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**Analysis of New Pharmacy Services and Unnecessary Medications Sections of
SOM**
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**Summary of Changes and Answers to
Frequently Asked Questions**

The Centers for Medicare and Medicaid Services (CMS) recently revised survey guidance for Pharmacy Services and Unnecessary Medications (F-Tags 329, 425, 428, and 431) in Appendices P and PP of the State Operations Manual. This is the first substantive change in these sections since 1999. CMS released an “Advance Copy” of the new guidelines on September 15, 2006 and the final version on December 15, 2006, shortly before implementation on December 18, 2006. The final version contained significant changes compared to the “Advance Copy” version, primarily within the gradual dose reduction/tapering section. To ensure accurate interpretation and implementation, be sure that the most current, final version of the guidelines is being used.

It is important to keep in mind that the regulations have not changed. It is the “Guidance to Surveyors” or interpretive guidelines, investigative protocol, and severity guidance that have been updated. Nevertheless, some of the survey tags have been combined and reorganized, as follows:

Unnecessary Medications

New Tag F329 = Old Tags F329, F330, F331

Pharmaceutical Services

New Tag F425 = Old Tags F425, F426, and F427 (b) (1)

Medication Regimen Review (previously referred to as Drug Regimen Review)

New Tag F428 = Old Tags F428, F429, F430

Storage, Labeling, and Controlled Medications

New Tag F431 = Old Tags F427 (b) (2) and (3), F431, F432

While the tags listed above are the primary sections within Appendix PP pertaining to pharmacy services and medication use in nursing facilities, they are

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not the only tags or sections with which the consultant pharmacist and dispensing pharmacist should be familiar. Medications are referred to or mentioned in various tags throughout Appendix PP, including but not limited to F-Tag 332-333 Medication Errors.

The following questions and answers are not all-inclusive nor is it a complete overview of the guidelines document. They are meant merely to be a snapshot of issues. Despite the length of the documents, we strongly encourage you to read through the entire guidelines document in order to familiarize yourself with the upcoming changes.

Q. To what types of facilities do these new guidelines apply?

A. The regulations and new guidance to surveyors in Appendix P and PP of the State Operations Manual only apply to skilled nursing facilities (SNFs) and nursing facilities (NFs) that meet the requirements for each set forth in the Social Security Act. The new guidelines do NOT apply to ICFs (ICF-MR/DD), assisted living facilities, or hospitals (except portions of a hospital that are licensed as a SNF or NF).

Q. Since the changes are pretty extensive, how have surveyors been trained on these new guidelines?

A. In November, representatives from each of the state survey agencies attended a live 2-day "Train the Trainer" meeting in Baltimore to learn about the changes. They primarily received training on F329 and F428 from CMS staff, pharmacists, physicians, and other professionals on the expert advisory panels. They will use information gleaned from this meeting along with DVDs they receive that contain prerecorded educational sessions to train fellow surveyors. In addition, CMS held a satellite training program on December 15 to provide additional information about the impending changes. CMS frequently uses these satellite training sessions to educate surveyors in the field about various issues. Past satellite sessions are available as archived webcasts and accessible to anyone that fills out the free, online registration. The website containing the registration and the list of future and archived programs is: <http://cms.internetstreaming.com>.

Q. Are once monthly drug regimen reviews performed by a pharmacist still required?

A. Yes. The once monthly review of each resident's medication regimen is a regulatory requirement. And, as mentioned above, the regulations themselves have not changed. The frequency of review is still monthly – but, as stated in both the new guidelines and the current guidelines, there is mention of more frequent reviews when necessary (i.e., depending on resident's condition and risks or adverse consequences related to medications). In addition, the

consultant pharmacist is still key to appropriate medication management in nursing facilities. In fact, through these new guidelines, the consultant pharmacist's role has expanded.

Q. What does the document say about reviewing medication regimens more than once a month? Is there an expectation that the pharmacist review the regimens of short-stay residents who may be admitted and discharged between the routine monthly visits?

