

[HOSPITAL LETTERHEAD]

REQUEST FOR MEDICARE PRECERTIFICATION / PRIOR AUTHORIZATION
INPATIENT REHABILITATION FACILITY ADMISSION

Date Submitted: [MM/DD/YYYY]

Submitted Via: ☐ Secure Fax ☐ Electronic Portal ☐ Other: _____

Total Pages, Including Cover Letter: [Number]

PATIENT INFORMATION

Patient Name: [Full Name]

Date of Birth: [MM/DD/YYYY]

Medicare Beneficiary Identifier: [MBI]

Current Facility: [Facility Name]

Requested IRF: [Inpatient Rehabilitation Hospital Name]

Anticipated Admission Date: [MM/DD/YYYY]

Primary Rehabilitation Diagnosis: [Diagnosis]

Other Active Diagnoses/Comorbidities: [Diagnoses]

Reference or Tracking Number: [If Applicable]

Dear Clinical Reviewer:

Please accept the enclosed clinical documentation in support of the above-referenced patient's proposed admission to [Inpatient Rehabilitation Hospital Name]. The following summary identifies the specific clinical and functional information supporting the medical necessity of an inpatient rehabilitation facility admission.

1. CURRENT MEDICAL AND FUNCTIONAL CONDITION

Acute condition or event resulting in the need for rehabilitation:

[Describe the acute illness, injury, surgery, or exacerbation that resulted in the patient's current impairments.]

Prior level of function:

[Describe the patient's level of independence before the current event, including mobility, activities of daily living, cognition, communication, swallowing, and living situation.]

Current level of function:

[Describe the assistance presently required for bed mobility, transfers, ambulation, self-care, toileting, cognition, communication, or swallowing. Include objective measures and distances when available.]

Significant change from prior level of function:

[Explain how the patient's current abilities differ from baseline.]

2. NEED FOR MULTIPLE THERAPY DISCIPLINES

The patient requires active treatment from the following disciplines:

- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech-Language Pathology
- ☐ Prosthetics/Orthotics
- ☐ Other: _____

Specific skilled needs to be addressed by each discipline:

Physical Therapy:

[Describe mobility, balance, strength, endurance, transfer, gait, stair, wheelchair, or safety needs.]

Occupational Therapy:

[Describe self-care, upper-extremity, visual-perceptual, cognitive, home-management, or adaptive-equipment needs.]

Speech-Language Pathology:

[Describe cognitive-communication, language, speech, voice, or swallowing needs.]

Other Rehabilitation Discipline:

The patient requires coordination among these disciplines because:

[Explain why the patient's impairments are interrelated and require a coordinated rehabilitation plan rather than isolated or sequential therapy services.]

3. NEED FOR AN INTENSIVE REHABILITATION PROGRAM

Proposed therapy schedule:

- ☐ Approximately three hours of therapy per day, at least five days per week
- ☐ At least 15 hours of therapy within a seven-consecutive-day period
- ☐ Other medically appropriate intensive schedule: _____

Clinical evidence supporting the patient's ability to actively participate in and benefit from an intensive rehabilitation program:

[Describe the patient's participation in current therapy, activity tolerance, motivation, ability to follow instructions, therapy duration, rest breaks, and response to treatment.]

If the therapy schedule will require modification or accommodation, explain the medical reason and proposed schedule:

4. EXPECTED MEASURABLE AND PRACTICAL IMPROVEMENT

Specific functional improvements reasonably expected during the IRF stay:

[Identify anticipated improvements in mobility, transfers, ambulation, self-care, cognition, communication, swallowing, caregiver burden, or safety.]

Clinical evidence supporting the expectation of improvement:

[Describe progress already demonstrated, rehabilitation potential, ability to learn or carry over strategies, prior response to therapy, and other supporting factors.]

