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MDS Alert

Medicare Compliance: Protect Your SNF Against Fiscal Illness--Code Physician Visits, Orders Correctly

Undercoding P7 or P8 can cost your resident a RUG.

Physician visits and orders can be a RUG driver, but make sure miscoding them doesn't head you into the red or a hot seat with auditors.

The frequency of physician visits coded at P7 and orders (written, phone, fax or consultation orders for new or altered treatment) at P8 can be an indicator of the clinical complexity of a resident's care. You code the number of days of physician visits at P7 and the number of days of order changes at P8 during the 14-day lookback (or since admission if the resident has been in the facility less than 14 days). Medicare Part A-stay residents who receive one or more days of physician visits and four or more days of order changes--or two or more days of physician visits plus two or more days of order changes within the lookback--may go into the clinically complex RUG category, if their total ADL score also qualifies them.

Example: During the 14-day lookback, the physician provides a phone order for a urinalysis to rule out UTI in a resident with genitourinary symptoms, says **Nemcy Cavite Duran, RN, BSN, CRNAC,** director of MDS for **William O. Benenson Rehabilitation Pavilion** in Flushing, NY. The physician visits the patient and writes an order for antibiotic therapy to treat the UTI. The physician returns a week later to visit the patient and writes an order for UTI follow-up. "That counts as three days of orders and two days of visits"during the 14-day assessment reference period, according to Duran.

The intent at P7 (physician visits) is to record the number of days within the 14-day lookback that a physician has examined a resident in the facility or the physician's office. The exam may be a partial or full exam. (Do not count exams in the emergency room.) You can count off-site evaluations of the resident by a physician (for example, during dialysis or radiation therapy). The evaluation can include a full or partial exam, monitoring the resident for response to treatment--or adjusting treatment based on the exam, according to the RAI manual.

Sidestep Top Reasons for Overcoding P7, P8

Some facilities still code the number of order changes or physician visits rather than the number of days they occurred, cautions **Rita Roedel, RN, MS**, a consultant with **BDO Healthcare Group** in Milwaukee. For example, if several specialists visit the patient on the same day, you can only count one day of visits, states the RAI manual. Do not include physician visits that occurred during the resident's acute care stay.

Another common problem: "Sometimes facilities count an order that they shouldn't," based on RAI manual instructions, comments **Jane Belt, RN**, a consultant and geriatric nurse practitioner with **Plante & Moran Swartz Group** in Dublin, OH. You can't include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes (for a rundown of coding "don'ts" for P7 and P8, see the article titled 'RAI Manual Compliance' later in this issue).

Facilities can, however, legitimately include orders requesting a consultation by another physician. **But there's a caveat:** "The order must be 'reasonable,' e.g., for a new or altered treatment," according to the RAI manual. The facility should "carefully review" an order written on the last day of the MDS observation period for a consultation planned three to six months in the future, cautions the manual. Writing orders to increase the resident's RUG classification is "not acceptable," states the RAI manual.

Stay Off the Undercoding Ropes

Overcoding physician visits and orders can a compliance headache make. But undercoding them robs your facility of well-earned PPS reimbursement. Follow these key tips to ensure you're capturing physician visits and orders where you can:

Count the days of visits by any MD, including psychiatrists and podiatrists. Also include dentists and osteopaths. "While you can't count a visit by an optometrist, you can count one by an ophthalmologist," says Roedel.

Tip: Don't forget to count nurse practitioner or physician assistant visits or order changes. "If a nurse practitioner or physician assistant visits the patient or writes an order, you can count that as a day of visits or orders," advises Belt.

Include any changes to the standard admissions orders resulting from a change in the resident's condition. You can't normally count admission orders as a day of orders. But count that day if you have to call the physician after the resident's admission because the resident's had a change in condition, Roedel says.

Example: The resident has chest pain on the day of admission and requires new orders to assess or manage the symptom, such as lab testing, an EKG, nitroglycerin or oxygen.

Remember: "Not documented means not done," cautions **Cheryl Field, MSN, RN**, a consultant with **LTCQ Inc**. in Lexington, MA. "Physician visits require documentation in the medical record," she emphasizes. If a patient is going for a procedure off-site, send a blank physician progress note with him--and request the doctor complete the documentation and send it back with the resident, Field advises.