Exploring the Impact of the RAC Program on Hospitals Nationwide

Results of AHA RACTRAC Survey, 2\textsuperscript{nd} Quarter 2013

September 19, 2013
Agenda

- Thanks for making RAC Trac a success!
- RAC legislative update
- RAC legal update
- RAC policy update
- Key findings of the RAC Trac Report, Q2 2013
- Q&A session
THANKS
To All Participating Hospitals for Submitting Your Data to RAC Trac!

2,425 Responding Hospitals; 1,273 Participating This Quarter
RAC Legislative Update

Robyn Bash, Senior Associate Director
The Medicare Audit Improvement Act of 2013 would:

- Establish a consolidated limit for medical requests
- Improve auditor performance by implementing financial penalties, and by requiring medical necessity audits to focus on widespread payment errors
- Improve RAC auditor transparency
- Restore due process rights under the AB rebilling demonstration
- Require physician review for Medicare denials...
- Medical necessity
- Allow denied inpatient claims to be billed as outpatient claims when appropriate

The AHA has hosted multiple sessions with hospital leaders and Congressional staff members to illustrate the need for RAC reform
“We’ll see what makes sense here...we’ll look at it, and seriously, because there are obviously some questions...we can’t overburden legitimate providers who play by the rules.”

“Such a high rate of reversals raises questions as to whether RACs are being too aggressive or do not understand current medical practice.”

Senators Sympathetic to Complaints That Medicare Audits Are Too Burdensome
By John Reichard

Senate Finance Committee members from both sides of the aisle expressed concern Tuesday that a Medicare program that audits provider reimbursement claims creates unreasonable administrative burdens on hospitals.

Such a high rate of reversals raises questions as to whether RACs are being too aggressive or do not understand current medical practice.
Congressional Support for H.R. 1250/S. 1012

• The following have formally co-sponsored H.R. 1250/S. 1012:
  – 146 co-sponsors in U.S. House of Representatives
    • Sam Graves (R-MO), lead sponsor
    • Adam Schiff (D-CA), lead sponsor
  – Seven co-sponsors in U.S. Senate
    • Mark Pryor (D-AR), lead sponsor
    • Roy Blunt (R-MO), lead sponsor
    • Barbara Boxer (D-CA)
    • Thad Cochran (R-MS)
    • Roger Wicker (R-MS)
    • Mark Begich (D-AK)
    • Lisa Murkowski (R-AK)

• Continued advocacy by hospitals, health systems and state associations is urgently needed in order to explain how RACs impact the hospitals serving their constituents and to ask for co-sponsorship of the Medicare Audit Improvement Act of 2013
RAC Legal Update

Lawrence Hughes, Assistant General Counsel
The AHA, et. al., v. Sebelius

- CMS’s motion to dismiss pending
- Court considering whether to hear oral argument
- Parties preparing briefs to address effect of final rebilling rule
RAC Policy Overview

- Part B Rebilling and the “Two-midnights” Rule
- Government Accountability Office Report
- Office of the Inspector General Report
- Delays in Administrative Law Judge Hearings
• 2014 IPPS rule finalized two policies:
  – Part B rebilling
  – “2-midnight” inpatient admission requirements and medical review criteria
• Both policies effective October 1, 2013
Part B Rebilling Policy

• Hospitals may rebill under Part B when:
  – Part A claim is denied by a Medicare contractor on the basis that the admission was not reasonable and necessary, or
  – The hospital determines during a self-audit that the inpatient admission was not reasonable and necessary.

• CMS continues to apply the one-year timely filing limit.
  – Claims rebilled under Part B after one year from the date of service will be rejected as untimely claim submissions, even if the Part A claim was timely filed.
Services Eligible for Rebilling

• All services “that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient.”

