Helpful Hints for the Review Choice Demonstration For Inpatient Rehabilitation Facility Services

The Review Choice Demonstration (RCD) for Inpatient Rehabilitation Facility (IRF) Services is designed to reduce Medicare improper payments and appeals, improve provider compliance with Medicare program rules, and ensure that patients in IRFs are receiving the appropriate level of care. The RCD provides flexibility for IRFs, giving them a choice to choose initially between pre-claim review (PCR) or postpayment review. Pre-claim review allows the provider to submit a review request while the beneficiary is receiving IRF services to try to obtain an affirmed decision. IRFs that received a non-affirmed decision can resubmit the PCR request an unlimited number of times to correct errors or omissions prior to the final claim being submitted for payment to the Medicare program.

This program does not alter the Medicare IRF benefit or create new clinical documentation requirements; rather, it requires only submission of the same information providers are currently required to maintain. This helps ensure that all relevant coverage and clinical documentation requirements are met, prior to claim submission. IRFs that demonstrate compliance with Medicare requirements may choose from additional, less intense review choices, such as spot checks, to ensure continued compliance.

The RCD has been operating successfully in Alabama since August 21, 2023, and in Pennsylvania since June 17, 2024. Most non-affirmations occur when IRFs admit beneficiaries who are unable to participate in, or benefit from, an intensive rehabilitation therapy program. In addition to medical necessity errors, some non-affirmations are due to avoidable documentation errors, such as when the pre-admission screening (PAS) is incomplete or not completed within the required time frame.

While PCR requests can be submitted an unlimited number of times, CMS has identified several reasons for non-affirmations due to IRF conditions of payment that are not able to be corrected:

PAS was not fully completed or completed timely

If there are elements missing from the PAS or it is completed and signed after the 48 hours immediately preceding the IRF admission, the PCR request will be non-affirmed. The PAS will be accepted as long as an update is conducted in person or by telephone to update the patient's medical and functional status within the 48 hours immediately preceding the IRF admission. The update must include the patient's medical and functional status. If any of the required elements are missing from the PAS, it will be non-affirmed as it was not fully completed (42 CFR 412.622(a)(4)(i)(A)). All the following elements are required to be

included:

- Prior level of function,
- Expected length of time necessary to achieve that level of improvement,
- Expected level of improvement,
- The patient's anticipated discharge location,
- An evaluation of the patient's risk for clinical complications,
- The conditions that caused the need for rehabilitation, and
- The treatments needed.

The PAS must be conducted by one or more licensed or certified clinician(s) within the 48 hours immediately preceding the IRF admission. The rehabilitation physician must document that he or she has reviewed and concurs with the findings and results of the PAS prior to the IRF admission. If there is no signature on the PAS from the rehabilitation physician or the signature is not timely, the PCR request will be non-affirmed. If the PAS was conducted by a clinician other than the rehabilitation physician, there still needs to be documentation that the rehabilitation physician concurred with the findings.

Therapy Evaluations were not completed timely

All therapy treatments documented in the PAS must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations are generally considered to constitute the beginning of the required therapy treatment and are required to meet the standard of the regulatory guidance. If the therapy evaluations that are noted in the PAS are not completed within the 36 hours from midnight of the day of admission, the PCR request will be non-affirmed.

Best Practices

Below are best practices to help avoid non-affirmations and correct potential errors resulting in non-affirmations:

- Use the PCR IRF RCD checklist.
- Remember your PCR request must include documentation for the PAS and all therapy initial evaluations with therapies identified as a need for the patient.
- All therapy treatments documented in the PAS for the patient must begin within 36 hours from midnight of the day of admission to the IRF.
- Remember that the Medicare IRF benefit requires the patient be expected to actively participate in and benefit significantly from the intensive therapy program.
- Carefully review the non-affirmation decision letter to make any necessary adjustments to the PCR request before resubmission.
- Review the IRF Reason Codes and Statements (PDF).
- Reach out to your provider call center, as needed.

- Subscribe to your Medicare Administrative Contractor (MAC) email updates.
- If desired, submit an education request form to have someone contact your agency for 1 on 1 education assistance.

Important Items to Note

- **Medicare Advantage Informational Claims**
    - Medicare Advantage beneficiary informational claims are not subject to the IRF RCD. The only claims that are subject to the RCD are standard Medicare fee-for-service (FFS) admissions, regardless of whether an informational-only claim must be submitted to the Medicare FFS MAC for administrative purposes.

- **Interrupted Stays**
    - Interrupted stays of less than 3 days are included in the IRF RCD. In order to avoid a non-affirmation, the IRF should only submit PCR requests once they have all required documentation. If the beneficiary returns to the acute care facility before the PCR request has been submitted, the IRF should wait to submit the request until they have the rest of the documentation.

    - Providers should ensure that Occurrence Span Code 74 is present on the claim if there is an interrupted stay less than 3 days. If the patient returns to the IRF by midnight of the 3rd day, the bill continues under the same Case Mix Group (CMG) [1]. Common Work File (CWF) will need to edit to ensure that if another IRF bill comes in during the interrupted stay, it is rejected, as it should be associated with the original CMG (Medicare Claims Processing Manual – 100-04, Chapter 3, Section 140.3.1 – Shared Systems and CWF Edits). If the interruption is greater than 3 days, the bill should be considered a discharge.

- **Short Stays**
    - Short stays with CMG A5001 are not included in the IRF RCD. Under the IRF PPS, if a patient is in an IRF for 3 days or less, they may be eligible for and receive the IRF short stay payment (CMG A5001). A UTN is not needed if the claim is processed with CMG A5001.

[1] Classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a “case mix group”), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups; and a method of classifying specific patients in rehabilitation facilities within these groups.

- **Short Stay Transfers**
    - Short stay transfers are included in the IRF RCD. Short stay transfers are transfers from an IRF to another institutional setting prior to the average length of stay given the patient's CMG and comorbidities. A patient can be transferred to another IRF, a short-term, acute-care prospective payment hospital, a long-term care hospital as described in 42 CFR 412.23(e), or a nursing home that qualifies to receive Medicare or Medicaid payments.

- **Interdisciplinary Team Meetings**
    - The Interdisciplinary team meetings are held a minimum of once per week. The team meetings are led by a rehabilitation physician and consist of a registered nurse with specialized training or experience in rehabilitation; a social worker or case manager (or both); and a licensed or certified therapist from each therapy discipline involved in treating the patient. A calendar week is defined in 42 CFR 412.622(a)(5) as 7 consecutive days beginning with the admission day as "Day 1".

Resources

- CMS Internet-Only Manual (IOM), Pub 100-02, Chapter 1, Section 110
- Code of Federal Regulations 42 CFR 412.622 –Basis of Payment
- CMS Webpage - Review Choice Demonstration for Inpatient Rehabilitation Facility Services
- IRF RCD Operational Guide
- IRF RCD Frequently Asked Questions
- IRF RCD Review Guidelines