The Law Offices of
Jason M. Healy PLLC

Health Care Provider
Legal Alert

September 2023 Vol. 6, No. 6

New Review Choice Demonstration (RCD) Program for Inpatient Rehabilitation Facility (IRF) Services

In This Issue:

Jason M. Healy, Esq.
1701 Pennsylvania Ave., NW
Suite 200
Washington, DC 20006
(202) 706-7926
(888) 503-1585 fax
jhealy@healylawdc.com

First Time that Medicare Will Review All IRF Claims Before Payment

CMS is instituting a new claim review policy for Inpatient Rehabilitation Facilities ("IRFs") through a program called Review Choice Demonstration ("RCD"). Complete information regarding this new review policy can be found in the program Operation Guide, FAQ document, and Flow Chart. The claim review policy will require all IRF claims for Medicare Fee-for-Service ("FFS") reimbursement to be reviewed by Medicare Administrative Contractors ("MACs"). CMS expects the program to last approximately five years.[1]

Under the new RCD program, providers must choose whether their claims will be held for review before payment or whether they will be reviewed postpayment. MACs will evaluate whether the claims meet the IRF coverage and documentation requirements listed at 42 C.F.R. § 412.622. The RCD Operational Guide clarifies that provider types 04 (Rehabilitation Facility) and 50 (Rehabilitation Distinct Part), bill type 11X, and an extensive list of case-mix group ("CMG") codes, are subject to the program.[2] Certain claims will not be eligible for pre-claim or postpayment review. The Operational Guide states that "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, and all Part A and Part B demonstrations are not part of this demonstration."[3]

It is likely that both the prepayment and postpayment claim review options will result in substantial provider burden. Both policies will require providers to devote significant time and resources into collecting, organizing, and transmitting medical records to establish that each claim satisfies Medicare IRF coverage and documentation requirements. Any inaccuracies or delays in claim reviews will negatively impact the amount and timing of IRF reimbursement from Medicare. Moreover, the MAC claim reviewers will need to be well-versed in IRF coverage requirements to ensure accurate and timely claim reviews. These are issues that IRFs frequently encounter under existing Medicare claim reviews. However, as compared to other types of reviews and audits, there is a greater potential burden and disruption from this new RCD

program because the MACs will review all IRF Medicare FFS claims for affected providers, rather than a partial selection or sample of claims.

The Medicare IRF coverage requirements that providers must document and demonstrate to MACs under the RCD program are as follows:

- 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 generally must 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.[4]

IRFs are also subject to certain documentation requirements. This requires that IRF medical records include a comprehensive preadmission screening, interdisciplinary team meeting notes, and an individualized overall plan of care.[5] Claim reviews under the RCD program will evaluate whether every IRF Medicare FFS claim satisfies these requirements.

Timeline. The new RCD program demonstration began August 21, 2023 for IRF providers in Alabama. Initially, the demonstration will only impact providers located in Alabama that bill Jurisdiction J MAC (Palmetto GBA). According to CMS, the RCD will subsequently expand to IRFs located in Pennsylvania, Texas, and California on a date to be determined. CMS will give 90 days' notice before the program expands to the new locations and jurisdictions.[6] The program will later expand on an undetermined date to all IRFs that bill the Jurisdiction J MAC (Palmetto GBA), Jurisdiction L MAC (Novitas), Jurisdiction H MAC (Novitas), and Jurisdiction E MAC (Noridian), regardless of the IRF's location.

IRFs will be notified 60 days before the RCD is implemented in their state, and will be given a 30-day selection period to choose the type of claim review it prefers (pre-claim review or postpayment review). In Alabama, the first cycle selection period was from July 7, 2023 to August 6, 2023, and the claim reviews began August 21, 2023. CMS reduces the selection period to two weeks for subsequent cycles of the RCD program.[7] Only IRF services that begin on or after the RCD program's start date in a provider's state or jurisdiction are subject to review under the RCD program.

RCD Review Process. The first stage of the RCD program begins with providers choosing either Pre-Claim Review or Postpayment Review of their claims through their MAC's portal.

Choice 1: Pre-Claim Review

- All claims are subject to pre-claim review.

- 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.

