Centers for Medicare and Medicaid Services
Special Open Door Forum:
Review Choice Demonstration for Inpatient Rehabilitation Facility Services
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Jill Darling: Hi, everyone, and good morning and good afternoon. My name is Jill Darling, and I am in the Office of Communications here at CMS. Welcome to today's Special Open Door Forum: Review Choice Demonstration for Inpatient Rehabilitation Facilities Services. Thank you again for joining us. Before we begin, I have a few announcements. If you are a member of the press, you may listen in, but please refrain from asking questions during today's webinar. If you have questions, please e-mail press@cms.hhs.gov. For those who need closed captioning, the link is located in the chat function of the webinar. We will be answering questions related to the presentation provided today. We will do our best to get to as many questions as possible today. During that time, you may use the raise hand feature at the bottom of the screen, and we will call on you to ask your questions. Now I will turn the webinar over to Chirymeria Wilson.

Chirymeria Wilson: Good afternoon, and welcome to today's Special Open Door Forum, where we will discuss the Review Choice Demonstration for Inpatient Rehab Facility Services (IRF). My name is Chirymeria Wilson, and I'm a Nurse Consultant within the Division of Payment Methods and Strategies. Also on the panel, we have Ashley Stedding, Health Insurance Specialist, and Dr. Lieberman, Palmetto GBA Chief Medical Director. In addition, we have Amy Cinquegrani, who is the Director; Sabrina Betts, Deputy Director; and other Palmetto GBA staff to help with the Q&A. Next slide, please.

This slide has some acronyms that we frequently use at Medicare Fee-for-Service. I will try not to speak in alphabet soup, but they are here just in case I do. So why are we conducting this Demonstration? Over the years, there have been concerns noted from some of our oversight bodies about various concerns with Inpatient Rehab Services. Over the years, CERT (Comprehensive Error Rate Testing) has estimated very high improper payment rates for IRFs. At its highest, 40 percent in 2018, and falling to about 19 percent in the most recent 2022 report. So, while we are pleased that the rate has been cut in half, that is still over a billion dollars in error for inpatient rehab hospitals and units. The Office of Inspector General (OIG) has had concerns with IRF claims not meeting documentation and medical necessity requirements. Also, MedPAC has raised concerns about high-profit margins, possibly incentivizing IRFs to admit patients that do not meet Medicare requirements. So, we feel additional Program Integrity action is warranted. The purpose of the Demonstration is to establish a review choice process for IRF services to test improved methods for identification, investigation, and prosecution of potential Medicare fraud.

Additionally, the Demonstration should improve compliance with Medicare program requirements to ensure the right payments are made at the right time for IRF services. We have a quick overview of the IRF Benefit which I'm not going to read, but essentially the patient must

require and actively participate in intensive rehab from multiple therapy disciplines. We have embedded a link to the ECFR regulation in the slides for further reading. The implementation date for IRFs physically located in Alabama and bill to JJ will begin August 21. There will be once a month choice selection window which will run from July 7 through August 6 and a two-week preparation window before the August 21 implementation date. We do intend to expand the Demonstration to Pennsylvania, Texas, and California and then move to the rest of the states within the MAC jurisdictions, but we are not putting any time frames associated with that yet. We want to ensure things work as intended in Alabama, and then we will give at least a 90-day notice before any additional activity.

So, here we can go through the choices available. Initially, there will be two choices to select from, Pre-Claim Review or Post-Payment Review. For choice 1, Pre-Claim Review, there will be Pre-Claim Review for all claims, unlimited resubmissions of non-affirmed request, and claims associated with a provisionally affirmed request will not undergo further medical review, except in limited circumstances. For choice number two, Post-Payment Review, 100 percent of claims will be reviewed after the final claim submission—this selection follows current post-payment medical review processes, and this is the default selection if no initial review selection is made. On to you, Ashley.

Ashley Stedding: Thank you Chirymeria. So, moving on to slide number eight for those following the today's presentation, we will talk in more detail about the different review choices starting with choice number one, which is Pre-Claim Review. So here, the IRF or other requester will submit a Pre-Claim Review request to their MAC. The MAC will review the request and communicate a decision via telephone within two business days and in writing within 10 business days. A provisional affirmed decision means the claim will be paid so long as all other Medicare requirements are met, and a non-affirmed decision means the request did not demonstrate that Medicare requirements were met. If a Pre-Claim Review request is non-affirmed, the requester can resolve the reasons for non-affirmation and resubmit the request. Unlimited resubmissions are allowed prior to submission of the claim, and the same review time applies for resubmissions, as mentioned on the previous slides. Claims submitted with a non-affirmed request will be denied and the standard appeals process will apply. If no Pre-Claim Review request was submitted, the claim will be subject to pre-payment medical review. The decision letters will be sent to both the requester and the beneficiary and will include a Unique Tracking Number, or UTN, that must be submitted on the claim. Non-affirmations will also provide additional detail on which policy requirements were not met in order to help requesters understand what needs to be resolved prior to resubmitting the request. For choice number two, Post-Payment Review, the IRF will follow the standard intake, service, and billing procedures, and the claim will pay according to normal claim processes. The IRF will send ADR, or Additional Documentation Request letter, following receipt of the claim and follow the normal Post-Payment Review processes. IRFs who do not select an initial choice will default to this option.

So here I will talk a little bit about the compliance check and additional review choice options that may be available. So, every six months the MACs will calculate the approval rate of initial submissions and resubmissions depending on the review choice option that was selected by the providers. For cycle 1, the affirmation will be 80 percent and the rates will increase with each

subsequent cycle, as you can see here on the slide. If the IRF meets the target affirmation rate, they will have additional review choices available from which they can select. Choice 1 is Continuation with the Pre-Claim Review, Choice 3 is Selective Post-Payment Review, and Choice 4 is Spot Check Pre-Payment Review. And again, IRFs must meet the target affirmation threshold each cycle to continue to be eligible for these subsequent choices, otherwise providers will need to select from those first two initial review choice options. For Choice 3, Selective Post-Payment Review, the IRFs will follow standard intake, service, and billing procedures, and the claims will pay according to normal claims processes. The MACs will select a statistically valid random sample based on the previous six months' claim volume. The MACs will then send an ADR letter to the IRF and follow the normal CMS Post-Payment Review procedures. For Choice 4, Spot Check Pre-Payment Review, the IRFs will, again, follow the standard intake, service, and billing procedures, and the MACs will select five percent of the submitted claims based on the previous six months' claim volume. The IRF must meet the target review affirmation or approval rate threshold in order to be eligible for subsequent review choices. So, during the choice selection process, the IRFs will have until two weeks prior to the start of the review cycle to select an initial review choice, and those choice selections will be made through the MAC portal. As previously mentioned, IRFs that do not select an initial review choice will default to Choice 2, Post-Payment Review, and IRFs who did not select a subsequent review choice will default to Choice 3, Selective Post-Payment Review.

