

Specialty Writing Task #1: Medical Necessity (MN)

Track: Medical Necessity Appeals

Subject: Inpatient Status, Two-Midnight Rule, and CMS-4201-F

Case Scenario

Payer: UnitedHealthcare (UHC) Medicare Advantage

Patient: Robert Miller, 74-year-old male

Admission Diagnosis: Sepsis secondary to Urinary Tract Infection (UTI)

Clinical Course:

Mr. Miller presented to the Emergency Department with a temperature of 102.4°F, tachycardia (HR 112), and altered mental status (baseline alert/oriented x4). Laboratory findings included WBC 16.5k and lactic acid of 2.8. His medical history is significant for congestive heart failure (CHF) and chronic immunosuppression due to rheumatoid arthritis.

The physician admitted the patient to inpatient status, citing the need for aggressive IV fluid resuscitation and parenteral antibiotics. Due to the patient's immunosuppressed status and the increased risk of fluid overload related to CHF, the physician documented the need for frequent lung auscultation and strict intake/output monitoring. The physician expected the hospital stay to span at least two midnights. The patient ultimately required a 50-hour stay due to a slow return to mental baseline.

Denial Rationale:

"Clinical documentation does not support inpatient level of care per commercial utilization review criteria (e.g., MCG). The patient did not demonstrate persistent hypotension or multi-organ failure. Services could have been safely managed in Observation."

II. Writing Task

In **300 words or less**, write a clinical medical necessity rebuttal using a formal, professional appeal tone.

Your response must:

1. **Regulatory Compliance**
Cite applicable CMS authority (including 42 CFR § 422.101, 42 CFR § 412.3, and CMS-4201-F as appropriate) to support that Medicare Advantage plans must follow Medicare coverage standards.
2. **Clinical Defense**
Defend the inpatient admission based on the physician's reasonable expectation at the time of admission, including expectation of a two-midnight stay.
3. **Risk-Based Justification**
Explain how CHF and immunosuppression created elevated risk requiring hospital-level monitoring and careful resuscitation.
4. **Invalidation of Denial**
Explain why reliance on proprietary utilization review criteria represents a more restrictive, non-Medicare standard that conflicts with federal coverage requirements under 42 CFR § 412.3.

III. Instructor Reference: Expert Benchmarks

High-performing responses will demonstrate:

- **At-Admission Perspective**
The physician's decision is defended based on expected clinical course at the time of admission, not retrospective outcomes.
- **Iatrogenic Risk Framing**
CHF is presented as an active constraint on fluid resuscitation, requiring monitored care to prevent complications such as pulmonary edema.
- **Regulatory Hierarchy**
Medicare Advantage plans must follow CMS requirements and cannot apply proprietary criteria in a manner that is more restrictive than Medicare coverage standards.
- **Two-Midnight Presumption (Advanced)**
Recognition that a stay exceeding two midnights (greater than 48 hours) supports inpatient status under CMS's Two-Midnight Presumption.
- **Clear Distinction of Standards**
Medicare coverage criteria are clearly differentiated from proprietary utilization review tools.

IV. Scoring Rubric (Total: 100 Points)

A. Regulatory Application (21–25 points)

- Correctly applies CMS regulatory authority (including 42 CFR §§ 422.101 and 412.3 and/or CMS-4201-F)
 - Demonstrates that Medicare Advantage plans must follow Medicare coverage standards
 - Identifies that proprietary criteria cannot be applied in a more restrictive manner than federal requirements
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B. Defense of Physician Judgment (17–20 points)

- Clearly references decision-making at the time of admission
 - Supports expectation of a two-midnight stay
 - Avoids reliance on retrospective outcomes
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C. Risk Stratification (17–20 points)

- Explains how CHF increases risk during fluid resuscitation
 - Links immunosuppression to increased clinical complexity
 - Supports need for hospital-level monitoring
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D. Denial Rebuttal (17–20 points)

- Identifies proprietary criteria (e.g., MCG) as more restrictive than CMS guidance
 - Explains why requiring organ failure exceeds Medicare requirements
 - Clearly challenges the validity of the denial rationale
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E. Professional Writing (13–15 points)

- Uses formal, medically and legally appropriate language
 - Maintains clear structure and logical flow
 - Adheres to the 300-word limit
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Critical Scoring Note

Failure to demonstrate CMS regulatory authority over Medicare Advantage coverage, or failure to identify reliance on proprietary utilization review criteria as an inappropriate primary standard, may result in the response being marked incorrect regardless of total score.

V. AI Grading Prompt

Role: Physician Advisor evaluating a certification candidate

Task: Grade the submission based on clinical reasoning and regulatory accuracy

Evaluation Requirements:

- Evaluate only what is explicitly stated; do not infer unstated reasoning
- Confirm correct application of CMS regulatory hierarchy
- Assess whether clinical risk supports inpatient level of care
- Confirm that proprietary criteria (e.g., MCG) are identified as an inappropriate primary standard when applied more restrictively than Medicare requirements

Evaluation Checkpoints:

- Does the response apply CMS authority to Medicare Advantage requirements?
- Is physician decision-making clearly framed at the time of admission?
- Are comorbidities used to support risk-based inpatient care?
- Is the denial rationale challenged as more restrictive than CMS standards?

Constraints:

Do not evaluate coding or DRG accuracy. Focus only on medical necessity.

Output Required:

- Domain Scores
- Total Score
- Pass/Fail (≥ 75)
- Specific technical feedback