- This is the 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.[8]

If providers choose the pre-claim review option, they will need to submit pre-claim review requests for all eligible claims. This is different from a final claim for services. Unlike final claims, pre-claim review submissions will receive either a provisional affirmative decision, indicating the beneficiary met the IRF coverage requirements, or a non-affirmative decision indicating the beneficiary did not meet coverage requirements. CMS does not state whether a provisional affirmative decision guarantees that a claim will be approved. Instead, CMS only explains that a final claim which has received a non-affirmative decision will be denied.[9] Also unlike a final claim, a provider can send unlimited pre-claim review requests before the end of an RCD review cycle. Effectively, providers using the pre-claim review option can continue modifying and re-requesting pre-claim reviews of a specific claim until they receive a provisional affirmative decision, to the extent supporting documentation is available.

IRFs must include certain information in a pre-claim review request. The required information is listed on pages 10 to 12 of the Operational Guide. The IRF must provide basic information regarding the beneficiary, physician, IRF, the pre-claim submitter at the IRF, and other basic information regarding the submission.[10] Furthermore, IRFs will need to submit the following medical record documentation: pre-admission screening, documentation supporting the admission to the IRF, plan of care, interdisciplinary team conference notes, and therapy evaluations/skilled notes.[11] The guide also instructs providers to make the pre-claim review requests through "Mail, Fax, esMD (available in October 2023), or [the] MAC Provider Portal."[12] Importantly, there is no separate appeal or review process for pre-claim review non-affirmed decisions. Therefore, a provider must submit a final claim, have it denied, and can only then follow existing appeal procedures under the Medicare Claims Processing Manual.[13] As discussed above, an IRF that receives a non-affirmative decision also has the option of modifying and re-requesting a pre-claim review for the claim at issue.

If an IRF instead chooses the postpayment review option, it will submit claims for services as normal. The MAC will then issue an IRF ADR following receipt of the claim.[14] In response, the IRF will send the MAC the medical documentation for the claim. The list of documents to submit is found on pages 22 to 23 of the Operational Guide. The list includes the preadmission screening, overall plan of care, and other documentation that demonstrates the beneficiary met the IRF coverage criteria under 42 C.F.R. § 412.622(a)(3) and

documentation requirements at 42 C.F.R. § 412.622(a)(4).[15] IRFs will have all existing appeal rights for any claims that the MAC denies after the postpayment review.

The RCD program will begin with a first stage composed of a 6-month cycle. For Alabama providers, the first cycle started on August 21, 2023. Any IRF Medicare FFS claims for services that began on or after August 21 will be reviewed, either a pre-claim review or postpayment review depending on the IRF's selection. CMS has not clarified whether services that begin before the end of a cycle, but end after a cycle concludes will be considered under the initial or the subsequent cycle. At the end of a cycle, IRFs will receive a pre-claim review affirmation rate or postpayment review approval rate from their MAC based on the percentage of claims that were found to meet all IRF Medicare coverage and documentation requirements. These criteria are satisfied if the IRF's documentation shows the beneficiary required physical or occupational therapy, was able to participate in IRF therapy programs, and required IRF-level interdisciplinary therapy care.[16] The IRF's medical records also must have the required documents, including the preadmission screening, interdisciplinary care notes, overall plan of care, and any other documentation that establishing that the beneficiary met the IRF coverage criteria.

The MAC will inform IRFs if they met the minimum required approval rate or affirmation to advance to the next step in the RCD program. If an IRF meets the required threshold, it advances to a second stage where it has the option of less stringent claim reviews in the next 6-month cycle. The minimum threshold required in the first 6-month review cycle is 80%. The second 6-month review cycle threshold is 85%, and from the third cycle on, the threshold is 90%. Once a provider reaches Its third cycle, the minimum threshold remains at 90% for all subsequent cycles. New IRFs will be subject to whatever threshold is required by the review cycle its state is using at the time the IRF is established. If a provider fails to meet a threshold, or submits less than 10 claims for review, then it must choose one of the first two options again, 100% pre-claim review or 100% postpayment review, for the next 6-month cycle. If a provider has submitted multiple pre-claim review requests for a single claim, only the last decision by the provider's MAC will be counted for the affirmation rate.[17] Additionally, any final claims overturned on appeal will not be recounted in the determination of the affirmation rate.[18]

If an IRF has advanced to stage 2, it has the choice of three review options:

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.[19]

If an IRF fails to meet the minimum required threshold in stage 2, its review options for the next 6-month cycle will revert to the initial choice of having 100% of its claims go through pre-claim review or 100% of its claims reviewed postpayment.[20] If a provider meets the minimum threshold, it continues to have Choice 1, Choice 3, and Choice 4, available for its next cycle.

