AHA RACTrac Survey Questions and Data Definitions
March 2015
Contact RACTrac Support with Questions:
RACTracsupport@providercs.com or 1-888-722-8712

RACTrac Question (As they appear on the survey)	User Definition	Vendor Notes (VNote) and Comments
General		
Have you experienced RAC Activity? Yes or No If yes, please tell us the date and month in which activity started.	Being notified by the Medicare Recovery Audit Contractor (e.g. DCS, HDI, CGI or Connelly Associates) of audit activity; would include correspondence of either a medical record request or a demand letter.	Comment: The user is prompted to answer this question every quarter until the response is YES. The date of the start of RAC activity is captured in the AHA admin reports.
☐ **Check here if your hospital currently uses a RACTrac compatible vendor or the AHA Claim Level Tool to track/upload your survey data.** *(If unchecked, skip to Overpayments – automated RAC Reviews)*	By checking this box you have indicated that your organization is using either one of the recognized RACTrac compatible vendors or the AHA Claim Level Tool to track and/or upload your RAC activity.	
Indicate the RACTrac compatible software that your hospital uses to track/upload your survey data.	Please choose from the available drop-down the name of the RACTrac compatible software that your hospital currently uses to track/upload to the survey site. If you currently use a non-compatible vendor please indicate in "other". *The choices for selection include:* • *Claim Level Tool, AHA* • *3M™ Audit Expert RAC Management Tool* • *Audit-TRAX, NJ Hosp Assoc – Healthcare Business Solutions, Inc.* • *AudiTrends™ Online (formerly RAC Tracker Online)* • *Axis – Audit Control, Quadax, Inc.* • *ChartMaxx® RAC Manager MedPlus, a Quest Diagnostics Company* • *ClickON® RADs, The SSI Group, Inc.* • *Cobius Audit Manager, Cobius Healthcare Solutions, LLC* • *Compliance 360® Claims Audit Manager* • *Compliance and Revenue Integrity (CRI), MedeAnalytics* • *ComplyTrack, Wolters Kluwer Law and Business, MediRegs* • *HealthPort AudaPro™, HealthPort®* • *IOD – RAC assist™ - RAC & Appeal Management Tool* • *InSight Audit, Craneware Insight* • *Midas+ Care Management, Midas+ Solutions* • *OnBase RAC Administration Solution, Hyland Software, Inc.* • *RAC Audit Tracking, Rycan Technologies, Inc.* • *RAC Guard, The Wellington Group LLC* • *RACTelligence Tracking, PACE Healthcare Consulting, LLC* • *Revenue Integrity Compass, Advisory Board Company* • *TRACK+, Array Software* • *Veracity, Intersect Healthcare* • Other RAC Vendor (enter the information in the box provided)	

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General		
RAC Software Product Name	Please enter the name of the software product you are using if different from above.	
Did your facility participate in the CMS 68% Settlement Offer for resolving appeals of patient status denials? *(You MUST check a box in order to move forward with the survey.)* ☐ **Yes** ☐ **No**	Check yes or no to indicate whether your hospital took advantage of the CMS 68% Settlement Offer which hospitals were required to elect by no later than Friday, October 31st, 2014.	Comment: In order to progress with the survey there MUST be a positive value in one of the check boxes.
☐ **Check here if your RACTrac data represents your hospital's cumulative experience since RACs began auditing nationwide in January 2010**	Please indicate whether your hospital's data represents data since the beginning of the nationwide permanent RAC program which began January 2010.	

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RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Overpayments – Automated		
☐ **Check here if your hospital has not had any automated denials.** *(If checked, skip to Overpayments – complex RAC Reviews.)*	By checking this box you have indicated that your organization is not currently experiencing automated claim denials. By checking this box you will skip this section and immediately move to the next section of the survey.	Comment: This is captured in the Status report available to state, regional and metropolitan association and health system RAC*TRAC* users.
	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	Automated review occurs when a RAC makes a claim determination without a human review of the medical record. RACs use proprietary software that is designed to detect certain types of errors, including but not limited to: duplicate payments, billing or coding errors. The RAC notifies the provider via a demand letter when an overpayment has been identified through automated review. Report the total cumulative number of claims denied through the automated review process through the end of the quarter for which you are reporting. Each claim identified as having an overpayment will count once.	VNote: Often times the provider will get one demand letter that will reference several claims identified as overpayments. Each claim - not the number of demand letters - counts as an automated claim denial.
2. Total cumulative automated claim denial Medicare reimbursement dollar amount (sum of all demand letter amounts)	Report the total cumulative estimated dollar value of the claims denied through the RAC automated review process through the end of the quarter for which you are reporting. The estimated dollar value is indicated on the review results letter and on the demand letter from the RAC.	VNote: The word "estimated" remains in this question because sometimes the letters do not necessary match the dollars recouped. The dollar amount of an overpayment should be clearly stated in the RAC demand letter.
3. Total cumulative Medicare reimbursement dollars recouped for automated claim denials	Report the total cumulative dollars that have been recouped pursuant to a RAC automated claim denial, without regard to appeal activity. Include only actual dollars returned to Medicare program by your organization from the date your facility was first affected thru the end of the quarter for which you are reporting. Do not include estimated recoupments for automated denials that have not yet been processed or for those denials in which you have filed an appeal within 30 days and therefore stopped recoupment from occurring.	Comments: The claims processing contractors (FI/MAC) have been known to be delayed in processing the overpayments. Regulations state that the provider can stop recoupment from occurring if filing an appeal within 30 days. Therefore we are asking for the actual total dollars recouped to date at the time hospitals are reporting data.

