

IRF MEDICAL NECESSITY APPEAL

Customizable template for denials asserting criteria were not met at admission

Patient	[PATIENT NAME]
Member ID	[MEMBER ID]
Claim/Auth No.	[CLAIM OR AUTHORIZATION NUMBER]
IRF stay	[ADMISSION DATE] through [DISCHARGE DATE]
Denial date	[DATE]
Appeal level	[FIRST / SECOND / EXTERNAL / RECONSIDERATION]

How to use this template

Replace all bracketed text. Retain only statements supported by the contemporaneous record. The strongest appeal ties each conclusion to a dated source and explains why the need existed at admission. Post-admission findings may corroborate the admission assessment, but should not substitute for it.

Quote the denial rationale and the payer criterion at issue; do not rely on a generic statement that the patient was “appropriate.”

For each criterion, identify the admission-day facts, the source document, the date/time, and the clinical inference.

Describe why a lower level of care could not safely or effectively deliver the required intensity, physician oversight, nursing, and team coordination.

Remove alternative language that does not apply and confirm all therapy minutes, dates, and functional scores against the record.

Important: This template is a drafting aid, not a substitute for review of the specific payer contract, coverage policy, denial notice, and governing law.

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IRF MEDICAL NECESSITY APPEAL TEMPLATE

[FACILITY LETTERHEAD]

[DATE]

[PAYER / REVIEW ENTITY]

[APPEALS DEPARTMENT]

[ADDRESS]

RE: Appeal of IRF Medical Necessity Denial

Patient	[PATIENT NAME]
DOB	[DOB]
Member ID	[MEMBER ID]
Claim No.	[CLAIM NUMBER]
Dates of service	[DATES]

To the Appeals Reviewer:

On behalf of [IRF NAME], we request reversal of the denial of inpatient rehabilitation facility (IRF) services for the above-referenced patient. The denial states that “[QUOTE OR ACCURATELY SUMMARIZE THE DENIAL RATIONALE],” and concludes that the patient did not meet medical

necessity criteria at the time of admission. That conclusion is not supported by the patient's condition, functional deficits, risks, and treatment needs documented before and at admission. The contemporaneous record demonstrates that, at admission, the patient: (1) required active and ongoing treatment by multiple therapy disciplines, including [PT/OT] and [SECOND DISCIPLINE]; (2) required and could reasonably participate in an intensive rehabilitation program; (3) was reasonably expected to make measurable, practical functional improvement during the IRF stay; (4) required rehabilitation-physician supervision; and (5) required a coordinated interdisciplinary team approach. The record also shows why treatment at [SNF / HOME HEALTH / OUTPATIENT / OTHER] would not have safely or effectively met these needs.

I. Clinical Background and Admission-Day Status

Acute event and treatment

[Describe the illness/injury, onset, acute hospitalization, procedures, complications, and condition immediately before transfer. Cite dates and record sources.]

Premorbid function and living situation

[State baseline mobility, ADLs, cognition/communication, equipment, living arrangement, caregiver availability, and environmental barriers.]

Functional status at IRF admission

[State assistance levels for bed mobility, transfers, ambulation/wheelchair mobility, stairs, toileting, bathing, dressing, eating, cognition, swallowing, and communication. Include objective scores when documented.]

Medical complexity and active risks

[Identify diagnoses and risks requiring active management, such as neurologic change, cardiopulmonary instability, blood-pressure variability, anticoagulation, pain, wounds, infection, dysphagia/aspiration, bowel/bladder dysfunction, diabetes, falls, delirium, or medication titration.]

II. The Patient Met Each IRF Medical Necessity Criterion at Admission

A. Multiple therapy disciplines were required

At admission, the patient required active and ongoing treatment from [PHYSICAL THERAPY] and [OCCUPATIONAL THERAPY / SPEECH-LANGUAGE PATHOLOGY / PROSTHETICS-ORTHOTICS]. The disciplines addressed distinct but interdependent deficits:

[PT: impairment → planned skilled intervention → functional goal → admission source/date.]

