
Program Memorandum Intermediaries/Carriers

**Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)**

Transmittal AB-02-143

Date: OCTOBER 25, 2002

CHANGE REQUEST 2318

SUBJECT: Provider Education Article: Psychotropic Drug Use in Skilled Nursing Facilities (SNF)

An article is attached that will assist you in reminding the provider community about Medicare guidelines for psychotropic drug use in SNFs.

Include this article in your next regularly scheduled bulletin and post it immediately on any web sites or electronic bulletin boards you maintain. You are encouraged to include any additional information in your bulletin to supplement or complement the article.

The effective date for this Program Memorandum (PM) is October 25, 2002.

The implementation date for this PM is October 25, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded October 25, 2003.

If you have questions, please contact the appropriate regional office.

Attachment

Psychotropic Drug Use in Skilled Nursing Facilities (SNF)

In response to concerns expressed by the Senate Special Committee on Aging, the Office of Inspector General (OIG) studied the extent to which psychotropic drugs are being used in nursing homes as inappropriate chemical restraints. The OIG found that, in general, these drugs are being used appropriately. Where there are problems, they are related to inappropriate dosage, chronic use, lack of documented benefit to the resident, and unnecessary duplicate drug therapy. This article explains Medicare's guidelines for psychotropic drug use in SNFs including the definition of an unnecessary drug, justification for drug use outside guidelines, and antipsychotic drugs.

Definition of an Unnecessary Drug

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

- In excessive dose (including duplicate drug therapy);
- For excessive duration;
- Without adequate monitoring;
- Without adequate indications for its use;
- In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or
- Any combination of the above reasons.

NOTE: When a resident receives duplicate drug therapy, an evaluation should be completed for accumulation of the adverse effects.

NOTE: Adequate indications for use means that there is a valid clinical reason for the resident to receive the drug based on some, but not necessarily all, of the following:

- Resident assessment;
- Plan of care;
- Reports of significant change;
- Progress notes;
- Laboratory reports;
- Professional consults;
- Drug orders; or
- Observation and interview of the resident.

Justification for Drug Use Outside Guidelines

A drug used outside these guidelines must be based on sound risk-benefit analysis of the resident's symptoms and potential adverse effects of the drug. Some examples of evidence that would support a justification as to why a drug is being used outside these guidelines, but in the best interest of the resident, may include:

- A physician's note indicating that the dosage, duration, indication, and monitoring are clinically appropriate and the reasons as to why they are clinically appropriate. The note should demonstrate that the physician has carefully considered the risk/benefit to the resident in using a drug outside the guidelines.
- A medical or psychiatric consultation or evaluation (e.g., Geriatric Depression Scale) confirming the physician's judgment that use of a drug outside the guidelines is in the best interest of the resident.
- Documentation of a physician, nursing, or other health professional indicating that the resident is being monitored for adverse consequences or complications of the drug therapy;

- Documentation confirming that previous attempts at dosage reduction have been unsuccessful;
- Documentation (including MDS documentation) showing the resident's subjective or objective improvement or maintenance of function while taking the medication;
- Documentation showing that the resident's decline or deterioration has been evaluated by the interdisciplinary team to determine whether a particular drug, a particular dose, or duration of therapy may be the cause; and
- Documentation showing why the resident's age, weight, or other factors would require a unique drug dose or drug duration, indication, or monitoring.

