American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

October 24, 2012

Daniel R. Levinson
Inspector General
Office of Inspector General
Department of Health & Human Services
Room 5441, Cohen Building
330 Independence Avenue, SW
Washington, DC 20201

Dear Mr. Levinson:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations and our nearly 42,000 individual members, the American Hospital Association (AHA) is pleased that the Office of Inspector General's (OIG) *Work Plan for Fiscal Year 2013* (Work Plan) includes review of the effectiveness of various Medicare contractors, including Recovery Audit Contractors (RACs), in addition to hospital reviews.

RACs and a host of other contractors – known by a variety of acronyms such as MACs, ZPICs, etc. – have been enlisted by the Centers for Medicare & Medicaid Services (CMS) to help detect and correct billing errors and abuses. The differences between the types of contractors are not material for present purposes; they all essentially function as auditors.

These programs auditing payment accuracy are well intentioned; no one questions the need for auditors to identify billing mistakes. But hospitals continued to be frustrated with the RACs' considerable inaccuracy in determining whether the hospital received any overpayments. They also are overwhelmed by the significant overlap and duplication of efforts among the RACs and CMS's other contractors. For example, RACs, MACs and ZPICs are all charged with reviewing hospital Medicare claims, and hospitals may be required to respond to simultaneous audits of the same claims or to duplicative record requests. These redundant audits drain time, funding and attention that could more effectively be focused on patient care.

Inappropriate denials of payment by RACs must be halted. We urge that the OIG's review of the effectiveness of the RACs and CMS-related oversight efforts pay particular attention to the extent to which RAC determinations result in inappropriate denials of payment for services that are medical necessary and reasonable for the care of patients, not solely on whether these contractors are identifying improper payments and referring potential fraud cases to law enforcement.

In addition, we urge that all integrity programs be streamlined and duplicative audits eliminated. Finally, we suggest that additional investments be made in provider education and payment system fixes to prevent payment mistakes before they occur.

In support of our recommendations, we summarize below relevant data from the AHA's RAC*Trac* quarterly survey that currently includes responses from 2,266 hospitals. The full report is provided as an attachment.

RACs Are Often Wrong But Not Penalized for Their Numerous Inaccuracies

Data collected by the AHA shows that an astonishing 75 percent of appealed RAC decisions are ultimately reversed (see AHA, *Exploring the Impact of the RAC Program on Hospitals Nationwide*, at 50 (Aug. 22, 2012) (RAC Report), included herein as Attachment 1). This reversal on appeals rate has been consistent across quarterly reporting periods.

These data are not surprising because the RACs have a strong financial incentive to deny claims. RACs are paid on a contingent basis for collecting overpayments (42 USC § 1395ddd(h)(1)(B)(i)) — currently, between 9 percent and 12.5 percent of the overpayment amount (76 Fed. Reg. 57808, 57809 (Sept. 16, 2011)). The more claims the RAC denies, the more the RAC is paid.

These financial considerations also drive the RACs' focus on hospital claims for short inpatient stays (see RAC Report at 4; the majority of medical necessity denials reported were for one-day stays where the care was found to have been provided in the wrong setting, not because the care was not medically necessary). Denying payment for an entire inpatient stay is far more lucrative for the contractors than identifying an incorrect payment amount or an unnecessary medical service. Through the second quarter of 2012, RACs recovered more than $267 million, or more than two-thirds of the total amount recovered, for care that was supposedly provided in the wrong setting (Id. at 34). Two hundred twenty-eight dollars of that total dollar value recovered involved claims for short inpatient stays of one day or less.

Providers can challenge a RAC's finding, but the multi-level appeal process is expensive and cumbersome. Moreover, AHA data show that nearly three-fourths of all appealed claims are still sitting in the appeals process (see RAC Report at 52). Obtaining a favorable decision on appeal has little to no precedential value: RACs suffer no penalty for their frequently inaccurate determinations and, consequently, continue to review and deny substantially similar claims, forcing hospitals to continually engage the same cumbersome and expensive appeals process on a claim by claim basis. Should the hospital accept the RAC's decision that medically necessary care was provided in the wrong setting, CMS policy prohibits the hospital from properly rebilling the claim at the appropriate level of care or service code determined by the RAC (e.g., properly rebilling an inpatient claim as an outpatient claim).

The AHA believes that the RAC audit process would be improve significantly if auditors were required to improve their accuracy or face financial penalties. In addition, RACs should be prohibited from issuing medical necessity denials, which invalidate the medical judgment of a

trained health care professional and force hospitals into the costly and complex Medicare appeals process. Finally, CMS must be required to establish a process for re-billing RAC denials for medically necessary and reasonable care provided in the wrong setting. Requirements for deductibles, co-pays and benefits should be waived to prevent any new beneficiary liability.

BURDENS OF RESPONDING TO RAC REQUESTS ARE SIGNIFICANT

Interestingly, the AHA RAC*Trac* Survey results indicate that two-thirds of medical records reviewed by RACs **did not** contain an improper payment (see RAC Report at 17). Nevertheless, despite CMS's recent acknowledgement that RACs do not find improper payments in the majority of records they request, the agency recently *doubled* the amount of medical records RACs can request from hospitals.

Hospitals have hired additional staff solely to manage the government's audit processes (see, for example, RAC Report at 57). Fifty-four percent of the hospitals participating in the AHA's RAC*Trac* Survey reported a significant increase in administrative burden due to the RAC program. Fifty-five percent of hospitals reported spending more than $10,000 in the first quarter of 2012 to manage the RAC process alone, with 33 percent spending more than $25,000 and nine percent spending more than $100,000.

RAC audit activities in combination with the myriad other government auditors and programs divert hospital resources from patient care and contribute to the growing cost of providing health care.

The AHA believes that the RAC audit process would be streamlined by limiting the number of allowable requests for medical records. In addition, auditors should target legitimate payment mistakes. Finally, CMS needs to ensure that all auditing programs are fair to all parties and should require that auditors strictly adhere to program requirements for timely responses. Ultimately, CMS should streamline audit programs by channeling all improper payment audits into one program and eliminating all other auditing programs.

PROVIDER EDUCATION REMAINS LIMITED

AHA data suggest that resources devoted to provider education are extremely limited. Fifty-eight percent of respondents to the RAC*Trac* Survey indicate they have yet to receive any education related to avoiding payment errors from CMS or the RACs (see RAC Report at 61). Moreover, the perceived quality of education actually provided varies greatly by the RAC region in which the hospital is located, with Region B viewed as providing the worst quality (see RAC Report at 62).

Reducing improper payments before they occur would do much to improve all program integrity efforts, and reinvestment of a portion of auditor recoveries into provider education and payment system fixes should be encouraged.

The AHA and its member hospitals support a properly focused and thorough OIG review of the effectiveness of various Medicare contractors, including RACs, as part of the current Work Plan. As a vital part of that review, we urge that the OIG give particular attention to the finding from the AHA's RAC*Trac* Survey data and our specific recommendations for improving the RAC program and the audit processes. Please contact Lawrence Hughes, assistant general counsel (lhughes@aha.org or 202-626-2346) or Mindy Hatton, general counsel (mhatton@aha.org or 202-626-2336) if you have any questions about the survey data or recommendations.

Sincerely,

/s/

Richard J. Pollack
Executive Vice President

Attachment

ATTACHMENT

Exploring the Impact of the RAC Program on Hospitals Nationwide

Results of AHA RAC*TRAC Survey, 2nd Quarter 2012*

August 22, 2012

RAC 101

- Centers for Medicare & Medicaid Services (CMS) Recovery Audit Contractors (RACs) conduct *automated reviews* of Medicare payments to health care providers—using computer software to detect improper payments. RACs also conduct *complex reviews* of provider payments—using human review of medical records and other medical documentation to identify improper payments to providers.
- Improper payments include:
  - incorrect payment amounts;
  - incorrectly coded services (including Medicare Severity diagnosis-related group (MS-DRG) miscoding;
  - non-covered services (including services that are not reasonable and necessary); and
  - duplicate services.
- Automated activity includes the traditional automated activity as described above as well as semi-automated review activity. These claims are denied in an automated manner if supporting documentation is not received timely.

RAC*TRAC* Background

- AHA created RAC*TRAC*—a free, web-based survey—in response to a lack of data provided by CMS on the impact of the RAC program on America's hospitals.
  - Hospitals use AHA's online survey application, RAC*TRAC* (accessed at www.aharactrac.com), to submit their data regarding the impact of the RAC program.
  - Survey questions are designed to collect *cumulative* RAC experience data, from the inception of a hospital's RAC activity through the 2nd quarter of 2012.
  - Survey registration information and RAC*TRAC* support can be accessed at ractracsupport@providercs.com or 1-888-722-8712.
- The AHA recently enhanced the RAC*TRAC* survey to capture more detailed information on medical necessity review denials and the administrative burden due to problems with the RAC process.

Executive Summary

- 2266 hospitals have participated in RAC*TRAC* since data collection began in January of 2010.
- Participants continue to report dramatic increases in RAC activity:
  - Medical record requests are up 22% relative to last quarter.
  - The number of denials is up 24% relative to last quarter.
  - The dollar value of denials is up 21% relative to last quarter.
- Nearly two-thirds of medical records reviewed by RACs **did not** contain an improper payment.
- 84% of hospitals indicated medical necessity denials were the most costly complex denials.
- More than two-thirds of medical necessity denials reported were for 1-day stays where the care was found to have been provided in the wrong setting, not because the care was not medically necessary.

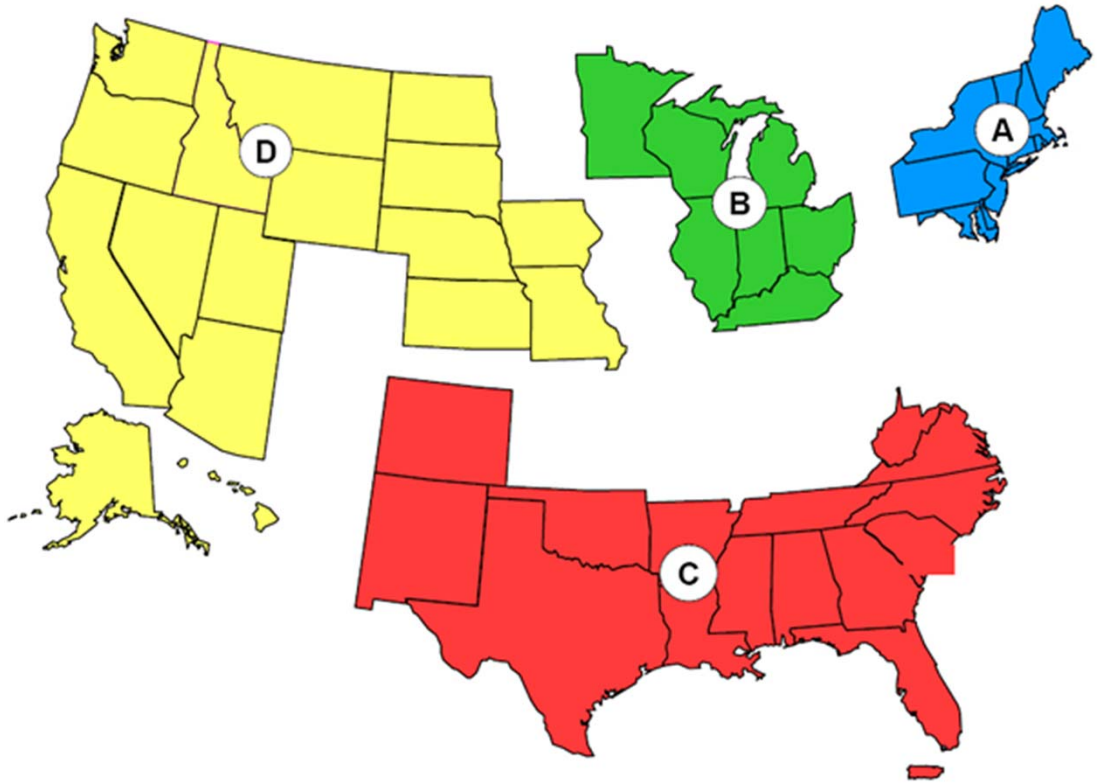
Executive Summary (cont.)

- Hospitals reported appealing more than 40% of all RAC denials, with a 75% success rate in the appeals process.
- Nearly two-thirds of all hospitals filing a RAC appeal during the 2nd Quarter of 2012 reported appealing short stay medically unnecessary denials.
- Nearly three-fourths of all appealed claims are still sitting in the appeals process.
- 55% of all hospitals reported spending more than $10,000 managing the RAC process during the second quarter of 2012, 33% spent more than $25,000 and 9% spent over $100,000.
- Hospital staff are spending an increasing amount of time responding to RAC activity.
- 58% of respondents indicated they have yet to receive any education related to avoiding payment errors from CMS or its contractors.
- The most frequently cited RAC process problem is ‘not receiving a demand letter’.

There are four RAC regions nationwide. Participation in RAC*TRAC* is generally consistent with hospital representation in each of the RAC regions.

Distribution of Hospitals by RAC Region and Hospitals Participating in RAC*TRAC* by RAC Region, through 2nd Quarter, 2012

	Percent of Hospitals Nationwide	Percent of Participating Hospitals by Region
Region A	15%	16%
Region B	19%	24%
Region C	40%	35%
Region D	26%	25%

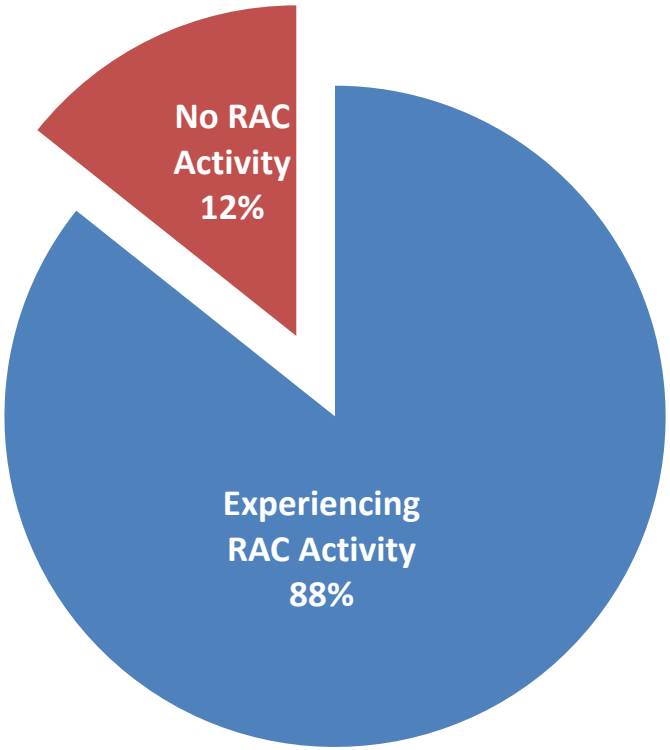


Source: Centers for Medicare and Medicaid Services

RAC Activity

Nearly nine out of ten hospitals participating in RAC*TRAC* reported experiencing RAC activity through June of 2012.

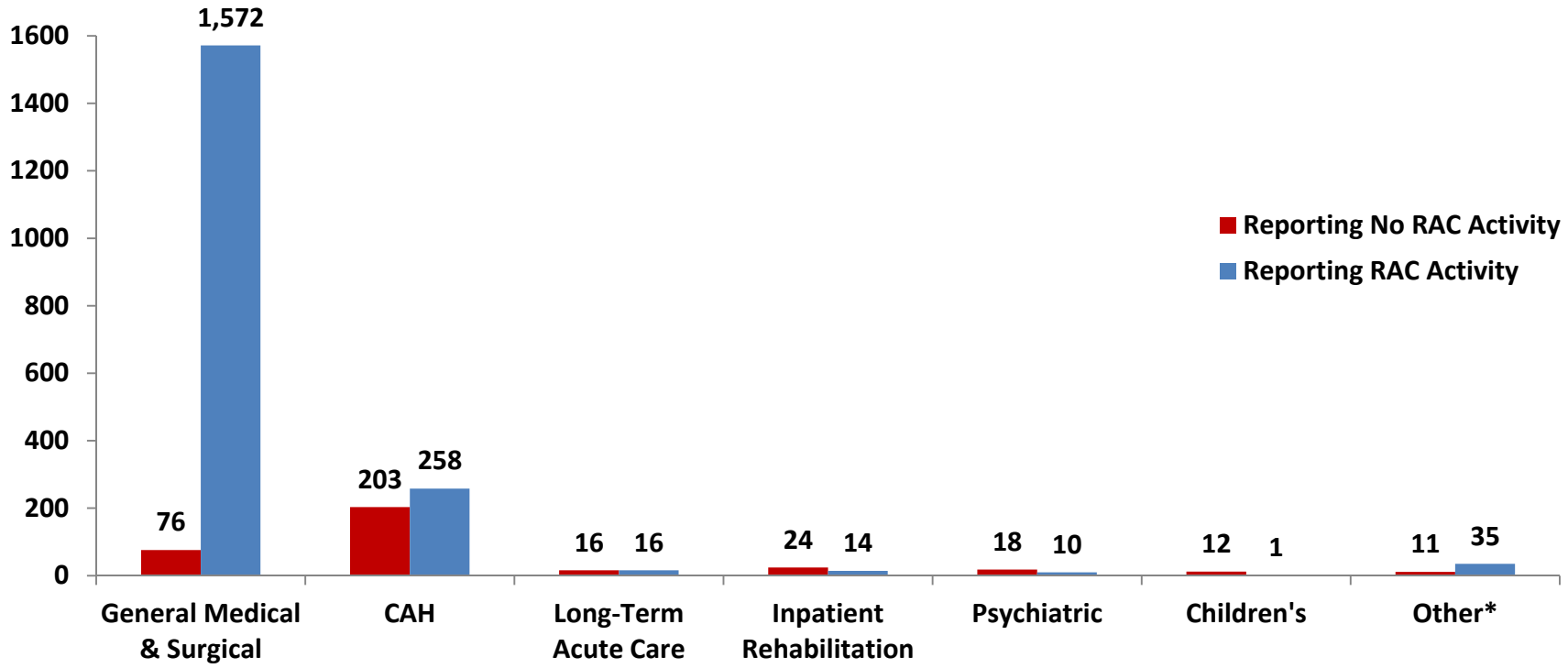
Percent of Participating Hospitals Experiencing RAC Activity, 2nd Quarter 2012



Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

The majority of hospitals reporting RAC activity were general medical and surgical hospitals.

Number of Hospitals Reporting RAC Activity by Hospital Type, through 2nd Quarter 2012



**Other includes: Cancer, Chronic Disease, Alcohol and Other Chemical Dep., Heart, Obstetrics & Gynecology, Orthopedic, Other Specialty, and Surgical hospitals.*

Source: AHA. (August 2012). RAC*TRAC* Survey

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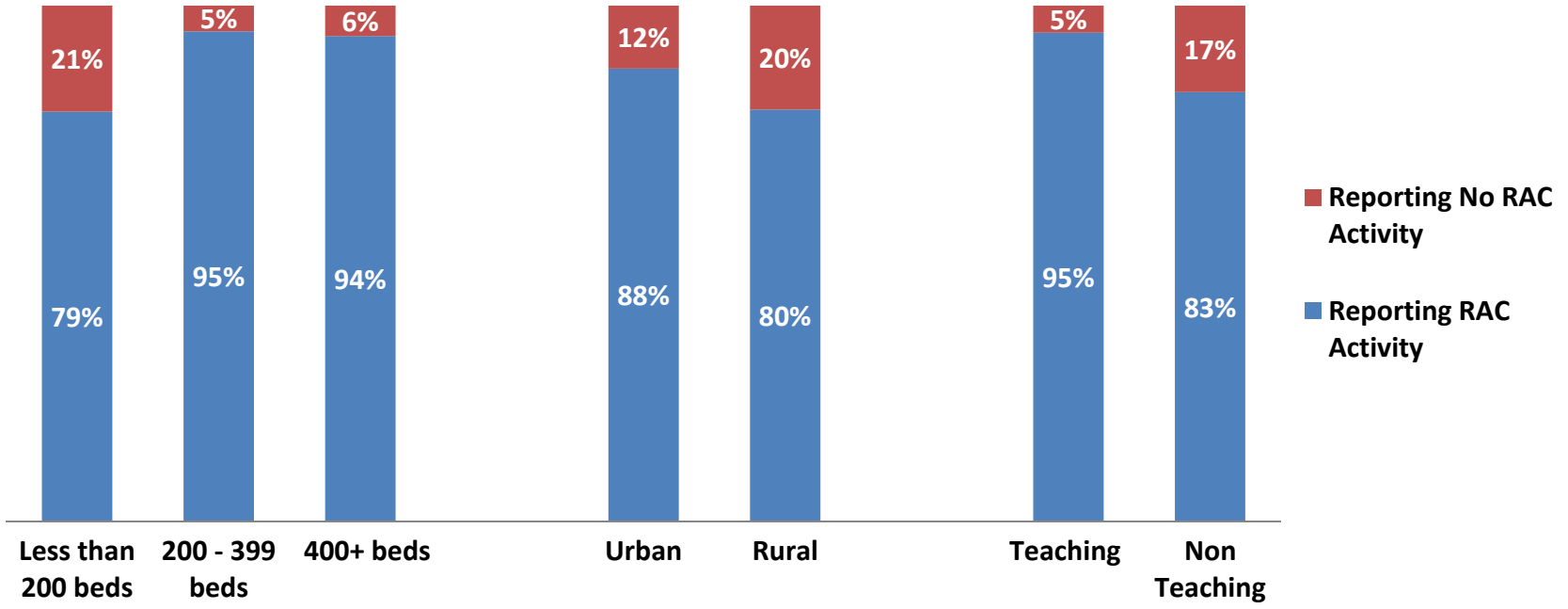
Different types and sizes of hospitals reported that they were subject to RAC review.

