Review Choice Demonstration for Inpatient Rehabilitation Facility Services (IRF RCD) Cycle 2 Report

***Alabama IRF RCD Cycle 2** (May 1, 2024 – October 31, 2024)*

This report provides a high-level progress update on cycle 2 of the IRF RCD in Alabama. It is intended to offer stakeholders a transparent overview of provider engagement, process integrity, and early demonstration outcomes. The summary reflects IRF providers in Alabama's cycle 2 experience with the RCD, highlighting trends in provider participation, compliance with Medicare documentation standards, and overall demonstration performance. The Cycle 2 snapshot that follows outlines key metrics and insights observed during the reporting period.

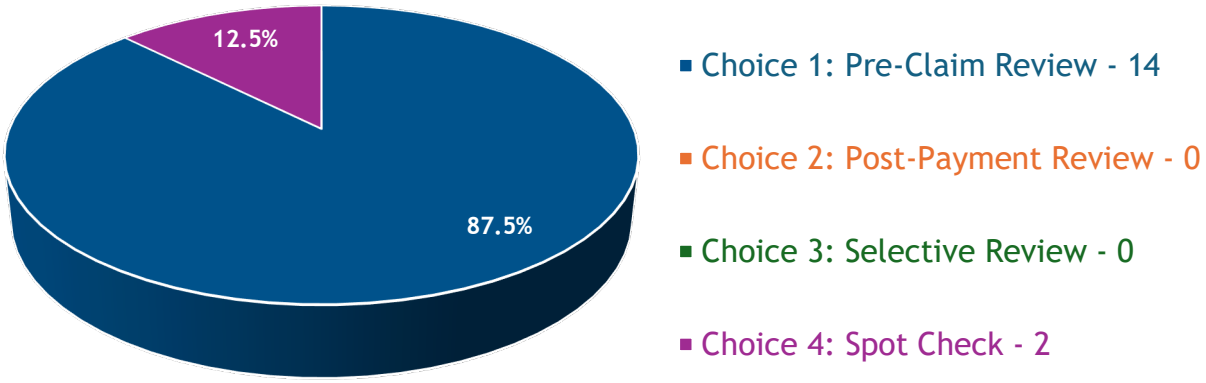
Cycle 2 Snapshot:

- 14 IRF providers in Alabama selected pre-claim review choice and 2 IRF providers selected spot check
- 7 IRF providers in Alabama met the 85% affirmation rate threshold for Cycle 2
- Medicare saw a 15% reduction in the average claim amount paid to IRF providers participating in the RCD by the conclusion of Cycle 2 (October 31, 2024), in comparison to the six months preceding the beginning of the RCD (Feb 2023-Aug 2023).

Choice Selection and Reviews

Demonstration operations continue to progress successfully through cycle 2. 14 facilities selected pre-claim review after meeting the affirmation threshold in cycle 1 and 2 facilities selected spot check. The ability to resubmit requests an unlimited number of times, combined with MAC Medical Director review of non-affirmations, has supported high engagement and compliance within the demonstration. These results suggest that with continued communication and preparation, the experience in Alabama can inform broader implementation efforts in other states.

