Review Choice Demonstration for Inpatient Rehabilitation Facility Services (IRF RCD) Cycle 1 Report

***Alabama IRF RCD Cycle 1** (August 23, 2023 – February 29, 2024)*

This report provides a high-level progress update on implementation of the IRF RCD for IRF facilities in the state of Alabama during cycle 1. It is intended to offer stakeholders a transparent overview of provider engagement, process integrity, and early demonstration outcomes. The summary reflects the initial experience with the IRF RCD in Alabama, highlighting trends in provider participation, compliance with Medicare documentation standards, and overall demonstration performance. The Cycle 1 snapshot that follows outlines key metrics and insights observed during the reporting period.

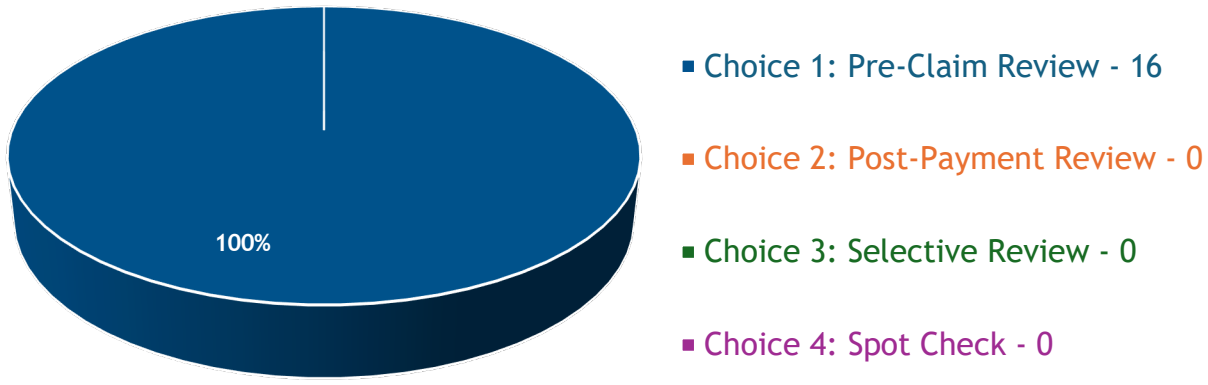
Cycle 1 Snapshot:

- All 16 IRF facilities in Alabama selected pre-claim review choice
- All IRF facilities in Alabama met the 80% affirmation rate threshold for Cycle 1
- Medicare IRF Expenditures in Alabama saw a decrease of 7.5%, by the end of cycle 1

Choice Selection and Reviews

Since implementation of the IRF RCD in Alabama, demonstration operations have continued to progress successfully. All 16 IRFs in Alabama selected the pre-claim review option even after meeting the affirmation threshold rate (80%). The ability to resubmit requests an unlimited number of times, combined with the Medicare Administrative Contractor (MAC) Medical Director's review of non-affirmations, has supported high engagement and compliance. These early results suggest that with continued communication and preparation, Alabama's experience can inform broader implementation efforts in other states.

