MDS Alert

RAI Compliance: 2 Do's + 2 Don'ts Help Ensure Your Coding Won't Be Off The Mark At P7 And P8

Give your coding know-how a boost.

P7 (physician visits) and P8 (physician orders) can be tricky to code correctly unless you know the key RAI rules cold.

"We tend to see tons of errors in P7 and P8 due to misunderstanding of the coding requirements," says **Gail Robison, RN**, **RAC-C**, a consultant with **Boyer and Associates** in Brookfield, WI. But this short list of what to do and what to avoid should help improve your coding accuracy.

Do remember that P7 and P8 have a 14-day lookback. That can be a source of miscoding because most of the MDS sections have a seven-day lookback, Robison cautions.

Do count consulting physician visits and physician visits in the physician's office. But the physician has to have performed at least a partial exam for you to code it. And you need documentation of the visit and exam. "To obtain needed documentation for coding P7, some facilities send a form with the resident when he or she goes to the doctor and ask the physician [or physician extender] to fill it out," Robison says.

Coding tip: Don't count physician exams that occurred in an emergency department setting.

Don't capture physician orders from the hospital lookback. People get confused about this, Robison says, "because you do look at physician orders sometimes for clues that the resident received extensive services indicators in the hospital lookback -- for example, an order for IV fluids or IV medications." But you have to obtain clinical record documentation from the hospital that those services were actually delivered before coding the services on the MDS.

Don't code the total number of physician visits and/or order changes. Instead, code the number of days of physician visits and order changes -- no matter how many of either occurred on one day. "A resident may have an acute change in condition and have six order changes on one day, but you count that as one day," says Robison.