

AMRPA

AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

IRF Boot Camp

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Know Your Writes: Winning Documentation and Appeals



Three points where care or payment is denied

Stage	Payer decision	IRF response
Before admission	MA plan declines authorization	Clinical rebuttal and timely appeal before transfer when possible.
During the stay	Plan denies additional covered days	Send current progress and continued need; appeal disputed days.
After payment	Medicare reviewer or MA plan questions the claim	Answer the precise audit issue and protect appeal and cash timelines.

Preadmission Denials

MA authorization before the patient arrives

A denial of the IRF level of care calls for a clinical argument tied to this patient.



Four Common Preadmission Denial Reasons

Plan rationale	What the IRF must establish
Unlikely to benefit from intensive rehabilitation	Potential for measurable functional improvement and ability to engage with the program.
Does not require multiple therapy disciplines	Active, ongoing need for at least two disciplines; one must be PT or OT.
SNF or lower level sufficient	Why physician supervision, rehab nursing and coordinated intensity matter.
Cognition limits participation	How cueing, communication support and therapy adaptation permit participation.

Preadmission Evidence that Answers the Denial

What to show	Record source
Prior function, new deficits and specific goals	Acute care notes, therapy evaluations and preadmission screen.
Medical risk needing rehabilitation physician management	Active diagnoses, medication changes, monitoring and orders.
Need for more than one therapy discipline	Distinct discipline goals and coordinated treatment plan.
Capacity to participate despite cognitive barriers	Observed engagement, cueing response and realistic learning strategy.

Peer to Peer: an Informal Clinical Opportunity

Process	Benefit	Limitation
Plan offers reviewer discussion. Schedule the IRF rehabilitation physician and confirm case details.	Can correct an incomplete or misunderstood record quickly.	Availability and scheduling follow plan workflow; a call does not replace formal appeal.
Present the denial sentence, patient function and physician/nursing need.	Direct clinician dialogue permits targeted clarification.	Record name, specialty, time, outcome and promised written action.

Ask for the written determination and keep the formal deadline on the calendar.

Physician Reviewer Requirements: Precise Distinction

Decision	Federal standard
Initial adverse medical necessity determination	Physician or other appropriate health professional with expertise suited to the service and knowledge of Medicare criteria.
Plan reconsideration of a medical necessity denial	Physician with expertise in the field of medicine appropriate to the service.

Expedited Reconsideration: When and How

Question	Operator answer
When is expedited review appropriate?	When waiting for a standard decision could seriously jeopardize health, life or ability to regain maximum function.
Who requests it?	Enrollee or representative, or physician acting for the enrollee as allowed by Part C rules.
How fast must the plan decide?	Generally as quickly as health requires and no later than 72 hours, subject to applicable extension rules.
If the plan upholds the denial?	The plan forwards an adverse reconsideration to the Part C independent review entity.

Preadmission Appeal Clock

Event	General deadline	IRF action
Initial authorization request	7 calendar days standard; 72 hours expedited	Submit the full clinical packet and retain receipt.
Adverse decision to plan reconsideration	Generally 65 calendar days from notice	File promptly; make a separate urgency request when clinically justified.
Plan reconsideration decision	30 days standard preservice; 72 hours expedited	Track receipt, reviewer contact and written result.
Adverse plan reconsideration	Automatic Part C IRE referral	Verify case transfer and complete supporting record.

Winning Argument: Anticipated Benefit

Denial: “Cannot benefit from intensive rehabilitation.”

Weak statement	Stronger, record based statement
Patient is motivated.	Patient followed two step cues in three therapy sessions and improved transfers from maximal to moderate assistance.
Patient needs therapy.	PT and OT have distinct mobility and self care goals; active physician management permits safe participation.
Patient has dementia.	Baseline cognition, observed cueing response and realistic task learning show meaningful rehabilitation potential.

When Authorization is Won but Payment is Denied

Find the break in the chain	Next operational step
Initial denial and successful reconsideration / IRE result	Retain every decision and the exact dates and services approved.
Final authorization versus claim adjudication	Demand the written payment denial reason and identify whether the issue is coverage, coding, additional days or contract terms.
Plan payment refusal despite upheld authorization	Escalate with the approval record, 2026 reopening rule and contract; use the correct provider or enrollee appeal route.

An upheld admission authorization does not, by itself, resolve every later claim or additional day dispute.

Preadmission Operations: What to Track

Field	Why it matters
Plan, product, network status and diagnosis	Find payer and case mix patterns.
Denial reason and reviewer criteria	Target the rebuttal and monitor recurring rationales.
Request, peer call, appeal and decision timestamps	Protect deadlines and document response time.
Physician participant and written authorization	Preserve clinical discussion and approved date range.
Ultimately admitted, paid and appealed outcome	Measure access and revenue, not overturns alone.

Rehabilitation Physician and Medical Director

Before a call

Review the denial language and evidence the reviewer may have missed.

During the call

Explain the need for physician oversight, nursing management, multiple therapies and expected benefit.

