AHA RACTRAC SURVEY QUESTIONS AS THEY APPEAR ONLINE
Updated January 1, 2014

Overpayments (Automated) - Screen 1 in Data Entry

OVERPAYMENTS - AUTOMATED RAC REVIEWS

If you have multiple reviews on the same claim, please only report the review with the largest financial impact

Entering Data for Hospital: Sample Hospital 2

Current Quarter: **October 01, 2013 to December 31, 2013** Entry Date: **January 07, 2014**

Overpayments (Automated) | Overpayments (Complex) | Medical Necessity Denials | Underpayments | Appeals | Administrative Burden

CMS Part A to Part B Rebill Experience

How many appeals has your hospital withdrawn from the appeals process in order to rebill for Part B payment?

Cumulative experience since 2008

☐ Check here if your hospital has not had any automated denials.
(If checked, skip to Overpayments - Complex RAC Reviews)

In this section, only enter information relating to overpayment reviews.
All underpayment information should be entered in the Underpayments Section.
Totals should reflect cumulative experience since October 2008

1. Total cumulative number of automated claim denials

2. Total cumulative automated claim denial Medicare reimbursement dollar amount (sum of all demand letter amounts) $

3. Total cumulative medicare reimbursement dollars recouped for automated claim denials $

CURRENT QUARTER

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

4. Indicate the service areas in which automated RAC denials have occurred this quarter.
Please select your hospital type in 4A. and then indicate the services in which automated RAC denials have occurred for your hospital this quarter in 4B and **check all that apply**

4A. Automated RAC Denials, Hospital Type Select a Facility Type

4B. Automated RAC Denials, Service Areas

5. Rank order the services by the number of automated claim denials this quarter.
(Number 1 for the largest and number 3 for the third largest number of claim denials in this quarter).

Number 1
Select Service Area
Number 2
Select Service Area
Number 3
Select Service Area

6. 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 3 being the third largest dollar value in this quarter).

Number 1
Select Service Area
Number 2
Select Service Area
Number 3
Select Service Area

7. Select the reasons cited by the RAC for automated 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 automated RAC denials for this quarter.

Medical/Surgical Acute Care Hospital/Service
- ☐ Medical/Surgical Acute Care Hospital/Services - Duplicate Payment
- ☐ Medical/Surgical Acute Care Hospital/Services - Incorrect Discharge Status
- ☐ Medical/Surgical Acute Care Hospital/Services - Inpatient Coding Error (MSDRG)
- ☐ Medical/Surgical Acute Care Hospital/Services - Outpatient Coding Error
- ☐ Medical/Surgical Acute Care Hospital/Services - Outpatient Billing Error
- ☐ Medical/Surgical Acute Care Hospital/Services - All Other (Enter in text box below)

Inpatient Rehabilitation Hospital/Unit
- ☐ Inpatient Rehabilitation Hospital/Unit - Duplicate Payment
- ☐ Inpatient Rehabilitation Hospital/Unit - Inpatient Rehabilitation Coding Error (CMG)
- ☐ Inpatient Rehabilitation Hospital/Unit - All Other (Enter in text box below)

Psychiatric Services Hospital/Unit
- ☐ Psychiatric Services Hospital/Unit - Duplicate Payment
- ☐ Psychiatric Services Hospital/Unit - Inpatient Psych Coding Error (MSDRG)
- ☐ Psychiatric Services Hospital/Unit - All Other (Enter in text box below)

Long Term Care Hospital/Unit
- ☐ Long Term Care Hospital/Unit - Duplicate Payment
- ☐ Long Term Care Hospital/Unit - Inpatient Coding Error (MSDRG)
- ☐ Long Term Care Hospital/Unit - All Other (Enter in text box below)

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

8. Rank order the denial reasons experienced by number of automated claim denials for this quarter.

(Number 1 for the largest and number 3 for the third largest number of claim denials in this quarter).

Number 1

Select Denial Reason

Number 2

Select Denial Reason

Number 3

Select Denial Reason

9. Rank order the denial reasons experienced by the estimated total medicare reimbursement dollar value of the automated claim denials for this quarter.

(Number 1 being the greatest medicare reimbursement dollar value and number 3 being the third largest dollar value in this quarter).

