# AHA RACTrac Survey Questions and Data Definitions
# Final as of July 16, 2010

| Data Element (As they appear on the screen) | User Definition for Help Text in RACTrac | Vendor Notes (VNote) and Comments |
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| **Overpayments – Automated** | | |
| **Have you experienced RAC Activity? Yes or No**<br><br>If yes, please tell us the date and month in which activity started. | Being notified by the Medicare Recovery Audit Contractor (e.g. DCS, HDI, CGI or Connelly Associates) would include correspondence of either a medical record request or a demand letter. | Comment: The user is prompted to answer this question every quarter until the response is YES.<br><br>The date of the start of RAC activity is captured in the AHA admin reports. |
| □ **Check here if your hospital is not tracking automated claim denials**<br><br>*If checked skip to Overpayments – complex RAC Reviews.* | By checking this box you have indicated that your organization is not currently tracking automated claim denials. By checking this box you will skip this section and immediately move to the next section of the survey. | Comment: This is captured in the Status report available to state, regional and metropolitan association and health system RACTrac users. |
| **1. Total number of automated claim denials** | Automated review occurs when a RAC makes a claim determination without a human review of the medical record. RACs use proprietary software that is designed to detect certain types of errors including but not limited to duplicate payments, billing or coding errors. The RAC notifies the provider via a demand letter when an overpayment has been identified through automated review.<br><br>Report the total cumulative number of claims denied through the automated review process through the end of the quarter for which you are reporting. Each claim identified as having an overpayment will count once. | VNote: Often times the provider will get one demand letter that will reference several claims identified as overpayments. Each claim - not the number of demand letters - counts as an automated claim denial. |
| **2. Total (estimated) dollars associated with automated claim denials** | Report the total cumulative estimated dollar value of the claims denied through the automated review process through the end of the quarter for which you are reporting. The estimated dollar value is indicated on the demand letter from the RAC. | VNote: The word "estimated" remains in this question because often times the letters that were issued in the demo did not necessary match the dollars recouped. This should no longer be the case in the permanent program. The dollar amount of an overpayment should be clearly stated in the RAC demand letter. |

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| **3. Total dollars recouped to date for automated claim denials** | Report the total cumulative dollars that have been recouped pursuant to a RAC automated claim denial, without regard to appeal activity. Include only actual dollars returned to Medicare program by your organization from the date your facility was first affected thru the end of the quarter for which you are reporting. Do not include estimated recoupments for automated denials that have not yet been processed or for those denials in which you have filed an appeal within 30 days and therefore stopped recoupment from occurring. | Comments: The claims processing contractors (FI/MAC) have been known to be delayed in processing the overpayments. Regulations now state that the provider can stop recoupment from occurring if filing an appeal within 30 days. Therefore we would only be asking for the actual total dollars recouped to date at the time hospitals are reporting data. |
| **Check here if your hospital has had no new activity this quarter.**<br><br>(If checked, skip to Overpayments-Complex RAC Reviews) | RACTrac is a quarterly survey and from time to time, there will be no new activity for hospitals between quarters. If data was reported in quarter one, but there is no new activity in quarter 2, the hospital should renter the data from quarter 1 into questions 1, 2 and 3 as those numbers remain the same and check this box to denote that there were no subsequent denials to be indicated in this quarter. | VNote: The survey tool does not carry forward data from the previous quarter. The only way it will be captured from quarter to quarter is if the hospital responds to the survey every quarter and reenters their data or notes in this checkbox, that there was no new activity in the requested quarter. |
| **4. Indicate the service areas in which automated RAC denials have occurred this quarter.**<br><br>Please select you hospital type in 4a and then indicate the services in which automated RAC denials have occurred for your hospital this quarter in 4b. Check all that apply. | Medicare claim denials from the RACs can fall in any number of service areas of the hospital. The choices presented allow the hospital to first associate itself a type of hospital listed in 4a and then indicate all the service areas within that hospital that experienced Medicare claim denials through the automated review process this quarter.<br><br>Example: An Inpatient Rehabilitation Hospital had outpatient automated denials as well as inpatient automated denials this quarter. In 4a the selection would be Inpatient Rehabilitation Hospital and 4b the selection would be both inpatient and outpatient.<br><br>NOTES – Definitions Below)<br>4a: Hospital Type:<br>▪ Medical/Surgical Acute Care Hospital (includes Critical Access Hospitals)<br>▪ Inpatient Rehabilitation Hospital<br>▪ Psychiatric Hospital<br>▪ Long Term Care Hospital<br><br>4b. Service Areas (Dependent on selection in 4a)<br>Medical/Surgical Acute Care Hospital (including CAH's)<br>▪ Inpatient<br>▪ Outpatient<br>▪ Psychiatric Services<br>▪ Inpatient Rehabilitation | The user must first associate them self with the type of facility and then check the appropriate services that were affected by the automated RAC Activity .<br><br>*Hospital type definitions noted below in gray.*<br><br>VNote: At this time we do not have any corresponding reasons for denial should it occur in the skilled nursing unit of a medical/surgical acute care hospital.<br><br>AHA will also be removing the long term care hospital outpatient service selection as it is not appropriate. |