Percent Reporting RAC Activity vs. No RAC Activity by Type of Participating Hospital, through 2nd Quarter 2012



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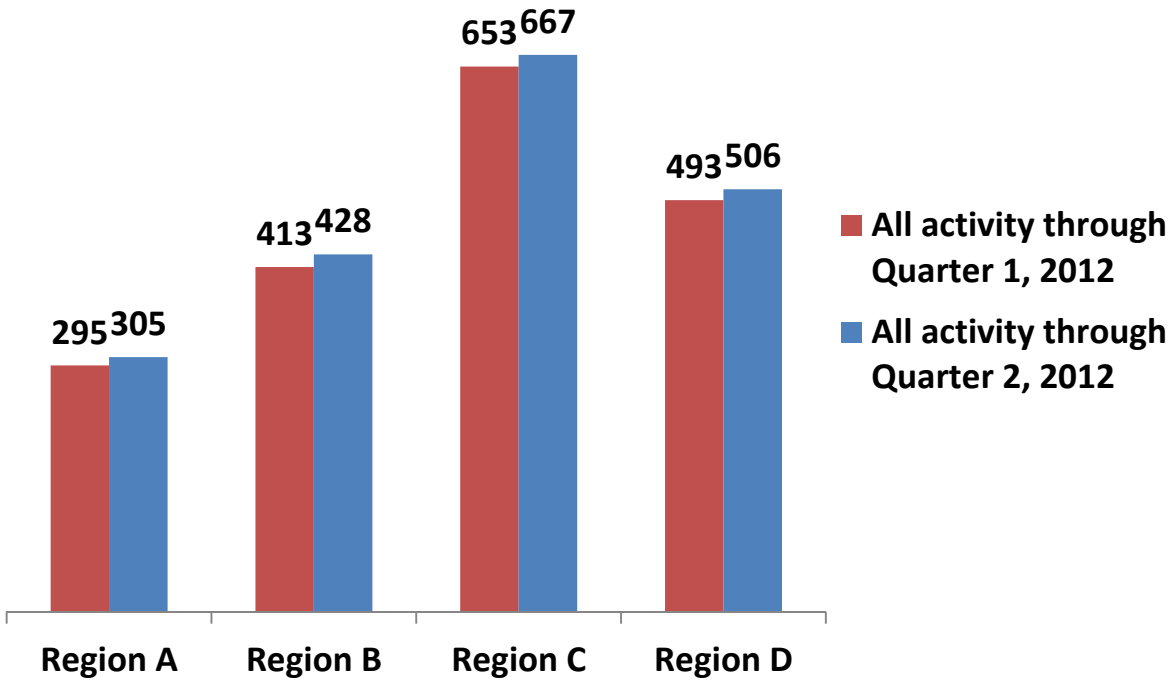
RAC Region C has the highest number of hospitals reporting RAC activity.

Number of Participating Hospitals Reporting RAC Activity by Region, through 2nd Quarter 2012



States By RAC Region

Region A: Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont

Region B: Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin

Region C: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia, Puerto Rico, and U.S. Virgin Islands

Region D: Alaska, Arizona, California, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, North Dakota, Nebraska, Nevada, Oregon, South Dakota, Utah, Washington, Wyoming, Guam, American Samoa, and Northern Marianas

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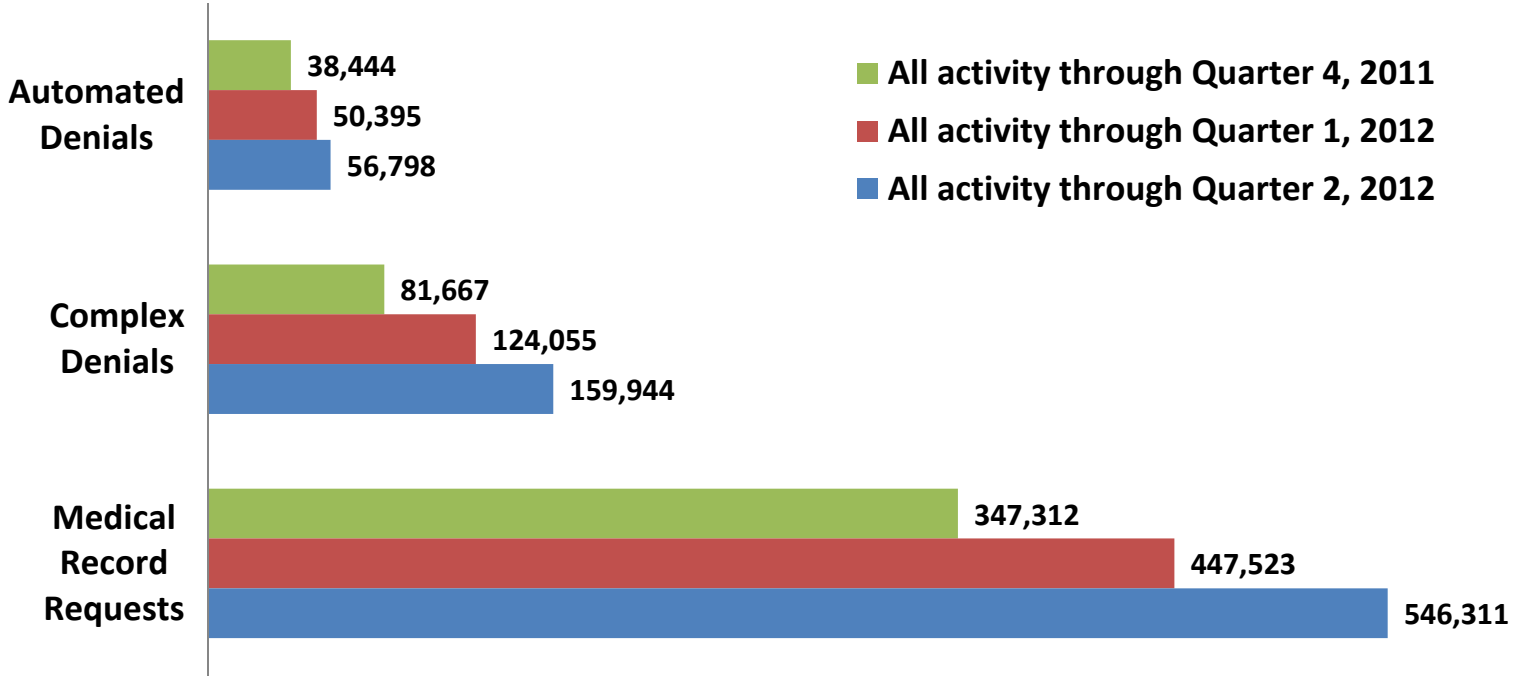
RAC Reviews

Participants continue to report dramatic increases in RAC denials and medical record requests.

Reported Automated Denials, Complex Denials and Medical Records Requests by Participating Hospitals, through 2nd Quarter 2012



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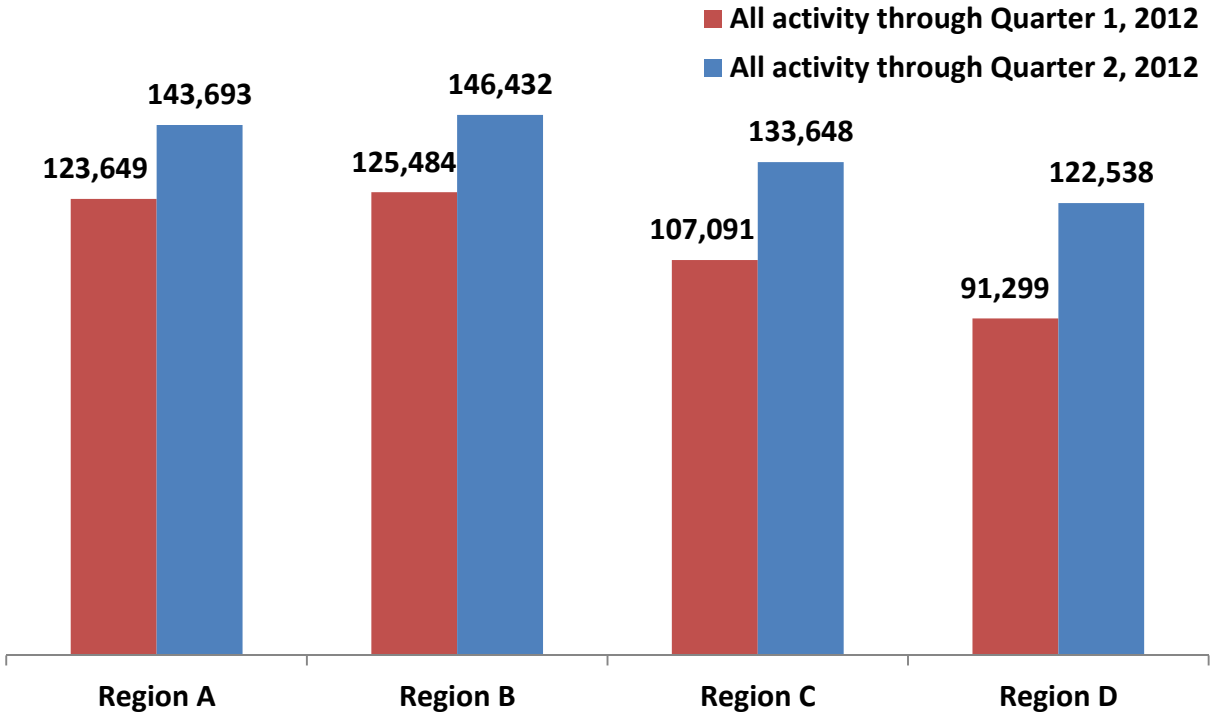
Regions C and D experienced the highest increases in medical record requests.

Number of Medical Records Requested from Participating Hospitals With Complex Medical Record RAC Activity, through 2nd Quarter 2012

Average Number of Medical Record Requests per Reporting Hospital, through Q2, 2012	
Region A	876
Region B	637
Region C	497
Region D	700



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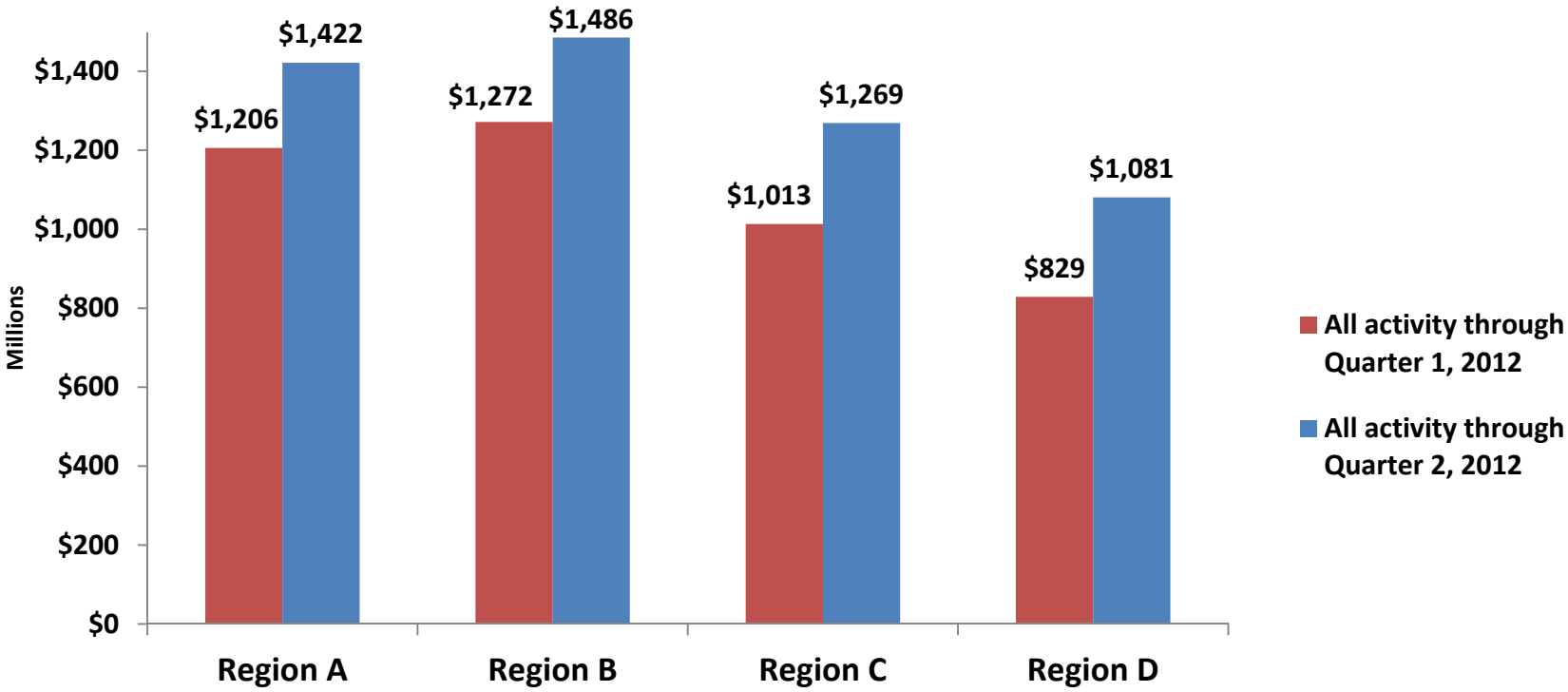
Among participating hospitals, $5.3 billion in Medicare payments were targeted for medical record requests through the 2nd quarter of 2012.

Medicare Payments Associated with Medical Records Requested from Participating Hospitals, through 2nd Quarter 2012, in Millions



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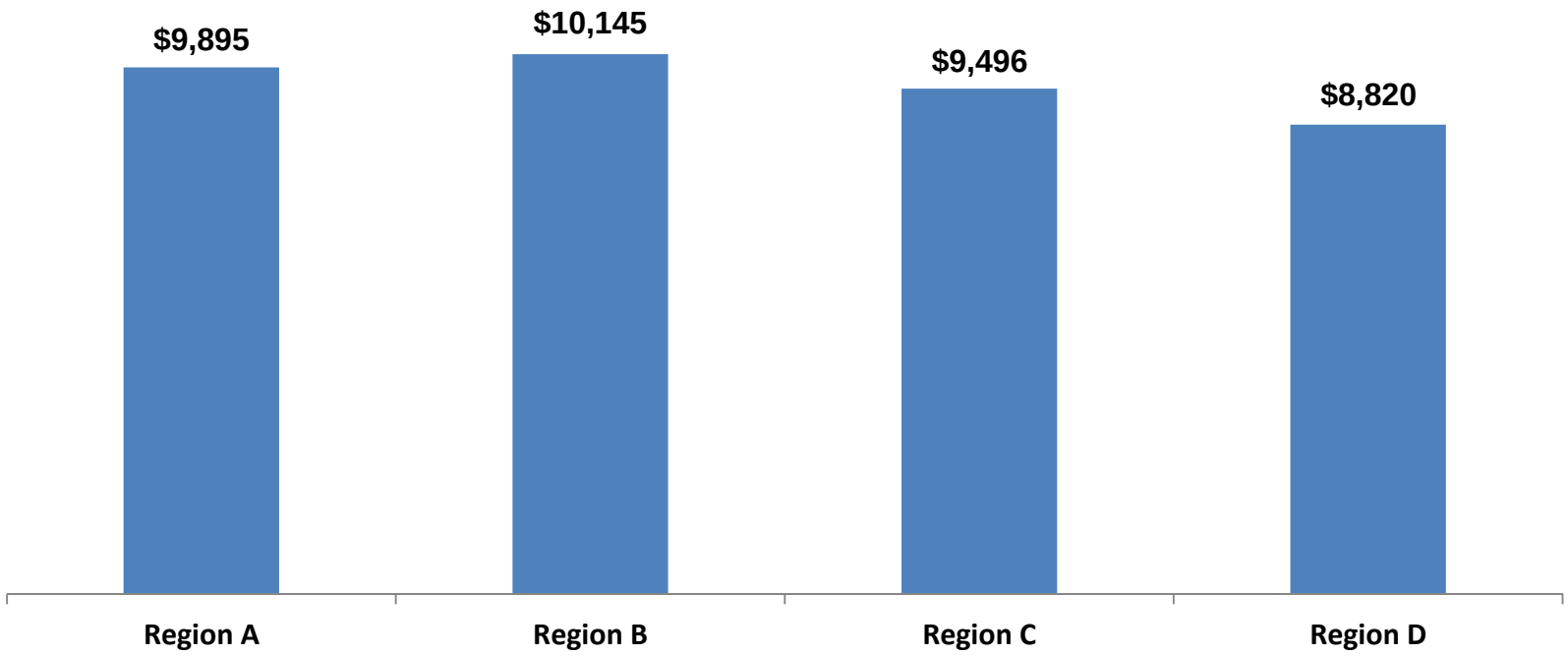
The average value of a medical record requested in a complex review was lowest in Region D.

Average Value of a Medical Record Requested in a Complex Review Among Hospitals Reporting RAC Activity, through 2nd Quarter 2012



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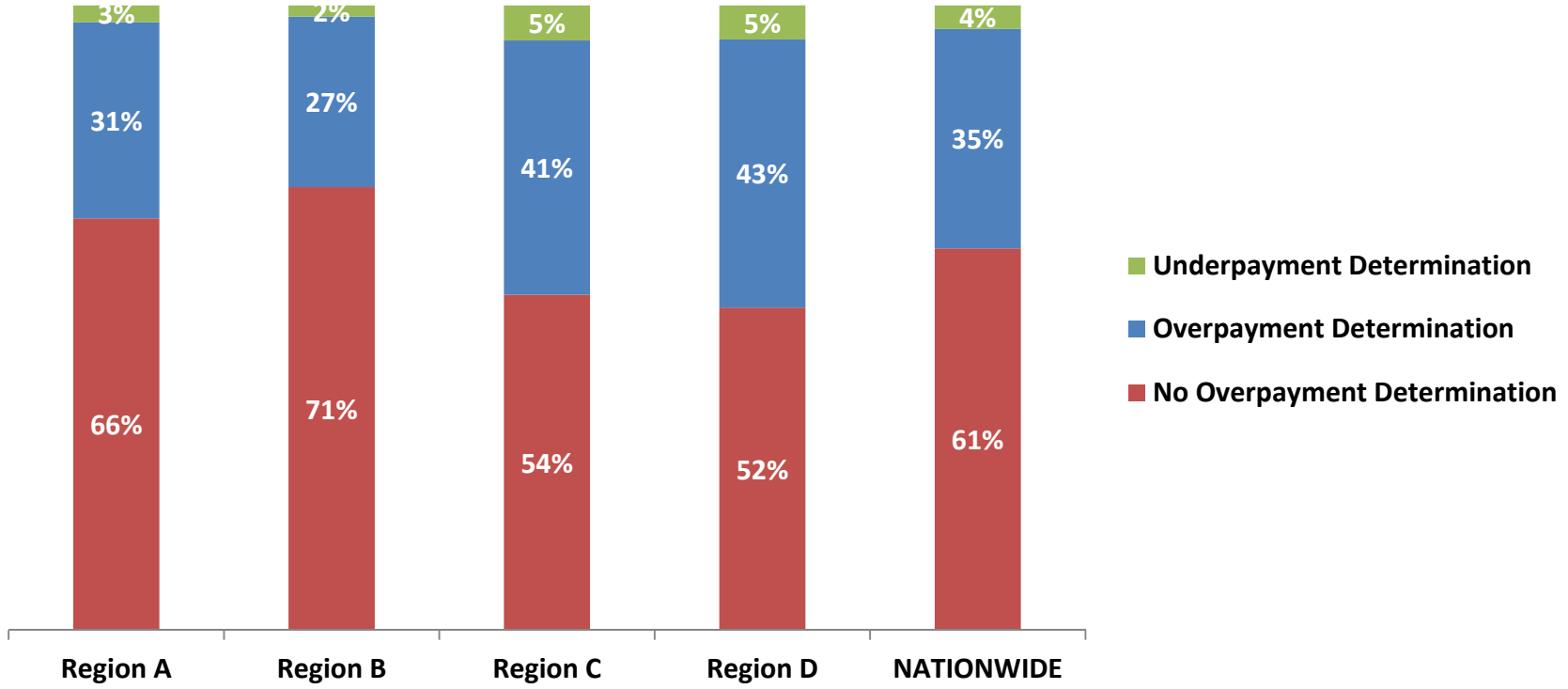
Nearly two-thirds of medical records reviewed by RACs **did not** contain an improper payment.