A. Yes, the consultant pharmacist and nursing facility are expected to collaboratively establish procedures that address medication regimen reviews for those short-stay residents who are anticipated to stay less than 30 days. Also expected is the development and implementation of procedures to address medication regimen reviews for residents who experience an acute change in condition. As stated in the new guidelines, procedures might include or address:

- How and when the need for a consultation will be communicated
- How the medication regimen review will be handled if the consultant pharmacist is off-site
- How the results or report of the pharmacist's findings will be communicated to the physician
- Expectations for the physician's response and follow-up
- How and where this information will be documented

Q. How might a facility and/or pharmacist identify those residents who are anticipated to be short-stay or who experience an acute change in condition?

CHANGE IN CONDITION:

Asking the facility to track and/or provide a list of residents who have been hospitalized in the past 30 days may be one method for identifying residents who have experienced an acute change in condition. In addition, the Minimum Data Set (MDS) can also serve as a helpful resource for identifying these residents, as seen below:

- Identify residents for which a "Change in Condition" MDS has been completed since the last pharmacist visit - Section AA and/or A of MDS, Question 8 (a) will be answered with a "3" if the resident has experienced a significant change in status
- Identify which residents have triggered Section J, Question 1 of MDS, as this indicates new problems present in the last 7 days
- Identify which residents have triggered Section P of the MDS, Questions 5, 6, 7, 8, or 9
 - o (5) - Hospital Stays in last 90 days
 - o (6) - ER Visits in last 90 days
 - o (7) - MD Visits in last 14 days
 - o (8) - MD Orders in last 14 days
 - o (9) - Abnormal Lab Values in last 90 days

SHORT-STAY

It is sometimes difficult to project the anticipated length of stay for a resident. The facility and consultant pharmacist may elect to perform medication regimen reviews shortly after admission on every new resident or they may choose to proactively conduct medication reviews on every Medicare Part A resident, since a large percentage of those residents may be in the nursing facility for rehabilitation or some other short-term purpose. The MDS also captures the probability of a resident being short-stay. Therefore, it can also serve as a valuable resource. For example:

- Section Q of MDS, Question 1 (c): Stay projected to be of a short duration - discharge projected within 90 days (do not expected discharge due to death):
 - o 0. No
 - o 1. Within 30 days
 - o 2. Within 31-90 days
 - o 3. Discharge status unknown

Q. Drug regimen review has never been defined in the previous guidelines. Is the drug regimen review process defined or explained in this new document?

A. Actually, drug regimen review – now referred to as medication regimen review – is included in the glossary and is explained in further detail in the interpretive guidelines at F-Tag 428. “Medication Regimen Review” is defined as:

“A thorough evaluation of the medication regimen of a resident by a pharmacist, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team.”

Q. Considering the modifications to the final guidelines released in December, periodic gradual dose reduction or tapering is mentioned for which classes of medications?

A. First and foremost, the guidance document emphasizes the importance of seeking an appropriate dose and duration for *each* medication. Nonetheless, specific classes are mentioned, including:

- Antipsychotics
- Sedatives/hypnotics
- Psychopharmacological medications

For the purposes of the guidelines document and the survey process, a psychopharmacological medication is defined as:

“Any medication used for managing behavior, stabilizing mood, or treating psychiatric disorders.”

Based on this definition, many different types of medications could be considered “psychopharmacological”- depending on how or why they are being used. Classes of medications from Table 1 in F-Tag 329 that refer to the section on tapering of psychopharmacologicals are:

- Anticonvulsants
- Antidepressants
- Anxiolytics

Note that the cognitive enhancers section of Table 1 previously referred readers to the tapering guidelines for psychopharmacological medications. This reference has been DELETED. Nevertheless like all medications, cognitive enhancers (cholinesterase inhibitors, memantine) should still be evaluated for appropriate indication, dose, duration, monitoring, etc.

It is important to keep in mind that all of these classes of medications include not only the older agents but also the newer agents and even atypical medications, such as medications used off-label for the purpose identified (e.g., trazodone for sleep). Therefore, medications are generally being defined by how they are being used rather than the pharmacologic class to which they officially belong. When evaluating a resident’s medication regimen, surveyors should be considering what the medication is being used for rather than its classification.

Q. Considering the modifications to the final guidelines released in December, what are the timeframes for gradual dose reduction/tapering of the various classes mentioned in the document?