[OT: impairment → planned skilled intervention → functional goal → admission source/date.]

[SLP/P&O, if applicable: impairment → intervention → goal → admission source/date.]

These were not maintenance or custodial services. Skilled treatment required clinical assessment, progression, safety training, and coordinated modification of the plan based on the patient's response and medical status.

B. Intensive rehabilitation therapy was required and reasonably feasible

The preadmission and admission assessments supported the need for an intensive program of approximately [THREE HOURS PER DAY ON FIVE DAYS PER WEEK / AT LEAST 15 HOURS OVER SEVEN CONSECUTIVE DAYS], tailored to the patient's condition. The proposed schedule was [DESCRIBE SCHEDULE AND DISCIPLINES].

[Explain why intensity was clinically necessary: multiple major deficits, need for repetition, rapid progression, caregiver training, short recovery window, prevention of complications, or other facts.]

[Explain ability to participate: alertness, command following, endurance, prior acute therapy tolerance, motivation, pain control, rest breaks, modified scheduling, or other accommodations. Address any contrary fact directly.]

The standard is a reasonable expectation at admission, based on the totality of the information then available. [IF APPLICABLE: Early treatment notes documenting participation and tolerance corroborate—not create—the reasonable admission expectation: cite examples.]

C. The patient was reasonably expected to benefit significantly

At admission, the team reasonably expected measurable, practical improvement within a defined period. The expected length of stay was [NUMBER] days, with anticipated discharge to [SETTING].

Key anticipated gains included:

[Mobility/transfer baseline → expected discharge level]

[Self-care baseline → expected discharge level]

[Cognition/communication/swallow baseline → expected discharge level]

[Caregiver training, equipment, or home-access goal]

[Explain why the goals were achievable based on premorbid function, recovery trajectory, learning ability, motivation, family support, and clinical prognosis.]

[OPTIONAL CORROBORATION: State actual improvement concisely, while emphasizing that coverage rests on the reasonable expectation at admission. Do not imply that a favorable outcome was required.]

D. Rehabilitation-physician supervision was required

The patient required close physician oversight because medical and functional issues were reasonably expected to affect participation, safety, and progression. The rehabilitation physician needed to assess and manage:

[Issue 1: specific risk/condition → required physician assessment or management → effect on rehabilitation.]

[Issue 2: medication/lab/vital/pain/wound/neurologic issue → management need → effect on rehabilitation.]

[Issue 3: need to integrate medical decisions with therapy intensity, precautions, equipment, and discharge planning.]

This need exceeded routine availability of a physician. The patient required rehabilitation-focused medical management integrated with the therapy and nursing plan, including [EXAMPLES SUPPORTED BY THE RECORD].

E. A coordinated interdisciplinary team approach was required

The patient's needs could not be managed as isolated therapy services. They required coordinated input from the rehabilitation physician, rehabilitation nursing, case management/social work, and each treating discipline. Coordination was necessary to address [MEDICAL ISSUE], [FUNCTIONAL ISSUE], [COGNITIVE/COMMUNICATION OR SWALLOW ISSUE], [NURSING ISSUE], and [DISCHARGE BARRIER].

[Give concrete coordination examples: shared precautions, medication timing, bowel/bladder program, skin protection, swallowing plan, fall prevention, caregiver training, equipment, home modification, or discharge placement.]

III. A Lower Level of Care Was Not Adequate

The denial [IDENTIFIES / IMPLIES] that [LOWER LEVEL] was appropriate. That alternative did not provide the combination of services required at admission:

[Therapy intensity/frequency that could not be reliably delivered at the lower level]

[Need for rehabilitation-physician management integrated with daily rehabilitation]

[24-hour rehabilitation nursing need, if supported]

[Need for rapid interdisciplinary reassessment and coordinated changes]

[Home/caregiver/environmental barriers or safety risks]

[Why delaying or fragmenting treatment risked harm, deterioration, or loss of recovery opportunity]

A lower level of care is not appropriate merely because it can provide some therapy. The relevant question is whether it could safely and effectively provide this patient's required intensity, medical oversight, nursing, and interdisciplinary coordination. Based on the admission record, it could not.