Providers in Each Choice



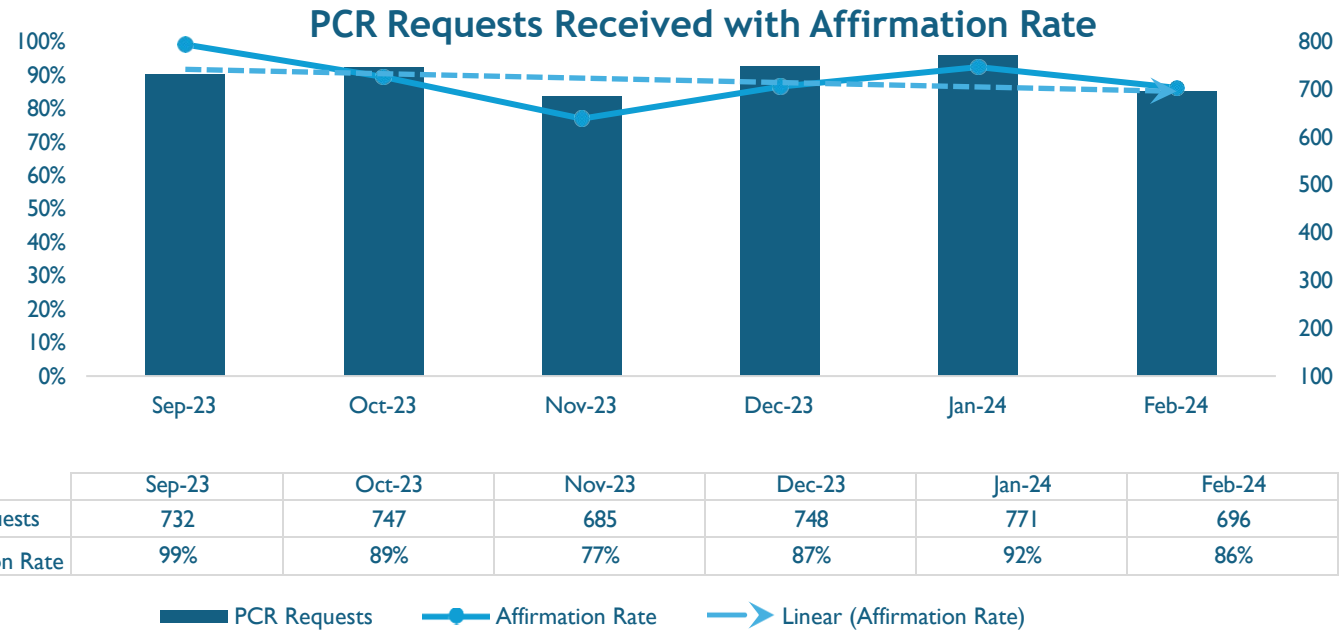
Pre-Claim Reviews	
Initial Requests Reviewed	4515
Initial Requests Provisionally Affirmed	3939
Resubmission Requests Reviewed	326
Resubmission Requests Affirmed	144
Total Requests Non-Affirmed	432
Provisional Affirmation Rate [1]	90%

Prepayment and Postpayment Reviews[2]	
Claims Reviewed	0
Claims Approved	0
Claims Denied	0
Claim Approval Rate	N/A

[1] Affirmation Rate (90%) = (Initial Requests Provisionally Affirmed (3939) + Total Number of Resubmission requests Affirmed (144))/Total Request Reviewed (4515)
[2] IRF RCD -AL did not have any IRF providers participate in prepayment or Postpayment review in cycle 1.

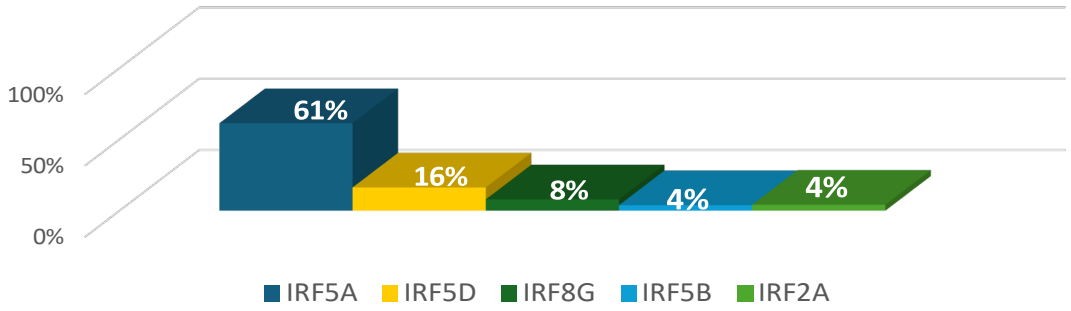
Affirmation Rate Trends

The chart below covers the first six months of the demonstration, beginning with September 2023. In November 2023, IRF providers in Alabama experienced a drop in affirmation rates due to an increase in technical errors on submitted claims. Throughout cycle 1, the volume of pre-claim review (PCR) requests stayed consistent. All IRF providers achieved the cycle 1 affirmation rate threshold of 80%.



	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
PCR Requests	732	747	685	748	771	696
Affirmation Rate	99%	89%	77%	87%	92%	86%

