Review Choice Demonstration for Inpatient Rehabilitation Facility Services

Operational Guide

July 11, 2024

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Purpose

The purpose of this Operational Guide is to interpret and clarify the review process for Medicare participating IRFs when rendering services for Medicare beneficiaries during the Review Choice Demonstration. This guide will advise IRFs on the process for submitting documents in support of the services as well as the final claim.

Chapter 1: Inpatient Rehabilitation Benefit

For any service to be covered by Medicare it must:

1. Be eligible for a defined Medicare benefit category;
2. Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member; and
3. Meet all other applicable Medicare statutory and regulatory requirements.

In accordance with 42 CFR § 412.622(a)(3)[1], in order for an IRF claim to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation that the patient meets all of the following requirements at the time of the patient's admission to the IRF:

1. Requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.
2. Generally, require and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least three hours of therapy per day and at least five days per week. In certain well-documented cases, this intensive rehabilitation therapy program may consist of at least 15 hours of intensive rehabilitation therapy per week. However, this is not the only way that such intensity of services can be demonstrated. The reviewer shall determine medical necessity of the intensive rehabilitation therapy program based on the individual facts and circumstances of the case, and not on the basis of any threshold of therapy time. Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the patient in improving the patient's functional capacity or adaptation to impairments. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF.
3. Is sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation therapy program that is described in paragraph (a)(3)(ii) of this section.
4. Require supervision by a rehabilitation physician. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least three days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

For additional information on the requirements for the Medicare IRF Benefit, see 42 CFR 412.622(a)(4)[2] and (5)[3]. See Chapter 1 of the Medicare Benefit Policy[4] for more information on the coverage criteria for IRF services.

[1] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.622#p-412.622(a)(3)
[2] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.622#p-412.622(a)(4)
[3] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-412/subpart-P/section-412.622#p-412.622(a)(5)
[4] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf

Chapter 2: Overview of the Review Choice Demonstration for IRF Services

This demonstration will include IRFs that: provide IRF services and are enrolled in the Medicare FFS program; and beneficiaries. The term submitter will be used throughout this document to describe the person or entity that submits the claims, documentation and/or pre-claim review request under the different choices.

The Review Choice Demonstration will apply to IRFs that bill to Medicare Administrative Contractor (MAC) jurisdictions JJ, JL, JH, and JE; regardless of where services are rendered.

The demonstration will apply to IRF services with a *from* date on or after:

- **08/21/2023 for IRFs located in Alabama**
- **06/17/2024 for IRFs located in Pennsylvania,**
- **TBD for IRFs located in Texas and California**
- **TBD for IRFs that bill to MAC jurisdictions JJ, JL, JH, and JE.**

IRFs will have the option to initially select between two review choices:

- Choice 1: Pre-Claim Review,
- Choice 2: Postpayment Review, or

An IRF's compliance determines their next step. Every 6 months, the IRFs pre-claim review affirmation rate or postpayment review approval rate will be calculated. If the IRF meets the target affirmation rate or greater (based on a 10 request/claim minimum), the IRF may select from one of the three subsequent review choices:

- Choice 1: Pre-Claim Review,
- Choice 3: Selective Postpayment Review, or
- Choice 4: Spot Check Review.

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

An IRF's target affirmation rate is based on the following sliding scale from the time an IRF starts the demonstration:

- First review cycle: 80% affirmation rate
- Second review cycle: 85% affirmation rate
- Third review cycle: 90% affirmation rate

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

An IRF under Unified Program Integrity Contractor (UPIC) review is not eligible for participation in this demonstration. However, all IRFs are encouraged to make a choice selection. Questions regarding UPIC review should be directed to the UPIC.

IRF Telephone Inquiries:
IRFs who have questions about the demonstration review process should call their billing MAC:
Palmetto GBA Jurisdiction J at 855- 696-0705.
Novitas Jurisdiction H at 855-340-5975
Novitas Jurisdiction L at TBD
Noridian Jurisdiction E at TBD

See Appendix A: Review Choice Demonstration Flowchart

Chapter 3: IRF Program Criteria Subject to the Demonstration

The following revenue code, type of bill, provider type, and CMG codes are subject to complex medical review for the demonstration:

- Provider Type
  - 04
  - 50
- Type of bill
  - 11X
- CMG codes
  - A0101, A0102, A0103, A0104, A0105, A0106, A0201, A0202, A0203, A0204, A0205, A0301, A0302, A0303, A0304, A0305, A0401, A0402, A0403, A0404, A0405, A0406, A0407, A0501, A0502, A0503, A0504, A0505, A0601, A0602, A0603, A0604, A0701, A0702, A0703, A0704, A0801, A0802, A0803, A0804, A0805, A0901, A0902, A0903, A0904, A1001, A1002, A1003, A1004, A1101, A1102, A1103, A1201, A1202, A1203, A1204, A1301, A1302, A1303, A1304, A1305, A1401, A1402, A1403, A1404, A1501, A1502, A1503, A1504, A1601, A1602, A1603, A1604, A1701, A1702, A1703, A1704, A1705, A1801, A1802, A1803, A1804, A1805, A1806, A1901, A1902, A1903, A1904, A2001, A2002, A2003, A2004, A2005, A2101, A2102, B0101, B0102, B0103, B0104, B0105, B0106, B0201, B0202, B0203, B0204, B0205, B0301, B0302, B0303, B0304, B0305, B0401, B0402, B0403, B0404, B0405, B0406, B0407, B0501, B0502, B0503, B0504, B0505, B0601, B0602, B0603, B0604, B0701, B0702, B0703, B0704, B0801, B0802, B0803, B0804, B0805, B0901, B0902, B0903, B0904, B1001, B1002, B1003, B1004, B1101, B1102, B1103, B1201, B1202, B1203, B1204, B1301, B1302, B1303, B1304, B1305, B1401, B1402, B1403, B1404, B1501, B1502, B1503, B1504, B1601, B1602, B1603, B1604, B1701, B1702, B1703, B1704, B1705, B1801, B1802, B1803, B1804, B1805, B1806, B1901, B1902, B1903, B1904, B2001, B2002, B2003, B2004, B2005, B2101, B2102, C0101, C0102, C0103, C0104, C0105, C0106, C0201, C0202, C0203, C0204, C0205, C0301, C0302, C0303, C0304, C0305, C0401, C0402, C0403, C0404, C0405, C0406, C0407, C0501, C0502, C0503, C0504, C0505, C0601, C0602, C0603, C0604, C0701, C0702, C0703, C0704, C0801, C0802, C0803, C0804, C0805, C0901, C0902, C0903, C0904, C1001, C1002, C1003, C1004, C1101, C1102, C1103, C1201, C1202, C1203, C1204, C1301, C1302, C1303, C1304, C1305, C1401, C1402, C1403, C1404, C1501, C1502, C1503, C1504, C1601, C1602, C1603, C1604, C1701, C1702, C1703, C1704, C1705, C1801, C1802, C1803, C1804, C1805, C1806, C1901, C1902, C1903, C1904, C2001, C2002, C2003, C2004, C2005, C2101, C2102, D0101, D0102, D0103, D0104, D0105, D0106, D0201, D0202, D0203, D0204, D0205, D0301, D0302, D0303, D0304, D0305, D0401, D0402, D0403, D0404, D0405, D0406, D0407, D0501, D0502, D0503, D0504, D0505, D0601, D0602, D0603, D0604, D0701, D0702, D0703, D0704, D0801, D0802, D0803, D0804, D0805, D0901, D0902, D0903, D0904, D1001, D1002, D1003, D1004, D1101, D1102, D1103, D1201, D1202, D1203, D1204, D1301, D1302, D1303, D1304, D1305, D1401, D1402, D1403, D1404, D1501, D1502, D1503, D1504, D1601, D1602, D1603, D1604, D1701, D1702, D1703, D1704, D1705, D1801, D1802, D1803, D1804, D1805, D1806, D1901, D1902, D1903, D1904, D2001, D2002, D2003, D2004, D2005, D2101, D2102

Important: 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.

Note: Above codes are subject to change.

Chapter 4: Overview of Choices

IRFs will initially select between two review choices:

- Choice 1: Pre-Claim Review,
- Choice 2: Postpayment Review

IRFs who do not actively select one of the initial two review choices will be automatically assigned to participate in Choice 2: Postpayment Review.

IRFs will have until two weeks prior to the start of the demonstration in their state to make their choice selection. IRFs can make their selection by utilizing the specific MAC provider portal. IRFs may select from one of the two review choices available to them. IRFs should be sure to read each choice thoroughly prior to making a selection.

IRFs will be evaluated for 6 months. If the full affirmation rate or claim approval for those 6 months meets the target affirmation rate/claim approval rate (based on a minimum of 10 submitted pre-claim review requests or claims) in the first year, the IRF may select one of the three subsequent review choices:

- Choice 1: Pre-Claim Review,
- Choice 3: Selective Postpayment Review, or
- Choice 4: Spot Check Review.

IRFs that do not actively choose one of the subsequent review options will automatically be assigned to participate in Choice 3: Selective Postpayment Review.

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

An IRF's target affirmation rate is based on the following sliding scale from the time an IRF starts the demonstration:

- First review cycle: 80% affirmation rate
- Second review cycle: 85% affirmation rate
- Third review cycle: 90% affirmation rate

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

An IRF's choice selection is made at the Provider Transaction Access Number (PTAN) level.