Guidelines for Use of Antipsychotic Drugs

SNFs must ensure, based on a comprehensive assessment of the resident, that:

I. When an antipsychotic drug has not been used in the past, it is not given unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record. Antipsychotic drugs should not be used unless the clinical record documents that the resident has one or more of the following specific conditions:

- Schizophrenia;
- Schizo-affective disorder;
- Delusional disorder;
- Psychotic mood disorders (including mania and depression with psychotic features);
- Acute psychotic episodes;
- Brief reactive psychosis;
- Schizophreniform disorder;
- Atypical psychosis;
- Tourette's disorder;
- Huntington's disease;
- Organic mental syndromes (now called delirium, dementia, and amnesic and other cognitive disorders by DSM-IV) with associated psychotic and/or agitated behaviors which:

A. Have been quantitatively and objectively documented. This documentation is necessary to assist in:

- Assessing whether the resident's behavioral symptom is in need of some form of intervention.
- Determining whether the behavioral symptom is transitory or permanent.
- Relating the behavioral symptom to other events in the resident's life in order to learn about potential causes (e.g., death in the family, not adhering to the resident's customary daily routine).
- Ruling out environmental causes (e.g., excessive heat, noise, overcrowding).
- Ruling out medical causes (e.g., pain, constipation, fever, infection).

B. Are persistent;

C. Are not caused by preventable reasons; and

D. Cause the resident to:

- Present a danger to himself/herself or to others;
 - Continuously scream, yell, or pace and results in an impairment of functional capacity; or
 - Experience psychotic symptoms (e.g., hallucinations, paranoia, delusions) that are not exhibited as dangerous behaviors or as screaming, yelling, or pacing but result in distress or impairment of functional capacity.
- Short-term (7 day) symptomatic treatment of hiccups, nausea, vomiting, or pruritus. Residents with nausea and vomiting secondary to cancer or cancer chemotherapy can be treated for longer periods of time.

Antipsychotics should not be used if the only indication is one or more of the following:

- Wandering;
- Poor self care;
- Restlessness;
- Impaired memory;
- Anxiety;
- Depression (without psychotic features);
- Insomnia;
- Unsociability;
- Indifference to surroundings;
- Fidgeting;
- Nervousness;
- Uncooperativeness; or
- Agitated behaviors that do not represent danger to the resident or others.

II. Unless clinically contraindicated, gradual dose reductions of the antipsychotic drug and behavioral interventions are considered in an effort to discontinue the drug. Close supervision should be provided when gradual dose reductions are carried out. If the gradual dose reduction causes an adverse effect on the resident and is discontinued, documentation of this decision and the reasons for it should be included in the clinical record. Gradual dose reductions consist of tapering the daily dose to determine whether symptoms can be controlled by a lower dose or the drug can be altogether eliminated.

NOTE: Behavior interventions is a modification of the resident's behavior or environment, including staff approaches to care, to the largest degree possible to accommodate the behavioral symptoms.

NOTE: Clinically contraindicated means that gradual dose reductions or behavioral interventions need not be undertaken if:

- The resident has a history of recurrence of psychotic symptoms (e.g., delusions, hallucinations) that have been stabilized with a maintenance dose of an antipsychotic drug without incurring significant side effects and has one of the following specific conditions:
 - Schizophrenia;
 - Schizo-affective disorder;
 - Delusional disorder;
 - Psychotic mood disorders (including mania and depression with psychotic features);
 - Acute psychotic episodes;
 - Brief reactive psychosis;
 - Schizophreniform disorder;
 - Atypical psychosis;

- Tourette's disorder; or
- Huntington's disease
- The resident has organic mental syndrome, and gradual dose reductions have been attempted twice in one year that resulted in the return of symptoms for which the drug was prescribed to a degree that a cessation in the gradual dose reduction or a return to previous dose reduction was necessary; or
- The resident's physician provides a justification as to why the continued use of the drug and the dose of the drug are clinically appropriate. This justification should include:
 - A diagnosis that includes a description of the symptoms (not simply a diagnostic label or code);
 - A discussion of the differential psychiatric and medical diagnosis (e.g., why the resident's behavioral symptom is thought to be the result of a dementia with associated psychosis and/or agitated behaviors and not the result of an unrecognized painful medical condition or a psychosocial or environmental stressor);
 - A description of the justification for the choice of a particular treatment or treatments; and
 - A discussion of why the present dose is necessary to manage the resident's symptoms.