Number 1

Select Denial Reason

Number 2

Select Denial Reason

Number 3

Select Denial Reason

Cancel Next >

Overpayments (Complex) - Screen 2 in Data Entry

Entering Data for Hospital: Sample Hospital 2

Current Quarter: **October 01, 2013 to December 31,** Entry Date: **January 07, 2014**

Overpayments (Automated) | **Overpayments (Complex)** | Medical Necessity Denials | Underpayments | Appeals | Administrative Burden

Cumulative experience since 2008

☐ Check here if your hospital has not had any complex denials.
(If checked, skip to Medical Necessity Denials)

In this section, only enter information relating to overpayment reviews.
All underpayment information should be entered in the Underpayments Section.
Medical records requests that have been rescinded by the RACs should not be reported.
Totals should reflect cumulative experience since October 2008

1. Total number of medical record requests received		**1A. Total medicare reimbursement dollar value of the claims associated with the medical records requested**	$
2. Total number of Medical Records where NO improper payment was identified		**2A. Total medicare reimbursement dollar value of medical records where NO improper payment was identified**	$
3. Total number of medical records where an overpayment was identified (i.e., denied)		**3A. Total medicare reimbursement dollar value of medical records in which an overpayment was identified (i.e., denied)**	$
4. Total number of medical records pending determination by the RACs		**4A. Total medicare reimbursement dollar value of medical records pending determination**	$
5. Estimate the total dollars associated with the overpayments identified during medical record review (complex claim denials)	$	**6. Report the total medicare reimbursement dollars recouped for complex claim denials**	$

CURRENT QUARTER

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

7. Indicate the service areas in which complex RAC denials have occurred <u>this quarter</u>.
Hospital type has been pre-selected from Overpayments (Automated) in 7A.
Please indicate the services in which complex RAC denials have occured for your hospital <u>this quarter</u> in 7B.

7A. Complex RAC Denials, Hospital Type None Selected
7B. Complex RAC Denials, Service Areas ————————

8. Rank order the services affected by the greatest number of complex claim denials this quarter.
(Number 1 for the largest and number 3 for the third largest number of claim denials in this quarter).

Number 1
Select Service Area
Number 2
Select Service Area
Number 3
Select Service Area

9. 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 3 being the third largest dollar value this quarter).

Number 1
Select Service Area
Number 2
Select Service Area
Number 3
Select Service Area

10. 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 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
- ☐ Medical/Surgical Acute Care Hospital/Services - Medically Unnecessary Inpatient Stay Longer than 3 days
- ☐ Medical/Surgical Acute Care Hospital/Services - Other Medically Unnecessary
- ☐ Medical/Surgical Acute Care Hospital/Services - Incorrect Discharge Status
- ☐ 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)

Psychiatric Services Hospital/Unit

- ☐ Psychiatric Services Hospital/Unit - No Documentation Provided or Insufficient Documentation
- ☐ Psychiatric Services Hospital/Unit - Incorrect MS-DRG or Other Coding Error
- ☐ Psychiatric Services Hospital/Unit - Medically Unnecessary
- ☐ Psychiatric Services Hospital/Unit - All Other (Enter in text box below)

Long Term Care Hospital/Unit

- ☐ Long Term Care Hospital/Unit - No Documentation Provided or Insufficient Documentation
- ☐ Long Term Care Hospital/Unit - Incorrect MS-DRG or Other Coding Error
- ☐ Long Term Care Hospital/Unit - Other Medically Unnecessary
- ☐ Long Term Care Hospital/Unit - All Other (Enter in text box below)

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

11. Rank order the denial reasons experienced by number of complex claim denials for this quarter.
(Number 1 for the largest and number 3 for the third largest number of claim denials in this quarter)

Number 1
Select Denial Reason

Number 2
Select Denial Reason

Number 3
Select Denial Reason

12. Rank order the denial reasons experienced by the estimated total medicare reimbursement dollar value of the complex claim denials for this quarter.
(Number 1 for the largest and number 3 for the third largest medicare reimbursement dollar value of claim denials in this quarter)

Number 1
Select Denial Reason

Number 2
Select Denial Reason

Number 3
Select Denial Reason

13. List the top three MS-DRGs (as measured by reimbursement impact) for which your hospital has experienced a complex denial for Incorrect MS-DRG or Other Coding Error. (Not including Medical Necessity Denials)

