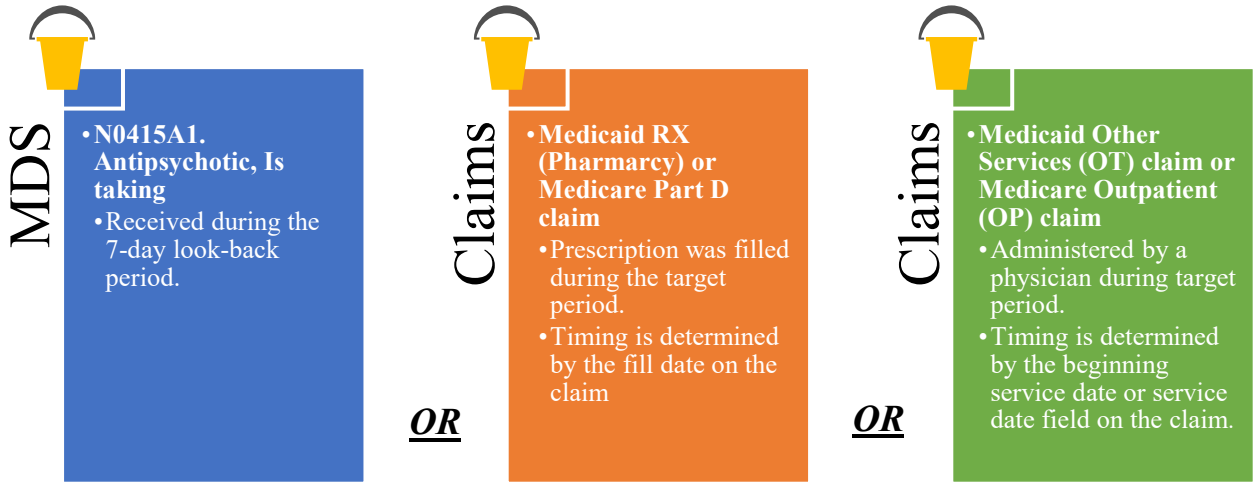
Measure Description:

This measure reports the percentage of long-stay residents who are receiving antipsychotic drugs in the target period, as evidenced by a qualifying Minimum Data Set (MDS) or certain claims-based data.

QM Triggers (Numerator):

As a hybrid quality measure, *both* MDS assessments and claims data are used to identify long stay residents who either received an antipsychotic medication and/or were prescribed one in the target period.

Data to identify residents who trigger this measure (i.e., identify residents who are included in the numerator) fall into one of the three data buckets, indicating the resident either received or was prescribed an antipsychotic medication during a specific time period.



Measure Exclusions:

Measure exclusions remove residents from the denominator of a quality measure, thereby removing any possibility of the resident triggering a measure. This measure excludes residents who do not have certain health care coverage in place for a specific length of time, the presence of certain diagnoses, and hospice care.

This means that all long-stay residents are included in this measure, except those with exclusions. These include:

1. **Residents who are not continuously enrolled in any of the coverage below during each month of the target period:**
    - **Medicare Part A, B, and D; or**
    - **Medicare Advantage with Part D enrollment, or**
    - **Medicaid only.**

    The target period is defined as a calendar quarter. For example, Q4 2025 or October 1, 2025, through December 31, 2025.

2. **Residents who are not continuously enrolled in any of the below coverage during each month of the measure exclusion look-back window:**
    - **Medicare Part A and B, or**
    - **Medicare Advantage, or**
    - **Medicaid only.**

    The exclusion look-back period is defined as the same date one year prior to the Assessment Reference Date (ARD) of the target MDS assessment.

    For example, if the target MDS ARD is May 1, 2026, the exclusion look-back period is May 1, 2025, through May 1, 2026.

Important Insight for Exclusions #1 & #2:

If a resident has certain payer changes during the target or exclusion look-back window, they will be excluded from the denominator and therefore the measure.

For example: A resident who converts from Medicare Advantage to traditional Medicare fee-for-service (or vice versa) during the target period or measure exclusion look-back window ***will be excluded from the measure for that target period***. The re-specification definition for continuous enrollment requires either continuous Medicare FFS **OR** Medicare Advantage, not Medicare FFS "and/or" Medicare Advantage.

Note, if this resident is continuously enrolled in the plan they switched to in the next target period, they would be included in the measure.