So here on slide 16, we have a flowchart which gives a nice visual of the IRF Review Choice Demonstration process and information that we have presented so far today, and this flowchart is also posted in the download section on the CMS webpage to serve as a helpful resource for those who are interested. Now we will go over some of the important dates for the first two cycles. Cycle 1, the choice selection period, will be from July 7 through August 6, followed by a preparation period from August 7 to August 20. Then Cycle 1 review dates will begin August 21 and continue through February 29 of 2024. The analysis of results and letters generated will begin on March 1 and go through March 31 of 2024. Moving to Cycle 2, the choice selection period will begin on April 1 and go through April 15, followed by a preparation period from April 16 to the 30, and the review start date for that cycle will begin on May 1 of 2024. We have also included, at the bottom of the slide, a link to the Palmetto GBA eService's Portal, where providers will go to make their review choice selections. At this time, I will turn it back to Chirymeria to talk about CMS oversight.

Chirymeria Wilson: Thank you, Ashley. So now that we have announced our start, we are working hard on getting additional resources and education out to everyone. We have a new website, and that's where we will be putting a lot of the resources, such as the operational guide, FAQs, and flowcharts. We will also post review guidelines and have shared those draft documents with some of our stakeholder partners. We want to make sure everyone is in agreement and that they align with our regulations, and we want to be transparent with how our contractors will be reviewing. For education, we will be working with Palmetto to schedule some additional sessions that will cover everything from how to make a selection within the portal to understanding the various ways to submit documentation for review. Dr. Lieberman will oversee the training and outreach reviews at Palmetto. Therefore, at this time, I like to introduce you to Dr. Lieberman.

Dr. Lieberman: Hi and thank you again. I am Jesse Lieberman—I went to NC State for my undergraduate, followed by medical school at Wake Forest. In 2003, during my third year of medical school, I fell trying to help a neighbor and sustained a C5 spinal cord injury, that's how I ended up in rehabilitation medicine. I went back to school, graduated, and did internship at ECU and then residency at Carolinas Rehab, where I was a patient. Then I did a spinal cord injury fellowship following this and a three-year post doc research fellowship, during which I got an MSPH. I've been practicing for 12 years at the Carolinas Medical Center and Carolinas Rehab, doing a variety of inpatient, outpatient, consults, and more recently, joined a Palmetto GBA as well as another part-time job treating brain and spinal cord injuries in long-term residential treatment centers. As said, I am the lead physician over the IRF Review Choice Demonstration. I've been directing all clinical review, training, and education activities for both providers as well as Palmetto GBA clinicians. I've also been reviewing and editing all the documents for the RCD portal, and we have an interrater reliability (IRR) case review study every week, which I'm participating in with the medical reviewers to ensure consent application of Medicare guidelines, and I am always available for questions and concerns.

Ashley Stedding: Thank you so much, Dr. Lieberman. I wanted to jump in before we wrap up the presentation portion of today's forum. To highlight the resources that we have included on slide 21, there is a link to our CMS IRF RCD webpage, where you can find information and resources referenced in the presentation today as well as future updates. We have listed our CMS mailbox address to submit questions or feedback, and that is IRF_RCD@cms.hhs.gov. We have also included a link to the Palmetto GBA website for additional resources and information from Palmetto. At this time, we are ready to move into the Q&A portion of today's call, so I will turn it over to our Zoom moderator to facilitate and instruct attendees on how to ask any questions.

Jackie Ryan: All right, so it looks like the first person to have your hand raised is Mario. You are able to unmute and speak to ask your question now.

Mario Ruiz: Yeah, hello?

Jackie Ryan: Yes, we can hear you.

Mario Ruiz: Perfect, I have some questions. In regard to the physician that was present, I couldn't understand. Is one doctor going to be reviewing the charts, or is it multiple doctors?

Dr. Lieberman: You want me to answer that, Ashley?

Ashley Stedding: Sure.

Dr. Lieberman: The medical reviewers, the nurses, will be reviewing the charts. Any questions or concerns they have will get bumped up to me. There are too many for one physician to review. The medical reviewers have been doing it for years and are very well trained. I have been a part of the training for this RCD process, so I'm highly confident they will do a great job.

Mario Ruiz: I have a follow-up question. In regard to the timeline, I saw it was during regular business days, Monday through Friday, so weekends and holidays are out. What about when, for

example, I'm in California, so let's say I get a referral about 2:00 California time, I know we have two days, but it's on a Friday, will I get a call by Monday morning to move the patient in? Because that means the patient is stuck in the acute center for three to four days.

Amy Cinquegrani: Hi, this is Amy from CMS, and I can take that. So, if you are choosing Pre-Claim Review, then I wanted to point out that it's different from a strict prior authorization process, so there's no need to wait for approval to begin services. We just ask that you go through the Pre-Claim Review process before submitting that claim for payment. So, we understand that because of the time frames involved, there is no possibility for immediate feedback from that perspective. So, it's not a true prior authorization process, and there's no need to wait to begin those services. Submit the request as soon as you are able and have the supporting documentation, and there will be a decision within that two-business-day time frame.

Jackie Ryan: All right, it looks like the next person whose hand is raised is Kate. Kate, you are unable to unmute yourself.

Kate Beller: Thank you so much, everyone. So, I have a question, in prior communications with CMS, I was under the impression that IRFs could eventually graduate out of the Demonstration if they could consistently demonstrate high rates of compliance. Can CMS confirm if that's correct or if IRFs will be subject to either a hundred percent, or select review, or spot check, or a combination for the entire Demonstration?

Amy Cinquegrani: Hi, Kate. I can take that. So IRFs will be in the Demonstration in some capacity for the entire length of the Demonstration, either within the initial review choices or the subsequent review choices. So, there is no leaving the Demonstration. So, provided that the IRF can maintain the 90 percent or whatever the appropriate review threshold is depending on the cycle, then an IRF can certainly move to one of the less intensive review choices, 3 and 4, with the small samples of review. There will still be some review throughout the Demonstration.

Kate Beller: I appreciate it, thank you, Amy. As a follow-up question, if that's the case and IRFs are subject to some kind of review for the duration of the Demonstration, will they also be exempt from some or all types of auditing for the same period of time? And even if you're in the more selective or spot check, so only five percent subject to review, would your other claims still get some relief from auditing, given the administrative burdens related to this Demonstration?

Amy Cinquegrani: Yes, absolutely, and that's a great clarification. So, if you are in one of the less intensive review choices where you are having only a sample of your claims reviewed, those other IRF claims that are not subject to review under the Demonstration are still off the table, for lack of a better term, from RAC review or MAC Targeted Probe and Educate (TPE) reviews.

