



Quarterly Recovery Audit Contractor Policy and RAC *Trac* Results Update

December 16, 2015



RAC Policy Update

Melissa Jackson, Senior Associate Director

House RAC Bill, H.R. 2156

The Medicare Audit Improvement Act

- Eliminates the contingency fee structure
- Reduces payments to RACs that are inaccurate
- Fixes the CMS's unfair rebilling rules
- Requires RACs to make their inpatient claims decisions using the same information the physician had when treating the patient



Rep. Graves (R-MO)



Rep. Schiff (D-CA)



Senate Finance Audit & Appeals Bill, S. 2368

Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act

- **Prohibits RACs from auditing patient status claims** (inpatient v. outpatient) more than 6 months from date of service
- **Providers with low error rates** get a one-year “pass” on post-payment audits by RACs and MACs
- **If provider agrees**, allows consolidation of claims
- **Establishes** voluntary alternative dispute resolution



Senate Finance Audit & Appeals Bill

AHA ensured key negative provisions were removed and positive provisions were included

Removed:

- **Filing fee for hospitals to file an appeal**

Added:

- **HHS to determine if financial penalties on RACs for high error rates will improve performance**
- **Makes a new alternative dispute resolution process voluntary**



FY 2016 OPPS Final Rule

- **Modifications to the two-midnight policy**
- **Changes to medical review strategy**
- **CMS did NOT reverse 0.2% payment reduction**



Modified Two-midnight Policy

Two midnights after admission order = **2MN presumption**

Expectation of two midnights (inpatient and outpatient time) = **2MN benchmark**

Stay less than two midnights, physician judgment and documentation = **case-by-case basis**

Inpatient only, national exceptions list (“rare and unusual circumstances”)
= always payable as inpatient



CMS Clarification: “Rare and Unusual”

Federal Register / Vol. 80, No. 219 / Friday, November 13, 2015 / Rules and Regulations 70545

threshold to determine the general appropriateness for claim payment; and (4) realign its policy with existing guidance by asserting that, regardless of the expected length of stay, documentation of the medical necessity as well as the need for inpatient hospital care is the requisite component of inpatient admission appropriately paid under Medicare Part A.

Response: In light of this comment, we would like to clarify that our proposed modification to the current exceptions process does not define inpatient hospital admissions with expected lengths of stay less than 2 midnights as rare and unusual. Rather, it modifies our current “rare and unusual” exceptions policy to allow Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark. This modification acknowledges other patient-specific circumstances where certain cases may nonetheless be appropriate for Part A payment, in addition to continuing to provide an opportunity for Part A payment in “rare and unusual” circumstances for which there is a national exception.

In addition, as previously stated in this final rule, we continue to expect it to be rare and unusual for a beneficiary to require inpatient hospital admission after having a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for only a few hours and not at least overnight, and thus such admissions will be prioritized for medical review.

With respect to the comment about hospital level of care, we note that while we do not refer to “level of care” in guidance regarding hospital inpatient admission decisions, but, rather, have consistently provided physicians with the aforementioned time-based guidelines regarding when an inpatient hospital admission is payable under Part A, we do note that, by definition, there are differences between observation services furnished in the outpatient setting and services furnished to hospital inpatients. Specifically, observation services, as defined in Section 290 of Chapter 4 of the Medicare Claims Processing Manual, are a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, that are furnished while a decision is being made, regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

In response to the request that the 2-midnight benchmark be used exclusively for determining the appropriateness of Part A payment, we note that we continue to believe that the 2-midnight benchmark and the 2-midnight rule are not the exclusive means for determining general appropriateness for Medicare Part A payment and whether a claim should be subject to medical review, respectively.

As stated earlier, we also believe that there may be other patient-specific circumstances where certain cases may nonetheless be appropriate for Part A payment, and, therefore, we will allow Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark, if the documentation in the medical record supports the admitting physician’s determination that the patient requires inpatient hospital care, despite an expected length of stay that is less than 2 midnights.

In response to the commenter’s request that CMS realign its policy with existing guidance by asserting that regardless of the expected length of stay, documentation of the medical necessity, as well as the need for inpatient hospital care, are the requisite components of every inpatient admission appropriately paid under Medicare Part A, we note that, consistent with our longstanding policy, all inpatient admissions must be medically reasonable and necessary and be supported by documentation in the patient’s medical record.

Comment: Commenters also commented on the following subject areas in their comments: Self-administered drugs; long observation stays; hospital admission orders; outpatient observation notice; and the 3-day inpatient stay requirement for Medicare skilled nursing facility (SNF) coverage.

Response: We did not include any proposals relating to these areas in the proposed rule. Therefore, we consider these comments to be outside the scope of the proposed rule and are not addressing them in this final rule.

After consideration of the public comments we received, we are finalizing, without modification, our proposal to revise our previous “rare and unusual” exceptions policy to allow for Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark, if the documentation in the medical record supports the admitting physician’s determination that the patient requires inpatient hospital care despite an expected length of stay that is less than 2 midnights. Accordingly, we also are finalizing our proposal to

revise § 412.3(d) to reflect the above policy modification and to increase clarity.

C. Announcement Regarding Changes to Medical Review Process

Shortly after adopting the 2-midnight rule, we instructed the MACs to engage in a Probe and Educate process under the 2-midnight rule from October 2013 through September 2015. We indicated in the CY 2016 OPPS/ASC proposed rule that, regardless of whether we finalize the policy proposals outlined under section XV.B. of this final rule with comment period, no later than October 1, 2015, we would be changing the medical review strategy and planned to have QIO contractors, rather than the MACs, conduct these reviews of short inpatient stays. Among the QIO’s statutory duties is the review of some or all of the professional activities of providers and practitioners in the QIO’s service area, subject to the terms of the QIO contracts, in the provision of health care items or services to Medicare beneficiaries. Such QIO reviews are for the purposes of determining whether providers and practitioners are delivering services that are reasonable and medically necessary, whether the quality of services meets professionally recognized standards of care, and, for inpatient services, whether the services could be effectively furnished on an outpatient basis or in a different type of inpatient facility. Section 1154(a)(1) of the Act authorizes QIOs to review whether services and items billed under Medicare are reasonable and medically necessary and whether services that are provided on an inpatient basis could be appropriately and effectively provided on an outpatient basis, while section 1154(a)(2) of the Act provides for payment determinations to be made based on these QIO reviews. Section 1154(a)(18) of the Act includes provisions that involve broad authority for the Secretary to direct additional activities by QIOs to improve the effectiveness, efficiency, economy, and quality of services under the Medicare program. These reviews are integral to the determination of whether items and services should be payable under the Medicare program.

In addition to the reviews to ensure coverage in accordance with Medicare standards under sections 1154(a)(1) and (a)(2) of the Act, QIO case review work is an effort to measurably improve the quality of health care for Medicare beneficiaries as well as all individuals protected under the Emergency Medical Treatment and Labor Act (EMTALA) and to provide peer review. QIOs have longstanding program experience in

...We would like to clarify that our proposed modification to the current exceptions process *does not define inpatient hospital admissions with expected lengths of stay less than 2 midnights as rare and unusual*. Rather it modifies our current “rare and unusual” exceptions policy to allow Medicare Part A payment on a case-by-case basis for inpatient admissions that do not satisfy the 2-midnight benchmark...

2 MN Changes: Other Key Issues

- **Minor procedures and other treatments with stays less than 24 hours – rare and unusual to require inpatient admission**
- **Stays less than one midnight will be prioritized for medical review**
- **CMS will review patterns of one-night inpatient stays and may add to national exceptions list**



2 MN Changes: AHA's Take

Keep the good

- Stays expected to cross at least two midnights are inpatient
- No changes to two-midnight presumption or benchmark



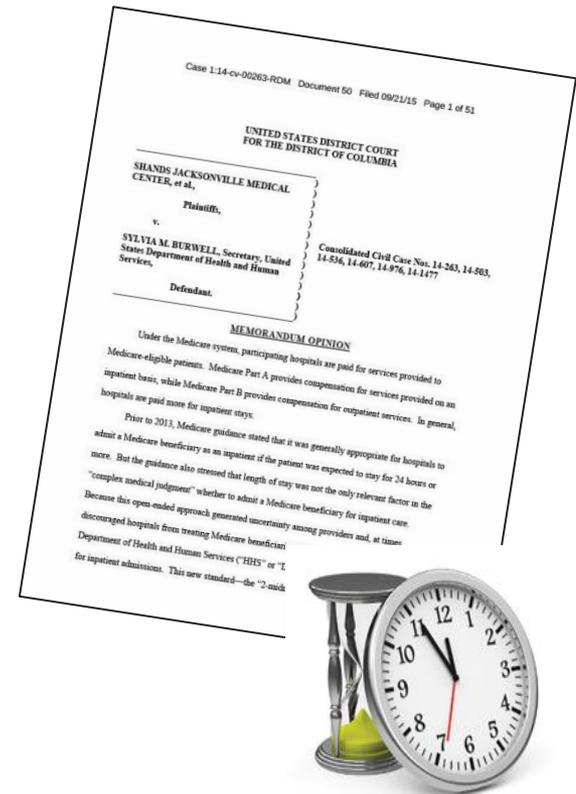
Fix the bad

- Stays less than two midnights may now be payable as inpatient “based on the clinical judgment of the admitting physician and medical record support for that determination”



0.2 % Lawsuit: Current Status

- Court rejected CMS's argument it met legal requirements for rulemaking
- CMS ordered to provide further justification of the 0.2% cut and opportunity for comment
- Notice with comment period released on November 30



Changes to Medical Review Strategy

- **Quality Improvement Organizations (QIOs), NOT RACs, now primarily responsible for patient status reviews**
- **QIOs may refer hospitals to RACs for further audits only if:**
 - ✓ High denial rates
 - ✓ Consistent failure to adhere to two-midnight rule
 - ✓ Failure to improve performance after QIO education
- **Number of RAC audits will be based on hospital's claim volume, denial rate**



Changes to Medical Review Strategy

- **QIOs have begun medical review for inpatient status**
 - ✓ Reviews through Dec. 31, 2015 = **current rule**
 - ✓ Review beginning Jan. 1, 2016 = **modified rule**
- **Process similar to MAC probe and educate**
- **Semiannual reviews: 25 claims for “large” hospitals, 10 claims for other hospitals; CAHs currently not included in claim selection/review**
- **Exclusions: Inpatient only procedures; already-reviewed claims; certain discharge disposition codes (AMA, death, transfer)**
- **QIOs will provide one-on-one education, with chance for discussion regarding individual claims**



To Be Continued...