Percent of Completed Complex Reviews with and without Overpayment or Underpayment Determinations for Participating Hospitals, by Region, through 2nd Quarter 2012



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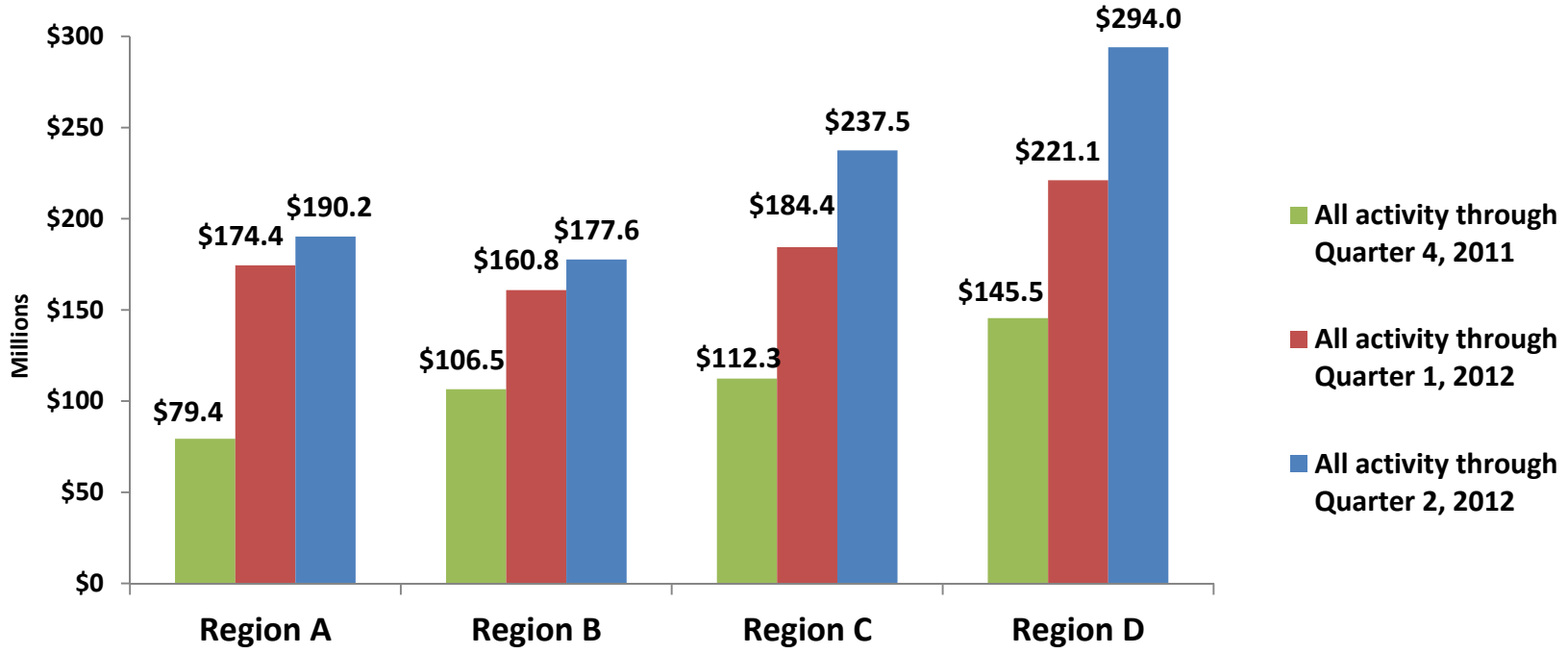
RAC Denials

$899 million in denials were reported through the second quarter of 2012, up 21% from the first quarter.

Dollar Value of Automated and Complex Denials by RAC Region for Participating Hospitals, through 2nd Quarter 2012, Millions



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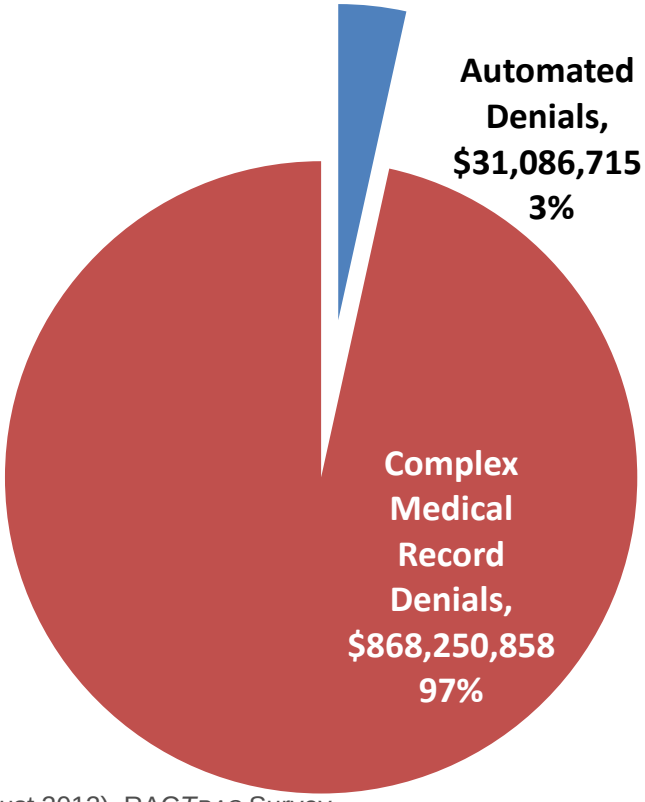
97% of denied dollars were for complex denials.

Percent and Dollar Amounts of Automated Denials Versus Complex Denials for Participating Hospitals, through 2nd Quarter 2012



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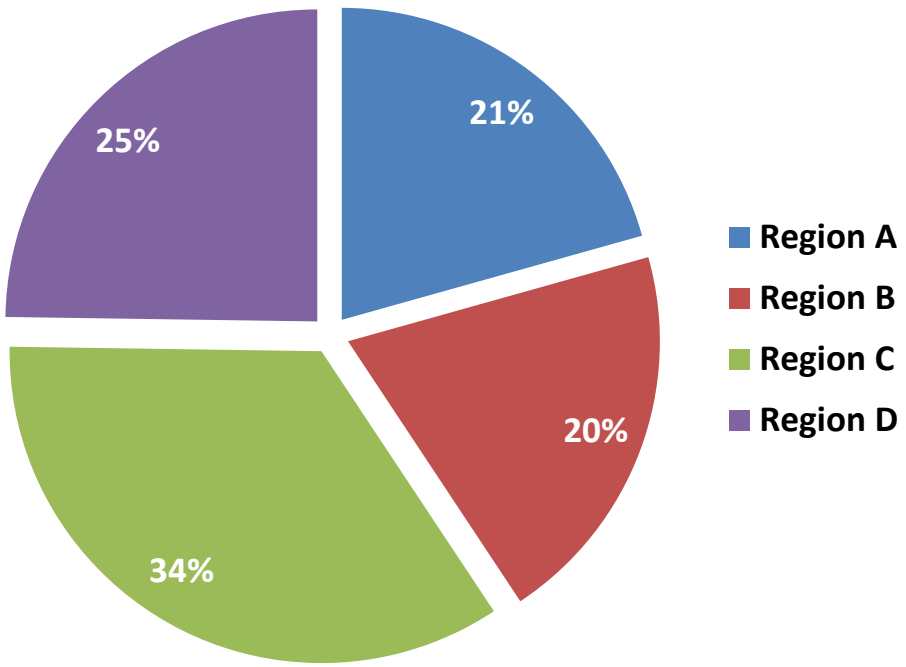
RAC denials are spread among all four RAC regions.

Percent of Automated and Complex Denials by RAC Region for Participating Hospitals, through 2nd Quarter 2012



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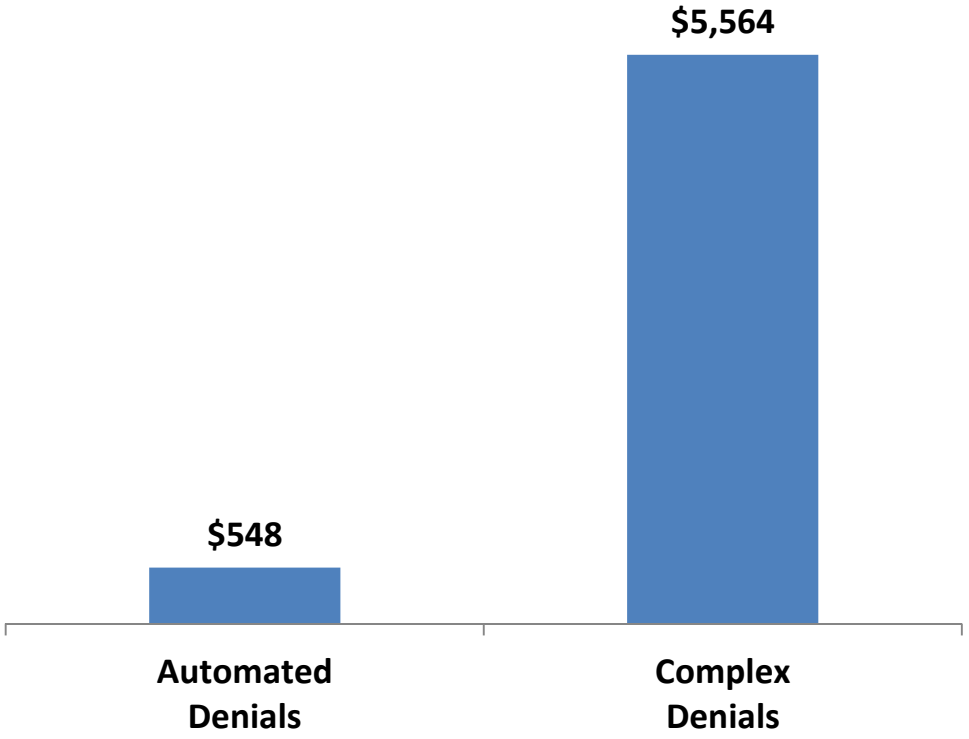
The average dollar value of an automated denial was $548 and the average dollar value of a complex denial was $5,564.

Average Dollar Value of Automated and Complex Denials Among Hospitals Reporting RAC Denials, through 2nd Quarter 2012

Average Dollar Amount of Automated and Complex Denials Among Reporting Hospitals, by Region		
RAC Region	**Automated Denial**	**Complex Denial**
NATIONWIDE	$548	$5,564
Region A	$378	$5,112
Region B	$460	$5,225
Region C	$585	$5,366
Region D	$662	$6,352



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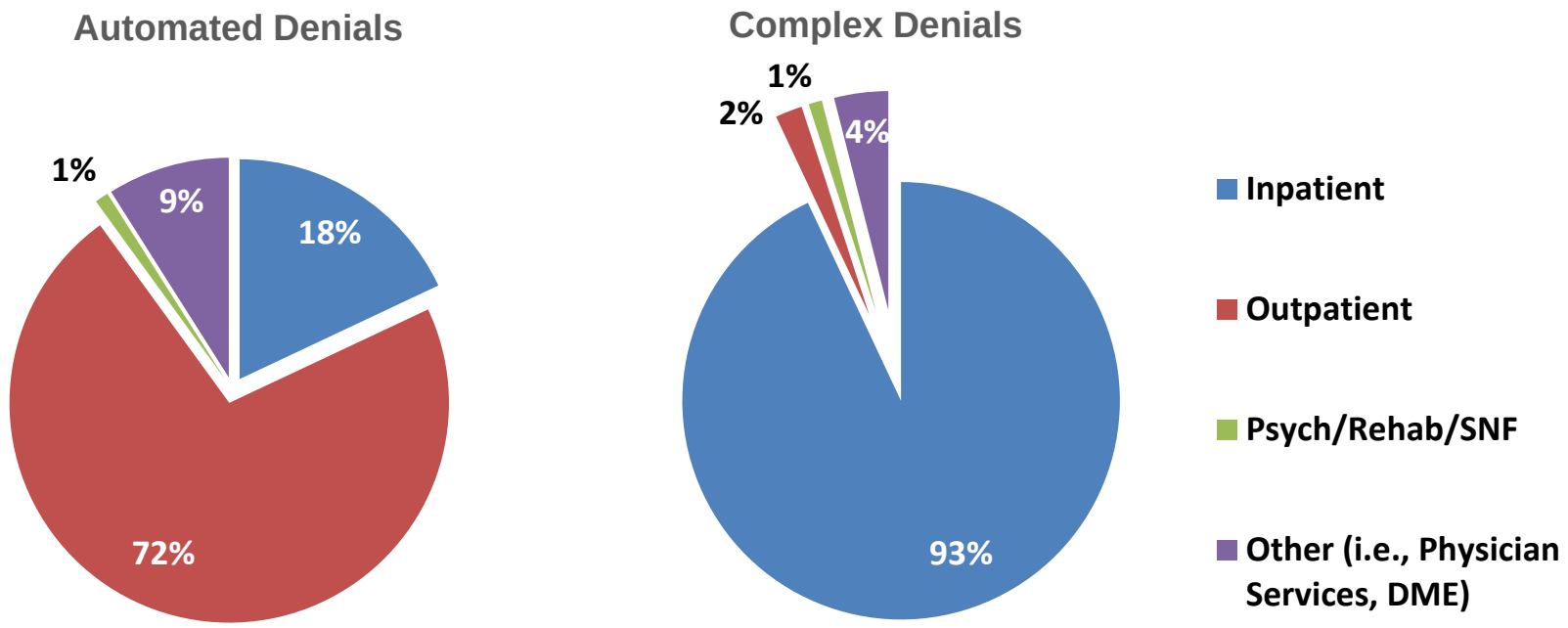
Denials in the outpatient setting were the automated denials with the largest financial impact while inpatient setting denials were the complex denials with the largest financial impact.

Percent of Participating Hospitals by Top Service Area for Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 2nd Quarter 2012

Survey participants were asked to rank denials by service, according to dollars impacted.



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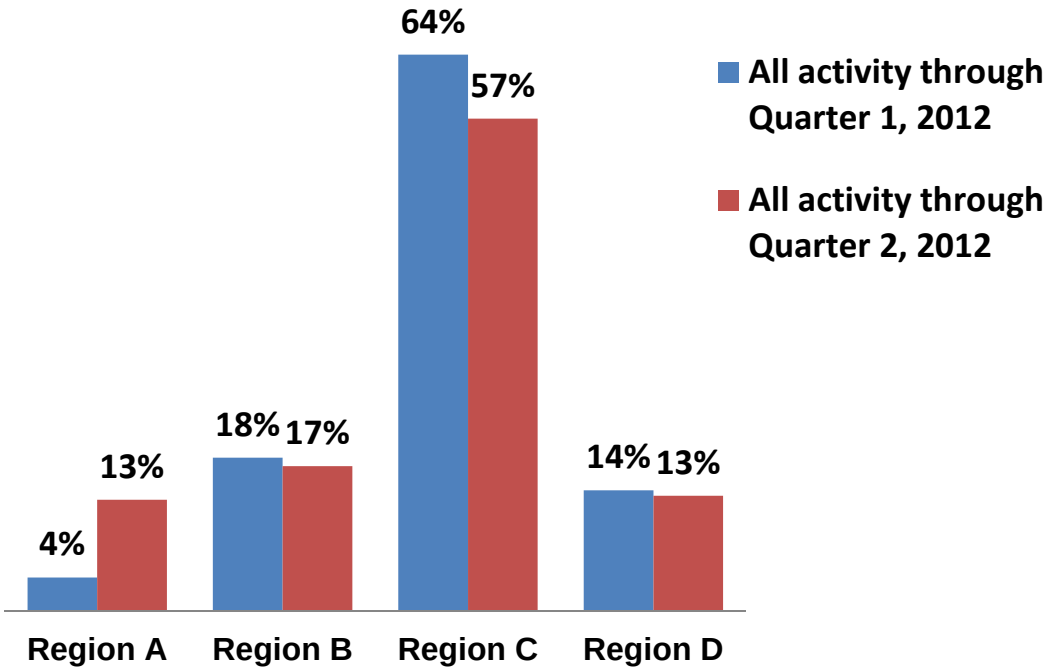
Automated RAC Denials

Region A had an uptick in automated denials in the second quarter.

Percent and Number of Reported Automated Denials for Participating Hospitals, by Region, through 2nd Quarter 2012

	Total Number of Automated Denials by RAC Region through 2nd Quarter 2012
Region A	7,334
Region B	9,537
Region C	32,336
Region D	7,591



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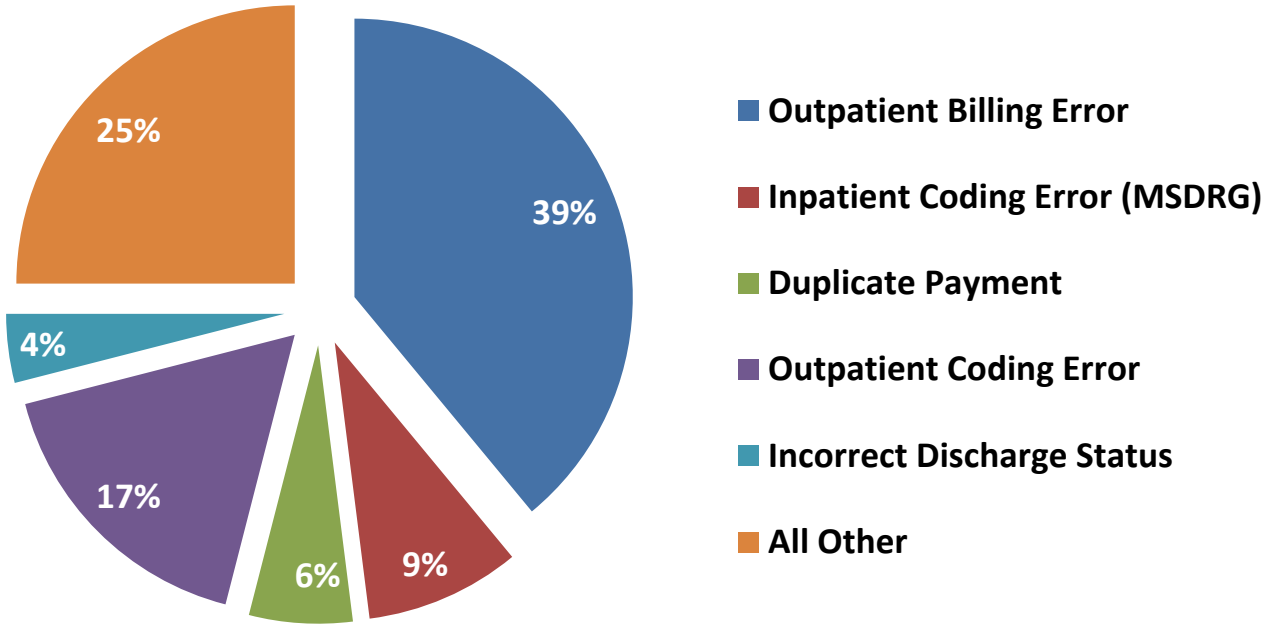
RACs are issuing automated denials for many different reasons.

Percent of Participating Hospitals by Top Reason for Automated Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 2nd Quarter 2012

Survey participants were asked to rank denials by reason, according to dollars impacted.



