# The Schizophrenia Diagnosis in a Skilled Nursing Facility

IIf a resident in a Skilled Nursing Facility (SNF) has a diagnosis of Schizophrenia, there are ramifications and consequences of miscoding that diagnosis on the Minimum Data Set (MDS). First, to code the diagnosis, the active diagnosis criteria must be met. Per the Resident Assessment Instrument (RAI) Manual, an active diagnosis is a physician-documented diagnosis within 60 days of the Assessment Reference Date (ARD) and demonstration of supportive interventions within the seven-day lookback of the assessment. However, in the case of schizophrenia, even if a physician documents the diagnosis, the required documentation must be included to support the schizophrenia diagnosis coding. The SNF must be alert and aware of coding requirements for schizophrenia outlined for SNF billing.

The diagnosis of schizophrenia is not often a diagnosis that occurs in late life. Most patients with late-onset schizophrenia have onset of illness during middle age. Onset after age 65 usually signifies very-late onset schizophrenia-like psychosis, which is typically secondary to general medical conditions, such as dementia or other neurodegenerative disorders[KH1] . Many of the major neuropsychiatric illnesses, including schizophrenia, have a typical age of onset in late adolescence. Late adolescence may reflect a critical period in brain development making it particularly vulnerable for the onset of psychopathology. The disease is characterized by hallucinations and delusions (commonly known as positive symptoms), social withdrawal, alogia, and flat affect (negative symptoms), and cognitive disabilities.

## Which SNF Residents May have a Diagnosis of Schizophrenia?

If a facility accepts residents with neuro-psych diagnoses as a specialty, the population may be comprised of younger residents with a long-standing diagnosis of schizophrenia. In this case, the residents should have appropriate psychiatric assessments to support the diagnosis.

However, CMS has been tracking the use of antipsychotics in SNF since 2012 and has identified an increase in the number of residents diagnosed with schizophrenia while a resident. See Long-Term Trends of Psychotropic Drug Use in Nursing Homes. When residents present with behaviors found in the typical list of schizophrenia symptoms, there must be diagnostic support from appropriate physicians to justify the diagnosis. If a resident is admitted to the SNF with a diagnosis of schizophrenia from the acute care hospital, or the SNF physician writes the diagnosis of schizophrenia while a resident, the MDS Coordinator and Interdisciplinary Team (IDT) must be on alert.

Having an accurate understanding of the diagnosis of schizophrenia is essential. In SNF residents who have recently been diagnosed with schizophrenia, what is often observed is not actually schizophrenia but rather dementia with psychotic features. This does not necessarily mean that they should be prescribed antipsychotic medication.

## What if you have a resident with a diagnosis of schizophrenia?

CMS has reason to believe that some SNFs may have mislabeled residents as schizophrenic in order to potentially mask their actual rate of antipsychotic use for the Quality Measure. This could mean that some nursing homes may be using this approach to make their antipsychotic use appear lower than it actually is.

Residents with a diagnosis of schizophrenia typically receive psychotropic drugs as treatment. CMS monitors psychotropic drug usage and the processes targeted to reduce the frequency of treatment with these drugs. The use of psychotropic drugs is included in the "Quality Measure Long Stay Measures as Percent of Residents Who Received an Antipsychotic Medication." Residents who use psychotropic drugs must receive gradual dose reductions (GDRs) and behavioral interventions, unless clinically contraindicated, to try to discontinue these drugs.

There are some exceptions to the rule. Residents with a schizophrenia diagnosis, Tourette's Syndrome or Huntington's Disease are exempt from review of antipsychotic medication monitoring and requirements. A resident with one of these three diagnoses will not show on the facility's Quality Measures related to use of antipsychotic medications. The SNF will not be required to demonstrate GDR for residents that qualify for a schizophrenia diagnosis. A resident with properly coded schizophrenia will not impact the facility quality measures for Long Stay Percent of Residents who receive Antipsychotic Medication.

## What are Potential Risks of having a Resident with a Diagnosis of Schizophrenia Coded on the MDS?

Because of the steady increase in coding of residents in the SNF with schizophrenia, CMS has initiated an audit review to identify improper coding of the schizophrenia diagnosis. The consequences of having residents with a schizophrenia diagnosis in the SNF include:

- Potential risk for a CMS Audit
- If documentation is not supported the facility 5-Star Rating may be dropped to a 1-Star Rating
- There is a related impact to Quality Measures

## What are the requirements for accurately coding a schizophrenia diagnosis?

Because it is imperative that the diagnosis of schizophrenia is accurate and supported by a psychiatric consultation assessment, the MDS Coordinator should thoroughly investigate the schizophrenia diagnosis prior to coding I6000, Schizophrenia on any MDS. The July 2022 errata sheet to the RAI User's Manual includes Coding Guidance updates to for Section I Active Diagnoses in the last seven days.

