RAC*TRAC* Survey Changes and Claim Level Tool Update

September 9, 2014

AGENDA

- Overview
- Survey Updates
- Claim Level Tool Review and Updates
- Next Steps

Overview

- AHA is updating the RAC*TRAC* survey to align with recent changes to the RAC program and to see how these changes have impacted hospitals nationwide. Recent changes now addressed in the survey include:
  - revised medical necessity review criteria,
  - rebilling,
  - RAC pre-payment demonstration program, and
  - insight into the extended appeals process.
- Questions have been both added and deleted from the current survey.
- Administrative Burden section has been condensed.

Survey Updates

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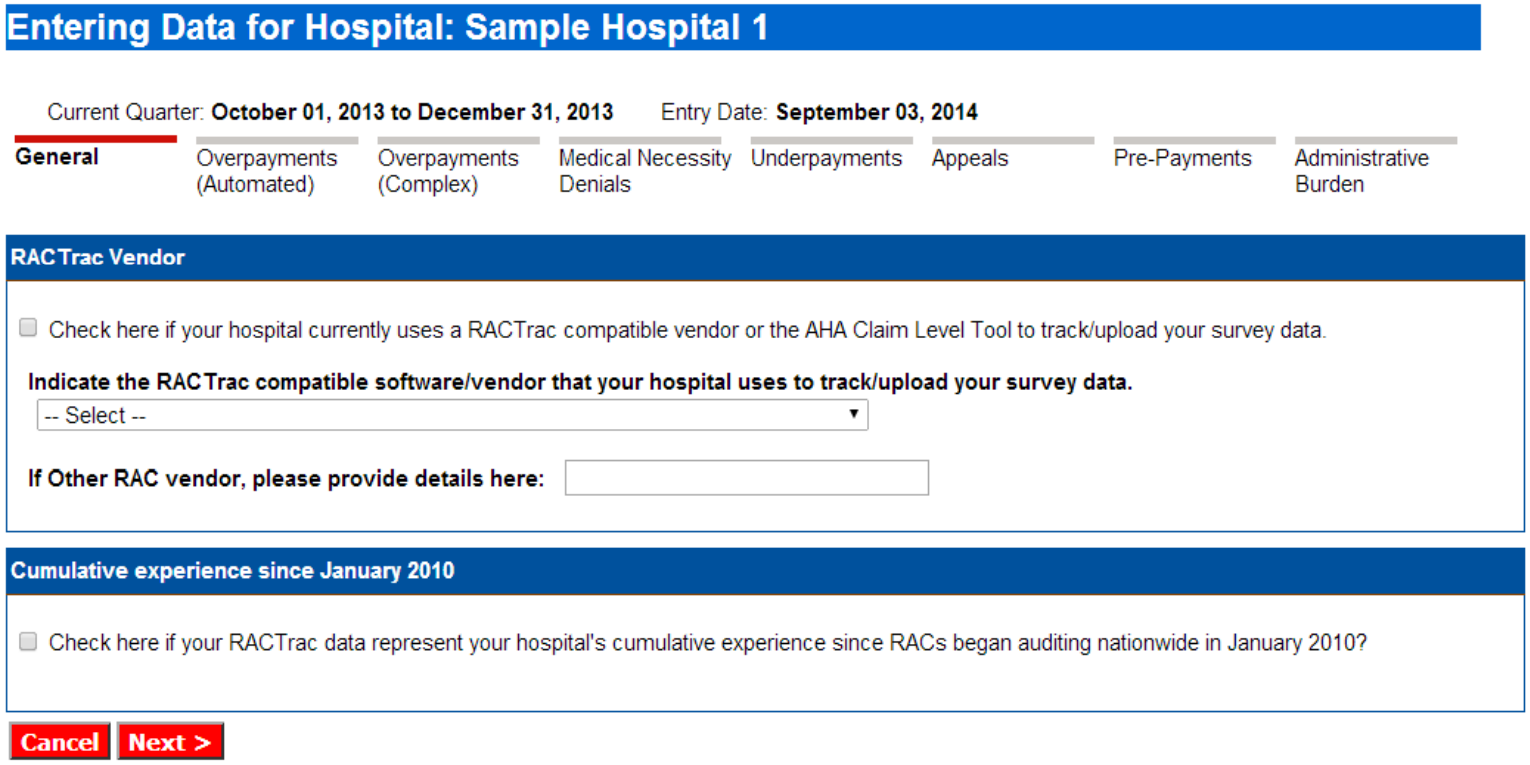
NEW Section - General



