The Hospital Saved Your Life. Who Will Help You Get It Back?

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President

The stroke didn't kill you.

The hospital's physicians and nurses did their jobs. The immediate crisis has passed. You're medically stable and ready to leave the hospital.

But you can't walk safely. Getting dressed requires help. Returning home, where your spouse may be your only caregiver, isn't yet realistic.

Your medical team believes intensive rehabilitation offers the best opportunity to regain your independence.

There's just one problem.

Your insurance company hasn't approved it.

And while everyone waits for a decision, you're occupying a hospital bed, your family is wondering what happens next, and the rehabilitation that could help you reclaim your life hasn't begun.

The hospital saved your life.

Now, who is going to help you get it back?

For a growing number of Americans, that question is becoming increasingly important.

America is getting older. By 2030, all baby boomers will be older than 65, and the U.S. Census Bureau projects that one in every five Americans will be retirement age. As our population ages, we can expect more patients living with the consequences of strokes, fractures, neurological conditions, joint replacements, and other serious illnesses and injuries.

At the same time, medical advances are allowing people to survive conditions that might have had very different outcomes a generation ago.

That is a remarkable healthcare success story.

But surviving isn't always the same thing as recovering.

For many patients, rehabilitation is the bridge between the two.

When the Next Step Requires Approval

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation and medical management for patients who require a level of care beyond what can appropriately be provided at home, through outpatient therapy, or in another post-acute setting. Their purpose isn't simply to discharge a patient from another hospital. It is to restore as much function and independence as possible.

Yet accessing that care can be difficult, particularly for patients enrolled in Medicare Advantage plans.

A June 2026 report from the U.S. Department of Health and Human Services Office of Inspector General examined prior authorization decisions for inpatient rehabilitation facilities and long-term acute care hospitals by 19 Medicare Advantage organizations.

The findings deserve attention.

The three largest Medicare Advantage organizations denied requests for these services at higher rates than most of the other organizations studied. When patients appealed inpatient rehabilitation denials, insurers collectively overturned 43 percent of them. Among individual organizations, the percentage overturned ranged from 14 percent to 86 percent.

The findings raised concerns that some patients were initially denied medically necessary care.

That raises a fairly simple question: **What happens to the patient while everyone is deciding?**

Phil Wright, FACHE, CEO of Memorial Regional Hospital South, believes rehabilitation has long been an essential component of healthcare delivery. Its importance will only increase as Americans live longer and remain active later in life.

"From my perspective, Rehab has been and will continue to be a crucial part of the healthcare landscape," Wright said.

He believes appropriately utilized rehabilitation benefits patients while also improving the effectiveness of the broader healthcare system.

But he raises an important question: Will the organizations financing healthcare continue to recognize and prioritize that value?

At Memorial Regional Hospital South, Wright describes admission coordinators, case managers, therapists, and other professionals spending considerable time assembling documentation, responding to payer requests, and appealing decisions.

He acknowledges the importance of responsible resource utilization and the legitimate role of payer review. But when initially denied requests are eventually approved, the appeals process can feel like an unnecessary barrier.

Those delays have consequences.

Additional hospital days, increased length of stay, potential readmissions, and concerns about patient outcomes create operational and financial pressures that extend beyond the rehabilitation hospital.

And as Wright observes, hospitals are devoting valuable resources to navigating these requirements, resources that could otherwise support patient care.

Who Really Needs Inpatient Rehabilitation?

There is another side to this discussion that shouldn't be ignored.

Not everyone leaving an acute-care hospital needs inpatient rehabilitation.

Some patients can safely recover at home with home health services or outpatient therapy. Others may be more appropriately treated in a skilled nursing facility. Inpatient rehabilitation is an intensive and expensive level of care. Insurers and Medicare have a legitimate responsibility to ensure that patients receiving it actually require it.

The question isn't whether there should be utilization review.

It is whether we are making the right decision for the right patient at the right time.