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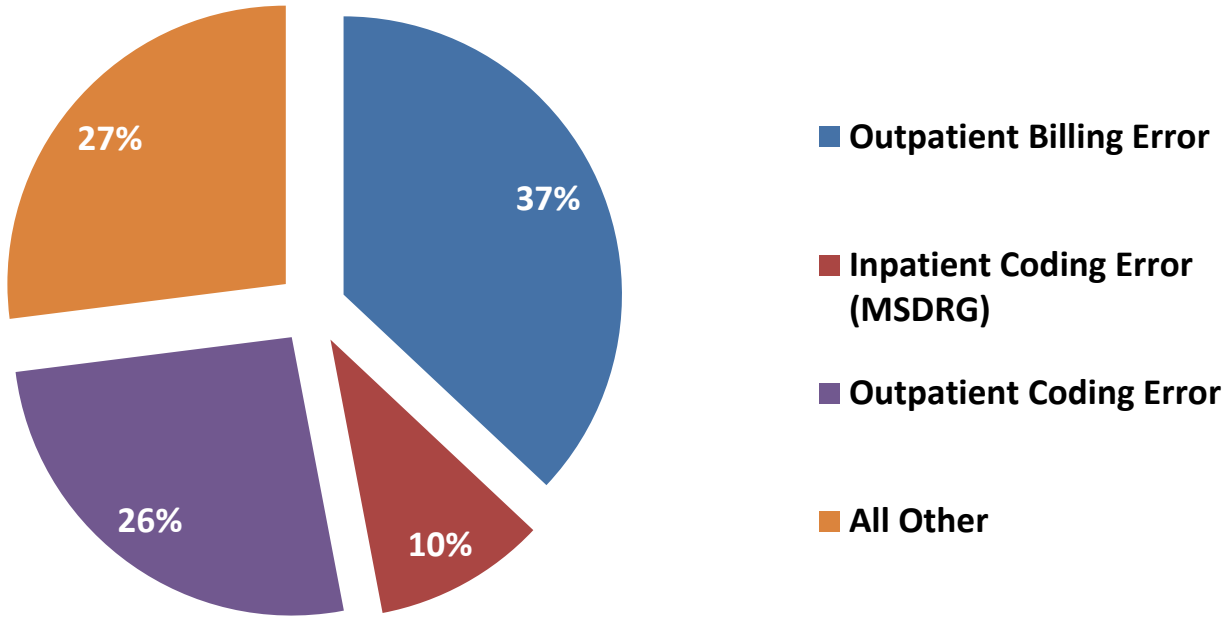
Region A: More than a third of hospitals ranked outpatient billing error as the top reason for automated denials.

Percent of Participating Hospitals by Top Reason for Automated Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 2nd Quarter 2012, Region A

Survey participants were asked to rank denials by reason, according to dollars impacted.



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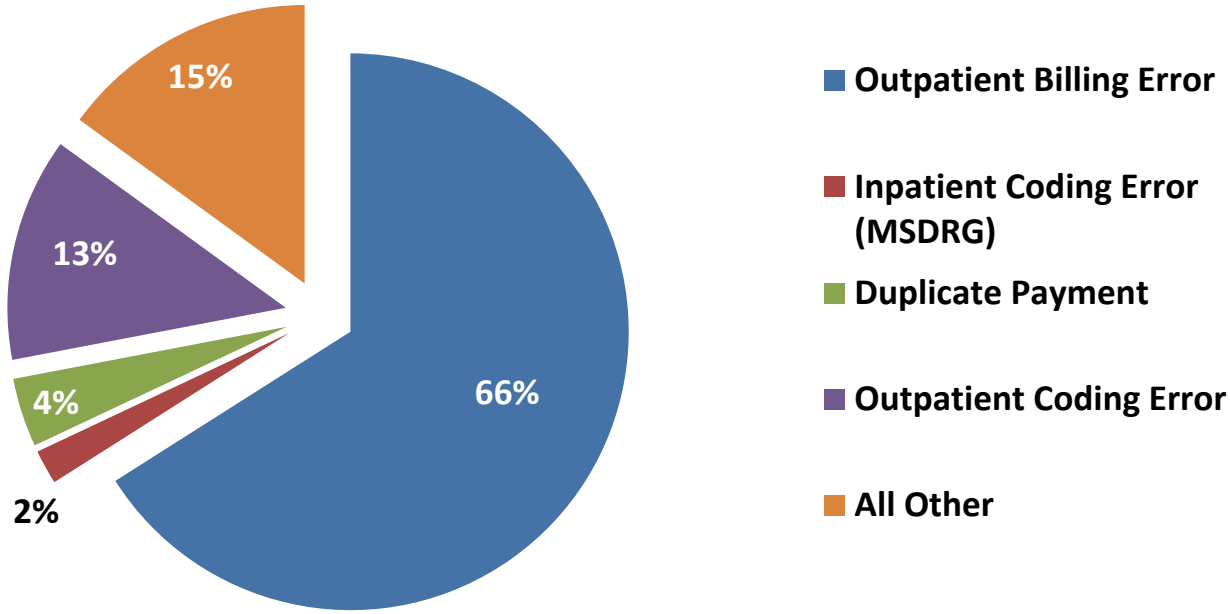
Region B: Hospitals more commonly ranked outpatient billing error as the top reason for automated denials than in other regions.

Percent of Participating Hospitals by Top Reason for Automated Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 2nd Quarter 2012, Region B

Survey participants were asked to rank denials by reason, according to dollars impacted.

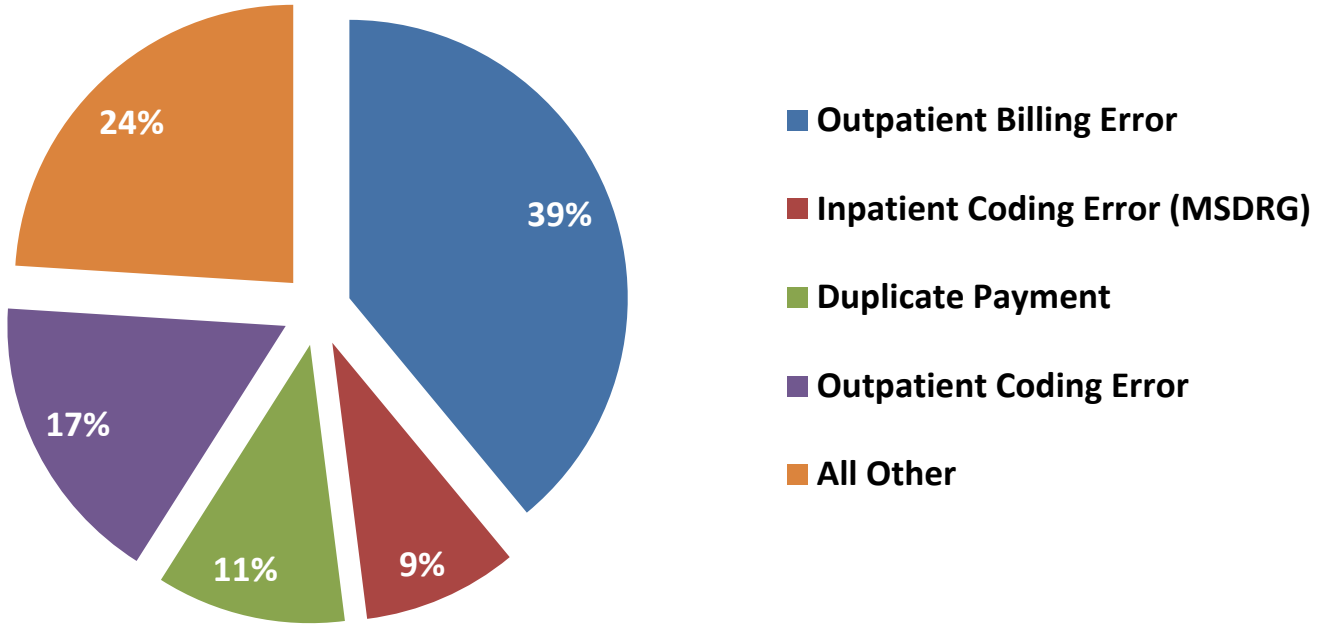


Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

Region C: Top denial reasons were fairly consistent with the national trend.

Percent of Participating Hospitals by Top Reason for Automated Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 2nd Quarter 2012, Region C

Survey participants were asked to rank denials by reason, according to dollars impacted.



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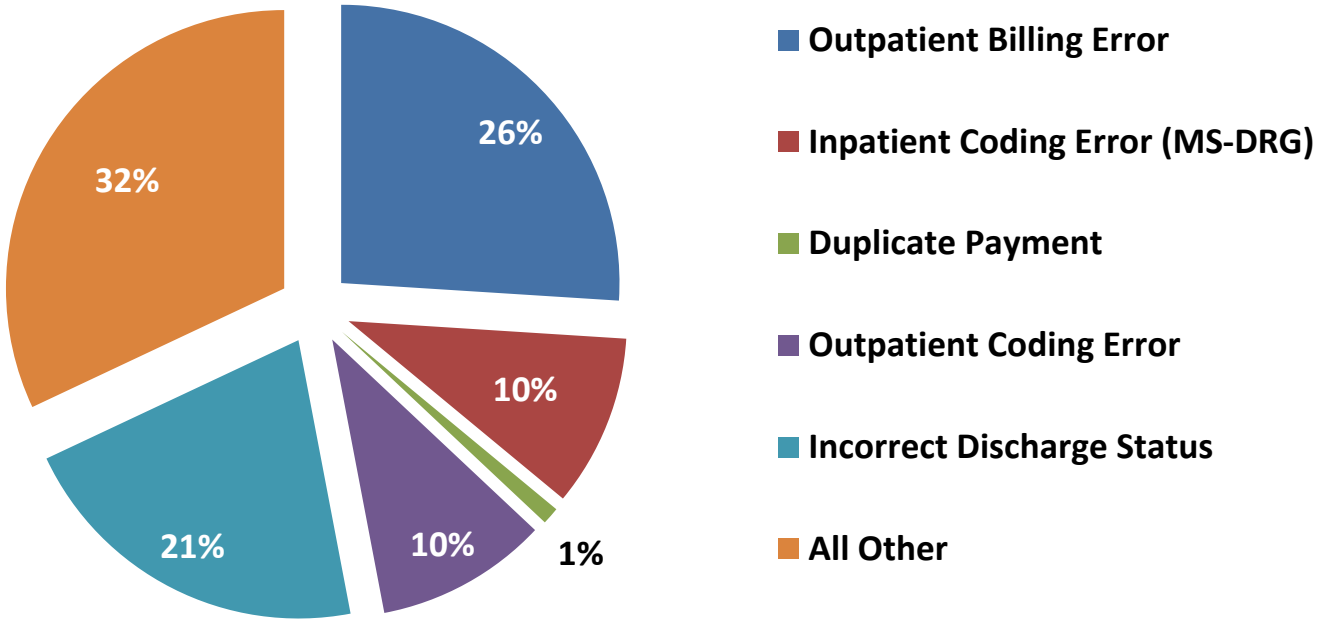
Region D: A significant portion of hospitals cited “other” as the top reason for automated denial in Region D.

Percent of Participating Hospitals by Top Reason for Automated Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 2nd Quarter 2012, Region D

Survey participants were asked to rank denials by reason, according to dollars impacted.



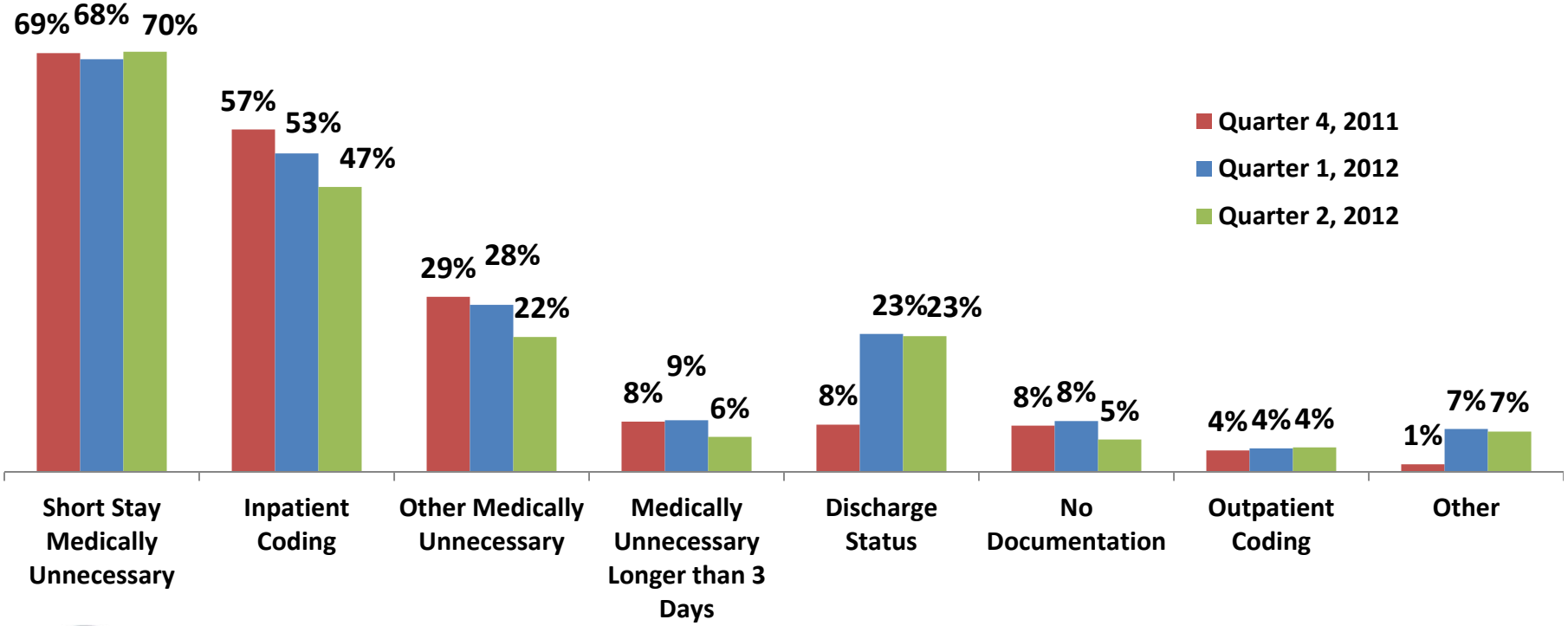
Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

Complex RAC Denials

The most commonly cited reason for a complex denial was 'short-stay medically unnecessary'.

Percent of Participating Medical/Surgical Acute Hospitals with RAC Activity Experiencing Complex Denials by Reason, 4th Quarter 2011 and 1st and 2nd Quarter, 2012

Survey participants were asked to select all reasons for denial.



Source: AHA. (August 2012). RAC*TRAC* Survey
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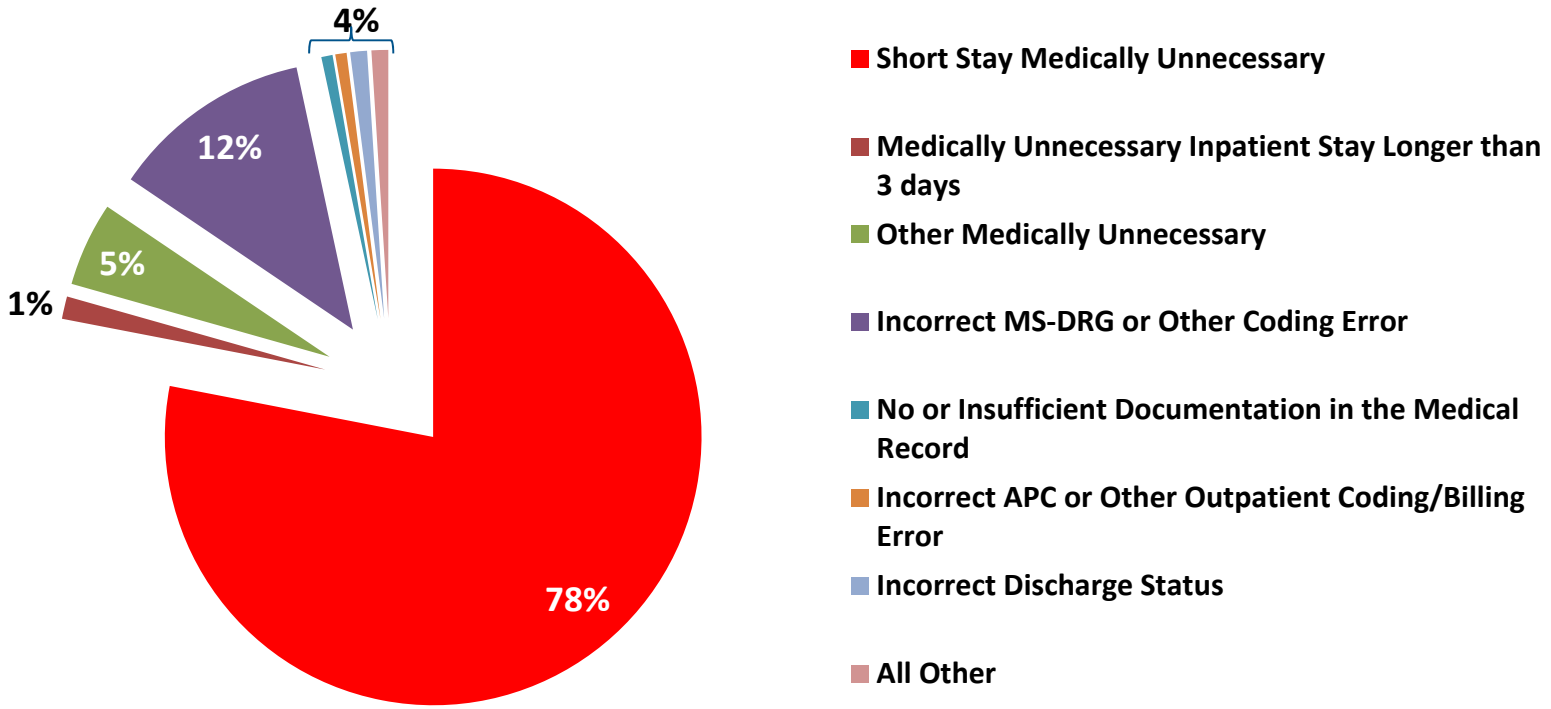
84% of hospitals indicated medical necessity denials were the most costly complex denials.

Percent of Participating Hospitals by Top Reason for Complex Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 2nd Quarter 2012

Survey participants were asked to rank denials by reason, according to dollars impacted, manual survey entries only.



Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

More than two-thirds of short-stay medical necessity denials were because the care was provided in the wrong setting, not because the care was not medically necessary.