Chapter 5: Pre-Claim Review; Submitting a Pre-Claim Review Request (Choice 1)

Submitters may submit a pre-claim review request at any time prior to the submission of the final claim. IRFs have an unlimited number of resubmissions of the pre-claim review request prior to the final claim being submitted for payment.

Submitters should include, at a minimum, the following data elements in an IRF pre-claim review request:

Beneficiary Information

- Beneficiary's Name;
- Beneficiary's Medicare Number (also known as MBI); and
- Beneficiary's Date of Birth.

Physician/Practitioner Information

- Physician/Practitioner's Name;
- Physician/Practitioner's National Provider Identifier (NPI);
- Physician/Practitioner PTAN; and
- Physician/Practitioner's Address.

Inpatient Rehabilitation Facility Information

- IRF Name;
- CMS Certification Number;
- PTAN (optional); and
- IRF Address.

Submitter Information

- Contact Name; and
- Telephone Number.

Other Information

- Submission Date;
- Indicate if the request is an initial or resubmission review; and
- If resubmission, the Unique Tracking Number (UTN) must be included.

Submission Methods

Submitters may submit a pre-claim review request to the appropriate MAC via the following options:

- Mail,
- Fax,
- esMD (available in August2023), or
- MAC Provider Portal.

For more information about submissions through electronic submission of medical documentation (esMD), see www.cms.gov/esMD or contact your MAC.

Please note the written response will be sent to the submitters using the same method as the request was sent if available. However, if the submission is via fax, a response is only sent via fax if a valid return fax number is included in the request. Otherwise, the response will be sent via mail.

MAC Contact Information

MAC Jurisdiction, States, Website	Telephone Number for Inquiries	Fax Number for Submissions	Mailing Address for Submissions	MAC Provider Portal
JJ – Alabama	855-696-0705	803-419-3263	Palmetto GBA JJ MAC IRF Pre-Claim Review PO Box 100131 Columbia, SC 29202-3131	Palmetto GBA Online Portal: eServices portal
JL – Pennsylvania	855-340-5975	844-599-913	Novitas Solutions Attention: JL IRF RCD PO. Box 3702 Mechanicsburg, PA 17055	Novitas Solutions Online Portal: Novitasphere_JL

Additional Required Documentation

Each pre-claim review request, at a minimum, must include the following documentation:

1. **Pre-Admission Screening**
   The pre-admission screening serves as the basis for the initial determination of whether or not the patient meets the requirements for an IRF admission to be considered reasonable and necessary.

   - Must be conducted or updated by a licensed or certified clinician(s) designated by a rehabilitation physician within the 48 hours immediately preceding the IRF admission.

   - Must include a detailed and comprehensive review of the patient's condition and medical history including the required components below:
     - Information about the condition(s) that caused the patient's need for inpatient rehabilitation
     - Patient's prior level of function
     - Patient's expected level of improvement
     - Expected length of time to achieve that level of improvement

- Evaluation of the patient's risk for clinical complications
- Expected treatments/therapies the patient will require (that is, physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics)
- Anticipated discharge destination

- Rehabilitation physician must review and document his or her concurrence with the findings and results of the preadmission screening prior to the IRF admission.

2. Supporting documentation for admission to the IRF

The documentation submitted must also support the following:

- The beneficiary's need for intensive therapy, expected treatments/therapies, ability to participate in extensive therapy, etc. (History and Physical, Plan of Care, Therapy Evaluations, Skilled Notes, Interdisciplinary Team notes, etc.).

- At time of admission, the patient's condition required at least 2 therapy disciplines (one of which must be physical or occupational therapy) and that those services were initiated within 36 hours from midnight of the day of admit to the IRF.

- The rehabilitation physician has conducted the initial face-to-face visit(s) that are required to be conducted at least 3 days per week throughout the patient's stay in the IRF. (Beginning with the second week, a non-physician practitioner who is determined by the IRF to have specialized training my conduct 1 or 3 of the required visits).

- The rehabilitation physician is a licensed physician who has been determined by the IRF to have specialized training and experience in inpatient rehabilitation.

If completed prior to submission of the pre-claim review request, the following additional documentation is encouraged to be included:

3. Plan of Care (POC)

- Must be completed within 4 days of the beneficiary's admission to the IRF.
- Must be developed by the rehabilitation physician with input from the interdisciplinary team.

4. Interdisciplinary Team Conference Notes

- Documentation must demonstrate that the initial weekly interdisciplinary team meetings has been held and meets the below requirements:
  - The rehabilitation physician, registered nurse, social worker/case manager (or both) and applicable licensed or certified therapist attend the meeting(s).
  - A rehabilitation physician led and concurred with the decisions made at the interdisciplinary team conference.
  - The beneficiary's progress or lack of progress towards the established goals reviewed.

