



Exploring the Impact of the RAC Program on Hospitals Nationwide

Quarterly National Webinar

December 19, 2012

Agenda

- RAC update
- Review of RAC resources
- Key findings of the RAC *Trac* Report, 3rd Quarter 2012
 - Access entire RAC *Trac* Report at: www.aha.org/ractrac
- RAC *Trac* data collection period, January 2013
- Questions and Answers



**American Hospital
Association**

THANK YOU

For Making the Latest *RAC*Trac Data Collection a
Success!!!!

2307 Participating Hospitals;
1299 Submitted Data in the 3rd Quarter.

H.R. 6575

- *Medicare Audit Improvement Act of 2012*
- Introduced Oct 16, 2012
- Reps. Sam Graves (R-MO) & Adam Schiff (D-CA)
- Among other measures, the bill would:
 - Establish a consolidated limit for medical record requests;
 - Improve auditor performance by implementing financial penalties and by requiring medical necessity audits to focus on widespread payment errors;
 - Improve recovery auditor transparency;
 - Restore due process rights under the AB Rebilling Demonstration;
 - Allow denied inpatient claims to be billed as outpatient claims; and
 - Require physician review for Medicare denials.

112TH CONGRESS
2D SESSION **H. R. 6575**

To amend title XVIII of the Social Security Act to improve operations of recovery auditors under the Medicare integrity program, to increase transparency and accuracy in audits conducted by contractors, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 16, 2012

Mr. GRAVES of Missouri (for himself, Mr. SCHIFF, Mr. LOPEZ, and Mr. ARDIS) introduced the following bill, which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned:

A BILL

To amend title XVIII of the Social Security Act to improve operations of recovery auditors under the Medicare integrity program, to increase transparency and accuracy in audits conducted by contractors, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**
4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Medicare Audit Improvement Act of 2012”.



Rebilling Lawsuit

Overview:

- Filed Nov 1, 2012
- AHA, Hospital Systems Sue HHS For Unfair Medicare Practices
- The AHA and four systems filed the complaint
 - Missouri Baptist Sullivan Hospital (MO),
 - Munson Medical Center (MI),
 - Lancaster General Hospital (PA) and
 - Trinity Health Corporation (MI)
- **The Problem:** Under CMS's RAC rebilling policy, CMS underpays hospitals for reasonable and necessary care.
 - Inpatient cases denied based on RAC decision that care was appropriate at the outpatient level. But hospitals only receive a portion of outpatient payment.
- **The Remedy:** The AHA is asking the court to overrule CMS's non-payment policy and fully reimburse hospitals for outpatient care.

THE AMERICAN HOSPITAL ASSOCIATION,)
325 Seventh Street, NW, Suite 700)
Washington, DC 20004;)

MISSOURI BAPTIST SULLIVAN HOSPITAL,)
751 Sappington Bridge Road)
Sullivan, MO 63080;)

MUNSON MEDICAL CENTER,)
1105 6th Street)
Traverse City, MI 49684;)

LANCASTER GENERAL HOSPITAL,)
555 North Duke Street)
Lancaster, PA 17602; and)

TRINITY HEALTH CORPORATION,)
20555 Victor Parkway)
Livonia, MI 48152.)

Plaintiffs,)

v.)

KATHLEEN SEBELIUS, in her official capacity)
as Secretary of Health and Human Services,)
200 Independence Avenue, SW)
Washington, DC 20204.)

Defendant.)

Case No. 1:12-cv-1770

COMPLAINT

Plaintiffs the American Hospital Association, Missouri Baptist Sullivan Hospital, Munson Medical Center, Lancaster General Hospital, and Trinity Health Corporation ("Plaintiffs") bring this action to end an unlawful government practice: The Medicare program has been refusing to pay hospitals for hundreds of millions of dollars' worth of care provided to patients, even though all agree that the care provided was reasonable and medically necessary as



Lawsuit Arguments

CMS's Payment Denial Policy is Unlawful

- Under the statute, **Medicare must pay for reasonable and necessary care.** And if payment cannot be made under Part A, it must be made under Part B.
 - 42 U.S.C. § 1395k(a)(2)

CMS's Payment Denial Policy is Arbitrary and Capricious

- The policy is arbitrary and capricious, and therefore also violates the APA.
- **No Policy Rationale from CMS.** CMS has never made *any* attempt to explain or justify the statutory or regulatory basis for only paying outpatient “ancillary” services, rather than the full outpatient amount.
 - In its litigation document CMS references only Medicare Benefits Policy Manual (MBPM) Chapter 6 § 10 which authorizes Part B payment after an “admission was disapproved,” but only for “the nonphysician medical and other health services listed below.” This manual provision contradicts the statute
- **CMS's is disregarding the findings of the Medicare Departmental Appeals Board and its own contractors.**
 - CMS has adhered to its policy of underpayment for these cases despite multiple decisions from the DAB that support full outpatient payment and the findings of the RACs/MACs that outpatient level payment is appropriate.
- **CMS's underpayment policy was never subjected to notice-and-comment rulemaking.** The APA requires notice-and-comment procedures before agencies may enact “legislative rules,” i.e., rules of “general . . . applicability” that have “future effect” and that define the rights and obligations of members of the regulated community.



OIG Report on ALJs

- Nov 2012 Report
- Reviewed all ALJ appeals decided in FY 2010
- Key Findings
 - 85% of appeals filed by providers;
 - Hospitals account for 1 out of 4 provider appeals;
 - 40% of provider appeals are on Part A
 - Average: 6 appeals per provider
 - ALJ decisions on hospital Part A: 72% overturned
- CMS's participation influences appeals outcome
 - Participated in 9% of Part A appeals; 5% of Part B
 - Full overturn 4% less likely for Part A when CMS participates.
- ALJs inconsistently handling suspected fraud.

Department of Health and Human Services
OFFICE OF
INSPECTOR GENERAL

**IMPROVEMENTS ARE NEEDED
AT THE ADMINISTRATIVE LAW
JUDGE LEVEL OF MEDICARE
APPEALS**



Daniel R. Levinson
Inspector General
November 2012
OEI-02-10-0340



OIG Report on ALJs (cont.)



ALJs

- 66 ALJs
- Tend to decide in favor of appellant when the intent of policy is met.
- Decide appeals from all areas of Medicare program.
- Tend to rely on testimony from treating physicians.
- An ALJ's personal philosophy may affect rate of fully favorable decisions.

QICs:

- 7 QICs
- Tend to follow policy more strictly.
- Tend to uphold prior decision unless evidence to reverse is compelling.
- QICs specialize: Part A, Part B, DMEPOS
- Have medical directors and clinicians on staff





OIG Report on ALJs (cont.)

OIG Recommendations to CMS

- Implement consistent training for ALJs and QICs;
- Clarify Medicare policies that are open to interpretation;
 - OMHA: Not a policy maker
- Standardize electronic format for appeals;
- Limit new evidence at the ALJ level to information that could not have been obtained earlier;
- Monitor the appeals of providers under fraud investigation;
 - CMS/OMHA: Expressed due process concerns
- Implement a modest filing fee;
- Review ALJ decisions; and provide education as needed;
- Consider specialization among ALJs (eg, Part A vs Part B);
- Establish referral policy for suspected fraud; and
- Increase CMS participation in ALJ appeals.



Additional AHA Advocacy on Audit Concerns

- Oct 2012: AHA letter to OIG calling for RAC effectiveness study.
- Sept 2012: AHA highlighted problems with inconsistent MAC and RAC audit protocols during meetings with GAO.
- Aug 2012: AHA letter on CMS OPPTS proposed rule made preliminary recommendations re: short-stay vs. observation cases.
- June 2012: AHA audit recommendations to Sen. Finance Comm.



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June 26, 2012

Submitted via e-mail (ProgramIntegrityWhitePapers@finance.senate.gov)

Chairman Baucus, Ranking Member Hatch and Senators Coburn, Wyden, Grassley and Carper
Committee on Finance
United States Senate
Washington, DC 20510-6200

Dear Honorable Members:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations and our 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to respond to the May 2 open letter to the health care community and present recommendations to better prevent and combat waste, fraud and abuse in the Medicare and Medicaid programs. America's hospitals take seriously their obligation to properly bill for the services they provide to Medicare and Medicaid beneficiaries.

Hospitals have a longstanding commitment to compliance, establishing programs and committing resources to ensure that they receive only the payment to which they are entitled. Hospital compliance programs are designed to meet the principles for effectiveness outlined in the U.S. Sentencing Guidelines and, more specifically, in the Office of the Inspector General's (OIG) compliance program guidance for hospitals. Every day hospital staff strive to comply in

August 29, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1589-P
P.O. Box 8013
Baltimore, MD 21244-1850

RE: CMS-1589-P, Hospital Outpatient Prospective and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Electronic Reporting Pilot; Inpatient Rehabilitation Facilities Quality Reporting Program; Quality Improvement Organization Regulations; (Vol. 77, No.146), July 30, 2012.

Dear Ms. Tavenner:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule for calendar year (CY) 2013 hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) PPS and quality reporting programs; electronic reporting pilot; inpatient rehabilitation facilities quality reporting program and quality improvement organization changes.

We provide detailed comments on several proposals in the attached document. The AHA is

AHA RAC and Audit Resources

AHA is Helping Hospitals Improve Payment Accuracy

- Main AHA RAC Page: www.aha.org/rac
- AHA RACTrac Page: www.aha.org/ractrac; www.aharactrac.com
- 2012 AHA Audit Series: www.aha.org/auditseries
 - 3 regulatory advisories
 - 7 webinars in May-Nov 2012
- AHA Members: Email RAC questions to racinfo@aha.org



**AHA Audit
Education Series**™1

CMS Provider Education Resources

– CMS provider education:

http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp

U.S. Department of Health & Human Services www.hhs.gov

CMS Centers for Medicare & Medicaid Services

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[CMS Home](#) > [Outreach and Education](#) > [MLN Products](#) > Provider Compliance

MLN Products	Provider Compliance
<ul style="list-style-type: none">» Overview» MLN Products Catalog» Web-Based Training (WBT)» Preventive Services» Provider Compliance» Ophthalmology Resource Information» Advanced Practice Nurses and Physician Assistants (APN/PA)» FFS Provider Web Pages» MLN Opinion Page» MLN Publications» MLN Multimedia	<p>FAST FACT</p> <p>Issue: Outpatient Rehabilitation Services – Medical Record Documentation and Claims Submission CERT Errors</p> <p>Solution: The medical record should clearly document:</p> <ul style="list-style-type: none">• Complete plan of care;• Date the plan of care is modified, including how it was modified and why the previous goals were not met or could not be met;• Confirmation that the plan of care is certified (recertified when appropriate) with physician/ NPP signature and date; and• Treatment time for timed codes and total treatment time (including timed and untimed codes).

The Medicare Learning Network® (MLN) Products **Provider Compliance** page contains educational products that inform Medicare Fee-For-Service (FFS) providers about how to avoid common billing errors and other improper activities when dealing with the Medicare Program. Since 1996, the Centers for Medicare &





RAC *Trac* 3rd Quarter 2012 Results

RAC TRAC Background

- AHA created RAC TRAC—a free, web-based survey—in response to a lack of data provided by CMS on the impact of the RAC program on America's hospitals.
 - Hospitals use AHA's online survey application, RAC TRAC (accessed at www.aharactrac.com), to submit their data regarding the impact of the RAC program.
 - Survey questions are designed to collect *cumulative* RAC experience data, from the inception of a hospital's RAC activity through the 2nd quarter of 2012.
 - Survey registration information and RAC TRAC support can be accessed at ractracsupport@providercs.com or 1-888-722-8712.
- The AHA recently enhanced the RAC TRAC survey to capture more detailed information on medical necessity review denials and the administrative burden due to problems with the RAC process.



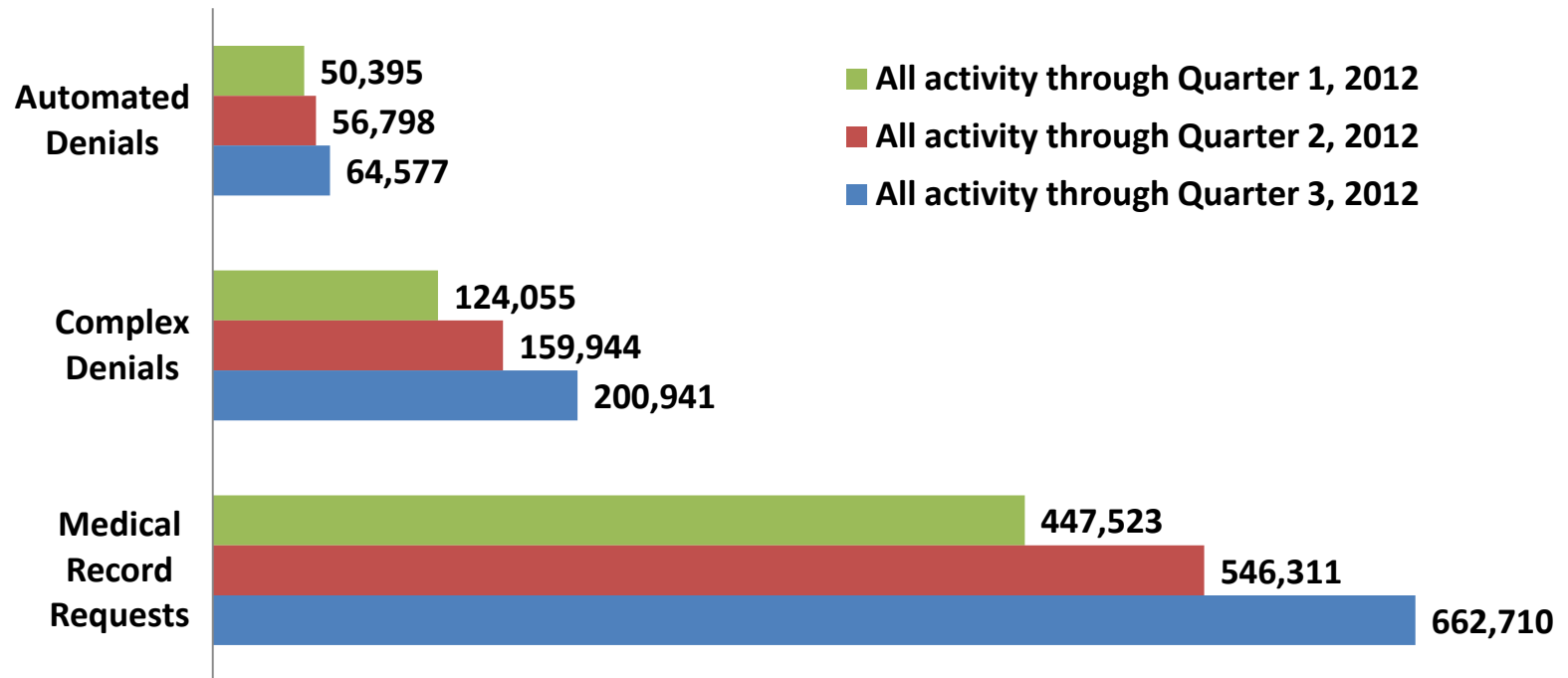
Highlights

- 2307 hospitals have participated in RAC *TRAC* since data collection began in January of 2010. 1299 hospitals participated this quarter.
- Participants continue to report dramatic increases in RAC activity:
 - Medical record requests are up 21% relative to last quarter.
 - The number of denials is up 23% relative to last quarter.
 - The dollar value of denials is up 26% relative to last quarter.
- Nearly two-thirds of medical records reviewed by RACs **did not** contain an overpayment, according to the RAC.
- 94% of hospitals indicated medical necessity denials were the most costly complex denials.
- 61% of medical necessity denials reported were for 1-day stays where the care was found to have been provided in the wrong setting, not because the care was medically unnecessary.



