AHA RACTrac Survey
New Survey Layout That Will Be in Effect as of April 1, 2015

General – Screen 1 in Data Entry

### Entering Data for Hospital: Sample Hospital 1

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

#### RACTrac Vendor

- 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/vendor that your hospital uses to track/upload your survey data.**

- Claim Level Tool, AHA
- 3MTM Audit Expert RAC Management Tool
- Audit-TRAX, New Jersey Hospital Association - Healthcare Business Solutions, Inc.
- AuditTrends(TM) Online (formerly RAC Tracker Online)
- Axis Audit Control, Quadax, Inc.
- ChartMaxx(R) RAC Manager MediPlus, a Quest Diagnostics Company
- ClickON(R) RADs, The SSI Group, Inc.
- Cobius Audit Manager, Cobius Healthcare Solutions, LLC
- Compliance 360(TM) Claims Audit Manager
- Compliance and Revenue Integrity (CRI), MedicaLogic
- CompLyTrack, Wolters Kluwer Law and Business, MediRegs
- HealthPort AuditsPro(TM), HealthPort(R)
- IOD - RACessio(TM) - RAC & Appeal Mgmt Tool
- iSight Audit, Craneware Insight
- Midsys, Care Management, Midsys Solutions
- OneBase RAC Administration Solution, Hyland Software, Inc.
- RAC Audit Tracking, Ryman Technologies, Inc.
- RAC Guard, The Wellington Group LLC
- RACTelligence Tracking, PACE Healthcare Consulting, LLC
- Revenue Integrity Compass, Advisory Board Company
- TRACK(TM), Array Software
- Veracity, Intersect Healthcare
- Other

If Other RAC vendor, please provide details here: ________________________________

#### CMS 68% Settlement Offer

- Did your facility participate in the CMS 68% Settlement Offer for resolving appeals of patient status denials? ○ Yes ○ No

#### Cumulative experience since January 2010

- Check here if your RACTrac data represent your hospital’s cumulative experience since RACs began auditing nationwide in January 2010?

[Cancel] [Next >]
Overpayments (Automated) - Screen 2 in Data Entry

Entering Data for Hospital:

Current Quarter: October 01, 2014 to December 31, 2014
Entry Date: January 12, 2015

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 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 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. 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 (CMRG)
   ☐ 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 (LTC-DRG)
   ☐ 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.
7. 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

8. 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
### Overpayments (Complex) - Screen 3 in Data Entry

#### Entering Data for Hospital:
- **Current Quarter:** October 01, 2014 to December 31, 2014
- **Entry Date:** January 12, 2015

#### 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.
Medical records requests that have been rescinded by the RACs should not be reported.
Totals should reflect cumulative experience since October 2008

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total number of medical record requests received</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Total number of medical records where no improper payment was identified</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Total number of medical records where an overpayment was identified (i.e., denied)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Total number of medical records pending determination by the RAC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Estimate the total dollars associated with the overpayments identified during medical record review (complex claim denial)</td>
<td>$</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### CURRENT QUARTER
- Check here if your hospital has had no new complex overpayment activity this quarter.
- (If checked, skip to Medical Necessity 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)

<table>
<thead>
<tr>
<th>Number 1</th>
<th>Select Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number 2</td>
<td>Select Service Area</td>
</tr>
</tbody>
</table>

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 MIS-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 - 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 MIS-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)

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 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

9. 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

10. 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
## Medical Necessity Reviews – Screen 4 in Data Entry

### Entering Data for Hospital:

- **Current Quarter:** October 01, 2014 to December 31, 2014
- **Entry Date:** January 12, 2015

<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>

Unless otherwise mentioned, all totals should reflect cumulative experience since October 2006.

### 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.**

### 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: 

### 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?  
   - [ ] Yes  
   - [ ] No

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?  
   - $
### Entering Data for Hospital:

- **Current Quarter:** October 01, 2014 to December 31, 2014
- **Entry Date:** January 12, 2015

<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

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*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.*
## Entering Data for Hospital:

**Current Quarter:** October 01, 2014 to December 31.

- **Entry Date:** January 12, 2015
- **Overpayments (Automated)**
- **Overpayments (Complex)**
- **Medical Necessity Denials**
- **Underpayments**
- **Appeals**
- **Pre-Payments**
- **Administrative Burden**