Overpayments – Automated Denials

CURRENT QUARTER

☐ Check here if your hospital has had no new automated overpayments activity this quarter.
(If checked, skip to Overpayments - Complex RAC Reviews)

4. Rank order the services by the number of automated claim denials this quarter.
(Number 1 for the largest and number 2 for the second largest number of claim denials in this quarter).

Number 1
Select Service Area ▾
Number 2
Select Service Area ▾

5. Rank order the services by the estimated Medicare reimbursement dollar value of automated claim denials this quarter.
(Number 1 being the greatest medicare reimbursement dollar value and number 2 being the second largest dollar value in this quarter).

Number 1
Select Service Area ▾
Number 2
Select Service Area ▾

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Overpayments – Complex Denials

6. Rank order the services by the estimated Medicare reimbursement dollar value of the complex claim denials this quarter.
(Number 1 being the greatest Medicare reimbursement dollar value and number 2 being the second largest dollar value this quarter).

Number 1
Select Service Area ▾

Number 2
Select Service Area ▾

7. Select the reasons cited by the RACs for complex claim denials for this quarter.
Please make the correct selection based on the type of services provided by your organization and then indicate the denial reasons for the complex RAC denials for this quarter.

Medical/Surgical Acute Care Hospital/Service

- ☐ Medical/Surgical Acute Care Hospital/Services - No Documentation Provided or Insufficient Documentation in the Medical Record
- ☐ Medical/Surgical Acute Care Hospital/Services - Incorrect Discharge Status
- ☐ Medical/Surgical Acute Care Hospital/Services - Incorrect MS-DRG or Other Coding Error
- ☐ Medical/Surgical Acute Care Hospital/Services - Incorrect APC or Other Outpatient Coding Error/Outpatient Billing Error
- ☐ Medical/Surgical Acute Care Hospital/Services - Short Stay Medically Unnecessary Less Than 2-midnights
- ☐ Medical/Surgical Acute Care Hospital/Services - Medically Unnecessary Inpatient Stay Greater than or equal to 2-midnights
- ☐ Medical/Surgical Acute Care Hospital/Services - Other Medically Unnecessary
- ☐ Medical/Surgical Acute Care Hospital/Services - All Other (Enter in text box below)

Inpatient Rehabilitation Hospital/Unit

- ☐ Inpatient Rehabilitation Hospital/Unit - No Documentation Provided or Insufficient Documentation
- ☐ Inpatient Rehabilitation Hospital/Unit - Incorrect CMG or Other Coding Error
- ☐ Inpatient Rehabilitation Hospital/Unit - All Joint Patients; Medically Unnecessary
- ☐ Inpatient Rehabilitation Hospital/Unit - Other Medically Unnecessary
- ☐ Inpatient Rehabilitation Hospital/Unit - All Other (Enter in text box below)

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Medical Necessity Denials

- The Medical Necessity Review section has been revised to align with CMS' 2014 IPPS Final Rule, which addressed both admission criteria and rebilling opportunity.
- Post payment status (level of care) reviews will shift focus from 1, 2, or 3-day stays to less than 2-midnights or equal to or greater than 2-midnights.
- Questions addressing rebilling for medical necessity denials have been added to this section.

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Medical Necessity Denials cont.

Unless otherwise mentioned, all totals should reflect cumulative experience since October 2008.

Medical Necessity Denials for Inappropriate Settings

☐ Check here if your organization is able to track whether medical necessity denials are due to inappropriate settings.