3. **Residents aged 65 years or older upon admission and were admitted within one year prior to the end of the target period, but were not continuously enrolled in each month of the preadmission look-back window in either:**
    - **Medicare Part A and B; or**
    - **Medicare Part C (Medicare Advantage), or**
    - **Medicaid only.**

    The pre-admission lookback window is defined as same date one year prior to the day before admission date, until one day before admission date.

    For example, if the resident was admitted to the nursing home on June 1, 2026, the pre-admission lookback window is May 30, 2025, through May 30, 2026.

4. **Any of the following related conditions are present on the target MDS assessment OR the prior MDS assessment AND in Medicare/Medicaid claims or encounter data:**
    - **Schizophrenia,**
    - **Tourette's,**
    - **Huntington's disease.**

    Which claims are reviewed depends on the residents' age and if they were admitted within one year of the end of the target period.

    Medicare or Medicaid claims/encounter data used to validate the diagnoses include Inpatient (IP), Outpatient (OP), Physician/Carrier (PB), Home Health (HH) and Hospice (HS) settings in Medicare claims/encounter data, and IP and Other Services (OT) files in Medicaid claims/encounter data.

Coding Requirements Impacting Measure

MDS Coding Requirements:

N0415A1, High-Risk Drug Classes: Antipsychotic Medication, Is taking

- Medications are coded on the MDS per pharmacological classification, not how they are being used.
- Medications with more than one therapeutic category and/or pharmacological classification should be coded in all categories/classifications assigned in N0415.
    - For example, if a resident receives prochlorperazine for nausea/vomiting during the 7-day look-back period, this would be captured on the MDS as it is dually classified as an antiemetic and antipsychotic medication.

- Combination medications should be coded in all categories and/or pharmacological classifications in the combination.
    - For example, if a medication includes both an antipsychotic medication and antidepressant, both are coded on the MDS assessment.
- Count long-acting medications, such as fluphenazine decanoate or haloperidol decanoate, that are given every few weeks or monthly only if they are administered during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
    - For example, if fluphenazine decanoate was administered 3 weeks prior to the ARD of the MDS, this medication would NOT be captured on the assessment, as it was administered prior to the look-back period of the MDS.

I5250, Huntington's Disease; I5350, Tourette's syndrome; and I6000, Schizophrenia

MDS items I0100 through I8000 have two look-back periods, with the exception of I2300, Urinary Tract Infections:

1. **Identify diagnoses:** These items require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 calendar days.
2. **Determine whether diagnoses are active:** Once a diagnosis is identified through step 1, it must then be determined if the *diagnosis is active*.
    - Active diagnoses are *diagnoses that have a direct relationship* to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.
    - Do not include:
        - Conditions that are resolved.
        - Conditions that do not meet the definition of active.
        - Conditions that do not drive the resident's plan of care during the 7-day look-back period.

In alignment with guidance in Appendix PP, the RAI Manual also notes the following coding tip:

- 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.

Given the scrutiny to these diagnoses, it will be important that MDS coders for this section familiarize themselves with the guidance related to coding mental health conditions in Appendix PP found at F605 and F658.

ICD-10-CM Guidelines (Claims):

ICD-10-CM coders should familiarize themselves with the ICD-10-CM Guidelines for coding and reporting on resident claims. It is important to note that additional requirements found within the RAI Manual must also be met when adding ICD-10-CM codes to the MDS in I8000.

While full details are found within the guidelines, key general coding guidelines to be aware of include:

- To select a code in the classification that corresponds to a diagnosis or reason for a stay documented in a medical record, first locate the term in the Alphabetic Index, and then verify the code in the Tabular List. Read and be guided by instructions found in both the Alphabetic Index and the Tabular List.
- It is essential to use ***both*** the Alphabetic Index and Tabular List when locating and assigning a code. The Alphabetic Index does not always provide the full code.
- ICD-10-CM code assignment is based on the documentation by the resident's provider (i.e., physician or physician extender).
- DO NOT code a diagnosis documented by the medical provider as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out". That is, only code a confirmed diagnosis.
- For reporting purposes, only code clinically significant conditions that affect care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of stay, or require increased nursing care and/or monitoring.