- **CMS has provided few details regarding RACs' role in two-midnight reviews going forward**
 - ✓ Timeframe for RACs to begin review
 - ✓ Threshold for hospital referral to RACs
 - ✓ Volume of claims subject to review
 - ✓ Interaction with RACs' other work
 - ✓ Limits to RAC review – designated period of time or reduction in error rate?
- **QIO review under modified two-midnight rule**



New RAC Contracts – Update

- Legal proceedings invalidated a portion of the initial proposed scope of work; CMS back to the drawing board
- Last month CMS issued new RFPs for the long-term RAC contracts
- Incumbent RACs operating under contract extensions; currently through June 30, 2016



AHA RAC and Audit Resources

AHA is Helping Hospitals Improve Payment Accuracy and Advocating for Needed Improvements to the Medicare RAC Program

- RAC Updates on latest RAC news and other RAC resources: www.aha.org/rac
- AHA RACTrac: www.aha.org/ractrac; www.aharactrac.com
- Email RAC Questions: racinfo@aha.org





RAC *Trac* Update

Michael Ward, Senior Associate Director

Executive Summary

- 2,568 hospitals have participated in RAC TRAC since data collection began in January of 2010. 604 hospitals participated this quarter.
- 60% of reviewed claims in Q3 2015 were found to not have an overpayment.
- 40% of hospitals indicated, for automated denials, that outpatient coding error had the largest financial impact.
- 83% of hospitals received a complex denial based on inpatient coding in Q3 2015.
- Hospitals report appealing 47% of all RAC denials.
- 45% of hospitals report having a denial reversed in the discussion period.
- 51% of all hospitals reported spending more than \$10,000 managing the RAC process during the 3rd quarter of 2015, 36% spent more than \$25,000 and 8% spent over \$100,000.

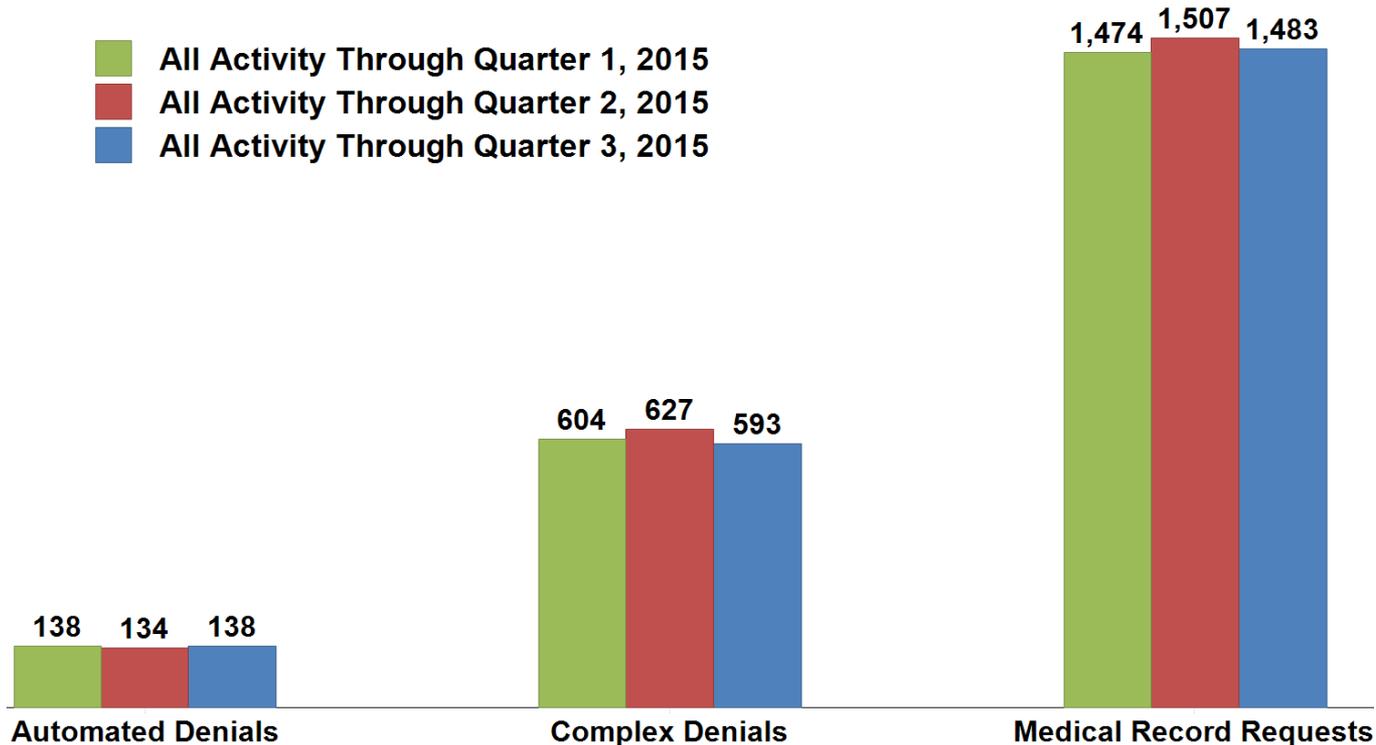




RAC Reviews

The average cumulative number of medical record requests per hospital has remained relatively steady over the last three quarters.

Average Automated Denials, Complex Denials and Medical Records Requests Per Participating Hospital, through 3rd Quarter 2015*



*Response rates vary by quarter.

Source: AHA. (November 2015). RAC TRAC Survey

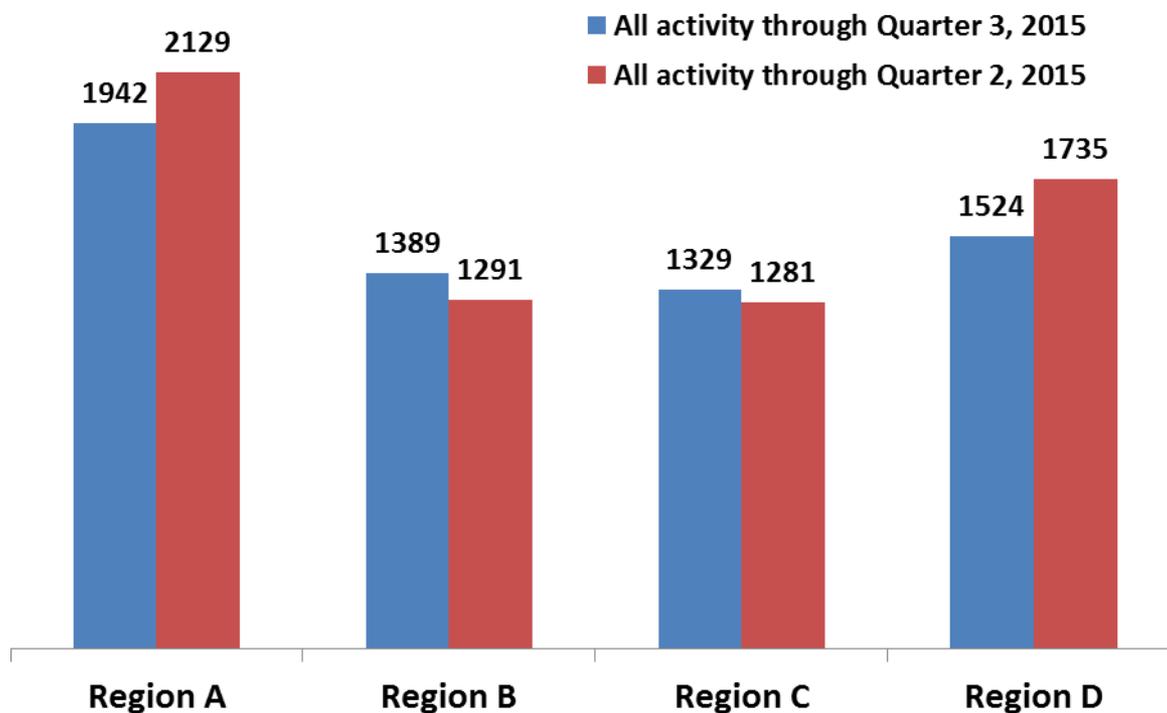
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Region A has the highest average number of medical record requests per hospital.

