COMMUNITY HOSPITAL SYSTEM | SOUTHEAST U.S. | MEDICAL NECESSITY REVIEW

Sayvant Reflect: Real Time Medical Necessity Analysis

A medium-sized community hospital system in the Southeast partnered with Sayvant to analyze 1,000 recent admissions (inpatient and observation) for medical necessity strength, and pre-flag potential denial risk.

BACKGROUND

Representative community hospital system

Four hospitals ranging from 2,000 discharges to 12,000 discharges per year, with shared emergency and hospital medicine coverage, and payer mix shifting away from commercial payers. Leadership contending with Length of Stay and Case Mix Index performance.

THE PROBLEM

Under-resourced UM

Case management was available from 9am to 4pm on weekdays. Utilization reviews often queued for days while documentation propagated from admission to follow-on progress notes, leading to increased rework and variable documentation quality.

THE COST

Denials landed months later

The system saw increases in medical-necessity denials consistent with industry trends (+70% YoY, per MDAudit). Documentation for 50%+ of denials was deemed insufficient for credible appeal.

$1.59m

in Sayvant-identified medical necessity denial exposure per 1,000 discharges

22%

of charts contained insufficient clinical narrative to defend the requested level of care

$598k

in short-stay medical necessity exposure per 1,000 discharges (14% of admissions)

KEY FINDING

39% of admissions had significant gaps in medical necessity documentation that resulted in downstream case management rework or denials.

RESULTS

Analyzing strength and defensibility of medical necessity

Sayvant Reflect evaluated 1,000 admission notes for adequate level-of-admission support, calculated potential denial exposure, and identified prescriptive opportunities for improvement.

- **96% of observation stays were supported as placed.** Documentation gaps were heavily weighted toward inpatient stays with poor justification.
- **Only 70% of charts defended the two-midnight expectation.** Clearly stating the expected stay and reasoning for full inpatient admission is the single largest lever for improvement.
- **The top 20% of charts carry 66% of total exposure.** Focusing on high-risk areas (top 30 admitting diagnoses, short stays) would drive significant improvement without scaling commensurate review burden.
- **19% of charts documented an expected stay under two midnights against a DRG mix with a 3-day GLOS.** A reviewer would conclude that the documentation undersells the severity, or a short-stay exception applies but has not been documented.

Results: Medical Necessity Analysis

STATUS	CHARTS	SHARE
Supported	450	45%
IP, requires stronger documentation	**326**	**33%**
OBS, requires stronger documentation	**72**	**7%**
Not IP eligible	104	10%
Not OBS eligible	6	<1%
Unclear (escalated to case management)	42	4%

The 33% of inpatient charts in the second row hold the most exposure: supportable admissions based on clinical facts in the chart, but documentation was weak. Reflect highlights missing rationale and narrative inferred from chart evidence.

The Sayvant Reflect Difference

1

Analyzes charts in real time

Reads the full note in seconds and extracts the elements of the clinical narrative pertinent to determining medical necessity.

2

Assesses medical necessity

Compares the clinical narrative to level-of-admission criteria specific to the site or hospital system, backed by CMS and society guidelines.

3

Delivers improvement opps

Shows UM and physician teams where the chart stops short of the care they delivered, and how to strengthen documentation to better reflect reality at the bedside.

Methodology. Based on Sayvant Reflect analysis of de-identified inpatient and observation admission notes across four community hospital sites, reviewed as written; exposure figures are expressed per 1,000 discharges. Modeled exposure prices a supported but thinly documented inpatient note at the inpatient-observation payment differential ($4,300 × DRG weight) and an unsupported or weakly supported observation stay at its full payment ($2,700 × weight), on CMS FY2026 IPPS relative weights. Findings that depend on a physician's response to a query are reported as conditional and excluded from every figure above.

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