Exploring Medicare RAC Program Updates and Changes to the RAC Trac Survey

Quarterly National Webinar

September 24, 2014
Today’s Webinar

• Advocacy Update

• Legal Update

• Policy Update

• RAC Trac survey update to launch in October 2014
  – Overview
  – Survey Question Updates
  – Vendor Recertification
  – Claim Level Tool Review and Updates
  – Next Steps
RAC Advocacy Update

Robyn Bash, Executive Director, Federal Relations
RAC Legal Update

Lawrence Hughes, Assistant General Counsel
AHA Medicare Litigation

- **Rebilling**
  - Retroactive reimbursement

- **Two-Midnights**
  - Policy “redo”
  - Reimbursement refund

- **ALJ Delay**
  - Timely dispute resolution
CMS Appeals Settlement Offer

- **Administrative agreement**
  - Voluntary
  - 68% of value of inpatient claim
  - Admissions prior to October 1, 2013
  - Eligible hospitals
    - Acute care hospitals and CAHs
- **AHA Concerns**
  - Amount
  - Hospitals excluded
  - Addressing core issues for future
- **Complicates Litigation**
Settlement Offer Checklist

- Hospitals should carefully evaluate offer based on their own circumstances and priorities
- AHA contracted with a national accounting firm to develop a framework for evaluating the offer

 Appeal versus Settlement Checklist

### Summary

<table>
<thead>
<tr>
<th>Net Revenue Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
</tr>
<tr>
<td>Revenue</td>
</tr>
<tr>
<td>Net Revenue of Claims in Appeal Status</td>
</tr>
<tr>
<td>Historic Success Rate *</td>
</tr>
<tr>
<td>Anticipated Net Revenue (Historic Success Rate x Net Revenue in Appeal status)</td>
</tr>
<tr>
<td>Interest from overturned appeals</td>
</tr>
<tr>
<td>Costs (From Schedule A) **</td>
</tr>
<tr>
<td>Historic</td>
</tr>
<tr>
<td>Anticipated Future</td>
</tr>
<tr>
<td>Total Anticipated Costs</td>
</tr>
<tr>
<td>Net Realizable Revenue (Anticipated Net Revenue, less Total Anticipated Costs)</td>
</tr>
<tr>
<td>Hospital’s Current Net Revenue (based on historical success rate, and the historic/future costs)</td>
</tr>
</tbody>
</table>

* If something in your environment has changed to indicate more/less favorable appeal success rate, factor into calculation.

** Given your hospital’s environment for the portion of claims in appeal, there could be additional costs - refer to Schedule A for consideration.

### Settlement Revenue Calculation (at $ .88 on the dollar)

| Total Net Revenue in Appeal Status (pulled from Total column above) | $ - |
| Settlement Revenue (Total Net Revenue in Appeal Status x $ .88)    | $ - |
| Total Historic Costs (From Schedule A)                              | $ - |
| Total Net Settlement Revenue (Settlement Revenue, less Total Historic Costs) | $ - |
Friday, September 19, 2014

AHA Releases Tool for Hospitals to Evaluate CMS Appeals Settlement Offer

Late Friday, Aug. 29, the Centers for Medicare & Medicaid Services (CMS) issued a notice offering a settlement of hospital appeals of short stay denials. CMS’s intent in offering the settlement is to address the significant backlog of Medicare appeals at the administrative law judge (ALJ) level, which resulted in the Office of Medicare Hearings and Appeals suspending assignment of appeals to ALJs for at least two years.

Each hospital should evaluate carefully the terms of the offer and the hospital's own situation in making a decision about whether to pursue the settlement offer. To assist with this analysis, the AHA commissioned a national accounting firm to develop the attached tool to help hospitals compare the settlement they might expect to receive under CMS’s offer with what they might recover if they choose to continue the appeals process for claims eligible for the settlement. The tool includes an overview and instructions pertaining to the checklist. It was developed to be simple to use and broadly applicable across hospitals. As a result, it may not address all nuances of the financial considerations for all hospitals. However, it should help hospitals approximate the financial impact of accepting CMS’s settlement offer.

CMS’s offer is to provide partial payment, equal to 68 percent of the net allowable amount of the claim, for pending administrative appeals of inpatient status denials. CMS has defined “net allowable amount” as the diagnosis-related group payment plus applicable add-on payments (such as disproportionate share hospital and indirect medical education payments), minus patient deductible and co-insurance obligations. In exchange for the partial payment, a hospital will have to withdraw all of its pending administrative appeals for these inpatient denials. The deadline for hospitals to accept the CMS offer is Oct. 31, 2014, though the agency has stated that it may grant extensions upon request. Additional details regarding CMS’s proposal were included in a Sept. 2 AHA Special Bulletin.