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
☐ **Check here if your hospital has had no new activity this quarter.** *(If checked, skip to Overpayments - Complex RAC Reviews)*	RAC*TRAC* is a quarterly survey and from time to time, there will be no new automated audit activity for hospitals between quarters. If the hospital has experienced and reported automated denial information previously, but there is no new activity in the most recent quarter, the hospital should check this box to denote that there were no automated denials issued to the hospital in this quarter.	VNote: The survey tool does not carry forward data from the previous quarter. The only way it will be captured from quarter to quarter is if the hospital responds to the survey every quarter and reenters their data/ notes in this checkbox that there was no new activity in this quarter.
Data definitions for Hospital Types For All of AHA RAC*TRAC* Hospital Type Questions		
Medical/Surgical Acute Care Hospital	Medical/Surgical Acute Care Hospitals include: critical access hospitals, cancer hospitals, specialty med/surg hospitals (surgical, women's, cardiac, orthopedic, etc.), children's hospitals and federal or state run hospitals that provide medical/surgical acute care services. These hospitals may have several distinct part units including skilled nursing, inpatient rehabilitation and swing beds, but the majority of services are provided in the inpatient or outpatient settings of these hospitals.	VNote: RAC*TRAC* is currently not seeking data from free standing skilled nursing facilities or ambulatory surgery centers that may be owned or operated by the hospital or health system.
Inpatient Rehabilitation Hospital	Freestanding inpatient rehabilitation hospitals are facilities that are paid under the Medicare inpatient rehabilitation perspective payment system and primarily provide inpatient and outpatient rehabilitation services to patients.	
Psychiatric Hospital	Freestanding psychiatric hospitals are facilities that are paid under the Medicare psychiatric hospital perspective payment system and primarily provide inpatient psychiatric services to patients.	
Long Term Care Hospital	Freestanding long term care hospitals are facilities paid under the Medicare long term care hospital perspective payment system. CMS defines a long term care hospital as one which has an average inpatient length of stay greater than 25 days.	
4. Rank order the services by the number of automated claim denials this quarter. (Number 1 for the largest number 2 for the second largest number of claims denied in this quarter)	Under number 1, please indicate the service with the largest number of claims denied this quarter, number 2 for the second largest number of claims denied this quarter. Each claim identified as having an overpayment counts as one automated denial (i.e., not the number of demand letters received for automated denials as it is likely there will be more than one claim cited for improper payment in the demand letter). Example: If your hospital is a medical/surgical acute care hospital and you only experienced outpatient automated claim denials this quarter, you would choose number 1 as Medical/Surgical Acute Care Hospital – Outpatient and leave number 2 blank. If you had 35 outpatient claim denials and 42 inpatient claim denials, you would rank inpatient as number 1 and outpatient as number 2. VNote: The choices for selection include and should be selected based on the hospital type: ▪ *Medical/Surgical Acute Care Hospital - Inpatient*	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
	▪ *Medical/Surgical Acute Care Hospital - Outpatient* ▪ *Medical/Surgical Acute Care Hospital - Psychiatric Services* ▪ *Medical/Surgical Acute Care Hospital - Inpatient Rehabilitation* ▪ *Medical/Surgical Acute Care Hospital - Skilled Nursing* ▪ *Medical/Surgical Acute Care Hospital - Other (i.e., Physician Services, DME)* ▪ *Inpatient Rehabilitation Hospital - Inpatient* ▪ *Inpatient Rehabilitation Hospital - Other* ▪ *Psychiatric Services Hospital - Inpatient* ▪ *Psychiatric Services Hospital - Other* ▪ *Long Term Care Hospital - Inpatient* ▪ *Long Term Care - Other*	
5. Rank order the services by the <u>estimated Medicare dollar value</u> of automated claim denials <u>this quarter.</u>	Rank the top three services by estimated total dollar value of the automated claim denials. In number 1, please indicate the type of claims associated with the greatest dollar value of automated denials; number 2 corresponds to the second largest dollar value of automated denials for your hospital. The dollar value of the claim is indicated on the RAC demand letter. Example: Each automated denial will have a corresponding dollar value associated with it. If the hospital has 23 inpatient denials that total $3,000 and 10 outpatient denials that total $5,000, then you would rank outpatient as number 1 and inpatient as number 2. The choices for selection include: (please select the appropriate hospital and claim type): ▪ *Medical/Surgical Acute Care Hospital - Inpatient* ▪ *Medical/Surgical Acute Care Hospital - Outpatient* ▪ *Medical/Surgical Acute Care Hospital - Psychiatric Services* ▪ *Medical/Surgical Acute Care Hospital - Inpatient Rehabilitation* ▪ *Medical/Surgical Acute Care Hospital - Skilled Nursing* ▪ *Medical/Surgical Acute Care Hospital - Other (i.e., Physician Services, DME)* ▪ *Inpatient Rehabilitation Hospital - Inpatient* ▪ *Inpatient Rehabilitation Hospital - Other* ▪ *Psychiatric Services Hospital - Inpatient* ▪ *Psychiatric Services Hospital - Other* ▪ *Long Term Care Hospital - Inpatient* ▪ *Long Term Care – Other*	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
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 during this quarter.	On the automated denial demand letter from the RAC to the provider, the RAC indicates the reason for the overpayment. AHA has broadly categorized several reasons by hospital/service type that were identified during the demonstration program. Please read carefully through each of the denial reasons to determine ANY and ALL categories which reflect the reason(s) for automated denial notifications received during this quarter. Example: Medical/Surgical Acute Care hospital experiences outpatient billing and coding errors as well as duplicate payment denials in their inpatient and inpatient rehabilitation unit in Quarter 3, 2014. The correct selections would be 1. Medical/Surgical Acute Care Hospital/Services - Outpatient Coding Error 2. Medical/Surgical Acute Care Hospital/Services - Outpatient Billing Error 3. Inpatient Rehabilitation Hospital/Unit - Duplicate Payment The choices for selection include and should be selected based on the hospital type or unit (definitions noted below) and automated denial claim type: ▪ *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 (Enter the reason in the text box)* ▪ *Inpatient Rehabilitation Hospital/Unit - Duplicate Payment* ▪ *Inpatient Rehabilitation Hospital/Unit - Inpatient Rehabilitation Coding Error (CMG)* ▪ *Inpatient Rehabilitation Hospital/Unit - All Other (Enter the reason in the text box)* ▪ *Psychiatric Services Hospital/Unit - Duplicate Payment* ▪ *Psychiatric Services Hospital/Unit - Inpatient Psych Coding Error (MS-DRG)* ▪ *Psychiatric Services Hospital/Unit - All Other (Enter the reason in the text box)* ▪ *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 the reason in the text box) (Text box responses will be considered, based on the number and value of claim denials, by AHA to assess if this is a denial reason that is common among other facilities of the same type before adding to RACTrac.)*	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Definitions of Automated Denial Reasons for Question 6, 7, and 8 – Automated ***NOTE:*** *Responses are tracked on type of hospital and services denied. For example, a user can be associated with a Medical/Surgical Acute Care Hospital and still have denial reasons in the Inpatient Rehabilitation Hospital/Services area due to a distinct part unit. Please contact* RACTRAC *support@providerpcs.com if you have questions.*		
Medical/Surgical Acute Care Hospital/Services – Duplicate Payment	Use this reason code to note more than one claim was paid for the same service by the Medicare claims processor (e.g. two appendectomies billed for the same patient on the same day.)	
Medical/Surgical Acute Care Hospital/Services – Incorrect Discharge Status	Use this reason code to note an incorrect discharge status on the original claim and a subsequent automated denial by a RAC. For example, the claim indicates discharge to home or other facility but a subsequent claim for the same patient on the same day shows that the beneficiary was discharged to another hospital.	
Medical/Surgical Acute Care Hospital/Services – Inpatient Coding (MS-DRG)	Medicare has now moved to MS-DRGs, so what the RACs may or may not find with regard to automated reviews of inpatient claims is currently undefined. Use this reason code to note incorrect ICD-9 codes on the claim.	
Medical/Surgical Acute Care Hospital/Services – Outpatient Coding	Use this reason code to denote an error in HCPCS code assignment or other outpatient coding related error.	
Medical/Surgical Acute Care Hospital/Services – Outpatient Billing	Use this reason code to note incorrectly billed outpatient units or charge issues as well as misuse or incomplete billing modifiers. Examples include, but are not limited to, incorrect billing of the drug Neulasta or outpatient speech therapy units billed incorrectly.	
Medical/Surgical Acute Care Hospital/Services – All Other	Use this reason code for any denial reason that is not currently captured for your organization type. Please “contact us” and tell us about this reason for denial.	
Inpatient Rehabilitation Hospital/Unit – Duplicate Payment	Use this reason code to note more than one claim was paid for the same service by the Medicare claims processor.	
Inpatient Rehabilitation Hospital/Unit – Inpatient Rehabilitation Coding Error (CMG)	Use this reason code to denote inappropriate codes leading to incorrect billing of the case mix group (CMG) on the inpatient rehabilitation claim.	
Inpatient Rehabilitation Hospital/Unit – All Other	Use this reason code for any denial reason that is not currently captured for your organization/service types. In addition to selecting this reason code, please use the “contact us” link on this page and tell us about the more specific reason for denial.	
Psychiatric Hospital/Unit – Duplicate Payment	Use this reason code to note more than one claim was paid for the same service by the Medicare claims processor.	
Psychiatric Hospital/Unit – Inpatient Psych Coding (MS-DRG)	Medicare has now moved to MS-DRGs, so what the RACs may or may not find with regard to automated reviews of inpatient claims is currently undefined. Use this reason code to note incorrect ICD-9 codes on the claim.	
Psychiatric Hospital/Unit – All Other	Use this reason code for any denial reason that is not currently captured for your organization/service type. In addition to selecting this reason code, please use the “contact us” link on this page and tell us about the more specific reason for denial.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Long Term Care Hospital/Unit – Duplicate Payment	Use this reason code to note more than one claim was paid for the same service by the Medicare claims processor (e.g. two colonoscopies billed for the same patient on the same day.)	
Long Term Care Hospital/Unit - Inpatient Coding Error (LTC-DRG)	Medicare has now moved to LTC-DRGs, so what the RACs may or may not find with regard to automated reviews of inpatient claims is currently undefined. Use this reason code to note incorrect ICD-9 codes on the claim.	
Long Term Care Hospital/Unit – All Other	Use this reason code for any denial reason that is not currently captured for your organization/service type. In addition to selecting this reason code, please use the "contact us" link on this page and tell us about the more specific reason for denial.	
7. Rank order the denial reasons experienced by number of automated claim denials for this quarter. (Number 1 for the type of claims with the most denials and number 2 for the second largest number of claim denials during this quarter)	Select number 1 for the denial reason with the largest number of claims denied during **this quarter**, number 2 for the second largest number of claims denied during this quarter. For example, if your hospital is a medical/surgical acute care hospital and this quarter you had 20 claims denied for outpatient billing errors, 10 for duplicate payments and 5 were miscellaneous (and would fall under Other Medical/Surgical Acute Care Hospital/Unit reasons) then these would be your rankings. Number 1: Medical/Surgical Acute Care - Outpatient Billing Errors Number 2: Medical/Surgical Acute Care – Duplicate Payment A second example would be the following: If you are a medical/surgical acute care hospital with multiple units including a rehab and psych unit with the following claim denials: Inpatient Coding Errors – 25 claims Rehab Unit – Medically Unnecessary – 10 claims You would rank them in the following way: Number 1: Medical/Surgical Services – Inpatient Coding Errors Number 2: Inpatient Rehabilitation Unit – Medically Unnecessary	Use same automated denial definition reasons from above.
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 for the claim type associated with the greatest amount of dollars denied and number 2 for the second largest estimated total Medicare reimbursement dollar value of claim denials during this quarter)	See user definitions for Question 7 above.	

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Overpayments – Complex (Exclude Pre-Payment Reviews)		
☐ **Check here if your hospital has not had any complex denials.** *(If checked, skip to Medical Necessity Denials)*	By checking this box, you are indicating that your hospital has not experienced complex claim denial experience since the start of the RAC program.	Noted in Status Report
	In this section, only enter information relating to overpayment reviews. All underpayment and pre-payment review information should be entered in the Underpayments and Pre-Payment Review sections, respectively. Medical record requests that have been rescinded by the RACs should not be reported. *Totals should reflect cumulative experience since October 2008*	
1. Total number of medical record requests received	The total cumulative number of medical records requested for complex review to date. The RAC will send a letter (via US Mail) requesting the medical record for review. Please tally the number of medical records from these requests to date and indicate the total here.	VNote: Please do not include medical record requests that have been rescinded. We collect data on rescinded record requests in the Administrative Burden section of the survey.
1A. Total Medicare reimbursement dollar value of the claims associated with the medical records requested	Each medical record requested has an original Medicare reimbursement payment amount associated with the claim for that patient. Total the original Medicare reimbursement payment amounts for each of the claims associated with the medical records requested by the RAC.	VNote: We are not asking for billed charges, rather the Medicare reimbursement received for the claim.
2. Total number of medical records where NO improper payment was identified (i.e., record was "approved")	The RACs have 60 calendar days to make a determination of whether or not an inappropriate payment has been identified once the medical record has been received. *Some hospitals have noted that RACs have gone beyond this determination timeframe.* Once the RAC has made its determination, a hospital will be notified via a review results letter. Please indicate the total number of medical records for which you have been notified to date that NO improper payment has been identified.	VNote: An underpayment could be found upon review of a medical record. Underpayment, or determinations with a return of dollars to the hospital, should solely be counted in the Underpayment section.
2A. Total Medicare reimbursement dollar value of medical records where NO improper payment was identified (i.e., record was "approved")	Total the original Medicare reimbursement payment amounts for each of the claims associated with the medical records where NO improper payments were identified	VNote: We are not asking for billed charges, rather the Medicare reimbursement amount received for the claim.

