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AHA DRAFT RACTRAC SURVEY QUESTIONS

- ☐ Check here if your hospital currently uses a RACTrac compatible vendor or the AHA Claim Level Tool to track / upload your survey data.

- Indicate the RACTrac compatible software that your hospital uses to track / upload your survey data.
- If Other RAC vendor, please provide details here: _____
- Does your RACTrac data represent your hospital's cumulative experience since RACs began auditing in January 2010? Y/N

CMS Part A to Part B Re-bill Experience

- How many appeals has your hospital withdrawn from the appeals process in order to re-bill for Part B payment?

OVERPAYMENTS – AUTOMATED RAC REVIEWS

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

- Total cumulative number of automated claim denials
- Total cumulative automated claim denial Medicare reimbursement dollar amount (sum of all demand letter amounts)
- Total cumulative Medicare reimbursement dollars recouped for automated claim denials

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CURRENT QUARTER

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

- 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 _____

- 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 service area and number 2 being the second largest dollar value service area in this quarter).

- 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 (MS-DRG)
- ☐ 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

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

Psychiatric Services Hospital / United

- ☐ Psychiatric Services Hospital/Unit – Duplicate Payment
- ☐ Psychiatric Services Hospital/Unit – Inpatient Psych Coding Error (MS-DRG)
- ☐ Psychiatric Services Hospital/Unit – All Other

Long Term Care Hospital / Unit

- ☐ Long Term Care Hospital/Unit – Duplicate Payment
- ☐ Long Term Care Hospital/Unit – Inpatient Coding Error (LTC-DRG)
- ☐ Long Term Care Hospital/Unit – All Other

– Rank order the denial reasons experienced by number of automated 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 _____

– 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 2 being the second largest dollar value in this quarter).
Number 1
Select Denial Reason _____
Number 2
Select Denial Reason _____

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OVERPAYMENTS – COMPLEX REVIEWS

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 [Exclude pre-payment reviews]
All underpayment information should be entered in the Underpayments Section.
Totals should reflect cumulative experience since October 2008

- Total number of medical record requests received
  - Total Medicare reimbursement dollar value of the claims associated with the medical records requested
- Total number of medical records approved (i.e. no overpayment identified)
  - Total Medicare reimbursement dollar value of medical records approved
- Total number of medical records where an overpayment was identified (i.e. denied)
  - Total Medicare reimbursement dollar value of medical records in which an overpayment was identified (i.e. denied)
- Total number of medical records pending determination by the RACs
  - Total Medicare reimbursement dollar value of medical records pending determination
- Estimate the total dollars associated with the overpayments identified during medical record review (complex claim denials) to date.

CURRENT QUARTER

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

- 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 _____

- Select the reasons cited by the RAC 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
  - ☐ 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
- ☐ Inpatient Rehabilitation Hospital/Unit – Other Medically Unnecessary
- ☐ Inpatient Rehabilitation Hospital/Unit – All Other (Enter in text box below)

Psychiatric Services Hospital / United

- ☐ 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 LTC-DRG or Other Coding Error
- ☐ Long Term Care Hospital/Unit – Medically Unnecessary
- ☐ Long Term Care Hospital/Unit – All Other (Enter in text box below)

– Rank order the denial reasons experienced by number of complex 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 _____

– 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 2 for the second largest Medicare reimbursement dollar value of claim denials in this quarter).
Number 1
Select Denial Reason _____
Number 2
Select Denial Reason _____

– 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. (Excluding medical necessity denials).
First DRG Code _____
Second DRG Code _____
Third DRG Code _____
CMG _____

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MEDICAL NECESSITY REVIEWS
[Exclude pre-payment reviews]

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

Medical Necessity Denials for Less Than 2-Midnights

- Total number of all medical necessity denials with LOS less than 2-midnights
  - Total Medicare reimbursement dollar amount from the demand letter of medical necessity denials with LOS less than 2-midnights
- 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)
  - Medicare reimbursement dollar amount from the demand letter of medical necessity denials due to inappropriate setting only with LOS less than 2-midnights

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Medical Necessity Denials for Greater Than or Equal to 2-Midnights

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

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- List the top three MS-DRGs (as measured by reimbursement impact) for which your hospital has experienced a complex denial for a medical necessity.
  First DRG Code _____
  Second DRG Code _____
  Third DRG Code _____
  CMG_____

- How many claims denied for medical necessity level of care were denied more than one year from the date ofservice?
- Was your organization a participant in the Part A to Part B rebilling demonstration?

- How many medical necessity level of care denials has your organization re-billed under Part B since March 13, 2013?
- For denials re-billed since March 13, 2013, what was the original Medicare Part A total payment?
- How many Part A medical necessity level of care denials has your organization re-billed under Part B **AND** received Part B reimbursement?
- For denials re-billed **AND** paid under Part B, what was the original Medicare Part A total payment?
- For denials re-billed **AND** paid under Part B, what was the Medicare Part B total payment?