5. Therapy Evaluations/Skilled Notes

- Initial Physical Therapy Evaluation required (if applicable)
- Initial Occupational Therapy Evaluation required (if applicable)
- Initial Speech Language Pathology Evaluation required (if applicable)

- Physical Therapy Note(s) as available (if applicable)
- Occupational Therapy Note(s) as available (if applicable)
- Speech Language Pathology Note(s) as available (if applicable)

Cases Where Services are Not Covered Under the Medicare Benefit, Medicare is Primary, and Another Insurance Company is Secondary:

IRFs or beneficiaries may submit the claim without a pre-claim review decision if the claim is non-covered.

If an IRF or beneficiary chooses to use the pre-claim review for a denial, then the following process is to be followed:

- The submitter may submit the pre-claim review request with complete documentation as appropriate. If all relevant Medicare coverage requirements are **not** met for the IRF stay, then a non-affirmed pre-claim review decision will be sent to the IRF and to the beneficiary advising them that Medicare will not pay for the service.
- A claim with a non-affirmed decision submitted to the MAC for payment will be denied. The claim must include the UTN provided in the decision letter.
- The submitter may forward the denied claim to his/her secondary insurance payee as appropriate to determine payment for the IRF benefit period.

Cases Where Another Insurance Company is Primary and Medicare is Secondary:

If an IRF plans to bill another insurance first and bill Medicare second, the submitter and beneficiary have two options:

1. **Seek Pre-Claim Review:**
    - The submitter submits the pre-claim review request with complete documentation as appropriate. If all relevant Medicare coverage requirements are met for the IRF stay, then a provisional affirmative pre-claim review decision will be sent to the IRF and to the beneficiary advising them that Medicare will pay for the IRF benefit period as long as all other requirements are met.
    - The IRF renders the service and submits a claim to the other insurance company.
    - If the other insurance company denies payment on the claim, the IRF or beneficiary can submit a claim in accordance with Medicare Secondary Payer (MSP) provisions, to the MAC (listing the pre-claim review UTN on the claim). The MAC will process the claim according to the MSP provisions.
2. **Skip Pre-Claim Review:**
    - The IRF renders the service and submits a claim to the other insurance company.
    - If the other insurance company denies payment on the claim, the IRF or beneficiary can submit a claim in accordance with Medicare Secondary Payer (MSP) provisions, to the

MAC. The MAC will process the claim according to the MSP provisions.

3. Timeframe for Decisions:

- The MAC will send notification of the decision to the submitter and the beneficiary within 2 business days (excluding federal holidays) for an initial request.
- A resubmitted request is a request submitted with additional documentation after the initial pre-claim review request receives a non-affirmed decision. The MAC will send notification of the decision of these requests to the IRF and the beneficiary within 2 business days (excluding federal holidays).

Chapter 6: Pre-Claim Review: A Provisional Affirmative Decision

A provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the service likely meets Medicare's coverage, coding, and payment requirements.

Decisions and Decision Letter(s):
The MAC 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, the MAC will send a decision letter to the submitter within 10 business days via the MAC provider portal, mail, or fax for initial requests and for resubmitted requests. IRFs submitting via esMD will receive their decision letter via the MAC provider portal, if enrolled to receive greenmail, as decision letters sent via esMD are not available at this time. Decision letters will be mailed to IRFs that do not receive mail via the MAC provider portal. A copy of the decision letter(s) will also be mailed to the beneficiary.

Non-Transferability of a Provisional Affirmative Pre-Claim Request Decision:

- A provisional affirmative pre-claim review decision does not follow the beneficiary if they change IRFs.
- Only one IRF is allowed to request pre-claim review per beneficiary per IRF stay. In a situation where a patient is discharged and readmitted to the same IRF within 3 consecutive calendar days from the date of discharge, a new pre-claim review request is not needed unless a separate claim will be filed.
    - See 42 CFR Part 412[5], for further information on what constitutes discharge for billing and payment purposes.
- A subsequent IRF may submit a pre-claim review request to provide IRF services for the same beneficiary and must include the required documentation in the submission. A new pre-claim review request must be provided regardless of if an affirmed decision was made for the previous IRF.

IRF's Actions:

- Render services
- Submit pre-claim review request for an eligible service
- Submit the claim with the UTN on the claim.
    - See Chapter 9 for details
    - Should be submitted to the applicable MAC for adjudication.

(Positions 1-18) in positions 19 through 32 of loop 2300 REF02 (REF01=G1) on type of bill 11x.