Reason for Medical Necessity Denials by Length of Stay Among Hospitals Reporting Medical Necessity Denials, through 2nd Quarter 2012

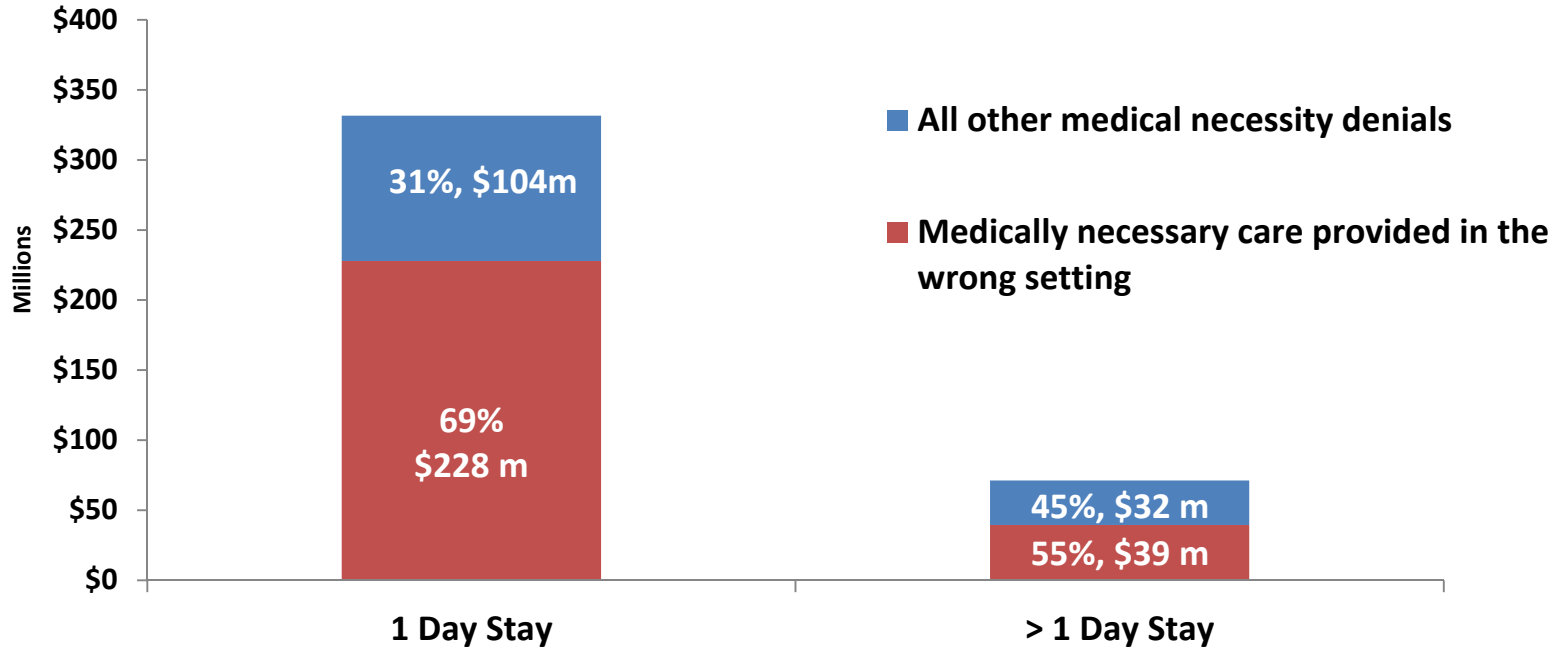


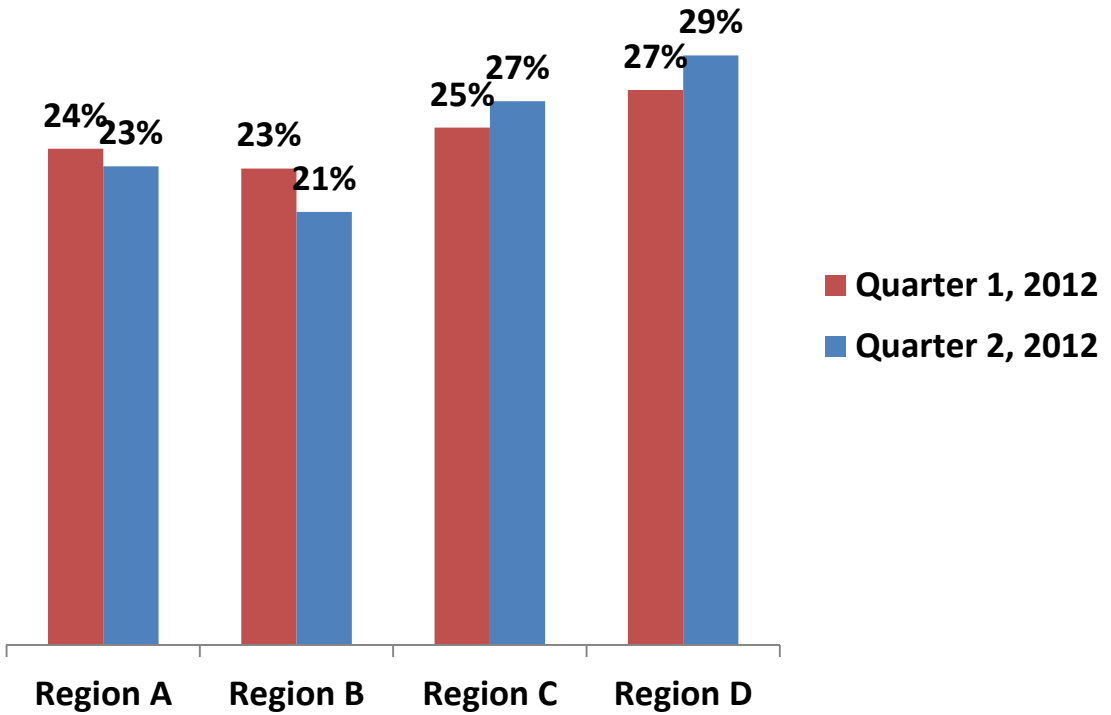
Chart includes hospitals reporting ANY inappropriate setting denials. Not all hospital decision-support systems and RAC*TRAC compatible vendors have made accommodations to allow hospitals to answer this question yet. As a result, the volume of medical necessity denials for inappropriate setting may be under-represented in this chart. Furthermore, older RAC claims may not be classified as "inappropriate setting" by the hospital.*

Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

All regions are reporting a significant number of complex denials.

Percent and Number of Reported RAC Complex Denials for Participating Hospitals, by Region, 1st and 2nd Quarter 2012

	Total Number of Claims with Overpayment Determination
Region A	37,435
Region B	33,869
Region C	42,530
Region D	46,110



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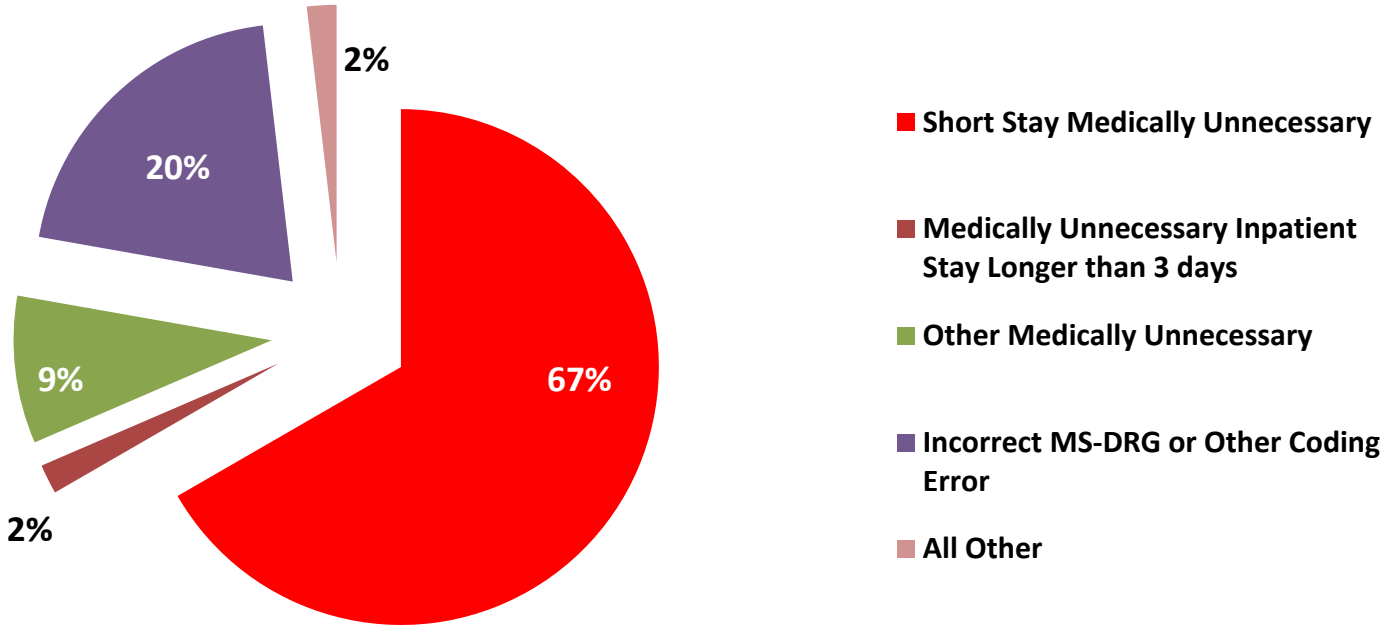
Region A: Medically unnecessary was identified by 78% of hospitals as the top reason for complex denials.

Percent of Participating Hospitals by Top Reason for Complex Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 2nd Quarter 2012, Region A

Survey participants were asked to rank denials by reason, according to dollars impacted, manual survey entries only.

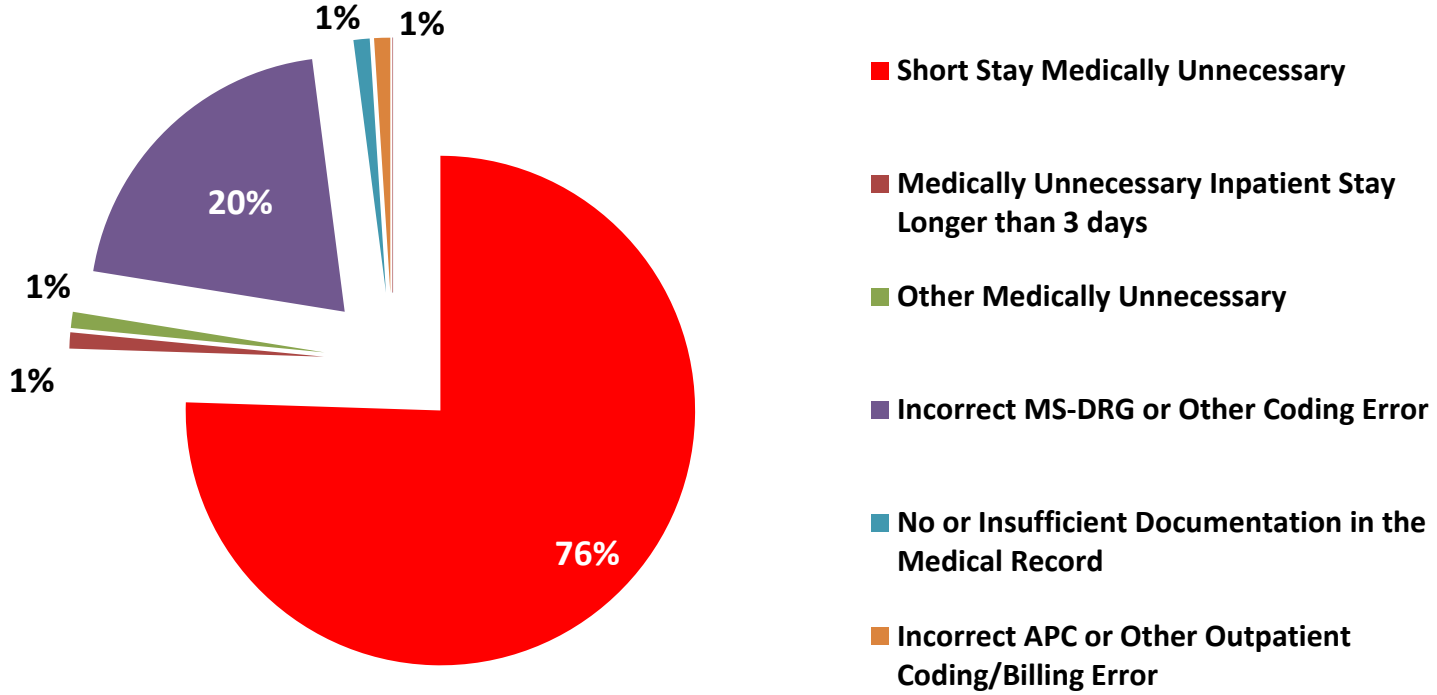


Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

Region B: Medically unnecessary was identified by 78% of hospitals as the top reason for complex denials.

Percent of Participating Hospitals by Top Reason for Complex Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 2nd Quarter 2012, Region B

Survey participants were asked to rank denials by reason, according to dollars impacted, manual survey entries only.

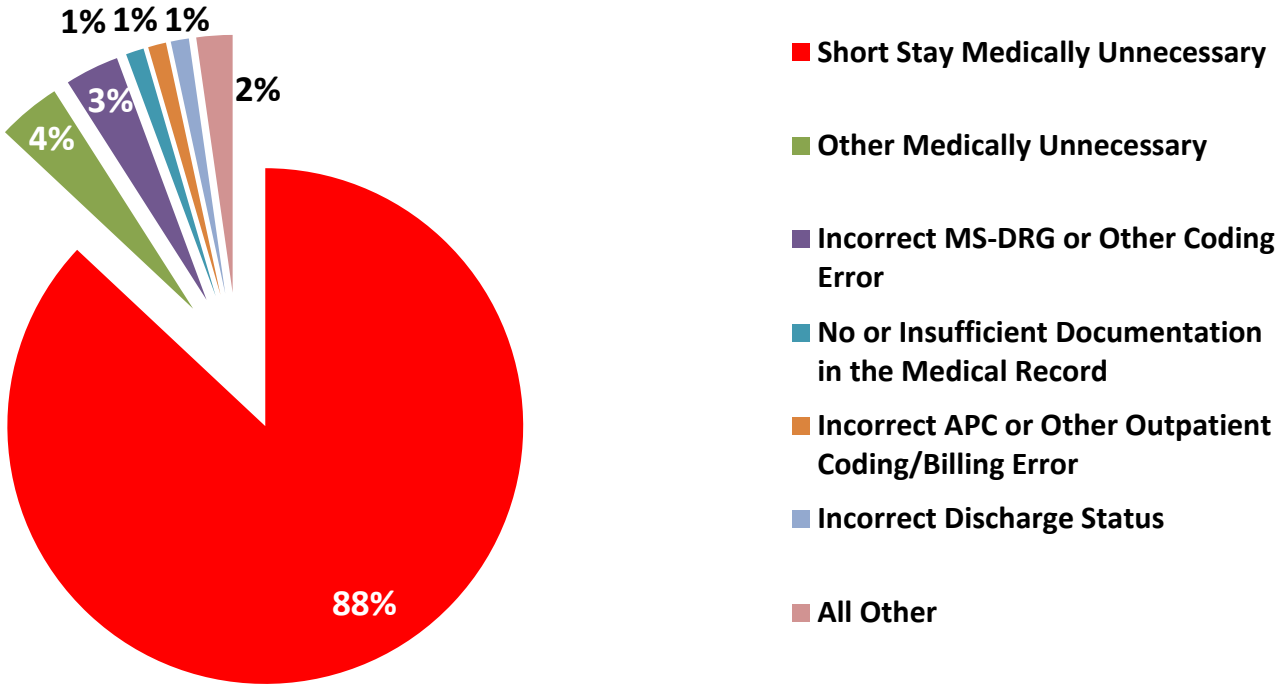


Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

Region C: Medically unnecessary was identified by 92% of hospitals as the top reason for complex denials.

Percent of Participating Hospitals by Top Reason for Complex Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 2nd Quarter 2012, Region C

Survey participants were asked to rank denials by reason, according to dollars impacted, manual survey entries only.

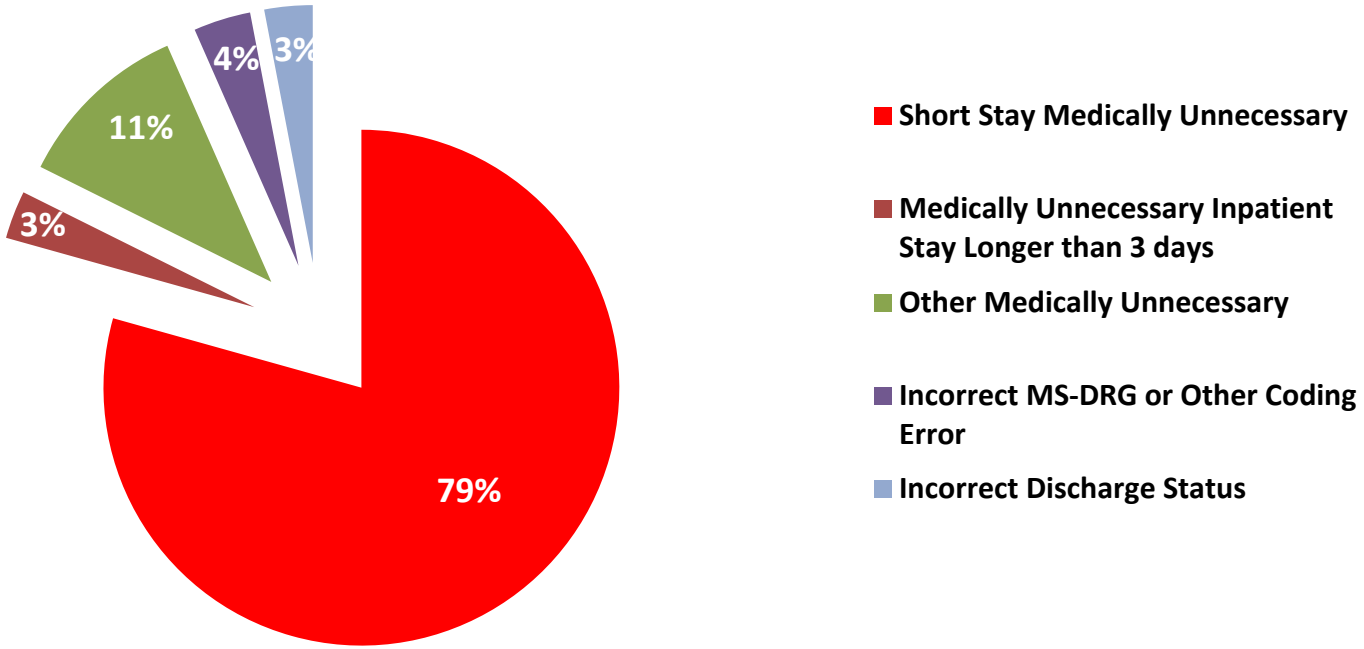


Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

Region D: Medically unnecessary was identified by 93% of hospitals as the top reason for complex denials.

Percent of Participating Hospitals by Top Reason for Complex Denials by Dollar Amount for Medical/Surgical Acute Hospitals with RAC Activity, 2nd Quarter 2012, Region D

Survey participants were asked to rank denials by reason, according to dollars impacted, manual survey entries only.



Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

Syncope & Collapse and Stents were the top MS-DRGs denied by RACs in terms of dollar impact.

Percent of Participating Hospitals Reporting the MS-DRG for Medically Unnecessary and all other Complex Denials With the Largest Financial Impact, through 2nd Quarter 2012

Survey participants were asked to identify top MS-DRGs, according to dollars impacted.

Medical Necessity Denials

MS-DRG	Description	% of Hospitals
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	25%
312	SYNCOPE & COLLAPSE	19%
313	CHEST PAIN	10%
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	9%
69	TRANSIENT ISCHEMIA	3%

All Other Complex Denials

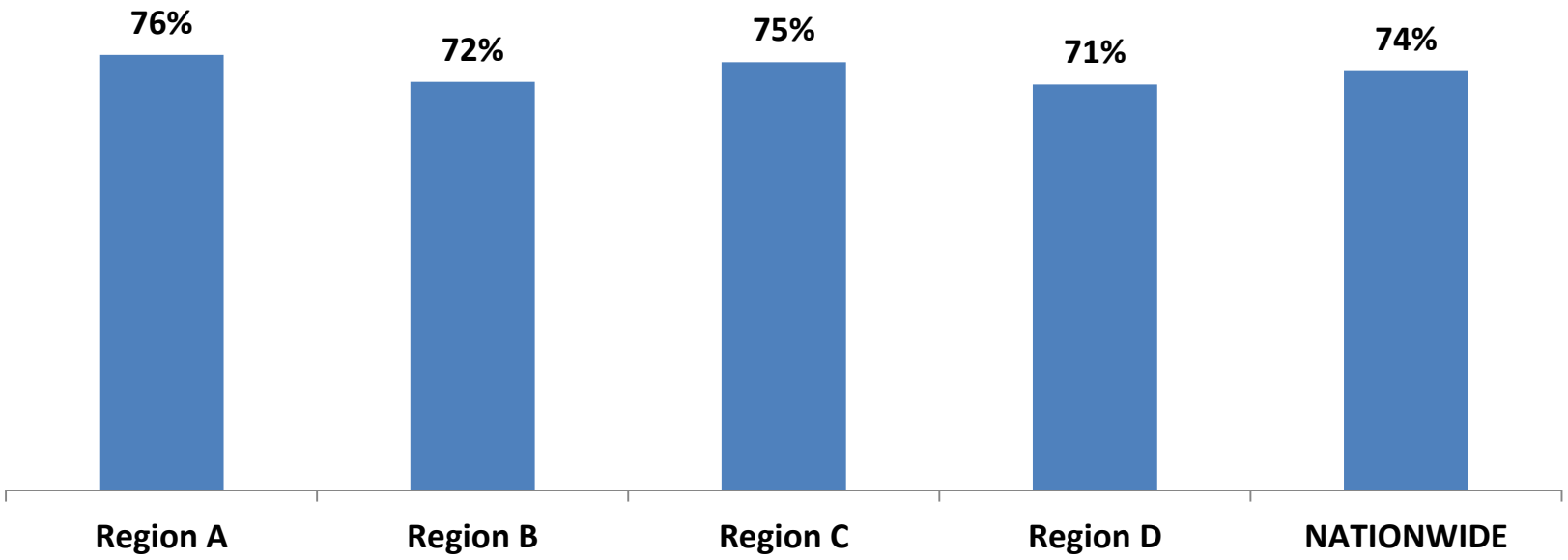
MS-DRG	Description	% of Hospitals
312	SYNCOPE & COLLAPSE	7%
166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	5%
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	4%
313	CHEST PAIN	4%
981	EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC	4%

Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

Underpayments

Nearly three-quarters of participating hospitals nationwide with RAC activity reported receiving at least one underpayment determination.

