Review Choice Demonstration for Inpatient Rehabilitation Facility Services

Frequently Asked Questions (FAQs)

August 10, 2023

Table of Contents

General Questions

1. **What does the Inpatient Rehabilitation Facility (IRF) Services Review Choice Demonstration (RCD) do?**

   This demonstration establishes a review choice process for IRF services to test improved methods for the identification, investigation, and prosecution of potential Medicare fraud. Additionally, improve compliance with Medicare program requirements to ensure that the right payments are made at the right time for IRF services.

2. **Will this demonstration delay beneficiaries from getting access to services?**

   No, the demonstration should have minimal effect on beneficiaries' access to care. Under the Pre-Claim Review (PCR) choice, services can begin prior to the submission of the PCR request and continue while the decision is being made. The PCR request must be submitted and reviewed before the claim is submitted for payment. In most circumstances, MACs will be required to review the request and make a review decision within 2 business days. Under the remaining choice, IRFs will provide services and submit all claims for payment following their normal processes. The MAC will send the IRF an Additional Documentation Request (ADR) following receipt of the claim for payment, and the IRF will submit medical records for review. This will determine whether the IRF service(s) for the beneficiary complied with applicable Medicare coverage and clinical documentation requirements.

3. **What is the start date of the IRF RCD?**

   The start date of the demonstration in Alabama is August 21, 2023.

4. **What states does this demonstration impact?**

   CMS will initially implement the demonstration for providers that are physically located in Alabama and bill to Medicare Administrative Contractor (MAC) Jurisdiction J, then will expand to Pennsylvania, Texas, and California, as well as IRFs located in any state that bill to the MAC jurisdictions JJ, JL, JH, and JE, regardless of where they are physically located. More information will be provided about the demonstration's expansion into other states in the future.

   ***Examples*:**

   - **I am an IRF located in a demonstration state but bill to a different MAC than the one for that state.**

     You are included in the demonstration if the MAC that you bill to is JJ, JE, JL, or JH. If you bill to another MAC, then you are not included in the demonstration.

- **I am an IRF located in a non-demonstration state but bill to a MAC in the demonstration.**

  You are included in the demonstration if you bill to any of the MAC jurisdictions included in the demonstration.

- **I am an IRF located in a demonstration state, but JJ, JE, JL, or JH is not my Medicare Administrative Contractor (MAC) jurisdiction.**

  You would not be included in the demonstration.

5. Will providers receive notification prior to the implementation date in their state?

At least 60 days prior to the implementation date in your state, CMS will announce the date the demonstration will begin. At that time, providers will be advised of the date that the 30-day choice selection period will open as well as the deadline when it will close. These activities will occur within the 60-day notification period.

6. Does the demonstration apply to beneficiaries already receiving IRF services before the demonstration's start dates?

IRF services that begin prior to the start date of the demonstration in each state/MAC jurisdiction are not subject to the demonstration. However, any IRF services or stays occurring on or after the start date of the demonstration in each state/MAC jurisdiction will be subject to pre-claim or postpayment review depending on the choice selected.

7. Does the Review Choice Demonstration create new documentation requirements?

The RCD does not create new documentation requirements; rather, it only requires submission of the same information currently required to be maintained for IRF payment. IRFs will have flexibility as they are able to choose their path to demonstrate compliance with the applicable Medicare rules and policy requirements.

8. What are the initial review choices?

The initial review choices are:

Choice 1: Pre-Claim Review
- All claims are subject to PCR.
- Unlimited resubmissions are allowed for non-affirmed decision prior to submission of the final claim for payment.
- Claims associated with a provisionally affirmed request will not undergo further medical review, except in limited circumstances.

Choice 2: Postpayment Review

- All IRF claims are reviewed after final claim submission.
- Default selection if no initial review choice made.
- Once the claim is submitted, the MAC will process the claim for payment then ask via an Additional Documentation Request (ADR) for the IRF to submit medical records.

After each six-month period, an end of cycle affirmation/approval rate will be calculated and communicated to the IRF.