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
3. Total number of medical records where an overpayment was identified (i.e. denied)	The RACs have 60 days to make a determination of whether or not an improper payment has been identified once the medical record has been received. *Some hospitals have noted that RACs have gone beyond this determination timeframe.* Upon that determination, a hospital will be notified via a review results letter if an improper payment was found and therefore the associated claim has been "denied". Please indicate the total number of medical records for which you have been notified to date that an improper payment has been identified and therefore a claim, either in part or in total has been "denied". **The official notification of an overpayment should be based on the receipt of the demand letter, not the review results letter.** Please count the number based on the number of the demand letters received, not the number of review results letters received.	VNote: We are not asking for billed charges, rather the Medicare reimbursement amount received for the claim. VNote: Due to the nature and timing of the demand letter, it is possible that a provider would receive a review results letter without the demand letter at the point of RAC*TRAC* reporting. Please only enter denials for which a demand letter has been received. We collect data on untimely demand letters in the Administrative Burden section of the survey.
3A. Total Medicare reimbursement dollar value of medical records in which an overpayment was identified (i.e. denied)	Total the original Medicare reimbursement payments for each of the claims associated with the medical records that were denied by the RAC.	
4. Total number of medical records pending determination by the RAC	The number of medical records that are "pending determination" are those for which the provider has not been notified via a review results letter (approval, no overpayment) or demand letter (overpayment) of the outcome of the review. Total number of medical records pending determination = Total number of medical records requested minus total number of medical records approved minus total number of medical records denied.	It will include medical records for which the request has been received, but the documentation has not yet been submitted to the RAC.
4A. Total Medicare reimbursement dollar value of medical records pending determination	Total the original Medicare reimbursement payments for each of the claims associated with the medical records that are pending determination. Total dollar value of medical records pending determination = Total dollar value of medical records requested minus total dollar value of medical records approved minus total number of medical records denied.	
5. Estimate the total dollars associated with the overpayments identified during medical record review (complex claim denials) to date.	The value of the overpayment is communicated via the demand letter from the RAC following the review results letter indicating an improper payment. Indicate the total dollar value for all overpayments identified in demand letters received.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
☐ **Check here if your hospital has had no new activity this quarter.** *(If checked, skip to Underpayments)*	RAC*TRAC* is a quarterly survey and from time to time, there will be no new activity for hospitals between quarters. If data was reported in quarter one, but there is no new activity in quarter 2, the hospital should re-enter the data from quarter 1 into questions 1 through 6 as those numbers remain the same and check this box to denote that there were no subsequent denials to be indicated in this quarter.	VNote: The survey tool does not carry forward data from the previous quarter. The only way it will be captured from quarter to quarter is if the hospital responds to the survey every quarter and re-enters their data or notes in this checkbox, that there was no new activity in the requested quarter.
6. Rank order the services by the <u>estimated Medicare reimbursement dollar value</u> of the complex claim denials <u>this quarter</u>. Number 1 being the greatest Medicare reimbursement dollar value and number 2 represents the second largest dollar value for complex claim denials <u>this quarter.</u>	Rank the top two services by estimated total dollar value of the complex claim denials. Number 1 is for claims associated with the greatest dollar value for complex denials; number 2 represents the second largest dollar value area for complex denials. The dollar value of the claim is indicated on the RAC demand letter. Example: Each complex denial will have a corresponding dollar value associated with the denied claim. If the hospital has 23 inpatient denials that total $3,000 and 10 outpatient denials that total $5,000 then you would rank outpatient as number 1 and inpatient as number 2. The choices for selection include and should be selected based on the hospital type: ▪ *Medical/Surgical Acute Care Hospital - Inpatient* ▪ *Medical/Surgical Acute Care Hospital - Outpatient* ▪ *Medical/Surgical Acute Care Hospital - Psychiatric Services* ▪ *Medical/Surgical Acute Care Hospital - Inpatient Rehabilitation* ▪ *Medical/Surgical Acute Care Hospital - Skilled Nursing* ▪ *Medical/Surgical Acute Care Hospital - Other (i.e., Physician Services, DME)* ▪ *Inpatient Rehabilitation Hospital - Inpatient* ▪ *Inpatient Rehabilitation Hospital - Other* ▪ *Psychiatric Services Hospital - Inpatient* ▪ *Psychiatric Services Hospital - Other* ▪ *Long Term Care Hospital - Inpatient* ▪ *Long Term Care Hospital - Other*	
7. Select the reasons cited by the RAC for complex claim denials <u>this quarter</u>. Please make the correct selections based on the type of services provided by your organization and indicate the denial reasons for the complex RAC denials for <u>this quarter</u>.	Below are the reasons for complex claim denial; the user can check all that apply. 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	

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	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 Longer than or Equal to 2-midnights Medical/Surgical Acute Care Hospital/Services – Other Medically Unnecessary Medical/Surgical Acute Care Hospital/Services – All Other (Enter the reason in text box) 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 the reason in text box) 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 the reason in text box) 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 the reason in text box)	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Definitions of Complex Denial Reasons for Questions 7, 8, and 9 – Complex ***NOTE:*** *Reasons for denial are hospital type and services based. For example, a user can be associated with a Medical/Surgical Acute Care Hospital and still have denial reasons in the Inpatient Rehabilitation Hospital/Services area due to a distinct part unit. Please contact* RACTRAC *support@providercs.com if you have questions.*		
Medical/Surgical Acute Care Hospital/Services – No Documentation Provided or Insufficient Documentation in the Medical Record	Use this reason code to denote when a RAC requests a medical record from the provider and the provider either failed to respond within the appropriate time limit (45 calendar days) or failed to send the complete medical record. This is often referred to as a "technical denial."	
Medical/Surgical Acute Care Hospital/Services – Incorrect Discharge Status	Use this reason code to note an incorrect discharge status on the original claim that was cited for inaccurate payment. For example, the claim indicates discharge to home or other facility but a subsequent claim for the same patient on the same day shows that the beneficiary was discharged to another hospital.	
Medical/Surgical Acute Care Hospital/Services – Incorrect MS-DRG or Other Coding Error	Use this reason code to denote that, upon review of the medical record, the RAC determined that an incorrect MS-DRG assignment was made based on the documentation provided.	
Medical/Surgical Acute Care Hospital/Services – Incorrect APC or Other Outpatient Coding Error / Outpatient Billing Error	Use this reason code to denote when a RAC determines that there has been improper billing related to APC assignment, fee-schedule based HCPCS assignment, or other outpatient coding.	
Medical/Surgical Acute Care Hospital/Services – Short Stay Medically Unnecessary Inpatient Stays Less than 2-Midnights	Use this reason code to denote a denial that generally pertains to acute inpatient stays of less than 2-midnights.The CMS 2014 IPPS final rule. Use this reason code to denote a denial that may include the following justifications for care being determined medically unnecessary: • Inpatient service provided should have been done in the outpatient setting • Inpatient should have been observation • No medical necessity for inpatient admission • Level of care not met for inpatient admission Please note that more than one procedure occurring on the same day AHA classifies as a duplicate payment – not medically unnecessary as defined in coverage guidelines etc. (e.g. 3 appendectomies in one day, while not medically necessary is really a duplicate payment and should be cited as such.)	

