

ORIGINAL RESEARCH

Recovery Audit Contractor Audits and Appeals at Three Academic Medical Centers

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BACKGROUND: Outpatient (observation) and inpatient status determinations for hospitalized Medicare beneficiaries have generated increasing concern for hospitals and patients. Recovery Audit Contractor (RAC) activity alleging improper status, however, has received little attention, and there are conflicting federal and hospital reports of RAC activity and hospital appeals success.

OBJECTIVE: To detail complex Medicare Part A RAC activity.

DESIGN, SETTING AND PATIENTS: Retrospective descriptive study of complex Medicare Part A audits at 3 academic hospitals from 2010 to 2013.

MEASUREMENTS: Complex Part A audits, outcome of audits, and hospital workforce required to manage this process.

RESULTS: Of 101,862 inpatient Medicare encounters, RACs audited 8110 (8.0%) encounters, alleged overpayment in 31.3% (2536/8110), and hospitals disputed 91.0% (2309/2536). There was a nearly 3-fold increase in RAC overpayment determinations in 2 years, although the

hospitals contested and won a larger percent of cases each year. One-third (645/1935, 33.3%) of settled claims were decided in the discussion period, which are favorable decisions for the hospitals not reported in federal appeals data. Almost half (951/1935, 49.1%) of settled contested cases were withdrawn by the hospitals and rebilled under Medicare Part B to avoid the lengthy (mean 555 [SD 255] days) appeals process. These original inpatient claims are considered improper payments recovered by the RAC. The hospitals also lost appeals (0.9%) by missing a filing deadline, yet there was no reciprocal case concession when the appeals process missed a deadline. No overpayment determinations contested the need for care delivered, rather that care should have been delivered under outpatient, not inpatient, status. The institutions employed an average 5.1 full-time staff in the audits process.

CONCLUSIONS: These findings suggest a need for RAC reform, including improved transparency in data reporting. *Journal of Hospital Medicine* 2015;10:000–000. © 2015 Society of Hospital Medicine.

Medicare patients are increasingly hospitalized as outpatients under observation. From 2006 to 2012, outpatient services grew nationally by 28.5%, whereas inpatient discharges decreased by 12.6% per Medicare beneficiary.¹ This increased use of observation stays for hospitalized Medicare beneficiaries and the recent Centers for Medicare & Medicaid Services (CMS) “2-Midnight” rule for determination of visit status are increasing areas of concern for hospitals, policymakers, and the public,² as patients hospitalized under

observation are not covered by Medicare Part A hospital insurance, are subject to uncapped out-of-pocket charges under Medicare Part B, and may be billed by the hospital for certain medications. Additionally, Medicare beneficiaries hospitalized in outpatient status, which includes all hospitalizations under observation, do not qualify for skilled nursing facility care benefits after discharge, which requires a stay that spans at least 3 consecutive midnights as an inpatient.³

In contrast, the federal Recovery Audit program, previously called and still commonly referred to as the Recovery Audit Contractor (RAC) program, responsible for postpayment review of inpatient claims, has received relatively little attention. Established in 2006, and fully operationalized in federal fiscal year (FY) 2010,⁴ RACs are private government contractors granted the authority to audit hospital charts for appropriate “medical necessity,” which can consider whether the care delivered was indicated and whether it was delivered in the appropriate Medicare visit

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status, outpatient or inpatient. Criteria for hospitalization status (inpatient vs outpatient) as defined in the Medicare Conditions of Participation, often allow for subjectivity (medical judgment) in determining which status is appropriate.⁵ Hospitals may contest RAC decisions and payment denials through a preappeals discussion period, then through a 5-level appeals process. Although early appeals occur between the hospital and private contractors, appeals reaching level 3 are heard by the Department of Health and Human Services (HHS) Office of Medicare Hearings and Appeals (OMHA) Administrative Law Judges (ALJ). Levels 4 (Medicare Appeals Council) and 5 (United States District Court) appeals are also handled by the federal government.⁶

Medicare fraud and abuse should not be tolerated, and systematic surveillance needs to be an integral part of the Medicare program.⁴ However, there are increasing concerns that the RAC program has resulted in overaggressive denials.^{7,8} Unlike other Medicare contractors, RAC auditors are paid a contingency fee based on the percentage of hospital payment recouped for cases they audit and deny for improper payment.⁴ RACs are not subject to any financial penalty for cases they deny but are overturned in the discussion period or in the appeals process. This may create an incentive system that financially encourages RACs to assert improper payment, and the current system lacks both transparency and clear performance metrics for auditors. Of particular concern are Medicare Part A complex reviews, the most fiscally impactful area of RAC activity. According to CMS FY 2013 data, 41.1% of all claims with collections were complex reviews, yet these claims accounted for almost all (95.2%) of total dollars recovered by the RACs, with almost all (96%) dollars recovered being from Part A claims.⁹ Complex reviews involve an auditor retrospectively and manually reviewing a medical record and then using his or her clinical and related professional judgment to decide whether the care was medically necessary. This is compared to automated coding or billing reviews, which are based solely on claims data.