- If all requirements are met the claim will be paid and, absent evidence of possible fraud or gaming, will be excluded from future medical review by the MAC, Recovery Audit Contractor, and Supplemental Medial Review Contractor (SMRC).
- Claims falling under this option may be subject to UPIC review if fraud is suspected. Claims may also be selected as part of the CERT sample.

[5] https://www.govinfo.gov/content/pkg/FR-2019-08-08/pdf/2019-16603.pdf

Chapter 7: Pre-Claim Review: A Non-Affirmed Decision

Incomplete Requests:
An incomplete request will result in the pre-claim review request being sent back to the submitter for resubmission, and the IRF and the Medicare beneficiary being notified.

When an incomplete request is submitted:

- The MAC will communicate and provide notification of what is missing with the pre- claim review request to the submitter within two (2) business days via telephone. Additionally, the MAC will send a detailed decision letter to the submitter within 10 business days via the MAC provider portal, mail, or fax for initial requests and for resubmitted requests.
- The submitter may resubmit another complete package with all documentation required as noted in the decision letter. See Chapter 8 for instructions on resubmitting a pre-claim review request.
- If the claim is submitted to the MAC for payment with a non-affirmed pre-claim review decision, it will be denied.
    - All ordinary claim appeal rights will then apply.
    - The claim could then be submitted to secondary insurance.

Non-Affirmed Decisions Following Review:
The pre-claim review package does not show requirements for coverage under the Medicare IRF benefit were met.

When a review results in a non-affirmed decision:

- The MAC will send a decision letter to the IRF that includes all of the reasons a non-affirmed decision was determined. The beneficiary will also receive a copy of the decision letter.
- For non-affirmed decisions due to documentation errors where the beneficiary seems to have otherwise met Medicare coverage criteria, the MAC will also reach out to the IRF via phone to provide individualized education on the reasons for the non-affirmed decision and encourage the IRF to resubmit the request as soon as possible.

IRF's Actions for All Non-Affirmed Decisions:
- Resubmit a pre-claim review request with additional documentation, if appropriate.
- Use the IRF pre-claim review request checklist/tool to ensure that the request package complies with all requirements.

Chapter 8: Pre-Claim Review: Resubmitting a Pre-Claim Review Request

A resubmission is any subsequent submissions to correct an error or omission identified after the initial pre-claim review request decision was non-affirmed and prior to claim submission. IRFs have an unlimited number of resubmissions of the pre-claim review request prior to the final claim being submitted for payment.

If the pre-claim review request is non-affirmed, the submitter should review the decision letter that was provided and make whatever modifications are needed to the pre-claim review package. This includes indicating the request is a resubmission of a non-affirmed decision and providing the non-affirmed UTN on the request form. The submitter may then resubmit the request using the same submission procedures.

The MAC will provide notification of the decision within 2 business days via telephone, as well as through a detailed decision letter sent to the IRF and the beneficiary within 10 business days of the review.

Chapter 9: Pre-Claim Review: Claim Submission Where Pre-Claim Review was Requested

Cases Where a Pre-Claim Review Request was Submitted and Received a Provisional Affirmative Decision:

- The submission of the IRF claim is to have the UTN that is located on the decision letter. For submission of electronic claims, the UTN must be in positions 1 through 18. When the claim enters the Fiscal Intermediary Shared System (FISS), the UTN will move to positions 19 through 32, and zeros will autofill the first field. For providers submitting electronic claims, the Medicare Treatment Authorization field must contain blanks or valid Medicare data in the first 14 bytes of the treatment authorization field at the loop 2300 REF02 (REF01=G1) segment for the ASC X12 837 claim.
- For all other submissions, the provider must TAB to the second field of the treatment authorization field (positions 19–32) and key the UTN. If information is entered into the first field (positions 1 through 18), it will come into FISS as zeros. If the Treatment Authorization Code is entered into the first field, FISS changes the Treatment Authorization code to zeros, and the claim will not be accepted. If the UTN is entered into the first Treatment Authorization field, FISS will change the UTN to all zeros. The claim is accepted into FISS with the zeros and without the UTN. The claim will process without the UTN but will edit for the IRF UTN.
- Should be submitted to the applicable MAC for adjudication.
- Final Claim:
    - Should be submitted with the pre-claim review UTN on the claim.
    - Should include the NPI of the rendering provider on the claim.
    - Should be submitted to the applicable MAC for adjudication.
    - If the IRF changes during the IRF benefit period, and the receiving IRF did not submit a pre-claim review request, the claim will undergo a complex medical review. The new IRF is required to submit all medical documentation to support the services billed.
- Each IRF stay will receive a unique UTN.