• Excludes services that require outpatient status:
  – Outpatient visits, including ED
  – Observation services
  – Outpatient diabetes self-management training services

• Includes outpatient services furnished during three days prior to inpatient admission
IPPS Final Rule’s Implications for the Appeals Process

- Hospital may not pursue Part A appeal and Part B rebilling at the same time
- CMS limited scope of Administrative Law Judges (ALJs) who hear third level appeals
  - ALJs may only determine whether Part A claim is reasonable and necessary
  - Cannot order payment under Part B
Interactions with Administrator’s Ruling

• Claims originally eligible for rebilling under March 13, 2013 Administrator’s Ruling are not impacted by the final rule

• Administrator’s Ruling also applies to claims for services provided before October 1, 2013 that are denied after September 30, 2013
  – There will continue to be claims eligible for rebilling under the Administrator’s Ruling for multiple years as a result of this determination

• Key difference with final rule – one-year timely filing limit does not apply for claims for services that are subject to the Administrator’s Ruling
“Two-midnight” Admission and Medical Review Criteria

• Changes to Part A requirements for admission and medical review criteria
  – Physician order and certification
  – Two-midnight benchmark
  – Two-midnight presumption
Physician Orders

• Physician or qualified practitioner must order inpatient admission in accordance with hospital conditions of participation

• Order must:
  – Include recommendation to admit “to inpatient,” “as an inpatient,” “for inpatient services,” or similar language
  – Be furnished at or before the time of the inpatient admission and documented in the medical record

• CMS’s September 5 guidance: order may be documented by an individual who is not a physician – such as physician assistants, residents or registered nurses – provided the documentation is consistent with State law, hospital policies, and medical staff bylaws and rules
Two-midnight Benchmark

- Applied by physicians/qualified practitioners at time of admission

- Should admit the beneficiary if:
  - Expect the beneficiary to remain in the hospital for more than two midnights, or
  - The beneficiary requires a procedure specified as inpatient-only.

- Time spent as outpatient “counts” for limited purpose of meeting two midnights

- Focus: reasonable expectation of the admitting physician/qualified practitioner
Two-midnight Presumption

- Applied by Medicare contractors during **medical review of inpatient admissions**

- Presumption that stays greater than two midnights after formal physician order are reasonable and necessary for purposes of Part A payment

- Medical review efforts:
  - Should not focus on stays crossing two midnights absent evidence of systematic gaming or abuse
  - Focus will shift to stays that cross fewer than two midnights
Implementation of Two-midnight Policy

• CMS Open Door Forums – next forum TBD

• Comments on subregulatory guidance: IPPSAdmissions@cms.hhs.gov
  – AHA requests to CMS:
    • Immediately implement two-midnight presumption, “counting” outpatient services toward two midnights, and limits to RAC review of medical information
    • At least three-month delay in all other provisions, including two-midnight benchmark and physician order and certification requirements

• AHA webinar on two-midnight policy
The GAO looked at the efficiency and effectiveness of Medicare contractors and administrative burden on providers

Conclusion: Contractors’ different process requirements impede efficiency and effectiveness and increase administrative burden for providers

Recommendation: CMS should reduce differences in contractors’ postpayment review requirements
The OIG looked at how CMS addresses payment vulnerabilities and potential fraud identified by RACs

Conclusions:
- RACs are only reporting limited cases of fraud to CMS – only 6 cases during FYs 2010 and 2011
- CMS does not evaluate RACs’ performance on all contract requirements, such as accuracy of identifying improper payments

Recommendations:
- CMS should ensure that RACs are educated regarding fraud and that all potential cases of fraud are referred to CMS
- CMS should develop additional performance metrics to improve RAC performance and ensure they are evaluated on contract requirements
Delay in Administrative Law Judge (ALJ) Hearings

- Requests for hearings received after July 15, 2013 will be held in the case processing system until there is room on an ALJ’s docket.

- CMS is currently estimating an 8-12 week delay to enter claims into the claims processing system, and a 28-month delay before an appeal will be assigned to an ALJ.
New AHA infographic on the RAC program illustrates the major problems with the RAC program.