Average Number of Medical Records Requested Per Participating Hospital With Complex Medical Record RAC Activity, through 3rd Quarter 2015*



*Response rates vary by quarter.

Source: AHA. (November 2015). RAC TRAC Survey

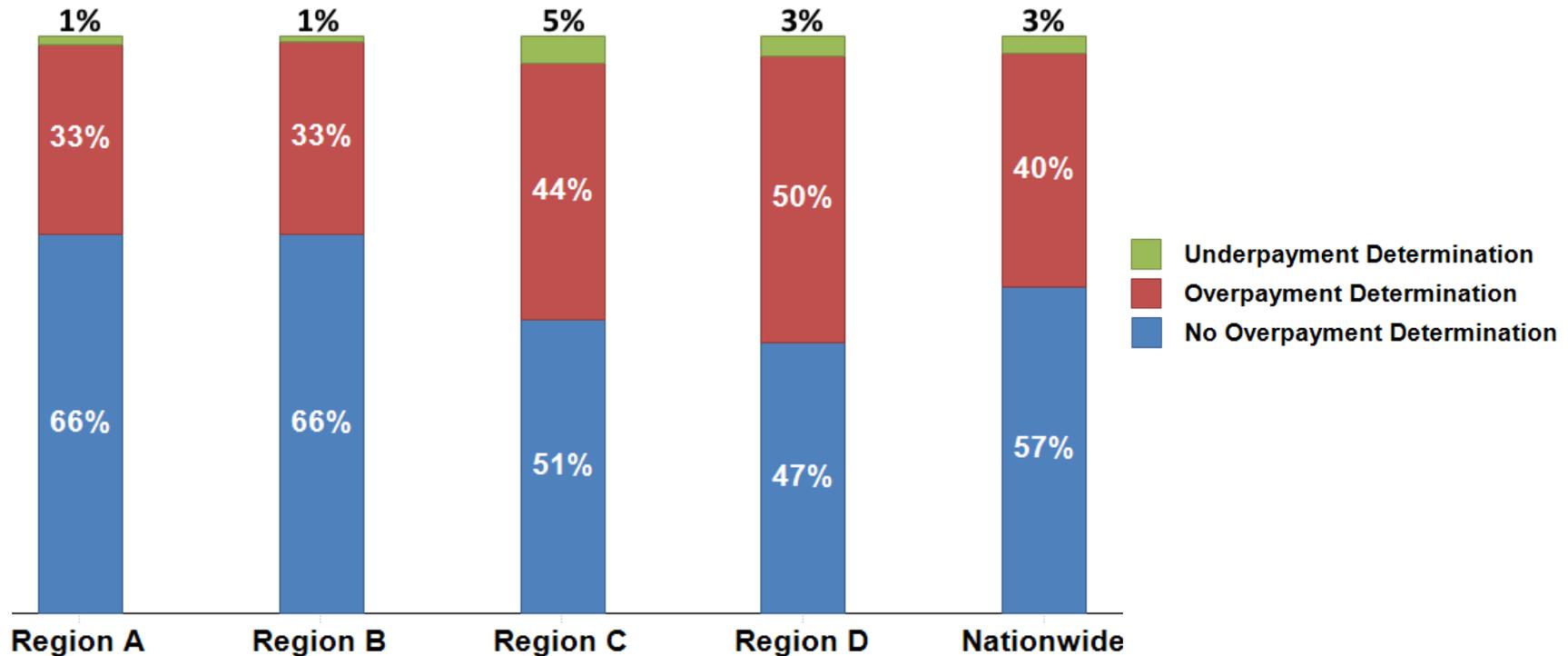
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60% of medical records reviewed by RACs did not contain an overpayment.

Percent of Completed Complex Reviews with and without Overpayment or Underpayment Determinations for Participating Hospitals, by Region, through 3rd Quarter 2015



Source: AHA. (November 2015). RAC TRAC Survey

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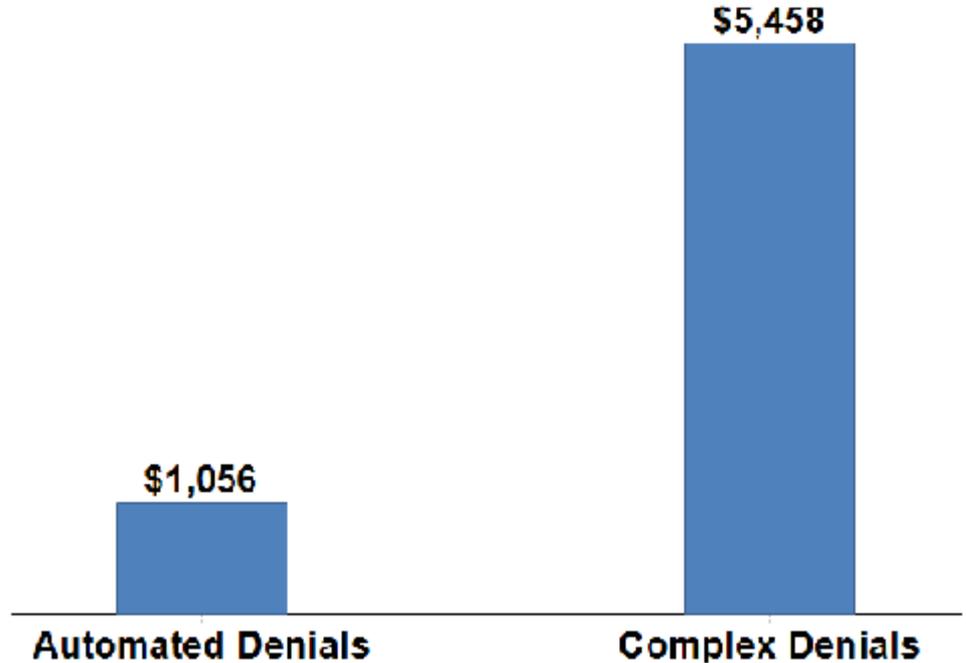


RAC Denials

The average dollar value of an automated denial was \$1,056 and the average dollar value of a complex denial was \$5,458.

Average Dollar Value of Automated and Complex Denials Among Hospitals Reporting RAC Denials, through 3rd Quarter 2015

Average Dollar Amount of Automated and Complex Denials Among Reporting Hospitals, by Region		
RAC Region	Automated Denial	Complex Denial
NATIONWIDE	\$1,056	\$5,458
Region A	\$715	\$5,214
Region B	\$1,912	\$4,668
Region C	\$878	\$5,554
Region D	\$1,172	\$6,078



Source: AHA. (November 2015). RAC TRAC Survey

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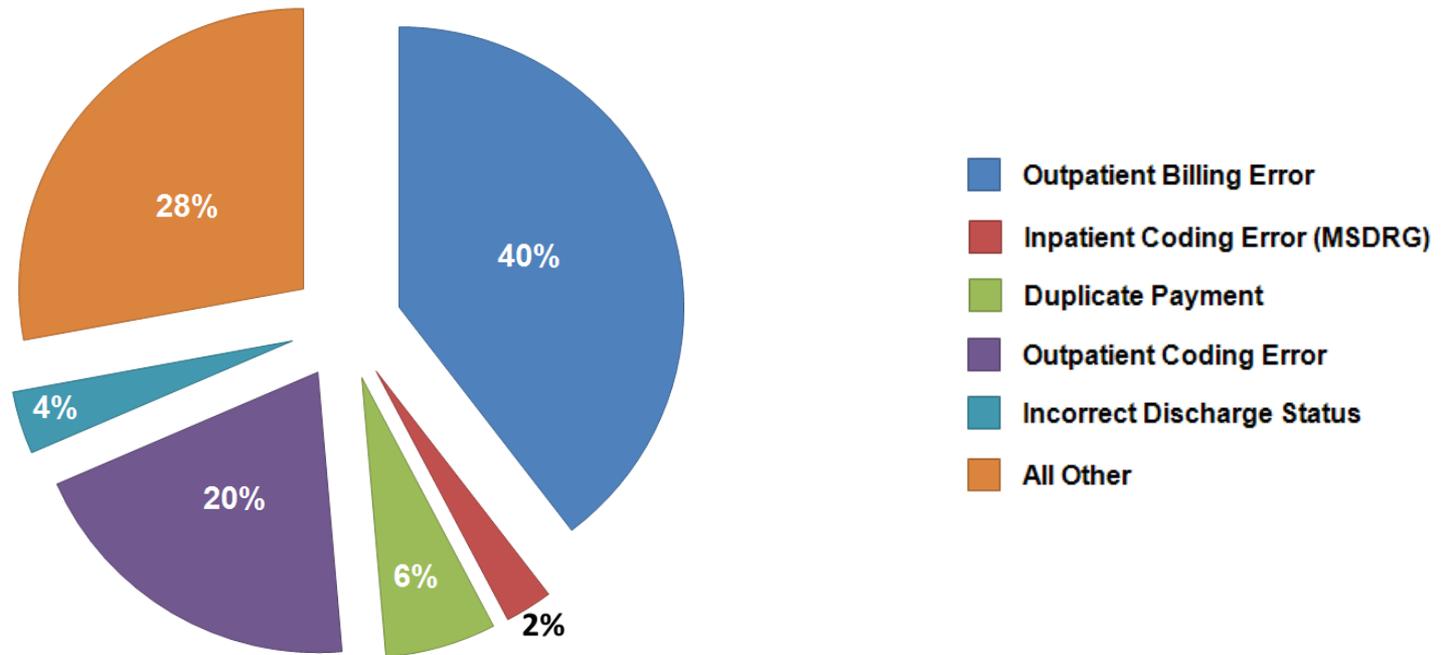


Automated RAC Denials

40% of hospitals report denials for Outpatient Billing Error have the greatest financial impact.

