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Example Clinical Situations Requiring Physician Notification

Medicare requires clinicians to notify the physician of any significant change in condition.
Source: **§484.18(b) Standard: Periodic Review of Plan of Care**
G163
The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; **a significant change in condition** resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60-day episode.
G164
Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.
Interpretive Guidelines §484.18(b)
Changes in the patient's condition that require a change in the plan of care should be documented in the patient's clinical record.

Scenario Example	Communication with Physician
83 year old alert/oriented female, living alone. *Clinical record documentation:* Admitted on 11/25/08 with chronic back pain with an initial pain rating 5/10 using methadone. Initial assessment reveals a left buttock stage II pressure ulcer. Orders are SNV for daily wound care for venous stasis wound to left lower leg. SNV 12/5/08 shows increased edema and weight gain. Wound to leg increased in size by 1cm, no sign and symptoms of infection noted. Gait unsteady, pain unchanged, taught to use Tylenol as ordered. SNV 12/15/08 noted redness to right lower extremity with new open wound. Buttock wound at stage III. Back pain increased to 8/10. SNV 1/7/09 with no change to left lower leg wound, redness and open area to right lower leg resolved. Patient reported a fall on 1/7/09 with on apparent injuries. Pain to lower back continues at 8/10.	Comments: MD should have been notified after 12/5/08 visit since it appears the interventions were not working after 10 days. Example notification: ***Situation/Problem:*** Increased edema, weight gain (include actual gain), 1 cm increase in wound size ***Background:*** Admitted to home care 11/25/08. *[describe any pertinent information leading to the current problem]* ***Assessment/Analysis*** Current wound care has not decreased wound size. Edema and weight gain have worsened. *[briefly describe any pertinent information contributing to the problem]* ***Recommendation*** Review medications to see if we can reduce weight gain and edema. Review wound treatment and have wound specialist visit to make recommendations for changes. *[include any other recommendation you have that would help resolve the problem]*
79 year old alert and oriented but "forgetful" female *Clinical record documentation:* Admitted 10/20/08 for skilled nursing visits. Diagnosis includes below the knee popliteal occluded bypass graph, DM 2, insulin dependant, HTN, CAD. Insulin	Comments: MD should have been notified after 10/26/08 visit since there is a new diagnosis, new symptoms and concerns regarding compliance with blood sugar checks. Example notification: ***Situation/Problem:*** Reports recent diagnosis of glaucoma, patient

dose 70/30 38 units AM and 30 units PM, other medications included 2.5 mg Coumadin and HCTZ 25mg p.o. daily. Initial weight 125#. Lives with son, who is deaf. Client reported to nurse "she had lots of diabetic teaching and had diabetes for 25 years." Orders obtained for BID glucose checks. Refused to demonstrate ability to check glucose and did not have any record of previous checks. SNV 10/23/08 - no glucose checks recorded, patient did check for nurse with non-fasting results at 125mg/dl. SNV 10/26/08 B/P 140/80 sitting, 118/50 standing, c/o intermittent dizziness. Wt 117# noncompliant to blood sugar testing. Reported a fall in the early AM "was yelling for son but he could not hear me." Reported complaints of blurred vision, had new dx of glaucoma but not using eye drops. SNV 10/27/08 patient reported she is "on the floor every morning" not checking blood sugars and stated " did not know how."	non-compliant with blood sugar checks & eye drop instillation, blurred vision, increased dizziness resulting in falls ***Background:*** Admitted to home care 10/20/08. Diabetic for 25 years but reluctant to demonstrate ability to do blood sugar checks. Recent history of falls related to dizziness. *[describe any other pertinent information leading to the current problem]* ***Assessment/Analysis*** In spite of long history of diabetes, client unable or unwilling to do regular blood sugar checks. *[briefly describe any pertinent information contributing to the problem]* ***Recommendation*** Increase visits to daily for one week to establish blood sugar record and teach client to self-check blood sugars. PT evaluation because of frequent falls. *[include any other recommendation you have that would help resolve the problem]*

Other potential triggers for physician notification of change in condition (not intended to be all-inclusive)	
Pain issues: current pain treatment does not control or reduce the pain.	Wound not improving with current treatment regimen.
Any changes that are new to the client such as unstable gait, dizziness, loss of appetite, excessive anxiety or apathy, depression, non-compliance with treatment plan.	Vital sign changes such as orthostatic hypotension with the use of diuretics or elevated temperature with the presence of a wound or catheter.
Fluctuating blood sugars, medication & diet compliance with diabetic.	Unanticipated weight gain and edema for client with cardiac or respiratory issues.
Medications issues such as non-compliance, unanticipated response to current medications, lack of anticipated response to current medications or any issues flagged as a result of the drug regimen review.	New or changed gastrointestinal issues such as vomiting, diarrhea/constipation, blood in stools, abdominal pain, change in appetite or change in tolerance to food.
Signs/symptoms of urinary tract infection	Family issues interfering with treatment
Respiratory changes such as wheezing, shortness of breath, lung sound changes	Skin changes such as redness, new open areas, infection, and rashes
Mental status changes such as confusion, increased forgetfulness, depression, agitation, change in intellectual function	Cardiac symptoms such as changes in heart sounds or pulse rate or rhythm, angina, dizziness, syncope.
Any need for additional services including nursing, aide, therapist or social worker.	Any issues, concerns or symptoms that are a change from previous assessment.