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| | ▪ Skilled Nursing - (No corresponding denial reasons)<br>▪ Other (i.e. Physician services, DME)<br>Inpatient Rehabilitation Hospital<br>▪ Inpatient<br>▪ Outpatient<br>▪ Other<br>Psychiatric Hospital<br>▪ Inpatient<br>▪ Outpatient<br>▪ Other<br>Long Term Care Hospital<br>▪ Inpatient<br>▪ ~~Outpatient~~<br>▪ Other | |
| **Data definitions for Hospital Types For All of AHARACTrac Hospital Type Questions** | | |
| Medical/Surgical Acute Care Hospital | Medical/Surgical Acute Care Hospitals include critical access hospitals, cancer hospitals, specialty med/surg hospitals (surgical, women's, cardiac, orthopedic, etc.), children's hospitals and federal or state run hospitals that provide medical/surgical acute care services. These hospitals may have several distinct part units including skilled nursing, inpatient rehabilitation and swing beds, but the majority of services are provided in the inpatient or outpatient settings of these hospitals. | Comment: The survey repeatedly asks for the hospital type throughout the survey. It is critical that the same question be answered the same way each time.<br><br>VNote: RACTrac is currently <u>not</u> seeking data from free standing skilled nursing facilities or ambulatory surgery centers that may be owned or operated by the hospital or health system. |
| Inpatient Rehabilitation Hospital | Freestanding inpatient rehabilitation hospitals are those that are paid under the Medicare inpatient rehabilitation perspective payment system and primarily provide inpatient and outpatient rehabilitation services to patients. | |
| Psychiatric Hospital | Freestanding psychiatric hospitals are those that are paid under the Medicare psyche perspective payment system and provide primarily inpatient and outpatient psychiatric services to patients. | |
| Long Term Care Hospital | Freestanding long term care hospitals are those paid under the Medicare long term care perspective payment system. CMS defines a long term care hospital as one which has an average inpatient length of stay greater than 25 days. | |
| **5. Rank order the services by the <u>number</u> of automated claim denials <u>this quarter.</u>**<br><br>(Number 1 for the largest number 3 for the third largest number of claims denied in this quarter) | Select number 1 for the service with the largest number of claims denied <u>this quarter</u>, number 2 for the second largest number and number 3 for the third largest number. Each claim identified as having an overpayment counts as one automated denial (not the number of demand letters received for automated denials as it is likely there will be more then one claim cited for improper payment in the demand letter).<br><br>Example: If your hospital is a medical/surgical acute care hospital and you only experienced outpatient automated claim denials <u>this quarter</u> then you would choose number 1 as Medical/Surgical Acute Care Hospital – Outpatient and leave the rest blank. If you had 35 outpatient claim denials and 42 inpatient claim denials, you would rank inpatient as number 1 | VNote: The Medicare payment received should be an indicator of how best to categorize these service denials (e.g. APC, MSDRG etc). |

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| | and outpatient as number 2 and not make any selection in number 3.<br><br>VNote: The choices for selection include and should be selected based on the hospital type:<br>▪ *Medical/Surgical Acute Care Hospital - Inpatient*<br>▪ *Medical/Surgical Acute Care Hospital - Outpatient*<br>▪ *Medical/Surgical Acute Care Hospital - Psychiatric Services*<br>▪ *Medical/Surgical Acute Care Hospital - Inpatient Rehabilitation*<br>▪ *Medical/Surgical Acute Care Hospital - Skilled Nursing*<br>▪ *Medical/Surgical Acute Care Hospital - Other (i.e., Physician Services, DME)*<br><br>▪ *Inpatient Rehabilitation Hospital - Inpatient*<br>▪ *Inpatient Rehabilitation Hospital – Outpatient*<br>▪ *Inpatient Rehabilitation Hospital - Other*<br><br>▪ *Psychiatric Services Hospital - Inpatient*<br>▪ *Psychiatric Services Hospital - Outpatient*<br>▪ *Psychiatric Services Hospital - Other*<br><br>▪ *Long Term Care Hospital - Inpatient* | |
| **6. Rank order the services by the <u>estimated dollar value</u> of automated claim denials <u>this quarter.</u>** | Rank the top three services by estimated total dollar value of the automated claim denials. Number 1 is for claims associated with the greatest dollar value; number 2 is second largest dollar value and number 3 for the third largest dollar value. The dollar value of the claim is indicated on the RAC demand letter.<br><br>Example: Each automated denial will have a corresponding dollar value associated with it. If the hospital has 23 inpatient denials that total $3,000 and 10 outpatient denials that total $5,000 then you would rank outpatient as number 1 and inpatient as number 2.<br><br>The choices for selection include and should be selected based on the hospital type:<br>▪ *Medical/Surgical Acute Care Hospital - Inpatient*<br>▪ *Medical/Surgical Acute Care Hospital - Outpatient*<br>▪ *Medical/Surgical Acute Care Hospital - Psychiatric Services*<br>▪ *Medical/Surgical Acute Care Hospital - Inpatient Rehabilitation*<br>▪ *Medical/Surgical Acute Care Hospital - Skilled Nursing*<br>▪ *Medical/Surgical Acute Care Hospital - Other (i.e., Physician Services, DME)*<br><br>▪ *Inpatient Rehabilitation Hospital - Inpatient*<br>▪ *Inpatient Rehabilitation Hospital – Outpatient*<br>▪ *Inpatient Rehabilitation Hospital - Other*<br><br>▪ *Psychiatric Services Hospital - Inpatient*<br>▪ *Psychiatric Services Hospital - Outpatient*<br>▪ *Psychiatric Services Hospital - Other*<br><br>▪ *Long Term Care Hospital - Inpatient*<br>▪ *~~Long Term Care Hospital – Outpatient~~* | |

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| **7. Select the reasons cited by the RAC for automated claim denials for <u>this quarter.</u>**<br><br>Please make the correct selection based on the type of services provided by your hospital. Check all that apply. | On the automated denial demand letter from the RAC to the provider, the RAC indicates the reason for the overpayment. AHA has broadly categorized several reasons by hospital/service type that were identified during the demonstration program. Please read carefully through each of the denial reasons to determine ANY and ALL categories which reflect the reason for automated denial notifications received for <u>this quarter.</u><br><br>Example: Medical/Surgical Acute Care hospital experiences outpatient billing and coding errors as well as duplicate payments in their inpatient and inpatient rehabilitation unit in quarter 2. The correct selections would be<br>1. Medical/Surgical Acute Care Hospital/Services - Duplicate Payment<br>2. Medical/Surgical Acute Care Hospital/Services - Outpatient Coding Error<br>3. Medical/Surgical Acute Care Hospital/Services - Outpatient Billing Error<br>4. Inpatient Rehabilitation Hospital/Unit - Duplicate Payment<br><br>The choices for selection include and should be selected based on the hospital type or unit (definitions noted below):<br>▪ Medical/Surgical Acute Care Hospital/Services - Duplicate Payment<br>▪ Medical/Surgical Acute Care Hospital/Services - Incorrect Discharge Status<br>▪ Medical/Surgical Acute Care Hospital/Services - Inpatient Coding Error (MSDRG)<br>▪ Medical/Surgical Acute Care Hospital/Services - Outpatient Coding Error<br>▪ Medical/Surgical Acute Care Hospital/Services - Outpatient Billing Error<br>▪ Medical/Surgical Acute Care Hospital/Services - All Other<br>▪ Inpatient Rehabilitation Hospital/Unit - Duplicate Payment<br>▪ Inpatient Rehabilitation Hospital/Unit - Inpatient Rehabilitation Coding Error (CMG)<br>▪ Inpatient Rehabilitation Hospital/Unit - Outpatient Rehabilitation Coding Error<br>▪ Inpatient Rehabilitation Hospital/Unit - All Other<br>▪ Psychiatric Services Hospital/Unit - Duplicate Payment<br>▪ Psychiatric Services Hospital/Unit - Inpatient Psych Coding Error (MSDRG)<br>▪ Psychiatric Services Hospital/Unit - Outpatient Psych Coding Error<br>▪ Psychiatric Services Hospital/Unit - All Other<br>▪ Long Term Care Hospital/Unit - Duplicate Payment<br>▪ Long Term Care Hospital/Unit - Inpatient Coding Error (MSDRG)<br>▪ Long Term Care Hospital/Unit - All Other | |