Percent of Participating Hospitals by Top Reason for Automated Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 3rd Quarter 2015

Survey participants were asked to rank denials by reason, according to dollar impact.



Source: AHA. (November 2015). RAC TRAC Survey

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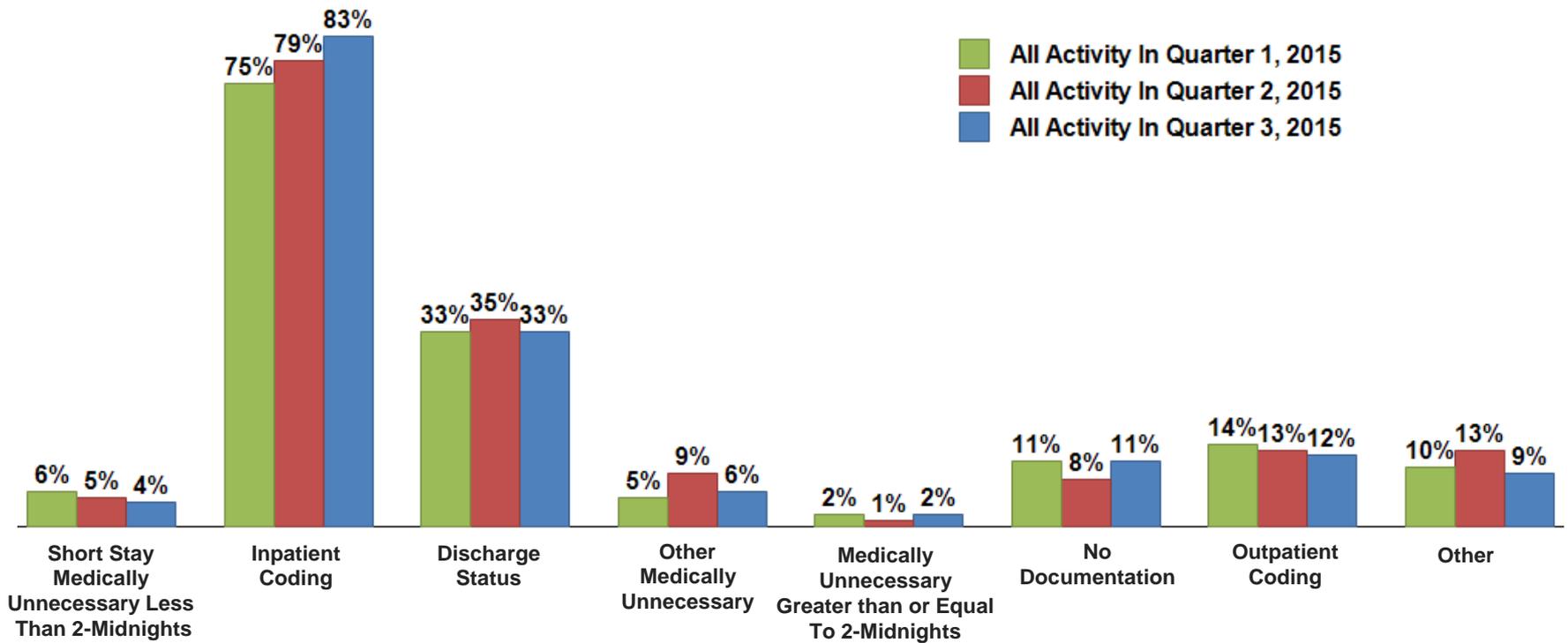


Complex RAC Denials

The most commonly cited reasons for a complex denial are inpatient coding and discharge status.

Percent of Participating Medical/Surgical Acute Hospitals with RAC Activity Experiencing Complex Denials by Reason, through 3rd Quarter 2015

Survey participants were asked to select all reasons for denial.



Source: AHA. (November 2015). RAC TRAC Survey

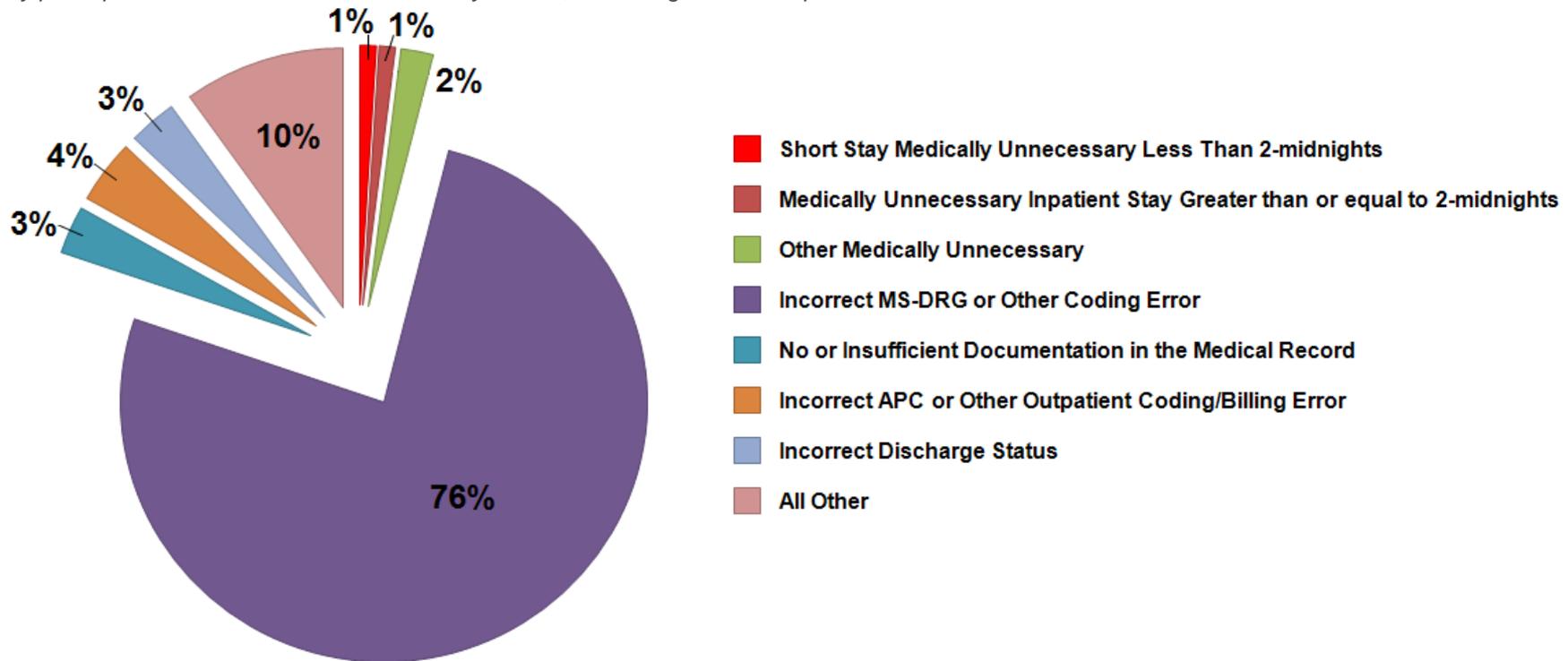
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Nationally, hospitals reported a high percentage of complex denials due to incorrect MS-DRG or other coding error.

Percent of Participating Hospitals by Top Reason for Complex Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 3rd Quarter 2015

Survey participants were asked to rank denials by reason, according to dollar impact.



Source: AHA. (November 2015). RAC TRAC Survey

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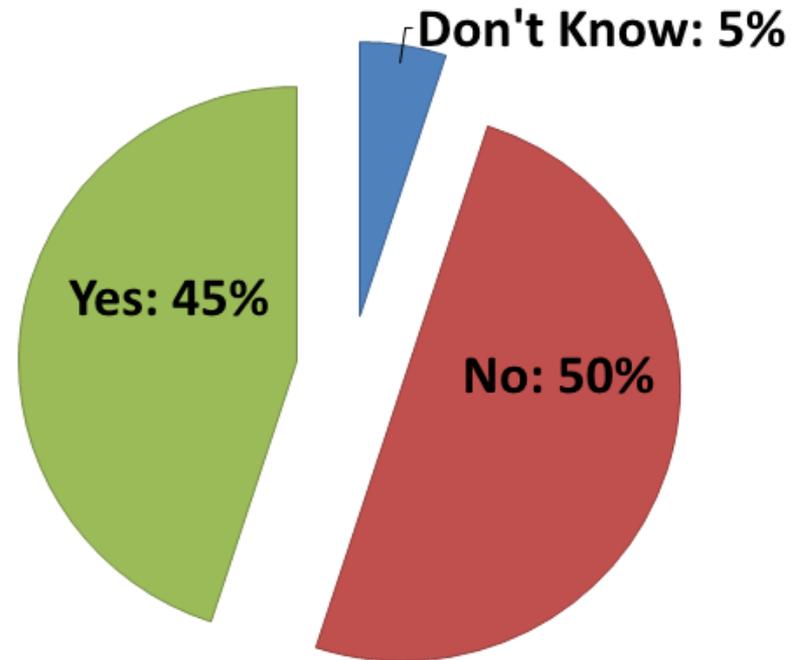
Appeals

45% of participating hospitals report having a denial reversed during the discussion period, including half or more of reporting hospitals in Regions A and C.