Important Considerations

- It is important to understand the measure specifications in order to implement quality improvement efforts.
    - This measure only includes long-stay residents, which are those residents whose episode of care is ≥101 days. New admissions or residents whose episode of care is ≤100 days are not included in this measure.
    - Understand which type of claims impact which measure triggers (i.e., residents who fall into the numerator) and exclusions to avoid undue documentation burden.
- Communication is essential, between clinicians within the nursing home and outside of the nursing home to ensure continuity of care. Ensuring key clinical information is shared with external providers during transitions of care will lead to better continuity of care and documentation.

- When the therapy is deemed appropriate, safe, and beneficial, it is recommended that all clinical providers keep quality documentation of diagnosis and ongoing safety and effectiveness of the medication. Documentation by the consultant pharmacist and nursing staff is considered extensively during survey examination related to this measure.

Key Reports for Quality Improvement:

It is recommended to run the following reports in iQIES at least monthly, but may be run up to weekly depending on a facility's management plan:

- **MDS 3.0 Facility Characteristics Report**: This report displays facility demographic information based upon data submitted in MDS assessments and includes comparison state and national percentages for a specified timeframe.
    - By comparing your facility percentages with the state and national average percentages, you can determine whether your facility's demographic characteristics differ from the norm. This may indicate a need to concentrate a review of certain resident groups.
- **MDS 3.0 Facility-Level Quality Measure (QM) Report**: This report displays the facility percentage and how the facility compares with other facilities in their state and in the nation for each quality measure.
    - This report helps to identify possible areas for further emphasis in facility quality improvement activities or investigation during the survey process.
    - NOTE: The measure calculations found in this report will not match the calculations in your Five-Star Preview Report or those found on Care Compare, due to timing and specifications of the final calculations. But the percentages within these reports are calculated in more real-time (updated weekly on Mondays) and therefore may be more beneficial for day-to-day quality improvement/QAPI programs.
- **MDS 3.0 Resident-Level Quality Measure (QM) Report**: This report displays the residents (active and discharged) who were included in the calculations for the selected facility and period that were used to produce the MDS 3.0 Facility-Level Quality Measure (QM) Report.
    - The report lists the residents by name and indicates which measures the resident triggered (if any). This allows the facility to review MDS assessments for accuracy and identify areas for improvement in clinical and/or documentation practices.
    - The report separates residents into active or discharged. Residents should only fall under one category for the report time period.

Questions to Ask:

- *Is there sufficient documentation in the medical record to support a mental health diagnosis?*
    - According to the State Operations Manual, Appendix PP under F658: "Supporting documentation should include, but is not limited to, evaluation of the resident's physical, behavioral, mental, psychosocial status, and comorbid conditions, ruling out physiological effects of a substance (e.g., medication or drugs) or other medical conditions, indications of distress, changes in functional status, resident complaints, behaviors, symptoms, and/or state Preadmission Screening and Resident Review (PASARR) evaluation."

- *Is the documentation consistent between the prescriber, consultant pharmacist, and nursing staff?*
- *Was the MDS coded per current RAI requirements?*
- *Are the residents' active diagnoses updated, signed, and documented by the medical provider in the last 60 days? Are all chronic health conditions addressed on a routine basis?*
- *Is there an appropriate indication for use documented by the medical provider for each medication?*
- *Is the resident's antipsychotic medication reviewed monthly by the consultant pharmacist for possible gradual dose reduction? Were recommendations followed up by the medical provider? Was a gradual dose reduction attempted and/or deemed clinically inappropriate?*
- *Is dementia training up to date for all appropriate staff?*
- *Have non-pharmacological strategies been utilized, documented, implemented, and evaluated in the person-center care plan for behavioral management?*
- *Are all behaviors/mood indicators and interventions being reported and appropriately documented, even if considered "normal for the resident"?*
- *Are care plans individualized and contributed to by all members of the interdisciplinary team?*
- *Are residents receiving PRN antipsychotic medications renewed every 14 days?*
- *Are primary assignments utilized for nursing staff and routinely reviewed?*
- *Are shift-to-shift reports utilized for: Nurse to nurse? CNA to CNA? Nurse to CNA?*
- *If there is a change in a residents' behavioral health status, is the resident reviewed for a Significant Change in Status Assessment? What referrals are implemented?*
- *Are all PASRRs up to date? Have Level II PASRRs been completed as required, and maintained in the medical record?*

Action Steps

- ✓ **Collaborate with external providers to obtain comprehensive records when a resident returns from the hospital and/or outpatient visits (including ED visits), including medication administration records and progress notes.**
    - This will assist with accuracy of MDS assessments and better understanding of the measure calculation to identify residents who fall into the numerator.