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| ***Definitions of Automated Denial Reasons for Question 7, 8 and 9 – Automated***<br>***NOTE:*** *Reasons for denial are hospital type and services based. For example, a user can be associated with a Medical/Surgical Acute Care Hospital and still have denial reasons in the Inpatient Rehabilitation Hospital/Services area due to a distinct part unit. Please contact RACTracsupport@providerpcs.com if you have questions.* | | |
| **Medical/Surgical Acute Care Hospital/Services - Duplicate Payment** | Use this reason code to note more than one claim was paid for the same service by the Medicare claims processor (e.g. two appendectomies billed for the same patient on the same day.) | |
| **Medical/Surgical Acute Care Hospital/Services – Incorrect Discharge Status** | Use this reason code to note an incorrect discharge status on the original claim and therefore cited for inaccurate payment. For example, the claim indicates discharge to home or other facility but a subsequent claim for the same patient on the same day shows that the beneficiary was discharged to another hospital. | |
| **Medical/Surgical Acute Care Hospital/Services – Inpatient Coding (MSDRG)** | Medicare has now moved to MS-DRGs so what the RACs may or may not find with regard to automated reviews of inpatient claims is currently undefined. Use this reason code to note incorrect ICD-9 codes on the claim. | |
| **Medical/Surgical Acute Care Hospital/Services – Outpatient Coding** | Use this reason code to denote an error in HCPCS code assignment or other outpatient coding related error. | |
| **Medical/Surgical Acute Care Hospital/Services – Outpatient Billing** | Use this reason code to note incorrectly billed units or charge issues as well as misuse or incomplete billing modifiers. Examples include but are not limited to incorrect billing of the drug Neulasta, or outpatient speech therapy units billed incorrectly. | |
| **Medical/Surgical Acute Care Hospital/Services – All Other** | Use this reason code for any denial reason that is not currently captured for your organization type. Please “contact us” and tell us about this reason for denial. | |
| **Inpatient Rehabilitation Hospital/Unit- Duplicate Payment** | Use this reason code to note more than one claim was paid for the same service by the Medicare claims processor. | |
| **Inpatient Rehabilitation Hospital/Unit – Inpatient Rehabilitation Coding Error (CMG)** | Use this reason code to denote inappropriate codes leading to incorrect billing of the case mix group (CMG) on the inpatient rehabilitation claim. | Not seen in demo – so we are testing out this reason |
| **Inpatient Rehabilitation Hospital/Unit – Outpatient Rehabilitation Coding** | Use this reason code to denote inappropriate codes leading to incorrect billing of an outpatient rehabilitation claim. | Not seen in demo so we are testing out this reason. |
| **Inpatient Rehabilitation Hospital/Unit – All Other** | Use this reason code for any denial reason that is not currently captured for your organization/service types. In addition to selecting this reason code, please use the “contact us” link on this page and tell us about the more specific reason for denial. | |

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| **Psychiatric Hospital/Unit- Duplicate Payment** | Use this reason code to note more than one claim was paid for the same service by the Medicare claims processor. | |
| **Psychiatric Hospital/Unit – Inpatient Psych Coding (MSDRG)** | Medicare has now moved to MS-DRGs so what the RACs may or may not find with regard to automated reviews of inpatient claims is currently undefined. Use this reason code to note incorrect ICD-9 codes on the claim. | Not seen in demo so we are testing out this reason. |
| **Psychiatric Hospital/Unit – Outpatient Psych Coding** | Use this reason code to denote inappropriate codes leading to potentially incorrect billing of an outpatient psych services claim. | Not seen in demo so we are testing out this reason. |
| **Psychiatric Hospital/Unit – All Other** | Use this reason code for any denial reason that is not currently captured for your organization/service type. In addition to selecting this reason code, please use the "contact us" link on this page and tell us about the more specific reason for denial. | |
| **Long Term Care Hospital/Unit – Duplicate Payment** | Use this reason code to note more than one claim was paid for the same service by the Medicare claims processor (e.g. two colonoscopies billed for the same patient on the same day.) | |
| **Long Term Care Hospital/Unit - Inpatient Coding Error (MSDRG)** | Medicare has now moved to MS-DRGs so what the RACs may or may not find with regard to automated reviews of inpatient claims is currently undefined. Use this reason code to note incorrect ICD-9 codes on the claim. | |
| **Long Term Care Hospital/Unit – All Other** | Use this reason code for any denial reason that is not currently captured for your organization/service type. In addition to selecting this reason code, please use the "contact us" link on this page and tell us about the more specific reason for denial. | |
| **8. Rank order the denial reasons experienced by <u>number</u> of automated claims denied for <u>this quarter.</u>**<br><br>(Number 1 for the largest and number 3 for the third largest number of claim denials in this quarter) | Select number 1 for the denial reason with the largest number of claims denied **this quarter**, number 2 for the second largest number and number 3 for the third largest number.<br><br>For example, if your hospital is a medical/surgical acute care hospital and this quarter you had 20 claims denied for outpatient billing errors, 10 for duplicate payments and 5 were miscellaneous (and would fall under Other Medical/Surgical Acute Care Hospital/Unit reasons) then these would be your rankings.<br>Number 1: Medical/Surgical Acute Care - Outpatient Billing Errors<br>Number 2: Medical/Surgical Acute Care – Duplicate Payment<br>Number 3: Medical/Surgical Acute Care – All Other<br><br>A second example would be the following:<br><br>If you are a medical/surgical acute care hospital with multiple units including a rehab and psyche unit with the following claim denials.<br>Inpatient Coding Errors – 25 claims<br>Rehab Unit – Medically Unnecessary – 10 claims<br>Psyche Unit – Duplicate payments – 2 claims<br><br>You would rank them in the following way:<br>Number 1 Medical/Surgical Services – Inpatient Coding Errors<br>Number 2 Inpatient Rehabilitation Unit – Medically Unnecessary<br>Number 3 Psychiatric Unit – Duplicate payments | Use same automated denial definition reasons from above. |