Percent of Participating Hospitals with Denials Reversed During the Discussion Period, National and by Region, 3rd Quarter 2015

Reversed Denials by RAC Region

	Yes	No	Don't Know
Region A	58%	27%	15%
Region B	41%	55%	4%
Region C	50%	48%	2%
Region D	22%	72%	6%



*The discussion period is intended to be a tool that hospitals may use to reverse denials and avoid the formal Medicare appeals process. All RACs are required to allow a **discussion period** in which a hospital may share additional information and discuss the denial with the RAC. During the discussion period a hospital may gain more information from the RAC to better understand the cause for the denial and the RAC may receive additional information from the hospital that could potentially result in the RAC reversing its denial.*

Source: AHA. (November 2015). RAC TRAC Survey

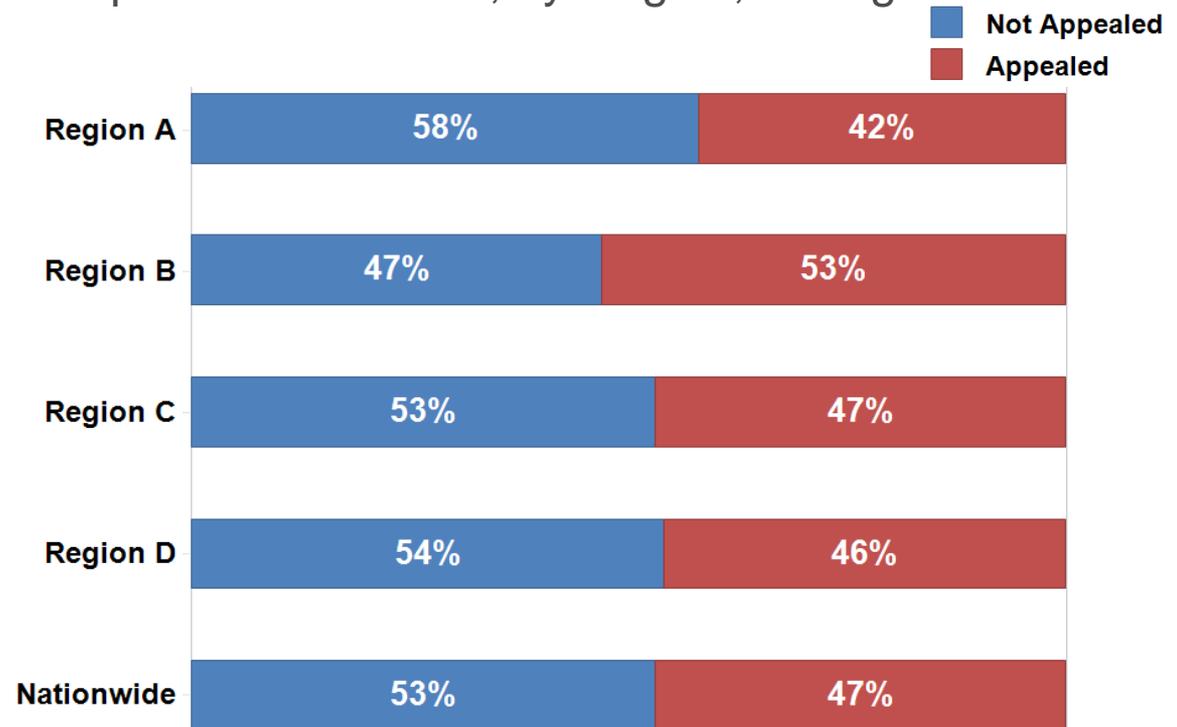
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Nationwide hospitals report appealing 47% of RAC denials including over half of all denials in Region B.

Total Number and Percent of Automated and Complex Denials Appealed by Hospitals with Automated or Complex RAC Denials, by Region, through 3rd Quarter 2015

	Total Number of Denials Available* for Appeal	Total Number of Denials Appealed
Nationwide	366,479	172,498
Region A	62,634	26,289
Region B	63,098	33,493
Region C	161,498	76,191
Region D	79,249	36,525



* Available for appeal means that the hospital received a demand letter for this claim, as a result of either automated or complex review.

Source: AHA. (November 2015). RAC TRAC Survey

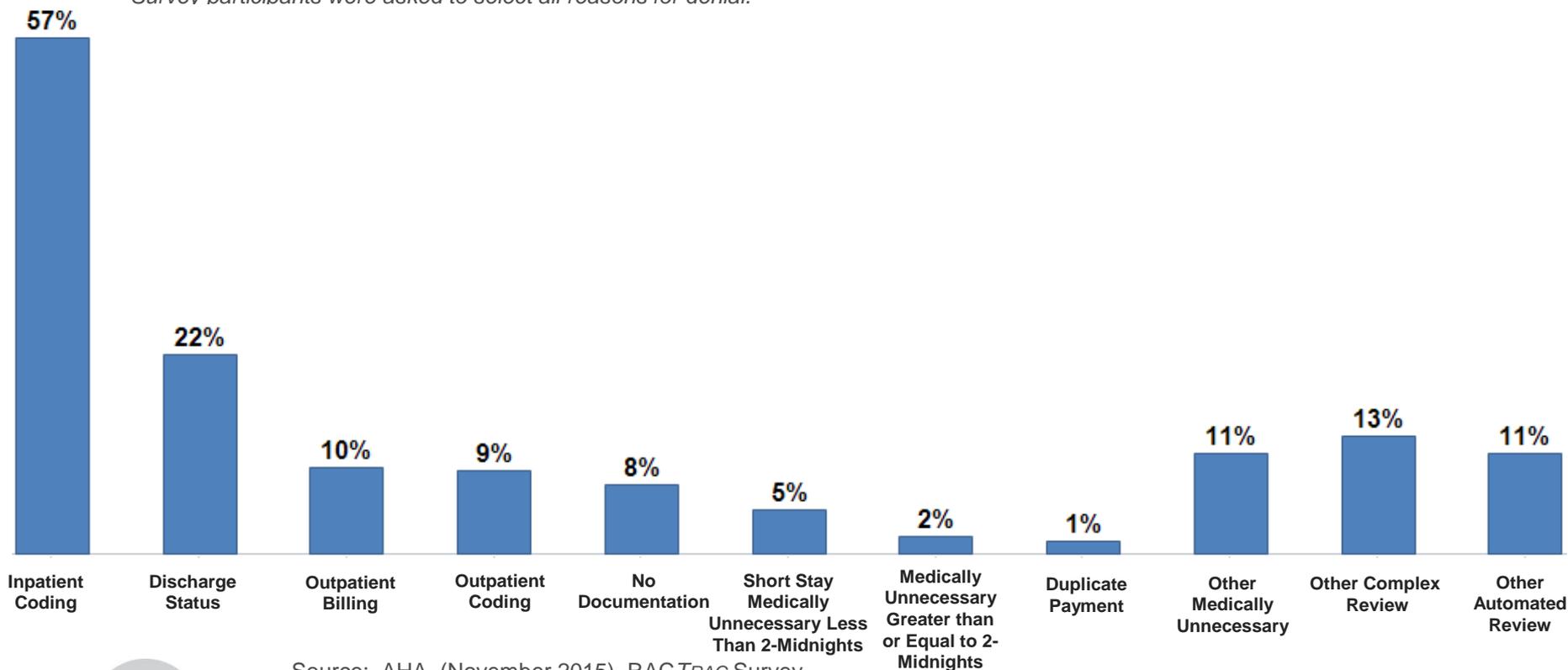
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57% of all hospitals filing an appeal of a RAC denial – to any level of the appeals system – during Q3 2015 reported appealing inpatient coding denials.

Percent of Participating Medical/Surgical Acute Hospitals Reporting RAC Appeals by Denial Reason, 3rd Quarter 2015

Survey participants were asked to select all reasons for denial.