Participants reported a 25 percent increase in complex RAC denials and a 21 percent increase in medical record requests.

Reported Automated Denials, Complex Denials and Medical Records Requests by Participating Hospitals, through 3rd Quarter 2012



Source: AHA. (October 2012). RAC TRAC Survey

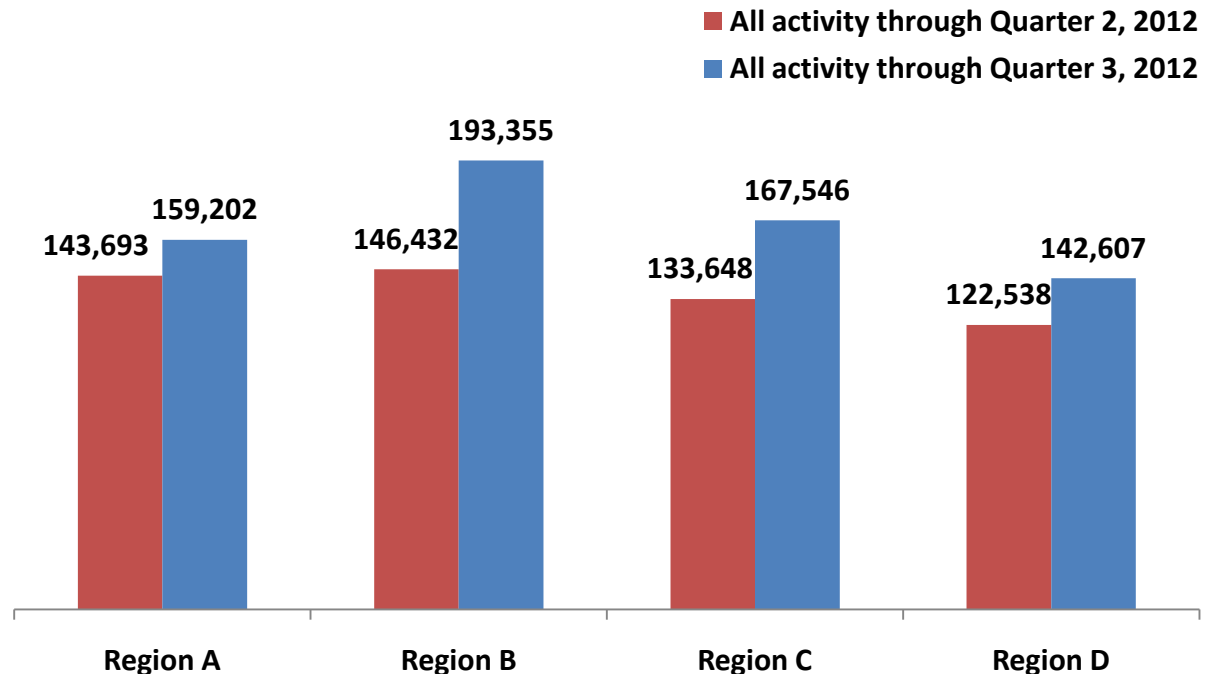
AHA analysis of survey data collected from 2,307 hospitals: 1,961 reporting activity, 347 reporting no activity through September 2012. 1,299 participating hospitals this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

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Regions B and C experienced the largest increases in medical record requests – 32 and 25 percent, respectively.

Number of Medical Records Requested from Participating Hospitals With Complex Medical Record RAC Activity, through 3rd Quarter 2012

Average Number of Medical Record Requests per Reporting Hospital, through Q3, 2012	
Region A	977
Region B	780
Region C	546
Region D	839



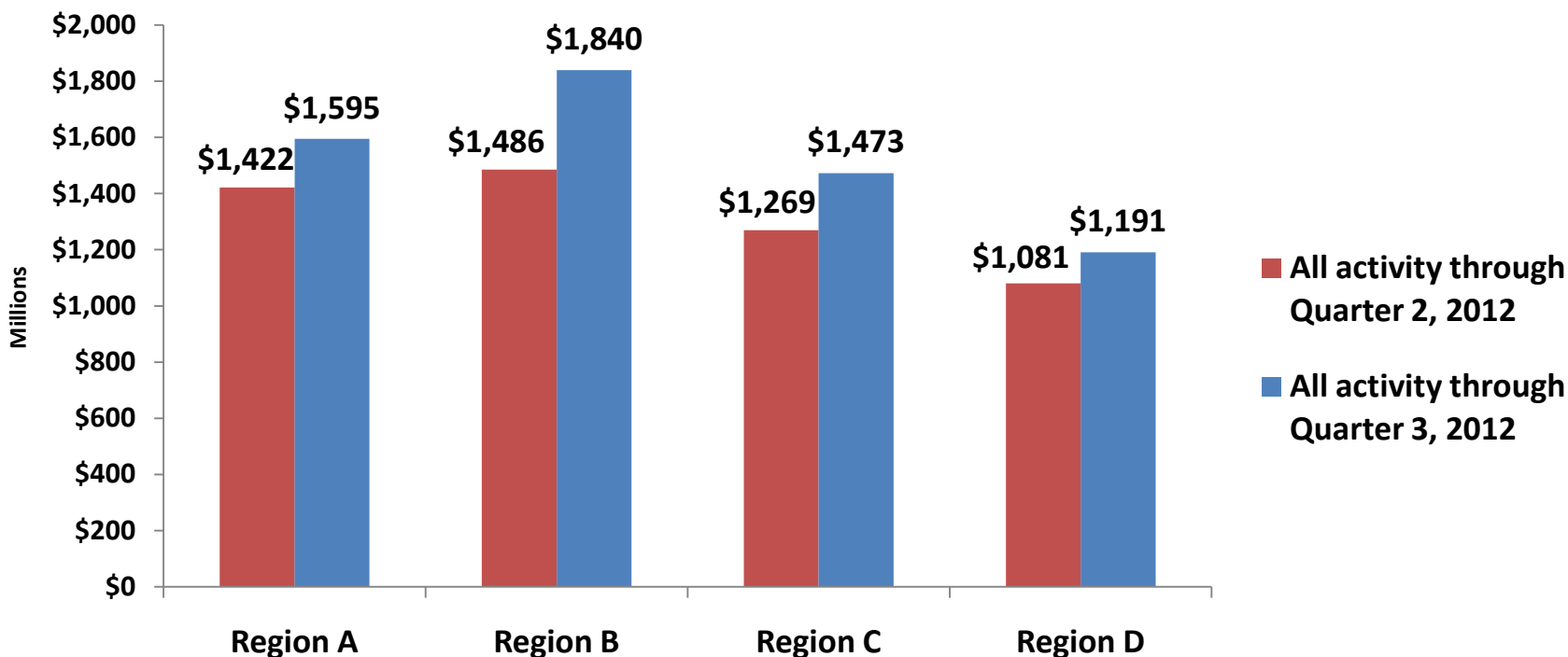
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Among participating hospitals, \$6.1 billion in Medicare payments were targeted for medical record requests through the 3rd quarter of 2012.

Medicare Payments Associated with Medical Records Requested from Participating Hospitals, through 3rd Quarter 2012, in Millions

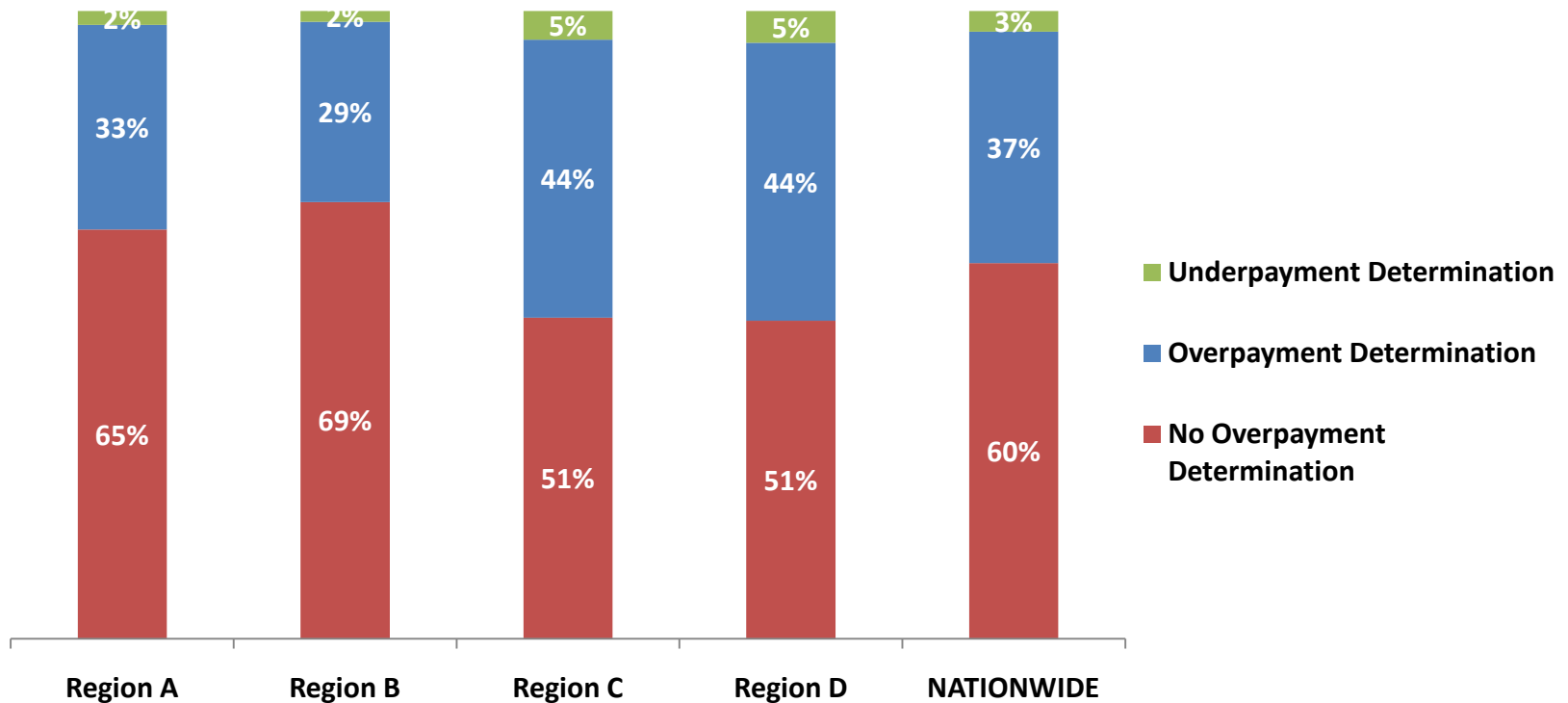


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60 percent of medical records reviewed by RACs did not contain an improper payment.

Percent of Completed Complex Reviews with and without Overpayment or Underpayment Determinations for Participating Hospitals, by Region, through 3rd Quarter 2012



Source: AHA. (October 2012). RAC TRAC Survey

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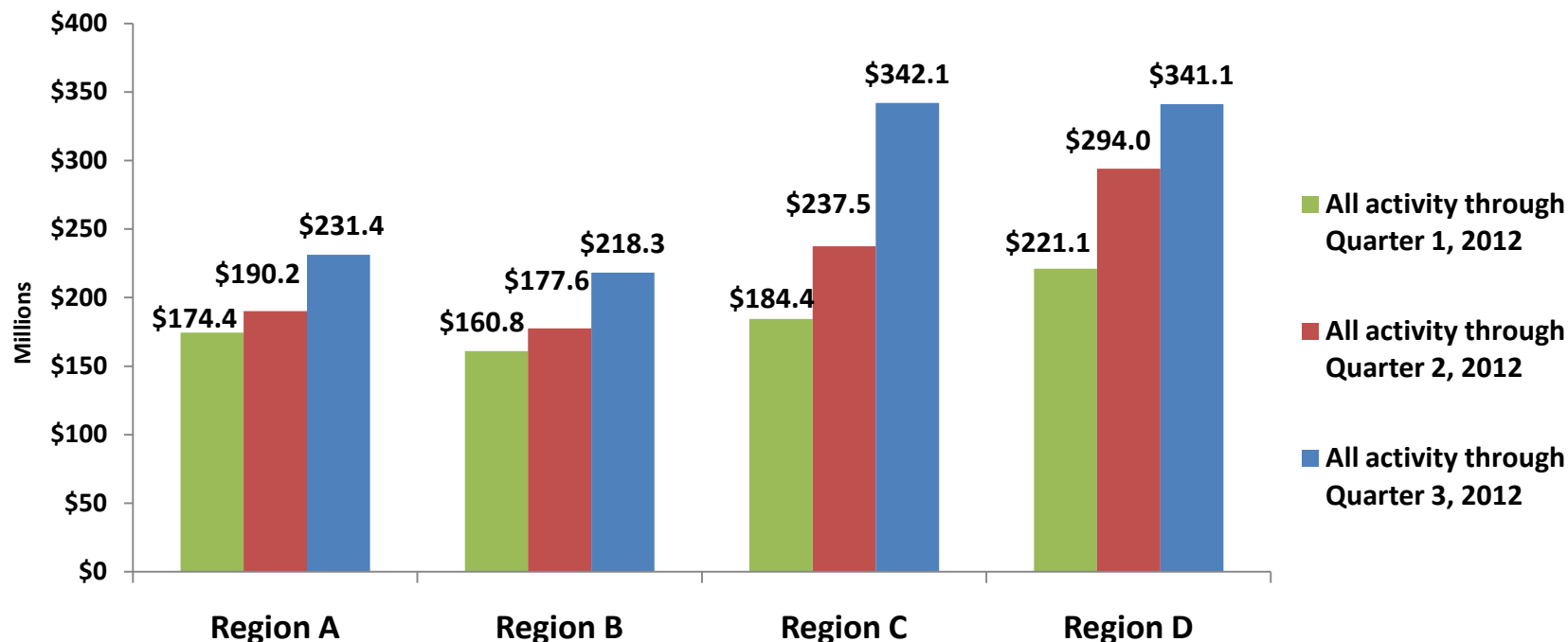
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RAC Denials

\$1.1 billion in denials were reported through the third quarter of 2012, up 26% from the second quarter. Region C experienced an extremely large increase of 44 percent.