First DRG Code
Second DRG Code
Third DRG Code
CMG

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Medical Necessity Reviews – Screen 3 in Data Entry

MEDICAL NECESSITY DENIALS

Entering Data for Hospital: Sample Hospital 2

Current Quarter: **October 01, 2013 to December 31, 2013** Entry Date: **January 07, 2014**

Overpayments (Automated) | Overpayments (Complex) | **Medical Necessity Denials** | Underpayments | Appeals | Administrative Burden

Medical Necessity Reviews

Is your organization able to track whether medical necessity denials are due to inappropriate settings?
○ No ○ Yes

Totals should reflect cumulative experience since October 2008

Medical Necessity Denials for 1-Day Stays

1. Total number and Medicare reimbursement dollar amount of medical necessity denials from the demand letter $
2. Number and Medicare reimbursement dollar amount of medical necessity denials due to inappropriate setting (For Example: Inpatient care that should have been provided in observation or outpatient setting) $

Medical Necessity Denials for 2-3 Day Stays

3. Total number and Medicare reimbursement dollar amount of medical necessity denials from the demand letter $
4. Number and Medicare reimbursement dollar amount of medical necessity denials due to inappropriate setting (For Example: Inpatient care that should have been provided in observation or outpatient setting) $

Medical Necessity Denials for Other Stays

5. Total number and Medicare reimbursement dollar amount of medical necessity denials from the demand letter $
6. Number and Medicare reimbursement dollar amount of medical necessity denials due to inappropriate setting (For Example: Inpatient care that should have been provided in observation or outpatient setting) $

Top 3 DRG's Associated with Medical Necessity Denials

List the top three MS-DRGs (as measured by reimbursement impact) for which your hospital has experienced a Medical Necessity denial.

First DRG Code

Second DRG Code

Third DRG Code

CMG

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Underpayments - Screen 4 in Data Entry

Entering Data for Hospital: Sample Hospital 2

Current Quarter: **October 01, 2013 to December 31, 2013** Entry Date: **January 07, 2014**

Overpayments (Automated) | Overpayments (Complex) | Medical Necessity Denials | **Underpayments** | Appeals | 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 $

3. Total cumulative Medicare reimbursement dollars actually returned to the facility $

CURRENT QUARTER

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

4. 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 - Screen 5 in Data Entry

APPEALS EXPERIENCE - AUTOMATIC AND COMPLEX COMBINED

Entering Data for Hospital: Sample Hospital 2

Current Quarter: **October 01, 2013 to December 31,** Entry Date: **January 07, 2014**

Overpayments (Automated) | Overpayments (Complex) | Medical Necessity Denials | Underpayments | **Appeals** | Administrative Burden

CUMULATIVE EXPERIENCE SINCE OCTOBER 2008

Enter the information on an Appeal ONLY if you have received a Demand Letter.
Totals should reflect cumulative experience since October 2008

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 currently in process		**4A. Total medicare reimbursement dollar value of the appeals currently in process**	$
5. Average administrative cost per appeal (cost associated with the appeals process)	$		

CURRENT QUARTER

6. For the appeals filed this quarter, please indicate the services in which the denials occurred.
Hospital type has been pre-selected from Overpayments (Automated) in 6A.
Please indicate the services in which automated and complex RAC denials have occured for your hospital this quarter in 6B. **(Check all that apply)**.

6A. Appeals, Hospital Type None Selected
6B. Appeals, Service Areas ————————

7. For the appeals filed this quarter, please indicate the denial reasons cited on those claims. (Check all that apply)

Please make the correct selection based on the type of services provided by your organization and then indicate the denial reasons for both the automated and complex RAC denials that you are appealing this quarter.