Kate Beller: Great, thanks so much Amy, I really appreciate the clarification. I want to be respectful of the request to limit to one question and one follow-up. If there's time permitting during the event, I have several other questions. But I will let you handle the rest of the meeting, and I very much appreciate your time.

Amy Cinquegrani: Thank you.

Jackie Ryan: So next up is going to be Joe. Joe, you can unmute yourself.

Joe Nahra: Hi, can you hear me?

Jackie Ryan: Yes.

Joe Nahra: Great, so two quick questions about the affirmation rate calculations. On slide 12, there's a new note that appeals will not be included in the Pre-Claim Review requests. It says both initial and resubmitted Pre-Claim Review requests will be calculated. If you have a claim that is denied at first during the Pre-claim track but then you resubmit and it's approved, does that count as one approval, or does that count as one denial and one approval in terms of calculating the affirmation rate?

Amy Cinquegrani: I want to make sure I'm understanding. Maybe Palmetto, can you jump in if you understand? Or we might need Joe to clarify.

Robin Free: Sorry, Amy, I was talking on mute. This is Robin with Palmetto GBA. So, in the scenario you provided, if you submit the PCR request the first time and it's non-affirmed, and you resubmit that, and it is affirmed, how will that impact the affirmation rate, it will only be counted once. So, in that case, if that's the only one you submit, then it will be a hundred percent affirmation rate. We only include what we call the latest iteration of the decision for that particular request within the six-month evaluation cycle.

Joe Nahra: Thank you Robin, that is really helpful. As a follow-up based on the important dates slide, it looks like there is a gap between the review cycle for the calculation of the affirmation rates and the generation of letters. What happens for IRFs during that period? Is the RCD paused, or are they still submitting claims for review? And if they are, what level of review are they subject to between review cycle periods?

Robin Free: Go ahead, Jason.

Jason Rhodes: This is Jason Rhodes at Palmetto GBA, and that's a great question. For the hundred percent review options for Choice 1 and Choice 2, that process will continue between the cycle rounds, and what we will do is utilize that information in the next round of calculations. So, if you submit 10 Pre-Claim Reviews during that period, we will calculate those 10 with the next cycle to help you with affirmation rates and such like that. For the non-100 percent reviews, Choice 3 and 4, there will be no activity that happens within those two months. This is mostly because we try to select the claims in a reasonable time period within the cycle so that we can have reviewed all of your claims and provide information back to you before the end of the cycle to use for calculations.

Joe Nahra: Thank you.

Jackie Ryan: All right, next up is Leigh Allen. You are able to unmute.

Leigh Allen: Hi there. So, two related questions. Will you finish with the Alabama review before starting any other states? And will you go with the additional states sequentially, or will there be several states that are starting at the same time?

Amy Cinquegrani: This is Amy. I think for the first answer, there is not necessarily a finish for the Alabama review. Alabama will be included for the duration of the Demonstration. Like Chirymeria mentioned in the slides, we want to make sure processes are working in place and systems are working as designed before moving into additional states. So, at this time we do not necessarily have time frame for moving in the additional states. When we move into additional states, Alabama Demonstration activity will continue. And at this time the plan is, at least for the three additional states that are mentioned in the slide presentation, to move into each one of those one at a time. Then, after making sure processes and everything is working as intended in those states, move into the remaining states within those MAC jurisdictions. At that point, it is likely that there would be more than one state starting at the same time but not until we get the four initial states. That is at least how we are planning it, but we are not tying any dates associated to that.

Leigh Allen: Okay, so sorry, when you say the duration of the Demonstration, I am seeing on slide 17, Cycle 2, the review start date is May of 2024. So how long is the Demonstration?

Amy Cinquegrani: The Demonstration is a five-year period.

Leigh Allen: Okay.

Chirymeria Wilson: Also, we will give a 90-day notice before we move into any other states or jurisdictions.

Jackie Ryan: All right, the next person is Mary Beth. You are able to unmute yourself. Mary Beth, you are able to unmute yourself. Are you there? Okay, I will move onto the next person and will come back to her. Next person is Regina. Regina, you are able to unmute yourself.

Regina Mudd: Hello, can hear me? I was wondering is this only for Medicare Fee-for-Service or will it apply to Medicare Advantage?

Sabrina Betts: Hi, this is Sabrina. This is only for Medicare Fee-for-Service.

Regina Mudd: Thank you.

Jackie Ryan: Let's try to go back to Mary Beth. Are you there Mary Beth? Okay. We will go to the next person. Gina Keene. You are able to unmute yourself.

Jenna King: Can you hear me okay? Regarding the eService's portal, I know there is supposed to be an RCD tab available at some point, but there's just no information about it, do you know when that will be available, as we are quickly approaching the date for us to submit our decision?

Robin Free: Hi, this is Robin Free again with Palmetto GBA. The selection period begins on July 7, and you will be able to see the selection in our eService's portal on that date.

Jenna King: Thank you, and will there be a transcript of this forum available?

Jackie Ryan: Was the question about a transcript?

Jenna King: Yeah, from this forum. Will that be available?

Jackie Ryan: Yes, I believe that will be available. Jill, can you confirm?

Jill Darling: Yes, after the call, we get a transcript. Give us a week or so to get it together for editing purposes.

Jenna King: Okay, thank you.

Jackie Ryan: Next up we have Ruth. Ruth, you are able to unmute yourself.

Ruth Leigh: Hi, this is Ruth. I think there is some confusion as far as the Pre- and Post, and I think the gentleman earlier was talking about the prior authorization, and it's not that, so thank you for clarifying that. But a good clarifying question is, will the chart documentation that's required to be submitted vary between the Pre- and Post-Payment Choice selection? I think answering that will help clarify the timing. So, for instance, for the Pre-Payment choice, would we be submitting documentation while the patient is still in the house, or will the documentation require for the completion of the stay? That completes my question.

Jason Rhodes: This is Jason from Palmetto again, and I want to clarify your question before we answer. So, are you talking about Pre-Payment versus Post-Payment Review? Meaning the Choice 2, Choice 3, and Choice 4?

Ruth Leigh: Correct, the first two choices. So, it helps us to decide, as a facility, which one we go with. Does the documentation for one versus the other vary? Or is it just a matter of the timing when we do a Post-Claim versus a Pre-Claim Review?

Jason Rhodes: Okay, just trying to clarify and make sure we get a good answer for you.