9. What happens if I do not select the pre-claim review option?

Providers who decide to not participate in choice 1, Pre-claim Review, can instead select Choice 2, the Postpayment Review option. If a provider does not make a selection, they will default into Choice 2- Postpayment Review.

10. When can an IRF select another review choice?

Both PCR and postpayment review will be evaluated over a 6-month review cycle. At the end of each 6-month period, and within 30 days, the MAC will communicate to the IRF their PCR affirmation or postpayment claim approval rate, and if they have met the review threshold. If the IRF's full affirmation rate or claim approval for that 6- month cycle meets target threshold, the IRF may select one of the three subsequent review choices.

11. What are the subsequent review choices?

Every six months, IRFs may select from one of the three subsequent review choices if the pre- claim review affirmation rate or postpayment review approval rate is at the target affirmation rate. The subsequent review choices are:

Choice 1: Continue with Pre-claim Review

Choice 3: Selective Postpayment Review

- A random sample of claims will be chosen for review every six months.
- Default selection if no subsequent review choice made.

Choice 4: Spot Check Review

- Every six months, 5 percent of a provider's claims are randomly chosen for review.
- Providers may remain in this option as long as they continue to show compliance with Medicare coverage rules and guidelines.

12. What is the target affirmation rate?

An IRF's target affirmation rate is based on the following sliding scale from the time an IRF starts the demonstration:

- First review cycle: 80% affirmation rate
- Second review cycle: 85% affirmation rate
- Third review cycle: 90% affirmation rate

Any new IRFs will be subject to the target affirmation rate review cycle that their state has in process at that time.

13. What if an IRF does not meet the threshold or affirmation/claim approval rate?

If the IRF's affirmation or claim approval rate is less than the target affirmation/approval or they have not submitted at least 10 requests/claims, the IRF must again choose from one of the initial two options.

14. For the review threshold, is it calculated based on only the initial submission or any submission/resubmission submitted within the 6-month review cycle?

An IRF's target affirmation rate is based on a sliding scale from the time an IRF starts the demonstration. PCR will be evaluated over a 6-month review cycle based on any submission that is affirmed. If the IRF's full affirmation rate for that 6- month cycle meets target threshold, the IRF may select one of the three subsequent review choices.

15. What should an IRF do during the time between review cycles? Should they continue submitting PCR requests or claims? If so, how are the claims between review cycles included/calculated?

IRFs will continue to submit claims or PCR requests (depending on which review choice they are in) during the 30-day interval after the 6-month review cycle is over, while the MAC is finalizing the IRF affirmation/approval rates. These claims/PCR requests will continue to be utilized in calculating the next cycle's affirmation/approval rate. The provider will have an opportunity to select a subsequent review option if they meet the target affirmation/approval rate threshold; however, the provider will be required to continue submitting claims or PCR requests utilizing the initial review choice until the beginning of the next review cycle.

16. Is there an appeal process under the demonstration for non-affirmed pre-claim review requests or postpayment reviews?

All existing claims appeal rights remain unchanged under the demonstration. Claims that are denied under the demonstration are appealable. Non-affirmed PCR determinations are not appealable; however, providers have the option of:

- Resubmitting the PCR request before filing a claim; or

- Submitting a claim, which will be denied, and then submitting an appeal.

17. Will there be a specific form to use for the demonstration?

There will not be a required form for the demonstration. The MAC will have a checklist to help submitters with the PCR requests and prepayment/postpayment reviews. Submitters are encouraged to use the checklist, but it is not required.

18. Under the demonstration, who will make the review decisions?

The MAC will be conducting medical reviews and will make these decisions using existing applicable regulations, and other CMS policies. All clinical activities will be directed by the Contractor Medical Director (CMD), who will be responsible for the clinical oversight of the IRF RCD program.

19. Are beneficiaries covered under a Medicare Advantage Plan included in the RCD?

No, the RCD only applies to Medicare beneficiaries covered under Fee-for-Service (FFS) Medicare.