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| **9. Rank order the denial reasons experienced by the <u>estimated total dollar value</u> of the automated claim denials for <u>this quarter.</u>**<br><br>(Number 1 for the largest and number 3 for the third largest dollar value of claims denied in this quarter) | The top three denial reasons are based on the estimated total dollar value of the claims denied this quarter through the automated claim review process and is often indicated on the demand letter from the RAC.<br><br>Number 1 is the denial reason with the greatest dollar amount of denied claims and Number 3 would be the reason with the third largest dollar amount of claims associated with it.<br><br>User chooses from reasons as noted above. | Use same denial definition reasons from above. |

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| **Overpayments – Complex** | | |
| □ **Check here if your hospital is not tracking complex claim denials.**<br><br>(If checked, skip to underpayments) | By checking this box, you are indicating that your hospital is not tracking complex claim denial experience at the present time. | Noted in Status Report |
| **1. Total number of medical record requests received** | The total cumulative number of medical records requested for complex review to date. The RAC will send a letter (via US Mail) requesting the medical record for review. Please tally the number of medical records from these requests to date and indicate the total here. | |
| **1a. Total dollar value of the claims associated with the medical records requested** | Each medical record requested has an original payment associated with the claim for that patient. Total the original payments for each of the claims associated with the medical record requested. | VNote: We are not asking for billed charges, rather the Medicare payment received for the claim. |
| **2. Total number of medical records approved** | The RACs have 60 calendar days to make a determination of whether or not an inappropriate payment has been identified once the medical record has been received. Upon that determination, a hospital will be notified via a review results letter if NO improper payments were found and therefore the medical record has been "approved". Please indicate the total number of medical records for which you have been notified to date that NO improper payment has been identified and therefore it has been "approved". | VNote: An underpayment could be found upon review of a medical record. Underpayment, or determinations with a return of dollars to the hospital, should solely be counted in the Underpayment section. |
| **2a. Total dollar value of medical records approved** | Total the original payments for each of the claims associated with the medical records that were approved. | VNote: We are not asking for billed charges, rather the Medicare payment received for the claim. |
| **3. Total number of medical records where an overpayment was identified (i.e. denied)** | The RACs have 60 days to make a determination of whether or not an improper payment has been identified once the medical record has been received. Upon that determination, a hospital will be notified via a review results letter if an improper payment was found and therefore the associated claim has been "denied". Please indicate the total number of medical records for which you have been notified to date that an improper payment has been identified and therefore a claim, either in part or in total has been "denied". The official notification of an overpayment should be based on the receipt of the <u>demand letter</u>, not the review results letter. Please count the number based on the number of the demand letters received, not the number of review results letters received. | VNote: We are not asking for billed charges, rather the Medicare payment received for the claim.<br><br>VNOTE: Due to the nature and timing of the discussion period its possible that a provider would receive a review results letter without the demand letter at the point of RACTrac reporting. |

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| **3a. Total dollar value of medical records in which an overpayment was identified (i.e. denied)** | Total the original payments for each of the claims associated with the medical records that were denied. | |
| **4. Total number of medical records pending determination by the RACs** | The number of medical records that are "pending determination" are those for which the provider has not been notified via a review results letter or demand letter of the outcome of the review.<br><br>Total number of medical records pending determination = Total number of medical records requested minus total number of medical records approved minus total number of medical records denied . | VNote: This is not an auto calculation in RACTrac. |
| **4a. Total dollar value of medical records pending determination** | Total the original payments for each of the claims associated with the medical records that are pending determination.<br><br>Total dollar value of medical records pending determination = Total dollar value of medical records requested minus total dollar value of medical records approved minis total number of medical records denied. | VNote: This is not an auto calculation in RACTrac. |
| **5. Estimate the total dollars associated with the overpayments identified during medical record review (complex claim denials)** | The value of the overpayment is communicated via the demand letter from the RAC following the review results letter indicating an improper payment. Indicate the total dollar value for all over payments identified in the demand letter. . | |
| **6. Report the total dollars recouped for complex claim denials.** | Recoupment should occur on day 41 unless action is taken by the hospital to either stop recoupment or to pay the money back directly. Please indicate the total dollars recouped or paid back to Medicare to date, without regard to appeal activity. Do not count any pending recoupments until they have occurred. | |
| □ **Check here if your hospital has no new activity this quarter.**<br><br>(If checked, skip to underpayments**)** | RACTrac is a quarterly survey and from time to time, there will be no new activity for hospitals between quarters. If data was reported in quarter one, but there is no new activity in quarter 2, the hospital should renter the data from quarter 1 into questions 1 thru 6 as those numbers could possibly (however unlikely) remain the same and check this box to denote that there were no subsequent denials to be indicated in this quarter. | VNote: The survey tool does not carry forward data from the previous quarter. The only way it will be captured from quarter to quarter is if the hospital responds to the survey every quarter and reenters their data or notes in this checkbox, that there was no new activity in the requested quarter. |

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| **7. Indicate the service areas in which complex RAC denials have occurred this quarter.**<br><br>Please select you hospital type in 7a and then indicate the services in which automated RAC denials have occurred for your hospital this quarter in 7b. Check all that apply | Medicare claim denials from the RACs can fall in any number of service areas of the hospital. The choices presented allow the user to first associate him or herself with a type of hospital listed in 4a and then indicate all the service areas within that hospital that experienced Medicare claim denials through the automated review process of the RACs for this quarter only.<br><br>NOTES – Definitions noted above<br>4a: Hospital Type:<br>Medical/Surgical Acute Care Hospital (includes Critical Access Hospitals)<br>Inpatient Rehabilitation Hospital<br>Psychiatric Hospital<br>Long Term Care Hospital<br><br>4b. Service Areas (Dependent on selection in 4a)<br><br>Medical/Surgical Acute Care Hospital (including CAH's)<br>• Inpatient<br>• Outpatient<br>• Psychiatric Services<br>• Inpatient Rehabilitation<br>• Skilled Nursing<br>• Other (i.e. Physician services, DME)<br>Inpatient Rehabilitation Hospital<br>• Inpatient<br>• Outpatient<br>• Other<br>Psychiatric Hospital<br>• Inpatient<br>• Outpatient<br>• Other<br>Long Term Care Hospital<br>• Inpatient<br>• ~~Outpatient~~<br>• Other | |
| **8. Rank order the services affected by the greatest number of complex claim denials this quarter.**<br><br>Number 1 is for the largest and number 3 is for the third largest number of claim denials this quarter. | Select number 1 for the service with the largest number of claims denied this quarter, number 2 for the second largest number and number 3 for the third largest number.<br><br>Example: If your hospital is a medical/surgical acute care hospital and you only experienced outpatient complex claim denials this quarter then you would choose number 1 as Medical/Surgical Acute Care Hospital – Outpatient and leave the rest blank. If you had 35 outpatient claim denials and 42 inpatient claim denials, you would rank inpatient as number 1 and outpatient as number 2 and not make any selection in number 3. | |