Jennifer Dowell: This is Jennifer Dowell from Palmetto GBA. I want to recap some of the choice selections. So, there are a lot of moving parts, but in the Pre-Claim Review, which is Choice 1, you will admit the patient into the IRF and then start services. Typically, within a couple of days, you will have enough documentation to meet all of the requirements to be able to submit the Pre-Claim Review request. We call that, in short, a PCR—again, this is for Choice 1. If you don't go through that process and get the UTN for when you file that final claim, if you file without it, the claim will suspend for a pre-payment ADR. So that is when all services have already been completed, but before we render payment, we are going to review that entire stay from start to finish. So that is a PCR, where you get the services to start and if you don't go through a PCR, you will do a pre-payment ADR, so that is all Choice 1. Choice 2 is a hundred

percent post-payment, and that is the standard review that you are used to. You would go through admission to discharge, you file the final claim, and after we render payment, we will do a complete ADR review, where we look at the entire stay again, but it's after payment has already been made to the IRF. That is Choice 2. In Choice 3 is a sampling of the post-payment. It still follows the same process, but it's just a sample of the post-payment claim. The last option is Choice 4, that is a Pre-Payment ADR. That means that you will admit the patient, go through the entire stay, discharge them, and when you file that claim before we render payment, we will suspend that and do a full review and look at the entire stay. Does that help explain? It's three different types of review.

Ruth Leigh: That does, absolutely, and thank you for the clarity on that. Just to recap, the PCR, if we go that route, is just based on the first few days of the admission process and not the totality. So, it gives us some days while the patient is in-house to clear up if there's anything we are missing as opposed to the other processes. Thank you, I just want to get that clarified and make sure I knew that. It helps other people make the decision if that's what the option is. Thank you.

Jennifer Dowell: Thanks.

Jackie Ryan: Next we have Annette. You are able to unmute.

Annette Houseworth: Thank you, I am here. My question is a follow-up to the conversation you were just having about the supporting documentation required for Choice 1. You said, Jennifer, within a couple of days, we would have enough documentation to submit the claim. Can you be more specific about what actual documentation is required to initially submit a claim under Choice 1?

Jennifer Dowell: Hi, this is Jennifer again. And I believe it's in one of the slides that Chirymeria went through, but basically, what we need to see is enough information that establishes the medical necessity. So, we need to see when the patient was admitted, that they needed the services at that intensity, with those multiple therapies. There will be additional resources that will be available on the CMS and Palmetto GBA websites that go through the exact specific things like the pre-admission screening, and the POC, or Plan of Care, and therapy evaluations that you go through. Those kinds of documents where we can see the patient or the beneficiaries' condition and we can see that the therapy services have started, the interdisciplinary team has met, and the patient is being overseen by a certified rehabilitation physician—all of those elements. Typically, during those three to four days, no later than the fourth day, you should have plenty of documentation to support each one of those items.

Ruth Leigh: Great, that is helpful, and I appreciate it.

Jennifer Dowell: Sure.

Jackie Ryan: Next, we have Jessica. Jessica, you are able to unmute yourself.

Jessica De La Rosa: Hi, good afternoon and thank you. So, my question is about the submission. My understanding is that on the Pre-Claim side, there will be a post-submission and two-day turnaround time to get the feedback on if the claim has been affirmed or not. If not, then 10 days post the two days, so 12 days total, there will be additional information provided to the facility regarding what is truly falling out. Can you confirm that's correct from the time frame standpoint? Because then we are bumping up the length of stay for the patient, which is a concern there.

Jennifer Dowell: This is Jennifer again. Let me clarify and make sure I understand your question as well. So, you are asking as far as the time frame from when you submit the Pre-Claim Review request to when you get something in writing from the MAC?

Jessica De La Rosa: Correct.

Jennifer Dowell: Ok, what will happen is, when you submit the request to us, you will get a phone call. Whoever the IRF designates as the requester or submitter is who we will contact, and we are going to give you UTN and the decision via telephone. Then, that night, we will create the letter and it will be sent out the next day. So, if we complete a Pre-Claim Review request on day 2, you will likely have the letter on day 3. But we have up to 10 business days, and of course, some of that is technology and us trying to get through all of the processes that we do. So, if you send in something via snail mail, it can take a little longer to get to you. So, we always post a letter in the eService's mailbox as well, so you will be able to see that the next day.

Jessica De La Rosa: Perfect and thank you for that clarification. Just to make sure I'm understanding, will the phone call that's provided within that two days provide specifics on if the claim is non-affirmed, or do we have to wait for the letter for that level of detail?

Jennifer Dowell: No, you will get all the information. So, if it is non-affirmed, you will get the reason why it is non-affirmed and those additional details that were identified during the review. So, if it's something related to the missing pre-admission screen, you will get that information, so you know how to resubmit and get the review affirmed.

Jessica De La Rosa: Wonderful, thank you so much for clarifying.

Jennifer Dowell: Of course.

Jackie Ryan: Next we have Marjorie. You are able to unmute yourself.

Marjorie Mantione: Thank you. I have a question relative to the RCD operational guide that was posted on the website. It stated that a non-physician practitioner can fulfill the IRF services and documentation requirements currently required to be performed by the rehab physician. It went on to say that if a non-physician practitioner with the current definition of a rehab physician in that, we expect the IRF to determine if the non-physician practitioner has specialized training and experience in inpatient rehab and may perform any of the duties as required. But technically, according to regulations, a non-rehab physician can only perform HNP and the third face-to-face

visit after the second week of a patient stay. So, can you please clarify the intent of that particular paragraph?

Amy Cinquegrani: Hi, this is Amy. Yes, we received some feedback on that and that is something we are going to make an update on shortly in the operational guide because you're right. The non-physician practitioner can only perform those limited services so it's a little confusing the way we have that—the first piece you mentioned.

Marjorie Mantione: Thank you. Just one follow-up, if I may, in regard to the Pre-Payment Review, so basically, you evaluate, for example, a pre-admission screen—are you looking for support for medical necessity for the admission? Or are you looking for technical deficits in a document, be it the pre-admission screen or POC et cetera? Because when it says you can then submit multiple times to make corrections or additions, you cannot correct a technical deficit citation because then the document is out of compliance. So, can you assist with that?

Jennifer Dowell: Hi, this is Jennifer Dowell from Palmetto GBA. So, in a Pre-Claim Review, this is the PCR, when you guys submit and it is non-affirmed, we look for medical necessity and also for the other elements to make sure everything is complete and accurate. There are some things that may be omitted to where there can be some type of order or correction. But you are right, that is a key part of the pre-admission screen, such as the patient does not meet the likelihood to have therapy services at that intensity at the time of admission and that time of admission has already passed, then some things are not correctable. However, that still doesn't mean you are not able to resubmit. Some things could be left off that you could submit, so we look at both aspects of that. However, we encourage education through the review team to help get those records complete at the time of submission.