Medical/Surgical Acute Care Hospital/Service (Automated)

- ☐ Medical/Surgical Acute Care Hospital/Services - Duplicate Payment - (Automated)
- ☐ Medical/Surgical Acute Care Hospital/Services - Incorrect Discharge Status - (Automated)
- ☐ Medical/Surgical Acute Care Hospital/Services - Inpatient Coding Error (MSDRG) - (Automated)
- ☐ Medical/Surgical Acute Care Hospital/Services - Outpatient Coding Error - (Automated)
- ☐ Medical/Surgical Acute Care Hospital/Services - Outpatient Billing Error - (Automated)
- ☐ Medical/Surgical Acute Care Hospital/Services - All Other - (Automated)

Inpatient Rehabilitation Hospital/Unit (Automated)

- ☐ Inpatient Rehabilitation Hospital/Unit - Duplicate Payment - (Automated)
- ☐ Inpatient Rehabilitation Hospital/Unit - Inpatient Rehabilitation Coding Error (MSDRG) - (Automated)
- ☐ Inpatient Rehabilitation Hospital/Unit - All Other - (Automated)

Psychiatric Services Hospital/Unit (Automated)

- ☐ Psychiatric Services Hospital/Unit - Duplicate Payment - (Automated)
- ☐ Psychiatric Services Hospital/Unit - Inpatient Psych Coding Error (MSDRG) - (Automated)
- ☐ Psychiatric Services Hospital/Unit - All Other - (Automated)

Long Term Care Hospital/Unit (Automated)

- ☐ Long Term Care Hospital/Unit - Duplicate Payment - (Automated)
- ☐ Long Term Care Hospital/Unit - Inpatient Coding Error (MSDRG) - (Automated)
- ☐ Long Term Care Hospital/Unit - All Other - (Automated)

Medical/Surgical Acute Care Hospital/Service (Complex)

- ☐ Medical/Surgical Acute Care Hospital/Services - No Documentation Provided or Insufficient Documentation in the Medical Record - (Complex)
- ☐ Medical/Surgical Acute Care Hospital/Services - Incorrect Discharge Status - (Complex)
- ☐ Medical/Surgical Acute Care Hospital/Services - Incorrect MS-DRG or Other Coding Error - (Complex)
- ☐ Medical/Surgical Acute Care Hospital/Services - Incorrect APC or Other Outpatient Coding Error - (Complex)
- ☐ Medical/Surgical Acute Care Hospital/Services - Short Stay Medically Unnecessary - (Complex)
- ☐ Medical/Surgical Acute Care Hospital/Services - Medically Unnecessary Inpatient Stay Longer than 3 days - (Complex)
- ☐ Medical/Surgical Acute Care Hospital/Services - Other Medically Unnecessary - (Complex)
- ☐ Medical/Surgical Acute Care Hospital/Services - All Other - (Complex)

Inpatient Rehabilitation Hospital/Unit (Complex)

- ☐ Inpatient Rehabilitation Hospital/Unit - No Documentation Provided or Insufficient Documentation - (Complex)
- ☐ Inpatient Rehabilitation Hospital/Unit - Incorrect CMG or Other Coding Error - (Complex)
- ☐ Inpatient Rehabilitation Hospital/Unit - All Joint Patients - (Complex)
- ☐ Inpatient Rehabilitation Hospital/Unit - Other Medically Unnecessary - (Complex)
- ☐ Inpatient Rehabilitation Hospital/Unit - All Other - (Complex)

Psychiatric Services Hospital/Unit (Complex)

- ☐ Psychiatric Services Hospital/Unit - No Documentation Provided or Insufficient Documentation - (Complex)
- ☐ Psychiatric Services Hospital/Unit - Incorrect MS-DRG or Other Coding Error - (Complex)
- ☐ Psychiatric Services Hospital/Unit - Medically Unnecessary - (Complex)
- ☐ Psychiatric Services Hospital/Unit - All Other - (Complex)

Long Term Care Hospital/Unit (Complex)

- ☐ Long Term Care Hospital/Unit - No Documentation Provided or Insufficient Documentation - (Complex)
- ☐ Long Term Care Hospital/Unit - Incorrect MS-DRG or Other Coding Error - (Complex)
- ☐ Long Term Care Hospital/Unit - Medically Unnecessary - (Complex)
- ☐ Long Term Care Hospital/Unit - All Other - (Complex)

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

8. For those appeals this quarter that have been overturned in favor of the provider please indicate the reason for the overturn. (Check all that apply).