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| **9. Rank order the services by the <u>estimated dollar value</u> of the complex claim denials this quarter.**<br><br>Number 1 being the greatest dollar value and number 3 being the third largest dollar value <u>this quarter.</u> | Rank the top three services by estimated total dollar value of the complex claim denials. Number 1 is for claims associated with the greatest dollar value; number 2 is second largest dollar value and number 3 for the third largest dollar value. The dollar value of the claim is indicated on the RAC demand letter.<br><br>Example: Each complex denial will have a corresponding dollar value associated with it. If the hospital has 23 inpatient denials that total $3,000 and 10 outpatient denials that total $5,000 then you would rank outpatient as number 1 and inpatient as number 2.<br><br>The choices for selection include and should be selected based on the hospital type:<br>▪ *Medical/Surgical Acute Care Hospital - Inpatient*<br>▪ *Medical/Surgical Acute Care Hospital - Outpatient*<br>▪ *Medical/Surgical Acute Care Hospital - Psychiatric Services*<br>▪ *Medical/Surgical Acute Care Hospital - Inpatient Rehabilitation*<br>▪ *Medical/Surgical Acute Care Hospital - Skilled Nursing*<br>▪ *Medical/Surgical Acute Care Hospital - Other (i.e., Physician Services, DME)*<br>▪ *Inpatient Rehabilitation Hospital - Inpatient*<br>▪ *Inpatient Rehabilitation Hospital – Outpatient*<br>▪ *Inpatient Rehabilitation Hospital - Other*<br>▪ *Psychiatric Services Hospital - Inpatient*<br>▪ *Psychiatric Services Hospital - Outpatient*<br>▪ *Psychiatric Services Hospital - Other*<br>▪ *Long Term Care Hospital - Inpatient*<br>▪ ~~*Long Term Care Hospital – Outpatient*~~ | |

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| **10. Select the reasons cited by the RACs for complex claim denials <u>this quarter</u>.**<br><br>Please make the correct selection based on the type of services provided by your organization and check all that apply. | Below are the reasons for complex claim denial and the user can check all that apply.<br><br>Medical/Surgical Acute Care Hospital/Services - No Documentation Provided or Insufficient Documentation in the Medical Record<br>Medical/Surgical Acute Care Hospital/Services - Incorrect MS-DRG or Other Coding Error<br>Medical/Surgical Acute Care Hospital/Services - Incorrect APC or Other Outpatient Coding Error<br>Medical/Surgical Acute Care Hospital/Services - Short Stay Medically Unnecessary<br>Medical/Surgical Acute Care Hospital/Services - Medically Unnecessary Inpatient Stay Longer than 3 days<br>Medical/Surgical Acute Care Hospital/Services - Other Medically Unnecessary<br>Medical/Surgical Acute Care Hospital/Services - All Other<br><br>Inpatient Rehabilitation Hospital/Unit - No Documentation Provided or Insufficient Documentation<br>Inpatient Rehabilitation Hospital/Unit - Incorrect CMG or Other Coding Error<br>Inpatient Rehabilitation Hospital/Unit - Outpatient Coding Error<br>Inpatient Rehabilitation Hospital/Unit - All Joint Patients; Medically Unnecessary<br>Inpatient Rehabilitation Hospital/Unit - Other Medically Unnecessary<br>Inpatient Rehabilitation Hospital/Unit - All Other<br><br>Psychiatric Services Hospital/Unit - No Documentation Provided or Insufficient Documentation<br>Psychiatric Services Hospital/Unit - Incorrect MS-DRG or Other Coding Error<br>Psychiatric Services Hospital/Unit - Outpatient Coding Error<br>Psychiatric Services Hospital/Unit - Medically Unnecessary<br>Psychiatric Services Hospital/Unit - All Other<br><br>Long Term Care Hospital/Unit - No Documentation Provided or Insufficient Documentation<br>Long Term Care Hospital/Unit - Incorrect MS-DRG or Other Coding Error<br>Long Term Care Hospital/Unit - Medically Unnecessary<br>Long Term Care Hospital/Unit - All Other | |

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| ***Definitions of Complex Denial Reasons for Question 10, 11and 12 – Complex***<br>***NOTE:*** *Reasons for denial are hospital type and services based. For example, a user can be associated with a Medical/Surgical Acute Care Hospital and still have denial reasons in the Inpatient Rehabilitation Hospital/Services area due to a distinct part unit. Please contact RACTracsupport@providerpcs.com if you have questions.* | | |
| **Medical/Surgical Acute Care Hospital/Services – No Documentation Provided or Insufficient Documentation in the Medical Record** | Use this reason code to denote when a RAC request a medical record from the provider and the provider either failed to respond within the appropriate time limit (45 calendar days) or failed to send the complete medical record. This is often referred to as a "technical denial". | |
| **Medical/Surgical Acute Care Hospital/Services– Incorrect MS-DRG or Other Coding Error** | Use this reason code to denote that upon review of the medical record the RAC determined that an incorrect MS-DRG assignment was made based on the documentation provided. | |
| **Medical/Surgical Acute Care Hospital/Services – Incorrect APC or Other Outpatient Coding** | Use this reason code to denote when a RAC determines that there has been improper billing related to APC assignment, fee-schedule based HCPCS assignment, or other outpatient coding. | Not seen in demo. Testing out denial reason. |
| **Medical/Surgical Acute Care Hospital/Services – Short Stay Medically Unnecessary** | Use this reason code to denote a denial that generally pertains to acute inpatient stays of 1 to 3 days, often referred to as a short stay denial. Examples of these types of denials during the demonstration included but were not limited to patients with pacemaker/surgical procedures, chest pain, back pain, congestive heart failure, and gastroenteritis. | |
| **Medical/Surgical Acute Care Hospital/Services – Medically Unnecessary Inpatient stay Longer than 3 Days** | Use this reason code to denote a denial that may include the following justifications for care being determined medically unnecessary:<br>• Inpatient service provided should have been done in the outpatient setting<br>• Inpatient should have been observation<br>• No medical necessity for inpatient admission<br>• Level of care not met for inpatient admission<br>• If the reason is cited that it's Medically Unnecessary and it is not a short stay case as defined above, then it belongs in this category.<br><br>Please note that more than one procedure occurring on the same day AHA classifies as an duplicate payment – not medically unnecessary as defined in coverage guidelines etc. (e.g. 3 appendectomies in one day, while not medically necessary is really a duplicate payment and should be cited as such.) | |
| **Medical/Surgical Acute Care Hospital/Services – Other Medically Unnecessary** | Use this reason code to denote other denials that are not mentioned above or are for more clinical reasons rather then utilization of services reason. | |
| **Medical/Surgical Acute Care Hospital/Services – All Other** | Use this reason code to denote if the above mentioned denial reasons are in no way related to the current denials you are experiencing. Please also contact AHA via our "contact us" email and let us know about the types of denials you are experiencing so that we can consider tracking them in RACTrac. | |
| **Inpatient Rehabilitation Hospital/Unit – No** | Use this reason code to denote when a RAC request a medical record from the provider and the provider either failed to respond within the | |