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UNDERPAYMENTS

Cumulative experience since 2008 [Exclude pre-payment reviews]

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

- Total cumulative number of claims identified as underpayments
- Estimate of total cumulative Medicare reimbursement dollars determined to be underpayments

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CURRENT QUARTER

- ☐ Check here is your hospital has had no new underpayment activity this quarter.
  (If checked, skip to Pre-payments)

- Indicate the reasons identified by the RAC for underpayments <u>this quarter</u>. (Check all that apply)
  Below are the choices for this question.
  - ☐ Billing Error
  - ☐ Inpatient Discharge Status
  - ☐ Incorrect MS-DRG / CMG / LTC-DRG
  - ☐ Outpatient Coding Error
  - ☐ All Other

  Please contact AHA if you have experienced a significant number of claims 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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RAC PRE-PAYMENT REVIEWS / DENIALS / APPEALS

Cumulative experience since 2008

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

- Total cumulative number of medical records requested for RAC pre-payment review
  - Total estimated Medicare reimbursement for medical records requested for RAC pre-payment review
- Total number of RAC pre-payment denials
  - Total estimated Medicare reimbursement for RAC pre-payment denials
- Total number of RAC pre-payment denials appealed
  - Total estimated Medicare reimbursement for RAC pre-payment denials appealed
- Total number of RAC pre-payment denials overturned
  - Total Medicare reimbursement for RAC pre-payment denials overturned

- 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 _____

- Rank order the denial reasons experienced by the estimated total Medicare reimbursement dollar value of the pre-payment claim denials for this quarter.
  (Number 1 for the largest and number 2 for the second largest Medicare reimbursement dollar value of claim denials in this quarter).
  Number 1
  Select Denial Reason _____
  Number 2
  Select Denial Reason _____

- List the top two MS-DRGs (as measured by estimated reimbursement impact) for which your hospital has experienced a pre-payment denial.
  First DRG Code _____
  Second DRG Code _____
  CMG _____

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April 21, 2014

APPEALS

Cumulative experience since 2008
Enter the information on an Appeal ONLY if you have received a Demand Letter.[Exclude appeals of pre-payment denials]
Totals should reflect cumulative experience since 2008.

- Total number of appeals filed
  - Total Medicare reimbursement dollar value of the denials filed for appeal
- Total number of appeals overturned in favor of the provider at any level of the appeals process
  - Total Medicare reimbursement dollars of appeals that have been overturned in favor of the provider at any level of the appeals process
  - Total number of appeals to date that were initially filed to the FI/MAC and later withdrawn from the process, or not continued
  - Total Medicare reimbursement dollar value of the appeals that were initially filed to the FI/MAC and later withdrawn or stop*ped by the provider at any level of the appeals proces*s
- 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 re-billed)*
  - Total Medicare reimbursement dollar value of the appeals that were initially filed to the FI/MAC and later withdrawn or stopped by the provider at any level of the appeals process in order to rebill the claim *(INCLUDE only those appeals withdrawn and re-billed)*
- Total number of appeals currently in process
  - Total Medicare reimbursement dollar value of the appeals currently in process
- Average administrative cost per appeal (cost associate with the appeals process)

CURRENT QUARTER

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

  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 (MS-DRG) – (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 (CMG) – (Automated)
  - ☐ Inpatient Rehabilitation Hospital/Unit – All Other – (Automated)

  Psychiatric Services Hospital / United (Automated)
  - ☐ Psychiatric Services Hospital/Unit – Duplicate Payment – (Automated)
  - ☐ Psychiatric Services Hospital/Unit – Inpatient Psych Coding Error (MS-DRG) – (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 (LTC-DRG) – (Automated)
  - ☐ Long Term Care Hospital/Unit – All Other – (Automated)

  Medical / Surgical Acute Care Hospital / Service (Complex)

- ☐ Medical/Surgical Acute Care Hospital/Services – No Document 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 (Less than 2 midnights) – (Complex)
- ☐ Medical/Surgical Acute Care Hospital/Services – Medically Unnecessary Inpatient Stay Greater Than or Equal to 2 midnights – (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 / United (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 LTC-DRG or Other Coding Error – (Complex)
- ☐ Long Term Care Hospital/Unit – Medically Unnecessary – (Complex)
- ☐ Long Term Care Hospital/Unit – All Other – (Complex)

– For those appeals that have been overturned in favor of the provider this quarter, 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

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

– Cumulative number of denials filed for appeal at Level 1
  – Total Medicare reimbursement dollar value of the denials filed for appeal at Level 1
– Cumulative number of denials overturned (in favor of provider) at Level 1
  – Total Medicare reimbursement for denials overturned (in favor of provider) at Level 1