The timeframes or frequencies of gradual dose reduction/ tapering for each of the classes of medication are as follows:

- Antipsychotics, no matter what the indication
 - o GDR/tapering timeframes:
 - o Within 1st year in which a resident admitted on an antipsychotic OR within first year after the facility initiates an antipsychotic, *unless clinically contraindicated*, GDR in 2 separate quarters with at least one month between attempts
 - o After 1st year, *unless clinically contraindicated*, GDR annually
 - o When used to treat behavioral symptoms related to dementia, clinically contraindicated means:
 - o Symptoms returned or worsened after the most recent attempt at a GDR *within the facility* **AND**
 - o MD has documented clinical rationale why additional GDR at this time would be likely to impair the resident’s function, increase distressed behaviors or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder

- When used to treat a psychiatric disorder, clinically contraindicated means:
 - Symptoms returned or worsened after the most recent attempt at a GDR *within the facility* **AND** MD has documented clinical rationale why additional GDR at this time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder **OR**
 - Continued use is in accordance with relevant current standards of practice **AND** MD has documented clinical rationale why additional GDR at this time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder
- Sedatives/Hypnotics
 - Tapering timeframes
 - If used routinely and beyond the manufacturer's recommendations for duration of use, *unless clinically contraindicated*, taper quarterly
 - Clinically contraindicated means:
 - Symptoms returned or worsened after the most recent attempt at a taper *within the facility* **AND** MD has documented clinical rationale why additional tapering at this time would be likely to impair the resident's function, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder **OR**
 - Continued use is in accordance with relevant current standards of practice **AND** MD has documented clinical rationale why additional tapering at this time would be likely to impair the resident's function, or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder
- Psychopharmacological medications
 - Tapering timeframes:
 - Within 1st year in which a resident admitted on a psychopharmacological **OR** within first year after the facility initiates a psychopharmacological, *unless clinically contraindicated*, tapering in two separate quarters with at least one month between attempts
 - After 1st year, *unless clinically contraindicated*, taper annually
 - Clinically contraindicated means...
 - Symptoms returned or worsened after the most recent attempt at a taper *within the facility* **AND** MD has documented clinical rationale why additional taper at this time would be likely to impair the resident's function

- or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder **OR**
- Continued use is in accordance with relevant current standards of practice **AND** MD has documented clinical rationale why additional taper at this time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder

Note that the gradual dose reduction/tapering timeframes are the same for antipsychotics and psychopharmacological medications. In addition, criteria for clinical contraindication are the same for antipsychotics used to treat psychiatric conditions, sedatives/hypnotics, and psychopharmacological medications.

Q. Do the final guidelines allow the physician to provide justification/documentation why a gradual dose reduction or taper is clinically contraindicated rather than requiring a failed taper attempt?

A. The final guidelines released in December, in some situations, allow the physician's documented clinical rationale to serve as clinical contraindication to further tapering. As seen in the Q+A above, this "documentation" option applies to:

- Antipsychotics used to treat psychiatric disorders (but NOT for antipsychotics used to treat dementia-related behaviors, as that indication requires a GDR attempt)
- Sedatives/hypnotics
- Psychopharmacological medications

The documentation should include:

- Evidence that the medication is being used in accordance with current relevant standards of practice
- Clinical rationale why additional GDR/tapering at this time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder

The document does specifically mentions the physician as the individual who would document clinical rationale. This specific aspect or detail may or may not be addressed by a surveyor, but it is important to keep in mind.

Q. If a resident is taking 2 antidepressants for 2 different reasons, is this duplicate therapy? When is it considered duplicate therapy and when is it not?

A. Anytime two medications from the same pharmacological class or with the same therapeutic properties are used concomitantly, it could be considered duplicate therapy. Each medication may be necessary, meaning it has an adequate indication, is being used at the appropriate dose, etc. – but the rationale

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for their use just needs to be documented. Since there is a greater potential for adverse consequences when used concomitantly, documentation also needs to be evident that potential adverse consequences are being monitored.

Q. The Beers medications, which are a large focus in the current guidelines, officially apply to those aged 65 and older. Now that the new guidelines provide many more examples than just the Beers medications, do these guidelines apply to all residents in a nursing facility or just those 65 years of age and older?

A. The document addresses this issue quite well by stating,
“Although these guidelines generally emphasize the older adult resident, adverse consequences can occur in anyone at any age; therefore, these requirements apply to residents of all ages.”