Percent of Hospitals Reporting Underpayment Determinations, By Region, through 2nd Quarter 2012



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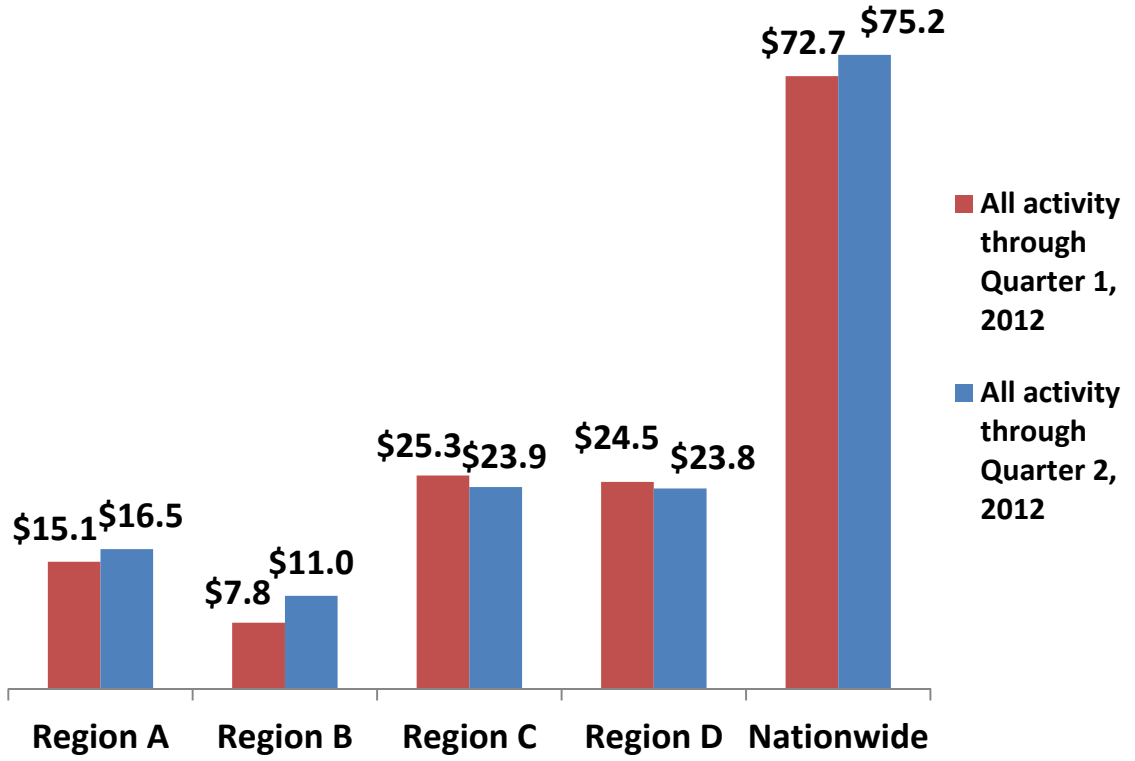
Hospitals reported RAC identified underpayments totaling $75 million dollars.

Total Dollar Value of Underpayment Determinations for Participating Hospitals, By Region, through 1st and 2nd Quarter 2012, Millions

	Number of RAC Underpayment Determinations, through Quarter 2, 2012
NATIONWIDE	17,087
Region A	3,186
Region B	2,191
Region C	5,866
Region D	5,844



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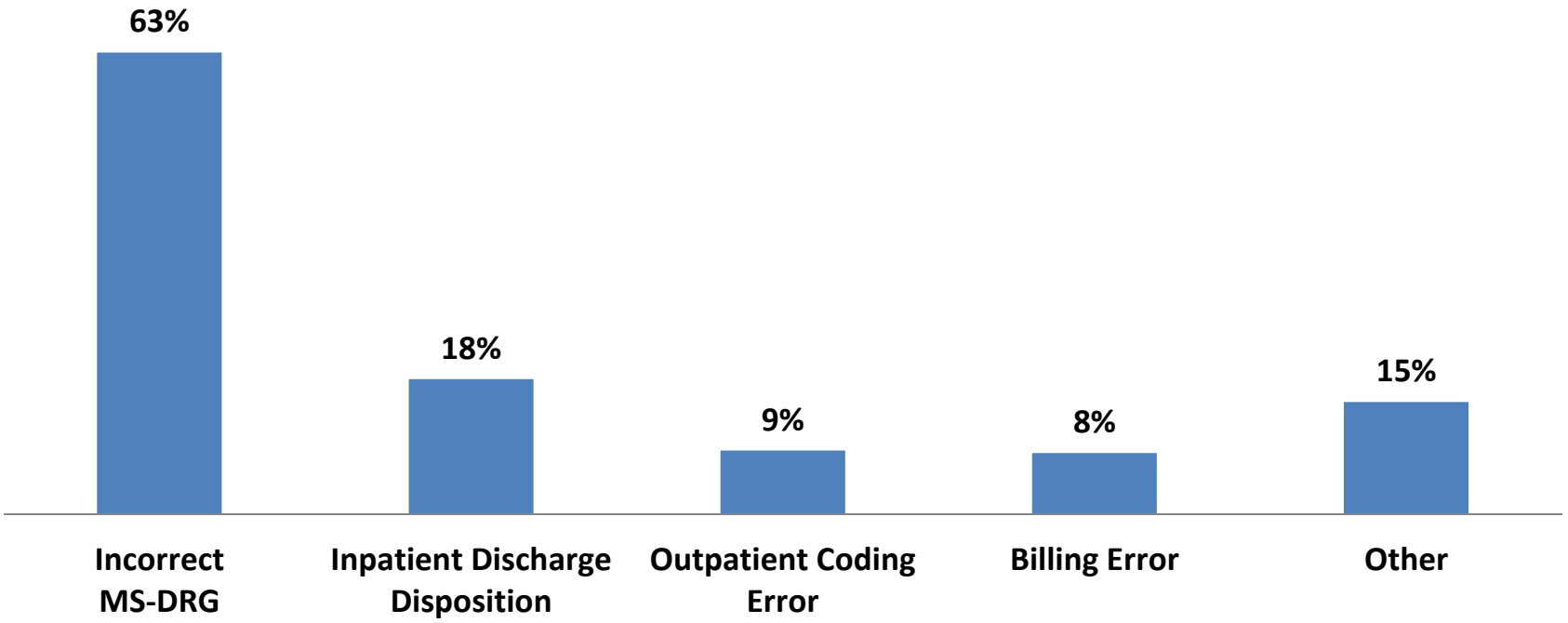
63% of hospitals with underpayment determinations cited incorrect MS-DRG as a reason for the underpayment and 18% cited discharge disposition.

Percent of Participating Hospitals with RAC Activity Experiencing Underpayments by Reason, 2nd Quarter 2012

Survey participants were asked to select all reasons for underpayment.



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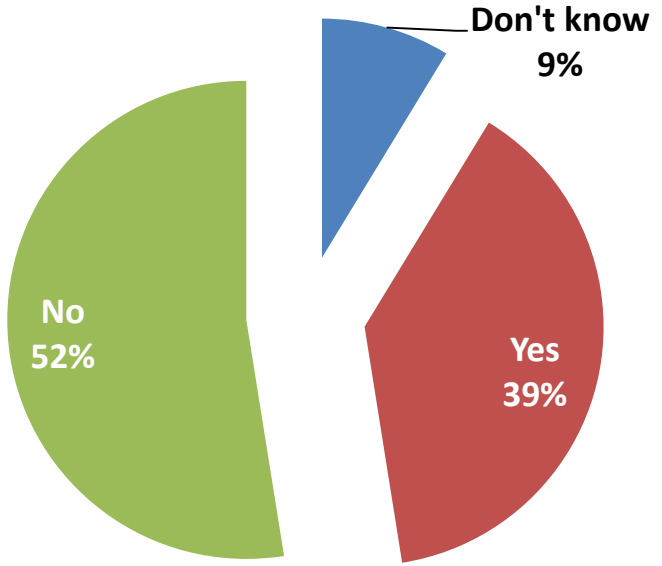
Appeals

More than one-third of participating hospitals report having a denial reversed during the discussion period.

Percent of Participating Hospitals With Denials Reversed During the Discussion Period, National and By Region, 2nd Quarter 2012

Reversed Denials by RAC Region

	Yes	No	Don't Know
Region A	50%	40%	10%
Region B	42%	51%	7%
Region C	31%	59%	10%
Region D	38%	55%	7%



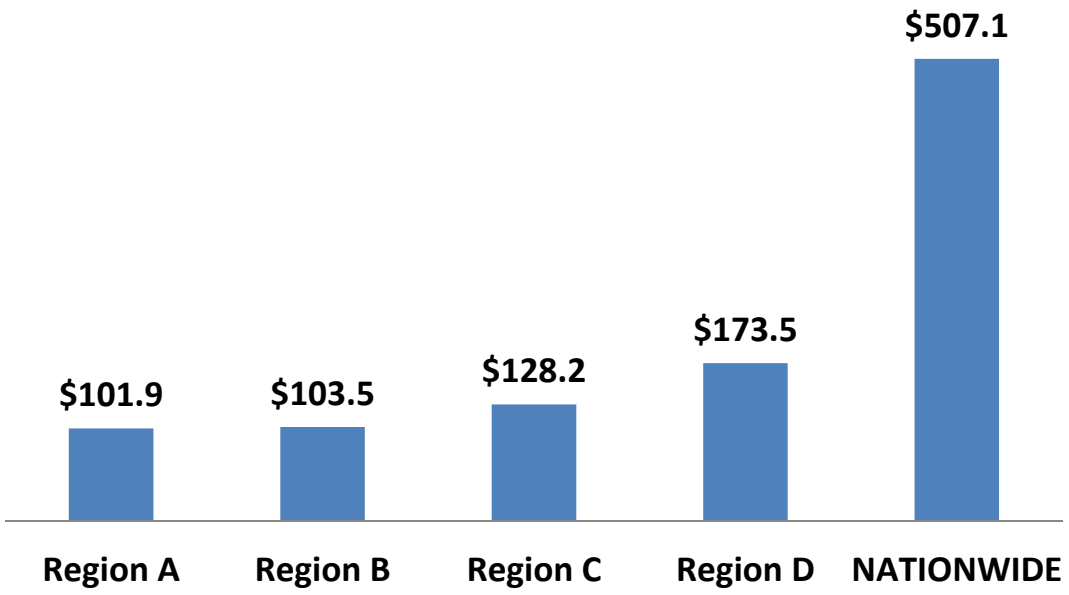
*The discussion period is intended to be a tool that hospitals may use to reverse denials and avoid the formal Medicare appeals process. All RACs are required to allow a **discussion period** in which a hospital may share additional information and discuss the denial with the RAC. During the discussion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

Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

The value of appealed claims exceeds a half a billion dollars. On average, hospitals report appealing 118 claims.

Total Dollar Value, Percent and Average Number of Appealed Claims for Hospitals with Automated or Complex RAC Denials, through 2nd Quarter 2012, Millions

	Percent of Hospitals with Any Appealed Denials	Average Number of Appealed Denials per Hospital
NATIONWIDE	86%	118
Region A	83%	134
Region B	92%	79
Region C	86%	111
Region D	83%	163



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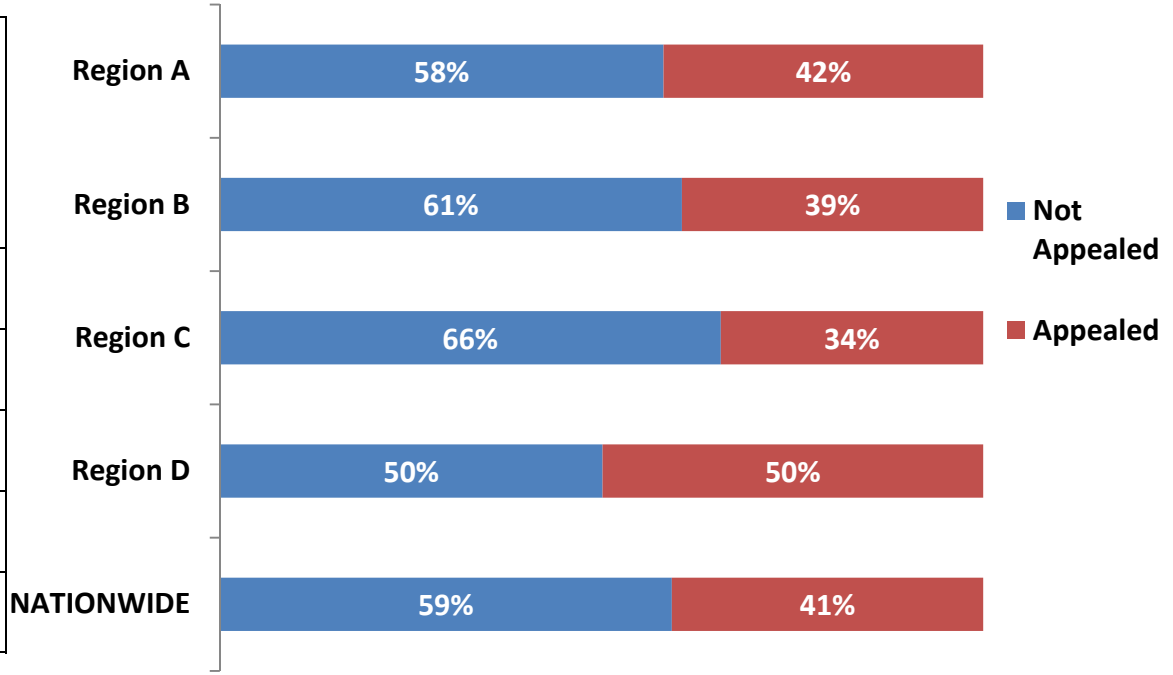
Nationwide hospitals report appealing more than 40% of all denials. In Region D, half have been appealed.

Total Number and Percent of Automated and Complex Denials Appealed by Hospitals with Automated or Complex RAC Denials, by Region, through 2nd Quarter 2012

	Total Number of Denials Available* for Appeal	Total Number of Denials Appealed
NATIONWIDE	216,742	88,410
Region A	44,769	18,750
Region B	43,406	17,133
Region C	74,866	25,741
Region D	53,701	26,786



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

Source: AHA. (August 2012). RAC*TRAC* Survey
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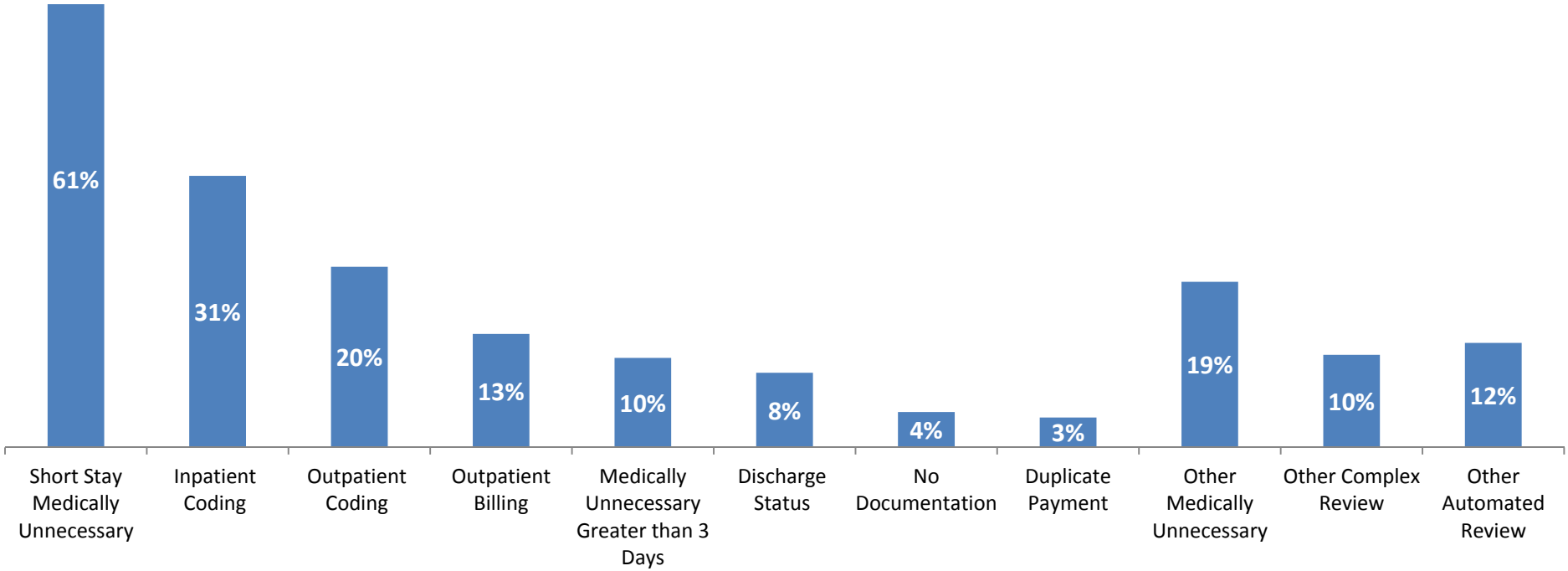
Nearly two-thirds of all hospitals filing a RAC appeal during the 2nd Quarter of 2012 reported appealing short stay medically unnecessary denials.

Percent of Participating Medical/Surgical Acute Hospitals Reporting RAC Appeals by Denial Reason, 2nd Quarter 2012

Survey participants were asked to select all reasons for denial.



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Of the claims that have completed the appeals process, 75% were overturned in favor of the provider.

Summary of Appeal Rate and Determinations in Favor of the Provider, for Hospitals with Automated or Complex RAC Denials, through 2nd Quarter 2012

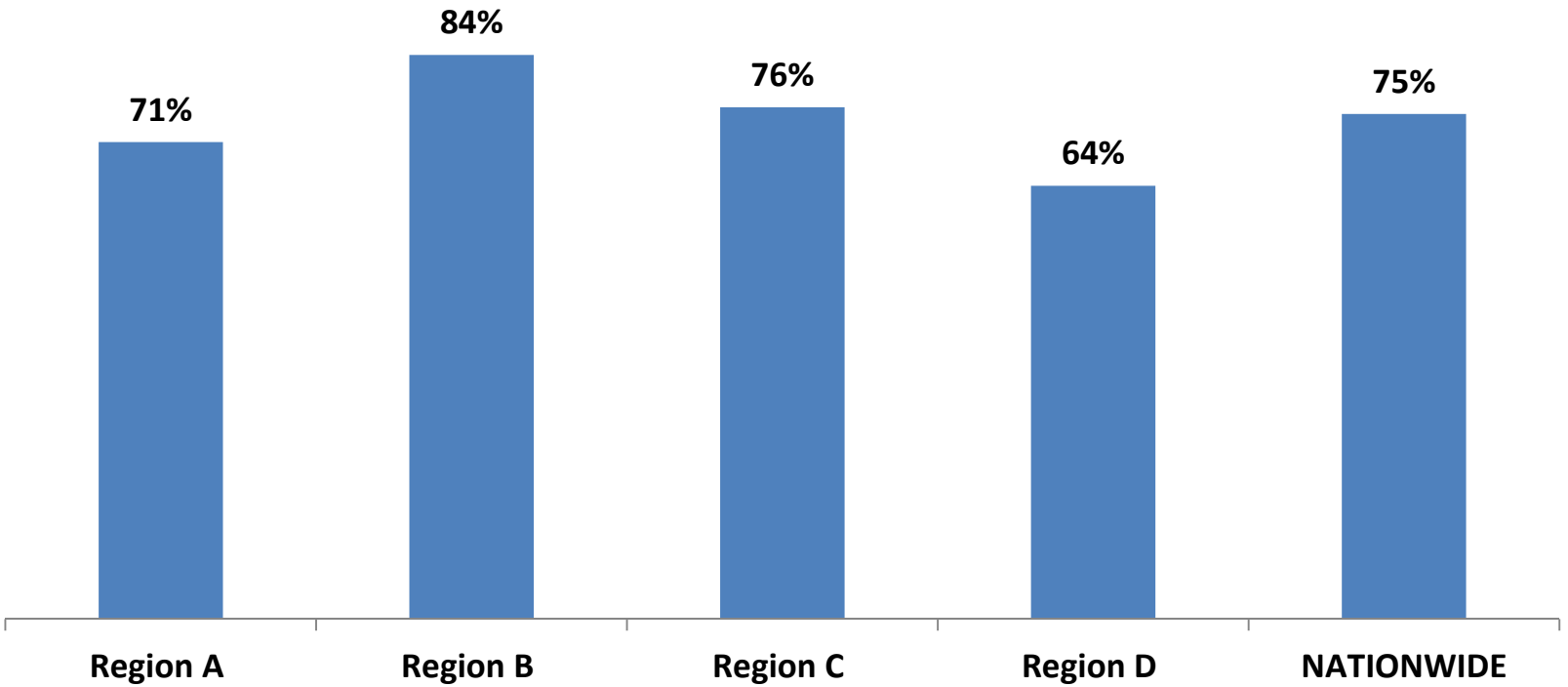
	Appealed	Percent of Denials Appealed	Number of Claims Pending Appeals Determination	Number of Claims Withdrawn from Appeals Process	Number of Denials Overturned in the Appeals Process	Percent of Appealed Denials Overturned *(as a Percent of Overturned or Withdrawn claims)*
NATIONWIDE	77,243	41%	55,111	5055	15,147	75%
Region A*	7,583	42%	5,914	487	1,182	71%
Region B	17,133	39%	10,002	1142	5,890	84%
Region C	25,741	34%	18,613	1395	4,413	76%
Region D	26,786	50%	20,582	2031	3,662	64%

** Survey submission error stemming from a problem with a* RAC*TRAC compatible vendor's tool required the exclusion of some appeals data in Region A. If you have questions or would like to find out if your data was excluded, contact* RAC*TRAC Support: 1-888-722-8712 or ractracsupport@providercs.com*

Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

When hospitals choose to appeal, they win 75% of the time. Region B has the highest overturn rate upon appeal at 84%.