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Medical/Surgical Acute Care Hospital/Services – Medically Unnecessary Inpatient stay Greater Than or Equal to 2-Midnights	Use this reason code to denote a denial that generally pertains to acute inpatient stays of greater than or equal to than 2-midnights. The CMS 2014 IPPS final rule. Use this reason code to denote a denial that may include the following justifications for care being determined medically unnecessary: • Inpatient service provided should have been done in the outpatient setting • Inpatient should have been observation • No medical necessity for inpatient admission • Level of care not met for inpatient admission	
Medical/Surgical Acute Care Hospital/Services – Other Medically Unnecessary	Use this reason code to denote other denials that are not mentioned above or are for clinical reasons rather than utilization of services.	
Medical/Surgical Acute Care Hospital/Services – All Other (Enter in text box below)	Use this reason code to denote if the above mentioned denial reasons are in no way related to the current denials you are experiencing. Please also contact AHA via our "contact us" email and let us know about the types of denials you are experiencing so that we can consider tracking them in RAC*TRAC*.	
Inpatient Rehabilitation Hospital/Unit – No Documentation Provided or Insufficient Documentation	Use this reason code to denote when a RAC requests a medical record from the provider and the provider either failed to respond within the appropriate time limit (45 calendar days) or failed to send the complete medical record. This is often referred to as a "technical denial".	
Inpatient Rehabilitation Hospital/Unit – Incorrect CMG or Other Coding Error	Use this reason code to denote that upon review of the medical record the RAC determined that an incorrect case mix group (CMG) assignment or other coding error was made based on the documentation provided.	
Inpatient Rehabilitation Hospital/Unit – All Joint Patients: Medically Unnecessary	Use this reason code to denote when an inpatient rehabilitation service provided to a joint patient was deemed medically unnecessary for any of the following reasons, including but not limited to: • Documentation does not support the need for 24-hour rehab nursing • Documentation does not support the need for 24-hour medical supervision • Documentation does not show a coordinated care plan • Documentation does not show a significant practical improvement • Patient could have been served in a less intense setting • Documentation does not support that therapy services were of relatively intense level of service • Documentation does not reflect realistic goals/progress toward established goals	
Inpatient Rehabilitation Hospital/Unit – Other Medically Unnecessary	Use this reason code to denote when inpatient rehabilitation was denied as medically unnecessary. There are seven criteria outlined in the Medicare Coverage Guidelines to assist providers in determining whether or not care in an IRF setting is clinically appropriate. Reasons for denial under this category include the following.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
	• Documentation does not support the need for 24-hour rehab nursing • Documentation does not support the need for 24-hour medical supervision • Documentation does not show a coordinated care plan • Documentation does not show a significant practical improvement • Patient could have been served in a less intense setting • Documentation does not support that therapy services were of relatively intense level of service • Documentation does not reflect realistic goals/progress toward established goals	
Inpatient Rehabilitation Hospital/Unit – All Other (Enter in text box below)	Use this reason code to denote if the above mentioned denial reasons are in no way related to the current denials you are experiencing. Please also contact AHA via our "contact us" email and let us know about the types of denials you are experiencing so that we can consider tracking them in RAC*TRAC*.	
Psychiatric Services Hospital/Unit – No Documentation Provided or Insufficient Documentation	Use this reason code to denote when a RAC requests a medical record from the provider and the provider either failed to respond within the appropriate time limit (45 calendar days) or failed to send the complete medical record. This is often referred to as a "technical denial".	
Psychiatric Services Hospital/Unit – Incorrect MS-DRG or Other Coding Error	Use this reason code to denote that, upon review of the medical record, the RAC determined that an incorrect MS-DRG assignment was made based on the documentation provided.	
Psychiatric Services Hospital/Unit - Medically Unnecessary	Medicare does not have criteria for admission into psychiatric hospitals and therefore this reason for denial is currently not specified. Use this reason code to denote a denial reason that may be characterized "as the care could have been provided in a less intensive setting."	
Psychiatric Services Hospital/Unit – All Other (Enter in text box below)	Use this reason code to denote if the above mentioned denial reasons are in no way related to the current denials you are experiencing. Please also contact AHA via our "contact us" email and let us know about the types of denials you are experiencing so that we can consider tracking them in RAC*TRAC*.	
Long Term Care Hospital/Unit – No Documentation Provided or Insufficient Documentation	Use this reason code to denote when a RAC requests a medical record from the provider and the provider either failed to respond within the appropriate time limit (45 calendar days) or failed to send the complete medical record. This is often referred to as a "technical denial".	
Long Term Care Hospital/Unit – Incorrect LTC-DRG or Other Coding Error	Use this reason code to denote that, upon review of the medical record, the RAC determined that an incorrect LTC-DRG assignment was made based on the documentation provided.	
Long Term Care Hospital/Unit - Medically Unnecessary	Medicare does not have criteria for admission into long term acute care hospitals and therefore this reason for denial is currently not specified. Use this	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
	reason code to denote a denial reason that may be characterized as the care could have been provided in a less intensive setting.	
Long Term Care Hospital – All Other (Enter in text box below)	Use this reason code to denote if the above mentioned denial reasons are in no way related to the current denials you are experiencing.	
	Please also "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 RAC*TRAC*.	
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 this quarter.	Select number 1 for the denial reason with the largest number of claims denied **this quarter**, number 2 for the denial reason with the second largest number of claims denied **this quarter**.. For example, if your hospital is a medical/surgical acute care hospital and this quarter you had 20 claims denied for inpatient medically unnecessary, 10 for not responding in time to the RACs or no documentation provided and 5 were miscellaneous (and would fall under Other Medical/Surgical Acute Care Hospital/Unit reasons), then these would be your rankings. Number 1: Medical/Surgical Acute Care Hospital/Services – Medically Unnecessary Inpatient stay Longer than 3 Days Number 2: Medical/Surgical Acute Care Hospital/Services – No Documentation Provided or Insufficient Documentation in the Medical Record	
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 this quarter.	The top two denial reasons are based on the estimated total dollar value of the claims denied this quarter through the complex claim review process. The dollar value for the denial is indicated on the demand letter from the RAC. Number 1 is the denial reason with the greatest dollar amount of denied claims and Number 2 is the reason with the second largest dollar amount of claims associated. User chooses from reasons listed above.	VNote: This dollar value is from the estimated Medicare reimbursement overpayment amount provided on the demand letter.
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.)	The top three MS-DRGs for which your hospital has experienced a complex denial for Incorrect MS-DRG or Other Coding Error. List the top three MS-DRGs for which your hospital received an Incorrect MS-DRG or Other Coding Error denial. Select the top three MS-DRGs based on the estimated total dollar value of the claims denied for the MS-DRG. Number 1 is MS-DRG with the greatest dollar amount of denied claims and Number 2 is the MS-DRG with the second largest dollar amount of denied claims associated. Enter the CMG code if your hospital uses these codes instead of MS-DRGs.	VNote: This dollar value is from the estimated overpayment amount. VNote: Please do not include the MS-DRGs for which you have received denials for *medical necessity*. You will enter those MS-DRGs in the Medical Necessity Review section of the survey.

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Medical Necessity Review		
Medical Necessity Reviews		
Is your organization able to track whether medical necessity denials are due to inappropriate settings? *(Selection includes either No or Yes)*	If your organization does not track whether medical necessity denials are due to inappropriate setting and "No" is selected, questions 2 and 4 are not required.	
Medical Necessity Denials for Less Than 2-Midnights		
1 and 1A. Total number and Medicare reimbursement dollar amount of ALL medical necessity denials with LOS < 2-midnights from the demand letter.	Enter the total number of claims with length of stay **less than 2-midnights** medical necessity review denials your hospital has received. Enter the total Medicare reimbursement dollar amount of those medical necessity review denials.	VNote: We are not asking for billed charges, rather the amount on the demand letter.
2 and 2A. Number and Medicare reimbursement dollar amount of medical necessity denials *due to inappropriate setting* (For example: inpatient care that should have been provided in observation or outpatient setting)	Enter the total number of claims with length of stay **less than 2-midnights** medical necessity review denials your hospital has received because the RAC determined the care should have been provided in a different setting (i.e. inpatient care that should have been provided in observation or in the outpatient setting). Enter the total Medicare reimbursement dollar amount associated with these denials.	VNote: Only enter the claims that were determined to be medically necessary, but were denied due to inappropriate setting.
Medical Necessity Denials for Greater Than or Equal to 2-Midnights		
3 and 3A. Total number and Medicare reimbursement dollar amount of medical necessity denials	Enter the total number of claims with length of stay **greater than or equal to 2-midnight** medical necessity review denials your hospital has received. Enter the total Medicare reimbursement dollar amount of those medical necessity review denials.	VNote: We are not asking for billed charges, rather the amount on the demand letter.
4 and 4A. Number and Medicare reimbursement amount of medical necessity denials *due to inappropriate setting* (For example: inpatient care that should have been provided in observation or outpatient setting)	Enter the total number of claims with length of stay **greater than or equal to 2-midnight** medical necessity review denials your hospital has received because the RAC determined the care should have been provided in a different setting (i.e. inpatient care that should have been provided in observation or in the outpatient setting). Enter the total Medicare reimbursement dollar amount associated with these denials.	VNote: Only enter the claims that were determined to be medically necessary but were denied due to inappropriate setting.
Top 3 DRGs Associated with Medical Necessity Denials		
5. List the top three MS-DRGs (as measured by reimbursement impact) for which your hospital has experienced a medical necessity denial.	List the top three MS-DRGs for which your hospital received medical necessity denials. Select the top three MS-DRGs based on the estimated total dollar value of the claims denied for the MS-DRG. Number 1 is MS-DRG with the greatest dollar amount of denied claims and Number 3 would be the MS-DRG with the third largest dollar amount of claims associated with it. Enter the CMG code if your hospital uses these codes instead of MS-DRGs.	VNote: Please do not include the MS-DRGs for which you have received denials for Incorrect MS-DRG or Other Coding Error. Those should be entered in the Overpayments (Complex) section of the survey.

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Other Medical Necessity Questions		
6. How many claims audited for medical necessity level of care were requested for review more than one year from the date of service?	Enter the total number of claims audited for medical necessity where the date of the Additional Documentation Request (ADR) letter was greater than 365 days from the date of discharge.	
7. Was your organization a participant in the Part A to Part B rebilling demonstration?	Please indicate by checking either “yes” or “no” as to whether your hospital participated in the recent Part A to Part B Rebilling Demonstration. (Note: This demonstration was limited to certain RAC regions and concluded on March 18, 2013, when the Administrator’s Ruling' was announced.)	
8. How many medical necessity level of care denials has your organization rebilled under Part B since March 13, 2013?	Please tally all rebilled claims by your facility to date since March 13, 2013 and indicate the total here.	
9. For denials rebilled since March 13, 2013, what was the original Medicare Part A total payment?	Please tally original payments for those claims rebilled to date since March 13, 2013 and indicate the total here.	
10. How many Part A medical necessity level of care denials has your organization re-billed under Part B AND received Part B reimbursement?	Please provide the total number of medical necessity claims that were denied for level of care that have since been rebilled under Part B AND you have received the Medicare Part B reimbursement.	
11. For denials re-billed AND paid under Part B, what was the original Medicare Part A total payment?	For those claims that were rebilled and have received the Medicare Part B reimbursement please provide the total Medicare Part A payment that was originally paid on this claim.	
12. For denials re-billed AND paid under Part B, what was the Medicare Part B total payment?	Please provide the total Medicare Part B reimbursement amount for all claims that were denied for level of care that have been rebilled under Part B AND have received the Medicare Part B reimbursement.	