How the RCD program will Impact IRF Providers. A claim review policy that will initially subject nearly all of an IRF's Medicare claims to review is a large undertaking by CMS that will require efficient and accurate claim review by the agency and its contractors. If the reviews are not accurate and efficient, the RCD program will be extremely burdensome for IRF providers. Even if the MACs are able to handle this increased workload, the RCD program will still require significant provider resources to prepare and monitor the lengthy documentation submissions required for each IRF patient, and appeal final claims that are denied.

All IRFs will be subject to the RCD program and should be prepared for additional administrative burden because CMS contractors have not proven in the past that they are capable of properly evaluating IRF claims, including compliance with the IRF coverage criteria an documentation requirements. Many IRF providers have experienced audits, including TPE reviews, where Medicare reviewers improperly identified claims as failing to meet coverage criteria because the reviewers did not properly understand the IRF Medicare coverage criteria. A recently released CMS webinar suggested that the RCD will likely include less unqualified reviewers. A speaker from Palmetto GBA (the first MAC to begin conducting RCD reviews) informed providers that nurses will be reviewing claims because "[t]here are too many for one physician to review."[21] Moreover, Medicare reviews and audits frequently use claim reviewers who do not have specific experience with the IRF setting. Claim reviews conducted primarily by medical professionals who do not have significant IRF expertise are more prone to mistakes and delays. This problem is likely to be made worse by the large number of IRF claims that will be subject to this program. Inaccurate or delayed claim reviews will impact payment and will make budgeting and financial planning more challenging for IRF providers.

Both the American Hospital Association ("AHA") and American Medical Rehabilitation Providers Association ("AMRPA") submitted comments to CMS opposing this program when it was first announced. The AHA raised concern that the program would use the same type of auditors and audit safeguards that had previously been inadequate in other reviews or IRF claims, including reviews by the Office of Inspector General, Recovery Audit Contractors ("RACs"), and Comprehensive Error Rate Testing ("CERT") auditors.[22] Inexperienced auditors and a lack of safeguards have frequently led to inaccurate results with "high error rate[s]", and the AHA believes the RCD program will only exacerbate these issues.[23] The AHA also noted the immense burden that will be imposed on IRF providers if they must have all of their claims reviewed by MAC auditors, and advised CMS to narrow the scope of the program to affect fewer providers and claims.[24] The AMRPA echoed the AHA's criticism of the use of medical reviewers with insufficient experience to accurately conduct reviews of such a large number of IRF claims.[25]

Although these comments were published in 2021, when CMS first announced the RCD program, the concerns are still valid today. The structure of the RCD program criticized in the comment letters has functionally remained the same. The program still begins with a 100% review of claims, either prior to payment or postpayment, and only IRFs that meet a minimum threshold progress to a more limited claim review. CMS has stated it will provide outreach webinars and communicate with providers, and that it will review MAC decisions and data, but CMS failed to provide crucial information about exactly what data and what methods it will use to review and limit incorrect MAC decisions.[26] The AHA and the AMRPA concerns are even more relevant now that CMS has released additional information about how the RCD program is going to be implemented. The obvious problems that result from the use of non-physician reviewers, the ambiguous statements on CMS oversight, and the acknowledgement that physicians will be unable to review the claims submitted, were expected and criticized by the AHA and the AMRPA. These are the same issues that the AHA and AMRPA expect will lead to high error rates. In the RCD program, improper claim denials overturned on appeal will not change the MAC calculation of a provider's affirmation rate. Therefore, well-intentioned providers can be subject to claim review of 100% of their claims even if appeals later confirm that over 90% of their claims met the IRF coverage and documentation requirements.

The RCD program will also affect existing provider audits. IRFs that are currently subject to ongoing TPE reviews will see those reviews terminated at some point before the demonstration begins in their state.[27] However, CMS clarified that the program does not exempt IRFs, or their claims, from other CMS contractor audits, CERT audits, or Unified Program Integrity Contractor ("UPIC") reviews.[28] The Operational Guide clarifies that any provider currently under a UPIC review will not be eligible for participation in the demonstration.[29]

Unfortunately, IRF providers nationwide are accustomed to the flawed claim review process and the associated administrative burden of Medicare claim reviews. As the RCD program is implemented in more states and MAC jurisdictions, significantly more IRF claims will be subject to claim review. This is likely to cause a sharp increase in delayed payments, claim denials and appeals. It is important for providers to retain experienced legal representation to assist with the Medicare claims appeal process and to minimize the negative financial impact from frequent claim denials. When the RCD expands to an IRF's state or MAC jurisdiction, IRFs should ensure their documentation procedures are as detailed and complete as possible to prepare for their 100% pre-claim or postpayment review. Claim reviewers sometimes apply questionable interpretations of Medicare requirements. We can assist in those situations, raise concerns with the agency, and help appeal denied claims.

