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

***Pennsylvania IRF RCD Cycle 2** (March 1, 2025 – August 31, 2025)*

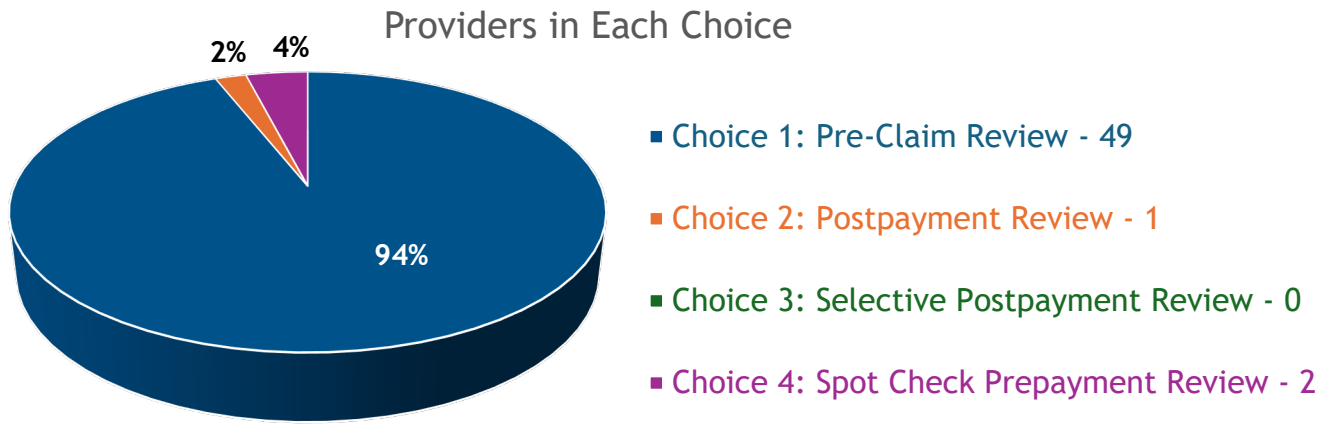
This report provides a high-level progress update on Pennsylvania's IRF RCD Cycle 2. It is intended to offer stakeholders a transparent overview of provider engagement, process integrity, and demonstration outcomes. The summary reflects the experience with the IRF RCD in Pennsylvania during Cycle 2, 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:

- The affirmation/approval rate threshold for Cycle 2 is 85%
- Of the 52 participating IRF providers:
  - 51 met the 85% threshold
  - 1 achieved an affirmation rate of 80%
- The majority of participating IRFs (49 of 52) selected the pre-claim review option
- Cycle 2 reflected relatively high affirmation rates and has shown that compliant IRFs can consistently meet Medicare requirements while preserving high-quality patient care, highlighting the importance of continued oversight to help sustain strong performance over time

Choice Selection and Reviews

Demonstration operations continue to progress as planned. In Cycle 2, 52 IRFs participated in the demonstration, with 49 selecting pre-claim review, 1 selecting postpayment review, and 2 selecting spot check prepayment review[1]. The IRF RCD offers multiple pathways, including flexibility and provider choice that rewards providers for sustained compliance with Medicare requirements. Based on the results of Cycle 1, 52 IRFs met the affirmation/approval rate threshold, and 50 IRFs elected to remain in pre-claim review, despite having the ability to participate in a different review choice. Based on the results of Cycle 2, 51 IRFs met the affirmation/approval rate threshold and now have the benefit of selecting from alternative review options in Cycle 3.



