Review Choice Demonstration for Inpatient Rehabilitation Facility Services (IRF RCD) Cycle 3 Report

***Alabama IRF RCD Cycle 3** (January 1, 2025 – June 30, 2025)*

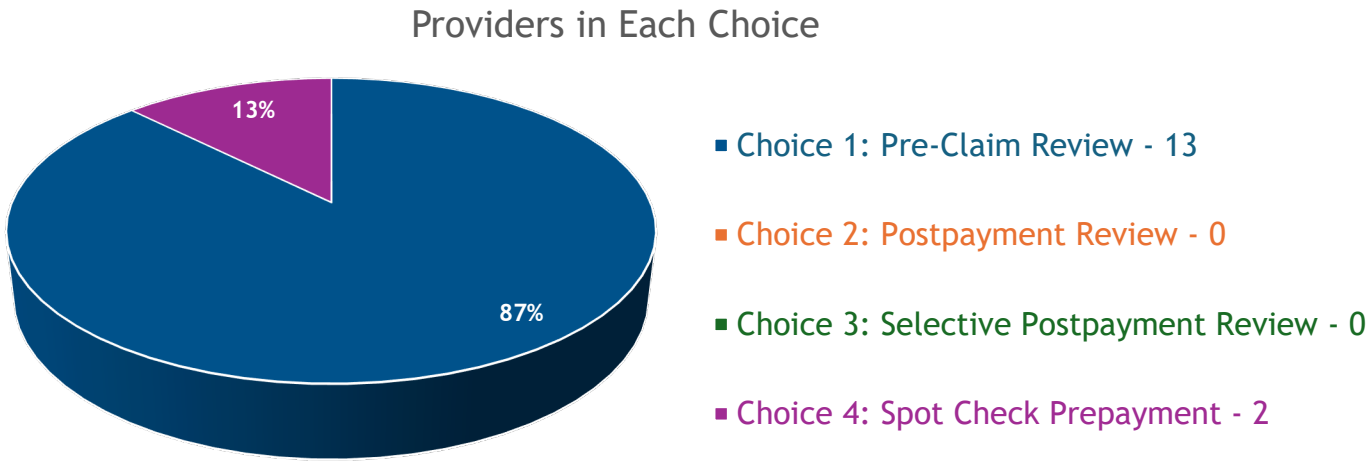
This report provides a high-level progress update on Alabama's IRF RCD Cycle 3. It is intended to offer stakeholders a transparent overview of provider engagement, process integrity, and demonstration outcomes. The summary reflects Alabama's Cycle 3 experience with the RCD, highlighting trends in provider participation, compliance with Medicare documentation standards, and overall demonstration performance. The Cycle 3 snapshot that follows outlines key metrics and insights observed during the reporting period.

Cycle 3 Snapshot:

- The affirmation/approval rate threshold for Cycle 3 is 90%
- Of the 15 participating IRF providers:
  - 6 met the 90% threshold
  - 9 achieved rates between 80 - 90%
- The majority of participating IRFs (13 of 15) selected the pre-claim review option
- Participating IRFs submitted 17% fewer claims for payment by the end of Cycle 3 compared to the six-month period prior to RCD implementation

Choice Selection and Reviews

Demonstration operations continue to progress as planned. In Cycle 3, 15 facilities participated in the demonstration, with 13 facilities selecting pre-claim review and 2 facilities selecting spot check postpayment review. The IRF RCD offers multiple review choice options that reward providers for sustained compliance with Medicare requirements and allows flexibility in how providers choose to participate in the demonstration. Based on the results of Cycle 2, 7 IRFs met the approval/affirmation rate threshold and had the ability to select a different review option; however, 5 IRFs still elected to remain in pre-claim review in Cycle 3. Based on the results of Cycle 3, 6 IRFs met the threshold and now have the benefit of selecting from alternative review options in Cycle 4.