Medical Necessity Denials for Less Than 2-Midnights for claims dated after October 1, 2013 ONLY

1. Total number of all medical necessity denials with LOS less than 2-midnights.		**1A. Total Medicare reimbursement dollar amount from the demand letter of medical necessity denials with LOS less than 2-midnights.**	$
2. Number of medical necessity denials due to inappropriate setting only with LOS less than 2-midnights. *(For example: Inpatient care that should have been provided in observation or outpatient setting)*		**2A. Medicare reimbursement dollar amount from the demand letter of medical necessity denials due to inappropriate setting only when LOS less than 2-midnights.**	$

Medical Necessity Denials for Greater Than or Equal to 2-Midnights for claims dated after October 1, 2013 ONLY

3. Total number of all medical necessity denials with LOS equal to or greater than 2-midnights.		**3A. Total Medicare reimbursement dollar amount from the demand letter of medical necessity denials with LOS equal to or greater than 2-midnights.**	$
4. Number of medical necessity denials due to inappropriate setting only with LOS equal to or greater than 2-midnights. *(For example: Inpatient care that should have been provided in observation or outpatient setting)*		**4A. Medicare reimbursement dollar amount from the demand letter of medical necessity denials due to inappropriate setting only when LOS equal to or greater than 2-midnights.**	$

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Medical Necessity – New Rebilling Questions

Rebilling Part A to Part B

5. How many claims denied for medical necessity level of care were requested for review more than one year from the date of service? [ ]
6. Was your organization a participant in the Part A to Part B rebilling demonstration? ○ Yes ○ No
7. How many medical necessity level of care denials has your organization rebilled under Part B since March 13, 2013? [ ]
   7A. For denials re-billed, what was the original Medicare Part A total payment since March 13, 2013? $ [ ]
8. How many Part A medical necessity level of care denials has your organization rebilled under Part B AND received Part B reimbursement? [ ]
   8A. For denials rebilled AND paid under Part B, what was the original Medicare Part A total payment? $ [ ]
   8B. For denials rebilled AND paid under Part B, what was the Medicare Part B total payment? $ [ ]

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Underpayments

Current Quarter: **October 01, 2013 to December 31, 2013** Entry Date: **September 03, 2014**

General | Overpayments (Automated) | Overpayments (Complex) | Medical Necessity Denials | **Underpayments** | Appeals | Pre-Payments | Administrative Burden

Cumulative experience since 2008

☐ Check here if your hospital has not had any underpayments.
(If checked, skip to Appeals)

Totals should reflect cumulative experience since October 2008

1. Total cumulative number of claims identified as underpayments

2. Estimate of total cumulative Medicare reimbursement dollars determined to be underpayments $

CURRENT QUARTER

☐ Check here if your hospital has had no new underpayment activity this quarter.
(If checked, skip to Appeals)

3. Indicate the reasons identified by the RAC for underpayment this quarter. (Check all that apply)
Below are the choices for this question.

- ☐ Billing Error
- ☐ Inpatient Discharge Status
- ☐ Incorrect MS-DRG
- ☐ Outpatient Coding Error
- ☐ All Other

Please Contact AHA if you have experienced a significant number of claims identified for underpayment for reasons not stated in one of our above categories. AHA will consider your submission for future tracking in RACTrac.

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Appeals

- Appeal information has been broken out to show data at each level of the appeals process.

Appeal Status - Level 1 (FI/MAC)

Please complete the following questions for appeal activity at Level 1 (Fiscal Intermediary / Medicare Administrative Contractor)
[Exclude appeals of pre-payment denials] ***CUMULATIVE*** *since 2008.*

1. Total Cumulative number of denials filed for appeal at Level 1?		1A. Total Medicare reimbursement dollar value of the denials filed for appeal at Level 1?	$
2. Cumulative number of denials overturned (in favor of provider) at Level 1?		2A. Total Medicare reimbursement for denials overturned (in favor of provider) at Level 1?	$
3. Cumulative number of appeals initially filed and then stopped / withdrawn by hospital at Level 1 excluding those withdrawn for rebilling?		3A. Total Medicare reimbursement for appeals initially filed and then stopped / withdrawn, by hospital at Level 1 excluding those withdrawn for rebilling?	$
4. Cumulative number of appeals initially filed and then stopped / withdrawn by hospital at Level 1 so claim can be rebilled?		4A. Total Medicare reimbursement for appeals initially filed and then stopped / withdrawn at Level 1 so claim could be rebilled?	$
5. Cumulative number of appeals with an unfavorable determination at Level 1		5A. Total Medicare reimbursment for appeals with an unfavorable determination at Level 1	$
6. Total number of appeals pending determination at Level 1?		6A. Total Medicare reimbursement dollar value for appeals pending determination at Level 1?	$

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Appeals cont.