Cases Where a Pre-Claim Review Request was Submitted and Received a Non-Affirmed Decision:

- The submission of the IRF claim must include the non-affirmed UTN that is located on the decision letter. For submission of electronic claims, the UTN must be in positions 1 through 18. When the claim enters the Fiscal Intermediary Shared System (FISS), the UTN will move to positions 19 through 32, and zeros will autofill the first field. For providers submitting electronic claims, the Medicare Treatment Authorization field must contain blanks or valid Medicare data in the first 14 bytes of the treatment authorization field at the loop 2300 REF02 (REF01=G1) segment for the ASC X12 837 claim.
- For all other submissions, the provider must TAB to the second field of the treatment authorization field (positions 19–32) and key the UTN. If information is entered into the first field (positions 1 through 18), it will come into FISS as zeros. If the Treatment Authorization

Code is entered into the first field, FISS changes the Treatment Authorization code to zeros, and the claim will not be accepted. If the UTN is entered into the first Treatment Authorization field, FISS will change the UTN to all zeros. The claim is accepted into FISS with the zeros and without the UTN. The claim will process without the UTN but will edit for the IRF UTN.

- Should be submitted to the applicable MAC for adjudication.
- Final Claim:
    - Should be submitted with the pre-claim review UTN on the claim.
    - Should include the NPI of the rendering provider on the claim.
    - Should be submitted to the applicable MAC for adjudication.
- If the claim is submitted to the MAC for payment with a non-affirmed pre-claim review decision, it will be denied.
    - The standard claims appeals process will apply.
    - This claim could then be submitted to secondary insurance.

Chapter 10: Pre-Claim Review: Claim Submission Where Pre-Claim Review was NOT Requested

If an applicable claim is submitted without a pre-claim review request being submitted, and the provider has selected Choice 1 – Pre-Claim Review, it will be stopped for prepayment review.

Prior to the start of the demonstration, IRFs do not need to do anything differently when submitting a claim without a UTN. They do not need to put any information in the remarks field. They do not need to submit any unsolicited documentation. They should include the NPI for the rendering provider on the claim.

Once the demonstration is live in a state, final claims submitted under the pre-claim review choice without a pre-claim review request decision on file will be stopped for prepayment review.

Stopping a Claim for Prepayment Review:

- The MAC will stop the claim and send an ADR through the US Postal Service or MAC Provider Portal.
- The IRF will have 45 days to respond to the ADR with all requested documentation. Claims will be denied for non-response on day 46.
- IRFs may submit documentation to the appropriate MAC via the following options:
  - Mail,
  - Fax,
  - esMD (available in August 2023, for more information see: www.cms.gov/esMD), or
  - MAC Provider Portal.
- Documentation should include the following:
  - A copy of the ADR letter
  - Preadmission Screening (PAS) that includes all required elements and has been completed or updated within 48 hours immediately preceding the IRF admission.
  - Documentation that supports the PAS was conducted by a licensed or certified clinician and that the Rehabilitation Physician concurred with the findings.
  - Documentation to support the Rehabilitation Physician has been determined by the IRF to have specialized training and experience in Inpatient Rehabilitation.
  - Individualized overall Plan of Care that was completed withing 4 days of admission and was developed by the Rehabilitation Physician with input from the Interdisciplinary Team.
  - Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI).
  - Documentation to support timely initiation of therapy services (therapy evaluations).
  - Documentation to support the patient requires the active and ongoing therapeutic intervention of multiple therapy disciplines, one of which is physical or occupational therapy.
  - Documentation to support intensive rehabilitation therapy (generally a minimum of 3 hours of therapy per day at least 5 days per week or a minimum of 15 hours per 7 consecutive days).
  - Documentation to support that at the time of admission the patient can reasonably be

expected to actively participate and benefit from the therapy program.
    - Documentation to support that upon admission a measurable improvement that will be of practical value was expected in a reasonable period of time.
    - Documentation to support the Rehabilitation Physician saw the patient a minimum of 3 times per week or beginning with the second week of the IRF admission, a qualified non-physician practitioner may conduct 1 of the 3 required Face to Face visits per week if the patient was discharged on/after 10/1/2022.
    - Interdisciplinary team meeting notes to support that the meetings were held at least once per week, support required disciplines attended the team meetings, support goal progress and or any problems impeding the goal progress were addressed, were led by the Rehabilitation Physician, and that the Rehabilitation Physician concurred with the results.
    - Patient History and Physical (IRF admission H&P).
    - Physician orders that are clear, legible, and dated including the admission orders.
    - Documentation to support the medical necessity of the IRF services.
- Do not resend or resubmit your form or documentation for claims that are pending a medical review response. Duplicate ADR responses will not be accepted.

Review

Reviewers will consider documentation in accordance with Medicare coverage rules and conditions. The prepayment review under this choice will follow the same review standards as are in place absent the demonstration.

Timing

The MAC will have 30 days to review the documentation and communicate a decision.