Pre-Claim Reviews	
Initial Requests Reviewed	5395
Initial Requests Provisionally Affirmed	4294
Resubmission Requests Reviewed	2107
Resubmission Requests Affirmed	559
Total Requests Non-Affirmed	2649
Provisional Affirmation Rate[1]	90%
Total Affirmation Rate[2]	65%

Prepayment and Postpayment Reviews	
Claims Received	183
Claims Approved	177
Claims Denied	8
Claim Approval Rate	97%

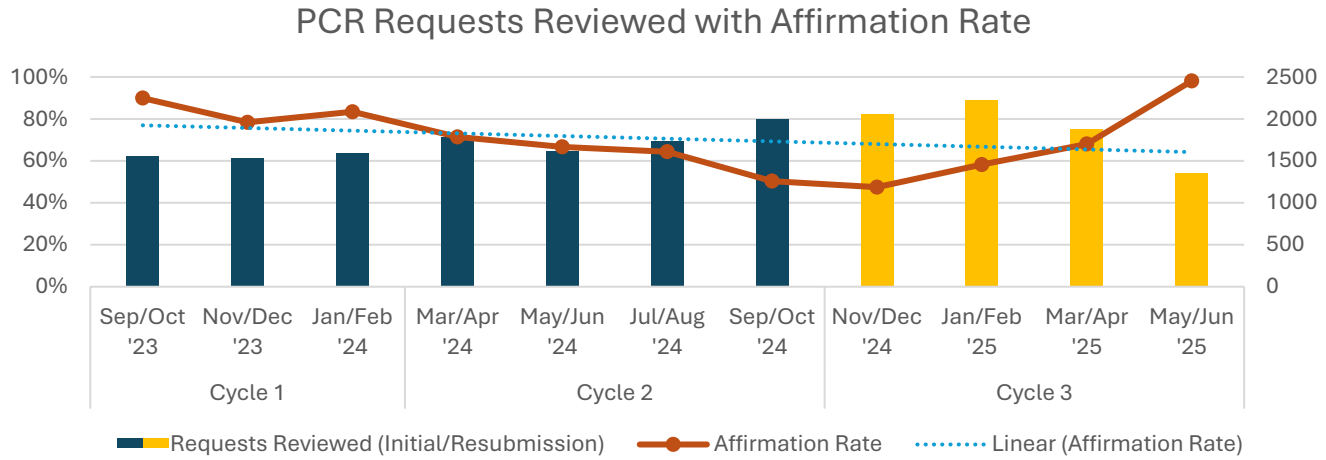
[1] Provisional Affirmation Rate (90%) = (Initial Requests Provisionally Affirmed (4294) + Total Number of Resubmission Requests Affirmed (559) / Initial Request Reviewed (5395)). This rate reflects cycle-level data used to determine whether applicable affirmation thresholds are met and does not take into account requests that take multiple resubmissions to achieve an affirmation. It differs from the percentage reported in the Prior Authorization and Pre-Claim Review Program FY Statistics Documents, which provides an aggregate, fiscal-year snapshot across all providers and operational states and includes all pre-claim review submissions regardless of outcome. The FY Statistics Documents are intended to reflect overall MAC review activity rather than cycle-level performance. Because these measures serve different purposes and use different methodologies, they are not comparable. The FY 2024 Statistics Document is available on the Prior Authorization and Pre-Claim Review Initiatives webpage in the Downloads section.

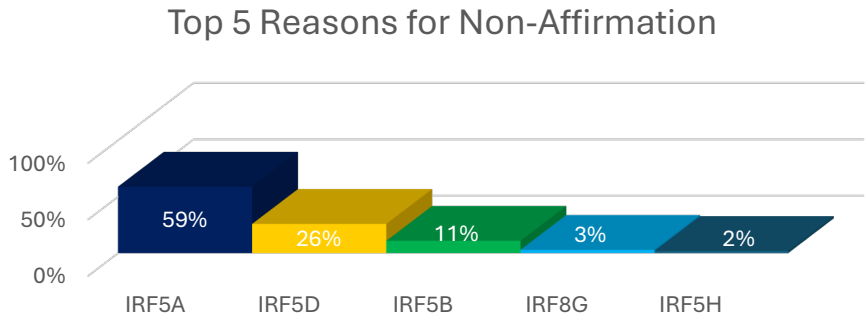
[2] Total Affirmation Rate (65%) = (Initial Requests Provisionally Affirmed (4294) + Total Number of Resubmission Requests Affirmed (559) / Total Request Reviewed (7511))

Affirmation Rate Trends

The chart below covers three operational cycles of the demonstration. In Cycle 2, affirmation rates gradually decreased, with an increase in medical necessity non-affirmations compared to Cycle 1, while PCR request volume remained steady. The affirmation rate threshold increased from 80% in Cycle 1 to 85% in Cycle 2. Some providers met this higher threshold; others did not and which led to enhanced support and education efforts.