- Encouraged use in conversations with legislators, policy audiences, and on social media.
- Infographic can be downloaded at www.aha.org/RAC.
AHA RAC and Audit Resources

**AHA is Helping Hospitals Improve Payment Accuracy and Advocating for Needed Improvements to the Medicare RAC Program**

- RAC Updates on latest RAC news and other RAC resources: [www.aha.org/rac](http://www.aha.org/rac)
- AHA RACTrac: [www.aha.org/ractrac](http://www.aha.org/ractrac); [www.aharactrac.com](http://www.aharactrac.com)
- 2012 AHA Audit Series: [www.aha.org/auditseries](http://www.aha.org/auditseries)
- Email RAC Questions: [racinfo@aha.org](mailto:racinfo@aha.org)
Executive Summary

- 2,425 hospitals have participated in RAC TRAC since data collection began in January of 2010. 1,273 hospitals participated this quarter.
- Participants continue to report dramatic increases in RAC activity:
  - Medical record requests have increased by 47% since Q4 2012.
  - The number of complex audit denials reported by respondents has increased by 58% since Q4 2012.
- 60% of medical records reviewed by RACs did not contain an overpayment, according to the RAC.
- 62% of short-stay denials for medical necessity were because the care was provided in the wrong setting, not because the care was medically unnecessary.
- 45% of participating hospitals reported having a RAC denial reversed through utilization of the discussion period.
RACTrac Participation Update

- THANK YOU for your participation
  - This is a pivotal time in RAC policy and it is essential that participating hospitals continue to submit data on an ongoing basis
  - The experience of hospitals participating in RAC Trac helps to counter claims being made by RACs on Capitol Hill and to other stakeholders

- Though RAC Trac data is powerful, it is still vitally important for hospitals to contact their Congressional offices and share the impact that RAC audits are having at the local (and constituent) level
Participants continue to report increases in RAC denials and medical record requests.

Reported Automated Denials, Complex Denials and Medical Records Requests by Participating Hospitals, through 2nd Quarter 2013*

*Response rates vary by quarter.

Source: AHA. (July 2013). RACTRAC Survey

AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
Region A reports the highest total number of medical record requests as well as has the highest average number of medical record requests per hospital.

Number of Medical Records Requested from Participating Hospitals With Complex Medical Record RAC Activity, through 2\textsuperscript{nd} Quarter 2013* 

<table>
<thead>
<tr>
<th>Region</th>
<th>Average Number of Medical Record Requests per Reporting Hospital, through Q2 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A</td>
<td>1,583</td>
</tr>
<tr>
<td>Region B</td>
<td>1,134</td>
</tr>
<tr>
<td>Region C</td>
<td>996</td>
</tr>
<tr>
<td>Region D</td>
<td>1,156</td>
</tr>
</tbody>
</table>

*Response rates vary by quarter.

Source: AHA. (July 2013). RACTrac Survey

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Among participating hospitals, $9.4 billion in Medicare payments were targeted for medical record requests through the 2nd quarter of 2013.

Medicare Payments Associated with Medical Records Requested from Participating Hospitals, through 2nd Quarter 2013, in Millions*

- Region A: $2,555 million ($3,106 million for Quarter 2, 2013)
- Region B: $1,931 million ($1,928 million for Quarter 1, 2013)
- Region C: $2,286 million ($2,394 million for Quarter 2, 2013)
- Region D: $1,894 million ($1,934 million for Quarter 2, 2013)

*Response rates vary by quarter.
Source: AHA. (July 2013). RAC TRAC Survey
AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
The average value of a medical record requested in a complex review was highest in Region A.

Average Value of a Medical Record Requested in a Complex Review Among Hospitals Reporting RAC Activity, through 2nd Quarter 2013

Source: AHA. (July 2013). RAC Trac Survey
AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
58% 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 2nd Quarter 2013

Source: AHA. (July 2013). RACTRAC Survey
AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
More than 65% of hospitals reported that over two-thirds of their claims were requested by a RAC after the timely filing window had elapsed.

