Historically, great deference was given to professional decision-making regarding the medical necessity for a particular service or item. The act of writing an order or signing a certification was often accepted as evidence that a physician or nurse practitioner made a clinical determination of the medical necessity for the item or service. That is no longer the case, especially for many services and items routinely ordered for geriatric patients. Requirements for documenting medical necessity to support Medicare payment are being enhanced and enforced for services and items where there is perceived risk of improper payments for unnecessary items or services.

The implications for not having the medical necessity documentation are significant under CMS’ policy for Medicare claims review. Beginning in 2009, under a new medical record review protocol, CMS demanded that its contractors performing medical record reviews strictly apply the Medicare documentation requirements. Reviewers were no longer allowed to render a finding that an item or service was medically necessary based on other available in the patient record if the specific documentation requirements needed for payment were missing, incomplete or illegible.1

A failure to provide the required medical record documentation does not, however, affect the payment to the physician or nurse practitioner. Rather, it is the provider that rendered care in response to the order who receives the denial for payment or recoupment in a payment audit. When audited, the provider is asked to include the supporting documentation of the medical necessity for the ordered item or service. Although the provider is not required to routinely maintain such documentation in its patient records, the provider must obtain the documentation from the ordering physician or nurse practitioner and submit it as part of the claims review process. It would not be surprising if providers who experience payment denials or recoupments respond by refusing to accept orders from a referring physician or nurse practitioner who routinely fails to create and/or maintain the supporting documentation of the medical necessity for the ordered item or service. This article will focus on the documentation requirements for certain commonly ordered items and services for geriatric patients that are under close scrutiny by CMS and its contractors.

Portable or mobile diagnostic testing

When residents in nursing or assisted living facilities are in need of diagnostic radiologic testing, the testing is often provided by a company that is enrolled in Medicare to provide portable diagnostic testing. The equipment is transported to the facility and brought to the bedside, rather than transporting the resident to the closest diagnostic testing center. There has been an increasing trend to deny claims, at least in part, when the documentation of the need for the test is insufficient to justify why the resident was unable to be transported to the testing center. For example, Medicare may deny the portion of the payment for transporting the equipment to the facility. Companies that provide portable x-ray testing, however, depend on that part of the payment to be able to maintain a profitable business.
Under the Medicare rules, portable x-rays are only covered by Medicare when certain conditions are met. With regard to the order for the diagnostic test, the Medicare regulations require not only that a "written, signed order specifies the reason a portable x-ray test is required, the area of the body to be exposed, the number of radiographs to be obtained, and the views needed" but also that it "includes a statement concerning the condition of the patient which indicates why portable X-ray services are necessary." It is the second part of this regulation that is gaining increased focus from CMS and its reviewers. In the past there seemed to be a presumption that residing in a nursing or assisted living facility was sufficient justification for a portable x-ray test. There are, however, many individuals residing in these types of facilities who routinely leave the facility for other health care needs, such as going to an orthopedic surgeon for a follow-up visit, the dentist, or an optometrist. For that reason, Medicare contractors are looking for specific documentation that justifies why a portable x-ray is needed.

Therefore, when ordering a portable x-ray diagnostic test, it is important to document the condition of the resident that requires the diagnostic test to be performed at the facility. This could be as simple as noting that the resident sustained a fall and transporting the resident is unsafe since the x-ray is needed to determine if the resident sustained a fracture. Similarly, the need for a chest x-ray to rule out pneumonia could be justified by documenting that the resident is bed bound.

**Hospice services**

In addition to the HHA face-to-face encounter, the ACA implemented a requirement for a hospice face-to-face encounter beginning with the 180th-day recertification (or the third benefit period) of the need for hospice services. The face-to-face visit must be performed within the 30-day period prior to this third benefit period recertification and within the 30-day period prior to any subsequent recertification.

A nurse practitioner who is employed by a hospice can perform the required face-to-face encounter visits. When documenting the face-to-face encounter, the nurse practitioner must note the clinical findings that justify the medical necessity for hospice services. Additionally, the nurse practitioner must sign an attestation that confirms that the clinical findings of the face-to-face encounter were provided to the certifying physician, for use in determining whether the patient continues to have a life expectancy of six months or less. To date, CMS has not developed examples of good and/or insufficient documentation of face-to-face encounters to support hospice payment. Some Medicare Administrative Contractors are publishing educational materials to assist with compliance.

Although not specific to the face-to-face encounter requirements, CMS recently implemented a policy change that will affect the identification of diagnoses justifying hospice services. No longer will a hospice be able to utilize "adult failure to thrive" or "debility" as the principal medical diagnosis. CMS established October 1, 2014, as the compliance effective date for this policy change. In establishing this policy, CMS noted this requirement is consistent with ICD-9-CM coding guidance. CMS further highlighted the trend over a ten-year period from use of cancer related diagnoses as the principal diagnoses for hospice to using these two diagnoses as the first and third most commonly reported diagnoses. Claims submitted after October 1, 2104, that include either "debility" or "adult failure to thrive" as the principal medical designation for hospice services will be denied.

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2 42 C.F.R. § 486.105(a)(2).
3 For more information regarding the face-to-face encounter requirements for HHA services, refer to the article "Home Health and Hospice Face-to-Face Encounter Visits," Geriatric Nursing, November/December 2011. 4 CMS quote from its website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/downloads/HospiceFace-to-FaceGuidance.pdf.
6 For more information regarding the face-to-face encounter requirements for hospice services, refer to the article “Home Health and Hospice Face-to-Face Encounter Visits,” Geriatric Nursing, November/December 2011. In addition to the face-to-face encounter visit requirements discussed in this article, CMS recently implemented a similar requirement when ordering power mobility devices. Refer to the article “Medicare Face-to-Face Encounter Rules Expand — Now Includes Additional Durable Medical Equipment Items” Geriatric Nursing, September/October 2013.
7 CMS did develop a slide presentation that highlights the requirements, which is available on CMS’ website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/downloads/HospiceFace-to-FaceGuidance.pdf.
8 For example, refer to the chart developed by CGS Administrator, LLC available on its website at: http://www.cgsmedicare.com/hhh/education/materials/pdf/hospice_ff_encounters.pdf.
diagnosis will be returned to the hospice provider to resubmit with a more definitive principal diagnosis code.

These types of changes enhancing the requirements for physicians and nurse practitioners to document the medical necessity for ordered items and services are likely to continue to increase. Utilizing best practices when recording the clinical findings during any patient visit will ensure that Medicare not only pays the nurse practitioner for the medical services provided, but also pays other providers for services in which the nurse practitioner was involved in ordering or certifying the need for the service.