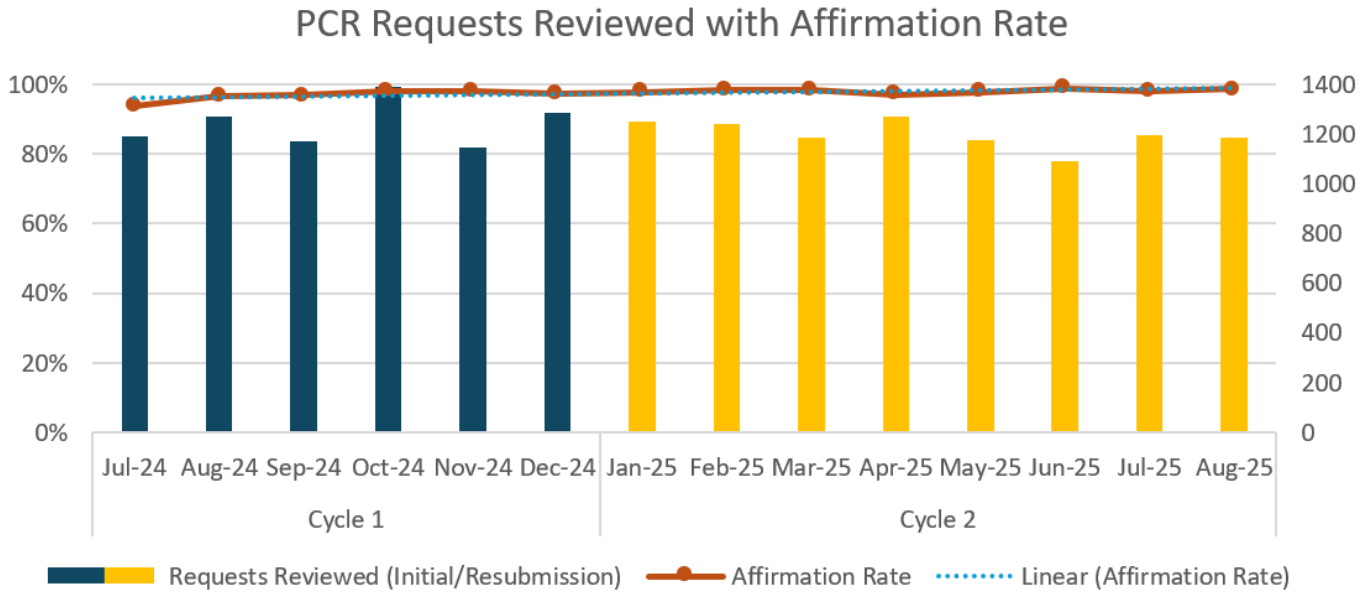
Pre-Claim Reviews	
Initial Requests Reviewed	9492
Initial Requests Provisionally Affirmed	9336
Resubmission Requests Reviewed	107
Resubmission Requests Affirmed	85
Total Requests Non-Affirmed	178
Provisional Affirmation Rate[2]	99%
Total Affirmation Rate[3]	98%

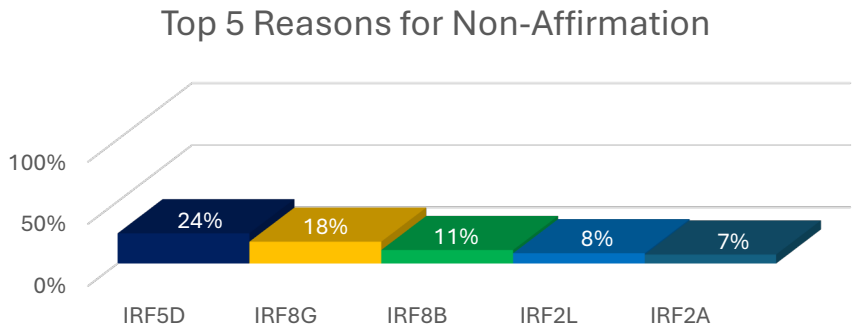
Prepayment and Postpayment Reviews	
Claims Received	141
Claims Approved	117
Claims Denied	32
Claim Approval Rate	83%

[1] In accordance with Medicare program requirements, one provider has been revoked from the Medicare program since the last cycle report.
[2] Provisional Affirmation Rate (99%) = (Initial Requests Provisionally Affirmed (9336) + Resubmission Requests Affirmed (85) / Initial Request Reviewed (9492)). 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.
[3] Total Affirmation Rate (98%) = (Initial Requests Provisionally Affirmed (9336) + Resubmission Requests Affirmed (85) / (Initial Requests Reviewed (9492) + Resubmission Requests Reviewed (107)).

Affirmation Rate Trends

The chart below reflects the two cycles of the demonstration, starting with Cycle 1 in July 2024. Pennsylvania IRF providers demonstrated strong performance at the outset, with affirmation rates remaining consistently high through Cycle 2. During Cycle 2, the volume of pre-claim review requests declined slightly compared to Cycle 1, affirmation rates remained stable, demonstrating that nearly all IRF providers achieved the Cycle 2 affirmation/approval rate threshold of 85%. These outcomes highlight the effectiveness of the IRF RCD in promoting sustained provider compliance through provider education and increased understanding of coverage criteria. High affirmation rates and submission levels suggest that providers understand the requirements and are applying them consistently. This indicates that the IRF RCD may be helping promote clearer and more consistent interpretation of Medicare policy.

