A Practical Guide to Medical Necessity Review

This training document is a guideline—not a mandatory tract. It is intended to teach how to think through utilization review (UR) medical necessity decisions across payer types, while acknowledging that real-world ambiguity and payer variability exist, even for experts.

Purpose of This Document

- Teach a practical way to think through UR medical necessity reviews (not just memorize rules).
- Provide standards without rigidity and support consistent, defensible reasoning.
- Apply across payer types:

1. Traditional Medicare (TMCR),
2. Medicare Advantage/Medicare Replacement (MR), and
3. Commercial (under-65) plans.

- Serve as a foundation for Physician Advisors at any level—from novice to experienced to expert.
- Function as a reference framework, not a policy or checklist.

If you are looking for certainty, PA work will frustrate you. If you are willing to apply disciplined clinical judgment in an imperfect system, this guide will help.

What a Medical Necessity Review Really Is

A medical necessity review is a clinical determination of whether a patient requires inpatient (IP) hospital-level care versus outpatient or observation (OBS/OP) services. The determination is based on:

- The patient's condition (severity, stability, complexity).
- The intensity of services required (monitoring, interventions, clinician involvement).
- The risks of managing care at a lower level (deterioration, missed diagnosis, delayed intervention).
- The expected clinical course.

It is not defined by payment outcomes, screening tools alone, payer behavior, or retrospective review logic. Payment may follow defensible decisions—but it does not define them.

The Three Payer Worlds Physician Advisors Must Navigate

1) Traditional Medicare (TMCR): The Baseline Standard

Traditional Medicare provides the clearest and most consistent framework for medical necessity determinations and serves as the baseline reference point for all other payer types.

In general, inpatient admission is appropriate when the admitting physician reasonably expects the patient to require medically necessary hospital care spanning at least two midnights, based on:

- Severity of illness
- Intensity of services
- Patient-specific risk factors
- Clinical judgment at the time of admission

This is the Two-Midnight (2MN) Rule*. It is a Rule—not a guarantee. It is based on expectation, not hindsight. Exceptions exist and must be documented. Observation status is intended for short-term evaluation, monitoring, or stabilization when prolonged hospital-level care is not reasonably expected.

- The 2 MN Rule will be discussed in greater detail in a subsequent lesson.

TMCR is regulatory-driven: standards are public, consistent, and traceable to CMS guidance. The 2MN benchmark is not a slam dunk, but it offers a clearer framework than other payer environments.

2) Medicare Advantage (MA) / Medicare Replacement (MR): Regulation + Contract

Medicare Advantage plans are expected to follow Traditional Medicare coverage rules and generally to be no more restrictive than Traditional Medicare. In practice, enforcement and interpretation are inconsistent, and CMS has acknowledged limited nuances/exceptions. MR plans often apply proprietary internal policies and utilization controls that diverge from the Traditional Medicare logic and regulations.

MR is both regulatory-guided and contract-driven. This dual governance model changes how cases are reviewed, challenged, and defended:

- The rule exists, but application may be inconsistent.
- Plans may substitute internal criteria and medical policies in place of Medicare logic.
- Retrospective and concurrent denials are more common; the burden often shifts to the hospital and Physician Advisor.
- Appeals frequently hinge on documentation precision, not just clinical or even regulatory disagreement.

For Physician Advisors, the practical reality is that the documentation bar is higher. This does not invalidate the 2MN Rule; it means you must anticipate skepticism and make the reasoning unmistakable.

3) Commercial (Under-65) Plans: Contract-Driven with Clinical Overlay

Commercial payer plans (typically under Medicare age) are primarily contract-driven and are not governed by the Two-Midnight Rule. Medical necessity is defined by plan contract

language, internal medical policies, and payer-specific criteria (often including InterQual/MCG or proprietary variants).

Commercial realities include:

- Wide variability across payers and products—even for identical clinical scenarios.
- Appeals that often hinge on contract interpretation and payer policy language.
- Greater need to understand payer-specific expectations while preserving sound clinical reasoning.

The Core Truth Across All Payers

Regardless of payer type, medical necessity begins with clinical judgment. Every review comes down to three questions:

1. What is wrong with the patient? (Severity, instability, complexity)
2. What care do they reasonably require? (Monitoring, interventions, clinician involvement)
3. What is the risk of managing this patient at a lower level of care? (Deterioration, missed diagnosis, delayed intervention)

If you cannot answer all three clearly, the determination is weak.

Screening Tools: Helpful, Not Decisive

Tools such as InterQual or MCG can provide structure, highlight thresholds, and improve consistency. They do not replace physician judgment, do not override CMS standards, and do not guarantee payment. There are AI programs available but at the time of this writing, they are not considered a standard.

Guiding principles:

- Failure of criteria does not automatically mean lack of medical necessity.
- Meeting criteria does not automatically justify inpatient admission.
- They are commercial guidelines, not strict measures, although many times are considered as such and InterQual and MCG have disclaimers stating so.
- Use tools to inform—not to decide.