After the call

Document the clinical points made, reviewer response and any change to authorization.

At program level

Review trends by plan and coach the team on recurring documentation gaps.

Admitting without MA preauthorization

Potential reason to consider	Exposure to assess
Delay threatens timely access to appropriate care.	Plan may deny payment; contract may require prior authorization.
Clinical team has strong IRF evidence and an appeal is underway.	Financial loss, collections limits and beneficiary liability rules may apply.
Leadership elects to assume the risk after review.	Need a documented clinical, financial and contract decision with clear ownership.

Escalate the decision to hospital leadership and revenue cycle before admission when time permits.

Continued stay denials

Authorization for additional covered days during the stay

An initial approval may cover only a short interval. The next review depends on current evidence.



The Reauthorization Cycle

Before current days expire	Submission	After the plan responds
Know the last authorized day and the plan's update deadline.	Send progress, active medical needs and reason for further intensive care.	Save the decision, newly approved dates and any adverse rationale.
Set an internal deadline earlier than the payer cutoff.	Use secure portal or required channel and keep proof of receipt.	Escalate a denial immediately for clinical discussion and formal appeal.

A Continued Stay Update Answers Four Questions

Progress

What changed in transfers, gait, self care, swallowing or communication?

Participation

How did the patient engage, including after a medical interruption?

Medical need

What does the rehabilitation physician manage, and what does nursing do between therapies?

Remaining work

Which goals and discharge barriers require additional IRF days?

Example: a temporary therapy setback

Day	Record fact	What to submit
5	Orthostasis limits morning sessions.	Physician assessment, intervention and nursing monitoring.
6	Therapy resumes after medication adjustment.	Actual participation and response to revised plan.
7	Gait and transfers improve; stairs remain unsafe.	Current function, discharge goals and requested days.

A missed session needs a clinical explanation and a plan, not merely a therapy-minute tally.

Continued Stay Denial: Appeal Route

Plan decision	Action
Additional future days denied	Request expedited plan reconsideration when the urgency standard is met; submit day specific clinical evidence.
Termination of preauthorized inpatient hospital coverage	Evaluate the beneficiary's timely BFCC QIO fast review rights and required notices.
Payment denied after discharge	Identify the claim and applicable plan / provider dispute route; preserve authorization history.

Postpayment denials

Medicare audits, MA reviews and clawbacks

**Technical errors and medical necessity
are the focus of this section.**



Postpayment Denial Categories

Category	Examples	This session's focus
Administrative / payment	Wrong insurance, duplicate claim, coordination, rate or coding.	Separate claim correction from a medical appeal.
Technical IRF record	Missing or untimely required records, signatures or team documentation.	Build the complete chronology and verify the exact rule.
Medical necessity	Intensity, benefit, lower level of care and physician/nursing need.	Answer the clinical rationale with contemporaneous facts.
Clawback	Previously paid amount reversed or offset.	Identify basis, math, authority and appeal or contract route.

Original Medicare Review Programs

Program	What it does	IRF response
RAC	Reviews approved issues for improper payments.	Check issue scope, record request and discussion/appeal clocks.
CERT	Samples claims to measure improper payment.	Supply complete record; monitor MAC correction.
TPE	MAC targeted review with provider education.	Learn from each round and fix future documentation.
UPIC	Investigates program integrity concerns.	Centralize and preserve communications and records.
SMRC	Performs CMS directed medical reviews.	Respond to the issue and documentation request.
IRF RCD	Preclaim or postpayment review demonstration.	Track choice, affirmations and claim disposition.

RAC, CERT and TPE: how the response differs

Review	First question	What follows
RAC	Is the issue on the approved list and was the requested record complete?	Discussion where available, adjustment and formal FFS appeal.
CERT	Which sampled claim and evidence did CERT request?	A sampled error estimate; MAC may correct the claim.
TPE	What error pattern did the MAC identify?	Claim review plus education; correct the next cohort.

Most Common Denials

Denial	Appeal evidence
Cognitive impairment means no likely benefit	Observed participation, cueing, prior function and realistic gains.
No reasonable expectation that patient will be able to participate and benefit from intense rehab program	Clinical interruptions, medical response and expectation of benefit, participation in therapy 3- hour rule
No need for multidisciplinary care	Specific physician management, rehabilitation nursing and coordinated therapies.
Technical denials	Physician not seeing patient for 3 face to face visits, POC not signed by day 4, Orders not written prior to admission, *RCD- PAS as standalone- Speech orders

The Therapy Intensity Issue

The usual expectation is 3 hours on 5 days or, in documented circumstances, 15 hours over 7 consecutive days.

Review the actual record	Appeal point
Planned program and delivered therapy	Show the expected intensity and the patient's participation.
Missed or shortened sessions	Explain the medical event, physician response and return to treatment.
Reviewer relies only on a minute threshold	CMS instructs reviewers not to issue absolute denials solely for missed therapy time.