---

[1] *See* CMS, *Review Choice Demonstration for Inpatient Rehabilitation Facility Services: Special Open Door Forum* at 6 (June 27, 2023), https://www.cms.gov/files/document/irf-rcd-open-door-forum-presentation-06272023.pdf.
[2] CMS, *Review Choice Demonstration for Inpatient Rehabilitation Facility Services: Operational Guide* at 7 (Jul. 26, 2023), https://www.cms.gov/files/document/irf-rcd-operational-guide.pdf.
[3] *Id*. at 8.
[4] CMS, *Review Choice Demonstration for Inpatient Rehabilitation Facility Services: Frequently Asked Questions (FAQs)* at 11 (Jul. 17, 2023), https://www.cms.gov/files/document/irf-rcd-faqs.pdf; *see also* 42 C.F.R. § 412.622(a)(3); Medicare Benefit Policy Manual (CMS Pub. 100-02), Ch. 1, § 110.2.
[5] 42 C.F.R. § 412.622(4),(5).

[6] CMS, *Review Choice Demonstration for Inpatient Rehabilitation Facility Services: Special Open Door Forum* at 6.
[7] *Id.* at 17.
[8] CMS, *Review Choice Demonstration for Inpatient Rehabilitation Facility Services: Frequently Asked Questions (FAQs)* at 4-5.
[9] *Id.* at 13.
[10] CMS, *Review Choice Demonstration for Inpatient Rehabilitation Facility Services: Operational Guide* at 10.
[11] CMS, *Review Choice Demonstration for Inpatient Rehabilitation Facility Services: Frequently Asked Questions (FAQs)* at 11-12.
[12] *Id.* at 11.
[13] Medicare Claims Processing Manual, (Pub. 100-04), Ch. 29.
[14] CMS*, Review Choice Demonstration for Inpatient Rehabilitation Facility Services: Operational Guide* at 22.
[15] *Id.* at 22-23.
[16] 42 C.F.R. § 412.622; Medicare Benefit Policy Manual, Ch. 1, § 110.
[17] CMS, *Transcript: Special Open Door Forum* at 6 (June 27, 2023), https://www.cms.gov/files/document/transcriptsodfreviewchoicedemoforirfservices06272023.pdf.
[18] *Id.* at 22.
[19] CMS, *Review Choice Demonstration for Inpatient Rehabilitation Facility Services: Frequently Asked Questions (FAQs*) at 5.
[20] CMS, *Review Choice Demonstration for Inpatient Rehabilitation Facility Services: Operational Guide* at 5.
[21] CMS, *Transcript: Special Open Door Forum* at 4 (June 27, 2023).
[22] AHA, *AHA Comments to CMS on Review Choice Demonstration for Inpatient Rehabilitation Facilities* (Oct. 8, 2021), https://www.aha.org/lettercomment/2021-10-08-aha-comments-cms-review-choice-demonstration-inpatient-rehabilitation.
[23] *Id.*
[24] *Id.* at 3.
[25] AMRPA, *AMRPA Response to IRF RCD Second Notice with Appendix* (Oct. 8, 2021), https://ampra.org/Portals/0/AMRPA%20Response%20to%20IRF%20RCD%20Notice%20with%20Appendix_Final.pdf.
[26] CMS, *Review Choice Demonstrations for Inpatient Rehabilitation Facility Services: Special Open Door Forum* at 18.
[27] *Id.* at 8.
[28] CMS, *Review Choice Demonstration for Inpatient Rehabilitation Facility Services: Frequently Asked Questions (FAQs*) at 7
[29] CMS, *Review Choice Demonstration for Inpatient Rehabilitation Facility Services: Operational Guide* at 6.

About Us

The Law Offices of Jason M. Healy PLLC is a Washington, D.C. based law firm serving national and local clients. We focus primarily on legal issues affecting health care providers under Medicare and Medicaid laws and regulations. We represent health care providers in reimbursement audits, appeals, litigation, and transactions. Located in Washington, DC, just minutes from the Department of Health and Human Services, Congressional offices, and the White House, we are well positioned to provide legal support for advocacy efforts. Our Principal, Jason M. Healy, is a health care lawyer with over 20 years of experience with the array of legal issues facing health care providers.