There are factors in addition to the direct financial impact of the settlement on appealed claims that hospitals should consider when evaluating the settlement offer. Those considerations include:

RAC Contracting: The Saga Continues

• Recap:
  – Former contracts expired in February
  – Two RACs filed a bid protest with the Government Accountability Office and ultimately lost
  – CGI, current RAC for Region B, filed suit in federal court

• Latest:
  – In August, a federal court decided CGI’s suit in favor of CMS, clearing the agency to award contracts
  – CGI has appealed this decision, and the court has enjoined CMS from awarding contracts until the appeal is decided
  – CMS has issued limited, temporary extensions to current contractors – mostly automated reviews, with some complex reviews as approved by CMS
How is the American Hospital Association advocating for fair and streamlined audits?

Started in 2010, the national RAC program needs serious reform. Many payment denials are for inpatient care that was medically needed but RACs contend it could have been provided in outpatient settings.

Medicare rules prohibit hospitals from rebilling these services as outpatient if they are older than 12 months, while RACs can audit medical records up to 3 years old and do so 75% of the time. Pressure from the AHA lawsuit forced CMS to allow hospitals some flexibility to rebill RAC-denied claims going forward. Claims that predated change are not eligible.

AHA is considering an appeal of the recently dismissed lawsuit that would have allowed hospitals to rebill older claims denied by RACs.
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 RAC Trac: [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)
RAC Administrative Burden Survey

Michael Ward, Senior Associate Director
RAC Administrative Burden Survey (separate from RACTrac survey)

• The AHA has requested that hospitals provide information about their experience with additional administrative costs and expenses related to complying with RAC audits, handling denials, and appealing denials

• Hospital CEOs were sent a unique login and password for their facilities in late-August; additional reminders have been sent in recent weeks

• Deadline was last Friday, extension has been provided to this Friday, September 26

• Questions about the survey should be directed to AHA Member Relations at (800) 424-4301 or email at RACinfo@aha.org
  – Please also contact us if you do not have the survey access information for your hospital and would like to participate
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
RAC Trac Update

- The AHA has made changes to questions in the manual section of the survey in recent years; however, in recent months a more comprehensive update of the survey has occurred

  - Updates to questions
    - New questions for relevant policy issues
    - Appeals data at a more granular level (i.e., by appeals level)
    - Stopping data collection on questions that have limited policy-related application

  - Increased automation and organization
    - Many of the questions previously in the Administrative Burden section are being moved into the automated sections of the survey
    - New questions will require limited additional information for facilities that utilize the AHA Claim Level Tool
Upcoming Data Collection Periods

• For October 2014 RAC Trac data collection period:
  – Data through Q3 2014 (September 2014)
  – Collecting information based on current question list
  – Use previous AHA Claim Level Tool, 3rd party vendor product, or manual entry

• For January 2015 RACTrac data collection period (data from Q4 2014):
  – Data through Q4 2014 (December 2014)
  – Collecting information based on updated question list
  – Strongly preferred: utilize new AHA Claim Level Tool, compliant vendor product, or manual entry
  – RAC Trac will maintain backwards compatibility during the January 2015 reporting period for vendor products that have not completed recertification
Survey Updates
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 ▼
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)
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.
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.
   - 

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)

1A. Total Medicare reimbursement dollar amount from the demand letter of medical necessity denials with LOS less than 2-midnights.
   - $ 

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.
   - 

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)

3A. Total Medicare reimbursement dollar amount from the demand letter of medical necessity denials with LOS equal to or greater than 2-midnights.
   - $ 

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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### Rebilling Part A to Part B

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. How many claims denied for medical necessity level of care were requested for review more than one year from the date of service?</td>
<td></td>
</tr>
<tr>
<td>6. Was your organization a participant in the Part A to Part B rebilling demonstration?</td>
<td></td>
</tr>
<tr>
<td>7. How many medical necessity level of care denials has your organization rebilled under Part B since March 13, 2013?</td>
<td></td>
</tr>
<tr>
<td>7A. For denials re-billed, what was the original Medicare Part A total payment since March 13, 2013?</td>
<td>$</td>
</tr>
<tr>
<td>8. How many Part A medical necessity level of care denials has your organization rebilled under Part B AND received Part B reimbursement?</td>
<td></td>
</tr>
<tr>
<td>8A. For denials rebilled <strong>AND</strong> paid under Part B, what was the original Medicare Part A total payment?</td>
<td>$</td>
</tr>
<tr>
<td>8B. For denials rebilled <strong>AND</strong> paid under Part B, what was the Medicare Part B total payment?</td>
<td>$</td>
</tr>
</tbody>
</table>
Underpayments

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

<table>
<thead>
<tr>
<th>General</th>
<th>Overpayments (Automated)</th>
<th>Overpayments (Complex)</th>
<th>Medical Necessity Denials</th>
<th>Underpayments</th>
<th>Appeals</th>
<th>Pre-Payments</th>
<th>Administrative Burden</th>
</tr>
</thead>
</table>

**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)*

   - 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.