| | | |
|---|---|---|
| **Documentation or Insufficient Documentation** | appropriate time limit (45 calendar days) or failed to send the complete medical record. This is often referred to as a "technical denial". | |

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|---|---|---|
| **Inpatient Rehabilitation Hospital/Unit – Incorrect CMG or Other Coding** | Use this reason code to denote that upon review of the medical record the RAC determined that an incorrect case mix group (CMG) assignment or other coding error was made based on the documentation provided. | |
| **Inpatient Rehabilitation Hospital/Unit– Outpatient Coding** | Denial reason to be defined. | Not seen in demo |
| **Inpatient Rehabilitation Hospital/Unit – All Joint Patients: Medically Unnecessary** | Use this reason code to denote when an inpatient rehabilitation service provided to a joint patient that was deemed medically unnecessary for any of the following reasons including but not limited to:<br>• Documentation does not support the need for 24-hour rehab nursing<br>• Documentation does not support the need for 24-hour medical supervision<br>• Documentation does not show a coordinated care plan<br>• Documentation does not show a significant practical improvement<br>• Patient could have been served in a less intense setting<br>• Documentation does not support that therapy services were of relatively intense level of service<br>• Documentation does not reflect realistic goals/progress toward established goals | |
| **Inpatient Rehabilitation Hospital/Unit – Other Medically Unnecessary** | Use this reason code to denote when inpatient rehabilitation was denied as medically unnecessary. There are seven criteria outlined in the Medicare Coverage Guidelines to assist providers in determining whether or not care in an IRF setting is clinically appropriate. Reasons for denial under this category include the following.<br>• Documentation does not support the need for 24-hour rehab nursing<br>• Documentation does not support the need for 24-hour medical supervision<br>• Documentation does not show a coordinated care plan<br>• Documentation does not show a significant practical improvement<br>• Patient could have been served in a less intense setting<br>• Documentation does not support that therapy services were of relatively intense level of service<br>• Documentation does not reflect realistic goals/progress toward established goals | Note to users of ERehab Data: These reasons for denial are noted separately in the ERehab claims denial tracking module. We have chosen to group them as one category. |
| **Inpatient Rehabilitation Hospital/Unit – All Other** | Use this reason code to denote if the above mentioned denial reasons are in no way related to the current denials you are experiencing.<br><br>Please also contact AHA via our "contact us" email and let us know about the types of denials you are experiencing so that we can consider tracking them in RACTrac. | |
| **Psychiatric Hospital/Unit - No Documentation or Insufficient Documentation** | Use this reason code to denote when a RAC request a medical record from the provider and the provider either failed to respond within the appropriate time limit (45 calendar days) or failed to send the complete medical record. This is often referred to as a "technical denial". | |

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|---|---|---|
| **Psychiatric Hospital/Unit- Incorrect MS-DRG or Other Coding** | Use this reason code to denote that upon review of the medical record the RAC determined that an incorrect MS-DRG assignment was made based on the documentation provided. | |
| **Psychiatric Hospital/Unit – Outpatient Coding** | Denial reason to be defined. | Not seen in demo so unclear as to how to define at this time, This is only a placeholder |
| **Psychiatric Hospital/Unit -Medically Unnecessary** | Medicare does not have criteria for admission into psychiatric hospitals and therefore this reason for denial is currently not specified. Use this reason code to denote a denial reason that may be characterized "as the care could have been provided in a less intensive setting". | Not seen in demo |
| **Psychiatric Hospital/Unit – All Other** | Use this reason code to denote if the above mentioned denial reasons are in no way related to the current denials you are experiencing.<br><br>Please also contact AHA via our "contact us" email and let us know about the types of denials you are experiencing so that we can consider tracking them in RACTrac. | |
| **Long Term Care Hospital/Unit – No Documentation or Insufficient Documentation** | Use this reason code to denote when a RAC request a medical record from the provider and the provider either failed to respond within the appropriate time limit (45 calendar days) or failed to send the complete medical record. This is often referred to as a "technical denial". | |
| **Long Term Care Hospital/Unit- Incorrect MS-DRG or Other Coding** | Use this reason code to denote that upon review of the medical record the RAC determined that an incorrect MS-DRG assignment was made based on the documentation provided. . | |
| **Long Term Care Hospital/Unit - Medically Unnecessary** | Medicare does not have criteria for admission into long term acute care hospitals and therefore this reason is for denial is currently not specified. Use this reason code to denote a denial reason that may be characterized as the care could have been provided in a less intensive setting. | |
| **Long Term Care Hospital – All Other** | Use this reason code to denote if the above mentioned denial reasons are in no way related to the current denials you are experiencing.<br><br>Please also contact AHA via our "contact us" email and let us know about the types of denials you are experiencing so that we can consider tracking them in RACTrac. | |

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|---|---|---|
| **11. Rank order the denial reasons experienced by number of complex claim denials for this quarter.**<br><br>Number 1 for the largest and number 3 for the third largest number of claim denials this quarter. | Select number 1 for the denial reason with the largest number of claims denied **this quarter**, number 2 for the second largest number and number 3 for the third largest number.<br><br>For example, if your hospital is a medical/surgical acute care hospital and this quarter you had 20 claims denied for inpatient medically unnecessary, 10 for not responding in time to the RACs or no documentation provided and 5 were miscellaneous (and would fall under Other Medical/Surgical Acute Care Hospital/Unit reasons) then these would be your rankings.<br>Number 1: Medical/Surgical Acute Care Hospital/Services – Medically Unnecessary Inpatient stay Longer than 3 Days<br>Number 2: Medical/Surgical Acute Care Hospital/Services – No Documentation Provided or Insufficient Documentation in the Medical Record<br>Number 3: Medical/Surgical Acute Care Hospital/Services – All Other | |
| **12. Rank order the denial reasons experienced by the estimated total dollar value of the complex claim denials for this quarter.**<br><br>Number 1 for the largest and number 3 for the third largest dollar value of claim denials this quarter. | The top three denial reasons are based on the estimated total dollar value of the claims denied this quarter through the complex claim review process and is indicated on the demand letter from the RAC.<br><br>Number 1 is the denial reason with the greatest dollar amount of denied claims and Number 3 would be the reason with the third largest dollar amount of claims associated with it.<br><br>User chooses from reasons as noted above. | VNote: This dollar value is from the estimated overpayment amount. |