Providers in Each Choice



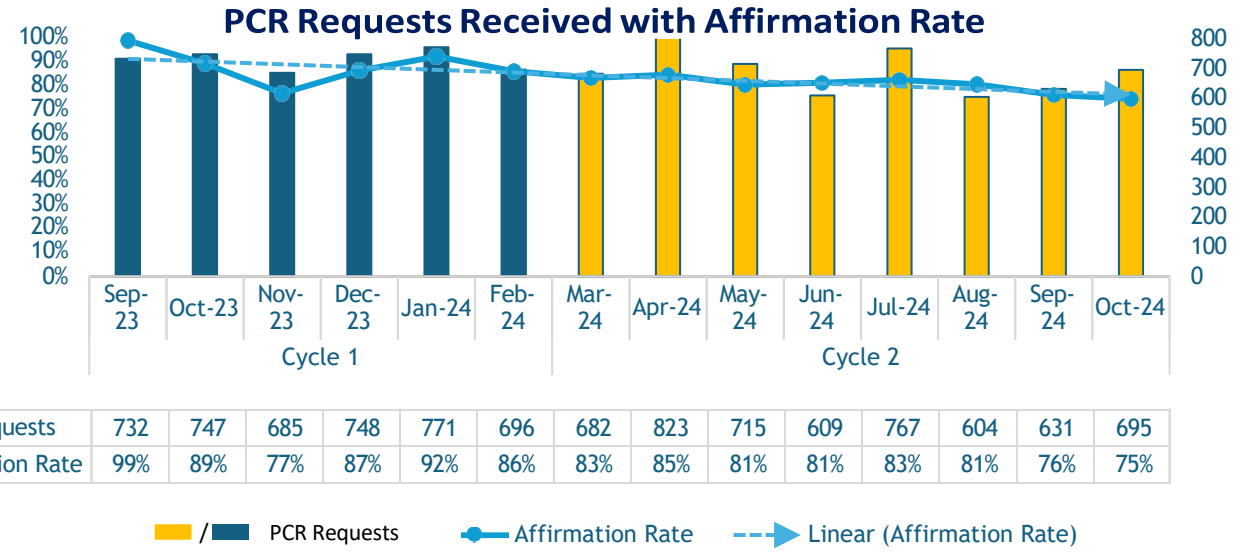
Pre-Claim Reviews	
Initial Requests Reviewed	5526
Initial Requests Provisionally Affirmed	4040
Resubmission Requests Reviewed	1607
Resubmission Requests Affirmed	423
Total Requests Non-Affirmed	1063
Provisional Affirmation Rate[1]	81%

Prepayment and Postpayment Reviews	
Claims Received	278
Claims Approved	250
Claims Denied	26
Claim Approval Rate	90%

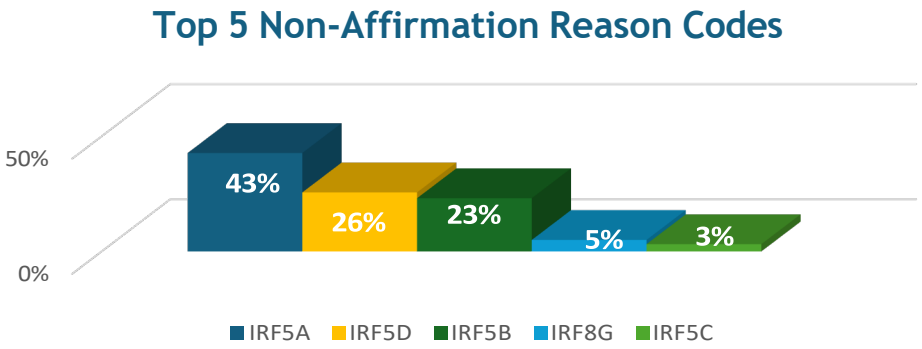
[1] Affirmation Rate (81%) = (Initial Requests Provisionally Affirmed (4040) + Total Number of Resubmission requests Affirmed (423)/Total Request Reviewed (5526)

Affirmation Rate Trends

The chart below covers the two cycles of the demonstration, starting with cycle 1 in September 2023. In cycle 2, IRF providers in Alabama saw a gradual decrease in affirmations, with an increase in medical necessity non-affirmations compared to cycle 1. During cycle 2, the volume of pre-claim review (PCR) requests remained steady. However, unlike cycle 1, not all IRF providers met the increased cycle affirmation rate threshold, which was raised from 80% in cycle 1 to 85% in cycle 2, highlighting the need for targeted improvement efforts.