The Cycle 3 threshold was set at 90%. In response to lower affirmation rates in the previous cycle, CMS worked closely with both the MAC and providers to provide targeted support and enhanced education. Affirmation rates increased progressively throughout the cycle, with measurable improvements during May/June and July/August, as seen below. Overall, the consistent volume of requests reviewed coupled with rising affirmation rates in Cycle 3 illustrates improved provider compliance with demonstration requirements.



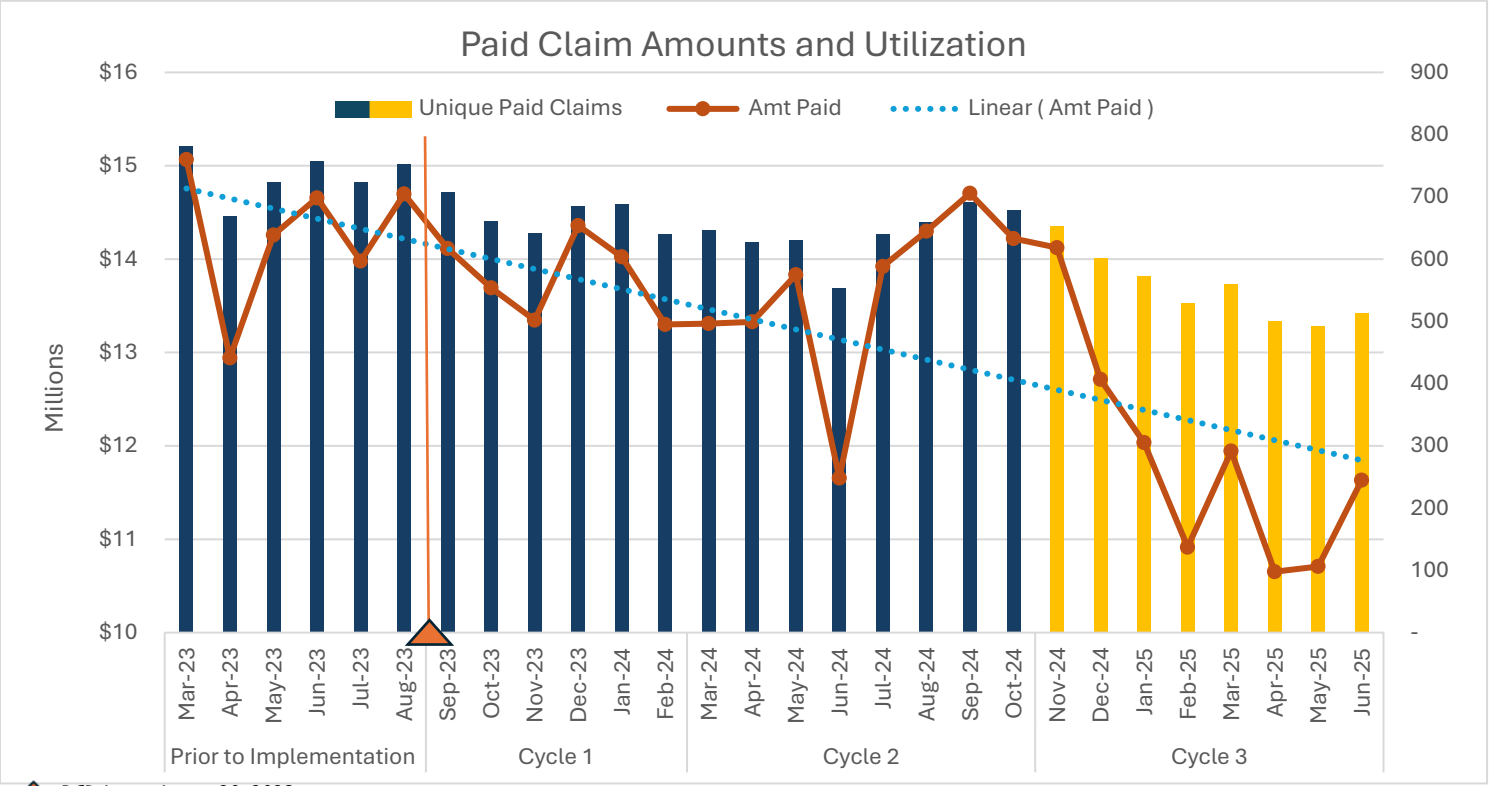


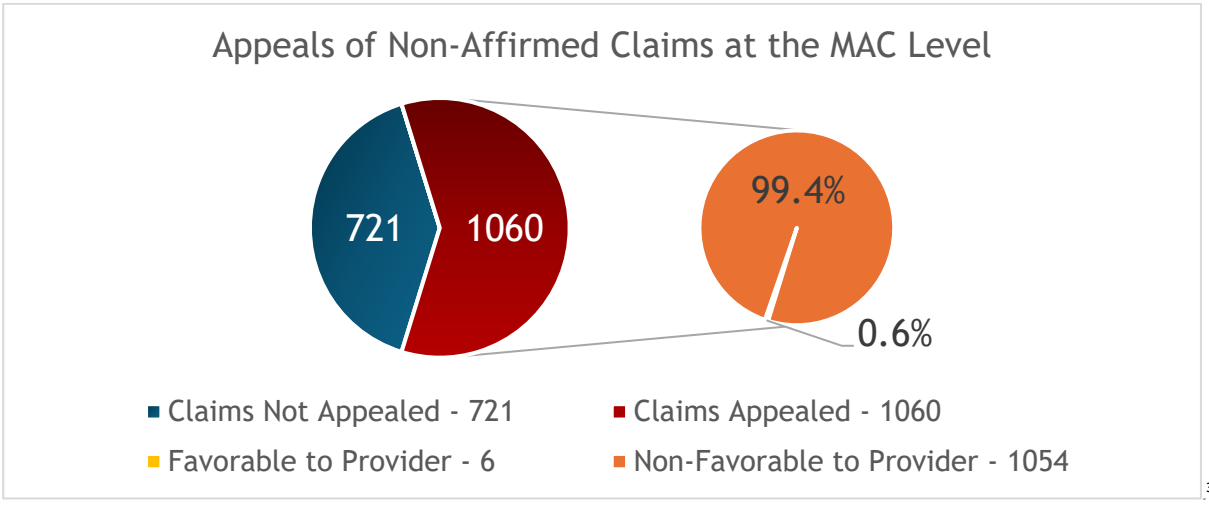
Code	Top 5 Non-Affirmation Reason Codes
IRF5A	The documentation does not support the beneficiary required supervision by a rehabilitation physician.
IRF5D	The documentation does not support the patient is sufficiently stable at the time of admission to the IRF to be able to actively participate in and benefit significantly from the intensive rehabilitation therapy program.
IRF8G	Documentation does not support that therapy services began within thirty-six hours from midnight of the day of admission to the IRF.
IRF5B	Documentation does not support that upon admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs.