Q. Previous drafts mentioned the development of a pharmaceutical care plan. Is that mentioned in the new document, and is a medication-specific care plan required?

A. The term “pharmaceutical care plan” is not used in the new document. But, the document stresses that medication use is just one part of the overall care for a resident. Therefore, incorporating medication-related goals and preferences into the resident’s care plan is important. The guidelines suggest incorporating medication-related goals and parameters for monitoring the resident’s condition – both for efficacy and adverse consequences – into the resident’s comprehensive care plan. See guidance at F-Tag 279 for more information about the comprehensive care plan.

Q. Has the guideline requiring that a drug be provided in a timely manner been clarified in the new document? Has “timeliness” been defined?

A. The current guidelines at F-Tag 425, which requires that a drug be provided in a timely manner, has been controversial due to the varied interpretation of “timeliness” by providers and surveyors. During the public comment periods for the draft documents, many comments were received requesting clarification or specific timeframes that would constitute “timeliness.” However, because every situation is different, a specific timeframe (e.g., delivery / administration within 3 hours of a new order) could not be included in the guidelines. Nevertheless, general guidance has been provided to help surveyors determine if medications have been acquired and administered in a timely manner and to help guide facilities’ acquisition procedures. Factors that help determine how quickly a medication should be acquired and administered include:

- Availability of medications to enable continuity of care for an anticipated admission or transfer of a residents from acute care or other institutional setting

- Condition of the resident (e.g., severity, instability, discomfort, risk factors, etc.) and the potential impact of any delay in acquiring the medications
- Category of medication (e.g., antibiotics, analgesics, etc.)
- Availability of medications in emergency supply, if applicable
- Whether there is an ordered start time for the medication

Q. Does the medication regimen review process have to be performed in the facility, according to the new guidelines?

A. Appendix N, which was officially deleted in 2004, used to state that - while a pharmacist cannot be required to perform reviews in the facility - drug regimen reviews SHOULD be performed in the facility. Appendix N suggested that, in order to perform acceptable reviews, the pharmacist must be examining data sources such as the resident's drug administration record, physician orders, nursing notes, and laboratory reports. At the time Appendix N was released and utilized, these data sources were only located in the facility. Therefore, to adequately perform reviews, Appendix N concluded that the pharmacist should conduct reviews in the facility. With the increasing utilization of technology such as electronic health records, providers will be able to access resident information from off-site. The new guidelines combine the on-site review philosophy from Appendix N while accommodating for emerging technology. it states,

“Generally, MRRs are conducted in the facility because important information about indications for use, potential medication irregularities or adverse consequences (such as symptoms of tardive dyskinesia, dizziness, anorexia, or falls) may be attainable only by talking to the staff, reviewing the medical record, and observing and speaking with the resident. However, electronic health and medication records and other available technology may permit the pharmacist to conduct some components of the review outside the facility.”

Q. In previous drafts of the guidelines, a timeframe was suggested for surveyors to gauge whether a pharmacist's monthly regimen review was performed in a timely manner (e.g., timely if it occurs no later than 10 days after the date due). Is this timeframe mentioned in the new document?

A. After a few iterations of suggested timeframes, it was finally decided not to provide any specific timeframe guidance in the final document. Providing detailed guidance or clarification regarding what “monthly” means could inadvertently cause more opportunities for varied or incorrect interpretation by surveyors. Therefore, simplicity in wording was the final decision. The guidelines merely reiterate the regulatory language, requiring reviews at least every month.

Q. Is there a timeframe after which a consultant pharmacist's report that is not acted upon by the physician officially becomes delinquent?

A. No, a specific timeframe is not provided as to when a consultant pharmacist's report can be classified as having not been acted upon. Because situations and facilities are diverse, a mandated timeframe may not be appropriate in every situation. Therefore, the new guidance suggests that facilities and consultant pharmacists work together to develop and implement policies and procedures for dealing with reports that are not acted upon, such as when to contact and involve the medical director and procedures to resolve such situations when the medical director and attending physician are one in the same. The necessity of intervention will largely depend on the severity or clinical significance of the pharmacist's findings and recommendations.

Q. Is a diagnosis alone sufficient to comply with the requirement at F-Tag 329 that every medication have an adequate indication?