Technical Denials: identify the exact requirement

Record at issue	Audit response
Preadmission screening / physician concurrence	Find original timestamp, reviewer and approval; flag genuine omissions.
Individualized plan of care	Verify required content, completion timing and physician approval.
Interdisciplinary team documentation	Confirm meeting timing and rehabilitation physician signature; other participants need not individually sign.
Orders and other signatures	Tie missing signature allegation to the applicable rule and record as it existed.

MA Clawbacks and GG scoring

Plan allegation	IRF response
Section GG score differs from reviewer interpretation	Compare assessment timing, item definitions, source notes and coding guidance.
Different score changes payment or level of care assertion	Ask for the exact contract or payment methodology and claim calculation.
Plan recoups a previously paid stay	Match authorization, claim, overpayment notice and offset to disputed dates.

A GG disagreement and a medical necessity denial are different theories. Require the plan to specify which it asserts.

Other Reasons to Look For in the Letter

Type	Examples
Coverage	Noncovered service, benefit limit or incorrect member eligibility.
Contract	Out of network status, rate, effective date or delegated reviewer.
Claim	Coding, duplicate, corrected claim mismatch or coordination of benefits.
Record	ADR unanswered, partial chart, unreadable upload or deadline missed.

Audit Record Request: the First 48 hours

Action	Owner
Log request, reviewer, claim, dates, record due date and delivery channel.	Central audit coordinator
Tell HIM, clinical leadership, compliance and revenue cycle.	Audit coordinator
Assemble a complete indexed record; confirm legibility and all required signatures.	HIM + clinical review
Transmit through secure portal or approved channel and retain exact copy plus receipt.	HIM / audit coordinator

The Audit and Appeal Tracker

Track	Why
Each ADR, due date, submission and proof of receipt	Avoid late or missing record denials.
Expected decision, result, denial reason and claim amount	Anticipate exposure and select next action.
Appeal level, deadline, filed date and reviewer response	Protect rights at each stage.
Demand, interest, offset and cash recovered	Give revenue cycle a reliable financial view.
Payer portal and remittance review	Catch MA recoupment before a separate notice arrives.

Deciding Whether to Appeal

Assess	Decision question
Merits	Does the contemporaneous record answer the actual denial basis?
Procedure	Was the notice, review, record request or recoupment defective?
Finance	What dollars are disputed, and what cash has actually been offset?
Pattern	Will an appeal address a recurring plan or auditor position?
Route	Is this a FFS claim appeal, MA enrollee appeal or contracted provider dispute?

Original Medicare: Five Appeal Levels

Level	Reviewer	General filing period
1	MAC redetermination	120 days from initial determination.
2	QIC reconsideration	180 days after redetermination.
3	OMHA ALJ / adjudicator	60 days after QIC decision; amount threshold.
4	Medicare Appeals Council	60 days after OMHA decision.
5	Federal district court	60 days after Council decision; amount threshold.

FFS Appeal Deadline Versus Recoupment Deadline

Clock	Operational implication
120 days to request first level redetermination	This is the general merits appeal filing limit.
Within 30 days of overpayment demand	A valid redetermination filed by then generally stops the usual day 41 offset pending decision.
After redetermination	A timely second level filing may again limit recoupment; follow the specific demand and MAC instructions.

A RAC discussion period does not replace a formal appeal or preserve its filing date.

MA Appeal Levels and Provider Disputes

Path	Typical progression
Enrollee service / coverage appeal	Plan reconsideration; adverse result goes to Part C IRE; qualifying cases may go to ALJ, Council and federal court.
Expedited preservice appeal	Plan generally decides within 72 hours if expedited standard applies; IRE also has expedited review rules.
Contracted IRF payment dispute	Follow the executed contract's dispute and payment provisions; do not assume enrollee appeal rules govern every offset.
Noncontract provider payment	Examine applicable Part C appeal rights and waiver requirements.

Successful Appeals: One Claim, One Rebuttal

Put this on page one

Exact denial language and disputed dates.

The applicable Medicare rule or contract term.

Specific answer to each alleged deficiency.

Requested remedy and amount.

Attach this evidence

A dated clinical chronology with page references.

Contemporaneous physician, nursing and therapy records.

Authorization and communication history.

Proof of timely filing and, if needed, remittance ledger.

Takeaways for IRF operators

Before admission

Make the clinical case and protect the MA appeal clock.

During the stay

Send the current trajectory before authorized days expire.

After payment

Respond with a complete record and track every claim and offset.

At every stage

Match the denial reason to the correct appeal route and reviewer standard.

Sources and presenter notes

CMS IRF coverage and medical review guidance

CMS CY 2026 Medicare Advantage final rule and Part C appeals guidance

42 CFR Part 422, Subpart M

CMS Original Medicare FFS appeals and recoupment guidance

CMS IRF RCD and IRF-PAI / Section GG manuals

These are general federal timelines. Apply the actual notice, plan contract and effective date to each case.
Source links and presenter cautions appear in the relevant slide notes.