Dollar Value of Automated and Complex Denials by RAC Region for Participating Hospitals, through 3rd Quarter 2012, in Millions

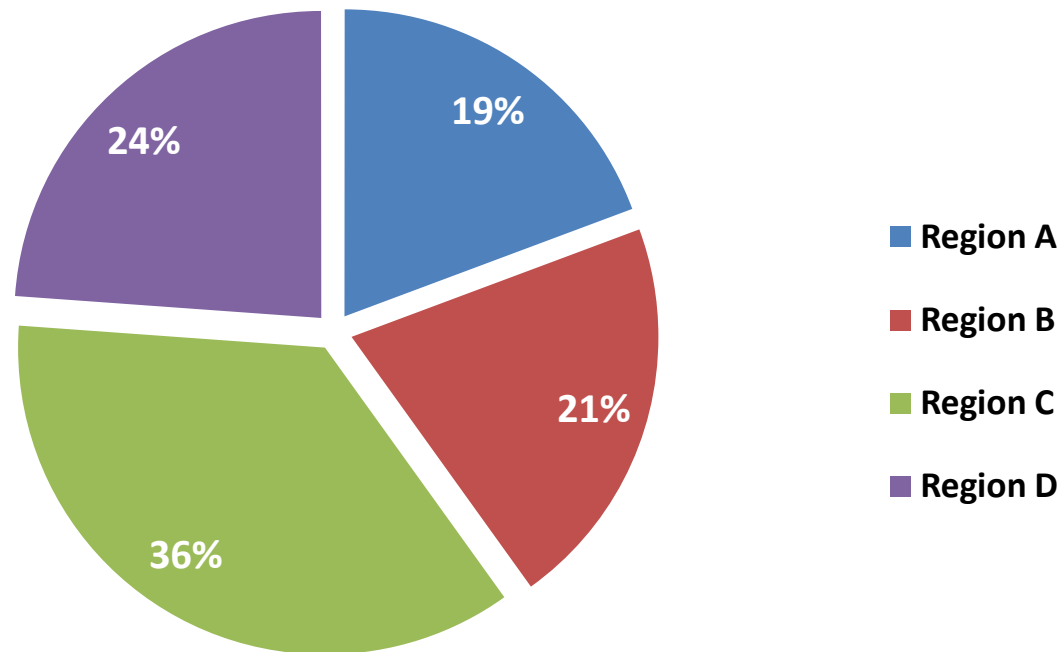


Source: AHA. (October 2012). RAC TRAC Survey

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RAC denials are spread among all four RAC regions.

Percent of Automated and Complex Denials by RAC Region for Participating Hospitals, through 3rd Quarter 2012



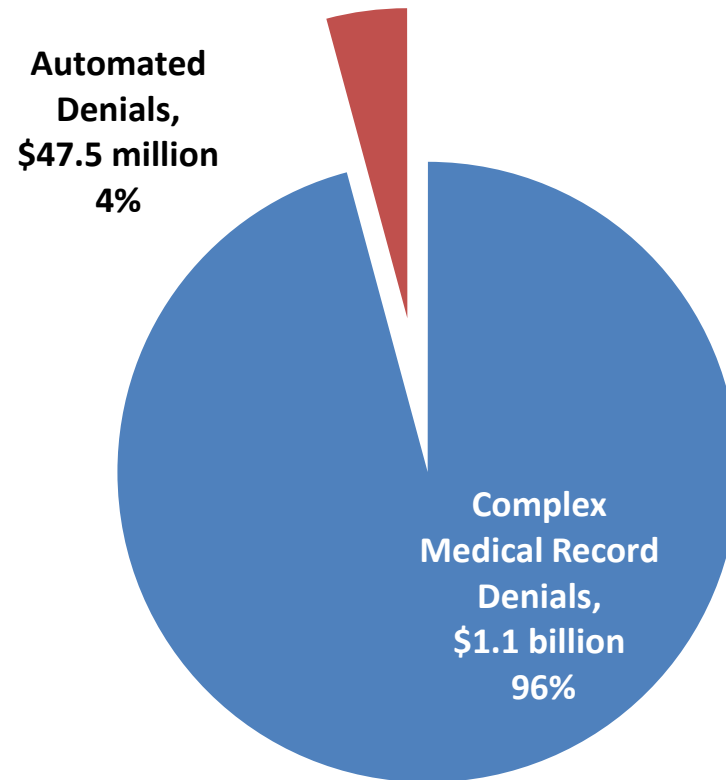
Source: AHA. (October 2012). RAC TRAC Survey

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96% of denied dollars were for complex denials.

Percent and Dollar Amounts of Automated Denials Versus Complex Denials for Participating Hospitals, through 3rd Quarter 2012



Source: AHA. (October 2012). RAC TRAC Survey

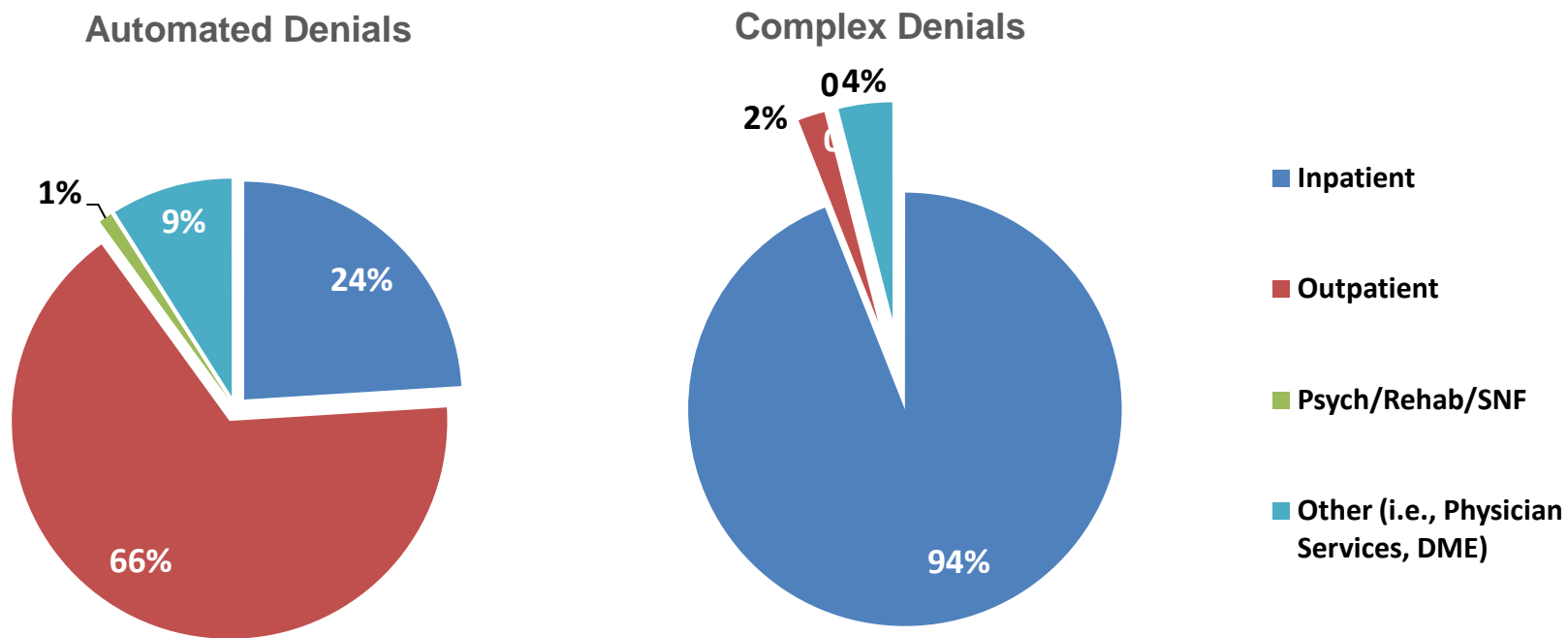
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In dollar terms, the top service area for automated denials was Outpatient and for complex denials, Inpatient.

Percent of Participating Hospitals by Top Service Area for Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 3rd Quarter 2012

Survey participants were asked to rank denials by service, according to dollar impact.



Source: AHA. (October 2012). RAC TRAC Survey

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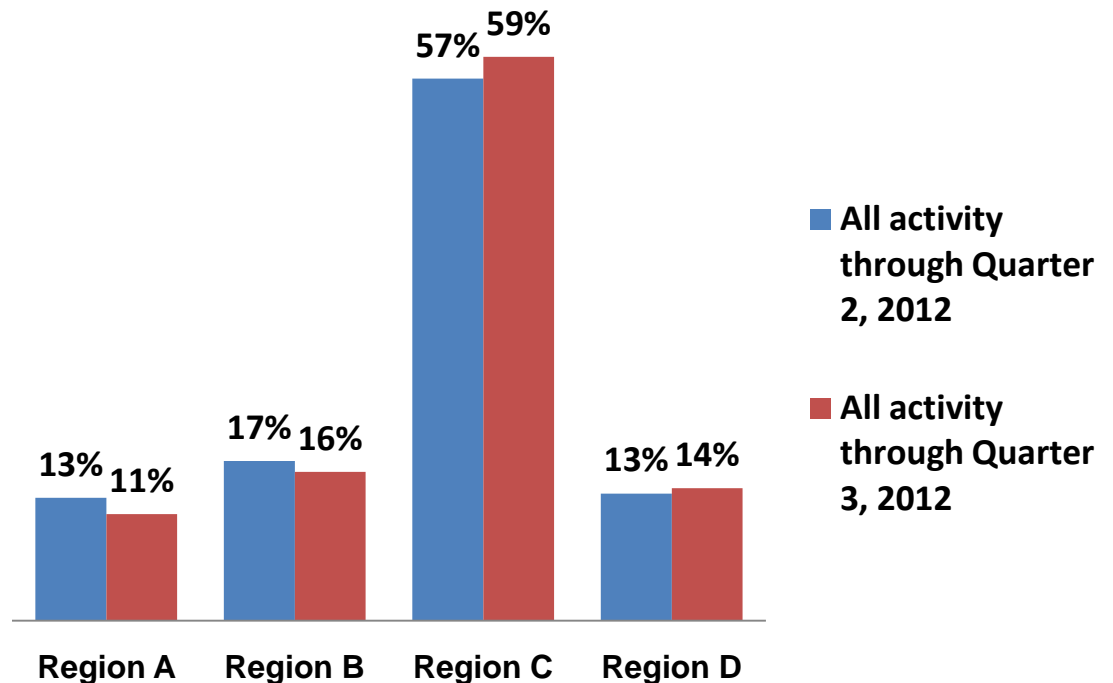


Automated RAC Denials

Region C continues to experience the vast majority of all automated denial activity.

Percent and Number of Reported Automated Denials for Participating Hospitals, by Region, through 3rd Quarter 2012

	Through 2 nd Quarter 2012	Through 3 rd Quarter 2012
Region A	7,334	7,246
Region B	9,537	10,099
Region C	32,336	38,243
Region D	7,591	8,989



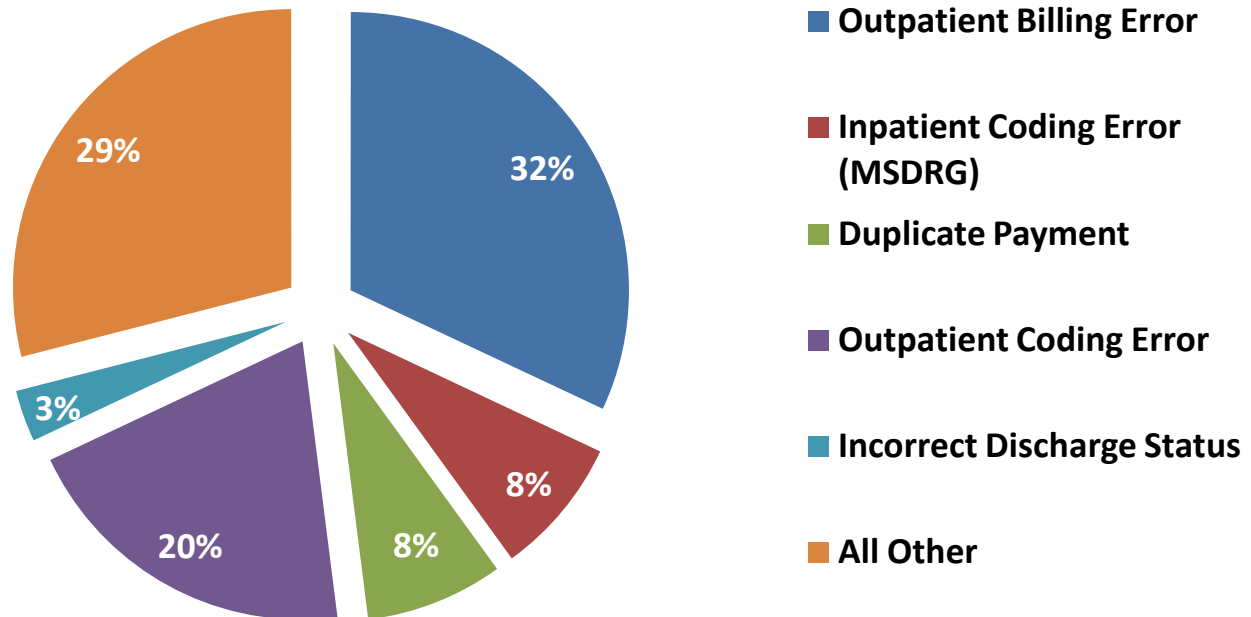
Source: AHA. (October 2012). RAC TRAC Survey

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RACs are issuing automated denials for many different reasons.