Estimated length of stay: [Number] days

Anticipated functional level at discharge:

Anticipated discharge destination:

☐ Home independently

☐ Home with family or caregiver

☐ Assisted living

☐ Other: _____

Anticipated services or support following discharge:

5. NEED FOR REHABILITATION PHYSICIAN SUPERVISION The patient has the following active medical conditions, risks, or potential complications requiring ongoing management by a rehabilitation physician:

[Identify conditions requiring frequent medical assessment and management, such as pain, blood pressure instability, anticoagulation, diabetes, wounds, infection, respiratory issues, bowel or bladder dysfunction, dysphagia, nutrition concerns, neurologic changes, medication adjustment, or risk of complications.]

The rehabilitation physician will need to assess and manage:

[Explain the anticipated medical and functional decisions, treatment modifications, medication management, diagnostic monitoring, and coordination requiring rehabilitation physician involvement.]

The patient requires rehabilitation physician supervision at the IRF level because:

[Explain why the patient's medical and functional needs require the frequency and specialized nature of physician oversight available in an IRF.]

6. NEED FOR 24-HOUR REHABILITATION NURSING

The patient's rehabilitation nursing needs include:

- ☐ Medication management or education
- ☐ Pain assessment and management
- ☐ Bowel or bladder management
- ☐ Wound or skin management
- ☐ Diabetes management
- ☐ Fall prevention and safety monitoring
- ☐ Dysphagia or aspiration precautions
- ☐ Patient or caregiver education
- ☐ Carryover of therapy techniques outside scheduled treatment
- ☐ Other: _____

Specific nursing interventions and risks requiring 24-hour availability of rehabilitation nursing:

7. NEED FOR AN INTERDISCIPLINARY TEAM APPROACH

The patient requires coordinated care from:

- ☐ Rehabilitation Physician
- ☐ Rehabilitation Nursing
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech-Language Pathology
- ☐ Case Management/Social Work
- ☐ Registered Dietitian
- ☐ Prosthetist/Orthotist
- ☐ Other: _____

The patient's medical, nursing, therapy, psychosocial, and discharge-planning needs require an interdisciplinary approach because:

[Describe why frequent communication, coordinated goal-setting, and modification of the treatment plan by the rehabilitation team are necessary.]

8. WHY A LESS INTENSIVE LEVEL OF CARE IS NOT SUFFICIENT

The patient's needs cannot be safely and effectively met through outpatient therapy, home health services, or skilled nursing facility care because:

[Address the patient's need for intensive therapy, rehabilitation physician supervision, 24-hour rehabilitation nursing, coordinated interdisciplinary treatment, medical complexity, safety risks, and expected functional improvement.]

Specific risks associated with treatment at a less intensive level of care include:

9. OVERALL CLINICAL JUSTIFICATION

Based on the patient's medical complexity, functional impairments, rehabilitation potential, and need for intensive interdisciplinary treatment, admission to an inpatient rehabilitation facility is reasonable and necessary because:

[Provide a concise, patient-specific summary connecting the supporting facts to the IRF admission criteria.]

ENCLOSED SUPPORTING DOCUMENTATION

- ☐ Preadmission screening/clinical assessment
- ☐ History and physical
- ☐ Physician progress notes
- ☐ Specialist consultation notes

- ☐ Physical therapy evaluation and treatment notes
- ☐ Occupational therapy evaluation and treatment notes
- ☐ Speech-language pathology evaluation and treatment notes
- ☐ Nursing documentation
- ☐ Medication administration record/current medication list
- ☐ Laboratory and diagnostic results
- ☐ Operative report
- ☐ Discharge summary or transfer summary
- ☐ Other: _____

We respectfully request approval of the proposed inpatient rehabilitation admission. Please contact the individual listed below if additional information is needed to complete the review.

Submitted By: [Name and Credentials]
Title: [Title]
Hospital: [Inpatient Rehabilitation Hospital Name]
Telephone: [Telephone Number]
Fax: [Fax Number]
Email: [Secure Email Address]

Sincerely,

[Name and Credentials]
[Title]
[Inpatient Rehabilitation Hospital Name]

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