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RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Underpayments		
☐ **Check here if your hospital has not had any underpayments.** (If checked, skip to Pre-payments.)	By checking this box, you are indicating that your hospital is not tracking or has not had underpayment experience through the present time.	
1. Total cumulative number of claims identified as underpayments	The RACs run Medicare claims through proprietary software to find potentially improper payments; this may include scenarios where the provider was paid less than the appropriate amount for the service. Alternatively, a provider may have an underpayment detected upon medical record review or complex review. Please total the number of claims (automated or complex) that were identified as an underpayment by the RAC.	
2. Estimate of total cumulative Medicare reimbursement dollars determined to be underpayments	The RAC will identify the underpayment on the notification letter and estimate an amount for that underpayment. Please total the estimated dollar value of all underpayments.	VNote: We are not asking for billed charges, nor are we asking for original payment. Please sum the Medicare reimbursement impact from any underpayment notification letters.
☐ **Check here if your hospital has had no new underpayment activity this quarter.** (If checked, skip to Appeals.)		
4. Indicate the reasons identified by the RAC for underpayment this quarter. **(Check all that apply)**	The reason(s) provided by the RAC for why claims are identified as underpayments. 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 identified for underpayment for reasons not included in one of our above categories. AHA will consider your submission for future tracking in RAC*TRAC*.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Underpayment Reasons		
Billing Error	Use this reason code to denote an inappropriate payment resulting in an underpayment.	
Inpatient Discharge Status	Use this reason code to denote when a provider billed an inaccurate discharge disposition for the patient. For example, patients who are intended to receive home-health services, but never do for a variety of reasons. In the post-acute care Medicare reimbursement methodology, these patients might otherwise inappropriately trigger a reduction in reimbursement for the hospital.	
Incorrect MS-DRG / CMG / LTC-DRG	Use this reason code to denote when a hospital incorrectly coded a lower paying MS-DRG / CMG / LTC-DRG when the documentation or information on the claim should have resulted in a higher paying code.	
Outpatient Coding Error	Use this reason code to denote an error in HCPCS code assignment or other outpatient coding related error.	
All Other	If the reason for the underpayment is not listed here, please check “other” and send AHA an email about the new reasons for underpayments that have been identified above. Please include the number of claims and the dollars associated with that underpayment reason so we can best determine if this is an isolated incident or if your reason should be added to the data we are capturing.	

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RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Pre-Payment Denials		
☐ **Check here if your hospital has NOT experienced any RAC pre-payment reviews.** (If checked, skip to Appeals.)	By checking this box, you have indicated that your hospital has never had any claims identified for RAC pre-payment review as of today's date.	
☐ **Check here if your hospital has experienced any RAC pre-payment denials.**	By checking this box, you have indicated that your hospital has experienced RAC pre-payment denials as of today's date.	
1. Total cumulative number of medical records requested for RAC pre-payment review.	Provide the total number of medical record requests that your hospital has received for RAC pre-payment review.	
1A. Total Medicare reimbursement for medical records requested for RAC pre-payment review	Please indicate the Medicare reimbursement value associated with all record requests your hospital has received for RAC pre-payment review.	
2. Total number of RAC pre-payment denials	Of the total number of medical record requests received for RAC pre-payment review, please indicate the total number of claims where the RAC denied payment for the claim.	
2A. Total Medicare reimbursement for RAC pre-payment denials	Please indicate the Medicare reimbursement amount for all pre-payment record requests that were denied by the RAC.	
3. Total number of RAC pre-payment denials appealed	Of the pre-payment reviews that were denied, please provide the total number of denials that your hospital has appealed.	
3A. Total Medicare reimbursement amount for RAC pre-payment denials appealed	Please indicate the total Medicare reimbursement amount of the pre-payment denials that have been appealed.	
4. Total number of RAC pre-payment denials overturned	Of the total number of medical record requests received for RAC pre-payment review, please indicate the total number of claims where the RAC overturned/approved payment for the claim.	
4A. Total Medicare reimbursement amount for RAC pre-payment denials overturned	Please indicate the Medicare reimbursement amount of all pre-payment reviews where the RAC overturned/approved payment for the claim.	
Definitions of Pre-Payment Denial Reasons for Questions 5 and 6 – Pre-Payment ***NOTE:*** *Reasons for denial are hospital type and service based. For example, a user can be associated with a Medical/Surgical Acute Care Hospital and still have denial reasons in the Inpatient Rehabilitation Hospital/Services area, due to a distinct part unit. Please contact RACTracsupport@providercs.com if you have questions.*		
Medical/Surgical Acute Care Hospital/Services – No Documentation Provided or Insufficient Documentation in the Medical Record	Use this reason code to denote when a RAC request a medical record from the provider and the provider either failed to respond within the appropriate time limit (45 calendar days) or failed to send the complete medical record. This is often referred to as a "technical denial."	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Medical/Surgical Acute Care Hospital/Services– Incorrect MS-DRG or Other Coding Error	Use this reason code to denote that, upon review of the medical record, the RAC determined that an incorrect MS-DRG assignment was made based on the documentation provided.	
Medical/Surgical Acute Care Hospital/Services – Incorrect APC or Other Outpatient Coding Error / Outpatient Billing Error	Use this reason code to denote when a RAC determines that there has been improper billing related to APC assignment, fee-schedule based HCPCS assignment, or other outpatient coding error.	
Medical/Surgical Acute Care Hospital/Services – Short Stay Medically Unnecessary Inpatient Stays Less than 2-Midnights	Use this reason code to denote a denial that generally pertains to acute inpatient stays of less than 2-midnights. The CMS 2014 IPPS final rule. Use this reason code to denote a denial that may include the following justifications for care being determined medically unnecessary: • Inpatient service provided should have been done in the outpatient setting • Inpatient should have been observation • No medical necessity for inpatient admission • Level of care not met for inpatient admission Please note that more than one procedure occurring on the same day AHA classifies as an duplicate payment – not medically unnecessary as defined in coverage guidelines etc. (e.g. 3 appendectomies in one day, while not medically necessary is really a duplicate payment and should be cited as such.)	
Medical/Surgical Acute Care Hospital/Services – Medically Unnecessary Inpatient stay Greater Than or Equal to 2-Midnights	Use this reason code to denote a denial that generally pertains to acute inpatient stays of greater than or equal to than 2-midnights. The CMS 2014 IPPS final rule. Use this reason code to denote a denial that may include the following justifications for care being determined medically unnecessary: • Inpatient service provided should have been done in the outpatient setting • Inpatient should have been observation • No medical necessity for inpatient admission • Level of care not met for inpatient admission	
Medical/Surgical Acute Care Hospital/Services – Other Medically Unnecessary	Use this reason code to denote other denials that are not mentioned above or are for clinical reasons rather than utilization of services.	
Medical/Surgical Acute Care Hospital/Services – Incorrect Discharge Status	Use this reason code to note an incorrect discharge status on the original claim that has been cited for inaccurate payment. For example, the claim indicates discharge to home or other facility, but a subsequent claim for the same patient on the same day shows that the beneficiary was discharged to another hospital.	
Medical/Surgical Acute Care Hospital/Services – All Other (Enter in text box below)	Use this reason code to denote if the above mentioned denial reasons are in no way related to the current denials you are experiencing.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
	Please also contact AHA via our "contact us" email and let us know about the types of denials you are experiencing so that we can consider tracking them in RAC*TRAC*.	
Inpatient Rehabilitation Hospital/Unit – No Documentation Provided or Insufficient Documentation	Use this reason code to denote when a RAC request a medical record from the provider and the provider either failed to respond within the appropriate time limit (45 calendar days) or failed to send the complete medical record. This is often referred to as a "technical denial."	
Inpatient Rehabilitation Hospital/Unit – Incorrect CMG or Other Coding Error	Use this reason code to denote that upon review of the medical record, the RAC determined that an incorrect case mix group (CMG) assignment or other coding error was made based on the documentation provided.	
Inpatient Rehabilitation Hospital/Unit – All Joint Patients: Medically Unnecessary	Use this reason code to denote when an inpatient rehabilitation service provided to a joint patient has been deemed medically unnecessary for any of the following reasons, including but not limited to: • Documentation does not support the need for 24-hour rehab nursing • Documentation does not support the need for 24-hour medical supervision • Documentation does not show a coordinated care plan • Documentation does not show a significant practical improvement • Patient could have been served in a less intense setting • Documentation does not support that therapy services were of relatively intense level of service • Documentation does not reflect realistic goals/progress toward established goals	
Inpatient Rehabilitation Hospital/Unit – Other Medically Unnecessary	Use this reason code to denote when inpatient rehabilitation was denied as medically unnecessary. There are seven criteria outlined in the Medicare Coverage Guidelines to assist providers in determining whether or not care in an IRF setting is clinically appropriate. Reasons for denial under this category include the following: • Documentation does not support the need for 24-hour rehab nursing • Documentation does not support the need for 24-hour medical supervision • Documentation does not show a coordinated care plan • Documentation does not show a significant practical improvement • Patient could have been served in a less intense setting • Documentation does not support that therapy services were of relatively intense level of service • Documentation does not reflect realistic goals/progress toward established goals	
Inpatient Rehabilitation Hospital/Unit – All Other (Enter in text box below)	Use this reason code to denote if the above mentioned denial reasons are in no way related to the current denials you are experiencing. Please also contact AHA via our "contact us" email and let us know about the types of denials you are experiencing so that we can consider tracking them in RAC*TRAC*.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Psychiatric Services Hospital/Unit – No Documentation Provided or Insufficient Documentation	Use this reason code to denote when a RAC request a medical record from the provider and the provider either failed to respond within the appropriate time limit (45 calendar days) or failed to send the complete medical record. This is often referred to as a "technical denial."	
Psychiatric Services Hospital/Unit – Incorrect MS-DRG or Other Coding Error	Use this reason code to denote that upon review of the medical record, the RAC determined that an incorrect MS-DRG assignment was made based on the documentation provided.	
Psychiatric Services Hospital/Unit – Medically Unnecessary	Medicare does not have criteria for admission into psychiatric hospitals and therefore this reason for denial is currently not specified. Use this reason code to denote a denial reason that may be characterized "as the care could have been provided in a less intensive setting."	
Psychiatric Services Hospital/Unit – All Other (Enter in text box below)	Use this reason code to denote if the above mentioned denial reasons are in no way related to the current denials you are experiencing. Please also contact AHA via our "contact us" email and let us know about the types of denials you are experiencing so that we can consider tracking them in RAC*TRAC*.	
Long Term Care Hospital/Unit – No Documentation Provided or Insufficient Documentation	Use this reason code to denote when a RAC request a medical record from the provider and the provider either failed to respond within the appropriate time limit (45 calendar days) or failed to send the complete medical record. This is often referred to as a "technical denial".	
Long Term Care Hospital/Unit – Incorrect LTC-DRG or Other Coding Error	Use this reason code to denote that, upon review of the medical record, the RAC determined that an incorrect LTC-DRG assignment was made based on the documentation provided.	
Long Term Care Hospital/Unit - Medically Unnecessary	Medicare does not have criteria for admission into long term acute care hospitals and therefore this reason for denial is currently not specified. Use this reason code to denote a denial reason that may be characterized as "the care could have been provided in a less intensive setting".	
Long Term Care Hospital – All Other (Enter in text box below)	Use this reason code to denote if the above mentioned denial reasons are in no way related to the current denials you are experiencing.	
	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 RAC*TRAC*.	
5. Rank order the denial reasons experienced by number of pre-payment claim denials for this quarter.	Select number 1 for the denial reason with the largest number of pre-payment claim denials this quarter and number 2 for the denial reason with the second largest number of pre-payment claim denials.	
6. Rank order the denial reasons experienced by the estimated total Medicare reimbursement dollar value of pre-payment claim denials for this quarter.	The top two three denial reasons are based on the total dollar value of the pre-payment claim denials this quarter. The dollar value for each claim is based on the estimated dollar value of the overpayment. Number 1 is the denial reason with the greatest dollar amount of denied claims associated with that reason; number 2 for the denial reason with the second greatest denied dollar amount.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
7. List the top two MS-DRGs (as measured by estimated reimbursement impact) for which your hospital has experienced a RAC pre-payment denial	List the top two MS-DRGs for which your hospital has experienced a RAC pre-payment denial. Select the top two MS-DRGs based on the estimated total dollar value of the claims denied for the MS-DRG. Number 1 is MS-DRG with the greatest dollar amount of denied claims and Number 2 would be the MS-DRG with the second largest dollar amount of claims associated with it. Enter the CMG code if your hospital uses these codes instead of MS-DRGs.	