# AHA RACTrac Survey Questions and Data Definitions
# Final as of July 16, 2010

| Data Element (As they appear on the screen) | User Definition for Help Text in RACTrac | Vendor Notes (VNote) and Comments |
|---|---|---|
| **Underpayments** | | |
| □ **Check here if your hospital is not tracking underpayments.**<br><br>(If checked, skip to Appeals.) | By checking this box, you are indicating that your hospital is not tracking underpayment experience at the present time. | |
| **1. Total number of claims identified as underpayments** | The RACs run Medicare claims through proprietary software to find potentially improper payments, this may include scenarios where the provider was paid less than the appropriate amount for the service. Alternatively, a provider may have an underpayment detected upon medical record review or complex review. Please total the number of claims (automated or complex) that were identified as an underpayment by the RAC. | |
| **2. Estimate of total dollars associated with underpayments** | The RAC will identify the underpayment on the notification letter and estimate an amount for that underpayment. Please total the estimated dollar value of the claims identified with underpayments. | . |
| **3. Total dollars returned to facility to date** | Indicate the actual total dollars returned to the facility to date by the Fiscal Intermediary or Medicare Administrative Contractor. | |
| □ **Check here if your hospital has no new activity this quarter.**<br><br>(If checked, skip to Appeals**)** | RACTrac is a quarterly survey and from time to time, there will be no new activity for hospitals between quarters. If data was reported in quarter one, but there is no new activity in quarter 2, the hospital should renter the data from quarter 1 into questions 1,2 and 3 as those numbers could possibly (however unlikely) remain the same and check this box to denote that there were no subsequent denials to be indicated in this quarter. | |
| 4. Indicate the reasons identified by the RAC for underpayment this quarter.<br><br>Check all that apply | The reason(s) provided by the RAC for why claims are identified as underpayments.<br><br>Below are the choices for this question<br>Billing Error<br>Inpatient Discharge Disposition<br>Incorrect MS-DRG<br>Outpatient Coding Error<br>All Other | |
| **Underpayment Reasons** | | |
| **Billing Error** | Use this reason code to denote an inappropriate payment resulting in an underpayment. | |
| **Inpatient Discharge Disposition** | Use this reason code to denote when a provider billed an inaccurate discharge disposition for the patient. For example, patients who are intended to receive home-health services, but never do for a variety of reasons. In the post-acute care Medicare reimbursement methodology, these patients might otherwise inappropriately trigger a reduction in reimbursement for the hospital. | |
| **Incorrect MS-DRG** | Use this reason code to denote when a hospital incorrectly coded a lower paying MS-DRG when the documentation or information on the claim should have resulted in a higher paying MS-DRG. | |

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|---|---|---|
| **Outpatient Coding** | Use this reason code to denote an error in HCPCS code assignment or other Outpatient coding related error. | Not noted in the demo |
| **All Other** | If the reason for the underpayment is not listed here, please check "other" and send AHA an email about the new reasons for underpayments that have been identified above. Please include the number of claims and the dollars associated with that underpayment reason so we can best determine if this is an isolated incident or if your reason should be added to the data we are capturing. | |

## AHA RACTrac Survey Questions and Data Definitions
## Final as of July 16, 2010

| Data Element (As they appear on the screen) | User Definition for Help Text in RACTrac | Vendor Notes (VNote) and Comments |
|---|---|---|
| **1. Total number of appeals filed** | The total (cumulative) number of appeals filed for claims denied through the automated and complex review processes. An appeal is NOT a rebuttal to the RAC but rather an appeal filed to the Fiscal Intermediary (FI) for redetermination (or for some the Medicare Administrative Contractor (MAC)). Each claim filed with the FI or MAC counts only once regardless of the number of levels of appeals it goes through.<br><br>*Regardless of whether or not this claim was identified through the automated or complex process, if it was appealed it should be noted here.* | VNote: Once it has been appealed to the FI or MAC then that appeal only counts once. |
| **1A. Total dollar value of the denials filed for appeal** | Please indicate the estimated total dollar value of all your denied claims filed for appeal to the FI or MAC to date.<br><br>*Regardless of whether or not this claim was identified through the automated or complex process, if it was appealed it should be noted here.* | VNote: Dollar value of a denied claim is what was indicated on the demand letter. |
| **2. Total number of appeals overturned in favor of the provider at any level of the appeals process** | Once a claim has been appealed, it can be overturned at any level of the appeals process (FI, QIC, ALJ, MAC etc.). Please indicate the total number of claims that have been successfully overturned in favor of the provider at any level to date. (This does not include any rebuttals to the RACs that were then overturned in favor of the provider.) | |
| **2A. Total dollars associated with appeals that have been overturned in favor of the provider at any level of the appeals process to date** | Once a claim has been appealed, it can be overturned at any level of the appeals process (FI, QIC, ALJ, MAC etc.). Please indicate the estimated total dollars associated with all the claims that have been successfully overturned in favor of the provider to date. (This does not include any rebuttals to the RACs that were then overturned in favor of the provider.) | VNote: In the AHA RACTrac claim tool the dollar value is pulled from the value stated on the demand letter. However, any appeal entity can issue a fully favorable or partially favorable finding. Ideally vendors should capture the actual dollar value as AHA's tool could over estimate the dollars returned. |