Percent of Participating Hospitals by Top Reason for Automated Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 3rd Quarter 2012

Survey participants were asked to rank denials by reason, according to dollar impact.



Source: AHA. (October 2012). RAC TRAC Survey

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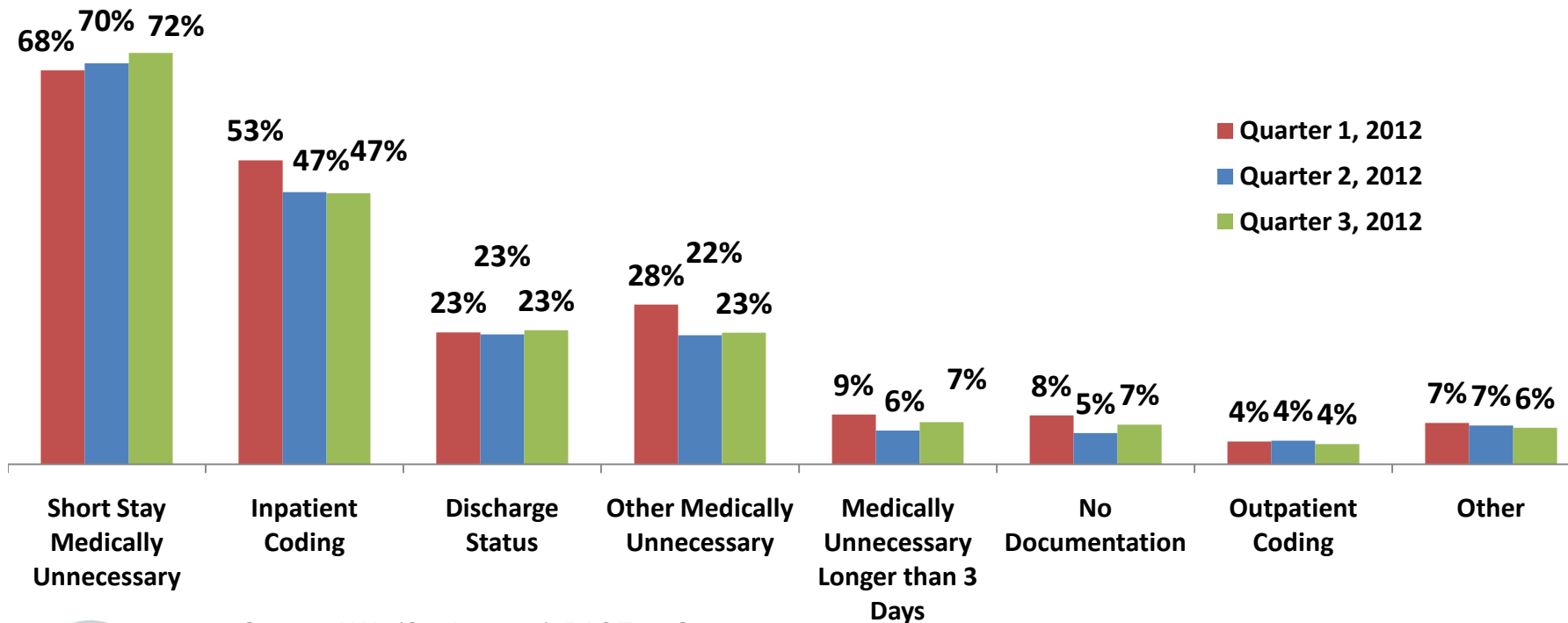


Complex RAC Denials

The most commonly cited reason for a complex denial was 'short-stay medically unnecessary.'

Percent of Participating Medical/Surgical Acute Hospitals with RAC Activity Experiencing Complex Denials by Reason, 1st, 2nd and 3rd Quarter, 2012

Survey participants were asked to select all reasons for denial.



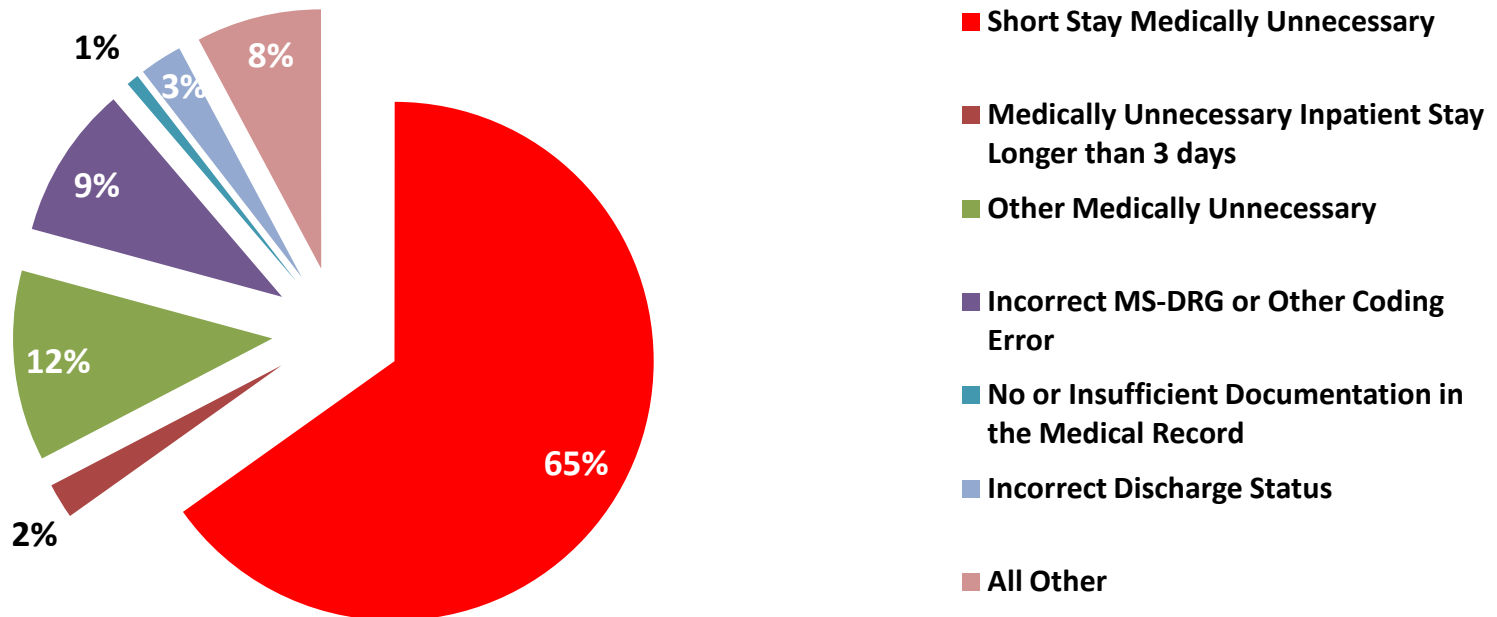
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65% of hospitals indicated medical necessity denials were the most costly complex denials.

Percent of Participating Hospitals by Top Reason for Complex Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 3rd Quarter 2012

Survey participants were asked to rank denials by reason, according to dollar impact.



Source: AHA. (October 2012). RAC TRAC Survey

AHA analysis of survey data collected from 2,307 hospitals: 1,961 reporting activity, 347 reporting no activity through September 2012. 1,299 participating hospitals this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

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More than 60% of short-stay medical necessity denial dollars were denied because the care was provided in the wrong setting, not because the care was not medically necessary.

Reason for Medical Necessity Denials by Length of Stay Among Hospitals Reporting Medical Necessity Denials, through 3rd Quarter 2012

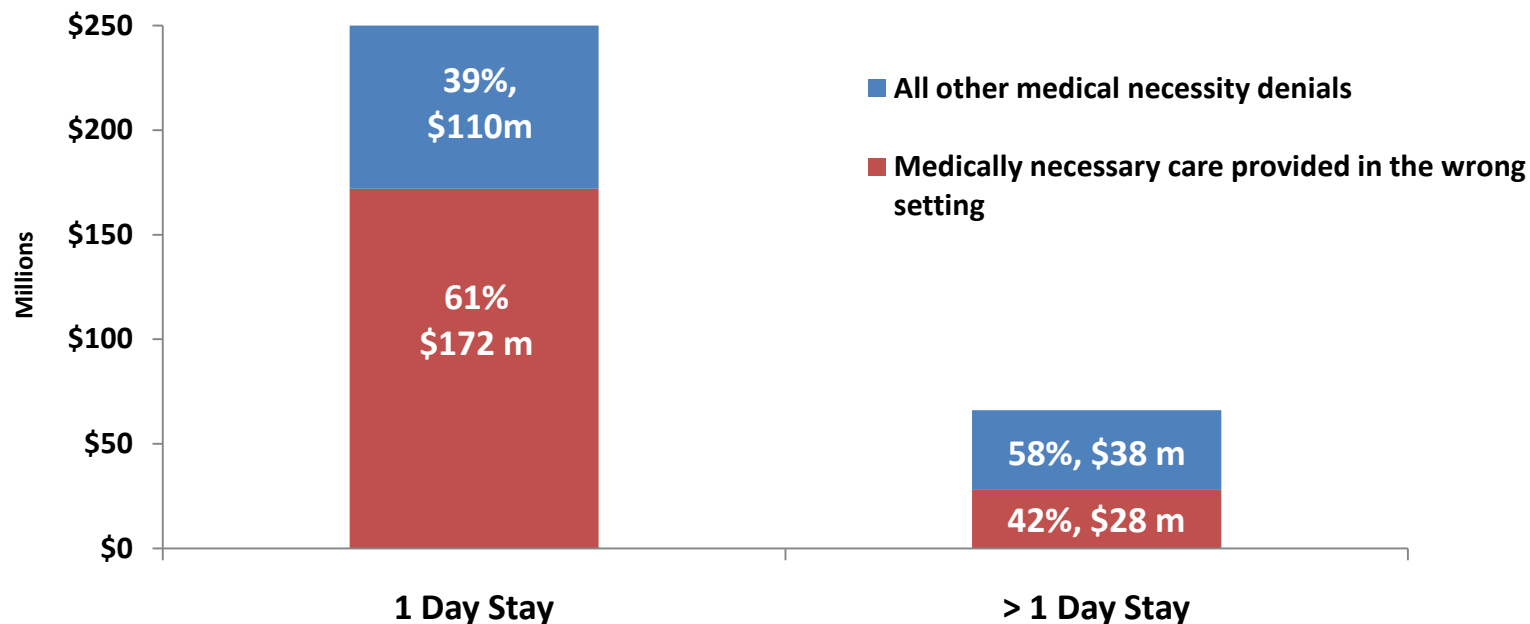


Chart includes hospitals reporting any inappropriate setting denials or the ability to track inappropriate setting denials. Not all hospital decision-support systems and RAC TRAC compatible vendors have made accommodations to allow hospitals to answer this question yet. As a result, the volume of medical necessity denials for inappropriate setting may be under-represented in this chart. Furthermore, older RAC claims may not be classified as "inappropriate setting" by the hospital.



Source: AHA. (October 2012). RAC TRAC Survey

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Syncope & Collapse, Stents were the top MS-DRGs denied by RACs in terms of dollar impact.

Percent of Participating Hospitals Reporting the MS-DRG for Medically Unnecessary and all other Complex Denials with the Largest Financial Impact, through 3rd Quarter 2012

Survey participants were asked to identify top MS-DRGs, according to dollar impact.

Medical Necessity Denials

MS-DRG	Description	% of Hospitals
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	23%
312	SYNCOPE & COLLAPSE	17%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	10%
313	CHEST PAIN	10%
491	BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	5%

All Other Complex Denials

MS-DRG	Description	% of Hospitals
312	SYNCOPE & COLLAPSE	6%
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	5%
981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	5%
166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	4%
313	CHEST PAIN	4%



Source: AHA. (October 2012). RAC TRAC Survey

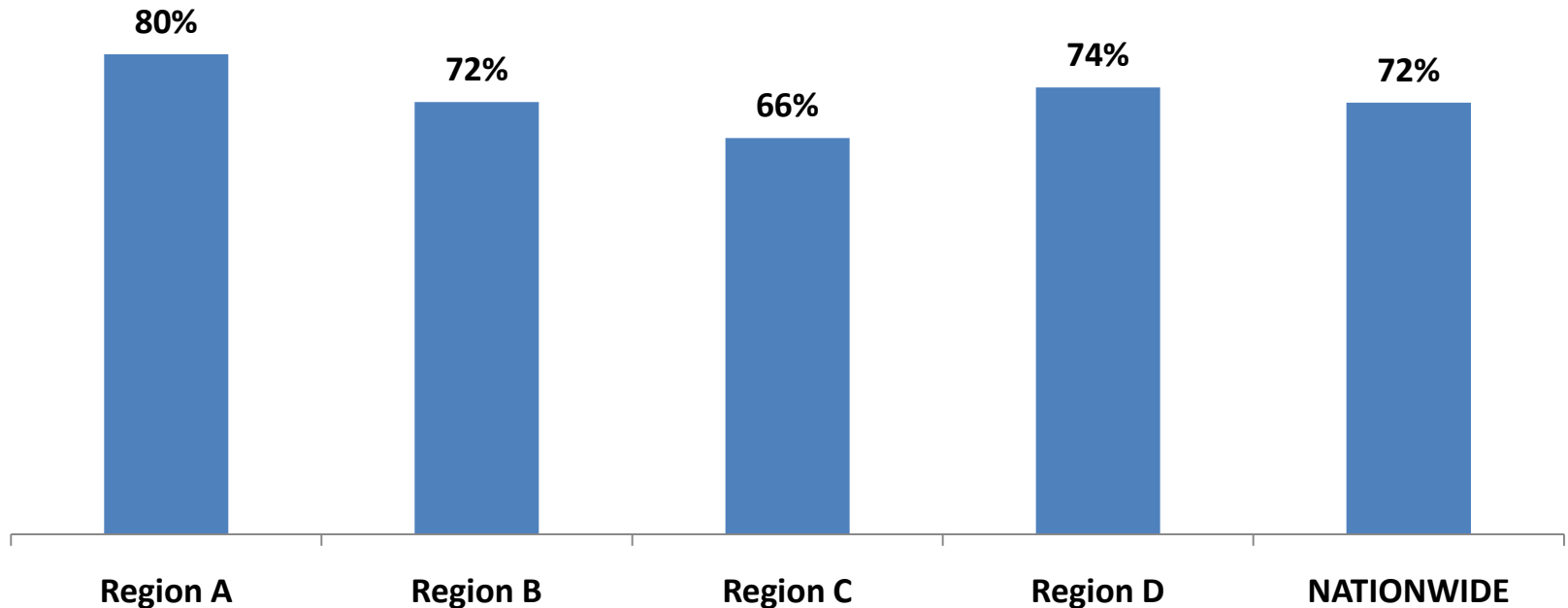
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Underpayments

Nearly three-quarters of participating hospitals nationwide with RAC activity reported receiving at least one underpayment determination.