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RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Appeals		
Enter the information on appeals ONLY if you have received a Demand Letter. [Exclude appeals of pre-payment denials.] *Totals should reflect cumulative experience since October 2008.*	Please indicate in this section only, values for those claims that you have received a demand letter for and are in the appeals process. Regardless of whether or not this claim was identified through the automated or the complex process, if it is in the appeals process, it should be noted here.	
1. Total number of appeals filed	The total (cumulative) number of appeals filed for claims denied through the automated and complex review processes. An appeal is NOT a rebuttal to the RAC but rather an appeal filed to the Fiscal Intermediary (FI) for redetermination (or for some the Medicare Administrative Contractor (MAC)). Each claim filed with the FI or MAC counts only once, regardless of the number of levels of appeals it goes through. *Regardless of whether or not this claim was identified through the automated or complex process, if it was appealed, it should be noted here.*	VNote: Once it has been appealed to the FI or MAC, then that appeal only counts once.
1A. Total Medicare reimbursement dollar value of the denials filed for appeal	Please indicate the estimated total dollar value of all your denied claims filed for appeal to the FI or MAC to date. *Regardless of whether or not this claim was identified through the automated or complex process, if it was appealed it should be noted here.*	VNote: Dollar value of a denied claim is what was indicated on the demand letter.
2. Total number of appeals overturned in favor of the provider at any level of the appeals process	Once a claim has been appealed, it can be overturned at any level of the appeals process (FI, QIC, ALJ, MAC, etc.). Please indicate the total number of claims that have been successfully overturned in favor of the provider at any level to date. (This does not include any rebuttals to the RACs that were then overturned in favor of the provider.)	
2A. Total Medicare reimbursement dollars of appeals that have been overturned in favor of the provider at any level of the appeals process	Once a claim has been appealed, it can be overturned at any level of the appeals process (FI, QIC, ALJ, MAC, etc.). Please indicate the estimated total dollars associated with all the claims that have been successfully overturned in favor of the provider to date. (This does not include any denials overturned in the discussion period.)	VNote: In the AHA RAC*TRAC* claim tool the dollar value is pulled from the value stated on the demand letter. However, any appeal entity can issue a fully favorable or partially favorable finding. Ideally, vendors should capture the actual dollar value, as AHA's tool could overestimate the dollars returned.

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
3. Total number of appeals to date withdrawn or stopped by the provider at any level of the appeals process (**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.)	Please indicate the total number of appeals withdrawn or stopped by the provider at any level of the appeals process. Include all appeals that were withdrawn or stopped: • In order to rebill under Part B. • To take advantage of the CMS 68% settlement offer. • Not continued for other reasons. Most often, these are appeals that the provider only pursued to a certain level and then made a determination that it was no longer worth pursuing further and the denial remains upheld. Several reasons may justify this decision, in addition to those mentioned above, including but not limited to: not enough documentation to support an appeal moving forward, the dollar value of the claim is not enough to warrant the cost of a lengthy appeals process, the hospital missed a deadline for filing an appeal to get it to the next step in the process, not enough resources to appeal every claim, or the merits of the case do not warrant pursuing the appeal further.	
3A. Total Medicare reimbursement dollar value of the appeals withdrawn or stopped by the provider at any level of the appeals process (**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.)	Please indicate the estimated total dollar value of appeals withdrawn or stopped by the provider at any level of the appeals process as counted in question 3. The dollar value is indicated on the demand letter.	
4. Total number of appeals 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. *(Include only those appeals withdrawn or stopped due to CMS 68% settlement offer.)*	Please indicate the total number of appeals that were initially filed to the FI or MAC and then withdrawn or stopped by the provider at any level of the appeals process to accept the CMS 68% settlement offer. To more quickly reduce the volume of inpatient status claims pending in the appeals process, CMS *offered* an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount). The deadline for hospitals to request settlement was October 31, 2014. Eligible claims were those denied by a Medicare contractors on the basis that services may have been reasonable and necessary but treatment on an inpatient basis was not, that were either under appeal or within their administrative timeframe to request an appeal review with dates of admissions prior to October 1, 2013, and where the patient was not a Part C enrollee. The hospital could not choose to settle some claims and continue to appeal others.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
4A. Total Medicare reimbursement dollar value of the appeals that were initially filed to the FI/MAC and later withdrawn or not continued in order to accept the CMS 68% settlement offer. *(Include only those appeals withdrawn due to CMS 68% settlement offer.)*	Please indicate the estimated total dollar value of appeals that were initially filed to the FI or MAC and then withdrawn or stopped by the provider at any level of the appeals process in order to accept the CMS 68% settlement offer. The dollar value is indicated on the demand letter.	
5. Total number of appeals to date that were initially files to the FI/MAC and later withdrawn from the process, or not continued in order to rebill the claim *(Include only those appeals withdrawn and rebilled)*	Please indicate the total number of appeals that were filed to the FI or MAC and then withdrawn or stopped by the provider so that the claims could be rebilled.	
5A. 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 rebilled)*	Please indicate the estimated total dollar value of appeals that were initially filed to the FI or MAC and then withdrawn or stopped by the provider so that the claim could be rebilled. The dollar value is indicated on the demand letter.	
6. Total number of appeals currently in process	These appeals have been filed and are currently in process at various levels of the appeals process. They have not been overturned or withdrawn or stopped for any reason.	
6A. Total Medicare reimbursement dollar value of the appeals currently in process	These appeals have been filed and are currently in process at various levels of the appeals process. They have not been overturned or withdrawn or stopped for any reason. Indicate the estimated dollar value of these appeals in process.	
7. Average administrative cost per appeal (cost associated with the appeals process)	Enter the costs incurred as a result of appealing RAC denials. Enter the average administrative (including legal costs) cost per appeal.	VNote: There are many different costs associated with pursuing the Medicare Appeals Process. The types of costs (staff time, legal costs, copying costs, etc) vary by hospital. Please indicate the average cost of pursuing the appeals process per appeal.