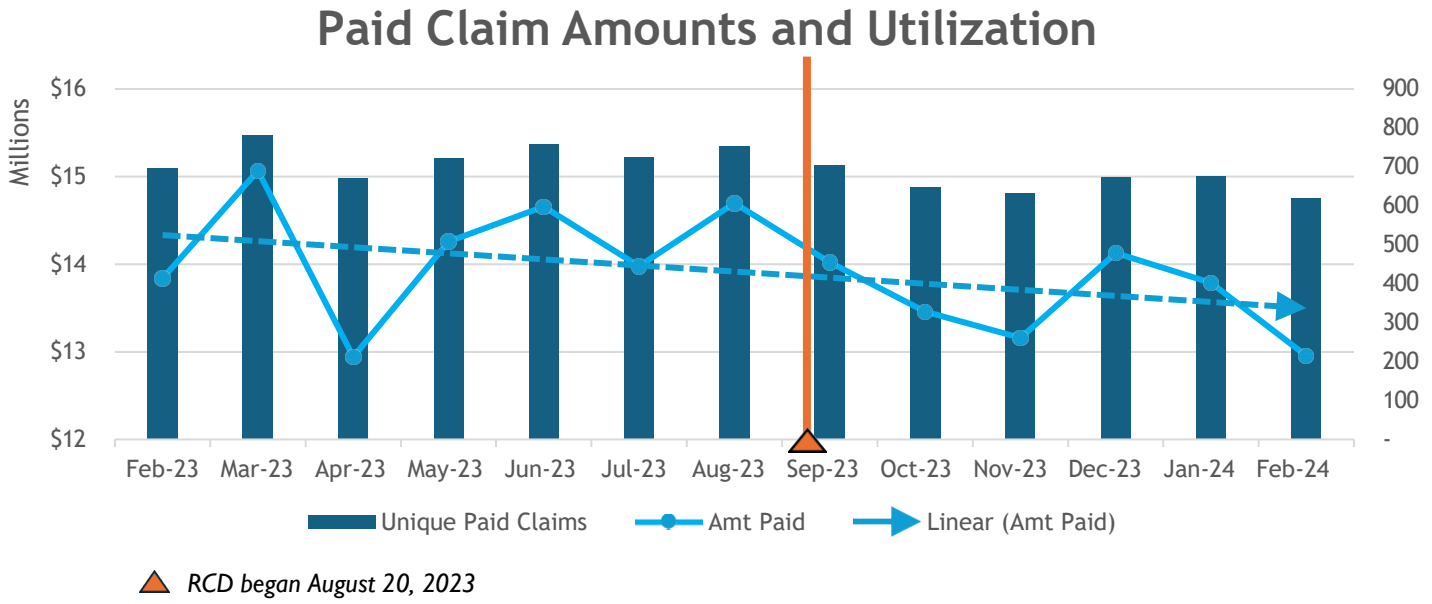
Top 5 Non-Affirmation Reason Codes

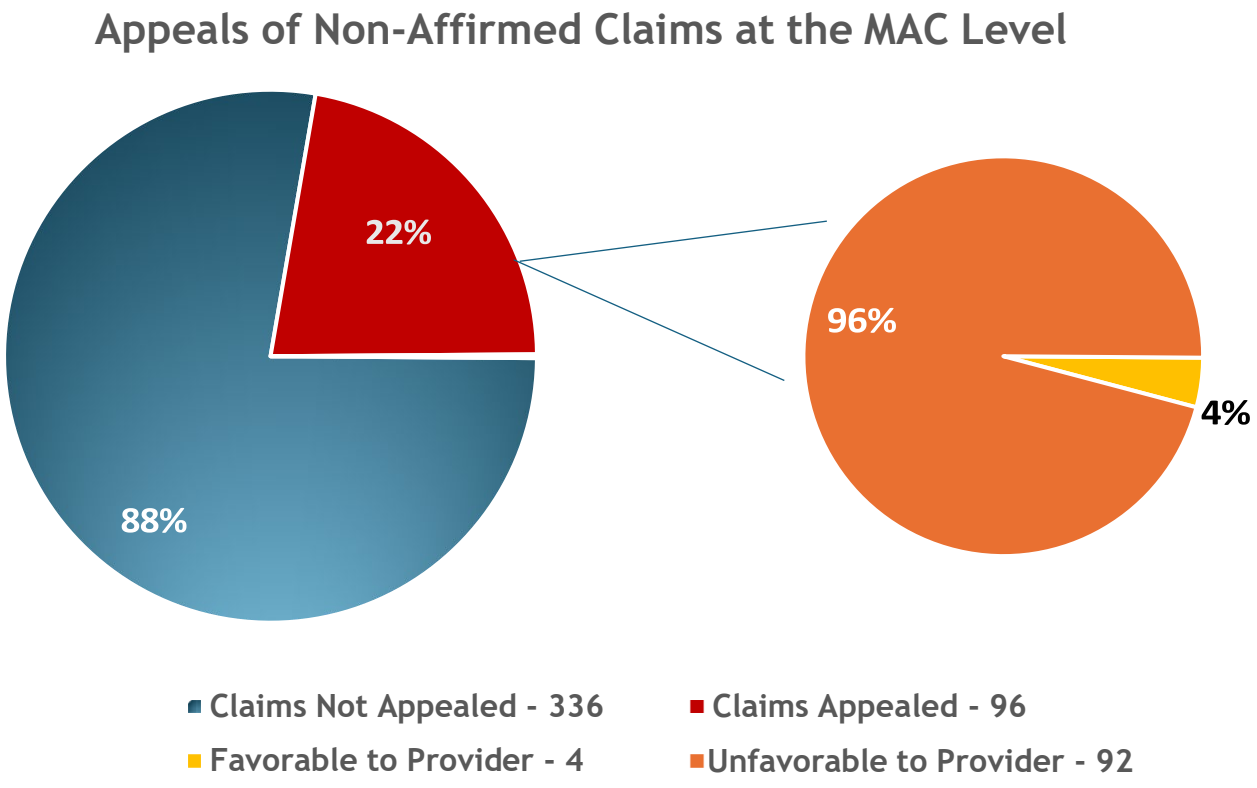


Code	Top 5 Non-Affirmation Reason Codes
IRF5A	The documentation does not support the beneficiary required supervision by a rehabilitation physician.
IRF5D	The documentation does not support the patient is sufficiently stable at the time of admission to the IRF to be able to actively participate in and 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 the 48 hours immediately preceding the IRF admission.

Utilization and MAC Appeal Trends

The chart below shows an overall decline in claim payments over the 6 months before the IRF RCD started and continuing through the first program cycle. The drop became more substantial after the demonstration began. In the six months preceding the implementation, the average claim payment amounted to $14.2 million. During the initial six months of implementation, there was a 4% reduction in claim payments, resulting in an average of $13.6 million. Additionally, the average number of claims decreased by 10%, with 660 claims per month compared to an average of 735 claims per month in the six months prior to the demonstration. We attribute this decrease to a reduction in the number of claims submitted that don't meet Medicare requirements, which resulted in a reduction in the total amount paid for those claims.