IRF2A	Documentation does not support the preadmission screen was completed or updated within 48 hours immediately preceding the IRF admission.

Utilization and MAC Appeal Trends

The chart below shows claim payment trends in Alabama, with baseline data from the 6 months prior to implementation. During the demonstration period, average claims paid decreased by 17% and claim volume decreased by 25% compared to the 6-month baseline period. These changes reflect improved understanding of Medicare coverage requirements and more accurate claim submissions, supported by the demonstration's education and technical assistance. Beneficiaries continue to receive medically necessary IRF services as the demonstration focuses on ensuring claims meet coverage criteria before submission.

This data reflects a snapshot in time, as providers are afforded one year from the date of service to submit claims, and additional claims may be submitted within the allowable timely filing period.



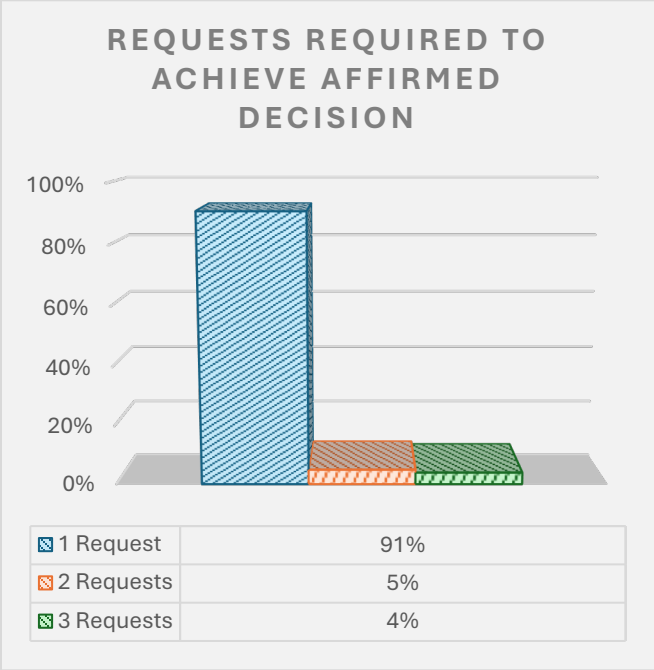


[3]

[3] This chart reflects a running total volume of denied claims eligible for appeal from the start of the demonstration through the end of Cycle 3.