20. If I am under a Unified Program Integrity Contractor (UPIC) review, do I need to make an RCD selection?

Yes, all providers should make an RCD selection during the choice selection period. Although providers under UPIC review will not participate in the demonstration while under review, if the UPIC review ends prior to the next cycle start date in their state, the review choice selection will become active for the provider at that time. Providers should make a review choice selection prior to the next cycle. Questions regarding UPIC review should be directed to the UPIC.

21. What do I do if I am selected for UPIC review during an active RCD cycle?

Providers under choice 1 should continue to submit PCR requests and affix the UTN to the claim when it is submitted. Once Palmetto GBA receives notification from the UPIC to exclude a provider, Palmetto GBA will begin rejecting PCR requests. At that time, the provider should discontinue submitting PCR requests and should not include a UTN on any claims submitted while under UPIC review. Claims received with a UTN will return to the provider (RTP) to remove the UTN and resubmit. However, if a provider is under UPIC review and UPIC review ends during the current cycle, the provider will remain excluded from the RCD for the duration of that cycle. The provider should make an RCD selection every cycle regardless of their UPIC review status, to ensure their RCD selection is accepted.

22. Are any claims exempt from the Review Choice Demonstration process?

IRF claims for Veteran Affairs, Indian Health Services, Part A/B rebilling, demand bills submitted with condition code 20, no-pay bills submitted with condition code 21, canceled claims, and all Part A and Part B demonstrations.

23. Will claims reviewed under the demonstration still be subject to additional review?

Absent evidence of potential fraud or gaming, the claims that have a provisional affirmation PCR decision or were approved under medical review will not be subject to additional review. However, CMS contractors, including Unified Program Integrity Contactors may conduct targeted prepayment and postpayment reviews to ensure that claims are accompanied by documentation not required or available during the PCR process. In addition, the CMS Comprehensive Error Rate Testing (CERT) program reviews a stratified, random sample of claims annually to identify and measure improper payments. It is possible for an IRF claim that is subject to the demonstration to fall within the sample. In this situation, the subject claim would not be excluded from the CERT audit.

24. Will IRFs in the demonstration states be allowed to require that beneficiaries sign an Advanced Beneficiary Notice (ABN)?

An ABN may only be given to a beneficiary on the basis of a genuine reason about the likelihood that Medicare may deny items or services furnished to the beneficiary as not medically reasonable and necessary under section 1862(a)(1) of the Act. Giving a beneficiary an ABN for all items or services without regard to the likelihood that the services would deny as being not medically reasonable and necessary is considered a blanket written notice and is not permitted. Furthermore, a beneficiary has the right to refuse to sign an ABN. Requiring a beneficiary sign an ABN is not permitted.

25. Will providers be required to participate in Targeted Probe & Education (TPE) and RCD at the same time?

No. Providers will not be under TPE review and RCD at the same time. Providers currently on TPE review will be removed prior to CMS implementing RCD in that particular state.

26. Where can I send additional questions?

Additional questions on the Review Choice Demonstration may be sent to CMS at IRF_RCD@cms.hhs.gov.

27. Where can I find more information related to the Review Choice Demonstration?

More information can be found https://www.cms.gov/research-statistics-data-systems/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives/review-choice-demonstration-inpatient-rehabilitation-facility-services.

Choice Selection Questions

28. How do we make an RCD selection?

Providers will have thirty calendar days to select an initial review choice prior to the start of the demonstration. The 30-day selection period will end two weeks prior to the start of the cycle to select an initial review choice. Choice selection will be announced and made through the MAC.

29. Is the MAC portal the only way to make my RCD choice selection?

Yes, providers need to make their selection in the MAC portal.

30. What if I do not make a selection?

IRFs who do not select an initial review choice will default to Choice 2: Postpayment Review. IRFs who do not select a subsequent review choice will default to Choice 3: Selective Postpayment Review.