Increased RAC activity and the willingness of hospitals to challenge RAC findings of improper payment has led to an increase in appeals volume that has overloaded the appeals process. On March 13, 2013, CMS offered hospitals the ability to rebill Medicare Part B as an appeals alternative.¹⁰ This did not temper level 3 appeals requests received by the OMHA, which increased from 1250 per week in January 2012 to over 15,000 per week by November 2013.¹¹ Citing an overwhelmingly increased rate of appeal submissions and the resultant backlog, the OMHA decided to freeze new hospital appeals assignments in December 2013.¹¹ In another attempt to clear the backlog, on August 29, 2014, CMS offered a settlement that would pay hospitals 68% of the net allowable amount of the original Part A claim (minus

any beneficiary deductibles) if a hospital agreed to concede all of its eligible appeals.¹² Notably, cases settled under this agreement would remain officially categorized as denied for improper payment.

The HHS Office of Inspector General (OIG)⁴ and the CMS^{9,13,14} have produced recent reports of RAC auditing and appeals activity that contain variable numbers that conflict with hospital accounts of auditing and appeals activity.^{15,16} In addition to these conflicting reports, little is known about RAC auditing of individual programs over time, the length of time cases spend in appeals, and staff required to navigate the audit and appeals processes. Given these questions, and the importance of RAC auditing pressure in the growth of hospital observation care, we conducted a retrospective descriptive study of all RAC activity for complex Medicare Part A alleged overpayment determinations at the Johns Hopkins Hospital, the University of Utah, and University of Wisconsin Hospital and Clinics for calendar years 2010 to 2013.

METHODS

The University of Wisconsin-Madison Health Sciences institutional review board (IRB) and the Johns Hopkins Hospital IRB did not require review of this study. The University of Utah received an exemption. All 3 hospitals are tertiary care academic medical centers. The University of Wisconsin Hospital and Clinics (UWHC) is a 592-bed hospital located in Madison, Wisconsin,¹⁷ the Johns Hopkins Hospital (JHH) is a 1145-bed medical center located in Baltimore, Maryland,¹⁸ and the University of Utah Hospital (UU) is a 770-bed facility in Salt Lake City, Utah (information available upon request). Each hospital is under a different RAC, representing 3 of the 4 RAC regions, and each is under a different Medicare Administrative Contractor, contractors responsible for level 1 appeals. The 3 hospitals have the same Qualified Independent Contractor responsible for level 2 appeals.

For the purposes of this study, any chart or medical record requested for review by an RAC was considered a “medical necessity chart request” or an “audit.” The terms “overpayment determinations” and “denials” were used interchangeably to describe audits the RACs alleged did not meet medical necessity for Medicare Part A billing. As previously described, the term “medical necessity” specifically considered not only whether actual medical services were appropriate, but also whether the services were delivered in the appropriate status, outpatient or inpatient. “Appeals” and/or “request for discussion” were cases where the overpayment determination was disputed and challenged by the hospital.

All complex review Medicare Part A RAC medical record requests by date of RAC request from the official start of the RAC program, January 1, 2010,⁴ to December 31, 2013, were included in this study. Medical record requests for automated reviews that related

to coding and billing clarifications were not included in this study, nor were complex Medicare Part B reviews, complex reviews for inpatient rehabilitation facilities, or psychiatric day hospitalizations. Notably, JHH is a Periodic Interim Payment (PIP) Medicare hospital, which is a reimbursement mechanism where “biweekly payments [are] made to a Provider enrolled in the PIP program, and are based on the hospital’s estimate of applicable Medicare reimbursement for the current cost report period.”¹⁹ Because PIP payments are made collectively to the hospital based on historical data, adjustments for individual inpatients could not be easily adjudicated and processed. Due to the increased complexity of this reimbursement mechanism, RAC audits did not begin at JHH until 2012. In addition, in contrast to the other 2 institutions, all of the RAC complex review audits at JHH in 2013 were for Part B cases, such as disputing need for intensity-modulated radiation therapy versus conventional radiation therapy, or contesting the medical necessity of blepharoplasty. As a result, JHH had complex Part A review audits only for 2012 during the study time period. All data were deidentified prior to review by investigators.