The Physician Advisor's Role

The Physician Advisor is not an adversary to the treating physician and not merely an auditor. The Physician Advisor is a clinical interpreter who bridges bedside care, regulatory expectations, and payer realities. Key functions include:

- Evaluating medical necessity objectively and consistently.
- Supporting defensible decisions through clear clinical reasoning.

- Educating providers on common pitfalls and documentation clarity.
- Facilitating appropriate status changes when needed.
- Reducing organizational risk without surrendering professional integrity.

A Disciplined Mental Framework for Reviews (Guideline)

This is a recommended thinking sequence, not a mandated script.

Step A: Anchor to Traditional Medicare Logic First

- Would this be defensible under Traditional Medicare?
- Is the physician expectation documented (including anticipated midnights when relevant)?
- Do severity, intensity, and risk support hospital-level care?

If the case is weak under Traditional Medicare logic, it will usually be weak everywhere.

Step B: Assess the Documentation Narrative

Strong cases tell a clear story: why inpatient resources are required and why OBS/OP is insufficient. Weak cases rely on vague language, copy-forward notes, or labs/imaging without interpretation. If the story isn't clear, the case is vulnerable.

Step C: Apply the Correct Payer Lens (Without Surrendering Judgment)

Traditional Medicare (TMCR)

- Focus on regulatory compliance and defensible physician judgment.
- Use the 2MN Rule thoughtfully, including recognized exceptions when documented.

Medicare Advantage / Medicare Replacement (MR)

- Anchor to Traditional Medicare first: would it be defensible there?
- Anticipate pushback and raise documentation clarity (risk, intensity, trajectory).
- Recognize MR as regulation + contract-driven; appeals may rely on policy/contract language.
- Do not default to a downgrade purely due to payer reputation; document to win the argument.

Teaching point: Traditional Medicare asks, "Is inpatient reasonable?" Medicare Advantage often asks, "Can you prove it—repeatedly?"

Commercial (Under-65)

- Know that coverage is primarily contract-driven and payer-variable.
- Use criteria and payer policy as inputs, while maintaining sound clinical reasoning.
- Be transparent about denial risk and what documentation strengthens the position.

Documentation Strategy That Works Across Payers

Effective documentation goes beyond listing data. It explains why inpatient-level care is required and why a lower level is insufficient. In MR and Commercial environments, clarity is survival.

- Explicitly address why observation/outpatient management is unsafe or insufficient.
- Tie comorbidities and risk factors to the need for hospital-level monitoring and intervention.
- Avoid ambiguous language (e.g., "rule-out," "monitor") without risk framing.
- State physician intent clearly, including expected course when relevant.

Status Changes and Escalation (Guideline)

Status changes are appropriate when new information emerges or the original expectation changes. They should not be used as a reflex response to payer pressure or as a retroactive fix for weak reasoning.

Early escalation is often the highest-value move a Physician Advisor can make.

What This Guide Is—and Is Not

This guide IS:

- A thinking framework
- A teaching foundation
- A reference for disciplined judgment
- Adaptable to different hospitals and payer mixes

This guide IS NOT:

- A policy
- A checklist
- A denial-prevention guarantee
- A substitute for professional judgment and experience

Final Perspective for Physician Advisors

Each payer asks a slightly different question:

- Traditional Medicare (TMCR): "Is inpatient care reasonable under federal standards?"
- Medicare Advantage / Replacement (MR): "Is inpatient reasonable—and can you prove it within our contract interpretation?"
- Commercial Plans: "Does this meet our policy—and can you defend it clinically?"

The Physician Advisor's job is not to eliminate uncertainty, but to manage it intelligently through sound judgment, disciplined reasoning, and clear documentation.

How to Use This Document

- Read it early in your PA role.
- Return to it when cases feel unclear.
- Use it to teach and mentor others.
- Adapt it to your organization's workflows.
- Do not treat it as scripture.

Medical Necessity Review: A Playbook Step-by-Step Process

This playbook is the desk-ready 'how-to' process. It intentionally excludes background lecture and focuses on a repeatable workflow that works across Traditional Medicare, Medicare Advantage, and Commercial payers. Use it as a guideline, not a rigid script.

What You Are Trying to Answer

You are deciding whether the patient requires:

- Inpatient (IP) level of care, or
- Observation / Outpatient (OBS/OP) level of care

Your output should be:

- A clear recommendation (IP vs OBS/OP).
- A short, defensible rationale that could survive external review.

Step 1 — Confirm the Basics (30 seconds)

- Patient identifiers (name/MRN/date of service)
- Current status: IP or OBS/OP
- Admission time and timing markers (including "midnight count" when relevant)
- Primary payer type: TMCR / MR / Commercial
- Care setting (ED, OBS unit, med-surg, ICU)—helps interpret intensity

If you don't know payer type and timing, you can't frame the review.