31. Can I change my selection after one has been made?

Yes, providers can make and change their review choice selections until the night the selection period ends.

32. How can I check to see what selection my IRF made?

Check with your MAC or the provider portal, information and education will be provided with each expansion of the demonstration.

33. How do I know if I am in the initial or subsequent choice stage?

All providers will begin in the initial review choice stage with either PCR or postpayment review and will be evaluated over a 6-month review cycle. At the end of the 6-month period, and within 30 days, the MAC will communicate to the IRF their PCR affirmation or postpayment claim approval rate, and if they have met the review threshold. If the IRF's full affirmation rate or claim approval for that 6-month cycle is at or above the threshold (based on a minimum of 10 submitted PCR requests or claims), the IRF may select one of the three subsequent review choices.

34. When and how will I receive the results of my 6-month review period?

The MAC will notify the provider at the end of each review cycle with the information on whether they met the review threshold for each review cycle in writing and issued no

later than the 30th calendar day following the end of the cycle.

Submission Questions

35. How should we submit PCR documentation?

IRFs may send documentation to the MAC via regular mail, fax, or electronically (e.g. – MAC portals or esMD). For providers that choose to use fax or mail, the MAC's IRF RCD web page will house a web-enabled version of the PCR request that will guide the provider through the required documentation for submittal via fax or mail.

36. Does the PCR affirmation rate calculation include appeals?

The PCR affirmation rate is based on your PCR submissions with decisions rendered during the active review cycle dates. Because PCR submissions are not subject to appeal, appeals data is not included in the affirmation rate. Providers have the ability to make as many resubmissions as needed to get a full affirmation prior to submitting the claim. The number of resubmissions is not counted against the affirmation rate. For example, if an initial submission is non-affirmed and the resubmission is affirmed, it will count only as one affirmed request for the affirmation rate.

37. If I select Choice 1: Pre-claim Review the first 6-month review cycle, then change to Choice 4: Spot check for the second 6 month review cycle, will the claims with affirmed UTNs that I submit during the second 6 months be exempt from spot check review?

Claims with affirmed UTNs will not be selected for the spot check review.

38. What happens if I qualify for a subsequent review choice, but do not make a selection?

IRFs with a full affirmation rate or claim approval rate of their sliding-scale threshold or greater that do not actively select one of the subsequent review choices by the deadline indicated in their letter will automatically be assigned to participate in Choice 3: Selective Postpayment Review.

Pre-Claim Review (PCR) Questions

39. What is the PCR option?

Pre-claim is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. PCR helps make sure that applicable coverage, payment, and coding rules are met before the final claim is submitted.

40. What documents are required for the PCR request?

The PCR request should include all documents and information that support medical necessity and all eligibility requirements for the beneficiary needing the applicable level of IRF services. We do not anticipate the entire record will need to be submitted to support medical necessity (e.g., not every PT note, interdisciplinary team meeting note, etc. may be needed.) The MAC website will provide more specific information for each state.

41. Should documentation supporting the overall plan of care be submitted with the pre-claim review request?

While we encourage submission of the plan of care with the pre-claim review request, we understand that IRFs may want to begin the submission process prior to its completion.

The pre-admission screening, which serves as the basis for the initial determination of whether or not the patient meets the requirements for an IRF admission to be considered reasonable and necessary, should be included, at a minimum. It must include a detailed and comprehensive review of the beneficiary's condition and medical history. Additional documentation may include but is not limited to the History & Physical, therapy evaluations, skilled notes, interdisciplinary team note(s), admission orders., etc. The documentation submitted must demonstrate the following:

- the beneficiary must require the active and ongoing therapeutic intervention of multiple therapy disciplines, one of which must be physical or occupational therapy.
- the beneficiary must generally require and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program.
- the beneficiary must require supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation.
- the beneficiary must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

You may submit the PCR request at any time prior to the final claim submission to allow time to collect this documentation.