The CMS document provides this example as guidance:

*"The resident was admitted without a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident's medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards.*

*Coding: Schizophrenia item (I6000), would not be checked. Rationale: Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, in accordance with professional standards (§483.21(b)(3)(i)), of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for the time period required."*

Based on this guidance, if the primary physician has documented the diagnosis of schizophrenia without consult for a psychiatric assessment, the MDS Coordinator cannot freely code the diagnosis on the MDS in I6000. This is a critical point for the entire IDT. In this scenario, the primary physician should be contacted via a Physician Query. The Coding Guidance from the RAI Manual should be shared regarding the required additional psychiatric assessment for coding schizophrenia. For most diagnoses, if the primary physician has documented the diagnosis, and the resident is receiving interventions during the assessment reference period, the MDS would be coded.

The National Institute of Mental Health (NIMH) provides information to help better understand schizophrenia. The gold standard clinical criteria for confirming a diagnosis of schizophrenia is found in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, also known as the DSM-5. Before a diagnosis can be made, a psychiatrist must conduct a thorough medical examination to rule out substance misuse or other neurological or medical illnesses whose symptoms mimic Schizophrenia.

Schizophrenia is a psychiatric syndrome characterized by positive psychotic symptoms of hallucinations, delusions, and disorganized speech. The syndrome includes negative symptoms such as decreased motivation and diminished expressiveness, and cognitive deficits involving impaired executive functions, memory, and speed of mental processing. The specific DSM-5 criteria for schizophrenia are as follows:

The presence of at least two of the following five items:

1. delusions - false beliefs that have no basis in reality.
2. hallucinations - makes them see, hear, feel, smell, or taste things that are not really there, but they feel completely real. Auditory hallucination, or hearing things that are not really happening, is the most common type of hallucination.
3. disorganized speech - inability to communicate or answer questions; thoughts may be completely unrelated or altered speech.
4. grossly disorganized or catatonic behavior.
5. negative symptoms (e.g., decreased motivation and diminished expressiveness).

At least one of the first three symptoms (delusions, hallucinations, or disorganized speech) must be present for a clinically significant amount of time during a one-month period (or less if successfully treated) to qualify for the diagnosis.

The documentation in the medical record should support continuous signs of the disturbance persisting for a period of at least six months, which must include at least one month of symptoms (or less if successfully treated). A specific challenge is if a SNF resident is discharged from the acute hospital with the diagnosis of schizophrenia with no past records.

It is important to rule out schizoaffective disorder and depressive or bipolar disorder with psychotic features. Many older residents have complicated comorbidities that can mask symptoms similar to schizophrenia. One example is a diagnosis of dementia.

Assessment of any mental or behavioral disturbance is necessary to ensure the behavior is not attributed to the physiological effects of a substance (e.g., a drug of abuse or a medication) or another medical condition.

In addition to the symptom domain areas identified in the first diagnostic criterion, assessment of cognition, depression, and mania symptom domains is vital for distinguishing between schizophrenia and other psychotic disorders. The licensed psychiatrist would be able to identify the root cause of symptom prevalence.

**What should the SNF do if the physician documents schizophrenia, but the medical records do not support all the requirements?**

In order to minimize any CMS scrutiny over mis-coding the diagnosis of schizophrenia, I6000 cannot be coded if the MDS coordinator is unable to verify that the required clinical and psychiatric assessments occurred after or before the admission. Based on the errata documentation, if the supporting documentation is not present, the diagnosis cannot be checked on the MDS.