Marjorie Mantione: So, technically, like if the pre-admission screen is missing the prior level of function, and it was cited because it was missing, you cannot really correct that because you would be out of the time frame. You're saying you should try to correct that or make an addendum?

Jennifer Dowell: I guess I am not following a hundred percent. So, if there is an element that was not included in the Pre-Claim Review request, and you have that as part of the record, you can absolutely use that as part of the resubmission.

Marjorie Mantione: Okay, but only if it's part of the record and you have it somewhere but technically, if it was missing from the document and you'd have to add it because it was an oversight, that's pretty much null and void, and that claim cannot be affirmed.

Jennifer Dowell: We would have to look at that and have an example to give a definitive answer.

Marjorie Mantione: Thank you.

Jackie Ryan: The next person is Joan. Joan, you are able to unmute yourself.

Joan Ragsdale: Good afternoon. I wonder what the process for resolution would be if there is disagreement about whether requirements are met. It could be simply an error in the review, or there could genuinely be disagreement as to whether or not the technical requirements are met.

Amy Cinquegrani: This is Amy from CMS, and I can take that. If there is a disagreement, if you're talking from a Pre-Claim perspective, that is why we allow multiple resubmission attempts if necessary. There's that phone call, so there is an interactive dialogue that's available to certainly work out issues if possible. If it really is that you are a provider that feels strongly that the patient meets certain criteria and the reviewer is not in agreement, you have the ability to file a claim, and that will get denied, and you can go through the formal appeal process. Like with any other Medicare service or claim. So, your ability to file those claims and utilize the appeal processes available is not changed here.

Joan Ragsdale: So, the Pre-Claim process offers an advantage, if I hear you correctly, in that you have the opportunity to have a discussion to resolve that issue. Whereas a Post-Claim Review, or retrospective review, is limited to a formal appeal for that disagreement.

Amy Cinquegrani: Right, if a discussion is possible, then that is certainly something that is available. Again, it's the ability to get feedback and submit additional documentation if possible or whatever is needed during the resubmission before the claim has been submitted, because once a claim is submitted, the appeal process is the only option.

Joan Ragsdale: Thank you.

Jackie Ryan: Next, we have Stephanie. You are able to unmute yourself.

Stephanie Zieno: Hi, I just have a question. If our MAC jurisdiction was not listed on the slide that goes through Alabama, California, Texas, and the other jurisdictions, if our MAC is not listed there, should we anticipate after those are through that, we will go through the Review Choice Demonstration?

Amy Cinquegrani: Hi, this is Amy again. No. If your MAC was not one of those four listed, we don't have any plans to include them in the Demonstration.

Stephanie Zieno: Okay, thank you.

Jackie Ryan: Next up we have Justin. Justin, you are able to unmute yourself.

Justin Hunter: Hi, this is Justin Hunter with Encompass Health. I want to clarify the subsequent review choices, Choice 3: Selective Post-Payment Review and Choice 4: Spot Check Pre-Payment Review. So, in Choice 3: Selective Post-Payment Review, as I am understanding, this is going to be a comprehensive chart review of a subset of claims that have been submitted and paid. Is that generally accurate? It's not going to be a hundred percent Post-Pay Review. It's going to be a statistically valid random sample review. Is that fair?

Jason Rhodes: Hi, this is Jason from Palmetto. Yes. We do an evaluation of the number of claims you submitted previously and use it to calculate a statistically valid random sample, and that's the number of Post-Pay ADRs we send to you.

Justin Hunter: Okay, thank you, Jason. And for Choice 4: Spot Check Pre-Payment Review, that is going to involve, as I'm reading and thinking it through, the IRF will admit, treat, discharge the patient and submit a full record of claims and billing and all of that for the patient, and five percent of what has been submitted for payment will be randomly selected and reviewed. So, it's not the Pre-Claim Review, whereby a subset of documentation is going to be reviewed. All documentation and the entire medical record will be reviewed. Is that correct?

Jason Rhodes: Correct. Yeah, the documentation requirement for Pre- and Post-Pay ADR is a full medical record.

Justin Hunter: Ok, so for both Choices 3 and 4, it is a full document or full chart review?

Jason Rhodes: The same as Choice 2.

Justin Hunter: Got it. So that's question number one. Question number two is, and this may be more of an Amy/CMS question, but I will ask it. I know within the past couple of weeks or so, CMS has received quite a bit of feedback, input, question and answer—or questions anyway. The question is when is all of that going to be reviewed and synthesized, and when will the next, final iteration of initial documents that will apply for purposes of looking at all of it and making a decision? When is that review choice decision—by early August—when is all of that going to be wrapped up and finalized and posted on the CMS and Palmetto websites?

Chirymeria Wilson: Hi, Justin. Right now, we are reviewing the documentation submitted, and since we incorporate that to make modifications, we will let you know and give you a time frame of when that documentation will be posted to the website. Right now, we are incorporating that feedback.

Justin Hunter: Okay, thank you.

Jackie Ryan: Next up we have Jonathan. Jonathan, you can unmute yourself.

Jonathan Gold: Jonathan Gold from the American Hospital Association. I just want to thank you for taking the time for our questions today. There is one thing I want to clarify regarding the Pre-Claim track. You discussed that in a lot of cases, you will get the letter to providers as early as three days after, which is great, but regarding the initial phone call the provider is expected to receive, how much detail will be provided in the initial conversation? And more importantly, will it be enough for the provider to start remedying any defects in the documentation or something similar like that, or will they have to wait for the letter in order to get the details of a non-affirmed decision?

Jennifer Dowell: Hi, this is Jennifer Dowell from Palmetto GBA. So, during that phone call, it will be very detailed. The reviewer will go through everything that was identified as potentially

deficient during that call and provide education on what resources were used and walk the provider through what was found during the review. So, it's a pretty detailed call and we go through the decision, and the overview of it was non-affirmed because the pre-admission screen was missing XYZ and also give more details as far as what was specifically identified. So those phone calls are used as provider education and are pretty in-depth calls.

Jonathan Gold: That is helpful, thank you for that. And as a follow-up, if for some reason the letter is delayed, is the provider able to resubmit prior to receiving the letter or rectify the situation quickly in order to get a second decision quickly?

Jennifer Dowell: Yes, you'll be able to resubmit relatively quickly. You don't have to wait on the letter if it's delayed. That's one of the reasons we want to make sure we give you the UTN over the phone.

Jonathan Gold: Thank you.

Jennifer Dowell: You're welcome.

Jackie Ryan: Next we have Raquel. Raquel, you are able to unmute yourself.

Raquel Largent: Hi and thank you for taking my question. We are not in one of those four states, Alabama, Pennsylvania, Texas, or California—so if we are not in one of those states, what happens to us during the five-year Demonstration period? Are we expected to come online? I know someone asked that question, but I just wanted to clarify. What is our responsibility during that time?