IV. Response to the Denial's Specific Findings

Denial finding 1

[Quote the finding. Then respond with the exact record evidence, date/time, and clinical explanation. Address contrary evidence rather than omitting it.]

Denial finding 2

[Quote and rebut. Explain whether the reviewer overlooked, misstated, or applied evidence inconsistently with the governing criterion.]

Denial finding 3

[Quote and rebut. If the denial applies an internal guideline, identify how the patient met it or why controlling Medicare/contract criteria govern.]

V. Documentation Supporting Admission

Preadmission screening dated [DATE/TIME]

Rehabilitation physician concurrence dated [DATE/TIME]

Acute-care therapy evaluations/notes dated [DATES]

IRF admission orders and history and physical dated [DATE/TIME]

Admission nursing and therapy evaluations dated [DATES]

Individualized plan of care dated [DATE]

Physician progress notes and interdisciplinary team documentation dated [DATES]

Other: [DOCUMENT]

Conclusion

The record, viewed as a whole and from the standpoint of the information reasonably available at admission, establishes that IRF care was reasonable and necessary. We respectfully request that [PAYER] overturn the denial and authorize/payment for the IRF stay from [DATES]. If the reviewer maintains the denial, please provide the specific criterion not met, the evidence relied upon, the credentials and specialty of the reviewer, and the complete clinical rationale for the determination.

Sincerely,

[NAME, CREDENTIALS]

[TITLE]

[IRF NAME]

[PHONE] | [EMAIL]

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Appeal Writer's Evidence Worksheet

Use this worksheet before finalizing the letter. Delete it from the submission packet unless your process calls for inclusion.

Criterion	Admission-day fact	Source and date/time	Why the fact satisfies the criterion
Multiple disciplines	[FACT]	[SOURCE]	[ANALYSIS]
Intensive therapy	[FACT]	[SOURCE]	[ANALYSIS]
Ability to participate	[FACT]	[SOURCE]	[ANALYSIS]
Expected measurable benefit	[FACT]	[SOURCE]	[ANALYSIS]
Physician supervision	[FACT]	[SOURCE]	[ANALYSIS]
Interdisciplinary care	[FACT]	[SOURCE]	[ANALYSIS]
Lower level inadequate	[FACT]	[SOURCE]	[ANALYSIS]

Final Quality Check

- ☐ All bracketed prompts and inapplicable alternatives were removed.
- ☐ Every factual assertion is supported by the record and dates are accurate.
- ☐ The argument focuses on the reasonable expectation at admission.
- ☐ Therapy intensity, disciplines, goals, and expected length of stay are internally consistent.
- ☐ Medical complexity is connected to the need for rehabilitation-physician management.
- ☐ The appeal explains why the proposed lower level was insufficient for this patient.
- ☐ The response directly addresses each reason stated in the denial.
- ☐ The payer's current policy, contract terms, and appeal deadline were confirmed.
- ☐ Patient identifiers and attachments were checked before transmission.

Reference Framework

For Medicare-aligned appeals, 42 C.F.R. § 412.622(a)(3) describes the admission requirements for IRF services to be considered reasonable and necessary. Medicare Advantage organizations must follow applicable Traditional Medicare coverage and payment criteria for basic benefits, including IRF admission criteria, subject to 42 C.F.R. § 422.101. Always confirm whether the payer's policy or contract adds permissible requirements and use the authority applicable to the claim.

Official sources: 42 C.F.R. § 412.622 and 42 C.F.R. § 422.101, Electronic Code of Federal Regulations.

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