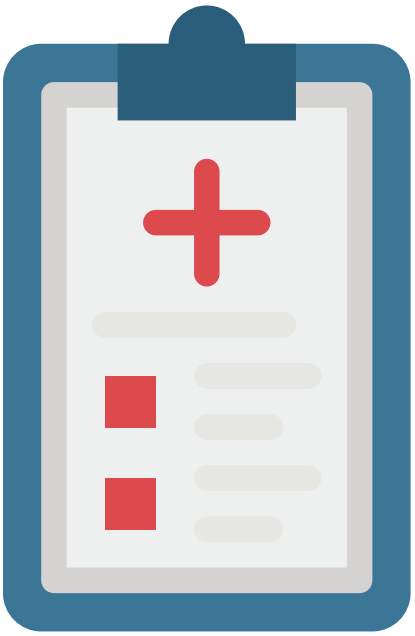
Not coding the schizophrenia diagnosis on the MDS will mean that if the diagnosis is in the record, the facility will need to initiate steps to either verify the diagnosis or change the diagnosis. For example, a psychological examination could be ordered.The resident may need implementation of GDR and non-opioid interventions to minimize behaviors. The care plans will need to support patient centered interventions and appropriate physician consults, including psychiatric consultations, will be necessary to support the documentation of the diagnosis and the prescribing of psychotropic drugs. Surveyors will be reviewing appropriate diagnosis coding and interventions. Surveyors will be looking to see appropriate follow up and actions to correct diagnoses that are not supported by sufficient clinical documentation and assessments.

If there are misdiagnoses of schizophrenia in MDS assessments, there might be a consequence of an F-tag identified upon Survey. The most common F-tags related to miscoding include: F641-Accuracy of Assessments, F658 Services Provided Meet Professional Standards, and F575 Drug Regimen is Free from Unnecessary Drugs or F758-Free from Unnecessary Psychotropic Medications/PRN Use.

If the facility has identified an error in coding in I6000, CMS does not require modification on the prior MDS; however, the interdisciplinary team must ensure coding accuracy in proceeding MDS completions.

The facility should be cognizant of the risks of coding I6000 in the event CMS audits are requested. The development of a plan of correction is recommended to educate and ensure appropriate systems are in place for proper identification and MDS coding for residents with similar symptoms to schizophrenia. If a facility chooses to not proceed with CMS schizophrenia audits, they must submit a plan of correction. Some of the root causes of incorrect coding of schizophrenia that might be identified on audit include:

1. MDS coding is not supported by documentation.
2. Physician Documentation does not support the diagnosis.
3. Psychiatric assessments are not provided.
4. Indications for medications are not supported for the diagnosis.
5. Medication management and GDR is needed.
6. There is inadequate monitoring of adverse consequences.
7. Insufficient evidence of receiving individualized nonpharmacological interventions, (unless contraindicated).
8. Behaviors are not recorded.
9. Insufficient documentation of antipsychotic use.
10. Care plans do not support care being documented.
11. Interventions are not adequate.
12. Inadequate staff training and education issues.
13. Out-dated policy and procedures.



The facility would then prepare corrective action plans to support the findings of the audit or known issues with documentation that is the reason for denying the CMS audit.

CMS is working to ensure that residents are not coded with a diagnosis of schizophrenia inappropriately.

## Resources


*Center for Clinical Standards and Quality/Quality, Safety & Oversight Group. QSO-23-05-NH - Centers for Medicare & Medicaid Services | CMS. (2023, January 18). https://www.cms.gov/files/document/qso-23-05-nh-adjusting-quality-measure-ratings-based-erroneous-schizophrenia-coding-and-posting.pdf*

*Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR). www.Psychiatry.org. (n.d.). https://www.psychiatry.org/psychiatrists/practice/dsm*

*Firman, G. (2019, December 13). DSM-5 Diagnostic Criteria for Schizophrenia. www.medicalcriteria.com. https://medicalcriteria.com/web/schizophrenia/*

*Long-Term Trends of Psychotropic Drug Use in Nursing Homes. OEI-07-20-00500 11-14-2022. (2022, November 17). https://oig.hhs.gov/oei/reports/OEI-07-20-00500.asp*

*MDS 3.0 RAI User's Manual (v1.17.1r) Errata (V2). www.CMS.gov. (2022, July 15). https://www.cms.gov/files/document/mds30raimanualv1171rerratav2july152022.pdf*

*Schizophrenia. National Institute of Mental Health. (n.d.). https://www.nimh.nih.gov/health/topics/schizophrenia*

*Sable, J. (n.d.). Antipsychotic treatment for late-life schizophrenia. Current psychiatry reports. https://pubmed.ncbi.nlm.nih.gov/12126599/*


**Does your organization need assistance with an MDS Audit focusing on the diagnosis of Schizophrenia?**

LW Consulting, Inc. can help! Our team of experts can audit your documentation & coding for residents with a diagnosis of Schizophrenia. Learn more on our website at www.lw-consult.com.

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