

## Part B Medical Necessity for Evaluation and Management Services

1. **Federal law requires that all expenses paid by Medicare, including expenses for Evaluation and Management (E/M) services, are “medically reasonable and necessary.”**
  - Medical necessity of E/M services is generally expressed in two ways: frequency of services and intensity of service (CPT level).
  - Medicare’s determination of medical necessity is separate from its determination that the E/M service was rendered as billed.
  - Medicare determines medical necessity largely through the experience and judgment of clinician coders along with the limited tools provided in CPT and by CMS.
  - At audit, Medicare will deny or downcode E/M services that, in its judgment, exceed the patient’s documented needs.
  
2. **Information used by Medicare is contained within the medical record documentation of history, examination and medical decision-making. Medical necessity of E/M services is based on the following attributes of the service that affected the physician’s documented work:**
  - Number, acuity and severity/duration of problems addressed through history, physical and medical decision-making.
  - The context of the encounter among all other services previously rendered for the same problem.
  - Complexity of documented comorbidities that clearly influenced physician work.
  - Physical scope encompassed by the problems (number of physical systems affected by the problems).

## **Tips for Correct Coding of E/M Services Based on Medical Necessity**

### **1. Identify all the presenting complaint(s) and/or reason(s) for the visit for which physician work occurred:**

- Demonstrate clearly the history, physical and extent of medical decision-making associated with each problem.
- Demonstrate clearly how physician work (expressed in terms of mental effort, physical effort, time spent and risk to the patient) was affected by comorbidities or chronic problems listed.

### **2. Ensure the nature of the patient's presentation corresponds to CPT's contributory factors of the nature of the presenting problem and/or patient's status descriptions for the code reported. For instance:**

- 99231 – “Usually the patient is stable, recovering or improving.”
- 99232 – “Usually the patient is responding inadequately to therapy or has developed a minor complication.”
- 99233 – “Usually the patient is unstable or has developed a significant complication or a significant new problem.”

### **3. Utilize Clinical Examples in CPT Appendix C.**

- The clinical examples are believed by CPT to represent the physician work that is reasonable and necessary to provide appropriate patient care in the specified clinical circumstances of the example.
- Understand that Medicare expects actual documentation of services similar to the ones in the examples to also satisfy CMS documentation requirements to demonstrate the service billed was provided.