42. When should the IRF PCR request be submitted?

The PCR request may be submitted at any time before the final claim is submitted. The PCR process, including submission of the request and receipt of the Unique Tracking Number (UTN), must occur before the final claim is submitted for payment. This includes resubmissions received after a non-affirmed decision. The PCR request should

be submitted when the IRF has obtained all required documentation from the medical record to support medical necessity and demonstrate eligibility requirements are met.

43. Will the demonstration allow for the electronic submission of PCR requests?

Submitters who choose to utilize the PCR process may send PCR requests to the MAC via mail, fax, online provider portal, or through the Electronic Submission of Medical Documentation (esMD) system (available in October 2023). Providers resubmitting through esMD should notate on the medical documentation that the submission is a resubmission. More information on esMD and availability can be found at http://www.cms.gov/esMD

44. Will the MAC send responses to Pre-Claim Review requests via the same mechanism by which they are received? For instance, if I send my request via a fax, will the response be sent back via a fax?

The MACs accept and respond to PCR requests via the following mechanisms:

- Online
  - The MAC will accept requests via online and will provide information on the process.

- esMD
  - Decision letters are sent via US postal service in addition to the MAC sending the PCR response via esMD.

- Fax
  - Decision letters are faxed if a return fax number is clearly identified in the request submitted.
  - Rejection and exclusion notification letters may be faxed as well, as long as a return fax number is clearly identified in the request.

- Mail
  - Decision letters are sent via US postal service.

45. Under the Review Choice Demonstration, how long will Medicare have to provisionally affirm or non-affirm a PCR request?

Medicare will make a decision on a PCR request within 2 business days for an initial request, and 2 business days for a resubmitted request following a non-affirmed decision.

46. What is a resubmitted request?

If the initial PCR request was non-affirmed, then an IRF may resubmit the request with additional documentation as many times as necessary. Medicare will work closely with

the IRFs during the PCR process to explain what documentation is needed, and why a prior submission was insufficient.

47. What are an IRFs options if it receives a non-affirmed decision?

The decision letter will specify why an IRF's PCR request was non-affirmed. The IRF can correct the deficiencies and resubmit the request with a new coversheet and relevant documentation. If the IRF does not wish to resubmit the request, it can submit the claim with the unique tracking number identified on the non-affirmed decision letter, the claim will be denied, and the IRF can appeal the denial.

48. How many times may a PCR request be resubmitted?

A submitter is allowed an unlimited number of resubmissions for PCR requests that have not been affirmed.

49. Will beneficiaries have to pay for services if an IRF provides care but ultimately does not obtain a provisional affirmed decision?

The Limitation on Liability protections of §1879 of the Social Security Act (the Act) will apply to this demonstration. The Limitation on Liability provisions require a provider to notify a beneficiary in advance of furnishing an item or service when such item or service is considered not medically reasonable and necessary under section 1862(a)(1) of the Act. Issuing a valid ABN in this instance is required in order for providers to shift financial liability to the beneficiary. In accordance with CMS polices, if an ABN was not issued when required prior to the start of care, and the PCR is non- affirmed, the beneficiary is not financially liable for the care that the IRF provided while awaiting the PCR decision. If the IRF believes that the PCR will be non-affirmed for any of the reasons (i.e. not medically reasonable and necessary), the provider must issue an ABN, prior to furnishing the items or services in question, in order to transfer financial liability to the beneficiary. The beneficiary has the right to choose whether or not to receive the item or service and to accept financial liability. If the IRF expects Medicare to cover the services, an ABN should not be issued.

Other requirements to qualify for the Medicare IRF benefit, such as the preadmission screening, are considered technical in nature and are not part of the Limitation on Liability provisions under section 1879 of the Act (i.e. advanced notice is not applicable). If this documentation is missing then it would be a technical denial, and the provider would be held liable (i.e., not be able to charge the beneficiary) based on section 1866(a)(1) of the Act.