## CUMULATIVE EXPERIENCE SINCE OCTOBER 2008

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

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total number of appeals filed</td>
<td>1A. Total Medicare reimbursement dollar value of the denial(s) filed for appeal</td>
<td>$</td>
</tr>
<tr>
<td>2. Total number of appeals overturned in favor of the provider at any level of the appeals process</td>
<td>2A. Total Medicare reimbursement dollars of appeals that have been overturned in favor of the provider at any level of the appeals process</td>
<td>$</td>
</tr>
<tr>
<td>3. Total number of appeals to date withdrawn or stopped by the provider at any level of the appeals process. <strong>INCLUDE ALL appeals withdrawn / stopped to re-bill, to accept the CMS 68% settlement offer, or withdrawn / not continued for other reasons. Do Not Include appeals overturned.</strong></td>
<td>3A. Total number of appeals to date withdrawn or stopped by the provider at any level of the appeals process. <strong>INCLUDE ALL appeals withdrawn / stopped to re-bill, to accept the CMS 68% settlement offer, or withdrawn / not continued for other reasons. Do Not Include appeals overturned.</strong></td>
<td>$</td>
</tr>
<tr>
<td>4. Total number of appeals to date that were initially filed to the FI/MAC and later withdrawn from the process, or not continued in order to accept the CMS 68% settlement offer.</td>
<td>4A. Total Medicare reimbursement dollar value of appeals to date that were initially filed to the FI/MAC and later withdrawn from the process, or not continued in order to accept the CMS 68% settlement offer.</td>
<td>$</td>
</tr>
<tr>
<td>5. 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 re-bill the claim. <strong>INCLUDE only those appeals withdrawn and re-billed.</strong></td>
<td>5A. Total Medicare reimbursement dollar value of the appeals currently in process</td>
<td>$</td>
</tr>
<tr>
<td>6. Total number of appeals currently in process</td>
<td>6A. Total Medicare reimbursement dollar value of the appeals currently in process</td>
<td>$</td>
</tr>
<tr>
<td>7. Average administrative cost per appeal (cost associated with the appeals process)</td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

## CURRENT QUARTER

7. For the first level 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 denial 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 - Other Medically Unnecessary (Less than 2-nights) - (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 (LTC-DRG) - (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 - Short Stay Medically Inappropriate (Less than 2-nights) - (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 LTC-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.

### Appeal Status - Level 1 (FIMAC)

Please complete the following questions for appeal activity at Level 1 (Fiscal Intermediary / Medicare Administrative Contractor). (Exclude appeals of pre-payment denials - CUMULATIVE since 2006.)

<table>
<thead>
<tr>
<th>Question</th>
<th>Value</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 or withdrawn by hospital at Level 1 excluding those withdrawn for rebilling and those withdrawn to accept the CMS 68% settlement offer.</td>
<td></td>
</tr>
<tr>
<td>4. Cumulative number of appeals initially filed and then stopped or withdrawn by hospital at Level 1 in order to accept the CMS 68% settlement offer.</td>
<td></td>
</tr>
<tr>
<td>5. Cumulative number of appeals initially filed and then stopped or withdrawn by hospital at Level 1 so claim can be rebilled.</td>
<td></td>
</tr>
<tr>
<td>6. Cumulative number of appeals with an unfavorable determination at Level 1</td>
<td></td>
</tr>
<tr>
<td>7. Total number of appeals currently pending determination at Level 1. INCLUDE ONLY those appeals still in process (i.e. awaiting a determination).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<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 or withdrawn by hospital at Level 1 excluding those withdrawn for rebilling and those withdrawn to accept the CMS 68% settlement offer.</td>
<td>$</td>
</tr>
<tr>
<td>4A. Total Medicare reimbursement for appeals initially filed and then stopped or withdrawn by hospital at Level 1 in order to accept the CMS 68% settlement offer.</td>
<td>$</td>
</tr>
<tr>
<td>5A. Cumulative Medicare reimbursement for appeals initially filed and then stopped or withdrawn by hospital at Level 1 so claim can be rebilled.</td>
<td>$</td>
</tr>
<tr>
<td>6A. Total Medicare reimbursement for appeals with an unfavorable determination at Level 1</td>
<td>$</td>
</tr>
<tr>
<td>7A. Total Medicare reimbursement for appeals currently pending determination at Level 1. INCLUDE ONLY those appeals still in process (i.e. awaiting a determination).</td>
<td>$</td>
</tr>
</tbody>
</table>
### 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.

1. Total Cumulative number of denials filed for appeal at Level 2
2. Cumulative number of denials overturned (in favor of provider) at Level 2
3. Cumulative number of appeals initially filed and then stopped or withdrawn by hospital at Level 2 excluding those withdrawn for rebilling and those withdrawn to accept the CMS 68% settlement offer.
4. Cumulative number of appeals initially filed and then stopped or withdrawn by hospital at Level 2 in order to accept the CMS 68% settlement offer.
5. Cumulative number of appeals initially filed and then stopped or withdrawn by hospital at Level 2 so claim can be rebilled.
6. Cumulative number of appeals with an unfavorable determination at Level 2
7. Total number of appeals currently pending determination at Level 2. INCLUDE ONLY those appeals still in process (i.e. awaiting a determination).
8. For how many level 2 QIC appeals has the QIC taken longer than 90 days to issue a decision?

