AUDIT-READY RESOURCE CENTER

Medical Necessity Decision Trees

Structured guidance for distinguishing coding accuracy from coverage and medical necessity decisions.

1	**Validate the Service** Confirm the service or item is correctly coded and supported by the medical record.
2	**Identify the Coverage Question** Determine whether the issue involves indication, frequency, setting, order, duration, or another coverage requirement.
3	**Follow the Official Guidance** Apply the applicable national or local coverage policy, payer policy, CMS manual instruction, and organizational standard.
4	**Determine Medical Necessity Support** Decide whether the service is supported, not supported, unclear, or requires additional documentation or review.
5	**Document the Rationale** Record the clinical facts, policy criteria, conclusion, impact, and next action so another reviewer can reproduce the decision.

Core principle: Correct coding and medical necessity are related but separate questions. A correctly coded service may still fail coverage criteria, and a covered service must still be coded accurately.

Think Like an Auditor. Code with Intent. Defend with Confidence.

Validate the code. Apply the policy. Support the service.

Core Medical Necessity Decision Pathways

Use these pathways as a structured starting point for coverage and medical necessity review.

Clinical Indication	**Decision question:** Does the record document a condition, symptom, or clinical need that supports the service?	**YES:** Continue to policy criteria, frequency, and setting review. **NO:** Identify the missing clinical support and determine whether clarification or denial rationale is appropriate.
Coverage Criteria	**Decision question:** Does the service meet the applicable national, local, or payer-specific coverage criteria?	**YES:** Document the policy requirement and how the record satisfies it. **NO:** Identify the unmet criterion and avoid treating correct coding as proof of coverage.
Order / Certification	**Decision question:** Is a valid order, referral, certification, or plan of care required and present?	**YES:** Verify the required elements, timing, and authorized practitioner. **NO:** Identify the missing or invalid requirement and follow payer or organizational process.
Frequency / Duration	**Decision question:** Does the service frequency, quantity, or duration fall within applicable policy limits?	**YES:** Confirm the units, dates, and treatment course are supported. **NO:** Review exceptions, additional documentation requirements, or noncoverage implications.
Place of Service	**Decision question:** Is the service medically necessary in the reported setting or level of care?	**YES:** Confirm the setting is supported by the patient's condition and policy. **NO:** Evaluate whether a lower-acuity or different setting would meet the documented need.
Prior Authorization	**Decision question:** Was prior authorization required, obtained, and consistent with the service billed?	**YES:** Verify authorization details and any conditions of approval. **NO:** Follow payer policy for absent, expired, or mismatched authorization without confusing authorization with coding accuracy.

Documentation Sufficiency	**Decision question:** Does the record contain enough clinical detail to evaluate medical necessity?	**YES:** Document the supported conclusion and policy basis. **NO:** Request clarification or additional records when permitted; do not infer missing clinical facts.

Medical Necessity Review Safeguards

These safeguards help keep medical necessity decisions accurate, objective, and defensible.

Validate Coding First

Confirm the reported service, diagnosis, units, and modifiers are correctly coded before evaluating coverage.

Follow the Official Guidance

Apply the applicable CMS manual, coverage policy, payer policy, and organizational standard before reaching a conclusion.

Use the Complete Medical Record

Review orders, assessments, results, treatment history, progress, and other relevant clinical documentation.

Separate Authorization From Necessity

Prior authorization may be required, but authorization alone does not establish correct coding or medical necessity.

State the Unmet Criterion

When support is lacking, identify the specific policy or documentation element that is not satisfied.

Preserve the Audit Trail

Retain the reviewed evidence, policy source, rationale, disposition, and follow-up action.

Three Questions Before Finalizing

QUESTION 1

Does the medical record support the clinical need for the service?

QUESTION 2

Did I apply the applicable coverage policy, payer requirements, and official guidance?

QUESTION 3

Could another coder or auditor reproduce the same conclusion from the same record and policy?