Amy Cinquegrani: This is Amy from CMS. Your facility would not be a part of the Demonstration. So, your claims would be subject to any sort of normal medical review process if chosen by the RAC or MAC as part of a Targeted Probe and Educate process.

Raquel Largent: Thank you for clarifying, I appreciate it.

Jackie Ryan: The next question is Kelly. You are able to unmute yourself.

Kelly Pratt: Hi, I wanted to clarify that if we are doing the Post-Claim Review, that process is the same, and so we get a letter, do we to submit a group of claims as we would have during a RAC audit? Is that the process we will work under?

Amy Cinquegrani: Hi, this is Amy from CMS. I may need you to clarify. So, are you talking about when you get an additional documentation request?

Kelly Pratt: So, it sounds like for the Pre-Claim Review, someone will be submitting claim by claim or case by case, so I'm wondering if we choose the Post-Review, are we going to be expected to submit a whole batch, or is it still going to be submitted case by case?

Jason Rhodes: This is Jason from Palmetto GBA. For the non-PCR options, it is an ADR process. So, similar to what you are used to working with MACs right now, you submit a claim and prepay, and you will get an ADR to alert you that you need to submit documentation and post-pay, you will receive a payment and you then you will get ADR to alert you that you need to submit documentation. It's the same format you are used to using with medical reviews.

Kelly Pratt: Ok, thank you.

Jackie Ryan: I think we have a little more time, so Heather you are next. You can unmute yourself.

Heather Girard: Hi there, thank you. I have a question about the additional required documentation as part of the Pre-Claim Review. A few of these documents have time frame requirements, like the POC has a four-day requirement and the weekly team conference. However, the first weekly team conference may not happen until day seven or possibly day eight. I believe Jennifer said you would be able to submit the documentation for the Pre-Claim request after about three days or so—is it your recommendation to wait until you have the POC in the record to submit that, or is that not necessarily required for the Pre-Claim Review?

Jennifer Dowell: This is Jennifer Dowell again. So, depending on how your particular IRF moves your patients through those processes, and there are certain requirements for the PCR, so obviously, we need to see the POC, we need to see that the interdisciplinary team conferences have started, we just need to see one of those. Just like we need to see the physician visit to the patient. So those certain requirements must happen before you submit the Pre-Claim Review request to us. So, depending on how your particular IRF does those different processes will determine when you will submit the Pre-Claim Review to us. But we would need all of those elements as part of the PCR.

Heather Girard: So, if there's a standing team conference and it doesn't happen until six or seven days from patients' admission, that needs to be completed before you send it in?

Jennifer Dowell: Right. We need to see that conference. Sure.

Heather Girard: Thank you, I appreciate it.

Jackie Ryan: Next up we have Charlotte. Charlotte, you are able to unmute yourself.

Charlotte Raymor: Yes, I'm going to follow up with what was talked about as far as the documentation. So typically, when we are looking at these cases in the past, any technical requirements, you know if something wasn't on the HMP, or if something wasn't on the pre-screen, it is pretty straightforward. But issues in relationship to medical necessity or IRF level of care have been where the challenges lie between providers and auditors. So, my thought process is, when I first thought about this, is I'm going to submit the pre-screen and HMP, and maybe the first progress notes and get feedback on if there are concerns or something they are not seeing that we see in relation to the medical management of the patient. So, I would not be inclined, unless required, to wait until day seven to submit IDT. I understand I may get an initial no, but at

least I get clarity in terms of concerns you may be seeing that we can ask the physicians or the team to clarify. But by day seven or eight or nine, if you get two days for an answer, it would be very hard for me to go back to clarify that related to the medical management of the patient so that is my question. Is there a minimum we have to submit, or is it our discretion what we submit if we are doing Pre-Payment Review? I think that is the advantage of doing it while the patient is in-house, so we can meet the intent if you feel our documentation is not supporting what we're doing for the patient. So that is why I am curious.

Jennifer Dowell: Hi, Charlotte, and this is Jennifer Dowell again. I'm so sorry because I know you had a couple of different questions in there, do you mind restating your question again?

Charlotte Raymor: Sure, my thought was if we picked the review while the patient was in-house my thought to the facilities is to send pre-screen, the HMP, maybe the first progress notes, because most of the time, like I said, the technical denial issues in terms of time frame are clear-cut. We need to know what needs to be in the pre-screen, we know that kind of thing, but I was not inclined to wait until the team conference to submit anything for an initial review because if we get a phone call they say it's not clear to us that they need IRF level of care because I don't see medical management, or whatever they tell us, I want to be able to rectify that because obviously we bring patients on in the intent that we are meeting the requirements. But when we have done appeals in the past, the discrepancy between what we see in the record and what the auditor sees has put us in a position to have to respond to clarify when we are doing those appeals. We are going to be doing it now in the record based on the feedback we get, and I didn't anticipate waiting until the first team conference to submit that first group of documentation. So, unless we are being told at minimum that this is what you need to submit, I would be telling my facilities to submit the pre-screen, HMP, to see what clarification they are going to request and what they see based on the documentation we are sending. So that's why I'm trying to understand, if there is a minimum, we have to submit for the first request, or is that our discretion?

Jennifer Dowell: Gotcha. Thank you for clarifying. So, there are certain requirements that will have to be submitted for the Pre-Claim Review request, and we will absolutely have tools and checklists to help you guys go through to make sure that you have all of those required elements. Those will be posted on the CMS and Palmetto GBA website to guide and walk you through exactly what is needed for that submission. So, we will make sure you have everything you need in order to achieve that affirmation when we start on August 21.

Charlotte Raymor: My only caution is to submit after the first team conference if a facility does it on day number six, it will be date eight before we have an answer, and that seems very long to be able to resubmit or have anything clarified before a patient is discharged. Because normally now when I query the physician on something that I'm questioning in the record, I usually do it after HMP is done or the Plan of Care, and I wouldn't wait until day seven to do that with the physician or the clinical team.

Jennifer Dowell: Understood. So, if you have a way to show the interdisciplinary team conference and how you work, that would absolutely be up to your discretion as far as how you

show that documentation. But we need to see evidence of the interdisciplinary team that is working with that patient. So that's up to you how you show that compliance.

Charlotte Raymor: Great, thank you.

Jackie Ryan: Next up we have Cynthia. You are able to unmute yourself.

Cynthia Dennis: Hi, I am just clarifying, so with the Post-Payment Review, which is similar to what we have done in the past, there is no interactive phone calls. It is all just paper. Is that correct?