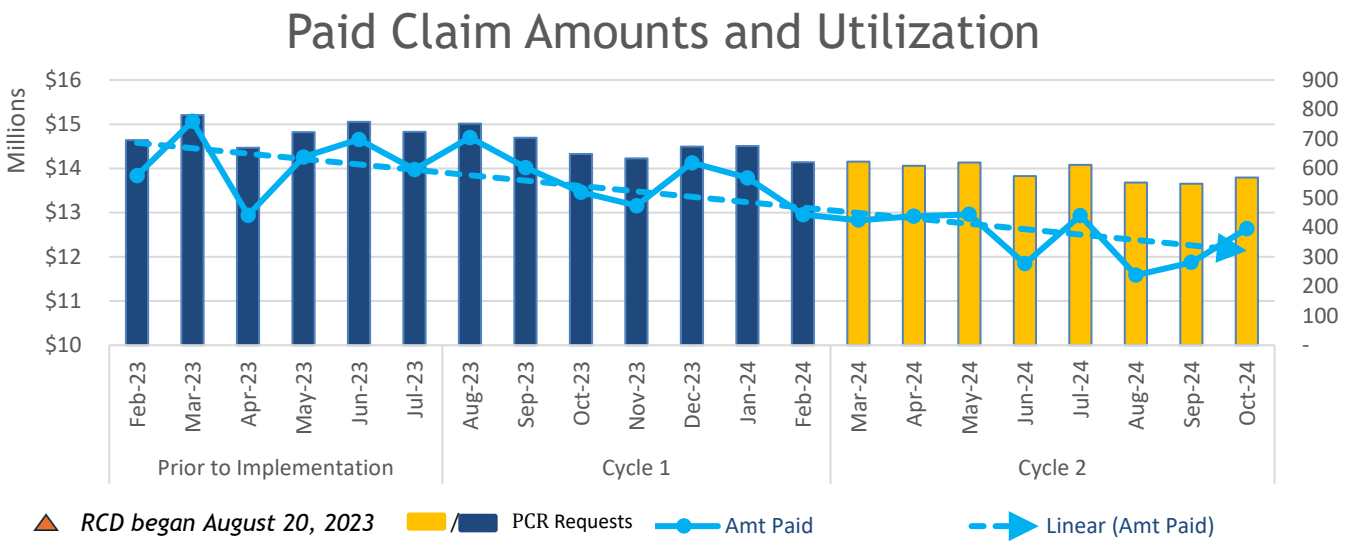
	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
PCR Requests	732	747	685	748	771	696	682	823	715	609	767	604	631	695
Affirmation Rate	99%	89%	77%	87%	92%	86%	83%	85%	81%	81%	83%	81%	76%	75%