Percent of Participating Hospitals Reporting the Percentage of Medical Records Requested after the Timely Filing Window had Elapsed, through 2nd Quarter 2013

<table>
<thead>
<tr>
<th>Percentage Range</th>
<th>Participating Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>less than 45%</td>
<td>23%</td>
</tr>
<tr>
<td>45%-54%</td>
<td>6%</td>
</tr>
<tr>
<td>55%-64%</td>
<td>5%</td>
</tr>
<tr>
<td>65%-74%</td>
<td>10%</td>
</tr>
<tr>
<td>75%-84%</td>
<td>21%</td>
</tr>
<tr>
<td>85%-94%</td>
<td>14%</td>
</tr>
<tr>
<td>95% or more</td>
<td>22%</td>
</tr>
</tbody>
</table>

Source: AHA. (July 2013). RAC TRAC Survey
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$2.2 billion in denials were reported through the 2\textsuperscript{nd} quarter of 2013.

Dollar Value of Automated and Complex Denials by RAC Region for Participating Hospitals, through 2\textsuperscript{nd} Quarter 2013, in Millions*

<table>
<thead>
<tr>
<th>Region</th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$282.3</td>
</tr>
<tr>
<td>B</td>
<td>$254.1</td>
</tr>
<tr>
<td>C</td>
<td>$310.4</td>
</tr>
<tr>
<td>D</td>
<td>$369.1</td>
</tr>
</tbody>
</table>

*Response rates vary by quarter.

Source: AHA. (July 2013). RAC TRAC Survey
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The average dollar value of an automated denial was $576 and the average dollar value of a complex denial was $5,704.

Average Dollar Value of Automated and Complex Denials Among Hospitals Reporting RAC Denials, through 2\textsuperscript{nd} Quarter 2013

<table>
<thead>
<tr>
<th>RAC Region</th>
<th>Automated Denial</th>
<th>Complex Denial</th>
</tr>
</thead>
<tbody>
<tr>
<td>NATIONWIDE</td>
<td>$576</td>
<td>$5,704</td>
</tr>
<tr>
<td>Region A</td>
<td>$365</td>
<td>$5,906</td>
</tr>
<tr>
<td>Region B</td>
<td>$641</td>
<td>$5,020</td>
</tr>
<tr>
<td>Region C</td>
<td>$618</td>
<td>$5,319</td>
</tr>
<tr>
<td>Region D</td>
<td>$565</td>
<td>$6,386</td>
</tr>
</tbody>
</table>

Source: AHA. (July 2013). RAC TRAC Survey
AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
In terms of dollars, 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, 2nd Quarter 2013

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

Source: AHA. (July 2013). RAC Trac Survey
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Automated RAC Denials
Region C continues to experience the vast majority of all automated denial activity.

Number of Reported Automated Denials for Participating Hospitals, by Region, through 2nd Quarter 2013

Source: AHA. (July 2013). RACTrac Survey
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Complex RAC Denials
Stents and Syncope & Collapse 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 2nd Quarter 2013

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

<table>
<thead>
<tr>
<th>Medical Necessity Denials</th>
<th>All Other Complex Denials</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MS-DRG</strong></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>247</td>
<td>PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC</td>
</tr>
<tr>
<td>312</td>
<td>SYNCOPE &amp; COLLAPSE</td>
</tr>
<tr>
<td>392</td>
<td>ESOPHAGITIS, GASTROENT &amp; MISC DIGEST DISORDERS W/O MCC</td>
</tr>
<tr>
<td>313</td>
<td>CHEST PAIN</td>
</tr>
<tr>
<td>491</td>
<td>BACK &amp; NECK PROC EXC SPINAL FUSION W/O CC/MCC</td>
</tr>
</tbody>
</table>

Source: AHA. (July 2013). RACTrac Survey
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62% of short-stay denials for medical necessity were because the care was provided in the wrong setting, not because the care was medically unnecessary.