Jennifer Dowell: Hi, this is Jennifer Dowell, and that is correct. For our Choice 2, 3, and 4 full ADRs, either Pre-Payment ADR or Post-Payment ADR, you will not receive a phone call. You will receive everything through a letter. If the claim is denied, you will receive that letter with that same information.

Cynthia Dennis: So, to me, that seems a little like I am not getting as selective information. I'm not getting where we ask questions and that kind of thing. So that is the plus of the Pre-Claim, is basically what you're telling me?

Jennifer Dowell: Right, you do get that education from the reviewer with the Pre-Claim Review, and you do have the option of resubmitting with the PCR.

Cynthia Dennis: Right, okay, and forgive me, I was having audio problems initially. I was under the understanding that there was going to be a hundred percent review of the cases. That's not correct, or is that correct? For that time period when the review is done.

Jennifer Dowell: So, for Choice 1 and 2, those are 100 percent, so every patient you have will need to go through one of those processes. PCR Choice 1 is 100 percent of everything that you will file a claim for will need that UTN in the decision you get from that. If you are in Choice 2, which is the hundred percent Post-Payment Review, that is, every claim you submit during that six months cycle will go through a Post-Payment Review process.

Cynthia Dennis: Thank you.

Jackie Ryan: Next up, we have Joe. You can unmute yourself.

Joe Nahra: Hi, I am Joe Nahra with AMRPA. I wanted to ask a question about the sampling methods for Choices 3 and 4. I know Choice 3 says that there will be a statistically valid random sample, and Choice 4 says five percent selection and specifically doesn't say anything about statistical methods. The question—is CMS going to provide information about what methodology is being used for both of those choices, and how you are going to make sure those samples are representative of the cases?

Jason Rhodes: Hello, this is Jason from Palmetto GBA. We will look at Choice 4 first, as it is the easiest math to understand. So, we take a period of time claim submissions, usually the

previous six months. From that, if you submitted a hundred claims, we would just select five percent of that in the following cycle, to check and see your compliance with the Medicare regulations. And as far as the other methodology for Choice 4, we can get with the statistical analysis team and provide you with more detail. But essentially, it's the same sort of math. We look at the previous six months, apply a statistically valid random sample to that, and then we are able to ascertain how many claims we should select in the next cycle to have a representative sample of what you are billing.

Joe Nahra: Just to follow up, I understand how you are determining the number of claims selected, but is there anything in that methodology for either choice about whether those claims themselves are actually representative? For example, like you said, if you submit a hundred claims in one cycle and then your spot check is five of those claims, if there is no method attached to that, it could just be selecting five claims that happen to be, you know, really on the fringe of IRF care or tend to be really representative of the cases' mixes. Is there anything that is going to ensure that it's both numerically and statistically valid and also valid compared to what the IRFs are actually seeing?

Jason Rhodes: So, if you're asking if we drill down to the CMG level to take a representative of the sample of the number of CMGs you are sending? Is that your question?

Joe Nahra: Yes, or any sort of method to identify what the claims actually look like beyond the number of claims.

Jason Rhodes: So, the random sampling that we are talking about is on a numeric value, and we are not drilling down to say, a provider submitted 12 of the CMGs, so we'll take one here, 13 of that, so we'll take one there—it's not to that level or granularity. It's more of a holistic look, we submitted X number of claims, then X number of claims goes through this mathematical equation, and this means that we should get this number.

Joe Nahra: And that's the same for Choice 3 as well?

Jason Rhodes: That is for Choice 3 and 4, yes.

Joe Nahra: Thank you.

Jackie Ryan: Next up is Mario. You are able to unmute yourself.

Mario Ruiz: Hi, I have a question in regard to the MACs. So, we are under the Noridian jurisdiction. How is it that we have to follow Palmetto? Is Palmetto running everything for the whole United States, or will we eventually get transferred to Noridian?

Amy Cinquegrani: This is Amy with CMS. No, if you're with Noridian and California, you will follow Noridian processes for when California becomes a part of the Demonstration. Generally, the IRF regulations are the same nationwide, and the operational guide that we're posting online and the review guidelines that we are posting online will be applicable to all states and all MACs. There may be some differences in the portal and such like that when it's time to make

your Choice selection and how to submit documentation. Because we have only committed to a time frame for the implementation of the Demonstration in Alabama, that is why we have Palmetto with us today.

Mario Ruiz: Thank you so much.

Jackie Ryan: Next up we have Kate. Kate, you are able to unmute yourself.

Kate Beller: Thank you so much this is Kate Beller with AMRPA. I appreciate the chance to ask an additional question. So, this is about the Post-Payment Review track and the claims that will be included in the calculation for each six-month review cycle, particularly the first. As I understand the program documents, there could be a hundred days between claim submission and the final decision in the review track. So, how will calculations adjust the claims that are not resolved by the end of the review cycle? Looking at the dates provided in the presentation, which is helpful, it seems like there's a fair number of cases that will not be fully resolved by the time hospital affirmation rate is calculated in cycle number one.

Jason Rhodes: Hi, this is Jason from Palmetto. Just so I can understand the question, can you restate that one more time for me?

Kate Beller: Of course, sure. So, in the Post-Payment Review track, as I understand the time frame provided to both the IRF and the contractor, there may be more than a hundred days between the claim's submission and the final decision as to whether that claim is affirmed or not. But then, looking at the time frame for when the hospital cycle compliance threshold is calculated, there may be quite a few claims that have not gone through the full resolution process yet by the time, especially in cycle one, a hospital's compliance rate is calculated. It seems like there will be a number of Post-Payment Review claims that are being resolved at the MAC level.

Jason Rhodes: Sure, that's a fair question. We have experienced a different Demonstration doing the same sort of process, where we've been able to work to have claims sampled early enough in the cycle to have enough time for providers to respond and for us to deliver a decision and have that within the six-month period. We do our best to strive to have all claims resolved prior to the calculations of the cycle, and we try our best to do the sampling within the first three months of that cycle to give adequate time for responses and review time and also to get information back out to providers as quickly as we can.

Kate Beller: Ok, I appreciate that information. Thank you very much.

Jackie Ryan: Next up, we have Leigh Allen again.

Leigh Allen: Hello, thank you. Asking for clarification on whether there is a specific time limit on sending documentation for the PCR for Choice 1 or if it can just be any time prior to the patient's discharge and the claim submission.

Jennifer Dowell: This is Jennifer Dowell. For Pre-Claim Review requests, you can submit any time before the final claim is submitted. There is no timeline or deadline. It just has to be before the claim is submitted to us.

Leigh Allen: Ok, one follow-up question. The later we wait, would the expectation be that we submit more documentation?

Jennifer Dowell: No, you have just the required elements that you have to submit. So, it doesn't matter if you submit the Pre-Claim Review on day 4 or 54, the documentation requirements for a PCR remain the same.