- ✓ **Conduct routine audits for all mental health diagnoses, especially those for schizophrenia, schizoaffective disorder, and schizophreniform disorders.** If there are gaps in documentation, address those gaps with actions steps that may include (but are not limited to) obtaining psychiatric evaluations, updating PASRRs, documentation of all behaviors, and clinical IDT assessments.
    - Insufficient documentation to support a mental health diagnosis would include:
        - A situation where schizophrenia or another diagnosis is only mentioned as an indication in medication orders without supporting documentation.
        - The addition of, or request by the facility to a practitioner for, a diagnosis of schizophrenia or another diagnosis without documentation supporting the diagnosis (i.e., a non-compliant physician query).
        - A practitioner's note or transfer summary from a previous provider stating "history of schizophrenia," "schizophrenia," or another diagnosis without supporting documentation confirming the diagnosis with a previous practitioner or family, and the facility failed to provide evidence that a practitioner conducted a comprehensive evaluation after admission.
        - A diagnosis list stating schizophrenia or another diagnosis without supporting documentation.
        - A note of schizophrenia or another diagnosis in an electronic health record (EHR) without supporting documentation which populates throughout the HER (i.e., auto-population).
        - A note of schizophrenia or another diagnosis in the medical record by a nurse without supporting documentation by the practitioner.

- ✓ **Ensure all residents receiving psychotropic medications are routinely evaluated for a potential gradual dose reduction (GDR).** If this is clinically contraindicated, the resident's medical provider must complete comprehensive documentation in the medical record.

- ✓ **Consider adding residents with active diagnoses of schizophrenia, schizoaffective disorder, schizophreniform disorder, Tourette's syndrome, and Huntington's disease to your monthly triple check procedures in order to ensure ICD-10-CM codes are included on applicable claims.**
    - While nursing home claims are only one of several used to validate diagnoses, this will ensure congruent documentation of active conditions.

- ✓ **Implement a robust behavioral management program, including comprehensive documentation.**

- ✓ **Implement steps to ensure a compliant diagnosis query practice.** Follow the *Guidelines for Achieving a Compliant Query Practice* (2022 Update) put forth by the American Health Information Management Association and the Association of Clinical Documentation Specialists (ACDIS).
    - This practice brief is intended to provide best practice standards for the clinical documentation integrity query process that is driven by the underlying goal of validating the clinical documentation within the medical record accurately representing the clinical picture of patients and residents. It should be used in conjunction with facility policies and is intended for use in all settings.

- ✓ **Ensure all those who participate in the RAI process receive the necessary education and skills to complete their portion of the assessment.**
    - Consider utilizing the AHCA education program: Learning the Minimum Data Set – Basic Training for the Interdisciplinary Team.
    - Adapt education for various IDT members depending on their role within the process. For example, adapt Section GG training for nursing assistants who may document ADL care.

- ✓ **Ensure all those who enter ICD-10-CM codes in the medical record have the necessary skills and access to a current manual.**
    - ICD-10-CM coding is like learning another language. Using an internet search or even using software in MDS/HER/data analytic programs may yield incorrect codes for several reasons:
        - Code descriptions are not equivalent to a diagnosis. ICD-10-CM codes are a statistical classification. Many code descriptions do not match the verbiage within a clinical diagnosis.

- Online searches/software may not consider important instructions within the manual that affect final code selection, such as Excludes 1 or Excludes 2 notes.
- When a medical provider enters codes within their documentation, it becomes the responsibility of the coders to validate the diagnosis using the provider documentation, not their ICD-10-CM codes (AHA Coding Clinic for ICD-9-CM, First Quarter 2012, Page 6, American Hospital Association Central Office).

Additional References:

State Operations Manual Appendix PP

ICD-10 | CMS

- This site will include the most recent and historical ICD-10-CM manual files, including guidelines, the Alphabetical Index, and Tabular List.

Internet Quality Improvement & Evaluation System (iQIES) Reports User Manual

- This user manual provides information about the processes necessary to request, view, download, and save reports in iQIES.

Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual | CMS

- Scroll down to "Downloads" for the current copy of the RAI Manual.

Quality Measures | CMS

- Scroll down to "Downloads" for the current copy of the MDS 3.0 and SNF QRP QM manuals, along with related supplemental documents.

Questions? Email Regulatory@AHCA.org