Decision

The MAC will communicate a claim review decision to the IRF and provide a written review results letter. Once the Medical Review decision has been rendered, the claim will receive a status of Paid, Rejected, or Denied. If the claim is Rejected, you may resubmit a corrected claim. If the claim is Denied, you may submit a Redetermination form to appeal the determination.

Note: Additional MAC information will be added at a later date.

Chapter 11: Postpayment Review (Choice 2 - Default Choice)

Under this choice all claims submitted during the cycle will be pulled for postpayment review. The postpayment review process will follow the procedures and rules in place under the IRF benefit. If an IRF doesn't make an initial choice selection, choice 2 will be automatically selected.

Claim Submission

- IRF collects all necessary paperwork such as the Plan of Care
- IRF provides inpatient rehabilitation services
- IRF submits the claim to the MAC

Additional Documentation Request

Once the claim is received the MAC will process for payment and send the IRF an ADR. The IRF will submit all medical documentation and other documents that are necessary in order to conduct a review and reach a conclusion about the eligibility of the beneficiary and medical necessity.

- IRFs may submit documentation to the appropriate MAC via the following options:
  - Mail,
  - Fax,
  - esMD (available in August 2023, for more information see: www.cms.gov/esMD), or
  - MAC Provider Portal.

- Records should include the following:
  - A copy of the ADR letter
  - Preadmission Screening (PAS) that includes all required elements and has been completed or updated within 48 hours immediately preceding the IRF admission.
  - Documentation that supports the PAS was conducted by a licensed or certified clinician and that the Rehabilitation Physician concurred with the findings.
  - Documentation to support the Rehabilitation Physician has been determined by the IRF to have specialized training and experience in Inpatient Rehabilitation.
  - Individualized overall Plan of Care that was completed withing 4 days of admission and was developed by the Rehabilitation Physician with input from the Interdisciplinary Team.
  - Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI).
  - Documentation to support timely initiation of therapy services (therapy evaluations).
  - Documentation to support the patient requires the active and ongoing therapeutic intervention of multiple therapy disciplines, one of which is physical or occupational therapy.
  - Documentation to support intensive rehabilitation therapy (generally a minimum of 3 hours of therapy per day at least 5 days per week or a minimum of 15 hours per 7 consecutive days).
  - Documentation to support that at the time of admission the patient can reasonably be expected to actively participate and benefit from the therapy program.
  - Documentation to support that upon admission a measurable improvement that will be of practical value was expected in a reasonable period of time.
  - Documentation to support the Rehabilitation Physician saw the patient a minimum of 3

times per week or beginning with the second week of the IRF admission, a qualified non-physician practitioner may conduct 1 of the 3 required Face to Face visits per week if the patient was discharged on/after 10/1/2022.
    - Interdisciplinary team meeting notes to support that the meetings were held at least once per week, support required disciplines attended the team meetings, support goal progress and or any problems impeding the goal progress were addressed, were led by the Rehabilitation Physician, and that the Rehabilitation Physician concurred with the results.
    - Patient History and Physical (IRF admission H&P).
    - Physician orders that are clear, legible, and dated including the admission orders.
    - Documentation to support the medical necessity of the IRF services.
- Do not resend or resubmit your form or documentation for claims that are pending a medical review response. Duplicate ADR responses will not be accepted.

Timing

The IRF will have 45 days to respond to the ADR. If no response is received within 45 days, an overpayment will be initiated.

The MAC will have 60-days to review the documentation and communicate a decision.

Review

Reviewers shall consider documentation in accordance with Medicare coverage rules and conditions. The postpayment review under this choice will follow the same review standards as are in place absent the demonstration.

Decision

The MAC will communicate the claim review decision to the IRF. If a claim is denied, the MAC will follow the standard payment recoupment procedures already in place. The IRF retains all appeal rights for denied claims.

Chapter 12: Review Cycle and Compliance Threshold

IRFs who select either Choice 1 or Choice 2 will be evaluated over a 6-month review cycle. Within 30 days of the end of the cycle, the MAC will communicate to the IRF their pre-claim review affirmation or postpayment claim approval rate, and if they have met the review threshold.

If the IRF's full affirmation rate or claim approval for those 6 months meets the target affirmation rate (based on a minimum of 10 submitted pre-claim review requests or claims), the IRF may select one of the three subsequent review choices:

- Choice 1: Pre-Claim Review,
- Choice 3: Selective Postpayment Review, or
- Choice 4: Spot Check Review.

If the IRF's affirmation or claim approval rate is less than the target affirmation rate or they have not submitted at least 10 requests/claims, the IRF must again choose from one of the initial two options. In Choice 1: Pre-Claim Review, only fully affirmed decisions will be factored into an IRF's affirmation rate.