Enter the information on appeals ONLY if you have received a demand letter.

Includes Automated and Complex Appeal Activity ONLY. Do not include Pre-Payment appeal activity.
Totals should reflect cumulative experience since October 2008

APPEALS EXPERIENCE – AUTOMATIC AND COMPLEX COMBINED

1. Total number of appeals filed		1A. Total Medicare reimbursement dollar value of the denials filed for appeal	$
2. Total number of appeals overturned in favor of the provider at any level of the appeals process		2A. Total Medicare reimbursement dollars of appeals that have been overturned in favor of the provider at any level of the appeals process	$
3. Total number of appeals that were initially filed to the FI/MAC and then withdrawn or stopped by the provider at any level of the appeals process.		3A. Total Medicare reimbursement dollar value of the appeals that were initially filed to the FI/MAC and later withdrawn from the process or not continued	$
4. Total number of appeals to date that were initially filed to the FI/MAC and later withdrawn from the process, or not continued in order to rebill the claim *(INCLUDE only those appeals withdrawn and rebilled).*		4A. Total Medicare reimbursement dollar value of the appeals that were initially filed to the FI/MAC and later withdrawn from the process, or not continued in order to rebill the claim *(INCLUDE only those appeals withdrawn and rebilled).*	$
5. Total number of appeals currently in process		5A. Total Medicare reimbursement dollar value of the appeals currently in process	$
6. Average administrative cost per appeal (cost associated with the appeals process)	$		

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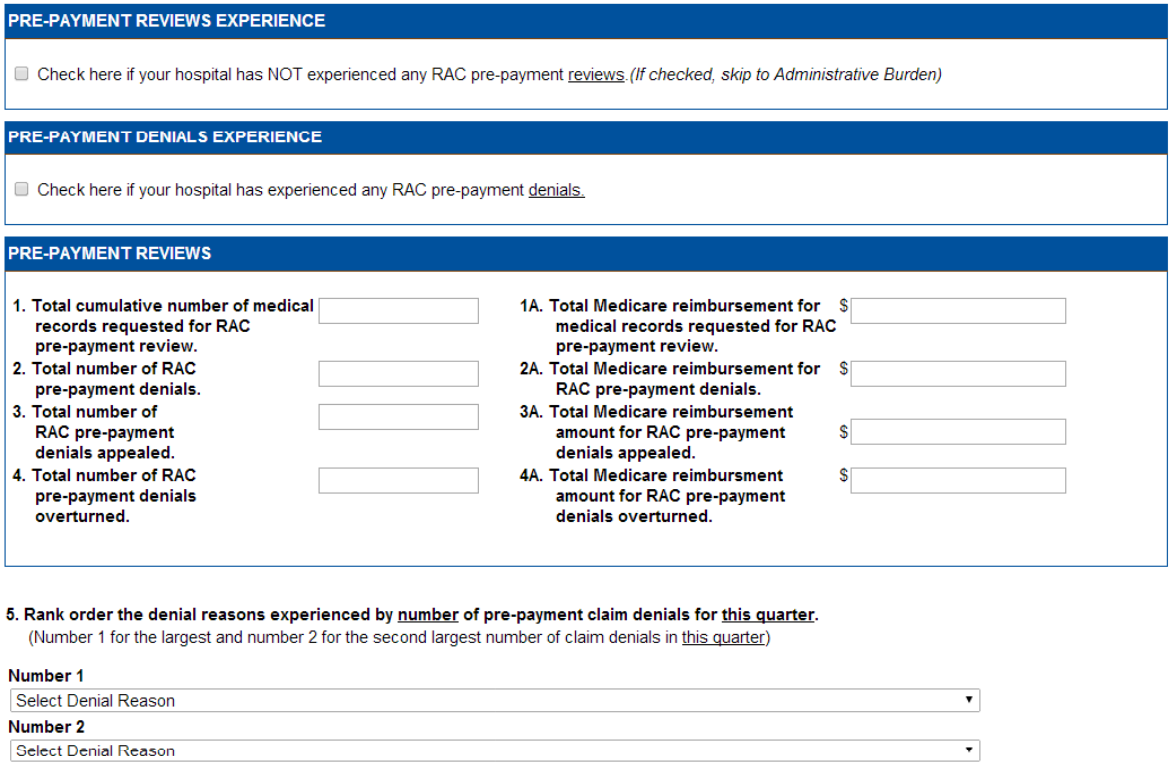
NEW – RAC Pre-Payment Reviews

