Lesson 6 - The Narrative Control Technique

A simple three-step communication strategy allows the Physician Advisor to guide the conversation effectively and maintain focus on clinical reasoning.

Step 1 — Ask Permission to Summarize the Case

At the beginning of the call, ask:

"Before we get into the specifics of the denial, would it be okay if I briefly summarize the clinical scenario so we are discussing the same case?"

This accomplishes two important goals:

• It sets a collaborative tone rather than an adversarial one.
• It allows the Physician Advisor to **frame the clinical context before the denial rationale dominates the discussion**.

Most reviewers will agree to this request.

Step 2 — Deliver a Structured 20–30 Second Summary

The summary should emphasize three key elements:

1. **The clinical problem**
2. **The risk to the patient**
3. **The intensity of treatment required**

Example structure:

"This patient presented with severe abdominal pain and significant hematochezia while anticoagulated for prior pulmonary embolism. His white blood cell count increased significantly with bandemia concerning for infection, and he required NPO status, IV fluids, and broad-spectrum IV antibiotics. During hospitalization he was found to have gram-negative bacteremia requiring escalation of care and transfer to a higher level of care."

This approach keeps the discussion focused on:

• clinical severity
• infection risk
• treatment intensity
• physician decision-making

Step 3 — Invite the Reviewer's Perspective

After presenting the summary, ask a collaborative question:

"Based on that clinical picture, can you help me understand the reasoning behind the observation determination?"

This question shifts the discussion into a **professional dialogue** and encourages the reviewer to respond within the clinical framework that has already been established.

A Common Reality in Peer-to-Peer Reviews

During many P2P discussions, a payer medical director may say something like:

"I only reviewed the admission documentation or the first day of the hospitalization."

While this comment can be frustrating, experienced Physician Advisors recognize an important reality:

Many initial denials are made using limited early clinical information.

In some cases, the reviewer may not have reviewed:

• the entire hospital course
• culture results
• consultant recommendations
• complications that developed later
• the final discharge summary

Even when that information exists in the record, it may not have been reviewed during the initial determination.

Turning Limited Review into an Opportunity

Rather than becoming frustrated when a reviewer indicates they only reviewed early documentation, experienced Physician Advisors recognize this as an opportunity.

A calm and professional response might be:

"I understand. Since the initial determination was based on the admission documentation, it may be helpful to review how the patient's clinical course evolved during the hospitalization."

This approach allows the Physician Advisor to introduce important developments such as:

• new diagnostic findings
• evolving infection
• culture results
• escalation of treatment
• specialist consultations
• transfer to higher levels of care

Providing this additional context often helps the reviewer understand the **full clinical picture**.

Clinical Trajectory Framing

One of the most powerful concepts Physician Advisors can use during P2P discussions is **clinical trajectory framing**.

Clinical trajectory refers to **how the patient's condition evolves over time**, rather than evaluating the patient based only on the initial presentation.

Many payer denials rely heavily on early data points such as:

• initial vital signs
• the first set of laboratory values
• the first few hours of documentation

However, these represent only a **snapshot** of the patient's condition.

Physicians must evaluate **where the patient is likely headed**, not just where the patient is at a single moment.

Why Clinical Trajectory Matters

Many serious medical conditions evolve gradually.

Early in the course of illness:

• vital signs may still appear stable
• laboratory abnormalities may be minimal
• complications may not yet be evident

Despite this, the treating physician must consider:

• risk of deterioration
• likelihood of complications
• need for monitoring and intervention

Admission decisions are therefore based on **anticipated clinical risk and expected disease progression**, not solely on initial data.

Explaining Clinical Trajectory During a P2P

A useful structure for presenting the clinical story is:

1. Presentation

What the patient looked like at arrival.

2. Risk Assessment

The clinical concerns that justified admission.

3. Clinical Course

How the patient's condition evolved during hospitalization.

Example:

"At presentation the patient had abdominal pain and hematochezia with rising leukocytosis concerning for infection. Because of these risk factors, the treating physician admitted the patient for monitoring and IV therapy. During hospitalization the patient was found to have gram-negative bacteremia, confirming that the concern for serious infection was clinically justified."

This structure helps the reviewer see the admission decision as part of a **continuum of care**.

Teaching Insight for Physician Advisors

A helpful perspective for Physician Advisors is this:

Payers often review a snapshot of the patient.
Physicians must evaluate the patient's trajectory.

Understanding this distinction helps Physician Advisors communicate the reasoning behind admission decisions more effectively.

Practical Rule Used by Experienced Physician Advisors

Many experienced Physician Advisors follow a simple rule:

"Control the first 30 seconds, control the conversation."

If the payer defines the patient as **"stable with mild symptoms,"** the remainder of the discussion often becomes an effort to reverse that characterization.

When the Physician Advisor defines the clinical narrative first, the conversation becomes centered on **patient risk and clinical judgment**.

Key Takeaways

- The first 30 seconds of a P2P set the tone for the discussion.
- Establish the clinical narrative early.
- Focus on **risk, trajectory of illness, and treatment intensity**.

• Maintain a professional and collaborative tone.
• Use the full clinical course to explain the admission decision.

When used consistently, this approach helps ensure that P2P discussions remain focused on **clinical reasoning and patient safety** rather than isolated data points.

Closing Thought

Peer-to-peer discussions are not debates about isolated laboratory values or vital signs.

They are professional conversations about **clinical judgment and patient care**.

When Physician Advisors clearly explain the **patient's risk, trajectory, and treatment needs**, the medical necessity of hospital admission often becomes much easier to recognize.

© 2026 Utilization Management University. All rights reserved. Licensed for individual use only. Redistribution prohibited.