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
8. For the 1st level appeals filed this quarter, please indicate the denial reasons cited on those claims. (Check all that apply)	On the correspondence from the RAC to the provider, the RAC indicates the reason for the overpayment. AHA has broadly categorized selected reasons by hospital type that were identified during the demonstration program. Please read carefully through each of the denial reasons to determine ANY and ALL categories which reflect the reason for appeal for **this quarter**. The denial reasons for both automated and complex are noted in the Automated and Complex sections above.	
9. 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).	AHA has broadly categorized reasons for the overturn determination on appeal, representing a win for the hospital. Please select ALL categories which represent the basis for the overturn decision on a RAC appeal, appreciating that more than one selection may apply. Please notify AHA if a reason is not represented for the overturn determinations experienced by the hospital.	
Appeal Overturn Reasons		
Additional information provided by the hospital substantiated the claim.	In the first 2 stages of appeal (FI and QIC), the hospital may introduce additional, relevant information and/or documentation to support the admission, DRG assignment, coding and/or services delivered.	
The RAC made an error in its determination process.	The RAC gave an inaccurate determination which can be referred to as "no good cause."	
Care provided was found to be medically necessary	The RAC's finding of care being medically unnecessary was not supported by the documentation or evidence provided.	
The claim is currently under review by a different auditor(s)	The claim is undergoing a secondary review.	
Other	If your reason for having an appeal overturned is not cited, please indicate it here. In addition, please contact AHA via our "contact us" email and let us know about the denials you are experiencing so that we can consider tracking them in RAC*TRAC*.	
	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 RAC*TRAC*.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Appeal Status – Level 1 (FI/MAC)		
Please complete the following questions for appeal activity at Level 1 (Fiscal Intermediary / Medicare Administrative Contractor) CUMULATIVE since 2008 *(Exclude appeals of pre-payment denials)*		
1. Total number of denials filed for appeal at Level 1?	Please indicate the total cumulative number of appeals the hospital has filed at Level 1.	
1A. Total Medicare reimbursement dollar value of the denials filed for appeal at Level 1?	Please indicate the total cumulative Medicare reimbursement dollar value of all appeals filed at Level 1 ONLY.	
2. Number of denials overturned (in favor of the provider) at Level 1?	Please indicate the total number of appeals that have been successfully overturned in favor of the provider at Level 1.	
2A. Total Medicare reimbursement for denials overturned (in favor of the provider) at Level 1?	Please indicate the total Medicare reimbursement dollar value of all appeals successfully overturned in favor of the provider at Level 1 (FI/MAC). (Please only total those claims overturned at Level 1.)	
3. Cumulative number of appeals stopped or withdrawn by the hospital at Level 1, excluding those withdrawn for rebilling and those withdrawn to accept the CMS 68% settlement offer?	Please indicate the total number of appeals at Level 1 (FI/MAC) that the hospital has withdrawn or not progressed to the next level of appeal. DO NOT include those withdrawn for rebilling or those withdrawn to accept the CMS 68% settlement offer.	
3A. Total Medicare reimbursement for appeals stopped or withdrawn by the hospital at Level 1 excluding, those withdrawn for rebill and those withdrawn to accept the CMS 68% settlement offer?	Indicate the total Medicare reimbursement dollar value for all appeals at Level 1 (FI/MAC) that the hospital has withdrawn or not progressed to the next level of appeal. DO NOT include those withdrawn for rebill or those withdrawn to accept the CMS 68% settlement offer.	
4. Number of appeals stopped or withdrawn by the hospital at level 1 in order to accept the CMS 68% settlement offer.	Please indicate the total number of appeals that were initially filed to the FI or MAC and then withdrawn or stopped by the provider at level 1 of the appeals process to accept the CMS 68% settlement offer. To more quickly reduce the volume of inpatient status claims pending in the appeals process, CMS *offered* an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount). The deadline for hospitals to request settlement was October 31, 2014. Eligible claims were those denied by a Medicare contractors on the basis that services may have been reasonable and necessary but treatment on an inpatient basis was not, that were either under appeal or within their administrative timeframe to request an appeal review with dates of admissions prior to October 1, 2013, and where the patient was not a Part C	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
	enrollee. The hospital could not choose to settle some claims and continue to appeal others.	
4A. Total Medicare reimbursement for appeals stopped or withdrawn at Level 1 by the hospital in order to accept the CMS 68% settlement offer?	Please indicate the estimated total dollar value of appeals that were initially filed to the FI or MAC and then withdrawn or stopped by the provider at level 1 of the appeals process in order to accept the CMS 68% settlement offer. The dollar value is indicated on the demand letter.	
5. Number of appeals stopped or withdrawn by the hospital at Level 1 so claim can be rebilled under Part B?	Indicate the total number of appeals at Level 1 (FI/MAC) that the hospital has withdrawn so the claim can be rebilled under Part B since implementation of 1455-R on March 13, 2013.	
5A. Total Medicare reimbursement for appeals stopped or withdrawn at Level 1 by the hospital so claim could be rebilled under Part B?	Please indicate the total Medicare reimbursement dollar value for all appeals at Level 1 (FI/MAC) withdrawn so claim can be rebilled under Part B since implementation of 1455-R on March 13, 2013.	
6. Total number of appeals with an unfavorable determination at Level 1	Indicate the total number of appeals at Level 1 (FI/MAC) that the hospital has received an unfavorable determination on.	
6A. Total Medical reimbursement dollar value for appeals with an unfavorable determination at Level 1	Please indicate the total Medicare reimbursement dollar value for all appeals at Level 1 (FI/MAC) that received an unfavorable determination.	
7. Total number of appeals currently pending determination at Level 1? (INCLUDE ONLY appeals still in process, i.e., awaiting a determination.)	Please indicate the total number of appeals at Level 1 (FI/MAC) that are pending a determination. Include only appeals still in process, i.e., awaiting a determination. DO NOT include any appeals that have been stopped, withdrawn, not continued, or denied.	
7A. Total Medicare reimbursement dollar value for appeals currently pending determination at Level 1?	Please indicate the total Medicare reimbursement dollar value for all appeals at Level 1 (FI/MAC) that are pending a determination.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Appeal Status – Level 2 (QIC)		
Please complete the following questions for appeal activity at Level 2 (QIC) CUMULATIVE since 2008 *(Exclude appeals of pre-payment denials)*		
1. Total cumulative number of denials filed for appeal at Level 2?	Please indicate the total cumulative number of appeals the hospital has filed at Level 2.	
1A. Total Medicare reimbursement dollar value of the denials filed for appeal at Level 2?	Please indicate the total cumulative Medicare reimbursement dollar value of all appeals filed at Level 2 ONLY.	
2. Number of denials overturned (in favor of the provider) at Level 2?	Please indicate the total number of appeals that have been successfully overturned in favor of the provider at Level 2.	
2A. Total Medicare reimbursement for denials overturned (in favor of the provider) at Level 2?	Please indicate the total Medicare reimbursement dollar value of all appeals successfully overturned in favor of the provider at Level 2 (QIC). (Please only total those claims overturned at Level 2.)	
3. Cumulative number of appeals stopped or withdrawn by the hospital at Level 2, excluding those withdrawn for rebilling and those withdrawn to accept the CMS 68% settlement offer?	Please indicate the total number of appeals at Level 2 (QIC) that the hospital has withdrawn or not progressed to the next level of appeal. DO NOT include those withdrawn for rebilling or those withdrawn to accept the CMS 68% settlement offer.	
3A. Total Medicare reimbursement for appeals stopped or withdrawn by the hospital at Level 2, excluding those withdrawn for rebill and those withdrawn to accept the CMS 68% settlement offer?	Indicate the total Medicare reimbursement dollar value for all appeals at Level 2 (QIC) that the hospital has withdrawn or not progressed to the next level of appeal. DO NOT include those withdrawn for rebill or those withdrawn to accept the CMS 68% settlement offer.	
4. Number of appeals stopped or withdrawn by the hospital at Level 2 in order to accept the CMS 68% settlement offer.	Please indicate the total number of appeals that were initially filed to the FI or MAC and then withdrawn or stopped by the provider at level 2 of the appeals process to accept the CMS 68% settlement offer. To more quickly reduce the volume of inpatient status claims pending in the appeals process, CMS *offered* an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount). The deadline for hospitals to request settlement was October 31, 2014. Eligible claims were those denied by a Medicare contractors on the basis that services may have been reasonable and necessary but treatment on an inpatient basis was not, that were either under appeal or within their administrative timeframe to request an appeal review with dates of admissions prior to October 1, 2013, and where the patient was not a Part C enrollee. The hospital could not choose to settle some claims and continue to appeal others.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
4A. Total Medicare reimbursement dollar for appeals stopped or withdrawn at Level 2 by the hospital in order to accept the CMS 68% settlement offer?	Please indicate the estimated total dollar value of appeals that were initially filed to the FI or MAC and then withdrawn or stopped by the provider at level 2 of the appeals process in order to accept the CMS 68% settlement offer. The dollar value is indicated on the demand letter.	
5. Number of appeals stopped or withdrawn by the hospital at Level 2 so claim can be rebilled?	Indicate the total number of appeals at Level 2 (QIC) that the hospital has withdrawn so the claim can be rebilled under Part B since implementation of 1455-R on March 13, 2013.	
5A. Total Medicare reimbursement for appeals stopped or withdrawn at Level 2 by the hospital so claim could be rebilled under Part B?	Please indicate the total Medicare reimbursement dollar value for all appeals at Level 2 (QIC) withdrawn so claim can be rebilled under Part B since implementation of 1455-R on March 13, 2013.	
6. Total number of appeals with an unfavorable determination at Level 2	Indicate the total number of appeals at Level 2 (QIC) that the hospital has received an unfavorable determination on.	
6A. Total Medical reimbursement dollar value for appeals with an unfavorable determination at Level 2	Please indicate the total Medicare reimbursement dollar value for all appeals at Level 2 (QIC) that received an unfavorable determination.	
7. Total number of appeals <u>currently</u> pending determination at Level 2? (INCLUDE ONLY appeals still in process, i.e., awaiting a determination.)	Please indicate the total number of appeals at Level 2 (QIC) that are pending a determination. (Include only appeals still in process, i.e., awaiting a determination. DO NOT include any appeals that have been stopped, withdrawn, not continued, or denied.	
7A. Total Medicare reimbursement dollar value for appeals <u>currently</u> pending determination at Level 2?	Please indicate the total Medicare reimbursement dollar value for all appeals at Level 2 (QIC) that are pending a determination.	
8. For how many appeals filed at Level 2 (QIC) has the QIC taken longer than 60 days to issue a decision?	Please provide the number of Level 2 (QIC) appeals ONLY where the QIC has taken longer than the statutory 60 days to issue a determination.	
Appeal Status – Level 3 (ALJ)		
Please complete the following questions for appeal activity at Level 3 (Administrative Law Judge) CUMULATIVE since 2008 *(Exclude appeals of pre-payment denials)*		
1. Total cumulative number of denials filed for appeal at Level 3?	Please indicate the total cumulative number of appeals that the hospital has filed at Level 3.	
1A. Total Medicare reimbursement dollar value of the denials filed for appeal at Level 3?	Please indicate the total cumulative Medicare reimbursement dollar value of all appeals filed at Level 3 ONLY.	
2. Number of denials overturned (in favor of the provider) at Level 3?	Please indicate the total number of appeals that have been successfully overturned in favor of the provider at Level 3.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
2A. Total Medicare reimbursement for denials overturned (in favor of the provider) at Level 3?	Please indicate the total Medicare reimbursement dollar value of all appeals successfully overturned in favor of the provider at Level 3 (ALJ). (Please only total those claims overturned at Level 3.)	
3. Cumulative number of appeals stopped or withdrawn by the hospital at Level 3, excluding those withdrawn for rebilling and those withdrawn to accept the CMS 68% settlement offer?	Please indicate the total number of appeals at Level 3 (ALJ) that the hospital has withdrawn or not progressed to the next level of appeal. DO NOT include those withdrawn for rebilling or those withdrawn to accept the CMS 68% settlement offer.	
3A. Total Medicare reimbursement for appeals stopped or withdrawn by the hospital at Level 3, excluding those withdrawn for rebill and those withdrawn to accept the CMS 68% settlement offer?	Indicate the total Medicare reimbursement dollar value for all appeals at Level 3 (ALJ) that the hospital has withdrawn or not progressed to the next level of appeal. DO NOT include those withdrawn for rebill or those withdrawn to accept the CMS 68% settlement offer.	
4. Number of appeals stopped or withdrawn by the hospital at Level 3 in order to accept the CMS 68% settlement offer?	Please indicate the total number of appeals that were initially filed to the FI or MAC and then withdrawn or stopped by the provider at level 3 of the appeals process to accept the CMS 68% settlement offer. To more quickly reduce the volume of inpatient status claims pending in the appeals process, CMS *offered* an administrative agreement to any hospital willing to withdraw their pending appeals in exchange for timely partial payment (68% of the net allowable amount). The deadline for hospitals to request settlement was October 31, 2014. Eligible claims were those denied by a Medicare contractors on the basis that services may have been reasonable and necessary but treatment on an inpatient basis was not, that were either under appeal or within their administrative timeframe to request an appeal review with dates of admissions prior to October 1, 2013, and where the patient was not a Part C enrollee. The hospital could not choose to settle some claims and continue to appeal others.	
4A. Total Medicare reimbursement for appeals stopped or withdrawn at Level 3 by the hospital in order to accept the CMS 68% settlement offer?	Please indicate the estimated total dollar value of appeals that were initially filed to the FI or MAC and then withdrawn or stopped by the provider at level 3 of the appeals process in order to accept the CMS 68% settlement offer. The dollar value is indicated on the demand letter.	
5. Number of appeals stopped or withdrawn by the hospital at Level 3 so claim can be rebilled under Part B?	Indicate the total number of appeals at Level 3 (ALJ) that the hospital has withdrawn so the claim can be rebilled under Part B since implementation of 1455-R on March 13, 2013.	
5A. Total Medicare reimbursement for appeals stopped or withdrawn at Level 3 by the hospital so claim could be rebilled under Part B?	Please indicate the total Medicare reimbursement dollar value for all appeals at Level 3 (ALJ) withdrawn so claim can be rebilled under Part B since implementation of 1455-R on March 13, 2013.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
6. Total number of appeals with an unfavorable determination at Level 3	Indicate the total number of appeals at Level 3 (ALJ) that the hospital has received an unfavorable determination on.	
6A. Total Medical reimbursement dollar value for appeals with an unfavorable determination at Level 3	Please indicate the total Medicare reimbursement dollar value for all appeals at Level 3 (ALJ) that received an unfavorable determination.	
7. Total number of appeals currently pending determination at Level 3? (INCLUDE ONLY appeals still in process, i.e., awaiting a determination.)	Please indicate the total number of appeals at Level 3 (ALJ) that are pending a determination. Include only appeals still in process, i.e., awaiting a determination. DO NOT include any appeals that have been stopped, withdrawn, not continued, or denied.	
7A. Total Medicare reimbursement dollar value for appeals currently pending determination at Level 3?	Please indicate the total Medicare reimbursement dollar value for all appeals at Level 3 (ALJ) that are pending 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?	Please provide the number of Level 3 (ALJ) appeals ONLY where the ALJ has taken longer than the statutory 90 calendar days to issue a determination.	
Appeal Status – Level 4 (Medicare Appeals Council)		
☐ Check here if your hospital has filed any appeals to Level 4 (Medicare Appeals Council) of the appeals process.	By checking this box, you are indicating that your hospital has filed appeals to Level 4.	
1. Total cumulative number of appeals hospital has filed to Level 4 (Medicare Appeals Council)?	Please provide the CUMULATIVE number of appeals that your hospital has filed to Level 4 (Medicare Appeals Council).	
1A. Total Medicare reimbursement dollar value of the denials filed for appeal at Level 4?	Please indicate the total Medicare reimbursement dollar value of all appeals filed at Level 4 ONLY.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
Administrative Burden		
Organization Experience		
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).	For this quarter, please estimate the total cost of the RAC program, in consideration of external and internal resources. This question attempts to understand the administrative burden to the hospital in its entirety. Because it can be both time consuming and overly granular to itemize individual costs, this question is looking for the overall cost of responding to RAC claim audits, with best estimates applied. Please be sure to include both employee-related costs as well as external agencies, consultants, software, etc. as required to support the RAC activity.	
2. Please select any external services you have hired to assist you in managing the RAC process within your organization. Please estimate the total dollars paid to these outside consultants this quarter.	Check all that apply and provide a dollar estimate for each service for this quarter ☐ No External Support ☐ External Legal Counsel Total Dollars $ _____ ☐ RAC Claim Management Tool Total Dollars $ _____ ☐ Medical Record Copying Service Total Dollars $ _____ ☐ Utilization Management Consultant Total Dollars $ _____ ☐ RAC Claim Tracking Service Total Dollars $ _____	
3. What has been the impact of the RAC (financial recoupment of dollars, costly appeals process, and increased administrative burden) on your organization this quarter? (Check all that apply)	☐ 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 staffing) ☐ 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 hire 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	
4. Have you escalated any appeals to the Medicare Appeals Council as a result of the untimely response of the ALJ?	Select either "yes" or "no" regarding whether your facility has escalated any appeals to the Medicare Appeals Council **as a result of an untimely response (more than 90 days) from the ALJ**.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
4A. If Yes, for how many appeals?	If you selected yes to question 4, please indicate the total number of appeals that you have escalated to the Medicare Appeals Council. *(Only include those appeals that you have escalated due to an untimely response by the ALJ.)*	
5. Have you submitted denials for discussion?	5. Please indicate, yes or no, as to whether your hospital has ever attempted to utilize the RAC discussion period to seek overturn of a denied claim.	
5A. If yes, for how many claims have you attempted to utilize the discussion period?	5A. If you answered yes to 5, please enter the number of denials for which you have initiated the discussion period with the RAC..	
5C. How many denials submitted for discussion, have been overturned?	5C. Please indicate the number of denials for which you have received a favorable determination on during the discussion period.	
6. Have you had any RAC denials overturned during the discussion period? **6A. If yes, how many?**	6. Please indicate, yes or no, as to whether your hospital has ever had any RAC denials overturned during the discussion period. 6A. If you answered yes to 6, please enter the cumulative number of denials that have been overturned during the discussion period.	
7. 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? **7B. If yes, for how many claims?**	7. Indicate, yes or no, as to whether your hospital has ever received correspondence from the QIC advising you that they will not be able to review your appeal within the 60 day review window and offering the option to escalate the appeal to the ALJ. 7A. If you answered yes to question 7, please provide the total cumulative number of appeals that have received communication from the QIC advising that they will not be able to review within the 60 day timeline.	
8. Have any claims denied for DRG Validation become full medical necessity denials during the appeals process? **8A. If yes, how many?**	8 Please indicate, yes or no, if your hospital had any claims that were initially denied for DRG Validation that were converted to full medical necessity denials during the appeals process. 8A If you marked yes for question 18, please enter the total (cumulative) number of claims that were initially denied for DRG Validation that were converted to full medical necessity denials during the appeals process.	

