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

Pennsylvania IRF RCD Cycle 1 (June 2024 – December 2024)

This report provides a high-level progress update on implementation of the IRF RCD for IRFs in Pennsylvania 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 Pennsylvania, 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.

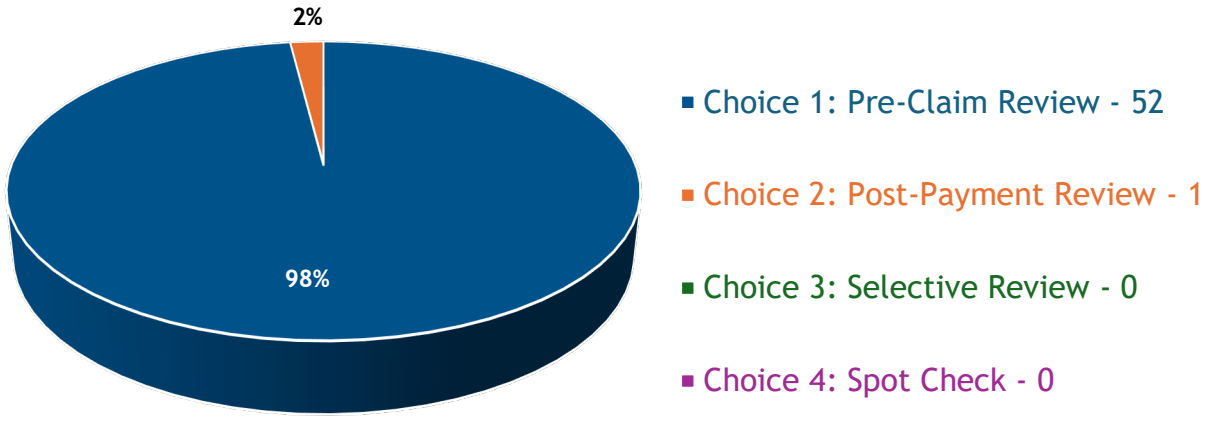
Cycle 1 Snapshot:

- 52 of 53 IRF providers in Pennsylvania selected pre-claim review choice
- IRF providers in Pennsylvania in the pre-claim review choice averaged an affirmation rate of 98% for Cycle 1
- Affirmation rates continued to increase despite larger claim volume
- During the initial six months of implementation, there was a 6.5% reduction in claim payments, resulting in a savings of $2 million in Medicare spending.

Choice Selection and Reviews

Since the IRF RCD was implemented in Pennsylvania, demonstration operations continue to progress successfully. Of the 53 IRFs participating in Pennsylvania, 52 selected the pre-claim review option and 1 selected the post-payment review option. 52 of the 53 providers met the overall affirmation rate of 80%. Unlimited resubmission opportunities, coupled with the MAC Medical Director's review of non-affirmations, have fostered high provider engagement and strong compliance. These early results indicate that, with ongoing communication and preparation, Pennsylvania's experience—like Alabama's—can help guide and strengthen broader implementation efforts in other states.