Percent of Hospitals Reporting Underpayment Determinations, By Region, through 3rd Quarter 2012



Source: AHA. (October 2012). RAC TRAC Survey

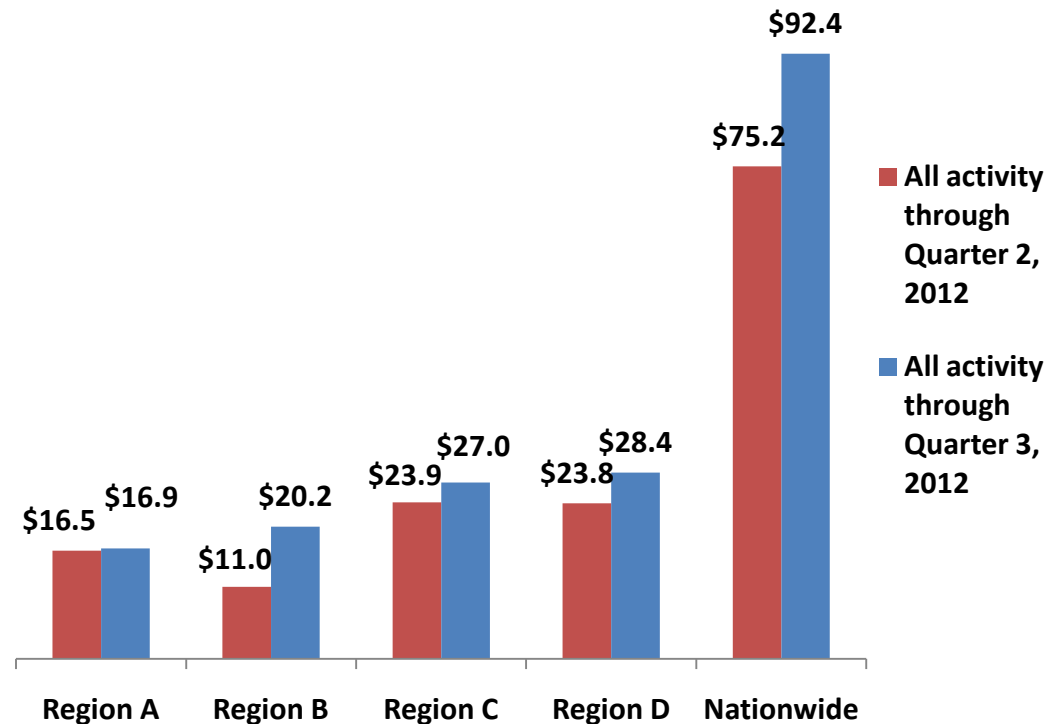
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Hospitals reported RAC-identified underpayments totaling \$92 million dollars.

Total Dollar Value of Underpayment Determinations for Participating Hospitals, By Region, through 2nd and 3rd Quarter 2012, in Millions

	Number of RAC Underpayment Determinations, through Quarter 3, 2012
NATIONWIDE	17,814
Region A	3,009
Region B	2,675
Region C	5,935
Region D	6,195



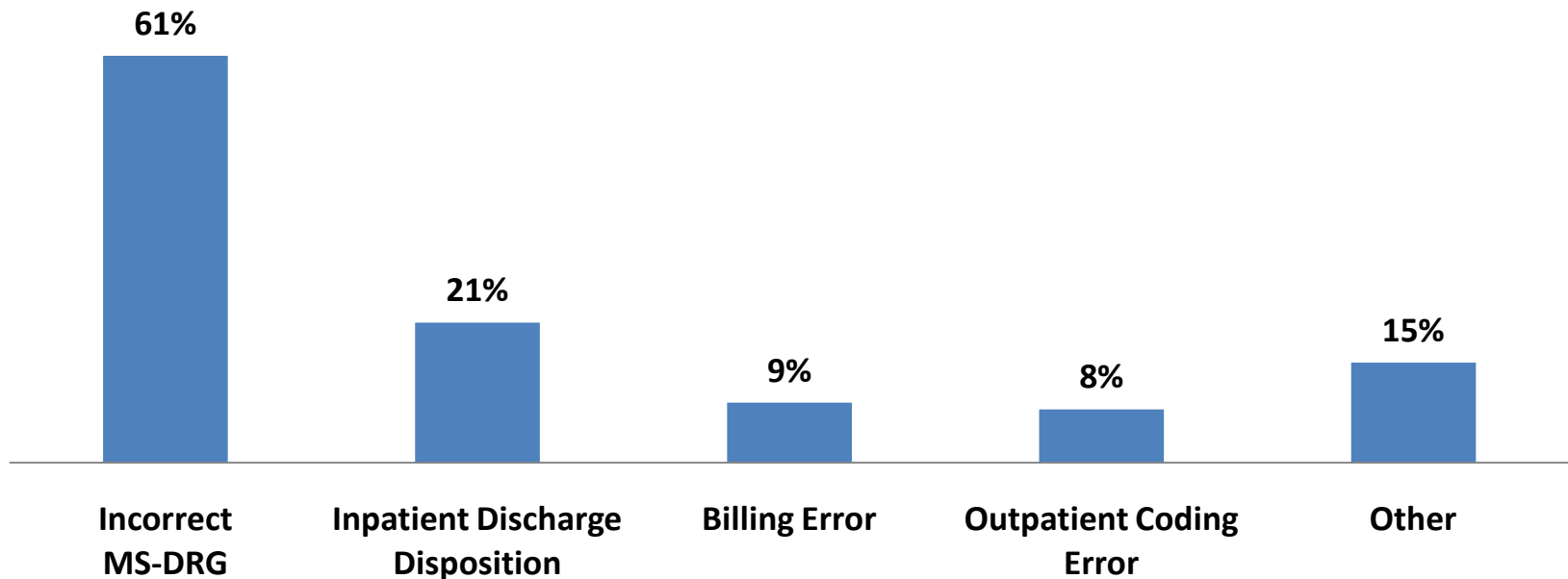
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61% of hospitals with underpayment determinations cited incorrect MS-DRG as a reason for the underpayment and 21% cited discharge disposition.

Percent of Participating Hospitals with RAC Activity Experiencing Underpayments by Reason, 3rd Quarter 2012

Survey participants were asked to select all reasons for underpayment.



Source: AHA. (October 2012). RAC TRAC Survey

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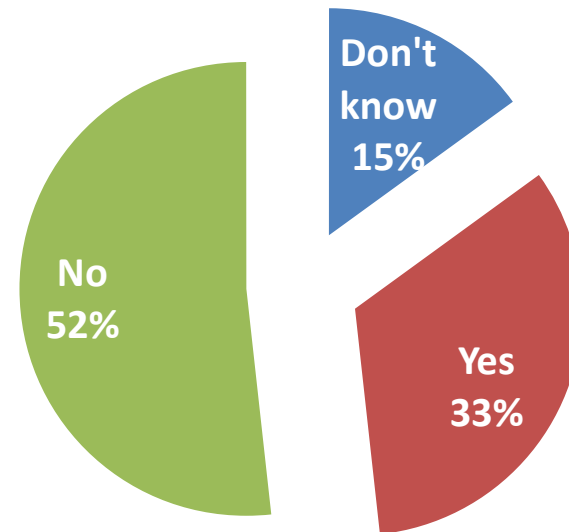
Appeals

One-third of participating hospitals report having a denial reversed during the discussion period.

Percent of Participating Hospitals With Denials Reversed During the Discussion Period, National and By Region, 3rd Quarter 2012

Reversed Denials by RAC Region

	Yes	No	Don't Know
Region A	44%	47%	9%
Region B	33%	52%	15%
Region C	29%	58%	13%
Region D	31%	45%	24%



*The discussion period is intended to be a tool that hospitals may use to reverse denials and avoid the formal Medicare appeals process. All RACs are required to allow a **discussion period** in which a hospital may share additional information and discuss the denial with the RAC. During the discussion period a hospital may gain more information from the RAC to better understand the cause for the denial and the RAC may receive additional information from the hospital that could potentially result in the RAC reversing its denial.*

Source: AHA. (October 2012). RACTRAC Survey

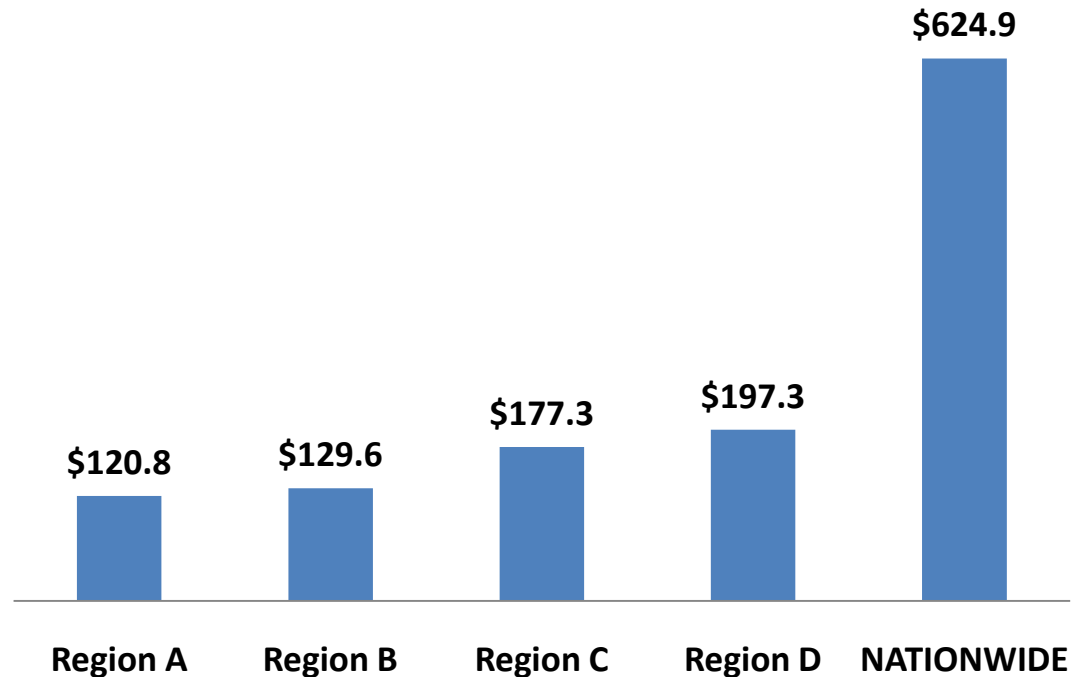
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The value of appealed claims exceeds a half a billion dollars. On average, hospitals report appealing 143 claims to date.

Total Dollar Value, Percent and Average Number of Appealed Claims for Hospitals with Automated or Complex RAC Denials, through 3rd Quarter 2012, Millions

	Percent of Hospitals with Any Appealed Denials	Average Number of Appealed Denials per Hospital
NATIONWIDE	84%	143
Region A	86%	160
Region B	88%	98
Region C	81%	143
Region D	81%	192



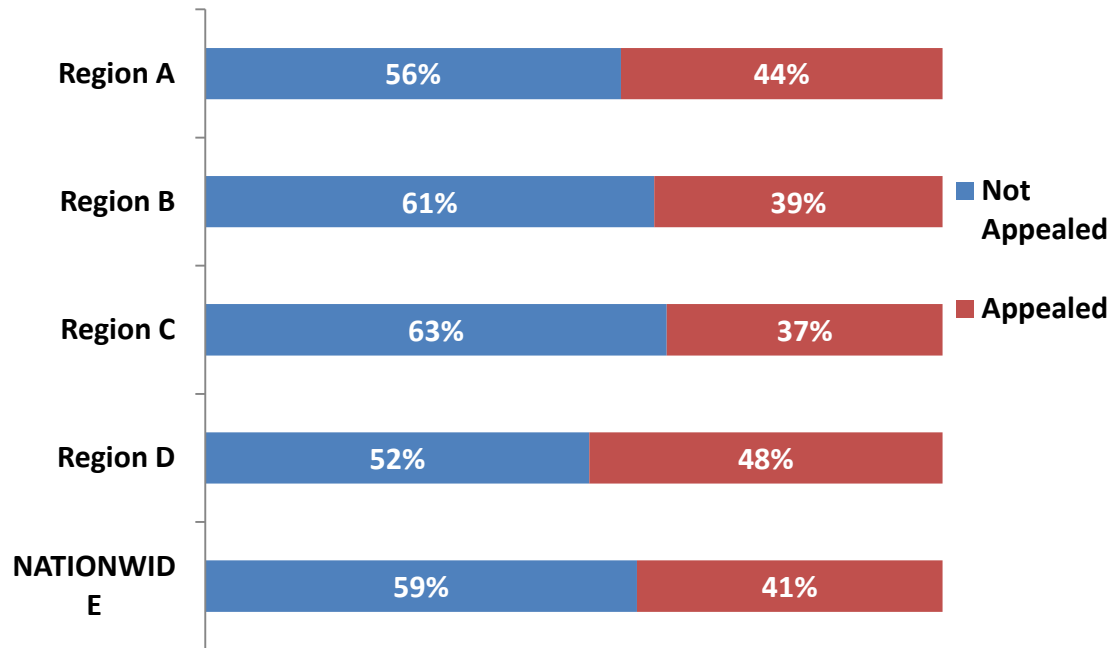
Source: AHA. (October 2012). RAC TRAC Survey

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Nationwide hospitals report appealing more than 40% of all denials. In Region D, nearly half have been appealed.

Total Number and Percent of Automated and Complex Denials Appealed by Hospitals with Automated or Complex RAC Denials, by Region, through 3rd Quarter 2012

	Total Number of Denials Available* for Appeal	Total Number of Denials Appealed
NATIONWIDE	265,518	110,159
Region A	51,285	22,376
Region B	55,157	21,575
Region C	95,699	35,826
Region D	63,377	30,382



* Available for appeal means that the hospital received a demand letter for this claim, as a result of either automated or complex review.