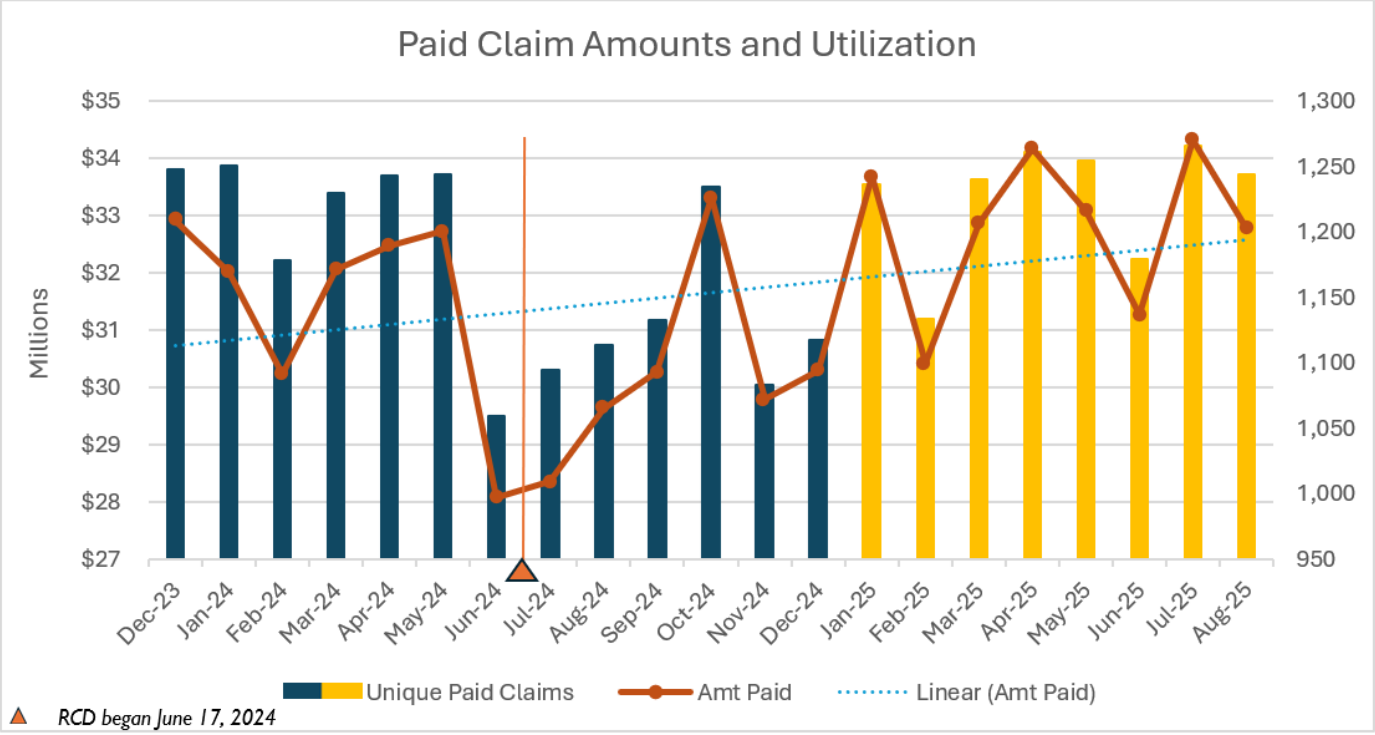


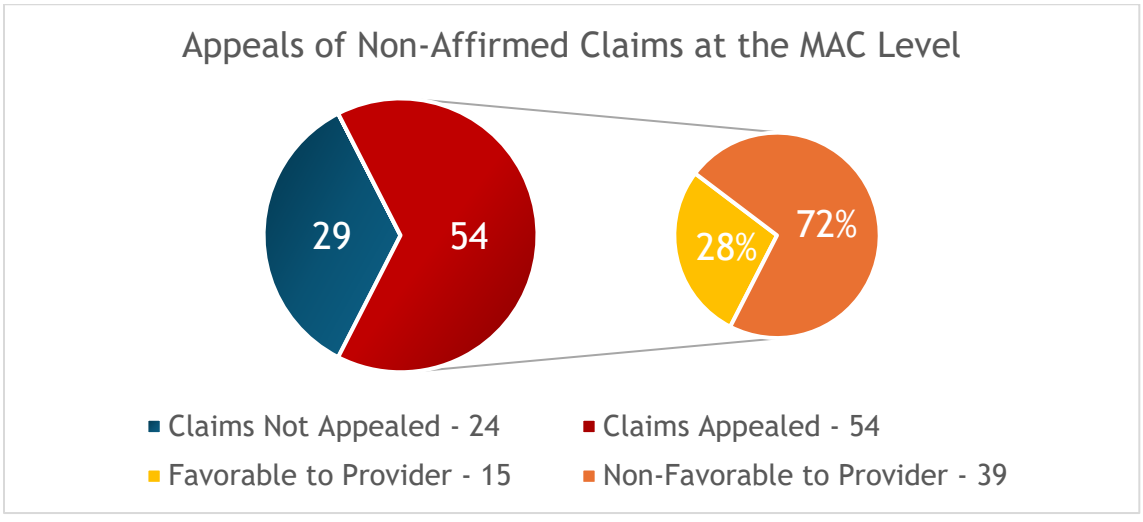


Code	Top 5 Non-Affirmation Reason Codes
IRF5D	Documentation does not support the patient is sufficiently stable at the time of admission to the IRF to be able to actively participate in and benefit significantly from the intensive rehabilitation therapy program.
IRF8G	Documentation does not support that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

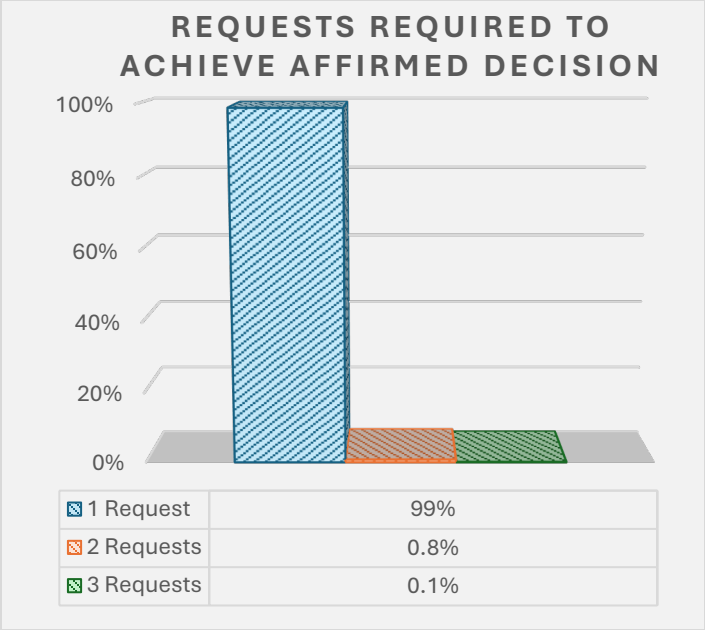
The chart below shows a reduction in claim payments over the 6 months before the IRF RCD started and continuing through the first program cycle. IRF RCD demonstrates effective early program impact, in the six months preceding the implementation, the average monthly claim payment amount was $32 million. The decline in paid amounts during early implementation reflects improved claim quality, as fewer claims that didn't meet Medicare requirements were submitted and paid resulting in appropriate admissions. During Cycle 2, claim payments and utilization increased relative to the pre-demonstration period, reflecting program stabilization following earlier RCD cycles. During early implementation, paid amounts declined, likely reflecting improved claim quality and fewer noncompliant claims. In Cycle 2, payments and utilization increased compared to the pre-demonstration period, suggesting program stabilization as providers adapted to IRF RCD requirements. Overall, this pattern indicates that the IRF RCD strengthened program integrity while continuing to support beneficiary access and appropriate service delivery.





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. This quality assurance process resulted in a 100% accuracy rate in Cycle 2. In Cycle 2, the low percentage of second and third submissions demonstrates that fewer cases required resubmission, and many cases were affirmed on the first submission.



MAC Oversight	
Average PCR Review Timeframe in Days	1.3
PCR Reviews Exceeding 2 Business Days	0
Number of Resubmission Outreach Attempts	61
Number of Physician-Led Provider Education Calls Requested	0
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.