As RACs can audit charts for up to 3 years after the bill is submitted,¹³ a chart request in 2013 may represent a 2010 hospitalization, but for purposes of this study, was logged as a 2013 case. There currently is no standard methodology to calculate time spent in appeals. The UWHC and JHH calculate time in discussion or appeals from the day the discussion or appeal was initiated by the hospital, and the UU calculates the time in appeals from the date of the findings letter from the RAC, which makes comparable recorded time in appeals longer at UU (estimated 5–10 days for 2011–2013 cases, up to 120 days for 2010 cases). Time in appeals includes all cases that remain in the discussion or appeals process as of June 30, 2014.

The RAC process is as follows (Tables 1 and 2):

1. The RAC requests hospital claims (“RAC Medical Necessity Chart Requests [Audits]”).
2. The RAC either concludes the hospital claim was compliant as filed/paid and the process ends or the RAC asserts improper payment and requests repayment (“RAC Overpayment Determinations of Requested Charts [Denials]”).
3. The hospital makes an initial decision to not contest the RAC decision (and repay), or to dispute the decision (“Hospital Disputes Overpayment Determination [Appeal/Discussion]”). Prior to filing an appeal, the hospital may request a discussion of the case with an RAC medical director, during which the RAC medical director can overturn the original determination. If the RAC declines to overturn the decision in discussion, the hospital may proceed with a formal appeal. Although CMS does not calculate the discussion period as part of the appeals process,¹² overpayment determinations contested by the hospital in either discussion or appeal represent the sum total of RAC denials disputed by the hospital.
4. Contested cases have 1 of 4 outcomes:
 - a. Contested overpayment determinations can be decided in favor of the hospital (“Discussion or Appeal Decided in Favor of Hospital or RAC Withdrew”)
 - b. Contested overpayment determinations can be decided in favor of the RAC during the appeal process, and either the hospital exhausts the appeal process or elects not to take the appeal to the next level. Although the appeals process has 5 levels, no cases at our 3 hospitals have reached level 4 or 5, so cases without a decision to date remain in appeals at 1 of the first 3 levels (“Case Still in Discussion or Appeals”).⁴
 - c. Hospital may miss an appeal deadline (“Hospital Missed Appeal Deadline at Any Level”) and the case is automatically decided in favor of the RAC.
 - d. As of March 13, 2013,¹⁰ for appeals that meet certain criteria and involve dispute over the billing of hospital services under Part A, CMS allowed hospitals to withdraw an appeal and rebill Medicare Part B. Prior to this time, hospitals could rebill “for a very limited list of ancillary “Part B Only” services, and only within the 1-year timely filing period.”¹³ Due to the lengthy appeals process and associated legal and administrative costs, hospitals may not agree with the RAC determination but make a business decision to recoup some payment under this mechanism (“Hospital Chose to Rebill as Part B During Discussion or Appeals Process”).

The administration at each hospital provided labor estimates for workforce dedicated to the review process generated by the RACs based on hourly accounting of one-quarter of work during 2012, updated to FY 2014 accounting (Table 3). Concurrent case management status determination work was not included in these numbers due to the difficulty in solely attributing concurrent review workforce numbers to the RACs, as concurrent case management is a CMS Condition of Participation irrespective of the RAC program.

Statistics

Descriptive statistics were used to describe the data. Staffing numbers are expressed as full-time equivalents (FTE).

RESULTS

Yearly Medicare Encounters and RAC Activity of Part A Complex Reviews

RACs audited 8.0% (8110/101,862) of inpatient Medicare cases, alleged noncompliance (all overpayments)

TABLE 1. Yearly Medicare Encounters and Recovery Audit Contractor Activity of Part A Complex Reviews by Date of Request at Three Academic Medical Centers (2010–2013)*