Source: AHA. (October 2012). RAC TRAC Survey

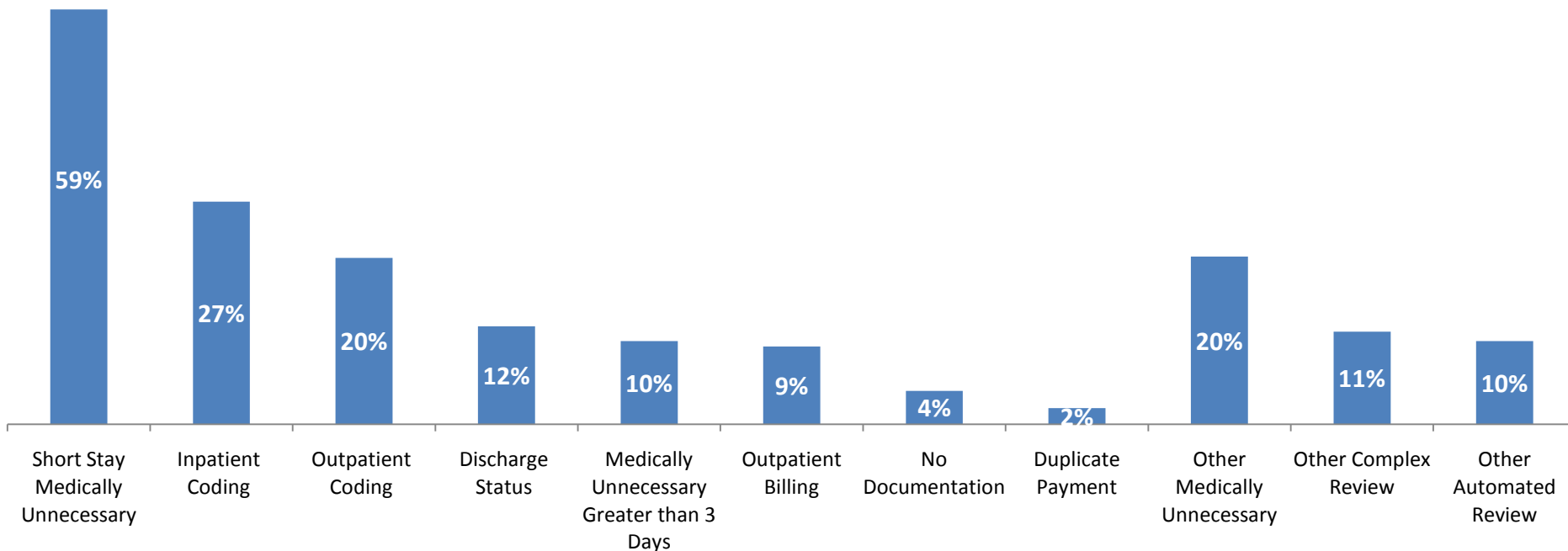
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Nearly 60% of all hospitals filing a RAC appeal during the 3rd Quarter of 2012 reported appealing short stay medically unnecessary denials.

Percent of Participating Medical/Surgical Acute Hospitals Reporting RAC Appeals by Denial Reason, 3rd Quarter 2012

Survey participants were asked to select all reasons for denial.



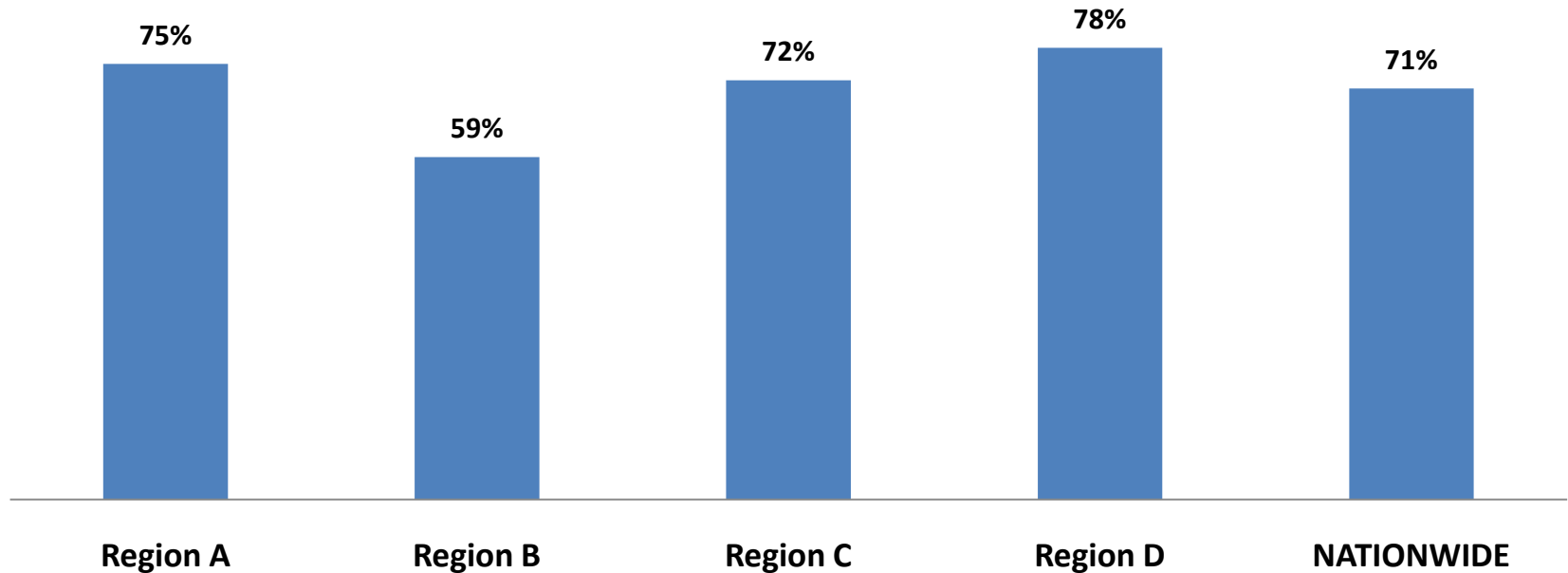
Source: AHA. (October 2012). RAC TRAC Survey

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Nearly three-fourths of all appealed claims are still sitting in the appeals process.

Percent of Appealed Claims Pending Determination for Participating Hospitals, by Region, through 3rd Quarter 2012



Manual survey entries only for Region A.



Source: AHA. (October 2012). RAC TRAC Survey

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Of the claims that have completed the appeals process, 74% were overturned in favor of the provider.

Summary of Appeal Rate and Determinations in Favor of the Provider, for Hospitals with Automated or Complex RAC Denials, through 3rd Quarter 2012

				Completed Appeals		
	Appealed	Percent of Denials Appealed	Number of Denials Awaiting Appeals Determination	Number of Denials Not Overturned from Appeals Process (Withdrawn/Not Continued)	Number of Denials Overturned in the Appeals Process	Percent of Appealed Denials Overturned (as a Percent of Total Completed Appeals)
NATIONWIDE	96,015	42%	68,415	7,113	19,996	74%
Region A*	8,232	51%	6,177	368	1,686	82%
Region B	21,575	39%	12,729	1,957	6,779	78%
Region C	35,826	37%	25,873	2,243	7,560	77%
Region D	30,382	48%	23,636	2,545	3,971	61%

Manual survey entries only for Region A. Due to survey submission error, total appeals may be greater than the sum of pending/withdrawn/overturned appeals.

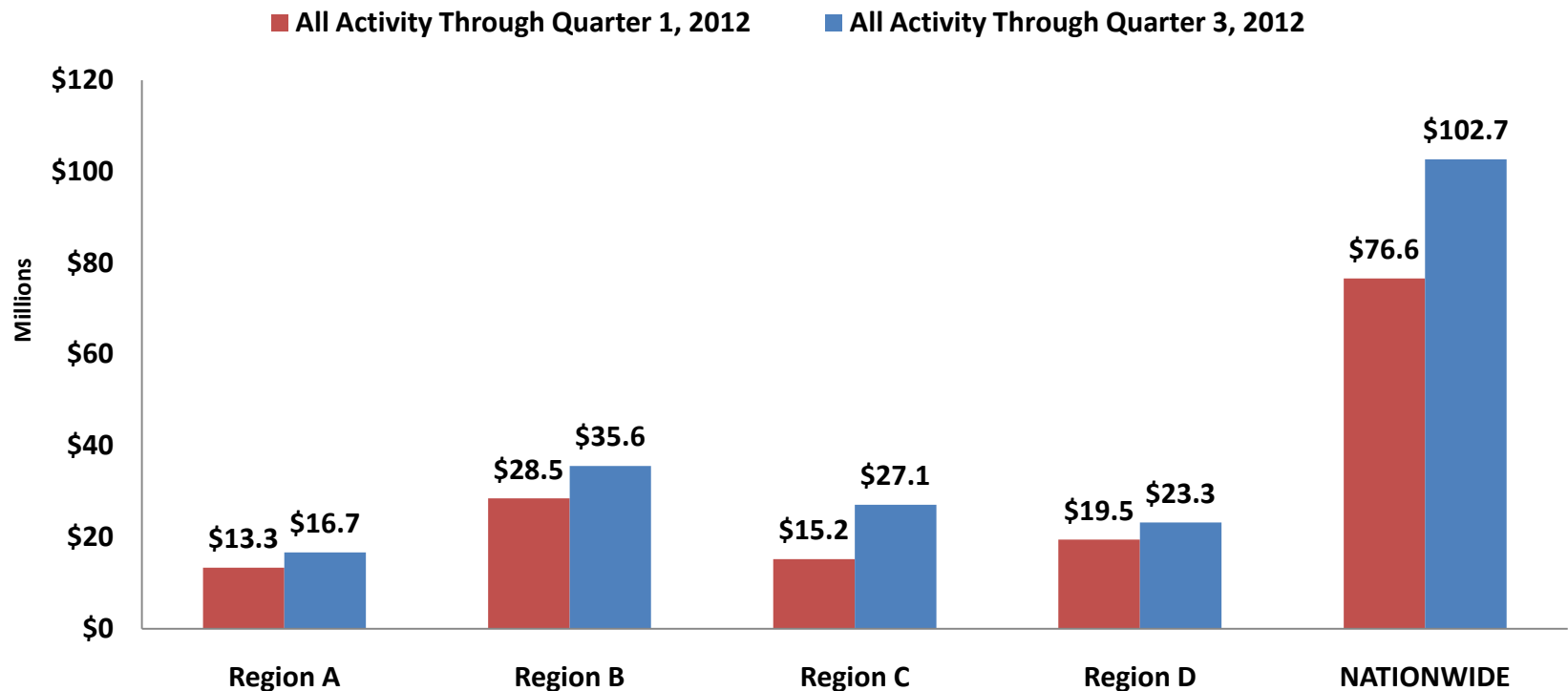


Source: AHA. (October 2012). RAC TRAC Survey

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Hospitals reported a total of \$76.6 million in overturned denials up nearly 50 percent versus last quarter.

Value of Denials Overturned in the Appeals Process, by Region, through 1st versus 2nd Quarter 2012, Millions



Source: AHA. (October 2012). RAC TRAC Survey

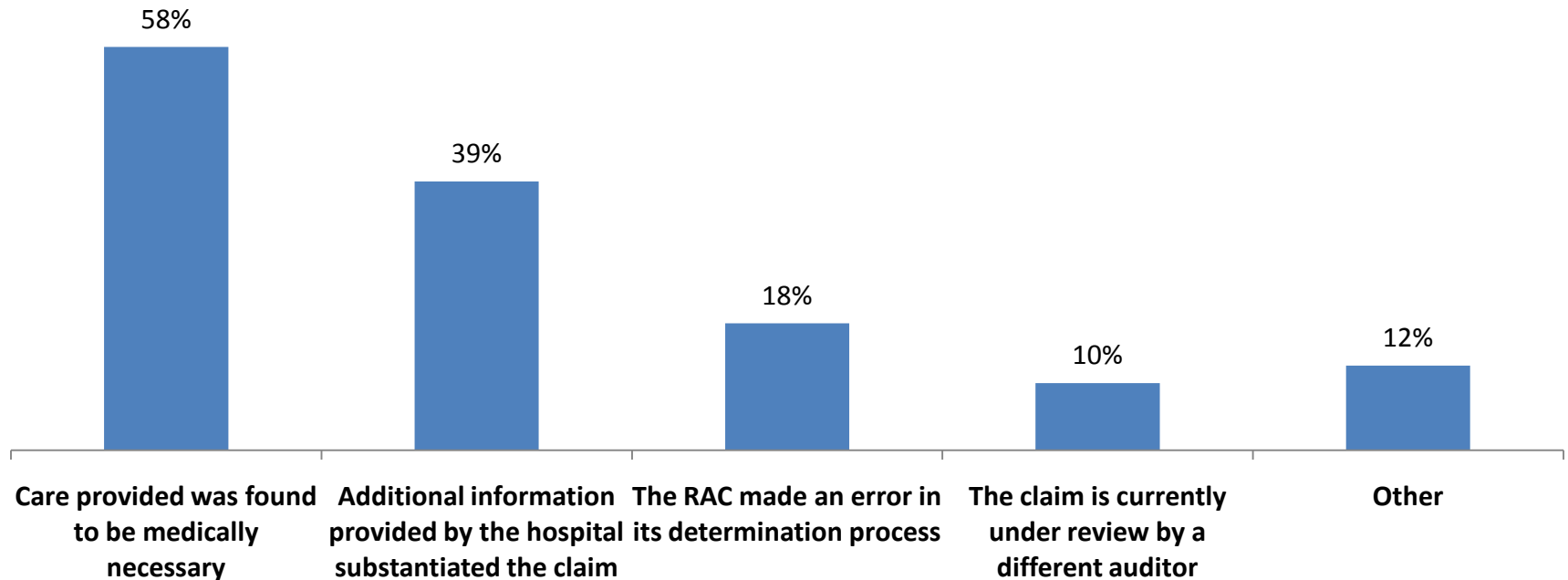
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More than half of all hospitals with a RAC denial overturned had a denial overturned because the care was found to be medically necessary.

Percent of Participating Hospitals That Had a Denial Overturned by Reason, 3rd Quarter 2012

Survey participants were asked to select all reasons for appeal overturn.