< Previous  Next >
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.

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

<table>
<thead>
<tr>
<th>APPEALS EXPERIENCE – AUTOMATIC AND COMPLEX COMBINED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total number of appeals filed</td>
</tr>
<tr>
<td>2. Total number of appeals overturned</td>
</tr>
<tr>
<td>(in favor of the provider at any level of the appeals process)</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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).</td>
</tr>
<tr>
<td>5. Total number of appeals currently in process</td>
</tr>
<tr>
<td>6. Average administrative cost per appeal (cost associated with the appeals process)</td>
</tr>
</tbody>
</table>
NEW – RAC Pre-Payment Reviews

• The RAC Pre-Payment Demonstration has been in effect since August 2012 in eleven (11) states.
# 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)
### Administrative Burden cont.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>4A. Have you escalated any appeals to the Medicare Appeals Council as a result of the untimely response of the ALJ?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>5A. Have you had any RAC denials overturned during the discussion period?</td>
<td>Yes, No, Don't know</td>
</tr>
<tr>
<td>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?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>7A. Have any claims denied for DRG Validation become full medical necessity denials during the appeals process?</td>
<td>Yes, No</td>
</tr>
</tbody>
</table>
### 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 N402
- [ ] 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.
Vendor Certification
# RAC TRAC Vendor Status

<table>
<thead>
<tr>
<th>Company</th>
<th>Software</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>3M™ Health Information Systems</td>
<td>3M™ Audit Expert</td>
<td>In Process</td>
</tr>
<tr>
<td>HealthPort LLC</td>
<td>AudaPro</td>
<td>In Process</td>
</tr>
<tr>
<td>Iatric Systems, Inc.</td>
<td>IatricTRAC: RAC Management</td>
<td>In Process</td>
</tr>
<tr>
<td>IOD Incorporated</td>
<td>PRISMAudit</td>
<td>In Process</td>
</tr>
<tr>
<td>MRO</td>
<td>AuditTrends™ Online</td>
<td>In Process</td>
</tr>
<tr>
<td>Rycan Technologies, Inc.</td>
<td>RAC Audit Tracking</td>
<td>In Process</td>
</tr>
<tr>
<td>SAI Global Compliance</td>
<td>Compliance 360®</td>
<td>In Process</td>
</tr>
<tr>
<td>The Wellington Group LLC</td>
<td>Rac Guard</td>
<td>In Process</td>
</tr>
</tbody>
</table>
# RAC TRAC Vendor Status cont.

<table>
<thead>
<tr>
<th>Company</th>
<th>Software</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advisory Board</td>
<td>Revenue Integrity Compass</td>
<td>In Development</td>
</tr>
<tr>
<td>Array Software, Inc.</td>
<td>TRACK+</td>
<td>In Development</td>
</tr>
<tr>
<td>Craneware</td>
<td>InSight Audit®</td>
<td>In Development</td>
</tr>
<tr>
<td>Intersect Healthcare</td>
<td>VERACITY™</td>
<td>In Development</td>
</tr>
<tr>
<td>MedAssets</td>
<td>Recovery Audit Management</td>
<td>In Development</td>
</tr>
<tr>
<td>MedeAnalytics</td>
<td>Compliance</td>
<td>In Development</td>
</tr>
<tr>
<td>NJHA – Healthcare Business Solutions</td>
<td>Audit-TRAX</td>
<td>In Development</td>
</tr>
<tr>
<td>PACE Healthcare Consulting, LLC</td>
<td>RACTelligence Tracking</td>
<td>In Development</td>
</tr>
<tr>
<td>Quadax, Inc.</td>
<td>Audit Control Axis</td>
<td>In Development</td>
</tr>
<tr>
<td>The SSI Group, Inc.</td>
<td>ClinON® RADs</td>
<td>In Development</td>
</tr>
<tr>
<td>Wolters Kluwer Law &amp; Business (MediRegS)</td>
<td>Comply Track</td>
<td>In Development</td>
</tr>
</tbody>
</table>

Updated vendor compatibility list:  
http://www.aha.org/content/14/ractracccompatible.pdf

Hospital to vendor sample letter:  
http://www.aha.org/content/14/ractraclettertovendor.pdf
Claim level tool updates

Claim Level Tool 2014.xlsb
Next Steps
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
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