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
RAC Process Problems		
9. How would you rate the responsiveness to your inquiries and the overall communication with your RAC?	Please indicate the responsiveness and overall communication from your RAC by selecting either Excellent, Good, Fair, or Poor.	VNote: The RAC Process Problems section of the survey was added to determine the impact on hospitals of a myriad of RAC operational issues. Your responses to these questions will help AHA in their discussions with CMS regarding problems with the RAC program.
10. What is the approximate timeline in which the RAC responded to your inquiries?	Please indicate the average amount of time it took for the RAC to respond to your inquiries: 24 hours, 2-3 days, 4-6 days, 7-13 days or no response received.	
11. Have you received any education from CMS and/or your FI 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.)?	Please indicate, to your knowledge, whether the Centers for Medicare and Medicaid Services (CMS) or your Fiscal Intermediary (FI) or Medicare Audit Contractor (MAC) have provided any education to assist your hospital in avoiding future RAC Audits. If you have received education, please indicate in question 11A how effective the education was by selecting either Excellent, Good, Fair, or Poor.	
11A. If yes, how effective was this education in helping your facility identify and correct issues that might lead to future RAC denials?	Please indicate the effectiveness of this education by selecting either Excellent, Good, Fair, or Poor.	
12. Please select from the following issues that you experienced during the current calendar quarter. **12A. If Other issues/problems was selected, please provide details here.**	Select each of the following issue your hospital experienced with your RAC during the **current quarter**. Full list of choices for question 12. ☐ 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 ☐ RAC is 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 is 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	VNote: Please only select the issues you experienced during the previous calendar quarter. We are attempting to determine which issues are ongoing and which issues have been resolved. A rescind is the decision by the RAC contractor to not continue with the targeting of a requested medical record. It occurs after you have received a request for documentation, but you do not receive a determination notice (because it has been stopped, or rescinded) from the RAC contractor.

RACTrac Question (As they appear on the Survey)	User Definition	Vendor Notes (VNote) and Comments
	☐ Long lag (greater than 30 days) between date on review results letter and receipt of demand letter from the MAC ☐ 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) 12A. Please use text box to indicate Other issues/problems not listed in question 12.	