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|---|---|---|
| **3. Total number of appeals that were initially filed to the FI/MAC and later withdrawn from the process or not continued** | Please indicate the total number of appeals that were initially filed to the FI or MAC and then withdrawn or stopped by the provider at any level of the appeals process.<br><br>Most often these are appeals that the provider only pursued to a certain level and then made a determination that it was no longer worth pursuing further and the denial remains upheld. Several reasons may justify this decision including but not limited to: not enough documentation to support an appeal moving forward, the dollar value of the claim is not enough to warrant the cost of a lengthy appeals process, the hospital missed a deadline for filing an appeal to get it to the next step in the process, not enough resources to appeal every claim, or the merits of the case do not warrant pursuing the appeal further. | |
| **3A. Total dollar value of the appeals that were initially filed to the FI/MAC and later withdrawn from the process or not continued** | Please indicate the estimated total dollar value of appeals that were initially filed to the FI or MAC and then withdrawn or stopped by the provider at any level of the appeals process. The dollar value is indicated on the demand letter. | |
| **4. Total number of appeals currently in process** | These appeals have been filed and are currently in process at various levels of the appeals process. They have not been overturned or withdrawn or stopped for any reason. | |
| **4A. Total dollar value of the appeals currently in process** | These appeals have been filed and are currently in process at various levels of the appeals process. They have not been overturned or withdrawn or stopped for any reason. Indicate the estimated dollar value of these appeals in process. | |
| **5. For the appeals filed this quarter, please indicate the services in which the denials occurred.**<br><br>Please select your hospital type in 5A and then indicate the services in which automated and complex denials have occurred for your hospital this quarter in 5B. | The user must choose in 5a the type of facility in which he or she is reporting for. The choices are:<br><br>•Medical/Surgical Acute Care Hospital (would include Critical Access Hospital)<br>•Inpatient Rehabilitation Hospital<br>•Psychiatric Services Hospital<br>•Long Term Care Hospital<br>By selecting one particular facility type, question 5b will then be pre populated with the appropriate choices.<br><br>The choices that may appear in 5b may include the following depending on your selection in 5a.<br>•Inpatient<br>•Outpatient<br>•Psychiatric Services<br>•Inpatient Rehabilitation<br>•Skilled Nursing | VNote: We do not have check boxes in this section as in previous sections.<br><br>So if the user has no new appeals activity in the quarter, the user will skip these questions and proceed to the admin burden section. |

| | | |
|---|---|---|
| | •Other (i.e., Physician Services, DME*)* | |
| **6. For the appeals filed this quarter, please indicate the denial reasons cited on those claims.**<br><br>Please make the correct selection based on the type of services provided by your organization and indicate the reasons that complex RAC both automated and complex RAC denials have occurred for your hospital this quarter. | On the correspondence from the RAC to the provider, the RAC indicates the reason for the overpayment. AHA has broadly categorized selected reasons by hospital type that were identified during the demonstration program. Please read carefully through each of the denial reasons to determine ANY and ALL categories which reflect the reason for appeal for **this quarter**.<br><br>The denial reasons for both automated and complex are noted above and listed in this section. | |

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|---|---|---|
| **7. For those appeals <u>this quarter</u> that have been overturned in favor of the provider, please indicate the reason for the overturn. Check all that apply.** | | |
| **Appeal Overturn Reasons** | | |
| **No reason yet provided by entity overturning the appeal.** | **During the demonstration the reasons for over turned denials were not stated. Dollars were just refunded to the provider.** | |
| **The RACs have not provided accurate justification for reopening a claim after a certain period of time** | **This is often related to "good cause", a legal argument challenging the legality of a provider reopening the claim greater then 1 year.** | |
| **Care provided was found to be medically necessary** | **Many of the claims appealed were denied based on the RACs findings of not medically necessary. A large number of appeals in the demonstration were over turned when the appeals entities found the care to have been appropriate.** | |
| **All Other** | | |

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|---|---|---|
| **Administrative Burden** | | |
| **1. Please estimate the average number of hours or percent of FTEs devoted to all activities related to managing the RAC process within your organization by type of staff <u>this quarter.</u>** | Activities include but are not limited to –<br>▸ Tracking Automatic Denials includes recording and tracking demand letters and tracking patient account adjustments based on RAC activity<br>▸ Tracking Complex Denials includes recording and tracking of chart requests, retrieving and reviewing requested charts, copying requested charts, sending charts to RAC, , tracking RAC determinations, and tracking patient account adjustments that result from RAC activity<br>▸ Rebuttals include conducting chart review and/or research, developing and creating rebuttal letters, sending rebuttal letters with supporting documentation, additional correspondence/conference calls with RAC regarding rebuttal, tracking and recording RAC rebuttal responses<br>▸ Appeals include tracking recoupment on accounts in advance of sending appeal to FI, assembling appeals materials (e.g., CMS 20027, appeal letter, supporting documentation), conducting re-review of case, sending appeal correspondence to FI, tracking and recording FI response.<br>▸ RAC Team Activities include RAC team meetings, time spent on RAC progress report, etc..<br><br>Choices of staff include:<br>▸ Administrative/Clerical Staff<br>▸ Case Managers<br>▸ Chief Financial Officer/Vice President Finance<br>▸ Coders/HIM<br>▸ Compliance Officer<br>▸ In-house Legal Counsel/Lawyer<br>▸ Medical Director/Vice President Medical Affairs<br>▸ Medical Records Director<br>▸ Medical Records Staff<br>▸ Patient Financial Services--Director<br>▸ Patient Financial Services--Staff<br>▸ Utilization Management<br>▸ Vice President (other than CFO)<br>▸ OTHER | |
| Average Number of Hours Per Week **OR** | The average number of hours worked per week this quarter by type of the staff on activities related to the RAC Program | |
| Number of FTEs (e.g., .75 or 2.5) | The full time equivalents (.25, .5, .75, etc) required by each type of staff to support each task identified by the facility this quarter. | |

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|---|---|---|
| **2. Please select any external services you have hired to assist you in managing the RAC process within your organization. Please estimate the total dollars paid to these outside consultants this quarter.** | Select and provide an estimate<br><br>☐ No External Support<br><br>☐ Outside Legal Counsel Total Dollars _____<br>☐ Other Consultant Total Dollars _____<br>☐ Medical Record Copying Service Total Dollars _____<br>☐ Utilization Management Consultant Total Dollars _____<br>☐ Other Total Dollars _____ | |
| **3. What has been the impact of the RAC (financial recoupment of dollars, costly appeals process, and increased administrative burden) on your organization <u>this quarter?</u>**<br><br>(Check all that apply) | ☐ No impact<br>☐ Modified admission criteria to reduce risk of future RAC denials<br>☐ Had to make cutbacks because of financial hardships due to RAC recoupment of Medicare dollars (e.g. limited services, reduced number of beds, reduced staffing)<br>☐ Additional administrative responsibilities of clinical staff to respond RAC has taken them away from direct patient care<br>☐ Increased administrative costs to manage responses to RAC requests and or appeals etc.<br>☐ Employed additional staff or hire external resources to manage the RAC process<br>☐ Initiated a new internal task force to manage and or respond to the RAC process<br>☐ OTHER | |