- Cumulative number of appeals initially filed and then stopped / withdrawn by hospital at Level 1, excluding those withdrawn for rebilling
  - Total Medicare reimbursement for appeals initially filed and then stopped / withdrawn, by hospital at Level 1, excluding those withdrawn for rebilling
- Cumulative number of appeals initially filed and then stopped / withdrawn by hospital at Level so claim can be re-billed
  - Total Medicare reimbursement for appeals initially filed and then stopped / withdrawn at Level 1 so claim could be re-billed
- Cumulative number of appeals with an unfavorable determination at Level 1
  - Total Medicare reimbursement for appeals with an unfavorable determination at Level 1
- Total number of appeals pending determination at Level 1
  - Total Medicare reimbursement dollar value for appeals pending determination at Level 1

Appeal Status – Level 2 (QIC)

Please complete the following questions for appeal activity at Level 2 (QIC) [Exclude appeals of pre-payment denials] CUMULATIVE since 2008

- Cumulative number of denials filed for appeal at Level 2
  - Total Medicare reimbursement dollar value of the denials filed for appeal at Level 2
- Cumulative number of denials overturned (in favor of provider) at Level 2
  - Total Medicare reimbursement for denials overturned (in favor of provider) at Level 2
- Cumulative number of appeals initially filed and then stopped / withdrawn by hospital at Level 2, excluding those withdrawn for rebilling
  - Total Medicare reimbursement for appeals initially filed and then stopped / withdrawn, by hospital at Level 2, excluding those withdrawn for re-bill
- Cumulative number of appeals initially filed and then stopped / withdrawn by hospital at Level 2 so claim can be re-billed
  - Total Medicare reimbursement for appeals initially filed and then stopped / withdrawn at Level 2 so claim could be re-billed
- Cumulative number of appeals with an unfavorable determination at Level 2
  - Total Medicare reimbursement for appeals with an unfavorable determination at Level 2
- Total number of appeals pending determination at Level 2
  - Total Medicare reimbursement dollar value for appeals pending determination at Level 2
- For how many appeals filed at level 2 (QIC) has the QIC taken longer than 60 days to issue a decision?

Appeal Status – Level 3 (ALJ)

Please complete the following questions for appeal activity at Level 3 (Administrative Law Judge) .[Exclude appeals of pre-payment denials] CUMULATIVE since 2008

- Cumulative number of denials filed for appeal at Level 3
  - Total Medicare reimbursement dollar value of the denials filed for appeal at Level 3
- Cumulative number of denials overturned (in favor of provider) at Level 3
  - Total Medicare reimbursement for denials overturned (in favor of provider) at Level 3
- Cumulative number of appeals initially filed and then stopped / withdrawn by hospital at Level 3, excluding those withdrawn for rebilling

  - Total Medicare reimbursement for appeals initially filed and then stopped / withdrawn, by hospital at Level 3, excluding those withdrawn for re-bill
- Cumulative number of appeals initially filed and then stopped / withdrawn by hospital at Level 3 so claim can be re-billed
  - Total Medicare reimbursement for appeals initially filed and then stopped / withdrawn at Level 3 so claim could be re-billed
- Cumulative number of appeals with an unfavorable determination at Level 3
  - Total Medicare reimbursement for appeals with an unfavorable determination at Level 3
- Total number of appeals pending determination at Level 3
  - Total Medicare reimbursement dollar value for appeals pending determination at Level 3
- For how many level 3 ALJ appeals has the ALJ taken longer than 90 calendar days to issue a decision from receipt of organization's request for hearing?

Appeal Status – Level 4 (Medicare Appeals Council)

- Has your hospital appealed any claims to Level 4 of the appeals process
  ☐ Yes ☐ No
  - If yes, how many _____

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ADMINISTRATIVE BURDEN

Appeals Experience

- 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

- 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 $ _____

- 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

- Have you escalated any appeals to the Medicare Appeals Council as a result of the untimely response of the ALJ?
  ☐ Yes ☐ No
  - If yes, how many _____

- Have you had RAC denials overturned during the discussion period?
  ☐ Yes ☐ No ☐ Don't Know
  - If yes, how many _____

- 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
  - If yes, for how many claims _____

- Have any claims denied for DRG Validation become full medical necessity denials during the appeals process?
  ☐ Yes ☐ No
  - If yes, how many _____

RAC Process Problems

- How would you rate the responsiveness to your inquiries and the overall communication with RAC?
  ☐ Excellent ☐ Good ☐ Fair ☐ Poor

- 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

- 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

- 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

- 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 no 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 RACs 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)
  - If other issues / problems was selected, please provide details here

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