Source: AHA. (October 2012). RAC TRAC Survey

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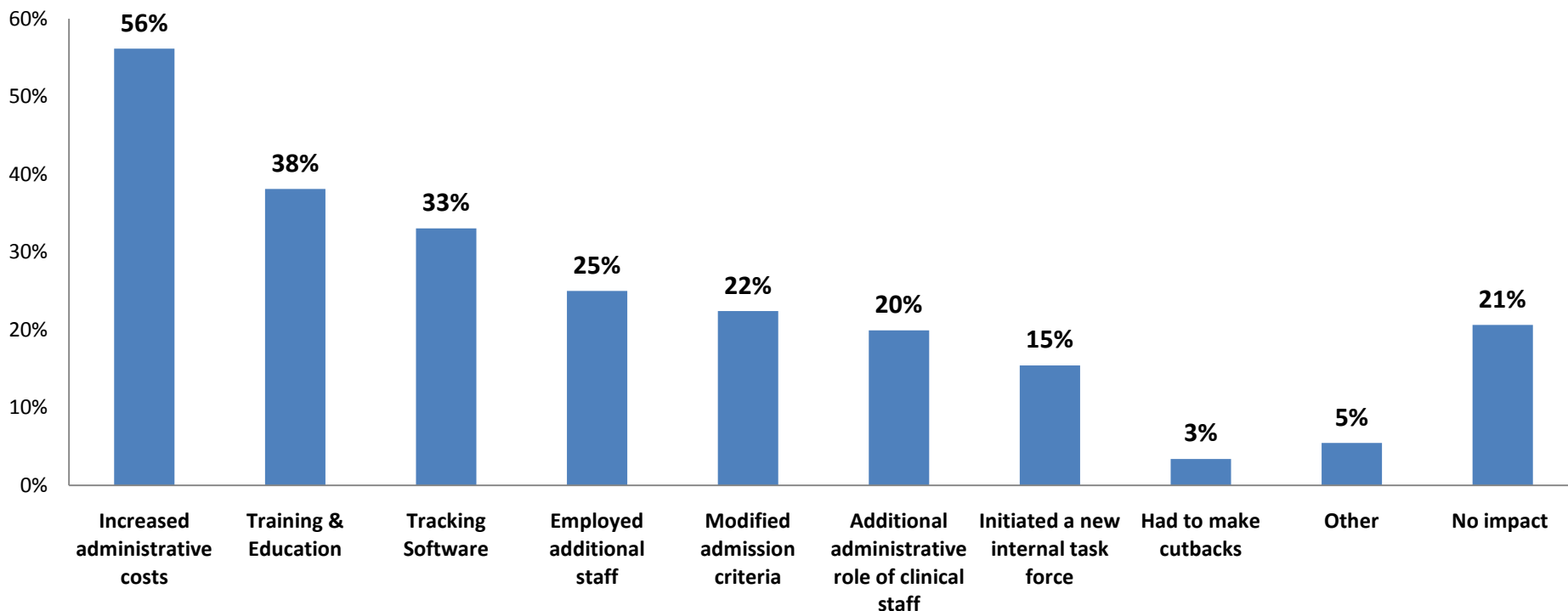
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Administrative Burden

79% of all participating hospitals reported that RAC impacted their organization this quarter and 56% reported increased administrative costs.

Impact of RAC on Participating Hospitals* by Type of Impact, 3rd Quarter 2012



* Includes participating hospitals with and without RAC activity

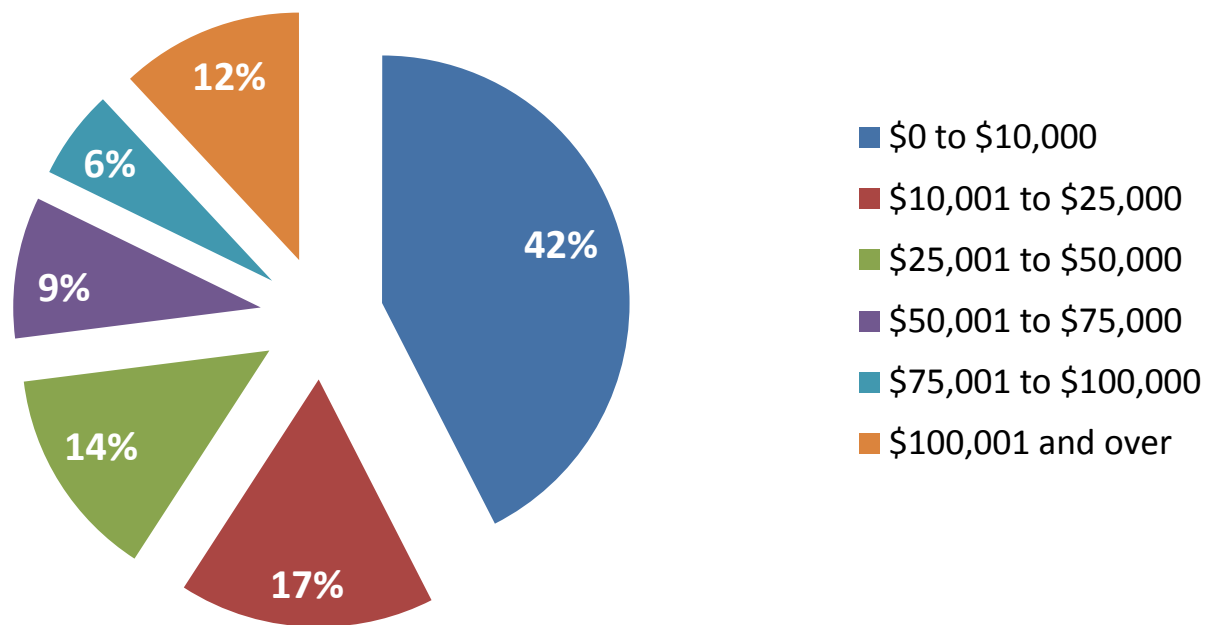
Source: AHA. (October 2012). RAC TRAC Survey

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58% of all hospitals reported spending more than \$10,000 managing the RAC process during the third quarter of 2012, 41% spent more than \$25,000 and 12% spent over \$100,000.

Percent of Participating Hospitals* Reporting Average Cost dealing with the RAC Program, 3rd Quarter 2012



* Includes participating hospitals with and without RAC activity

Source: AHA. (October 2012). RAC TRAC Survey

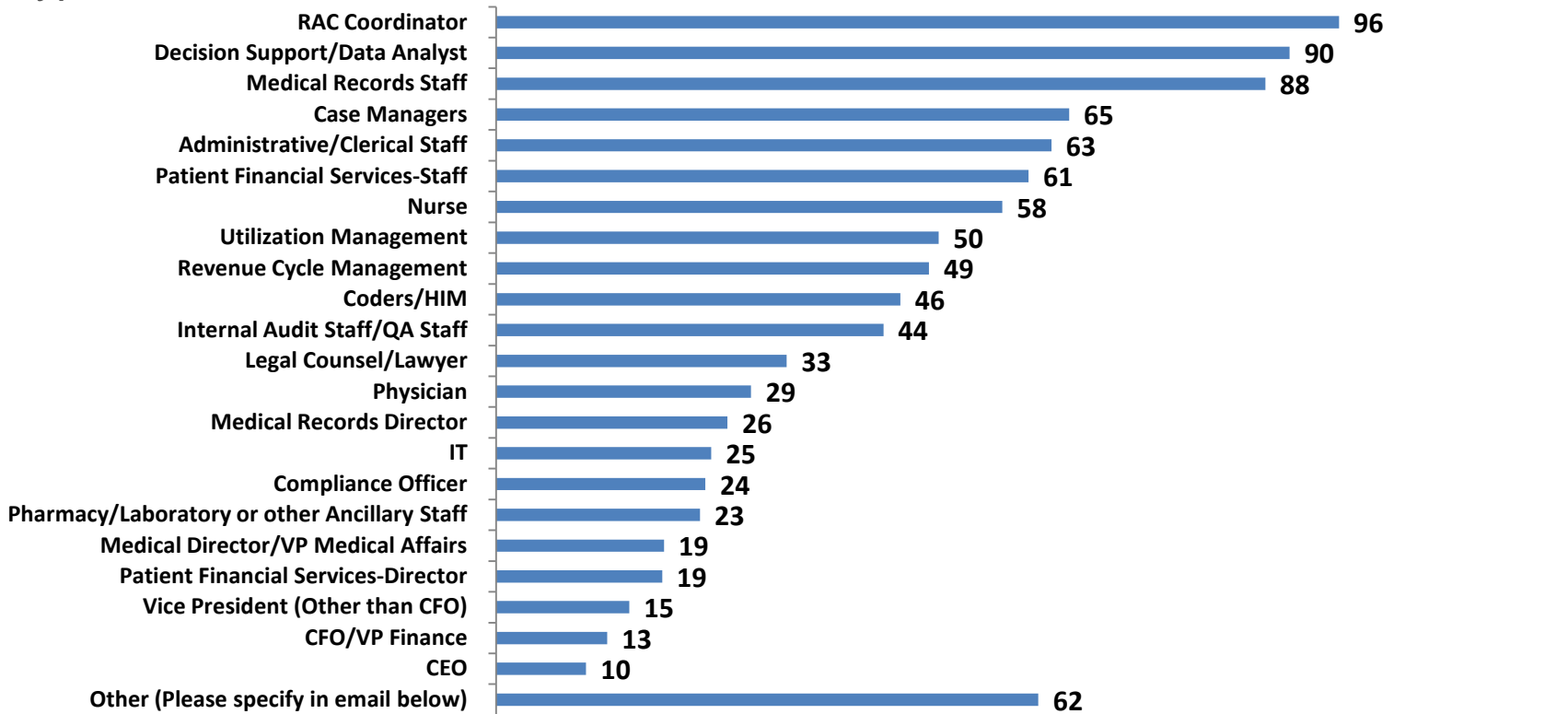
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Hospital staff spend hundreds of hours responding to RAC activity.

Average Hours of Staff Time Spent Per Participating Hospital* on RAC by Staff Type, 3rd Quarter 2012



* Includes participating hospitals with and without RAC activity

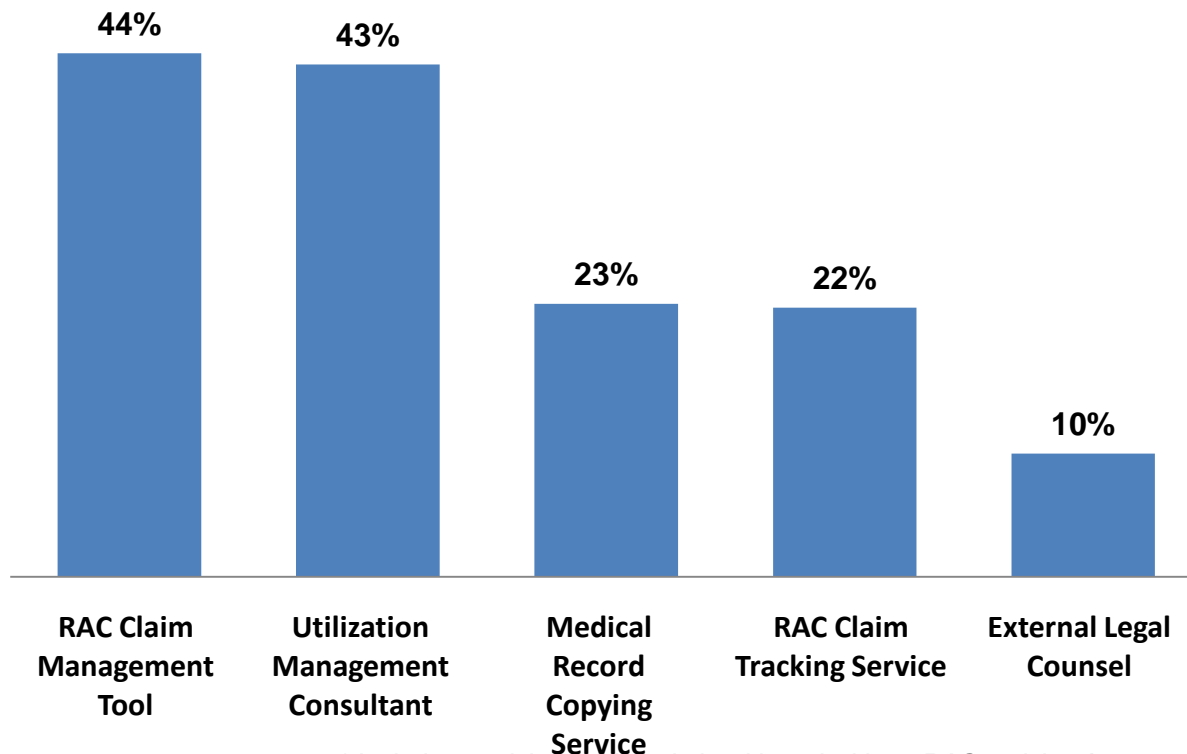


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Many hospitals report spending on external resources such as outside consultants to deal with the RAC process.

Percent of Participating Hospitals* that Use External Resources by Type and Average Dollars Spent *this quarter*, 3rd Quarter 2012



Administrative Burden	Average Dollar Amount This Quarter
Utilization Management Consultant	\$ 45,184
External Legal Counsel	\$ 23,175
RAC Claim Management Tool	\$ 8,977
RAC Claim Tracking Service	\$ 11,520
Medical Record Copying Service	\$ 3,572

* Includes participating hospitals with and without RAC activity. Average dollars spent and percentages reflect only those hospitals that reported utilizing external resources.

Source: AHA. (October 2012). RAC TRAC Survey

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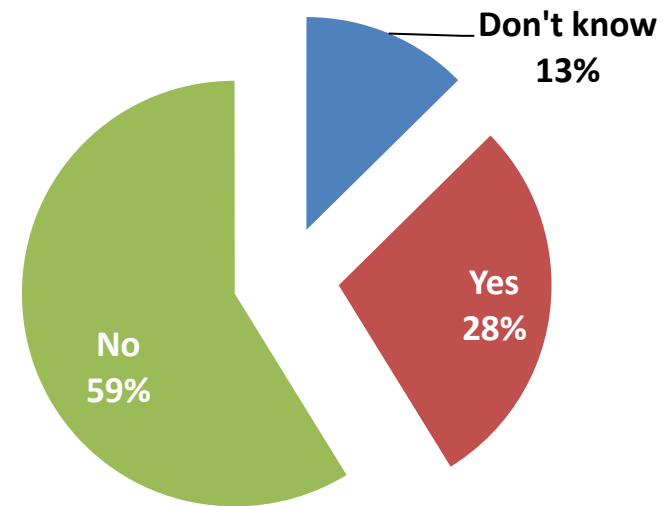
59% of respondents indicated they have yet to receive any education related to avoiding payment errors from CMS or its contractors.