MAC Oversight

CMS maintains ongoing oversight of MAC medical review activities through regular collaborative meetings. These sessions focus on program operations, medical review, and policy-related matters to ensure consistent application of Medicare coverage requirements. To ensure accuracy of MAC review decisions, CMS works with the Medical Review Accuracy Contractor (MRAC) to conduct sample reviews, which resulted in a 100% accuracy rate in Cycle 3. In Cycle 3, many cases were affirmed on the first submission. A small percentage required second or third submissions, demonstrating improved initial submission quality. These results indicate that the demonstration's education and technical assistance have strengthened provider understanding of documentation and review requirements.



MAC Oversight	
Average PCR Review Timeframe in Days	1.7
PCR Reviews Exceeding 2 Business Days	0
Number of Resubmission Outreach Attempts	2652
Number of Physician-Led Provider Education Calls Requested	17
MAC Accuracy Rate	100%

Glossary

Allowable Claims
The total amount of dollars that are allowed to be disbursed for all the claims that received affirmation.

Choice 1: Pre-Claim Review
A request for provisional affirmation of coverage submitted to the MAC for review before a final claim is submitted for payment. The provider can begin or complete services before submitting the request.

Choice 2: Postpayment Review
The MAC reviews every claim that has received payment from Medicare.

Choice 3: Selective Postpayment Review
The MAC reviews a statistically valid percentage of claims (based upon the previous six months of claim volume) that have received payment from Medicare.

Choice 4: Spot Check Prepayment Review
The MAC reviews a 5% sample of an IRF's submitted claims (based upon the previous six months of claim volume) before they are paid.

Linear Trendline
A straight line that best represents the overall direction of the data, helping to visualize a pattern or relationship between variables.

Medicare Administrative Contractor (MAC)
A private health care insurer that has been awarded a geographic jurisdiction to process claims for Medicare Fee-For-Service beneficiaries. CMS relies on a network of MACs to serve as the primary operational contact between Medicare and the health care providers enrolled in the program.

Number of Claims Reviewed
The number of claims that underwent prepayment or postpayment review through Choices 2, 3, or 4.

Number of Claims Approved
The number of claims that underwent prepayment or postpayment review through Choices 2, 3, or 4 and were found to be payable.

Number of Claims Denied
The number of claims that underwent prepayment or postpayment review through Choices 2, 3, or 4 and were found to be not payable.

Claim Approval Rate
The number of payable claims divided by the total number claims reviewed through Choices 2, 3, or 4.

Initial Requests Reviewed
The number of initial pre-claim review requests submitted to the MAC and either provisionally affirmed or non-affirmed.

Resubmitted Requests Reviewed
The number of resubmitted pre-claim review requests submitted to the MAC and either provisionally affirmed or non-affirmed.

Requests Provisionally Affirmed
The number of pre-claim review requests (whether initial or resubmitted) that received a provisional affirmation decision. A provisional affirmation decision is a preliminary finding that a future claim submitted to Medicare for the service likely meets Medicare's coverage, coding, and payment requirements.

Requests Non-Affirmed
The number of pre-claim review requests (whether initial or resubmitted) that received a non-affirmation decision. A non-affirmation decision is a preliminary finding that a future claim submitted to Medicare for the service does not meet Medicare's coverage, coding, and payment requirements.

Provisional Affirmation Rate
The number of provisionally affirmed pre-claim review requests (whether initial or resubmitted) divided by the total number of initial pre-claim review requests received.

Total Affirmation Rate
The number of provisionally affirmed pre-claim review requests (whether initial or resubmitted) divided by the total number of pre-claim review requests reviewed (whether initial or resubmitted).

Accuracy Rate
CMS's Medical Review Accuracy Contractor (MRAC) reviews a sample of MAC prior authorization and pre-claim review decisions to determine the accuracy rate for each program. To calculate the accuracy rate, divide the number of prior authorization/pre-claim review decisions when the MRAC agreed with the MAC's decision by the total number of prior authorization/pre-claim decisions the MRAC reviewed.