Step 2 — Start With the Reason for Hospital Care (H&P First)

Read the H&P or ED physician note before labs. Extract and write down:

- Why here today? (chief problem + trigger event)
- Clinical severity (vitals, exam findings, mental status, oxygen requirement)
- Key comorbidities that raise risk (e.g., CHF, COPD, CKD, frailty, anticoagulation)
- Working diagnosis vs "rule-out" language
- What could go wrong if managed outpatient?

If the presenting story is vague, the case is vulnerable.

Step 3 — Identify the Required Hospital-Level Services

Use orders, MAR, and nursing flowsheets. List what the patient is actually receiving that suggests hospital-level intensity:

- Continuous or high-frequency monitoring (telemetry, frequent neuro checks, etc.)
- IV medications requiring monitoring (pressors, IV antiarrhythmics, drips, etc.)
- Frequent interventions or reassessments tied to risk (not just 'serial labs' without context)
- Oxygen escalation or respiratory support
- Procedures/consult-driven plans that require inpatient setting
- Nursing workload signals (delirium, falls, frequent PRNs, instability)

Translate services into the key sentence: why OBS/OP is insufficient.

Step 4 — Determine Trajectory and Expected Course (The Pivot)

Use progress notes, consultant notes, and trends. Ask:

- Is the patient improving quickly or still unstable?
- What is the plan for the next 24–48 hours?
- What still must happen before safe discharge?

This step prevents 'admit because it feels right' decisions.

Step 5 — Apply the Right Payer Lens (Keep It Simple)

If Traditional Medicare (TMCR)

- Does the physician reasonably expect 2+ midnights of medically necessary hospital care?
- If not, is there a defensible exception that is documented?

If Medicare Advantage (MA/MR)

- Is this defensible under Traditional Medicare first?
- Is the documentation explicit enough to withstand a tougher reviewer?
- What is the appeal risk, and what documentation should be strengthened today?

If Commercial (Under-65)

- What does this plan typically require for IP in this scenario (policy/criteria)?
- Do we meet criteria—or do we need a stronger risk/intensity narrative?
- If criteria aren't met, is IP still defensible based on instability/intensity, or is OBS more appropriate?

Do not let payer cynicism replace clinical judgment. But don't ignore predictable denial behavior either.

Step 6 — Use Criteria Tools as Support (Not the Boss)

- Check criteria after you understand the case.

- If criteria are met: document that briefly (avoid pasting walls of text).
- If criteria aren't met: decide if the case is still defensible based on risk/intensity/trajectory.

Tools support consistency. They don't replace reasoning.

Step 7 — Decide: IP vs OBS/OP (Make the Call)

Make the decision plainly.

IP is generally supportable when:

- Instability + hospital-level services + expected course suggests prolonged care
- Risk of deterioration is meaningful
- The plan requires ongoing inpatient resources

OBS/OP is generally supportable when:

- Diagnosis is uncertain and requires short-term evaluation
- Patient stabilizes quickly and the plan has a short horizon
- Services are limited to brief monitoring/diagnostics

If truly on the fence, recommend short-interval reassessment (e.g., after the next midnight, after consult results, after imaging).

Step 8 — Identify Fixable Documentation Gaps (High-Value PA Move)

Most status problems are documentation problems. Common gaps to address today:

- No clear statement of expected hospital course
- "Rule-out" language without risk framing
- Weak explanation of why OBS is insufficient
- Missing comorbidity impact (frailty, CKD, CHF, baseline oxygen, etc.)
- Orders/monitoring intensity not reflected in the note

Often your job is to help the treating physician say what is already true.

Step 9 — Escalate When Needed (Don't Be the Lone Ranger)

Escalate to the right people early:

- Treating physician (clarify intent/course)
- UR leadership (system/process issues)
- UR committee pathway (if status conversion is required)
- Case management (discharge barriers driving LOS)
- Coding/CDI (diagnosis clarity affecting necessity narrative)

Early escalation beats late cleanup.

Step 10 — Write the PA Determination Note (Short, Repeatable Format)

Keep it simple. Five sentences is often enough:

4. Patient summary (problem + acuity)
5. Key risk factors/comorbidities
6. Required hospital-level services (intensity/monitoring)
7. Expected course / why OBS is insufficient
8. Recommendation (IP vs OBS/OP) + timing for reassessment if applicable

A 'Fill-in-the-Blank' Determination Template (Teaching Tool)

- Clinical Summary: _____
- Severity/Risk: _____ (vital instability, comorbidities, deterioration risk)
- Intensity of Services: _____ (monitoring, IV therapies, procedures)
- Expected Course: _____ (why ≥2 midnights / why short-term)
- Recommendation: _____ (IP vs OBS/OP)
- Next Review Trigger: _____ (after midnight, after consult, after imaging, etc.)

Quick Quality Check (10 seconds)

- If I removed acronyms, would a reasonable clinician understand my logic?
- Did I explain why a lower level of care is insufficient?
- Would this make sense to a skeptical payer reviewer?

If yes, you've done real work.

© 2026 Streamline Solutions Consulting, Inc. All rights reserved. Licensed for individual use only. Redistribution prohibited.