An IRF's target affirmation rate is based on the following sliding scale from the time an IRF starts the demonstration:

- First review cycle: 80% affirmation rate
- Second review cycle: 85% affirmation rate
- Third review cycle: 90% affirmation rate

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

Chapter 13: Subsequent Review Choices (Choices 1, 3, and 4)

Once an IRF reaches the target affirmation rate, they may choose one of three subsequent review choices:

- Choice 1: Pre-Claim Review: The IRF may begin or continue participating in pre-claim review for a 6-month period.
- Choice 3: Selective Postpayment Review: Under this choice the IRF will render services and submit claims according to their normal process. Every 6 months the MAC will select for postpayment review a statistically valid random sample of claims, based on the previous six month's claim volume.
- Choice 4: Spot Check Prepayment Review: Under this choice, the MAC will select a random sample of 5% of an IRF's submitted claims, based on their previous six month's claim volume, for pre-payment review, to ensure continued compliance.

If the IRF's provisional full affirmation/approval rate remains at or above the target threshold rate, the IRF may choose to continue to participate in a subsequent review choice. If the IRF falls below the target threshold rate, the IRF must select from one of the initial review choices.

IRFs with a full target affirmation rate or greater that do not actively select one of the subsequent review choices by their selection deadline (typically 2 weeks prior to the start of the new 6-month review cycle) will automatically be assigned to participate in Choice 3: Selective Postpayment Review.

Chapter 14: Advanced Beneficiary Notice (ABN)

An ABN may only be given to a beneficiary on the basis of a genuine reason about the likelihood that Medicare may deny items or services furnished to the beneficiary as not medically reasonable and necessary under section 1862(a)(1) of the Act. Giving a beneficiary an ABN for all items or services without regard to the likelihood that the services would deny as being not medically reasonable and necessary is considered a blanket written notice and is not permitted. Furthermore, a beneficiary has the right to refuse to sign an ABN. Requiring a beneficiary sign an ABN is not permitted.

The Limitation on Liability protections of §1879 of the Social Security Act (the Act) will apply to this demonstration. The Limitation on Liability provisions require a provider to notify a beneficiary in advance of furnishing an item or service when such item or service is considered not medically reasonable and necessary under section 1862(a)(1) of the Act. Issuing a valid ABN in this instance is required in order for providers to shift financial liability to the beneficiary. In accordance with CMS polices, if an ABN was not issued when required prior to the start of care, and the PCR is non- affirmed, the beneficiary is not financially liable for the care that the IRF provided while awaiting the PCR decision. If the IRF believes that the PCR will be non-affirmed for any of the reasons (i.e., not medically reasonable and necessary), the provider must issue an ABN, prior to furnishing the items or services in question, in order to transfer financial liability to the beneficiary. The beneficiary has the right to choose whether or not to receive the item or service and to accept financial liability. If the IRF expects Medicare to cover the services, an ABN should not be issued.

Other requirements to qualify for the Medicare IRF benefit, such as the preadmission screening, are considered technical in nature and are not part of the Limitation on Liability provisions under section 1879 of the Act (i.e., advanced notice is not applicable). If this documentation is missing then it would be a technical denial, and the provider would be held liable (i.e., not be able to charge the beneficiary) based on section 1866(a)(1) of the Act.

When a PCR is non-affirmed, the decision letter will include a detailed written explanation outlining which specific policy requirements were not met. If the non- affirmation is due to the item or service not being medically reasonable and necessary under section 1862(a)(1) of the Act, the IRF must issue an ABN in order to transfer financial liability to the beneficiary if the IRF believes Medicare may deny the item or service as not medically reasonable and necessary. If the non-affirmation was due to documentation errors, the IRF may correct the deficiencies and resubmit the request with all relevant documentation. In this situation, it would not be appropriate to issue an ABN. Also, if the PCR decision is non-affirmed for a reason for which the IRF would otherwise be financially liable (that is, the reason for denial is not one that triggers the limitation on liability provision), the IRF should not issue an ABN following a non-affirmed PCR decision in an attempt to shift liability.

Chapter 15: Claim Appeals

The Review Choice Demonstration does not include a separate appeal process for a non-affirmed pre-claim review decision. However, a non-affirmed pre-claim review decision does not prevent the IRF from submitting a final claim. A submission of a final claim with a non-affirmed UTN and resulting denial by the MAC would constitute an initial determination on the claim that would make the appeals process available for beneficiaries and IRFs.

Appeals will follow all current procedures no matter which choice an IRF selects. For further information consult the CMS Pub. 100-04, Chapter 29[6], Appeals of Claims Decision.

[6] https://www.cms.gov/RegulationsandGuidance/Guidance/Manuals/downloads/clm104c29.pdf

Appendix A: Review Choice Demonstration Flowchart