A. The guidelines specifically state that a diagnosis alone may not warrant treatment with medication. The indication for initiating, withdrawing, or withholding any medication or intervention is determined by carefully assessing the resident. This assessment might include:

- Ruling out other causes for the symptoms
- Determining whether the signs, symptoms, or causes are persistent or clinically significant enough to warrant the use of medication
- Considering non-pharmacological interventions
- Determining whether a particular medication is clinically indicated to manage the resident's symptom/condition
- Determining whether the intended or actual benefit is sufficient to justify the potential risks or adverse consequences associated with the selected medication(s), dose and duration

Q. The phrase - 'relevant current standards of practice' - is frequently used in the document. For example, the gradual dose reduction/tapering section states, "The GDR may be considered contraindicated, if: The continued use is in accordance with relevant current standards of practice..." How are 'relevant current standards of practice' defined?

A. While 'current relevant standards of practice' are not defined specifically, the document does allude to various medication-related resources that may be used by providers and surveyors. The Overview of F329 mentions the following:

- "Staff and practitioner access to current medication references and pertinent clinical protocols helps to promote safe administration and monitoring of medications. One of the existing mechanisms to warn prescribers about risks associated with medications is the Food and Drug Administration (FDA) requirement that manufacturers include

within the medication labeling warnings about adverse reactions and potential safety hazards identified both before and after approval of a medication, and what to do if they occur (Visit: www.fda.gov/medwatch/safety.htm).”

- “The facility’s pharmacist is a valuable source of information about medications.”
- “Listings or descriptions of most significant risks, recommended doses, medication interactions, cautions, etc. can be found in widely available, standard references, and computer software and systems that provide up-to-date information.”
- “Clinical standards of practice and clinical guidelines established by professional groups are useful to guide clinicians. Some of the recognized clinical resources available for understanding the overall treatment and management of medical problems, symptoms and medication consequences and precautions include the:
 - American Geriatrics Society www.americangeriatrics.org and www.geriatricsatyourfingertips.org;
 - American Medical Directors Association www.amda.com;
 - American Psychiatric Association www.psych.org;
 - American Society of Consultant Pharmacists www.ASCP.com;
 - Agency for Healthcare Research and Quality (AHRQ) www.ahrq.gov;
 - American Association for Geriatric Psychiatry www.aagp.org;
 - Association for Practitioners in Infection Control and Epidemiology www.apic.org;
 - CMS Sharing Innovations in Quality Web site maintained at: <http://siq.air.org>;
 - National Guideline Clearinghouse www.guideline.gov;
 - Quality Improvement Organizations, Medicare Quality Improvement Community Initiatives www.medqic.org;
 - U.S. Department of Health and Human Services, Food and Drug Administration Web site www.fda.gov/medwatch/safety.htm;
 - U.S. Department of Health and Human Services, National Institute of Mental Health Web site, which includes publications and clinical research information www.nimh.nih.gov;
 - Mace N, Rabins P. The 36-Hour Day: A Family Guide to Caring for Persons with Alzheimer Disease, Related Dementing Illnesses, and Memory Loss in Later Life; and
 - “Bathing without a battle” www.bathingwithoutabattle.unc.edu.”

Q. How are antidepressants used for depression dealt with in the new guidelines?

A. Since a psychopharmacological medication is defined as ANY medication used to manage behaviors, stabilize moods, or treat psychiatric disorders, the majority of reasons why antidepressants are used will cause these medications to

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fall within this definition. Antidepressants used to treat depression would fall under this definition because the treatment of depression is considered stabilization of mood and/or treatment of a psychiatric disorder. Falling within the definition of “psychopharmacological medication” means that the medication (including antidepressants used for depression) should be managed carefully, including periodic taper attempts OR documentation of the clinical rationale why a taper attempt would be detrimental. Tapering attempts are not an absolute requirement for psychopharmacological medications, as there is the documentation option. Nonetheless, something – either taper or documentation – must be done to address the medication’s risks and benefits. There may be exceptions. For example, use of an antidepressant for neuropathic pain might not fall under this definition. However, no matter why they’re being used, all antidepressants – whether they fall under the psychopharmacological medication definition or not, should be monitored and periodically re-evaluated to determine whether continuation is appropriate.