Percent of Completed Appeals with Denials Overturned for Participating Hospitals, by Region, through 2nd Quarter 2012



Survey submission error stemming from a problem with a RAC*TRAC compatible vendor's tool required the exclusion of some appeals data in Region A. If you have questions or would like to find out if your data was excluded, contact* RAC*TRAC Support: 1-888-722-8712 or ractracsupport@providercs.com*

Source: AHA. (August 2012). RAC*TRAC* Survey
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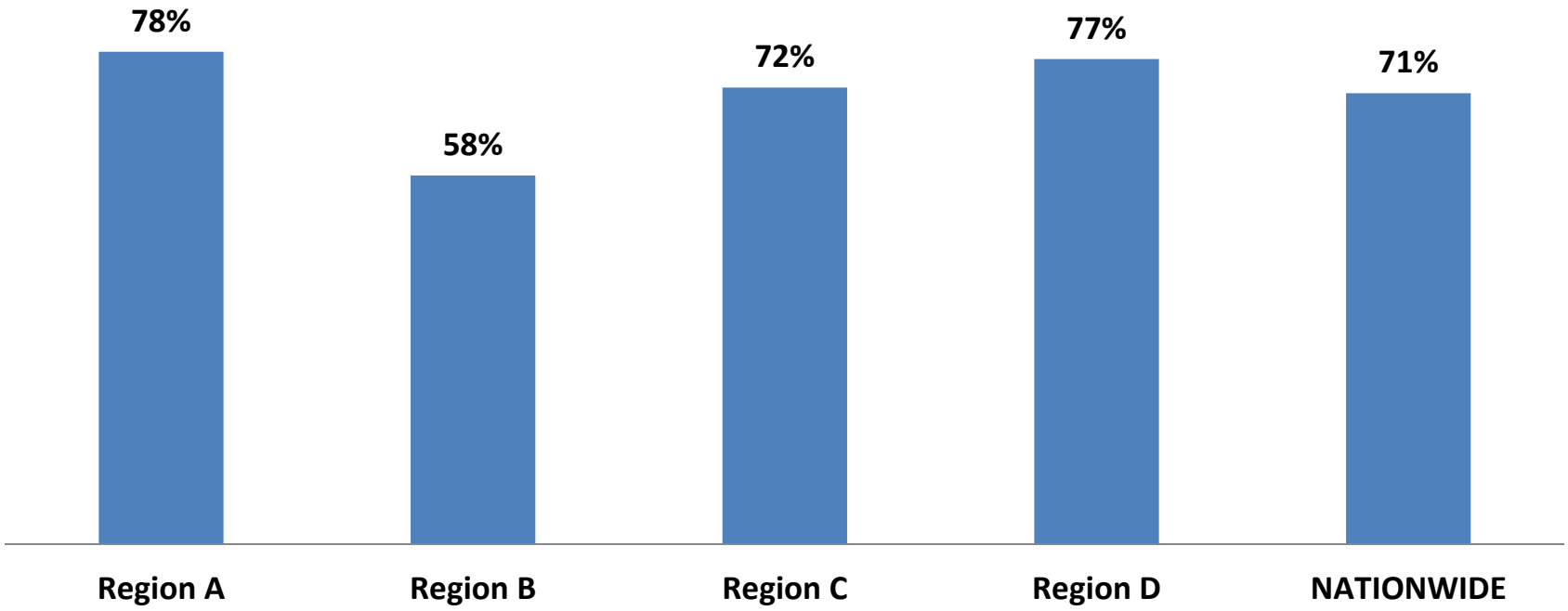
Nearly three-fourths of all appealed claims are still sitting in the appeals process.

Percent of Appealed Claims Pending Determination for Participating Hospitals, by Region, through 2nd Quarter 2012



Survey submission error stemming from a problem with a RAC*TRAC compatible vendor's tool required the exclusion of some appeals data in Region A. If you have questions or would like to find out if your data was excluded, contact* RAC*TRAC Support: 1-888-722-8712 or ractracsupport@providercs.com*

Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

Hospitals reported a total of $76.6 million in overturned denials, with $28.5 million in Region B alone.

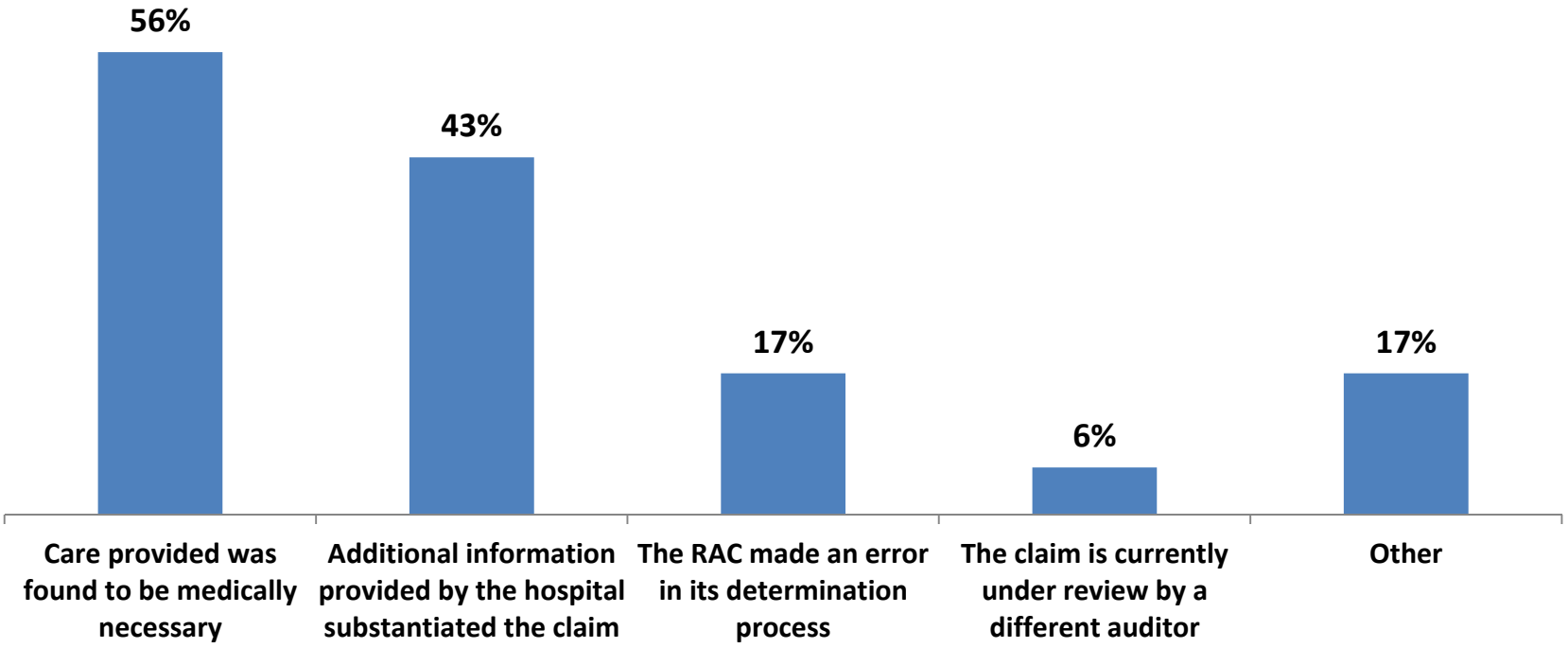
Value of Denials Overturned in the Appeals Process, by Region, through 2nd Quarter 2012, Millions

Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

More than half of all hospitals with a RAC denial overturned had a denial overturned because the care was found to be medically necessary.

Percent of Participating Hospitals That Had a Denial Overturned by Reason, 2nd Quarter 2012

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



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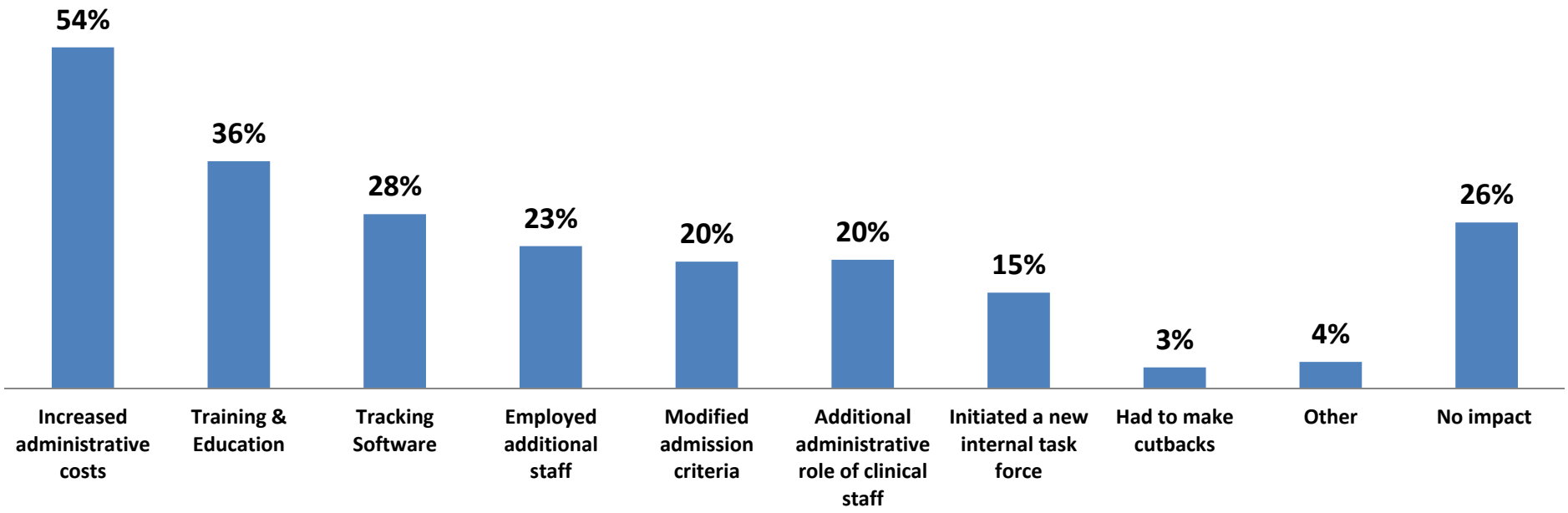
Administrative Burden

74% of participating hospitals reported that RAC impacted their organization this quarter and 54% reported increased administrative costs.

Impact of RAC on Participating Hospitals* by Type of Impact, 2nd Quarter 2012

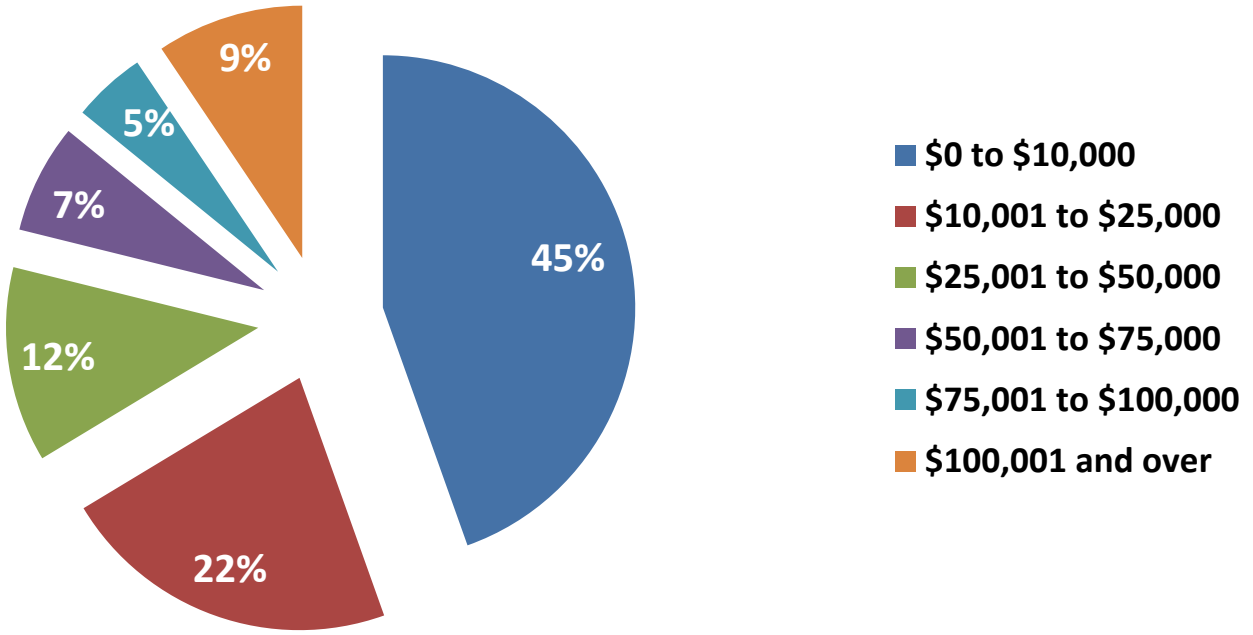


** Includes participating hospitals with and without RAC activity*

Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

55% of all hospitals reported spending more than $10,000 managing the RAC process during the second quarter of 2012, 33% spent more than $25,000 and 9% spent over $100,000.

Percent of Participating Hospitals* Reporting Average Cost dealing with the RAC Program, 2nd Quarter 2012



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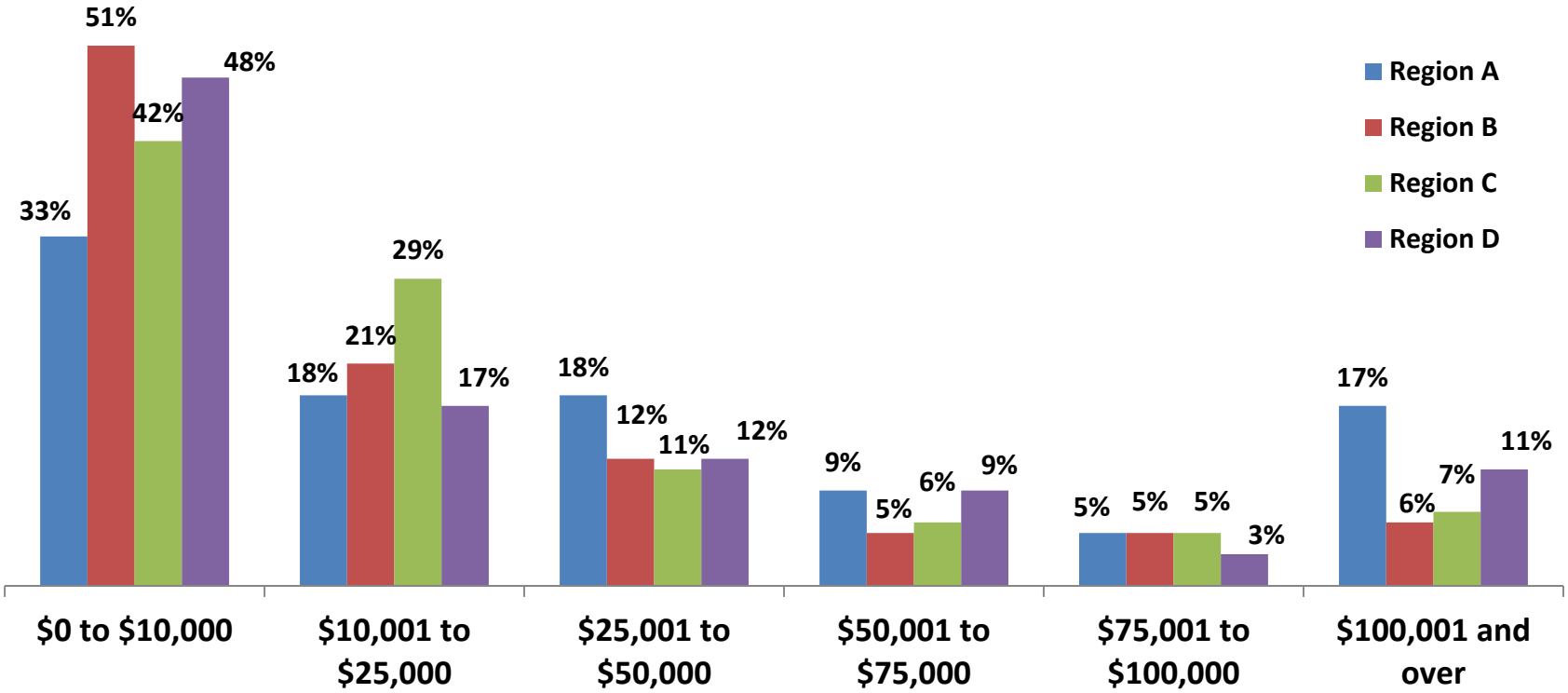
The average cost of managing the RAC process varies by region.

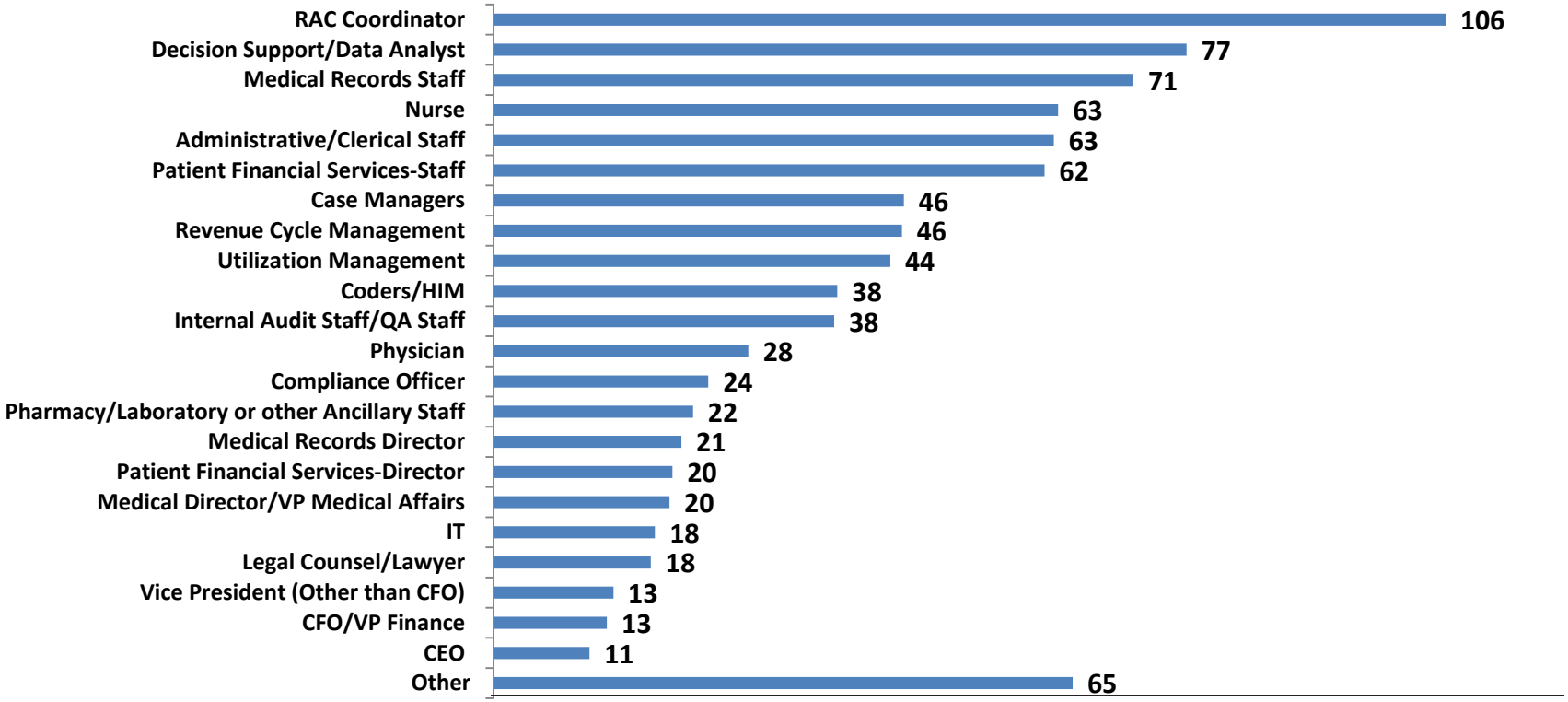
Percent of Participating Hospitals* Reporting Average Cost dealing with the RAC Program, by Region, 2nd Quarter 2012



Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

Hospital staff spend hundreds of hours responding to RAC activity.

