

Medical Necessity Documentation Standards

With the continued evolution of ICD-10 and payer policies, greater specificity is required to support medical necessity for imaging studies. As requirements shift, thorough documentation is more important than ever. Collaboration among referring providers, technologists, and interpreting physicians clinically relevant information is captured at every step.

Clear, comprehensive documentation that “tells the story” of the patient minimizes denials, reduces rework, and prevents delays in care delivery.

When describing the patient's condition, please be as specific as possible. Include:

- The **clinical indication** for the exam
- **Screening** versus **diagnostic** study
- **Location** and **laterality**, when applicable
- **Acute** versus **chronic** condition
- **Symptom details** (severity, duration, progression)
- **Clinical context** (mechanism of injury, post-op status, h/o malignancy)
- Relevant **medical history** or **concurrent conditions** affecting the current presentation

All associated signs and symptoms should be included in the dictation. When a study is normal, coders rely on the documented reason for the exam to assign the most accurate ICD-10 code. Terms such as “**fall**,” “**R/O**,” “**trauma**,” or “**MVA**” **alone** are nonspecific and frequently lead to vague code assignment, which may jeopardize reimbursement.

For follow-up studies, note interval changes, persistence of symptoms, and the clinical rationale for repeat imaging.

Attention to documentation detail strengthens coding alignment, ensures compliance, and promotes high-quality patient care.