Providers in Each Choice



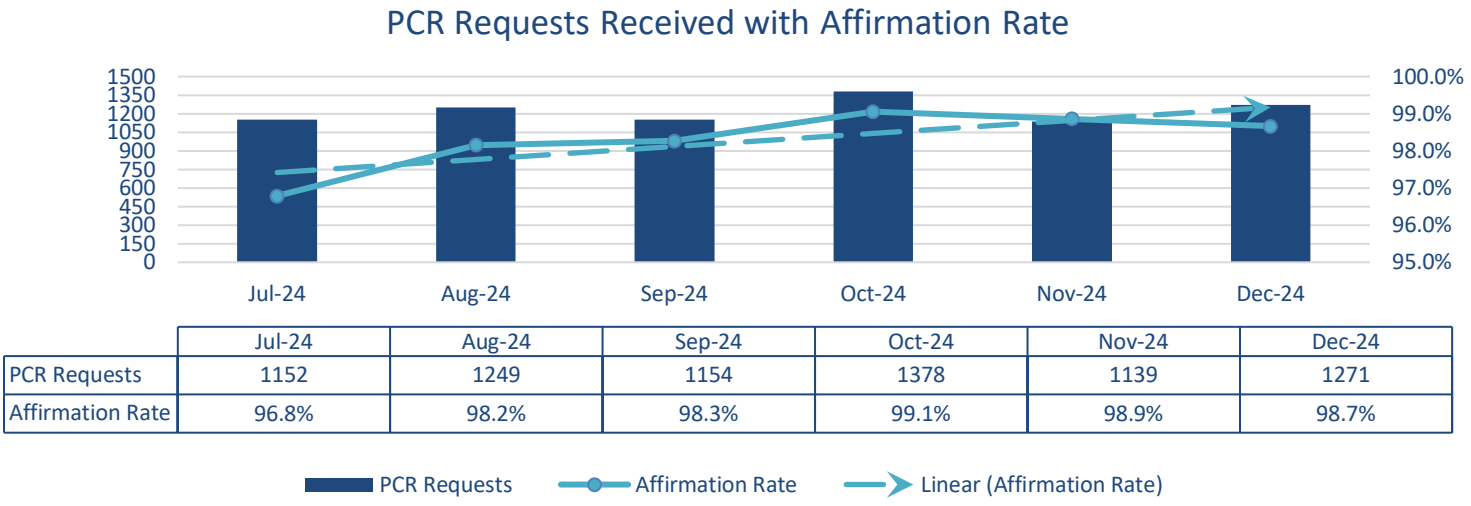
Pre-Claim Reviews	
Initial Requests Reviewed	7679
Initial Requests Provisionally Affirmed	7456
Resubmission Requests Reviewed	120
Resubmission Requests Affirmed	79
Total Requests Non-Affirmed	264
Provisional Affirmation Rate [1]	98%

Prepayment and Postpayment Reviews	
Claims Reviewed	50
Claims Approved	16
Claims Denied	21
Claim Approval Rate	32%

[1] Affirmation Rate (98%) = (Initial Requests Provisionally Affirmed (7456) + Total Number of Resubmission requests Affirmed (79))/Total Initial Request Reviewed (7679). 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.

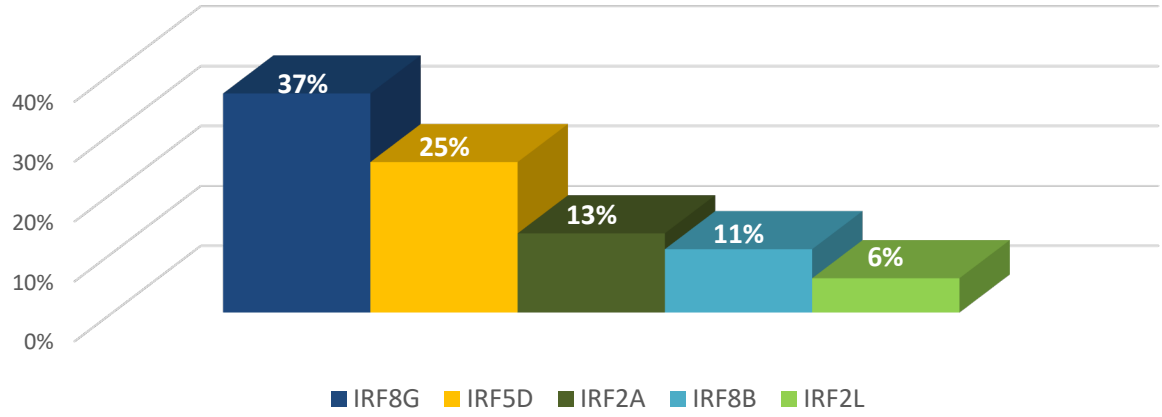
Affirmation Rate Trends

The chart below shows the first six months of the demonstration, beginning with July 2024. Throughout the demonstration, Pennsylvania IRF providers' affirmation rates began strong and remained high throughout cycle 1. The combination of high affirmation rates and gradual upward trend confirms strong provider compliance and effective IRF RCD review process. Throughout cycle 1, the volume of pre-claim review (PCR) requests stayed consistent and almost all IRF providers achieved the cycle 1 affirmation rate threshold of 80%.