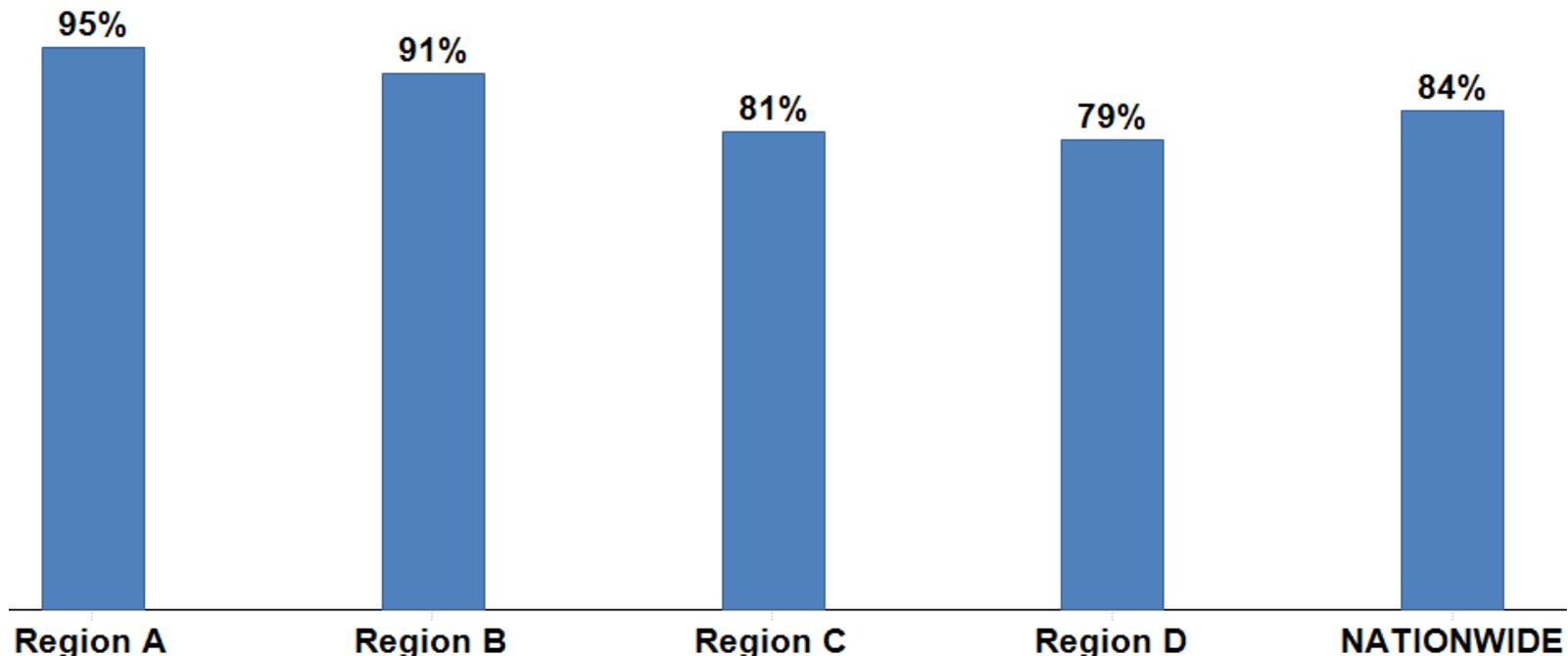
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For over 84% of claims appealed to the ALJ, the judge has taken longer than the statutory limit of 90 days to provide a determination to the hospital.

Percent of Appeals for which ALJ has taken Longer than the Statutory Maximum of 90 Calendar Days to Issue a Decision, through 3rd Quarter 2015



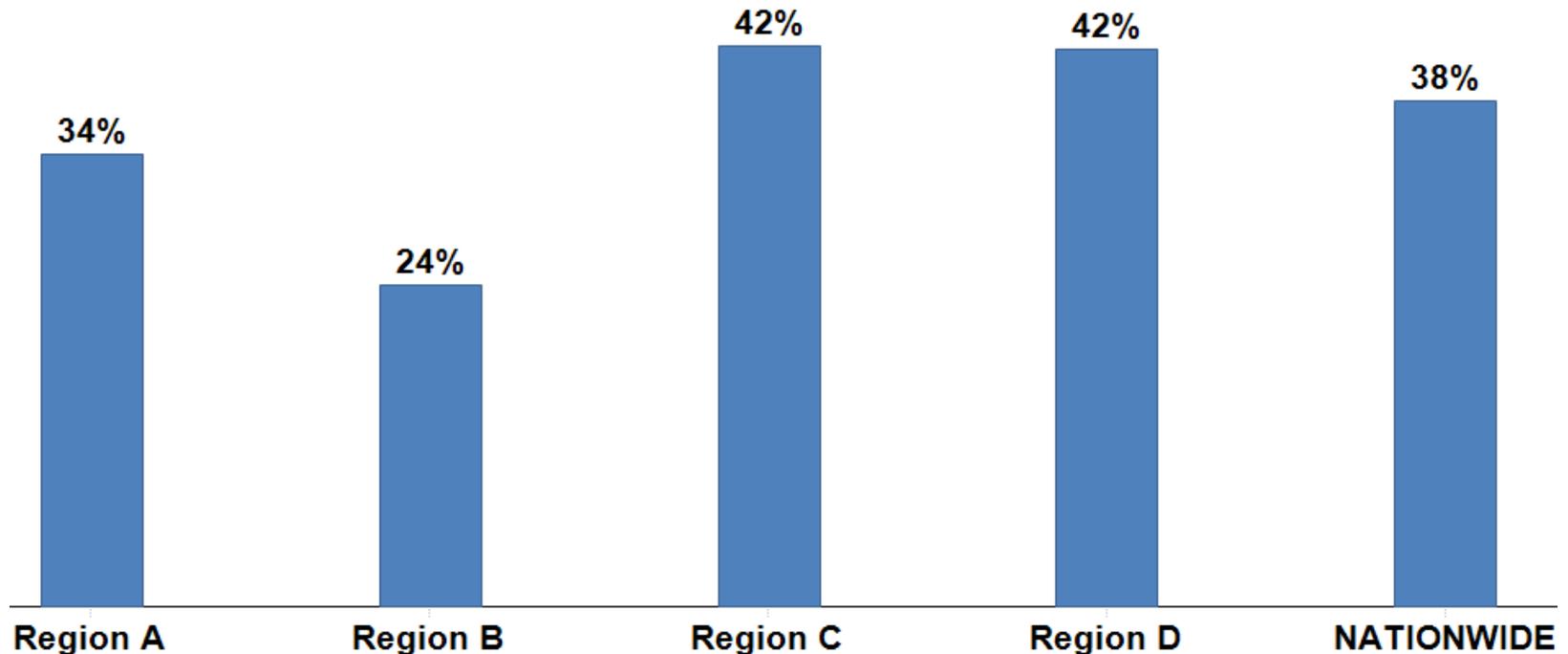
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38% of all cumulative claims appealed are still sitting in the appeals process.

Percent of Appealed Claims Pending Determination for Participating Hospitals, by Region, through 3rd Quarter 2015*



*Response rates vary by quarter.

Source: AHA. (November 2015). RAC TRAC Survey

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For complex denials that are re-billed under Part B, hospitals report receiving 58% of the original Part A reimbursement.

Summary of Medical Necessity Level of Care Denials Re-billed Under Part B, through 3rd Quarter, 2015

Region	Hospital Count	Total # Level of Care Denials Re-billed	Total Part A Denied Amount of Re-billed Claims	Total # Level of Care Denials Re-billed and Reimbursed under Part B	Average Part B Reimbursement	Average Part A Reimbursement	Average % of Part A Denied Amount Reimbursed Under Part B
Nationwide	107	11,509	\$58,424,997	9,897	\$2,597	\$4,487	58%
Region A	17	1,762	\$9,463,643	937	\$2,420	\$4,853	50%
Region B	30	1,791	\$9,470,620	1,070	\$2,081	\$5,017	41%
Region C	51	7,165	\$35,987,889	7,293	\$2,774	\$4,438	63%
Region D	Not enough responders to report.						

* too few hospital responses

*Response rates vary by quarter.

Source: AHA. (November 2015). RAC TRAC Survey

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Of the claims that have completed the appeals process, 62% were overturned in favor of the provider.

Summary of Appeal Rate and Determinations in Favor of the Provider, for Hospitals with Automated or Complex RAC Denials, through 3rd Quarter 2015*

	Appealed	Percent of Denials Appealed	Number of Denials Awaiting Appeals Determination	Completed Appeals		
				Number of Denials Not Overturned from Appeals Process* (Withdrawn/Not Continued)	Number of Denials Overturned in the Appeals Process	Percent of Appealed Denials Overturned (as a Percent of Total Completed Appeals)
NATIONWIDE	159,474	46%	60,863	31,019	50,638	62%
Region A	22,205	40%	7,598	5,222	7,607	59%
Region B	26,258	49%	6,371	6,256	9,557	60%
Region C	74,486	47%	31,525	11,920	21,143	64%
Region D	36,525	46%	15,369	7,621	12,331	62%

* May include appeals withdrawn to re-bill.

*Response rates vary by quarter.