### Reason for Medical Necessity Denials by Length of Stay Among Hospitals Reporting Medical Necessity Denials, through 2nd Quarter 2013

<table>
<thead>
<tr>
<th>Category</th>
<th>Denial Reason</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Day Stay</td>
<td>Medically necessary care provided in the wrong setting</td>
<td>$179 m</td>
</tr>
<tr>
<td></td>
<td>All other medical necessity denials</td>
<td>$109 m</td>
</tr>
<tr>
<td>&gt; 1 Day Stay</td>
<td>Medically necessary care provided in the wrong setting</td>
<td>$59 m</td>
</tr>
<tr>
<td></td>
<td>52%, 62%</td>
<td>$179 m</td>
</tr>
<tr>
<td></td>
<td>38%, 62%</td>
<td>$109 m</td>
</tr>
</tbody>
</table>

*Chart includes hospitals reporting any inappropriate setting denials or the ability to track inappropriate setting denials. Not all hospital decision-support systems and RACTrac 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. (July 2013). RACTrac Survey
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Appeals
45% of participating hospitals report having a denial reversed during the discussion period, including 60% of hospitals in Region A.

Percent of Participating Hospitals with Denials Reversed During the Discussion Period, National and by Region, 2nd Quarter 2013

Reversed Denials by RAC Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Don't Know (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A</td>
<td>60</td>
<td>34</td>
<td>6</td>
</tr>
<tr>
<td>Region B</td>
<td>46</td>
<td>50</td>
<td>4</td>
</tr>
<tr>
<td>Region C</td>
<td>41</td>
<td>53</td>
<td>6</td>
</tr>
<tr>
<td>Region D</td>
<td>35</td>
<td>54</td>
<td>11</td>
</tr>
</tbody>
</table>

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. (July 2013). RACTRAC Survey

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The value of appealed claims is approaching $1.1 billion dollars. Hospitals report appealing an average of 247 claims to date.

Total Dollar Value, Percent and Average Number of Appealed Claims for Hospitals with Automated or Complex RAC Denials, through 2\textsuperscript{nd} Quarter 2013, Millions

<table>
<thead>
<tr>
<th>Region</th>
<th>Percent of Hospitals with Any Appealed Denials</th>
<th>Average Number of Appealed Denials per Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>NATIONWIDE</td>
<td>81%</td>
<td>247</td>
</tr>
<tr>
<td>Region A</td>
<td>75%</td>
<td>234</td>
</tr>
<tr>
<td>Region B</td>
<td>83%</td>
<td>180</td>
</tr>
<tr>
<td>Region C</td>
<td>89%</td>
<td>248</td>
</tr>
<tr>
<td>Region D</td>
<td>76%</td>
<td>322</td>
</tr>
</tbody>
</table>

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Nationwide hospitals report appealing 40% of all denials.

Total Number and Percent of Automated and Complex Denials Appealed by Hospitals with Automated or Complex RAC Denials, by Region, through 2nd Quarter 2013

<table>
<thead>
<tr>
<th>Region</th>
<th>Total Number of Denials Available* for Appeal</th>
<th>Total Number of Denials Appealed</th>
</tr>
</thead>
<tbody>
<tr>
<td>NATIONWIDE</td>
<td>463,259</td>
<td>184,607</td>
</tr>
<tr>
<td>Region A</td>
<td>108,630</td>
<td>33,723</td>
</tr>
<tr>
<td>Region B</td>
<td>70,338</td>
<td>30,482</td>
</tr>
<tr>
<td>Region C</td>
<td>172,489</td>
<td>66,558</td>
</tr>
<tr>
<td>Region D</td>
<td>111,802</td>
<td>53,844</td>
</tr>
</tbody>
</table>

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

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Hospitals are receiving many notices from QICs stating that issuing a determination on a RAC appeal will take longer than the statutory maximum of 60 days.

Average Number of Claims per Participating Hospital Where the QIC Reported the Inability to Complete an Appeal Review within the Required 60 Day Window from Receipt, through 2\textsuperscript{nd} Quarter 2013

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A</td>
<td>86</td>
</tr>
<tr>
<td>Region B</td>
<td>34</td>
</tr>
<tr>
<td>Region C</td>
<td>70</td>
</tr>
<tr>
<td>Region D</td>
<td>104</td>
</tr>
<tr>
<td>Nationwide</td>
<td>72</td>
</tr>
</tbody>
</table>

**Source:** AHA. (July 2013). RAC TRAC Survey

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95% of reporting hospitals have experienced at least one delay longer than the statutory limit of 90 days for an ALJ determination to be issued.