Percent of Participating Hospitals Reporting they Received Education from CMS or its Contractors, National and by Region, through 3rd Quarter 2012

Reported Education by RAC Region

	Yes	No	Don't Know
Region A	36%	47%	17%
Region B	26%	58%	16%
Region C	28%	65%	7%
Region D	28%	59%	13%

National Reporting



* Includes participating hospitals with and without RAC activity

Source: AHA. (October 2012). RAC TRAC Survey

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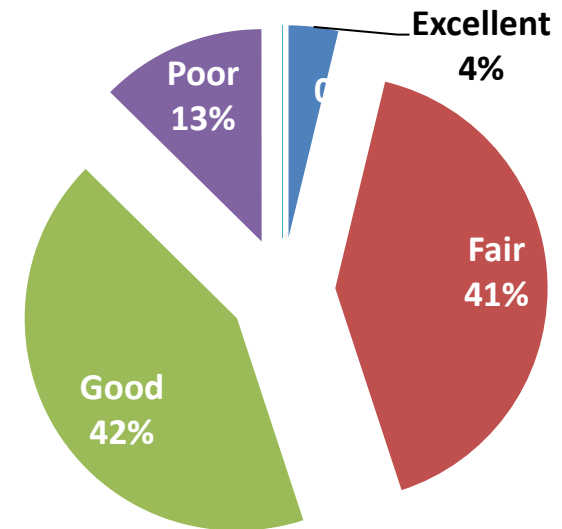
For those receiving education, the perceived quality varies by region with Region B performing the worst.

Percent of Participating Hospitals Reporting the Effectiveness of Received Education from CMS or its Contractors, National and by Region, through 3rd Quarter 2012

Reported Effectiveness of Education by RAC Region

	Excellent	Good	Fair	Poor
Region A	0%	54%	36%	10%
Region B	6%	30%	53%	11%
Region C	4%	44%	38%	14%
Region D	6%	53%	26%	15%

National Reporting



* Includes participating hospitals with and without RAC activity

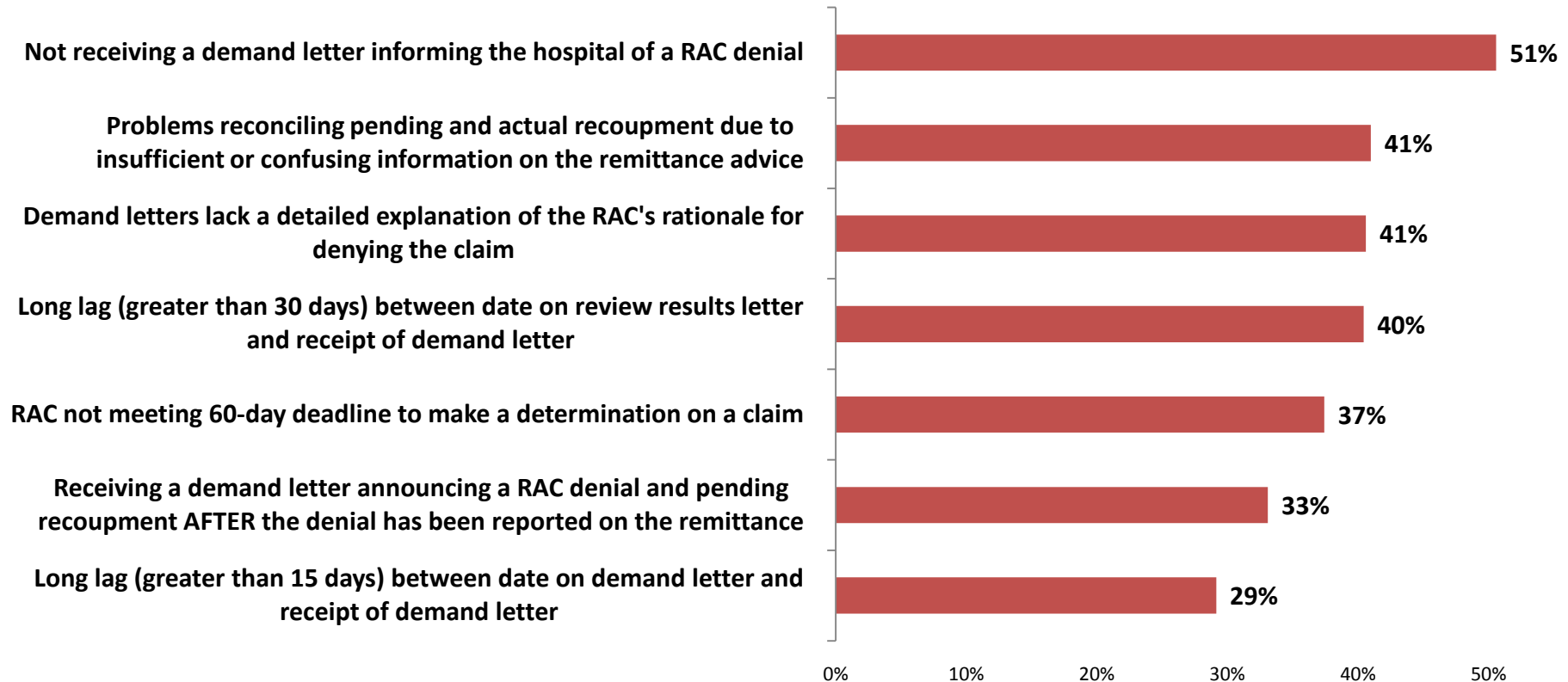
Source: AHA. (October 2012). RAC TRAC Survey

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More than 50% of hospitals reporting RAC process issues cite 'not receiving a demand letter' as an issue.

Percent of Participating Hospitals Reporting RAC Process Issues, by Issue, 3rd Quarter 2012



* Includes participating hospitals with and without RAC activity

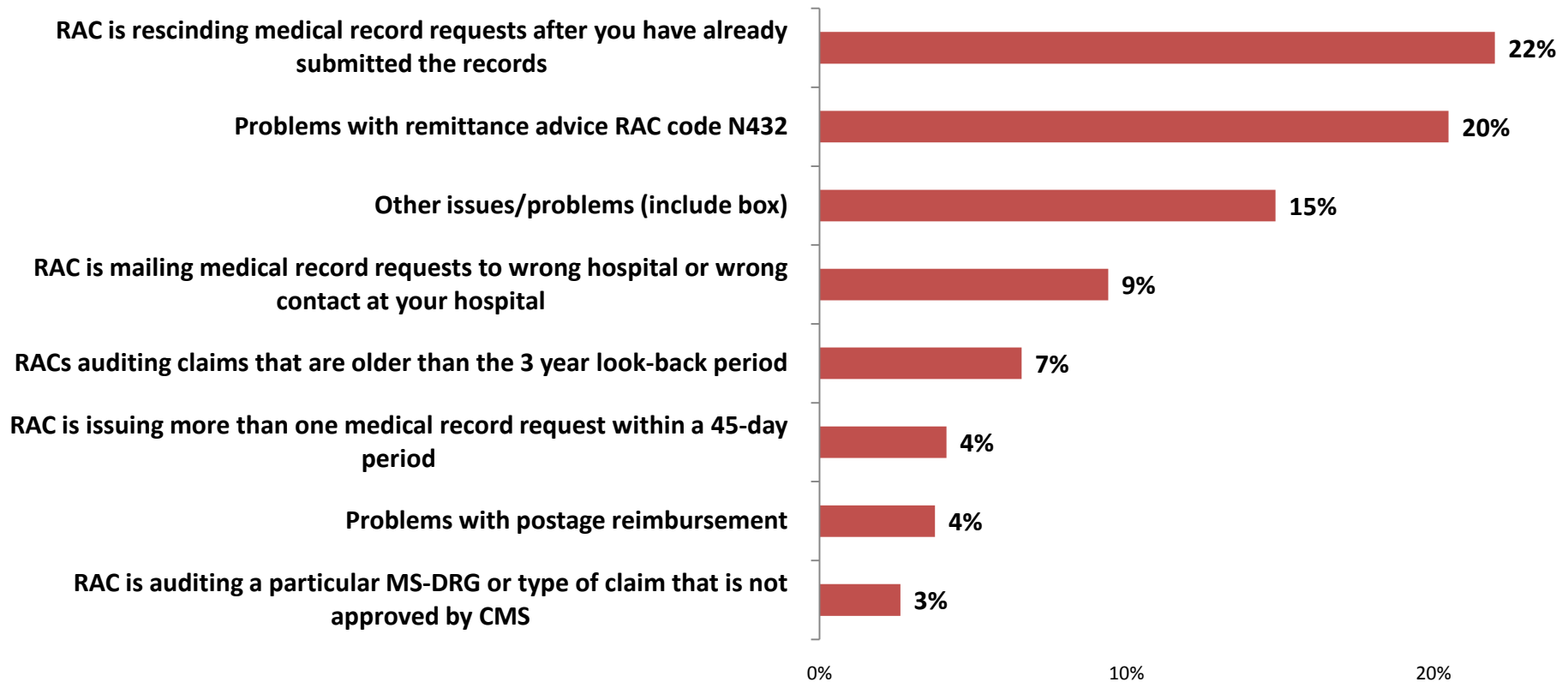
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Hospitals continue to report a wide variety of RAC process problems.

Percent of Participating Hospitals Reporting RAC Process Issues, by Issue, 3rd Quarter 2012



* Includes participating hospitals with and without RAC activity

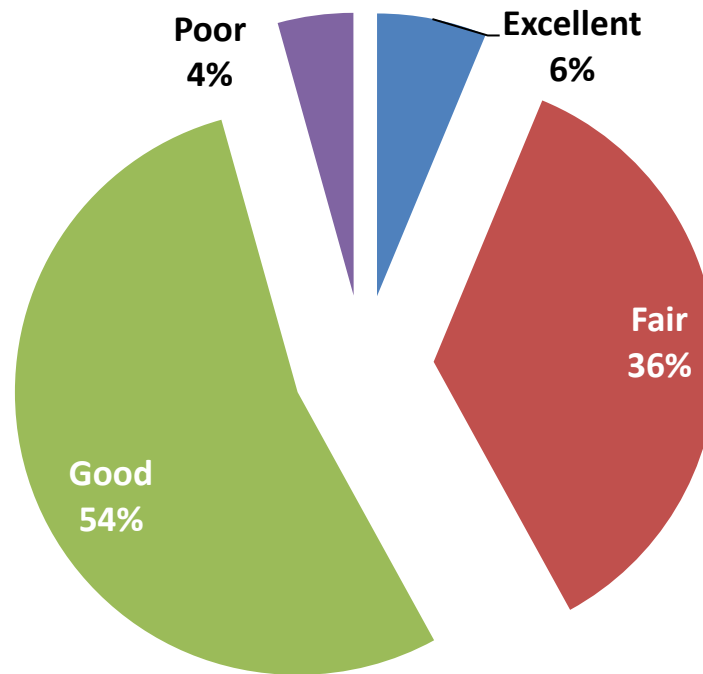
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The majority of hospital respondents indicated RAC responsiveness and overall communication was “fair” or “good.”

Participating Hospitals Rating of RAC Responsiveness and Overall Communication, 3rd Quarter 2012



Source: AHA. (October 2012). RAC TRAC Survey

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Participating hospitals rated RAC responsiveness and communication lowest in region B.

Participating Hospital Rating of RAC Responsiveness and Overall Communication, by Region, 3rd Quarter 2012

	Excellent	Good	Fair	Poor
Region A	16%	60%	23%	1%
Region B	3%	50%	40%	7%
Region C	5%	52%	40%	3%
Region D	4%	57%	34%	5%



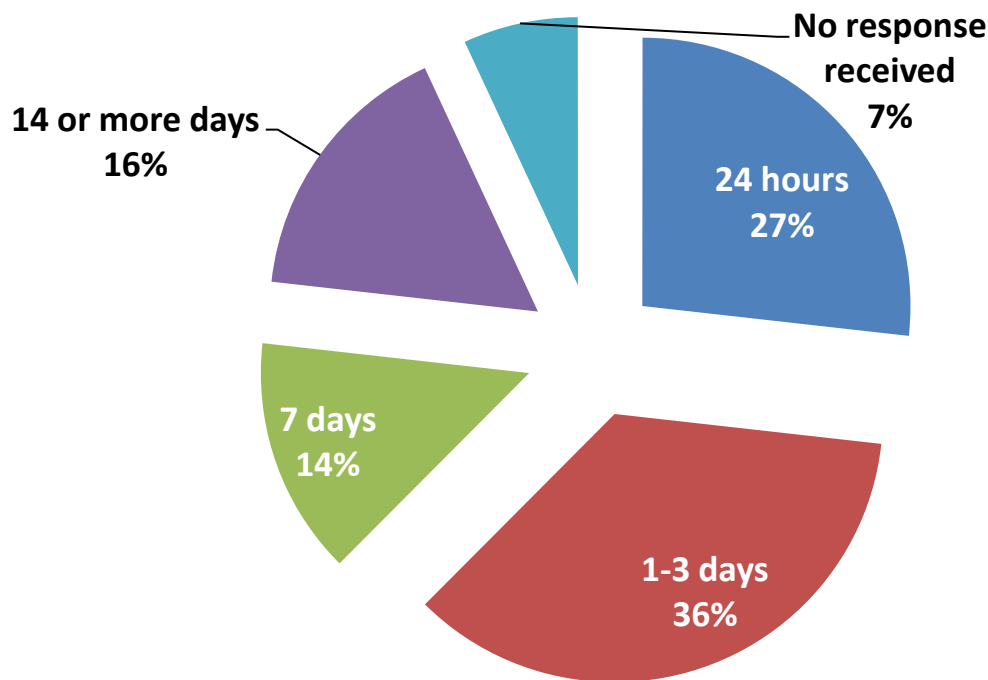
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The average wait time for a RAC response varied significantly, with nearly a quarter of hospitals reporting they did not receive a response from their RAC within 2 weeks.

Average Number of Days it Took RACs to Respond to Hospital Inquiries for Participating Hospitals, 3rd Quarter 2012



Source: AHA. (October 2012). RAC TRAC Survey

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RAC response time varied by region.

Average Number of Days For RACs to Respond to Hospital Inquiries for Participating Hospitals, by Region, 3rd Quarter 2012

	24 hours	1-3 days	7 days	14 or more days	No Response Received
Region A	49%	27%	13%	7%	4%
Region B	10%	44%	15%	21%	10%
Region C	31%	36%	9%	19%	5%
Region D	22%	32%	22%	15%	9%



Source: AHA. (October 2012). RAC TRAC Survey

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January 2013 RACTrac Data Collection Period

- Have your members contact **RACTrac Support** if they do not have your RACTrac registration information:
Ractracsupport@providercs.com or 1-888-722-8712
- RACTrac will collect data starting on January 1
- RACTrac will open at the beginning of each subsequent quarter to collect data on RAC activity experienced in the through the previous quarter



For more information visit AHA's RAC *TRAC* website:

www.aha.org/ractrac