	Totals														
	Johns Hopkins Hospital					University of Wisconsin Hospital and Clinics					University of Utah				
	2010	2011	2012	2013	All Years	2010	2011	2012	2013	All Years	2010	2011	2012	2013	All Years
Total no. of Medicare encounters	24,400	24,998	25,370	27,094	101,862	11,212 [†]	11,750 [†]	11,842	12,674 [†]	47,478	5,092	5,210	5,099	5,334	20,735
RAC Medical Necessity Chart Requests (Audits)	547	1,735	3,887	1,941	8,110 (8.0%)	0	0	938	0	938 (2.0%)	532	1,209	1,465	981	4,187 (20.2%)
RAC Overpayment Determinations Of Requested Charts (Denials) [‡]	164 (30.0%)	516 (29.7%)	1,200 (30.9%)	656 (33.8%)	2,536 (31.3%)	0 (0%)	0 (0%)	432 (46.1%)	0 (0%)	432 (46.1%)	161 (30.3%)	369 (30.5%)	528 (36.0%)	492 (100.0%)	1,550 (37.0%)
Hospital Disputes Overpayment Determination (Appeal/Discussion)	128 (78.0%)	409 (79.3%)	1,129 (94.1%)	643 (98.0%)	2,309 (91.0%)	0 (0%)	0 (0%)	431 (99.8%)	0 (0%)	431 (99.8%)	127 (78.9%)	338 (91.6%)	528 (100.0%)	492 (100.0%)	1,485 (95.8%)
Outcome of Disputed Overpayment Determination															
Hospital Missed Appeal Deadline at Any Level	0 (0.0%)	1 (0.2%)	13 (1.2%)	4 (0.6%)	18 (0.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	13 (2.5%)	0 (0.0%)	13 (0.9%)
Hospital Chose To Rebill as Part B During Discussion Or Appeals Process	80 (62.5%)	202 (49.4%)	511 (45.3%)	158 (24.6%)	951 (41.2%)	0 (0%)	0 (0%)	208 (48.3%)	0 (0%)	208 (48.3%)	564 (17.1%)	199 (58.9%)	290 (54.9%)	155 (31.5%)	723 (48.7%)
Discussion or Appeal Decided in Favor Of Hospital or RAC Withdraw [§]	45 (35.2%)	127 (31.1%)	449 (39.8%)	345 (53.7%)	966 (41.8%)	0 (0%)	0 (0%)	151 (35.0%)	0 (0%)	151 (35.0%)	393 (70.9%)	83 (24.6%)	175 (33.1%)	252 (51.2%)	555 (37.4%)
Case Still in Discussion or Appeals	3 (2.3%)	79 (19.3%)	156 (13.8%)	136 (21.2%)	374 (16.2%)	0 (0%)	0 (0%)	72 (16.7%)	0 (0%)	72 (16.7%)	54 (18.6%)	56 (16.6%)	50 (9.5%)	85 (17.3%)	194 (13.1%)
Mean Time for Cases Still in Discussion or Appeals, d (SD)	1208 (41)	958 (79)	518 (125)	350 (101)	555 (255)	N/A	N/A	478 (164)	N/A	478 (164)	1,208 (41)	970 (80)	544 (25)	365 (72)	589 (273)
	University of Wisconsin Hospital and Clinics										University of Utah				
Total no. of Medicare encounters [†]	8,096	8,038	8,429	9,086	33,649	5,092	5,210	5,099	5,334	20,735	5,092	5,210	5,099	5,334	20,735
RAC Medical Necessity Chart Requests (Audits)	15	526	1,484	960	2,985 (8.9%)	532	1,209	1,465	981	4,187 (20.2%)	532	1,209	1,465	981	4,187 (20.2%)
RAC Overpayment Determinations of Requested Charts (Denials) [‡]	3 (20.0%)	147 (27.9%)	240 (16.2%)	164 (17.1%)	564 (18.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	161 (30.3%)	369 (30.5%)	528 (36.0%)	492 (100.0%)	1,550 (37.0%)
Hospital Disputes Overpayment Determination (Appeal/Discussion)	1 (33.3%)	71 (48.3%)	170 (70.8%)	151 (92.1%)	393 (70.9%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	127 (78.9%)	338 (91.6%)	528 (100.0%)	492 (100.0%)	1,485 (95.8%)
Outcome of Disputed Overpayment Determination															
Hospital Missed Appeal Deadline at Any Level	0 (0.0%)	1 (1.4%)	0 (0.0%)	4 (2.6%)	5 (1.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	13 (2.5%)	0 (0.0%)	13 (0.9%)
Hospital Chose To Rebill as Part B During Discussion or Appeals Process	1 (100%)	3 (4.2%)	13 (7.6%)	3 (2.0%)	20 (5.1%)	0 (0.0%)	0 (0.0%)	3 (7.6%)	0 (0.0%)	3 (7.6%)	564 (17.1%)	199 (58.9%)	290 (54.9%)	155 (31.5%)	723 (48.7%)
Discussion or Appeal Decided in Favor of Hospital or RAC Withdraw [§]	0 (0.0%)	44 (62.0%)	123 (72.4%)	93 (61.6%)	260 (66.2%)	0 (0.0%)	0 (0.0%)	123 (72.4%)	0 (0.0%)	123 (72.4%)	393 (70.9%)	83 (24.6%)	175 (33.1%)	252 (51.2%)	555 (37.4%)
Case Still in Discussion or Appeals	0 (0.0%)	23 (32.4%)	34 (20.0%)	51 (33.8%)	108 (27.5%)	0 (0.0%)	0 (0.0%)	34 (20.0%)	0 (0.0%)	34 (20.0%)	54 (18.6%)	56 (16.6%)	50 (9.5%)	85 (17.3%)	194 (13.1%)
Mean Time for Cases Still in Discussion or Appeals, d (SD)	N/A	926 (70)	564 (90)	323 (134)	528 (258)	1,208 (41)	970 (80)	544 (25)	365 (72)	589 (273)	1,208 (41)	970 (80)	544 (25)	365 (72)	589 (273)