And that is fundamentally a clinical question.

Matthew Cowling, D.O., FAAPMR, Chief Clinical Officer for Medrina, says determining the appropriate rehabilitation setting begins by looking beyond the diagnosis.

"As a physiatrist, determining the appropriate rehabilitation setting starts with looking at the whole patient, not simply the diagnosis that brought them to the hospital," Cowling said.

That assessment includes the patient's previous level of function, current mobility, ability to perform activities of daily living, medical complexity, rehabilitation goals, available support at home, and ability to benefit from an intensive rehabilitation program.

Those distinctions matter because rehabilitation isn't one-size-fits-all.

A patient who can safely return home may be appropriately treated through home health or outpatient therapy. Someone who continues to need nursing and rehabilitation services but cannot tolerate an intensive rehabilitation program may be better served in a skilled nursing facility.

"Inpatient rehabilitation is most appropriate when a patient requires both intensive rehabilitation and ongoing physician-led medical management and has the potential to make meaningful functional gains from that level of care," Cowling said.

And inpatient rehabilitation is much more than additional physical therapy.

Depending upon the patient, the rehabilitation team may include physical therapy, occupational therapy, speech-language pathology, rehabilitation nursing, physician management, and other disciplines working together toward functional goals while managing medical barriers to recovery.

That distinction becomes particularly important when access to appropriate rehabilitation is delayed.

"When appropriate intensive rehabilitation is delayed or denied, the concern is not simply that therapy starts a few days later," Cowling said.

Patients recovering from strokes, neurological injuries, major surgery, fractures, or serious illnesses may already be vulnerable to deconditioning and complications associated with immobility. Delays can affect functional recovery, increase caregiver burden, and make a safe transition home more difficult.

A Denied Patient Doesn't Disappear

There is another part of this story that frequently receives less attention.

When a patient is medically ready to leave an acute-care hospital but cannot be discharged because authorization for rehabilitation is pending or has been denied, that patient doesn't disappear.

The patient remains in a hospital bed.

Taren O'Brien, MSN, RN, Vice President and Chief Nursing Officer at Holy Cross Health, explains that the transition from acute care to inpatient rehabilitation involves clinical evaluations and administrative steps that must come together before a patient can be transferred.

The process typically begins with physical and occupational therapists assessing whether the patient has the potential to benefit from intensive rehabilitation, including the ability to participate in approximately three hours of therapy daily.

A physiatrist may then evaluate the patient's medical complexity, rehabilitation potential, and need for ongoing physician management to determine whether inpatient rehabilitation is more appropriate than a skilled nursing facility or home-based services.

For patients covered by managed care plans, that clinical recommendation is followed by a request for insurance authorization.

And that is where delays can begin.

According to O'Brien, authorization decisions can take several days, particularly when requests are submitted near weekends or holidays. Waiting three to five days for a determination is not uncommon in her experience.

If the request is denied, the healthcare team may submit additional clinical documentation or arrange a peer-to-peer discussion between the treating physician and the insurer's medical director.

Case managers and social workers spend time gathering records, responding to requests, communicating with insurers, and coordinating appeals. Physicians may have to interrupt clinical responsibilities to participate in peer-to-peer reviews.

Meanwhile, the patient remains in the hospital.

These delays can increase hospital length of stay, reduce bed availability, and create bottlenecks throughout the organization. When acute-care beds remain occupied, other patients may experience delays in admission from the emergency department.

But perhaps the most difficult consequences are experienced by patients and their families.

"For patients and families, the process is often confusing and frustrating," O'Brien said.

A patient may have been told that inpatient rehabilitation is the appropriate next step. The family is preparing for the transition and hoping to see progress toward recovery.

Then they learn that authorization is pending or has been denied.

Patients continue receiving appropriate care and therapy while hospitalized, but that experience differs from the coordinated, interdisciplinary rehabilitation available in a dedicated inpatient rehabilitation setting.