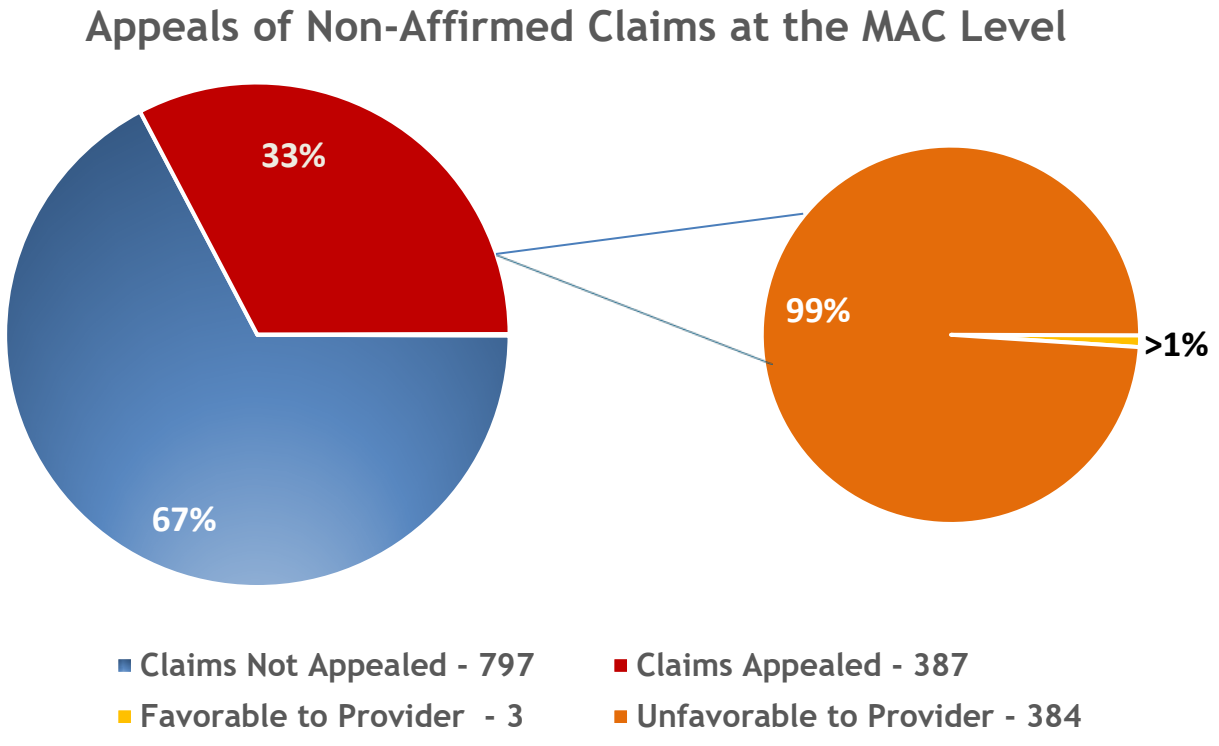


Code	Top 5 Non-Affirmation Reason Codes
IRF5A	The documentation does not support the beneficiary required supervision by a rehabilitation physician.
IRF5D	The documentation does not support the patient is sufficiently stable at the time of admission to the IRF to be able to actively participate in and benefit significantly from the intensive rehabilitation therapy program.
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.
IRF8G	Documentation does not support that therapy services began within thirty-six hours from midnight of the day of admission to the IRF.
IRF5C	Documentation does not support that upon admission to the IRF the patient required active and ongoing multiple therapy disciplines.

Utilization and MAC Appeal Trends

The chart below shows a steady drop in claim payments over the 6 months before the IRF RCD started and continued through cycle 2 in Alabama. The drop continues throughout the progress of the demonstration. Prior to the implementation, the first six months recorded an average monthly paid claim amount of $14.2 million. During cycle 2, this average declined to $12.4 million, constituting a 13% decrease. Additionally, the average monthly volume of claims was 735 before implementation, which was reduced to 588 during cycle 2, representing a 20% decrease. The decline in spending and claim volume can be attributed to IRF facilities becoming more familiar with compliance requirements, leading to fewer improper claim submissions.





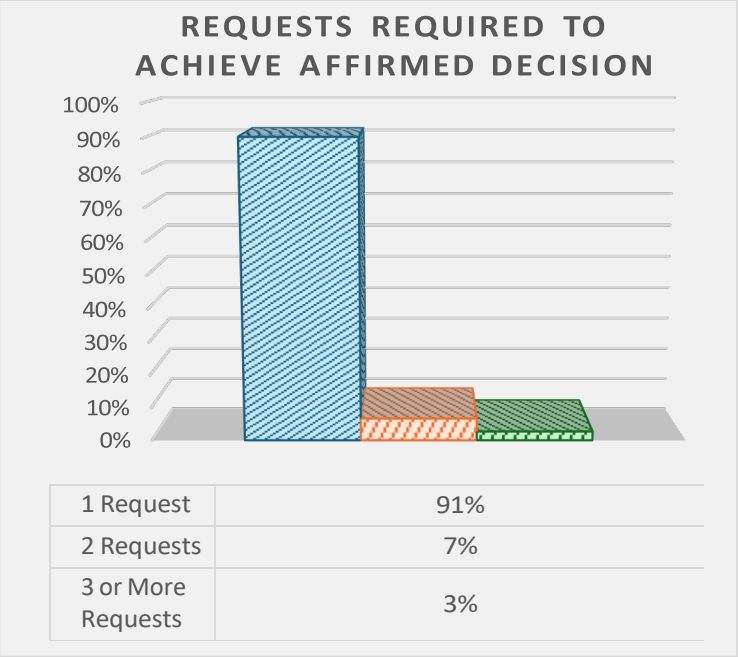
MAC Oversight

CMS and MACs continue to hold regular calls to review initial pre-claim submissions together. In addition, CMS works with the Medical Review Accuracy Contractor (MRAC) to help ensure the accuracy of medical review decisions through a sample review which has resulted in a 100% accuracy rate. Requests required to achieve an affirmed decision saw a slight increase compared to cycle 1. The most common reason for a resubmission in cycle 2 was due to documentation that does not support the beneficiary requiring supervision by a rehabilitation physician.

MRAC Claims Reviewed[2]:
50

Claims MRAC Agreed with Decision:
50

MAC Accuracy Rate:
100%



MAC Oversight	
Average PCR Review Timeframe	1.67
PCR Reviews Exceeding 2 Business Days	0
Number of Resubmission Outreach Attempts	2740
Number of Physician-Led Provider Education Calls Requested	2

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

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.