- ☐ Additional information provided by the hospital substantiated the claim
- ☐ The RAC made an error in its determination process
- ☐ Care provided was found to be medically necessary
- ☐ The claim is currently under review by a different auditor(s)
- ☐ Other

Please Contact AHA if you have experienced a significant number of claims being overturned and the reason is not stated in one of our above categories. AHA will consider your submission for future tracking in RACTrac.

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Administrative Burden - Screen 6 in Data Entry

ADMINISTRATIVE BURDEN

Entering Data for Hospital: Sample Hospital 2

Current Quarter: **October 01, 2013 to December 31, 2013** Entry Date: **January 07, 2014**

Overpayments (Automated) | Overpayments (Complex) | Medical Necessity Denials | Underpayments | Appeals | **Administrative Burden**

Organization Experience

1. Has your organization experienced any RAC pre-payment reviews? ○ Yes ○ No

2. Has your organization experienced any RAC pre-payment denials? ○ Yes ○ No

CURRENT QUARTER

3. 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

4. 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 $

5. 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)
- ☐ Additional administrative responsibilities of clinical staff to respond to RAC have taken them away from direct patient care
- ☐ Increased administrative costs to manage responses to RAC requests and or appeals etc.
- ☐ Employed additional staff or hired external resources to manage the RAC process
- ☐ Initiated a new internal task force to manage and or respond to the RAC process
- ☐ Tracking Software
- ☐ Training and Education
- ☐ Other

ALJ Appeals Experience (Cumulative)

6. How many claims has your hospital appealed to the ALJ level, in total?

☐ If your hospital has not appealed to the ALJ level, please check this box and skip to questions under the "Other Appeals Experience" header:

ALJ Appeals Experience (Cumulative)

7. If your hospital has appealed to the ALJ level, how many claims are currently awaiting determination at the ALJ level?

8. For how many inpatient cases has the ALJ:

A. overturned and awarded full inpatient payment?

B. awarded full outpatient level payment for all services (including, as appropriate, observation, surgery, et al.), instead of inpatient?

C. awarded partial outpatient payment, i.e. only the outpatient ancillary amount?

9. For how many appeals has the ALJ taken longer to issue a decision than the statutory maximum of 90 calendar days from receipt of the hospital's request for a hearing?

10. What is the longest delay your hospital has experienced for a determination at the ALJ level of appeal?

-- Select --

11A. 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?

12A. How many cases were remanded to the QIC by the ALJ, prior to the CMS Administrator's Ruling on March 14, 2013?

B. Of the cases the ALJ remanded to the QIC prior to the ruling, how many were still awaiting a second QIC review?

C. How many remanded cases had been awaiting a second QIC review decision for more than 60 days?

Other Appeals Experience (Cumulative)

13. How many appeals has your hospital withdrawn from the appeals process in order to rebill for Part B payment?

14. What percent of your hospital's claims that are audited by RACs are requested after the timely filing deadline, i.e. one year from the date of service provision, has passed?

-- Select --

15A. Have you had any RAC denials overturned during the discussion period?

○ Yes ○ No ○ Don't know

B. If yes, how many?

16. How many claims has your hospital appealed to the QIC level, in total?

17. How many overturned denials has your hospital experienced at the QIC appeal level?

18A. 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?

19A. Have any claims denied for DRG Validation become full medical necessity denials during the appeals process?

○ Yes ○ No

B. If yes, how many?

20A. Has your hospital appealed any claims to Level 4 of the appeals process?

○ Yes ○ No

B. If yes, how many?

21. For how many appeals has the Medicare Appeals Council taken longer than the statutory maximum of 90 days from the hospital's request for review to issue a decision?

22. What is the longest delay your hospital has experienced for a determination at the Medicare Appeals Council level of appeal?

-- Select --

23. Have you been unsuccessful in getting the Medicare Appeals Council to award full outpatient level payment for all services (including, as appropriate, observation, surgery, et al.) for any appeal where the RAC concluded that the care was medically necessary, but provided in the wrong setting?

○ Yes ○ No

RAC Process Problems

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

○ Excellent ○ Good ○ Fair ○ Poor

24. 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

25A. 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

26A. 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
- ☐ A RAC denial for MS-DRG or coding validation is converted to medical necessity denial during appeals process
- ☐ Other issues/problems (include box)

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

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