Leigh Allen: Thank you.

Jackie Ryan: Next we have Kristina. You are able to unmute yourself.

Kristina Gingrich: Hello, I am wondering how this process will impact the submission of the 60/40?

Amy Cinquegrani: Hi, this is Amy from CMS. I am not sure if Palmetto has any more information—I don't know that I am familiar with that, or is there any other information you can provide?

Kristina Gingrich: My question is that annually we submit our 60/40 to make sure we are in compliance, having 60 percent of cases qualify. So how will this impact [inaudible].

Jason Rhodes: You broke up on that last little bit. This is Jason from Palmetto again. You Are submitting that to the MAC for the 60/40?

Kristina Gingrich: No, to CMS.

Jennifer Dowell: This is Jennifer. I believe you're talking about the audit reimbursement where we are looking at percentages of Medicare patients. I think we will need to talk about that a little more internally. We do not believe it will impact, but just to confirm, we need to do a little more research.

Kristina Gingrich: Ok, thank you.

Jackie Ryan: Next up, we have Condor J.

Condor J: Thank you, I just had a question about the selection of IRF in the states. In Alabama, for instance, is it only IRFs that have Palmetto or other MACs as well?

Amy Cinquegrani: This is Amy.

Condor J: There's confusion some as to whether it's just Palmetto or others.

Amy Cinquegrani: So, the initial rollout in Alabama would be for those physically located in Alabama that submit claims to Palmetto.

Condor J: So, just physically located in Alabama and submit to Palmetto. Ok, thank you.

Jackie Ryan: Alright, Kristina you are able to unmute. Your hand is raised. Ok, we will go to Joe then. Joe, you can unmute yourself.

Joe Nahra: Thank you for letting me answer one question. I appreciate the comments earlier, specifically with documentation requested during the Pre-Claim Review process. Right now, for the Post-Payment Review, Choice 2, the operational guide has a list of potentially requested documentation but doesn't specify exactly what will be required during the ADR. Is there going to be a standardized list of documents that are requested for those ADRs, or would it differ from claim to claim in that Post-Payment Review cycle?

Jennifer Dowell: Hi, this is Jennifer Dowell again. The list you see, the operational guide, those would be the elements or the documentation pieces that we need to see on the Pre-Payment and Post-Payment ADRs.

Joe Nahra: So, any ADR you receive will be the same across all claims, and that will be the list?

Jennifer Dowell: Correct.

Joe Nahra: Thank you so much.

Jackie Ryan: So, I currently don't see any more hands raised right now. I spoke too soon. Charlotte, you can unmute yourself.

Charlotte Raymor: I had one thought about how to handle the patient because I know the patient will get notified if we end up getting a no. So how do we handle that in terms of non-coverage notices or situations where we are ready to discharge a patient if they have their appeal rights? How does that work in relation to if we don't get a yes on the pre-payment?

Amy Cinquegrani: This is Amy from CMS. Do you mean how you should communicate that to the patient or because the patient is getting a letter?

Charlotte Raymor: Right. So, if a patient is in-house, we go through this process and don't get an affirmed decision, and we are ready to discharge the patient, and they say we don't feel that we're ready, and we say they are, in a normal process they would have an appeal, right, and we would go through the process with them. But how will we handle it now? Will that process still be the same even though we know we are not going to get paid? I just don't know how to handle that with the patient because they will get the letter in 10 days, but we will get the verbal in two, and they may still be a patient and may not have received a letter, and I don't want them to get home and see the letter. It just opens up a can of worms as far as the patient side of things.

Amy Cinquegrani: Thank you for clarifying that. The early discharge appeals do not go to the MACs, they go to the QIOs?

Charlotte Raymor: Correct.

Amy Cinquegrani: So that is not something Palmetto would handle. Palmetto, do you have any feedback on this question? We may need to communicate more with some of our other internal CMS partners, QIOs, and MACs and make sure we're communicating the same information and have suggested language that can come from you all to them, unless Palmetto has anything to add now.

Jennifer Dowell: Hey Amy, this is Jennifer Dowell. I don't have anything to add. I agree with you that we probably need to talk internally and create suggested language.

Charlotte Raymor: Thank you.

Jackie Ryan: The next hand we have is Kate. You are able to unmute yourself.

Kate Beller: Thank you for your generosity with your time. One question I have as a follow-up to my last one involves what happens when a claim is overturned in favor of a provider upon appeal, perhaps second or third level of appeal, will that have an impact on the provider affirmation rate?

Jason Rhodes: This is Jason again from Palmetto. Unlike TPE, any appeals downstream will not have an impact on the affirmation rate. The reason why that is, is unlike TPE if you get an appeal overturned downstream, they recalculate your rates, and that could remove you from TPE and the key providers on the same cycles. In this Demonstration, we are not going backward in time changing affirmations. We are moving forward at the time that we do calculations. All the data that is required is there or present from the actual medical review, and then we will move forward working with providers through education and such like that. But no, we don’t take account for appeals in those calculations.

Kate Beller: As a follow-up, will that be taken into account or reported by CMS? If certain providers are struggling to get to the more selective review, but if you take into account the claims they appeal, they actually would have a high compliance threshold.

Amy Cinquegrani: Hi, Katie, it is Amy from CMS. We will certainly be reviewing appeals data, and that is something we get in our other program reporting, and we will make sure that we get that in this program. At this time, I cannot say if that will be considered for moving into subsequent review choices. Operationally, Jason was describing how they do that, and I don't know how they would work that in. But we will certainly be monitoring appeals, and when we have data to report publicly, we will include appeals information in there.

Kate Beller: Great, thank you so much, Amy and Jason.

Jackie Ryan: Alright, we will do one more question from Cynthia. You are able to unmute yourself.

Cynthia Dennis: Thank you, just a real quick one. I just want to wrap my head around everything. On Choice 4 when you're doing spot checks, it says MAC selects five percent of IRF claims every six months for five years, is that correct?

Amy Cinquegrani: Yes, that is correct.

Jill Darling: Thank you everyone for joining us, and I will hand it to Amy for closing remarks.

Amy Cinquegrani: Thank you, Jill, and everyone again who joined us. We had a lot of great questions, and we are working on incorporating feedback that we have already received into our operational guide. As well as getting feedback for review guidelines and checklists and all that good stuff that we hope to post within the next week or so as soon as possible, understanding that the choice selection time frame is going to open soon, and we want to get that out to you. These questions have been helpful in showing where we need to provide additional guidance in our materials, and we appreciate all of the feedback. If anyone has additional feedback, feel free to use the e-mail address that was posted at the beginning of the presentation. Keep an eye on the website for all the updates that I just talked about. Thank you again and have a great afternoon.