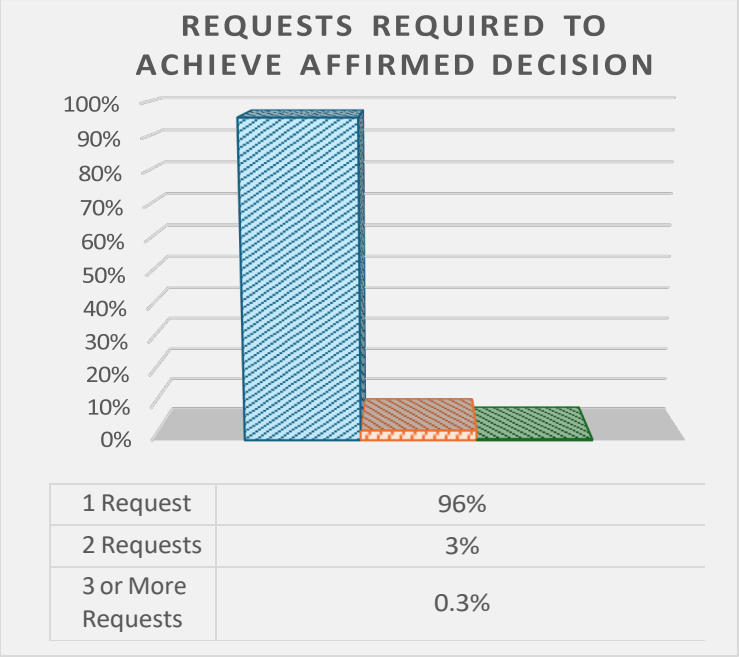
MAC Oversight

CMS and MACs hold monthly calls to review initial pre-claim submissions together. This collaboration helps ensure consistent review processes and decisions during the early stages of the demonstration. MAC Chief Medical Directors, nurse reviewers, and CMS staff work together regularly to improve the quality and consistency of their reviews. This teamwork helps standardize approaches across different MACs, leading to better outcomes for everyone involved.

MRAC Claims Reviewed[3]:
N/A

Claims MRAC Agreed with Decision:
N/A

MAC Accuracy Rate:
N/A



MAC Oversight	
Average PCR Review Timeframe	1.5
PCR Reviews Exceeding 2 Business Days[4]	1
Number of Resubmission Outreach Attempts	789
Number of Physician-Led Provider Education Calls Requested	0

[3] The MAC accuracy rate reviews began in late fiscal year 2024.

[4] The MAC experienced a system issue, resulting in the submission request to exceed 2 days. The issue was resolved, and the request was reviewed on the 3rd day.

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 contractor 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.

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.