Percentage of Reporting Hospitals by Longest Delay Experienced for ALJ to Issue a Decision on an Appeal, for Participating Hospitals, 2nd Quarter 2013

- Less than 90 days: 5%
- 91-100 days: 5%
- 101-110 days: 3%
- 111 to 120 days: 6%
- 120+ days: 81%

Source: AHA. (July 2013). RAC Trac Survey
AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
For over 40% of claims appealed to the ALJ, the judge has taken longer than the statutory limit of 90 days to provide a determination to the hospital.

Percent of Appeals for which ALJ has taken Longer than the Statutory Maximum of 90 Calendar Days to Issue a Decision, through 2\textsuperscript{nd} Quarter 2013

Source: AHA. (July 2013). RAC\textsuperscript{TRAC} Survey
AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
18% of reporting hospitals reported having claims denied for DRG Validation converted into full medical necessity denials when the determination was appealed.

Percent of Responding Hospitals Experiencing Denied Claims Converted to Full Medical Necessity Denials during Appeals Process, 2nd Quarter 2013

Source: AHA. (July 2013). RACTrac Survey
AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
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 2\textsuperscript{nd} Quarter 2013*

- **74%** for Region A
- **67%** for Region B
- **77%** for Region C
- **76%** for Region D
- **75%** NATIONWIDE

*Manual survey entries only for Region A.*

*Response rates vary by quarter.

Source: AHA. (July 2013). RAC TRAC Survey

AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
Of the claims that have completed the appeals process, 70% 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 2\textsuperscript{nd} Quarter 2013*

<table>
<thead>
<tr>
<th>Region</th>
<th>Appealed</th>
<th>Percent of Denials Appealed</th>
<th>Number of Denials Awaiting Appeals Determination</th>
<th>Number of Claims Withdrawn from Appeals Process</th>
<th>Number of Denials Overturned in the Appeals Process</th>
<th>Percent of Appealed Denials Overturned (as a Percent of Overturned or Withdrawn claims)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NATIONWIDE</td>
<td>167,119</td>
<td>43%</td>
<td>125,181</td>
<td>12,354</td>
<td>29,452</td>
<td>70%</td>
</tr>
<tr>
<td>Region A</td>
<td>16,235</td>
<td>44%</td>
<td>12,020</td>
<td>1,238</td>
<td>2,976</td>
<td>71%</td>
</tr>
<tr>
<td>Region B</td>
<td>30,482</td>
<td>43%</td>
<td>20,574</td>
<td>2,267</td>
<td>7,599</td>
<td>77%</td>
</tr>
<tr>
<td>Region C</td>
<td>66,558</td>
<td>39%</td>
<td>51,525</td>
<td>3,873</td>
<td>11,114</td>
<td>74%</td>
</tr>
<tr>
<td>Region D</td>
<td>53,844</td>
<td>48%</td>
<td>41,062</td>
<td>4,976</td>
<td>7,763</td>
<td>61%</td>
</tr>
</tbody>
</table>

**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.**

*Response rates vary by quarter.

Source: AHA. (July 2013). RAC TRAC Survey

AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
Hospitals reported a total of $169.4 million in overturned denials, with $54.8 million in Region C alone.

Value of Denials Overturned in the Appeals Process, by Region, through 2\textsuperscript{nd} Quarter 2013, in Millions

Source: AHA. (July 2013). RAC\textsuperscript{Trac} Survey
AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
Over 60% of hospitals with a RAC denial overturned had a denial reversed because the care was found to be medically necessary.

Percent of Participating Hospitals That Had a Denial Overturned by Reason, 2nd Quarter 2013

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

- 61% Care provided was found to be medically necessary
- 37% Additional information provided by the hospital substantiated the claim
- 16% The RAC made an error in its determination process
- 8% The claim is currently under review by a different auditor
- 12% Other

Source: AHA. (July 2013). RAC Trac Survey
AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
Administrative Burden
Hospitals experience many types of impacts due to RACs; over half of all reporting hospitals noted they had increased administrative costs due to the program.