	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
PCR Requests	1152	1249	1154	1378	1139	1271
Affirmation Rate	96.8%	98.2%	98.3%	99.1%	98.9%	98.7%

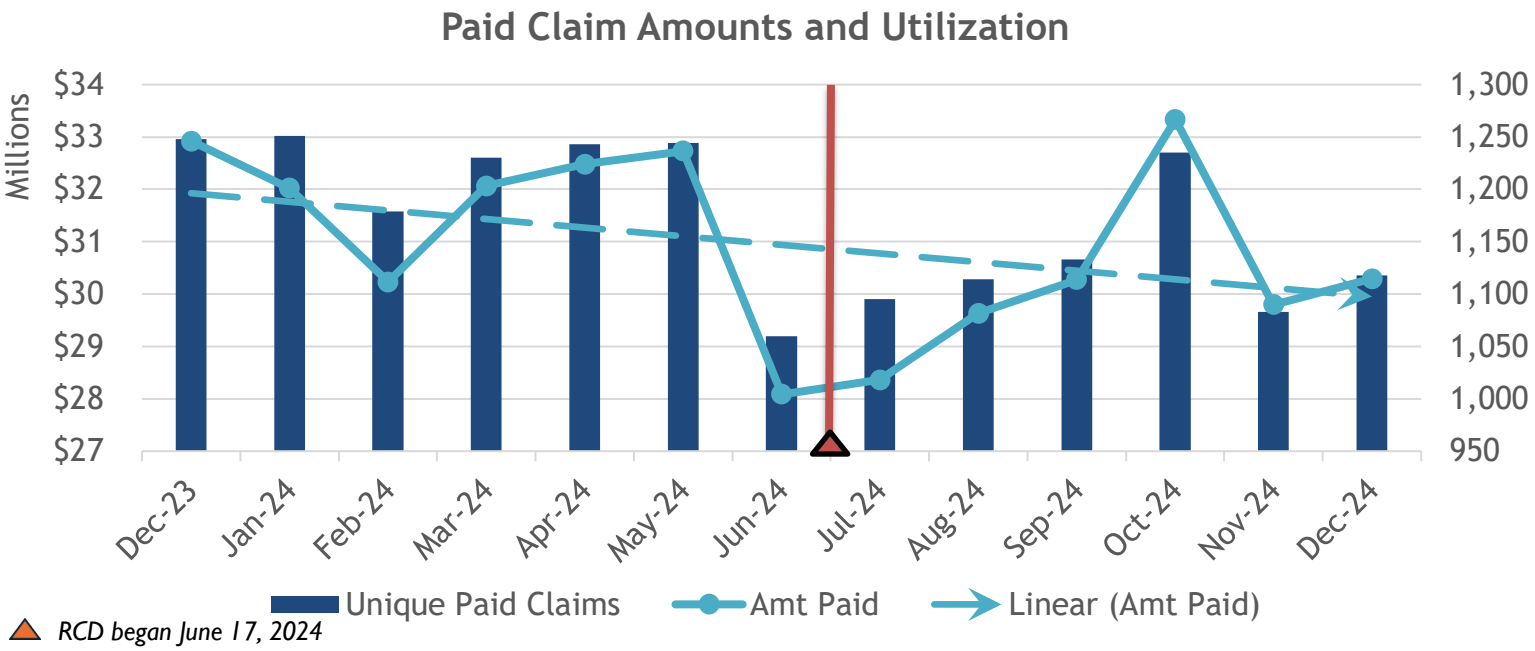
Top 5 Non-Affirmation Reason Codes

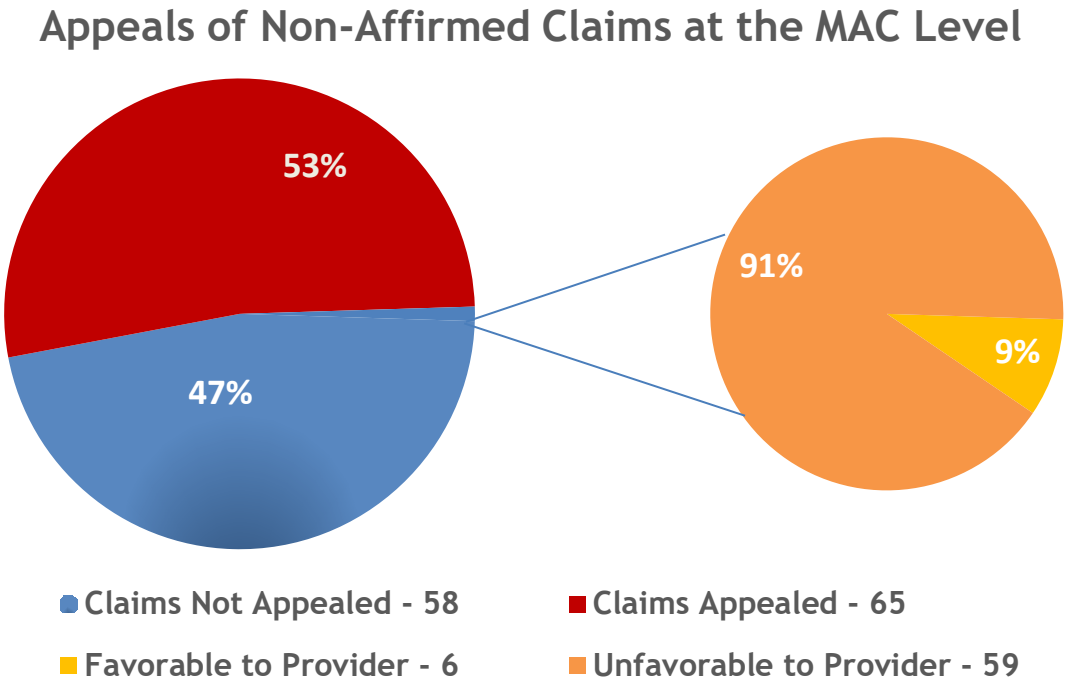


Code	Top 5 Non-Affirmation Reason Codes
IRF8G	Documentation does not support that therapy services began within thirty-six hours from midnight of the day of admission to the IRF.
IRF5D	The documentation does not support the patient is sufficiently stable at the time of admission to the IRF to be able to actively participate in and benefit significantly from the intensive rehabilitation therapy program.
IRF2A	Documentation does not support the pre-admission screen was completed or updated within the 48 hours immediately preceding the IRF admission.
IRF8B	Documentation does not support the patient received intensive rehabilitation therapy services.
IRF2L	The documentation does not include a preadmission screening