Source: AHA. (November 2015). RAC TRAC Survey

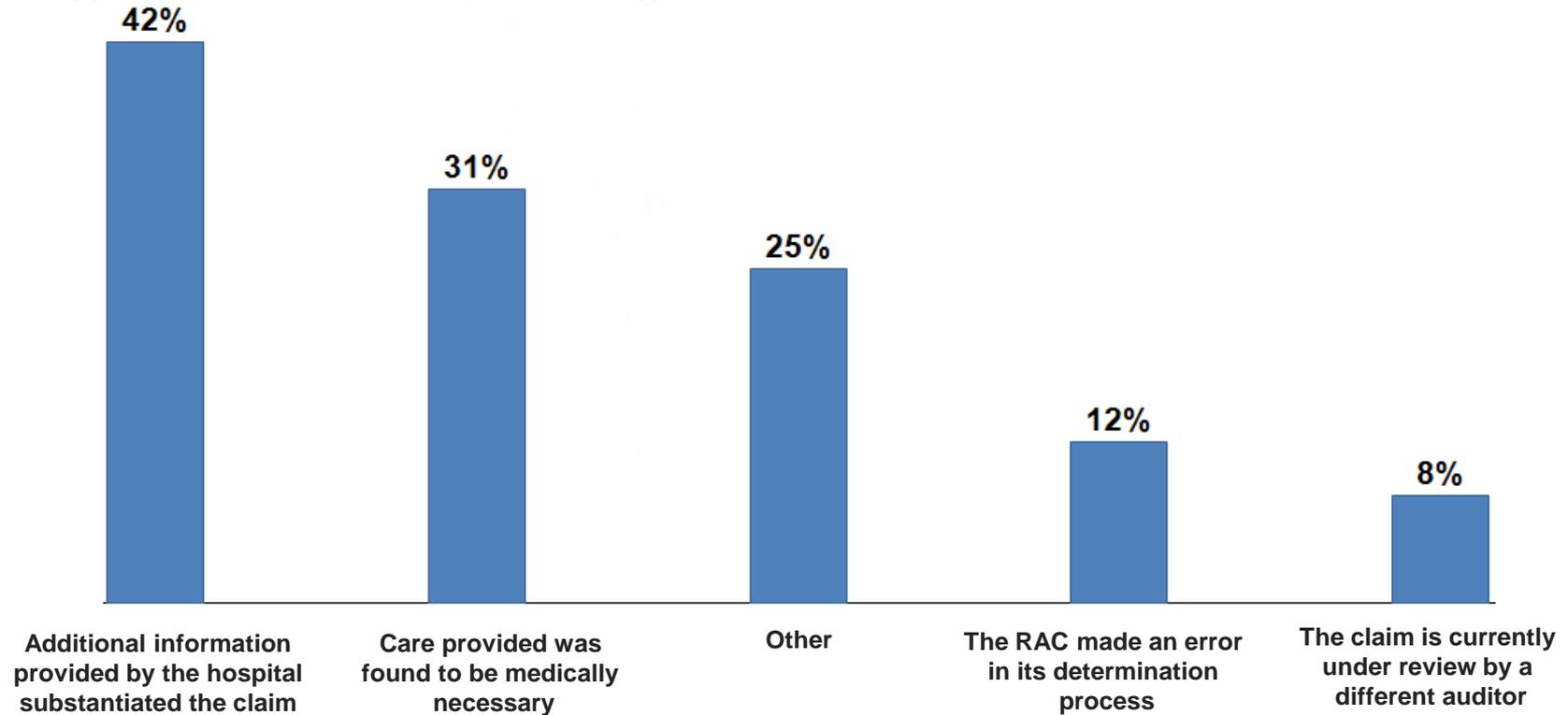
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42% of hospitals with a RAC denial overturned had a denial reversed when additional information was provided by the hospital to substantiate the original claim.

Percent of Participating Hospitals that Had a Denial Overturned by Reason, 3rd Quarter 2015

Survey participants were asked to select all reasons for appeal overturn.



Source: AHA. (November 2015). RAC TRAC Survey

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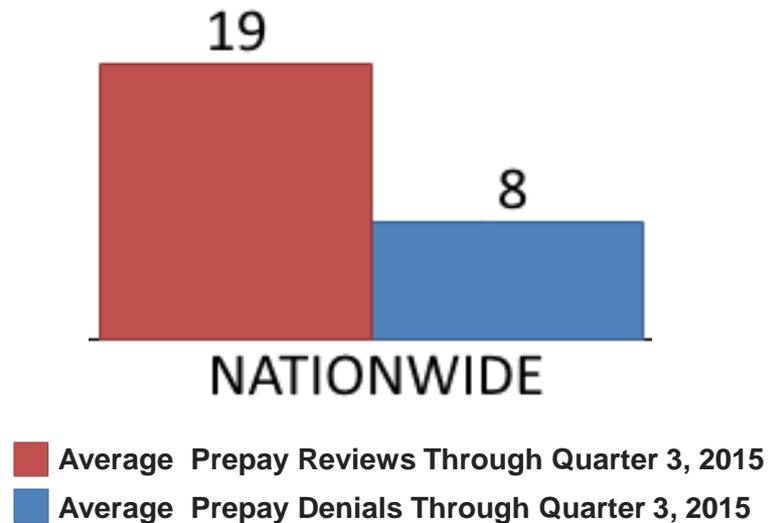


RAC Pre-payment Reviews

Hospitals experiencing prepayment denials report similar average dollar amounts associated with reviewed and denied claims, when compared to retrospective denials.

Total Number and Average Dollar Amount of Prepayment Reviews and Denials Reported by Hospitals in the Demonstration States, through 3rd Quarter, 2015

	Nationwide
Number Prepay Reviews	1,163
Average Dollar Amount Of Prepay Claims Reviewed	\$5,262
Number Prepay Denials	493
Average Dollar Amount Of Prepay Denials	\$4,668



*Response rates vary by quarter.

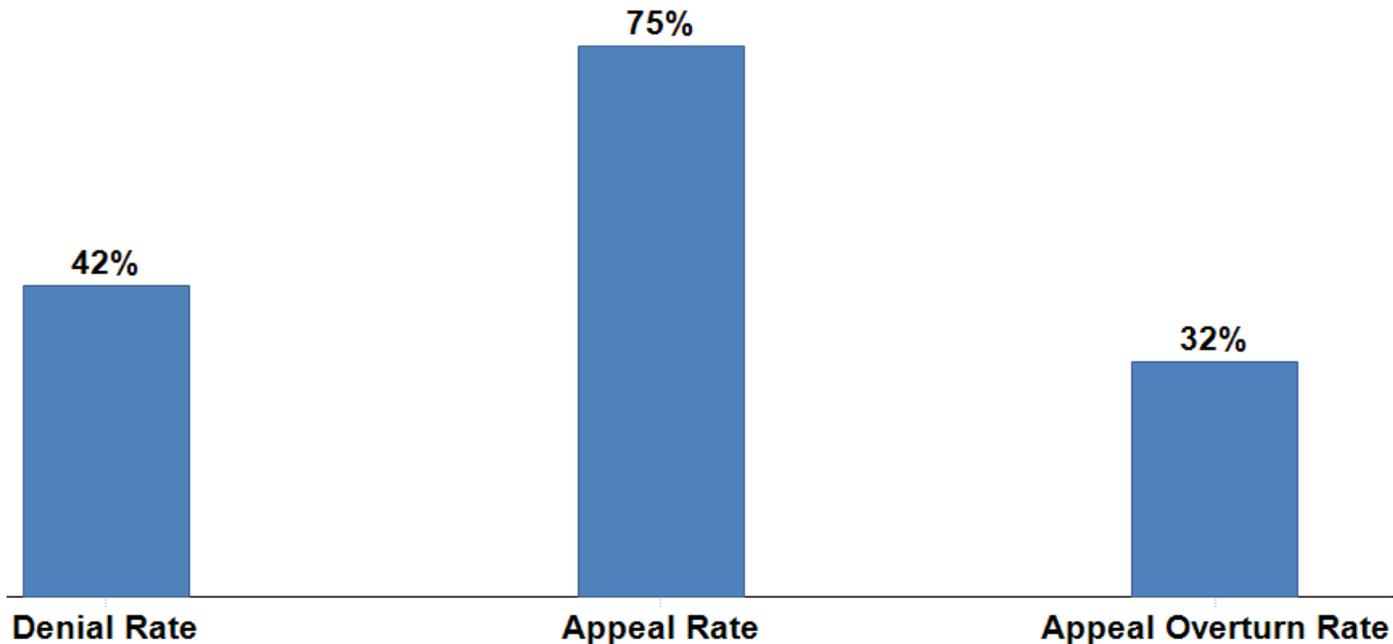
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42% of prepayment reviews are denied by a RAC and hospitals are appealing 75% of denied claims.

Summary of Denial Rate, Appeal Rate and Determinations in Favor of the Provider, for Hospitals with Reported Prepayment Reviews in the Demonstration States, through 3rd Quarter, 2015



*Response rates vary by quarter.