- The RAC Pre-Payment Demonstration has been in effect since August 2012 in eleven (11) states.



PRE-PAYMENT REVIEWS EXPERIENCE

☐ Check here if your hospital has NOT experienced any RAC pre-payment reviews. *(If checked, skip to Administrative Burden)*

PRE-PAYMENT DENIALS EXPERIENCE

☐ Check here if your hospital has experienced any RAC pre-payment denials.

PRE-PAYMENT REVIEWS

1. Total cumulative number of medical records requested for RAC pre-payment review.		1A. Total Medicare reimbursement for medical records requested for RAC pre-payment review.	$
2. Total number of RAC pre-payment denials.		2A. Total Medicare reimbursement for RAC pre-payment denials.	$
3. Total number of RAC pre-payment denials appealed.		3A. Total Medicare reimbursement amount for RAC pre-payment denials appealed.	$
4. Total number of RAC pre-payment denials overturned.		4A. Total Medicare reimbursment amount for RAC pre-payment denials overturned.	$

5. Rank order the denial reasons experienced by number of pre-payment claim denials for this quarter.
(Number 1 for the largest and number 2 for the second largest number of claim denials in this quarter)

Number 1
Select Denial Reason

Number 2
Select Denial Reason

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Administrative Burden

General | Overpayments (Automated) | Overpayments (Complex) | Medical Necessity Denials | Underpayments | Appeals | Pre-Payments | **Administrative Burden**

CURRENT QUARTER

1. Estimate the total dollar amount your hospital spent dealing with the RAC program this quarter (including employee cost, appeals cost, software, consultants, utilization review, etc).

- ○ $0 to $10,000
- ○ $10,001 to $25,000
- ○ $25,001 to $50,000
- ○ $50,001 to $75,000
- ○ $75,001 to $100,000
- ○ $100,001 and over

2. Please select all 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.

Check all that apply and provide a dollar estimate for each service for this quarter.

- ☐ No External Support

☐ External Legal Counsel	Total Dollars	$
☐ RAC Claim Management Tool	Total Dollars	$
☐ Medical Record Copying Service	Total Dollars	$
☐ Utilization Management Consultant	Total Dollars	$
☐ RAC Claim Tracking Service	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 this quarter?

- ☐ No impact
- ☐ Modified admission criteria to reduce risk of future RAC denials
- ☐ Had to make cutbacks because of financial hardships due to RAC recoupment of Medicare dollars (e.g. limited services, reduced number of beds, reduced staff)

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Administrative Burden cont.

Other Appeals Experience (Cumulative)

4A. Have you escalated any appeals to the Medicare Appeals Council as a result of the untimely response of the ALJ?

○ Yes ○ No

B. If Yes, for how many appeals? ____

5A. Have you had any RAC denials overturned during the discussion period?

○ Yes ○ No ○ Don't know

B. If yes, how many? ____

6A. Has your hospital received communication from the QIC reporting the inability to complete an appeal review within the required 60 day window and offering the option to escalate the appeal to the ALJ?

○ Yes ○ No

B. If yes, for how many claims? ____

C. Have you requested escalation to the ALJ for cases where the QIC cannot make a timely determination?

○ Yes ○ No

D. If yes, for how many claims? ____

7A. Have any claims denied for DRG Validation become full medical necessity denials during the appeals process?

○ Yes ○ No

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Administrative Burden cont.