For patients and families, the delay adds uncertainty at a time when they are already confronting difficult decisions about recovery, independence, and returning home.

Can We Find a Better Way?

Wright believes improving the rehabilitation process requires earlier collaboration among hospitals, physicians, patients, families, and insurers.

At Memorial Regional Hospital South, one priority is engaging providers earlier in discharge planning so potential barriers can be identified before the patient is ready to transition to the next level of care.

"If providers, families, and payers can partner early and often, I believe the benefits are immense," Wright said.

O'Brien's experience at Holy Cross Health reinforces the importance of timely decision-making. A more efficient authorization process could reduce unnecessary delays, ease administrative burdens, improve patient and family experiences, and support more effective use of hospital resources.

Wright also notes that his organization is exploring whether artificial intelligence might help address administrative challenges associated with authorizations and denials.

But the larger issue isn't simply finding more efficient ways to process paperwork.

It is creating a system in which clinical decisions, payer requirements, and discharge planning are better aligned from the beginning.

Rehabilitation should not be viewed as a luxury service or something considered only after other interventions have failed. It should be recognized as an important component of an effective continuum of care.

That doesn't eliminate the need for oversight.

Rehabilitation providers themselves face significant regulatory scrutiny, including Medicare documentation, coverage, and billing requirements. CMS is also expanding its Review Choice Demonstration for inpatient rehabilitation facilities to strengthen compliance and protect Medicare program integrity.

Such oversight is appropriate. Healthcare resources aren't unlimited, and every level of care should be clinically justified.

But oversight should work in both directions.

If providers must demonstrate that every inpatient rehabilitation admission is medically necessary, shouldn't we apply comparable scrutiny when an insurer determines that medically recommended rehabilitation isn't necessary?

What Is the Cost of Not Rehabilitating Someone?

Healthcare tends to measure what it pays for.

A rehabilitation admission has a price. Physical therapy has a price. Occupational therapy has a price. Additional days in a hospital have a price.

Independence is harder to put on a spreadsheet.

What is it worth if rehabilitation allows a patient to walk again?

What is the value of being able to get dressed without assistance, climb the stairs, prepare a meal, or use the bathroom independently?

What is the economic value when a spouse doesn't have to become a full-time caregiver or an adult child doesn't have to leave the workforce to care for a parent?

And what does it cost when an older person who might have regained independence instead requires substantially more assistance for months or years?

Cowling argues that this is precisely why we shouldn't evaluate rehabilitation simply by looking at the price of an individual stay.

When a patient is sent to a level of care that doesn't match their clinical and functional needs, medical issues may not be adequately managed, functional recovery may stall, or the patient may be discharged before being able to function safely in the community.

The result can be additional healthcare utilization, including emergency department visits, hospital readmissions, or additional post-acute care.

"We also have to consider the total episode of care and the potential downstream costs when a patient does not receive the appropriate level of rehabilitation at the appropriate time," Cowling said.

That may be one of the most important points in this discussion.

The three South Florida healthcare leaders approach rehabilitation from different perspectives, but their observations point toward a common conclusion.

The appropriate rehabilitation decision should consider more than the immediate cost of a particular service. It should also consider the patient's recovery, the resources consumed across the continuum of care, and the consequences of getting that decision wrong.

Being medically stable enough to leave an acute-care hospital isn't necessarily the same thing as being functionally ready to return home.

As Cowling put it, the goal should be "the right level of rehabilitation for the right patient at the right time," giving that patient the best opportunity to regain function, independence, and quality of life.

As America grows older, we should absolutely ask whether inpatient rehabilitation is necessary and appropriate for a particular patient. Providers should be accountable for demonstrating that it is.

But when the clinical evidence says intensive rehabilitation is the appropriate next step, our healthcare system should also be very careful about putting barriers between the patient and that care.

Modern medicine has become remarkably good at saving lives.

The next challenge may be making certain that we are equally committed to helping people get their lives back.