Impact of RAC on Participating Hospitals* by Type of Impact, 2nd Quarter 2013

* Includes participating hospitals with and without RAC activity

Source: AHA. (July 2013). RAC Trac Survey

AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
63% of all hospitals reported spending more than $10,000 managing the RAC process during the 2\textsuperscript{nd} quarter of 2013, 45% spent more than $25,000 and 11% spent over $100,000.

Percent of Participating Hospitals* Reporting Average Cost Dealing with the RAC Program, 2\textsuperscript{nd} Quarter 2013

* Includes participating hospitals with and without RAC activity

Source: AHA. (July 2013). RAC\textsuperscript{Trac} Survey

AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
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*, 2nd Quarter 2013

<table>
<thead>
<tr>
<th>Administrative Burden</th>
<th>Average Dollar Amount This Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>External Legal Counsel</td>
<td>$ 28,074</td>
</tr>
<tr>
<td>Utilization Management Consultant</td>
<td>$ 46,969</td>
</tr>
<tr>
<td>RAC Claim Tracking Service</td>
<td>$ 15,367</td>
</tr>
<tr>
<td>RAC Claim Management Tool</td>
<td>$ 10,367</td>
</tr>
<tr>
<td>Medical Record Copying Service</td>
<td>$ 5,191</td>
</tr>
</tbody>
</table>

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

Source: AHA. (July 2013). RAC TRAC Survey.
AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
51% of hospitals reporting RAC process issues cite ‘excessively long delays between receipt of the review results letter and the demand letter’ as an issue.

Percent of Participating Hospitals Reporting RAC Process Issues, by Issue, 2\textsuperscript{nd} Quarter 2013

- Long lag (greater than 30 days) between date on review results letter and receipt of demand letter: 51%
- Not receiving a demand letter informing the hospital of a RAC denial: 49%
- Demand letters lack a detailed explanation of the RAC’s rationale for denying the claim: 42%
- RAC not meeting 60-day deadline to make a determination on a claim: 40%
- Problems reconciling pending and actual recoupment due to insufficient or confusing information on the remittance advice: 39%
- Receiving a demand letter announcing a RAC denial and pending recoupment AFTER the denial has been reported on the remittance: 39%
- RAC is rescinding medical record requests after the facility has already submitted the records: 33%

*Includes participating hospitals with and without RAC activity.

Source: AHA. (July 2013). RAC\textsuperscript{Trac} Survey
AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
The average wait time for a RAC response varied significantly, with 21 percent 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, 2nd Quarter 2013

- 24 hours: 18%
- 7 days: 16%
- 1-3 days: 45%
- 14 or more days: 11%
- No response received: 10%
- 24 hours: 18%

Source: AHA. (July 2013). RAC TRAC Survey
AHA analysis of survey data collected from 2,425 hospitals: 2,129 reporting activity, 296 reporting no activity through June 2013. 1,273 hospitals participated 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.
RAC response time varied by region.

Average Number of Days For RACs to Respond to Hospital Inquiries for Participating Hospitals, by Region, 2nd Quarter 2013

<table>
<thead>
<tr>
<th>Region</th>
<th>24 hours</th>
<th>1-3 days</th>
<th>7 days</th>
<th>14 or more days</th>
<th>No Response Received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region A</td>
<td>34%</td>
<td>48%</td>
<td>7%</td>
<td>7%</td>
<td>3%</td>
</tr>
<tr>
<td>Region B</td>
<td>8%</td>
<td>51%</td>
<td>13%</td>
<td>12%</td>
<td>16%</td>
</tr>
<tr>
<td>Region C</td>
<td>15%</td>
<td>43%</td>
<td>17%</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Region D</td>
<td>18%</td>
<td>37%</td>
<td>29%</td>
<td>10%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: AHA. (July 2013). RAC TrAC Survey
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For more information visit AHA’s RAC TRAC website:

http://www.aha.org/ractrac