DAVE Tip Sheet

Common Reasons for Discrepancies:

P7—Physician Visits:

- Counting physician visits to the facility, when physician did not actually examine the resident
- Including exams that occurred in the emergency room
- Not using 14-day look-back period
- Omitting exams that occurred in the physician's office
- Omitting exams that occurred during dialysis or radiation treatments when there is a physician's progress note documenting the evaluation
- Miscalculation

P8—Physician Orders:

- Counting the number of orders versus the number of days
- Including admission orders, clarification orders or renewals without change
- Counting the different doses administered based on a written sliding scale dosage schedule
- Not using 14-day look-back period
- Omitting faxed orders
- Miscalculation

The Data Assessment and Verification (DAVE) Project

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Section P—Special Treatments and Procedures **April 2005**
Item P7—Physician Visits
Item P8—Physician Orders

Assessment Guidelines

The ***Intent*** of Item ***P7—Physician Visits*** is to record the **number of days** during the last 14-day period a physician has examined the resident (or since admission if less than 14 days ago). Examination can occur in the facility or in the physician's office. For ***P8—Physician Orders***, record the **number of days** during the last 14-day period (or since admission if less than 14 days ago) on which a physician has changed the resident's orders.

Errors in the coding of P7 and P8 may be avoided if the following are taken into consideration:

1. The physical exam may be a partial or full exam at the facility or physician's office.
2. Include evaluations by physicians at dialysis or during radiation therapy, however, documenation of the evaluation should be included in the clinical record.
3. Include written, telephone, fax, or consultation orders for new or altered treatments.
4. Count only the initial order for a sliding scale dosage schedule.
5. If several physicians visit and write several different orders on that same day, code as 1 day for a physician visit and 1 day on which orders were changed.
6. Count only the initial PRN order currently on file. Do not include the notification to the physician that the PRN order was activated.
7. Do not include examinations by a physician during an unscheduled emergency room visit. (See Item P6)
8. Do NOT include standard admission orders, return admission orders, renewal orders, or clarification orders that do not note a change.
9. Do not count visits or orders prior to the date of admission or facility reentry.
10. A monthly Medicare certification is a renewal of an existing order and should not be included when coding.
11. Do not include orders for transfers of care to another physician or orders written by pharmacists.

Reference Source: RAI Manual, Version 2.0 June 2004, pages 3-204 and 3-205

If the Following Occurs		Then Cross-Check this MDS Item
If P7 and P8 are coded 2 or higher		Then the following MDS items should be reviewed for possible coding inconsistencies: • **I2**—Infections • **J2a**—Pain Frequency and **J2b**—Pain Intensity • **J5a** and **J5b**—Stability of Conditions • **M**—Skin Conditions • **O2**—New Medications • **P1a(a-l)**—Special Care and Treatments • **P9**—Abnormal Lab Values • **Q2**—Overall Change in Care Needs
If documentation in the clinical record reflects instability of a resident		Then the following MDS items should be reviewed for possible coding inconsistencies: • **I2**—Infections • **J1**—Problem Conditions • **J2**—Pain Symptoms • **J5**—Stability of Conditions • **M**—Skin Conditions • **O1**—Number of Medications • **O2**—New Medications • **O3**—Injections • **P7**—Physician Visits • **P8**—Physician Orders • **P9**—Abnormal Lab Values • **Q2**—Overall Change in Care Needs