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. In the six months preceding the implementation, the average monthly claim payment amount was $32 million. During the initial six months of implementation, there was a 6.5% reduction in claim payments, resulting in an average claim payment amount of $30 million per month. Additionally, the average number of claims decreased by 9%, with 1,120 claims per month compared to an average of 1,233 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.





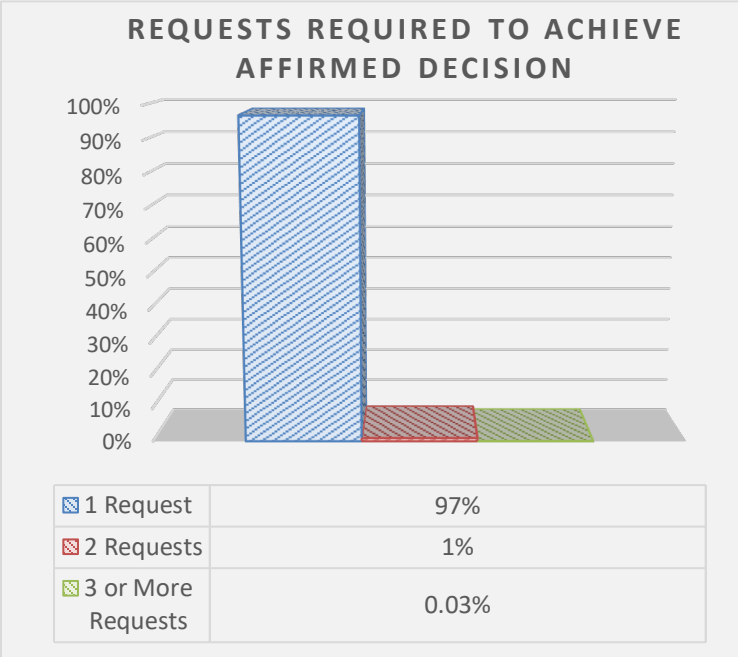
MAC Oversight

CMS' primary goal is to create successful partnerships while protecting the trust fund. CMS and MACs hold monthly calls to review initial pre-claim submissions together. The continuous collaboration helps ensure consistent review processes and decisions during the early stages of the demonstration. CMS does not want to create provider burden and the 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]:
60

Claims MRAC Agreed with Decision:
60

MAC Accuracy Rate:
100%



MAC Oversight	
Average PCR Review Timeframe in Days	1.5
PCR Reviews Exceeding 2 Business Days	0
Number of Resubmission Outreach Attempts	88
Number of Physician-Led Provider Education Calls Requested	1

[3] The MAC accuracy rate reviews began in July 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.