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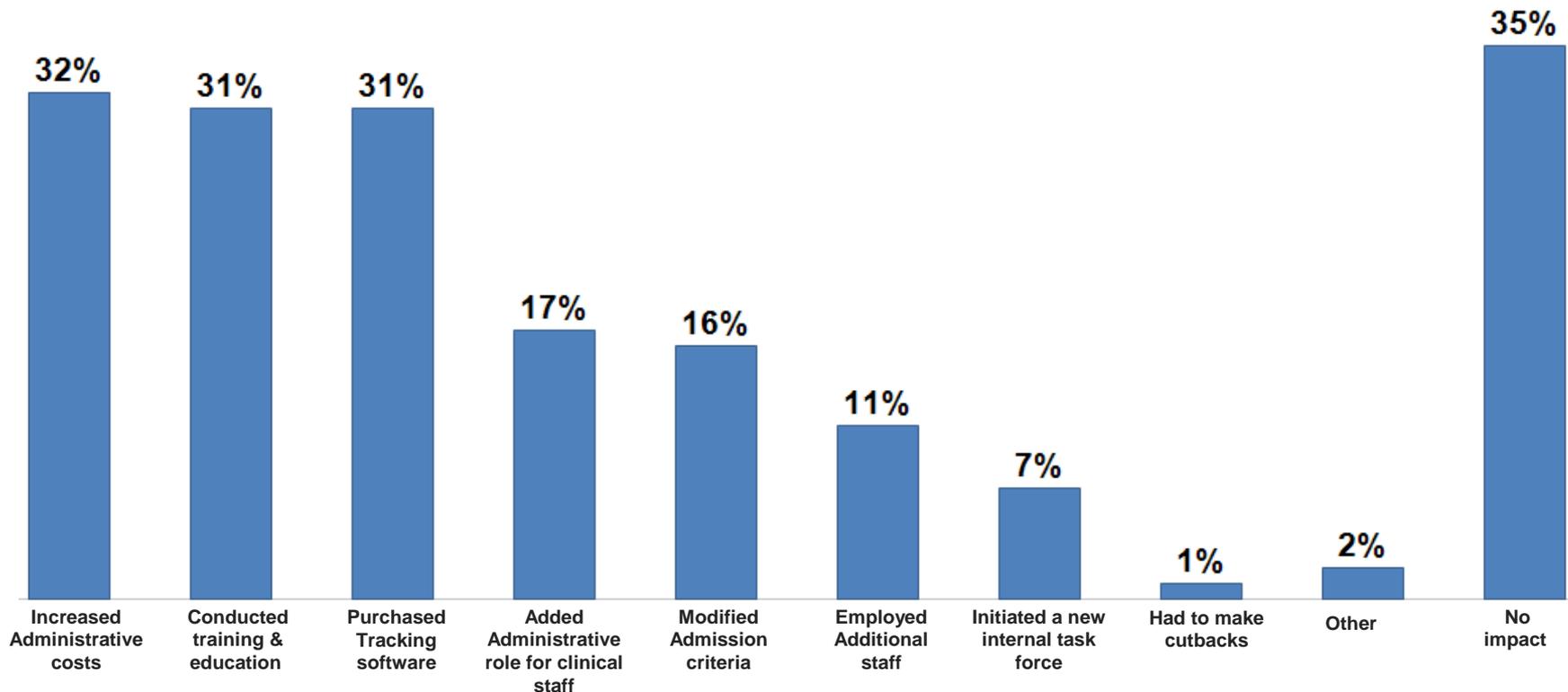




Administrative Burden

Hospitals experience many types of additional administrative impacts due to RACs.

Impact of RAC on Participating Hospitals* by Type of Impact, 3rd Quarter 2015



* Includes participating hospitals with and without RAC activity

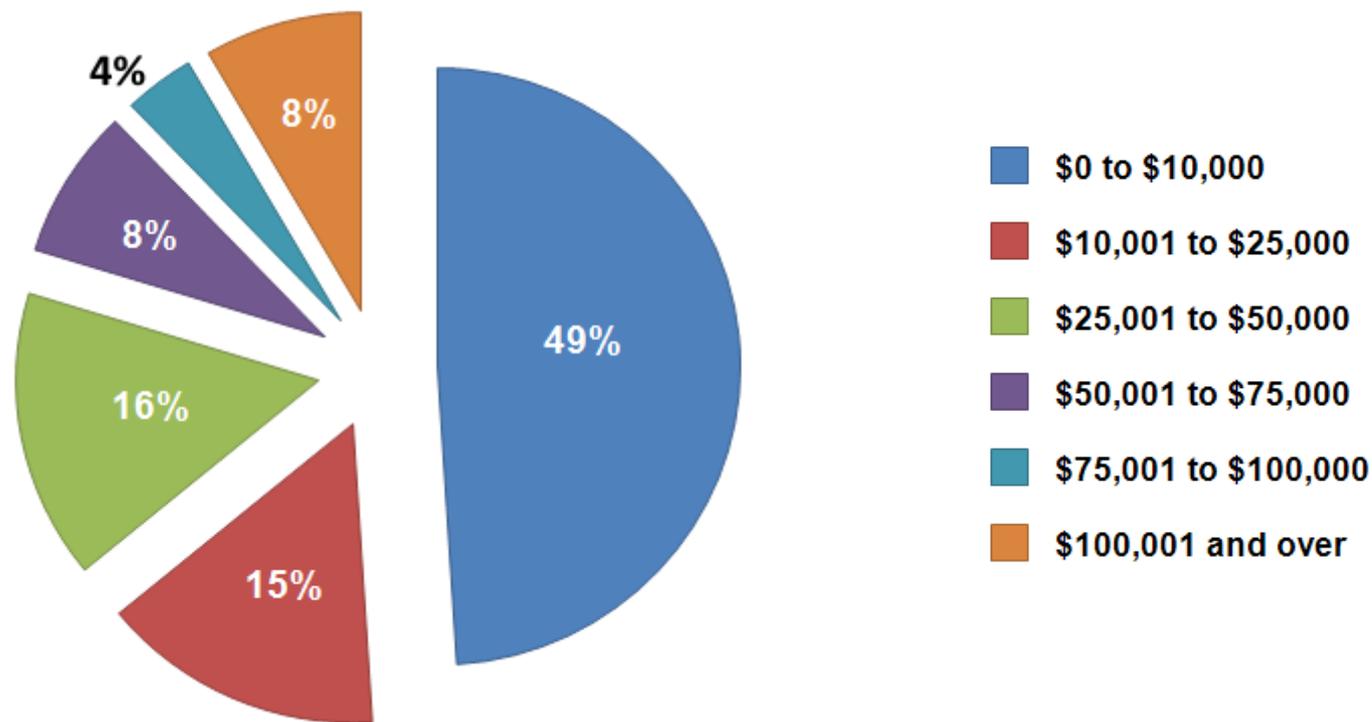
Source: AHA. (November 2015). RAC TRAC Survey

AHA analysis of survey data collected from 2,568 hospitals: 2,306 reporting activity, 262 reporting no activity through September 2015. 604 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.



51% of all hospitals reported spending more than \$10,000 managing the RAC process during the 3rd quarter of 2015, 36% spent more than \$25,000 and 8% spent over \$100,000.

Percent of Participating Hospitals* Reporting Average Cost Dealing with the RAC Program, 3rd Quarter 2015



* Includes participating hospitals with and without RAC activity

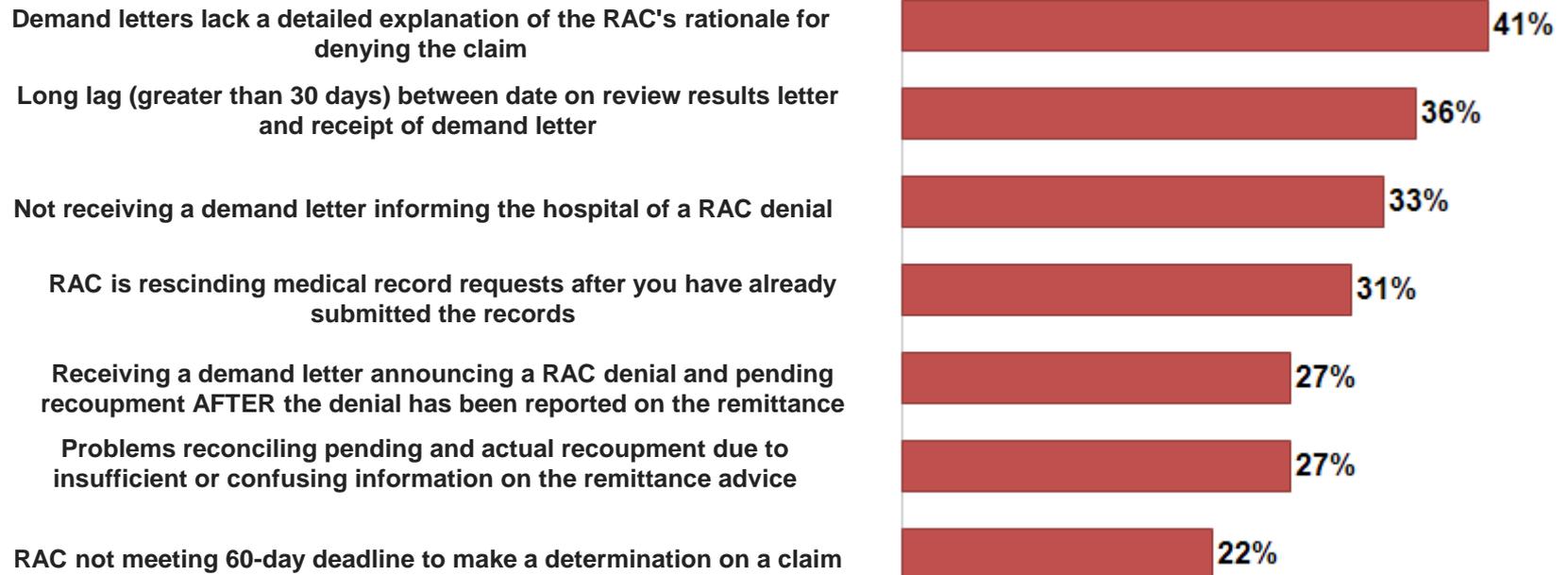
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Hospitals report widespread RAC process-related issues, including multiple problems with MACs and the demand letter process.

Percent of Participating Hospitals Reporting RAC Process Issues, by Issue, 3rd Quarter 2015



** Includes participating hospitals with and without RAC activity*

Source: AHA. (November 2015). RAC TRAC Survey

AHA analysis of survey data collected from 2,568 hospitals: 2,306 reporting activity, 262 reporting no activity through September 2015. 604 hospitals participated this quarter. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.





For more information visit AHA's RAC *TRAC* website:

<http://www.aha.org/ractrac>