Average Hours of Staff Time Spent Per Participating Hospital* on RAC by Staff Type, 2nd Quarter 2012



** Includes participating hospitals with and without RAC activity*

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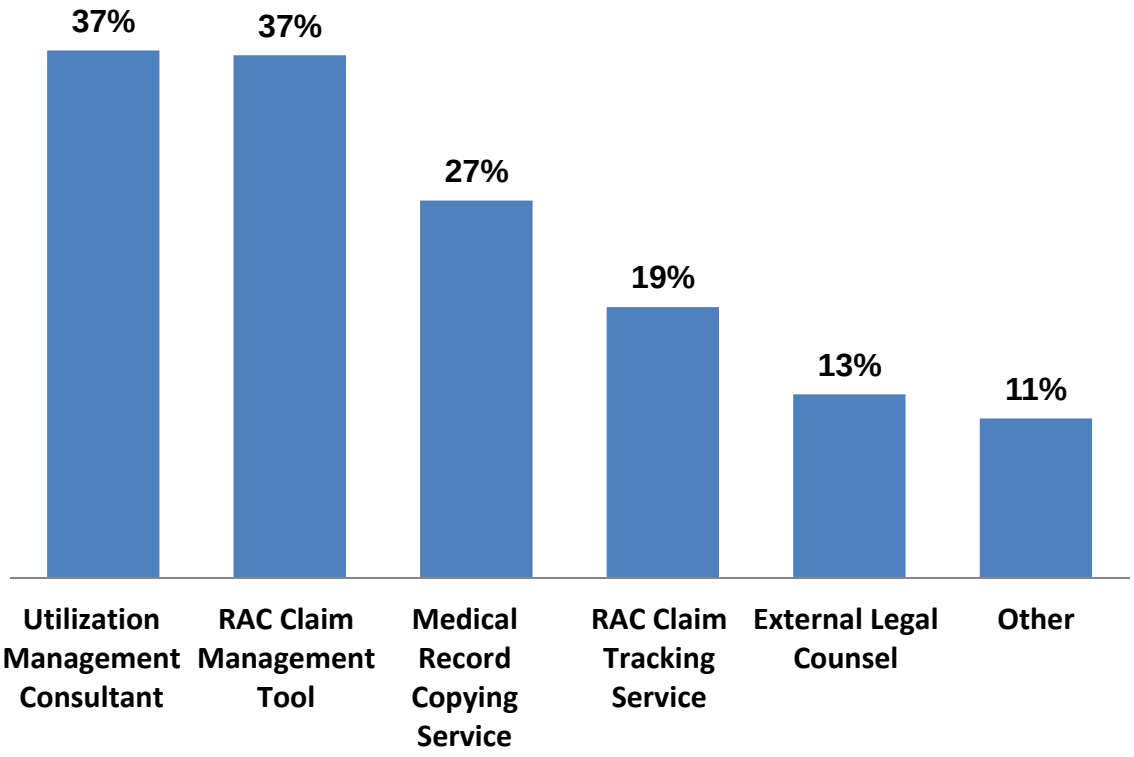
Many hospitals report spending on external resources such as outside consultants to deal with the RAC process.

Percent of Participating Hospitals* that Use External Resources by Type and Average Dollars Spent *this quarter*, 2nd Quarter 2012



Administrative Burden	Average Dollar Amount This Quarter
Utilization Management Consultant	$ 37,577
External Legal Counsel	$ 24,064
RAC Claim Management Tool	$ 8,407
RAC Claim Tracking Service	$ 8,113
Medical Record Copying Service	$ 3,529
Other	$ 28,153

** Includes participating hospitals with and without RAC activity. Average dollars spent and percentages reflect only those hospitals that reported utilizing external resources.*

Source: AHA. (August 2012). RAC*TRAC* Survey
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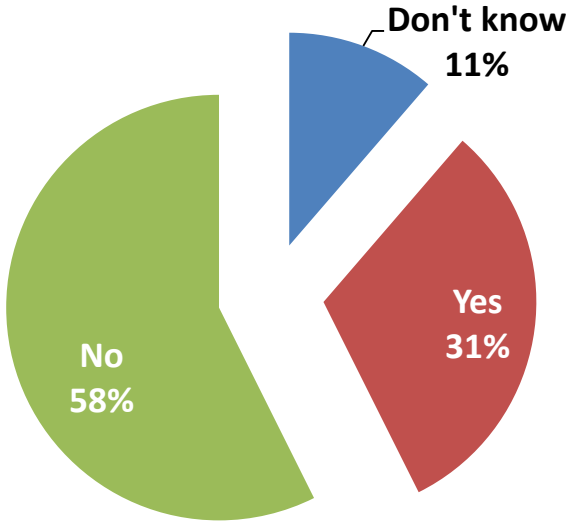
58% of respondents indicated they have yet to receive any education related to avoiding payment errors from CMS or its contractors.

Percent of Participating Hospitals Reporting they Received Education from CMS or its Contractors, National and by Region, through 2nd Quarter 2012

Reported Education by RAC Region

	Yes	No	Don't Know
Region A	**31%**	**57%**	**12%**
Region B	**24%**	**64%**	**12%**
Region C	**38%**	**53%**	**9%**
Region D	**30%**	**56%**	**14%**

National Reporting



** Includes participating hospitals with and without RAC activity*

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AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

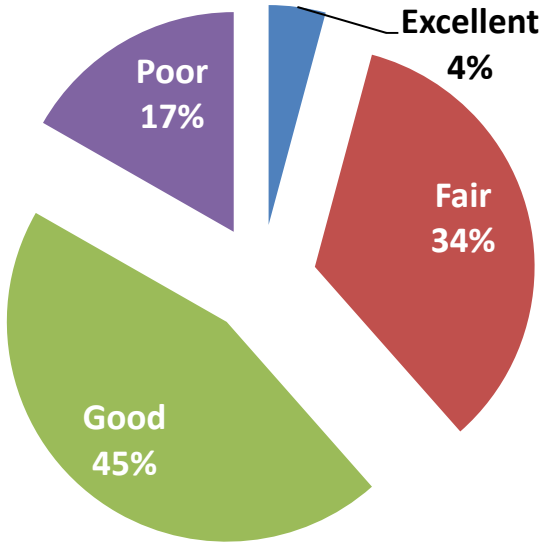
For those receiving education, the perceived quality varies by region with Region B performing the worst.

Percent of Participating Hospitals Reporting the Effectiveness of Received Education from CMS or its Contractors, National and by Region, through 2nd Quarter 2012

Reported Effectiveness of Education by RAC Region

	Excellent	Good	Fair	Poor
Region A	**2%**	**66%**	**30%**	**4%**
Region B	**4%**	**27%**	**50%**	**19%**
Region C	**1%**	**40%**	**39%**	**20%**
Region D	**12%**	**35%**	**31%**	**22%**

National Reporting



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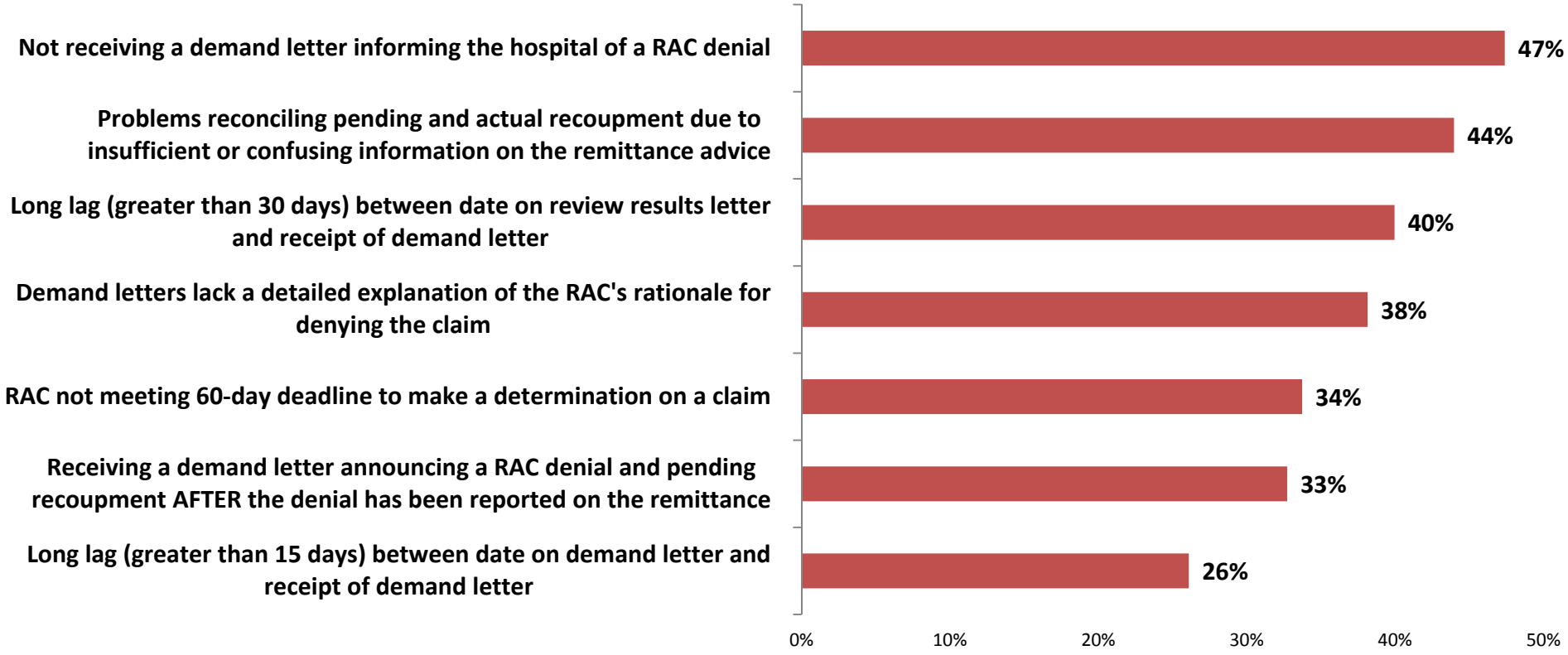
The most frequently cited RAC process problem is 'not receiving a demand letter.'

Percent of Participating Hospitals Reporting RAC Process Issues, by Issue, 2nd Quarter 2012



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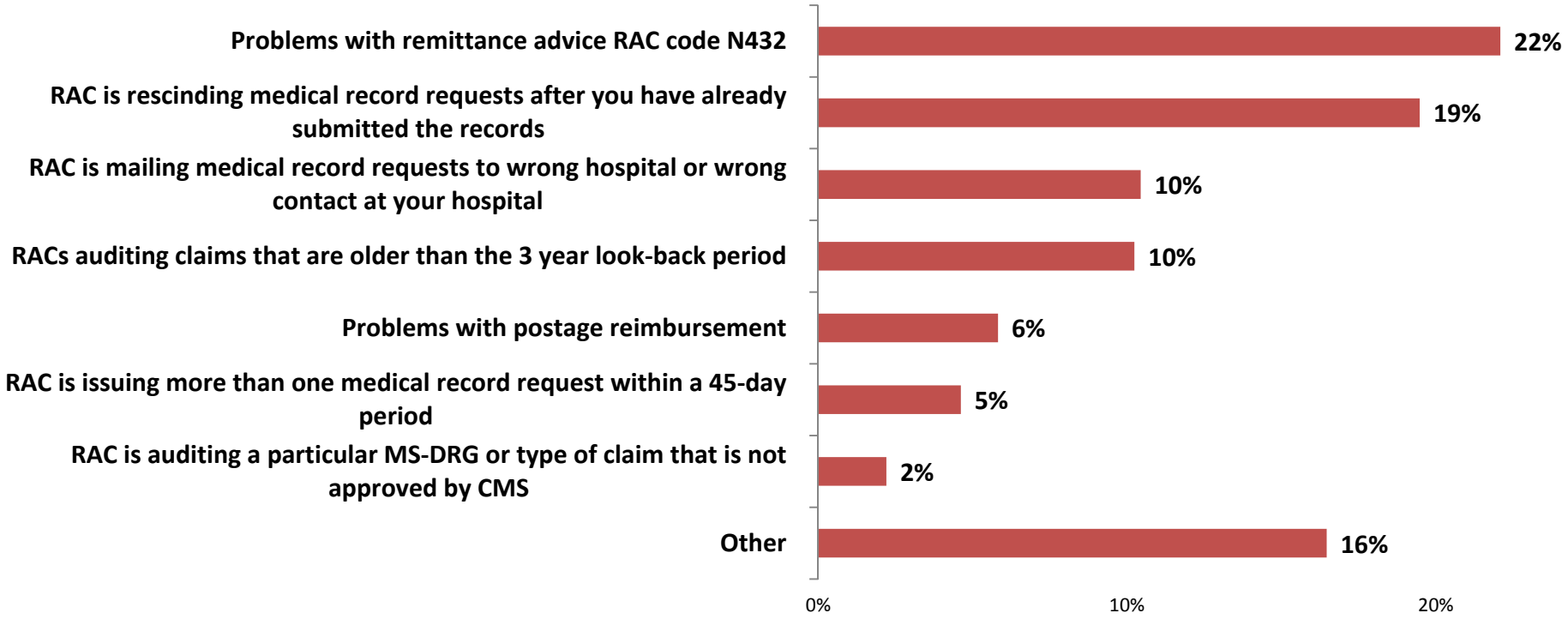
Hospitals continue to report that RACs are rescinding medical record requests after the hospital has already submitted the records.

Percent of Participating Hospitals Reporting RAC Process Issues, by Issue, 2nd Quarter 2012



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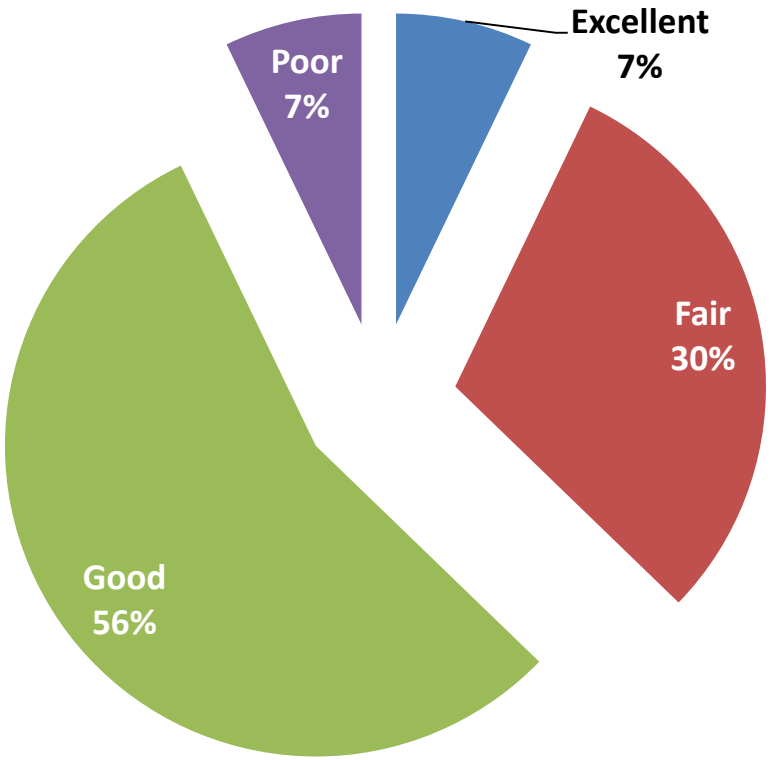
The majority of hospital respondents indicated RAC responsiveness and overall communication was “fair” or “good.”

Participating Hospitals Rating of RAC Responsiveness and Overall Communication, 2nd Quarter 2012



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Participating hospitals rated RAC responsiveness and communication lowest in region B.

Participating Hospital Rating of RAC Responsiveness and Overall Communication, by Region, 2nd Quarter 2012

	Excellent	Good	Fair	Poor
Region A	**14%**	**65%**	**17%**	**4%**
Region B	**4%**	**52%**	**33%**	**11%**
Region C	**5%**	**59%**	**30%**	**6%**
Region D	**8%**	**46%**	**39%**	**7%**

Source: AHA. (August 2012). RAC*TRAC* Survey
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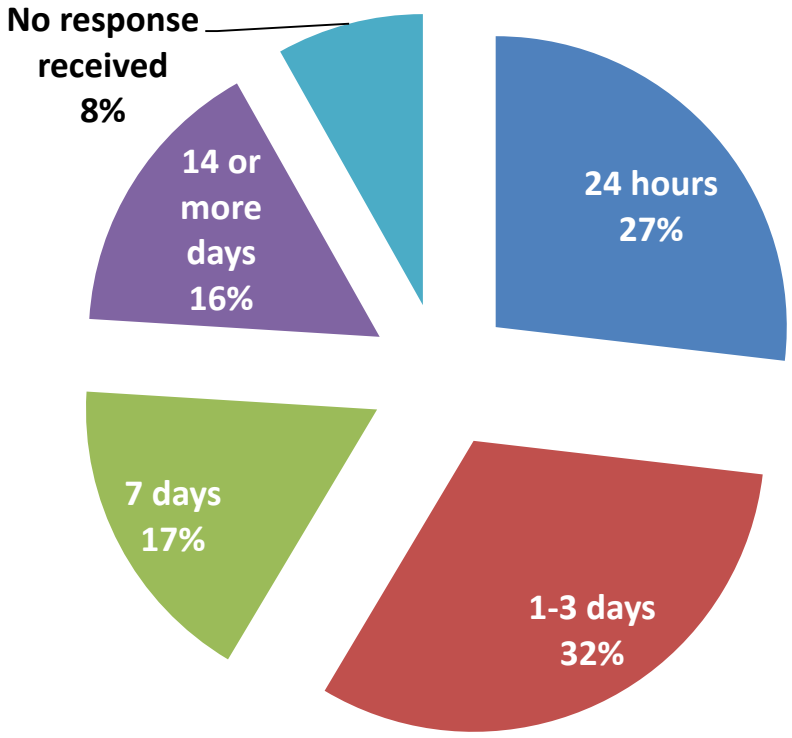
The average wait time for a RAC response varied significantly, with nearly a quarter of hospitals reporting they did not receive a response from their RAC for more than 2 weeks.

Average Number of Days it Took RACs to Respond to Hospital Inquiries for Participating Hospitals, 2nd Quarter 2012



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RAC response time varied by region.

Average Number of Days For RACs to Respond to Hospital Inquiries for Participating Hospitals, by Region, 2nd Quarter 2012

	24 hours	1-3 days	7 days	14 or more days	No Response Received
Region A	**44%**	**27%**	**15%**	**9%**	**5%**
Region B	**6%**	**29%**	**31%**	**25%**	**9%**
Region C	**36%**	**34%**	**10%**	**12%**	**8%**
Region D	**23%**	**35%**	**14%**	**17%**	**11%**

Source: AHA. (August 2012). RAC*TRAC* Survey
AHA analysis of survey data collected from 2,266 hospitals: 1,906 reporting activity, 360 reporting no activity through August 2012. Data were collected from general medical/surgical acute care hospitals (including critical access hospitals and cancer hospitals), long-term acute care hospitals, inpatient rehabilitation hospitals and inpatient psychiatric hospitals.

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

http://www.aha.org/aha/issues/RAC/ractrac.html