1A. Total Medicare reimbursement dollar value of the denials filed for appeal at Level 2
2A. Total Medicare reimbursement for denials overturned (in favor of provider) at Level 2
3A. Total Medicare reimbursement for appeals initially filed and then stopped or withdrawn by hospital at Level 2 excluding those withdrawn for rebilling and those withdrawn to accept the CMS 68% settlement offer.
4A. Total Medicare reimbursement for appeals initially filed and then stopped or withdrawn by hospital at Level 2 in order to accept the CMS 68% settlement offer.
5A. Total Medicare reimbursement for appeals initially filed and then stopped or withdrawn by hospital at Level 2 so claim can be rebilled.
6A. Total Medicare reimbursement for appeals with an unfavorable determination at Level 2
7A. Total Medicare reimbursement for appeals currently pending determination at Level 2. INCLUDE ONLY those appeals still in process (i.e. awaiting a determination).

### 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.

1. Total Cumulative number of denials filed for appeal at Level 3?
2. Cumulative number of denials overturned (in favor of provider) at Level 3
3. Cumulative number of appeals initially filed and then stopped or withdrawn by hospital at Level 3 excluding those withdrawn for rebilling and those withdrawn to accept the CMS 68% settlement offer.
4. Cumulative number of appeals initially filed and then stopped or withdrawn by hospital at Level 3 in order to accept the CMS 68% settlement offer.
5. Cumulative number of appeals initially filed and then stopped or withdrawn by hospital at Level 3 so claim can be rebilled.
6. Cumulative number of appeals with an unfavorable determination at Level 3
7. Total number of appeals currently pending determination at Level 3. INCLUDE ONLY those appeals still in process (i.e. awaiting a determination).
8. 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?

1A. Total Medicare reimbursement dollar value of the denials filed for appeal at Level 3
2A. Total Medicare reimbursement for denials overturned (in favor of provider) at Level 3
3A. Total Medicare reimbursement for appeals initially filed and then stopped or withdrawn by hospital at Level 3 excluding those withdrawn for rebilling and those withdrawn to accept the CMS 68% settlement offer.
4A. Total Medicare reimbursement for appeals initially filed and then stopped or withdrawn by hospital at Level 3 in order to accept the CMS 68% settlement offer.
5A. Total Medicare reimbursement for appeals initially filed and then stopped or withdrawn by hospital at Level 3 so claim could be rebilled.
6A. Total Medicare reimbursement for appeals with an unfavorable determination at Level 3
7A. Total Medicare reimbursement for appeals currently pending determination at Level 3. INCLUDE ONLY those appeals still in process (i.e. awaiting a determination).

### Appeal Status - Level 4 (Medicare Appeals Council)

- Has your hospital appealed any claims to level 4 of the appeals process?
  - 1A. If yes, how many?
  - 1B. Total Medicare reimbursement dollar value of the denials filed for appeal at level 4
Pre-Payments - Screen 7 in Data Entry

### Entering Data for Hospital:

- **Current Quarter:** October 01, 2014 to December 31, 2014
- **Entry Date:** January 12, 2015

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

### 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: 
2. Total number of RAC pre-payment denials: 
3. Total number of RAC pre-payment denials appealed: 
4. Total number of RAC pre-payment denials overturned: 

### 1A. Total Medicare reimbursement for medical records requested for RAC pre-payment review: 

### 2A. Total Medicare reimbursement for RAC pre-payment denials: 

### 3A. Total Medicare reimbursement amount for RAC pre-payment denials appealed: 

### 4A. Total Medicare reimbursement 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: 

6. Rank order the denial reasons experienced by estimated total Medicare reimbursement dollar value 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: 

7. List the top two MS-DRGs (as measured by reimbursement impact) for which your hospital has experienced a RAC pre-payment denial.

   - **First DRG Code:** 
   - **Second DRG Code:** 

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# Administrative Burden - Screen 8 in Data Entry

## Entering Data for Hospital:
- **Current Quarter:** October 01, 2014 to December 31, 2014
- **Entry Date:** January 12, 2015

### 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
   - [ ] RAC Claim Management Tool
   - [ ] Medical Record Copying Service
   - [ ] Utilization Management Consultant
   - [ ] 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)
   - [ ] 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

### 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 submitted denials for discussion?
   - [ ] Yes
   - [ ] No
   - [ ] Don't know

   **B. If yes, how many?** ____________

   **C. How many denials submitted for discussion, have been overturned?** ____________

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
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 or 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 receding 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.

< Previous  Verify Entered Data  Finish >