“Management & Evaluation of the Plan of Care” G-Code

There are 4 G-Codes for determining the reason for a visit:

- Observation and Assessment
- Teaching
- Hands on Care
- Management and Evaluation of the Care Plan

One of the G-codes to choose is Management and Evaluation of the Care Plan

Management & Evaluations CMS Definition - The RN visits for “Management and Evaluation” of the care plan are skilled and the conditions/complications require a RN to ensure essential non skilled care is achieving its purpose.

Facts about Management & Evaluation of the Plan of Care

- It is fairly rare to have a patient whose plan of care meets the criteria for Management and Evaluation of the Plan of Care
- You need to speak with Manager to discuss patient prior to using “Management and Evaluation” of the Plan of Care visit code
- After speaking with the MD, use the “Management & Evaluation of the Plan of Care” narrative template and send a narrative as a separate Interim Order. The narrative template states “Physician Narrative describing the clinical justification of the need for skilled nursing for management and evaluation of the patient's plan of care:_______”

To justify Management & Evaluation the beneficiary’s care plan has to be complex:

- Management of the unskilled services being provided
- Evaluation of the effectiveness of the unskilled services
- Oversight to avoid complications
- The unskilled services must be part of the medical treatment plan

Consider using Management and Evaluation of the Plan of Care when

- Typical skilled services have ended
- Clinical risk continue to exist in the face of poorly coordinated unskilled services
- Unskilled services and/or coordination of unskilled services are required to keep the patient stable

Key Points to Assess

- What would happen to this patient if the plan of care is not implemented correctly?
- Would the patient be a risk for:
    - Hospitalization?
    - Exacerbation?
    - Premature placement in a LTC facility?
- What makes the “unskilled” part of the patient’s plan of care so complex that oversight by an RN or therapist is necessary?

- Multiple physicians involved with POC and no one physician is taking the lead responsibility
- Many unskilled tasks necessary to ensure good outcome(s) for the patient
  - GT Feedings
  - Frequent Turning
  - Titration of Medications
  - Skin inspections
  - Pro active in general!!!

What types of patients are suitable for Management & Evaluation?

- Patients with multiple medical problems
- Require high frequency of HHA for assistance
- May require other unskilled services
- Complications that may result are considered as high risk issues and/or safety concerns
- Multiple medications/High risk medications
- Multiple or very restrictive functional limitations
- Cognition deficits that contribute to the complexity of the patient's care
- Deficits of some type that render the patient in need of assistance with
  - Social concerns
  - Personal care
  - Community resources

Management & Evaluation Notes Need to Clearly State:

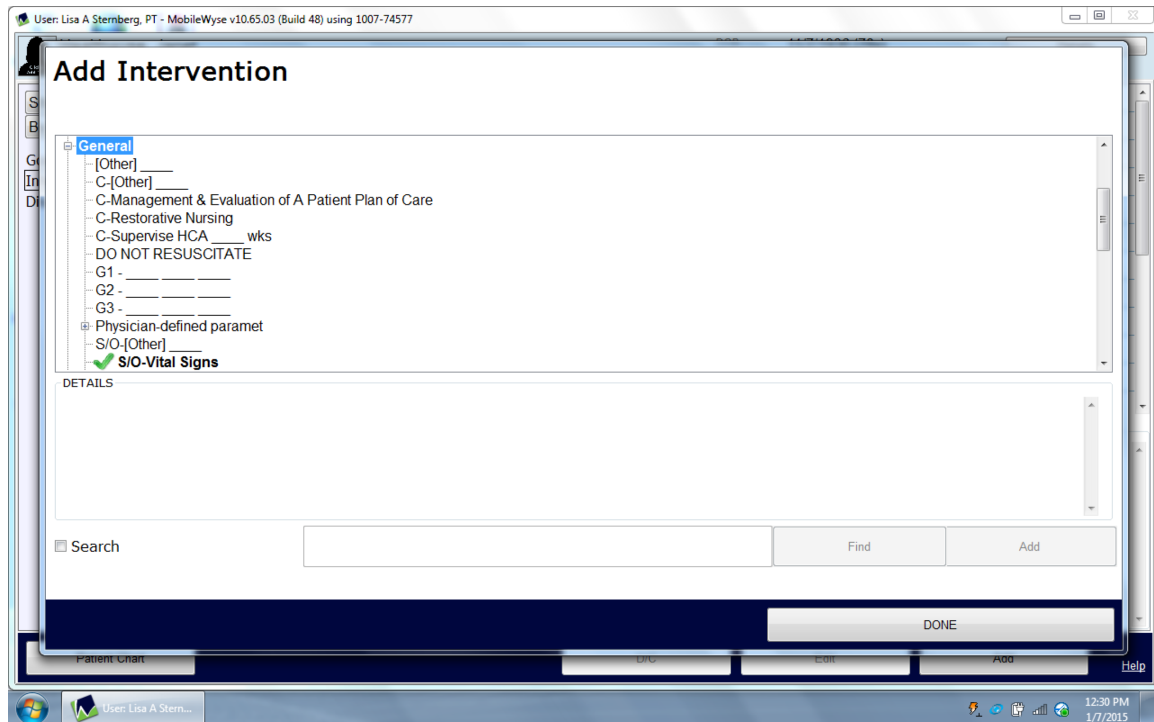
- The Plan of Care is being implemented as ordered
- The patient's medical needs are being met
- The patient's environment is being monitored to ensure medical safety and to promote recovery

