CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12093	**Date: June 22, 2023**
	Change Request 13243

SUBJECT: Provider Education for the Review Choice Demonstration (RCD) for Inpatient Rehabilitation Facility Services (IRFs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct the Medicare Administrative Contractor (MAC) Jurisdiction J (JJ) to provide education for IRF providers regarding the RCD process for IRFs who are physically located in and bill to Alabama, then expand to IRFs who bill to all the states in JJ, regardless of where services are rendered.

EFFECTIVE DATE: July 25, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 25, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

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I. GENERAL INFORMATION

A. Background: During this 5-year intervention period, the Centers for Medicare & Medicaid Services (CMS) will test the use of review options for IRFs covered under Part A of the Medicare Fee-for- Service (FFS) program through the IRF Review Choice Demonstration. CMS will test this demonstration in accordance with section 402(a)(1)(J) of the Social Security Act (the Act), which authorizes the Secretary to "develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs."

As part of the IRF, providers in the demonstration must submit 100 percent pre-claim review or postpayment review for all IRFs who bill to MAC jurisdictions JJ, JL, JH, and JE. IRFs that do not actively select one of the initial two review choices will be automatically assigned to participate in postpayment review. Every six months, the provider's pre-claim review affirmation rate or postpayment review will be calculated to determine compliance to choose from three subsequent review options - pre-claim review, selective postpayment review, or spot check prepayment review. Operational instructions for the IRF RCD are provided under separate instructions.

This CR provides instructions to the contractor for education regarding the IRF RCD. CMS will educate physicians and providers about this demonstration by sending the Introductory Letters attached to this CR, as well as communicating related requirements and resources to access additional information.

B. Policy: Section 1862(a)(1) of the Act and Section 402(a)(1)(J) of the Act

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13243.1	The MACs shall generate lists of all active IRF providers to receive the appropriate Introductory Letter attached to this CR (Attachments A), providers in Alabama, then expand to those IRF providers who bill to JJ									JJ A/B MAC

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	The MACs shall use the below criteria: • Any provider who billed Palmetto GBA in the last three (3) years AND is active in Provider, Enrollment, Chain, and Ownership System (PECOS). • Any provider who has billed Palmetto GBA in the last six (6) months regardless of status (i.e. include both active and inactive). • Providers with a termination date in PECOS are excluded.									
13243.1.1	The MACs shall determine, which active providers from the list are applicable to its jurisdictions and perform IRF services for receipt of the letters.									JJ A/B MAC
13243.2	The MACs shall use the Introductory Provider Letter template provided by CMS (Attachment A).									JJ A/B MAC
13243.2.1	The MACs shall prepare and mail the Introductory Letters to all applicable providers (those who perform these specific services in the IRF setting), no later than 60 days before the demonstration start date in Alabama and before the expansion to the providers who bill to all the states in JJ.									JJ A/B MAC
13243.3	The MACs shall create web postings describing the									JJ A/B MAC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	program parameters.									
13243.4	The MACs shall hold group or individualized training sessions, as appropriate, to notify stakeholders of the RCD and to ensure understanding of the specific requirements.									JJ A/B MAC
13243.5	The MACs shall use the information on the CMS website to begin education. At such time that additional MAC instructions are finalized, MACs shall include that information in their education.									JJ A/B MAC
13243.5.1	The MACs shall, at a minimum, provide public access to the agency-developed information, including, but not limited to, any developed RCD operational guides, special Medicare Learning Network materials, and/or other support materials, by posting the link(s) on their website.									JJ A/B MAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Ashley Stedding, 410-786-4250 or ashley.stedding@cms.hhs.gov , Chirymeria Wilson, 410-786-2818 or chirymeria.wilson@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard,
Baltimore, Maryland 21244-1850

MAC Header Here

PROVIDER NAME
PROVIDER ADDRESS
CITY ST ZIP

Mail Date (ex. June 15, 2023)
Provider NPI Number: Provider NPI

Dear Physician/Practitioner:
The purpose of this letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is implementing a Review Choice Demonstration (RCD) for Inpatient Rehabilitation Facility (IRF) services. As part of this demonstration, CMS initially allows IRFs to select one of two choices: Choice 1 - Pre-Claim Review (PCR) or Choice 2 - Postpayment Review, for all IRF services in the demonstration states. For either of the two choices selected, pre-claim or postpayment review will be required for every IRF service.