This is a different approach to antidepressant use than was previously surveyed and described in the old interpretive guidelines. In fact, the guidelines at F329 previously stated, “CMS continues to support the accurate identification and treatment of depression in nursing homes.” The remainder of the guidance consisted of a list of antidepressants. In addition, there has and continues to be a Quality Indicator pertaining to unrecognized and/or untreated depression: *Prevalence of symptoms of depression without antidepressant therapy*. The new guidelines are not necessarily in opposition to the old guidelines and Quality Indicator, but they merely stress the importance of monitoring and managing ALL medications, which include antidepressants. Once a medication is “protected” or “exempt” from the regulations and guidelines, they are sometimes over-utilized and/or inadequately monitored. Therefore, the guidelines treat antidepressants no differently than any other medication used in the nursing facility setting.

There is an additional statement of importance within the “Tapering” section of F329: “Sometimes, the decision about whether to continue a medication is clear; for example, someone with a history of multiple episodes of depression or recurrent seizures may need an antidepressant or anticonvulsant medication indefinitely.”

Q. How should documentation occur when a taper or dose reduction has been deemed clinically contraindicated? By Whom? What? Where?

A. First and foremost, most of the specifics regarding the documentation for clinical contraindication are NOT addressed in the State Operations Manual. Nevertheless, there are a few instances throughout the guidelines that allude to documentation. For example, the “Tapering” section of F329 describes how the pharmacist, physician, and facility staff each have opportunities to evaluate the effects of medications on a resident’s function and behavior, and to consider

whether the medications should be continued, reduced, discontinued, or otherwise modified. This is what it states specifically:

- “During the monthly medication regimen review, the pharmacist evaluates resident-related information for dose, duration, continued need, and the emergence of adverse consequences for all medications;
- When evaluating the resident’s progress, the practitioner reviews the total plan of care, orders, the resident’s response to medication(s), and determines whether to continue, modify, or stop a medication; and
- During the quarterly MDS review, the facility evaluates mood, function, behavior, and other domains that may be affected by medications.”

This provides insight into who may initiate the tapering discussion and what resources can be used to address these issues. However, it doesn’t necessarily match up with the individual designated in the guidelines to document clinical rationale. Within the discussion of tapering for each of the specific classes (i.e., antipsychotics, sedative/hypnotics, psychopharmacological medications), the guidelines specifically mention the PHYSICIAN documenting “the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident’s function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder.”

Based on the guidelines, there are some additional assumptions that can be made as to the specific information that might need to be addressed in the documentation. For example, in the “Tapering” section of F329, it states that clinical contraindication means: “The continued use is in accordance with relevant current standards of practice...” Therefore, documentation of the standard of practice, clinical practice guideline, or information reference backing up the decision to not attempt a taper would be warranted.

Generally based on the guidelines, the following pieces of information may be important to include in clinical contraindication documentation:

- Description of the resident’s target symptoms or behaviors and whether they have stabilized or improved
- Description of the resident’s functional status or capabilities and whether it has stabilized or improved
- Evidence that the dose and duration of the medication is appropriate
- Evidence that the resident is not experiencing significant adverse consequences related to the medication
- Evidence that monitoring of both efficacy and adverse consequences of the medication is occurring

Obviously if the information and documentation is consolidated in one location, it makes the surveyor’s job a little easier potentially resulting in less questions for the facility to answer during the survey. However, the guidelines do not specify a particular location within the chart where the rationale for clinical contraindication must be documented.

Q. Do medications for the treatment of bipolar disorder fall under the tapering guidelines in F-Tag 329?

A. Since the treatment of bipolar disorder, of any kind, would be considered stabilization of mood and/or treatment of a psychiatric disorder, any medication used to treat bipolar disorder would fall within the definition of “psychopharmacological medication.” Falling within the definition of “psychopharmacological medication” means that the medication should be managed carefully, including periodic taper attempts OR documentation of the clinical rationale why a taper attempt would be contraindicated. Tapering attempts are not an absolute requirement for psychopharmacological medications, as there is the documentation option. Nonetheless, something – either taper or documentation - must be done to address the medication’s risks and benefits. There is no exemption for medications used to treat bipolar disorder.