Supportive documentation for Management & Evaluation should include:

- Date of Last Inpatient Stay
- Type of Facility
- Any updated information that may be pertinent
- Functional Limitations
- Unusual Home/Social Environment
- What medical conditions/exacerbations is the patient currently experiencing?
  - What did the RN do about the stated issues
  - What were the outcomes?
- Clearly state what the RN did to reduce the risk of a negative outcome for the patient:
  - What was done to reduce the risk of exacerbation of disease?
  - What was done to ensure the patient's safety and health status?

The Plan of Care/485

- An “Intervention Statement” needs to be listed in the clinical orders on the 485
- Under “Interventions” in the Plan of Care click on “General.” Choose “Management & Evaluation of a Patient Plan of Care” as an intervention under the “General.”



Suggestions for Management & Evaluation Goal

- Patient will receive adequate care to promote recovery, ensure safety and prevent hospitalizations and emergent care for the next 60 days
- Unclick the “canned” goal in MobileWyse attached to the “Management & Evaluation of a Patient Plan of Care” intervention
- The “canned” goal is not individualized for each patient and goals must be individualized for each patient

Physician Narrative needed for Management & Evaluation

- Speak with the physician to discuss the clinical justification of the need for a nurse to ensure that essential unskilled care is achieving its purpose, and necessitates a nurse be involved in the development, management, and evaluation of a patient’s plan of care due to the patient’s underlying condition or complications.
- After speaking with the physician, use the “Management and Evaluation of the Plan of Care” narrative template to create a narrative with the information you and the physician discussed above. The narrative template states “Physician Narrative describing the clinical justification of the need for skilled nursing for management and evaluation of the patient's plan of care:_______”
- Send the narrative out as a separate Interim Order.

Do Not Assign a LPN to Any Visits

- Add the following Visit Order Memo to the RN visit frequency order
    - *"No LPN, Manage and Eval Visits"*

Adding Visit Order Memo in MobileWyse

- Go to 485 VFO's
- Click on Active VFO
- Click Memo

1. Order
2. Dates
3. Clinicians
4. Memo
5. Options

Cert: 12/30/2014 to 2/27/2015

Service SN Visit

Visit 1 to

Once Every

Per Mo

For 3 Mos

Begin 12/30/2014

Adding Visit Order Memo in MobileWyse

1. Order
2. Dates
3. Clinicians
4. Memo
5. Options

Memo

No LPN, Manage and Eval visits

Visit Note

- Required elements for Management & Evaluation of the Plan of Care visit note:
    - Homebound
    - Vital signs
    - Teaching

- Communication progress towards goals
- Describe interventions/outcomes/plan

Additional Elements to include in the visit note based on individualized patient plan of care

- Nutrition/hydration Status, dietary compliance
- Medications
- Mobility/functional limitations
- Incontinence issues
- Pain
- Mental status/orientation/behaviors/memory/depression
- Skin assessment
- Hygiene
- Social interaction
- Patient/Caregiver situation-stable/unstable complex/understanding of POC, Reportables
- Safety/Risks
- Environmental factors
- Hospitalization risk
- Care coordination/communications

Call Logs - There should be additional call logs to support management and evaluation coordination of the plan of care

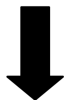
You Guessed it!!!!

- Enlist the skills of management that make you a professional!!
- Manage the care plan to assure:
    - The plan of care is carried out as the physician has prescribed
    - Essential non skilled care is achieving its purpose
    - Unskilled tasks necessary to achieve good patient outcome(s) are accomplished

What is the Top Priority for All of our Home Health Patients???

- Follow the prescribed care plan as ordered in the plan of care to achieve

Favorable Outcomes



Management and Evaluation