What You Need to Know

The RCD does not change Medicare benefit or coverage requirements, nor does it create new documentation requirements. The documentation required to be included with the demonstration is information that IRFs are regularly required to maintain for Medicare payments.

IRF providers can make their selection on the Palmetto GBA eServices online provider portal at www.palmettogba.com/eservices beginning July 7, 2023 and ending August 6, 2023. Providers can make unlimited changes to their choice selection until August 6, 2023. If you have not registered for eServices and are a new user, you can register by selecting the *Register Now* button in the *New User* field. If you are registered in eServices, please enter your username and password to make your review choice selection. Once you have signed in, you will be asked to select from one of two review choice options described below for medical review of your IRF services. Be sure to review both options thoroughly prior to making a selection. If you need to reset your eServices password or have an eService related question, please contact the Provider Contact Center at 855-696-0705 and choose option 1 for EDI.

Choice 1 – PCR
If an IRF chooses to participate in Choice 1 - PCR, the IRF or the beneficiary initiates the PCR process by submitting a pre-claim review request to [Insert MAC name here]. PCR will allow the beneficiary to begin receiving services before an affirmative (i.e., approved) decision is received, unlike prior authorization, which ensures that all relevant coverage, coding, and payment requirements are met before the service is rendered to the beneficiary and before the claim is submitted for payment. An IRF may begin providing inpatient rehabilitation therapy services prior to submitting the PCR request and may continue to do so

while waiting for a decision. All relevant documentation based on applicable Medicare rules and policy requirements should be included in the initial request.

[Insert MAC name here] will examine the PCR request to determine whether the inpatient rehabilitation service for the beneficiary complies with applicable Medicare coverage and clinical documentation requirements. For the initial submission of a PCR request, [Insert MAC name here] will make and communicate a decision to provisionally affirm or non-affirm the request for approval for the services via telephone within two (2) business days. Additionally, [Insert MAC name here] will send a decision letter to both the IRF provider and the beneficiary.

If the [Insert MAC name here] non-affirms the PCR request , the requester may revise and resubmit it an unlimited number of times. [Insert MAC name here] will review and communicate a decision within two (2) business days on each resubmitted PCR request. [Insert MAC name here] will send the provider detailed reasons for the non-affirmation decisions and offer education to help the provider understand the reason for the non-affirmation decision and how the issue can be fixed.

Choice 2 – Postpayment Review
If the IRF selects Choice 2 - Postpayment Review, the IRF will follow its standard intake, service, and billing procedures, and the claims will be paid according to normal claim processes as outlined in Pub.100-08, Ch.3 Following payment, an Additional Documentation Request (ADR) will be issued. IRFs will have up to 45 days to respond. [Insert MAC name here] will make a payment determination within 60 calendar days and issue a decision letter. Standard appeal rights apply.

IRFs that do not actively choose one of the initial review choices will automatically be assigned to participate in Choice 2 - Postpayment review.

An IRF's compliance determines their next step. Every six months, the provider's pre-claim review affirmation rate or postpayment review approval rate will be calculated. If the provider's approval rate meets or exceeds the target affirmation rate based on a 10 request/claim minimum, the provider may choose from one of the three subsequent review options:

- Choice 1: Pre-Claim Review
- Choice 3: Selective Postpayment Review
- Choice 4: Spot Check Prepayment Review

IRFs that do not actively choose one of the subsequent review choices will automatically be assigned to participate in Choice 3: selective postpayment review, and will remain there for the duration of the demonstration.

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

An IRFs target affirmation rate is based on the following sliding scale from the time the demonstration begins in each state:

- Cycle 1: 80% affirmation rate
- Cycle 2: 85% affirmation rate
- Cycle 3 and Greater: 90% affirmation rate

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

Additional Resources

Providers are vital partners in the Medicare program, and CMS is preparing additional resources to give you the information you need. To facilitate an open and ongoing dialogue with both patients and providers, and to support program transparency, CMS has established a dedicated website for the IRF RCD with comprehensive information for beneficiaries, IRFs, and physician/practitioner providers.

You may request an individual education session if you have concerns about the program. More information is available online. CMS and [insert MAC name] will post details of any upcoming educational sessions on its website (link noted above).

CMS Welcomes Feedback

CMS is committed to launching the IRF RCD with an open and transparent process that serves and protects beneficiaries and the health care providers that care for them. Send feedback to CMS at IRF_RCD@cms.hhs.gov.