When a PCR is non-affirmed, the decision letter will include a detailed written explanation outlining which specific policy requirements were not met. If the non-affirmation is due to the item or service not being medically reasonable and necessary under section 1862(a)(1) of the Act, the IRF must issue an ABN in order to transfer financial liability to the beneficiary if the IRF believes Medicare may deny the item or

service as not medically reasonable and necessary. If the non-affirmation was due to documentation errors, the IRF may correct the deficiencies and resubmit the request with all relevant documentation. In this situation, it would not be appropriate to issue an ABN. Also, if the PCR decision is non-affirmed for a reason for which the IRF would otherwise be financially liable (that is, the reason for denial is not one that triggers the limitation on liability provision), the IRF should not issue an ABN following a non-affirmed PCR decision in an attempt to shift liability.

50. What happens if an applicable claim in the demonstration area does not go through PCR?

If an IRF has selected Choice 1: Pre-Claim Review and submits a claim without going through the PCR process, the MAC will suspend the claim for pre-payment review.

51. Do I have to participate in 100 percent review?

Yes, providers will need to participate in either 100 percent pre-claim or postpayment reviews until the first review cycle. If the affirmation/approval rate meets the threshold for the review cycle, then the provider will have the option to choose from one of the subsequent choices.

52. Is there an option to remain in 100 percent review, even if I meet the target affirmation/approval rate threshold?

Yes, providers that prefer to remain in 100% review upon completing the initial 6-month review cycle have the option to continue with PCR.

Medical Necessity Questions

53. What documents may be required for submission?

The documentation in the beneficiary's IRF medical record must demonstrate a reasonable expectation that the criteria for medical necessity were met at the time of admission to the IRF under 1862(a)(1)(A)(i) of the Social Security Act. Records may include but are not limited to the Preadmission Screen, the comprehensive Plan of Care, therapy evaluations/visit notes, weekly rehabilitation physician visit notes, and interdisciplinary team conference notes. Additionally, documentation must demonstrate the following:

- Documentation supporting the beneficiary must require the active and ongoing therapeutic intervention of multiple therapy disciplines, one of which must be physical or occupational therapy.
- Documentation supporting the beneficiary must generally require and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program.
- Documentation supporting the beneficiary must require supervision by a

rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation.

- Documentation supporting the beneficiary must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

54. Is the IRF Patient Assessment Instrument (PAI) required?

This documentation will not be available for submission of PCRs. As per the requirements, the IRF PAI forms should generally be included in the beneficiary's medical record at the IRF (either in electronic or paper format).

55. What should be included in the Preadmission Screening?

Documentation should reflect an evaluation of the beneficiary's condition and need for rehabilitation therapy and medical treatment. Specifically, the beneficiary's prior level of function, expected length of improvement, estimated length of time to achieve level of improvement, evaluation of the beneficiary's risk for clinical complications, conditions that caused the need for rehabilitation, treatment needed, and anticipated discharge destination.

56. When should the Preadmission Screening be conducted?

The screening should occur within the 48 hours immediately preceding the IRF admission. The rehabilitation physician must also review and document concurrence with the pre-admission screening before the beneficiary is admitted to the IRF.

57. What should be included in the Plan of Care?

The overall plan of care should generally detail the beneficiary's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay. The POC must be completed within the first 4 days of the IRF admission, and include the expected intensity, frequency, and duration of therapy required by the beneficiary during the IRF stay.

58. What documentation is required for active and ongoing therapeutic intervention of multiple therapy disciplines?

Documentation should support the intensive and coordinated interdisciplinary approach to providing rehabilitative services began, and is documented in the weekly interdisciplinary team conference notes. The meeting should include a rehabilitation physician; registered nurse; social worker or a case manager (or both); and licensed or certified therapist from each therapy discipline involved in treating the beneficiary. The meeting must be led by a rehab physician either in person or remotely who documents concurrence with all decisions made at each meeting. The team meeting should focus on assessing the individual's progress towards the rehabilitation goals; considering possible resolutions to any problems that could impede progress towards the goals; reassessing the

validity of the rehabilitation goals previously established; and monitoring and revising the treatment plan, as needed.