RAC Process Problems

8. How would you rate the responsiveness to your inquiries and the overall communication with RAC?

○ Excellent ○ Good ○ Fair ○ Poor

9. What is the approximate timeline in which the RAC responded to your inquiries?

○ 24 hours ○ 2-3 days ○ 4-6 days ○ 7-13 days ○ No response received

10A. Have you received any education from the Centers for Medicare & Medicaid Services and/or Fiscal Intermediary on corrective actions your facility can take to limit the risk of additional RAC denials of paid claims (e.g. documentation and coding issues, criteria for medical necessity, etc.)?

○ Yes ○ No ○ Don't know

B. If yes, how effective was this education in helping your facility identify and correct issues that might lead to future RAC denials?

○ Excellent ○ Good ○ Fair ○ Poor

11A. Please select from the following issues that you experienced during the previous calendar quarter:

- ☐ RAC is auditing a particular MS-DRG or type of claim that is not approved by CMS
- ☐ RAC is mailing medical record requests to wrong hospital or wrong contact at your hospital
- ☐ RAC is rescinding medical record requests after you have already submitted the records
- ☐ RACs auditing claims that are older than the 3 year look-back period
- ☐ RAC is issuing more than one medical record request within a 45-day period
- ☐ RAC not meeting 60-day deadline to make a determination on a claim
- ☐ Long lag (greater than 15 days) between date on demand letter and receipt of demand letter
- ☐ Long lag (greater than 30 days) between date on review results letter and receipt of demand letter
- ☐ Problems reconciling pending and actual recoupment due to insufficient or confusing information on the remittance advice
- ☐ Problems with remittance advice RAC code N432
- ☐ Not receiving a demand letter informing the hospital of a RAC denial
- ☐ Receiving a demand letter announcing a RAC denial and pending recoupment AFTER the denial has been reported on the remittance
- ☐ Problems with postage reimbursement
- ☐ Demand letters lack a detailed explanation of the RAC's rationale for denying the claim
- ☐ Other issues/problems (include box)

B. If Other issues/problems was selected, please provide details here.

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RAC*TRAC* Vendor Status

Company	Software	Status
3M™ Health Information Systems	3M™ Audit Expert	In Process
Iatric Systems, Inc.	IatricTRAC: RAC Management	In Process
IOD Incorporated	PRISMAudit	In Process
MRO	AuditTrends™ Online	In Process
Rycan Technologies, Inc.	RAC Audit Tracking	In Process
SAI Global Compliance	Compliance 360®	In Process
The Wellington Group LLC	Rac Guard	In Process

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RAC*TRAC* Vendor Status cont.

Company	Software	Status
Advisory Board	Revenue Integrity Compass	In Development
Array Software, Inc.	TRACK+	In Development
HealthPort LLC	AudaPro	In Development
MedAssets	Recovery Audit Management	In Development
MedeAnalytics	Compliance	In Development
NJHA – Healthcare Business Solutions	Audit-TRAX	In Development
PACE Healthcare Consulting, LLC	RACTelligence Tracking	In Development
Quadax, Inc.	Audit Control Axis	In Development
The SSI Group, Inc.	ClinON® RADs	In Development
Wolters Kluwer Law & Business (MediRegs)	Comply Track	In Development

http://www.aha.org/content/14/ractraclettertovendor.pdf

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Claim level tool updates

Claim Level Tool 2014.xlsb

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Next Steps

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Next Steps

- Download the new AHA Claim Tool and Data Dictionary at www.aharactrac.com
- Accept / permit file defaults to ensure all macros work correctly.
- Transfer your historical data
- Enter new quarter data
- Review Survey Input
  - Click on the summary tab and review hospital survey responses prior to submission
  - Click on the survey category at the top to review each RAC area
  - Check that the quarter presented matches the requested reporting period

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Next Steps

- Create the CSV File
  - Click on the AHA Claims and Summary Tool tab
  - Make sure you answer the check boxes as appropriate on this tab.
  - Confirm that the correct year and quarter is selected in the overview tab before recalculating.
  - Recalculate by selecting the F9 key. At this time please click SAVE to save your claim tool.
- [Click on EXPORT TO CSV] and save your .csv file.

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Questions & Answers