NOTE: Abbreviations: JHH, Johns Hopkins Hospital; N/A, not available; RAC, recovery audit contractor; SD, standard deviation.

*All data are number (%) unless otherwise specified.

[†]JHH is a Periodic Interim Payment Medicare hospital, and due to the increased complexity of this reimbursement mechanism, RAC audits did not begin at JHH until 2012.

[‡]JHH did not receive any Part A complex review audits in 2013. All of JHH's 2013 complex review audits were for Part B cases.

[§]All of the alleged overpayment determinations contested billing location, that care should have been observation or outpatient. No cases claimed that actual care was medically unnecessary.

^{||}No appeals at any institution has reached the last level of appeals; therefore, no cases have been decided in favor of the RAC to date.

[¶]There were 4 cases in 2012 at JHH that were withdrawn by the RAC and awarded to the hospital on technical issues. No other cases at the 3 institutions were PAC withdrawals.

TABLE 2. Yearly Recovery Audit Contractor Part A Complex Review Overpayment Determinations Disputed by Hospitals With Decisions at Three Academic Medical Centers (2010–2013)*

	2010	2011	2012	2013	All	2010	2011	2012	2013	All
	Total Appeals With Decisions					Johns Hopkins Hospital				
Total no.	125	330	973	507	1,935	0	0	359	0	359
Hospital Missed Appeal Deadline at Any Level	0 (0.0%)	1 (0.3%)	13 (1.3%)	4 (0.8%)	18 (0.9%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Hospital Chose to Rebill as Part B During Discussion or Appeals Process	80 (64.0%)	202 (61.2%)	511 (52.5%)	158 (31.2%)	951 (49.1%)	0 (0.0%)	0 (0.0%)	208 (57.9%)	0 (0.0%)	208 (57.9%)
Discussion or Appeal Decided in Favor of Hospital or RAC Withdrew†	45 (36.0%)	127 (38.5%)	449 (46.1%)	345 (68.0%)	966 (49.9%)	0 (0.0%)	0 (0.0%)	151 (42.1%)	0 (0.0%)	151 (42.1%)
Discussion Period and RAC Withdrawals	0 (0.0%)	59 (17.9%)	351 (36.1%)	235 (46.4%)	645 (33.3%)	0 (0.0%)	0 (0.0%)	139 (38.7%)	0 (0.0%)	139 (38.7%)
Level 1 Appeal	10 (8.0%)	22 (6.7%)	60 (6.2%)	62 (12.2%) ¹	154 (8.0%)	0 (0.0%)	0 (0.0%)	2 (0.6%)	0 (0.0%)	2 (0.6%)
Level 2 Appeal	22 (17.6%)	36 (10.9%)	38 (3.9%)	48 (9.5%) ¹	144 (7.4%)	0 (0.0%)	0 (0.0%)	10 (2.8%)	0 (0.0%)	10 (2.8%)
Level 3 Appeal‡	13 (10.4%)	10 (3.0%)	N/A (N/A)	N/A (N/A)	23 (1.2%)	0 (0.0%)	0 (0.0%)	N/A (N/A)	0 (0.0%)	0 (0.0%)
	2010	2011	2012	2013	All	2010	2011	2012	2013	All
	University of Wisconsin Hospital and Clinics					University of Utah				
Total no.	1	48	136	100	285	124	282	478	407	1,291
Hospital Missed Appeal Deadline at Any Level	0 (0.0%)	1 (2.1%)	0 (0.0%)	4 (4.0%)	5 (1.8%)	0 (0.0%)	0 (0.0%)	13 (2.7%)	0 (0.0%)	13 (1.0%)
Hospital Chose to Rebill as Part B During Discussion or Appeals Process	1 (100.0%)	3 (6.3%)	13 (9.6%)	3 (3.0%)	20 (7.0%)	79 (63.7%)	199 (70.6%)	290 (60.7%)	155 (38.1%)	723 (56.0%)
Discussion or Appeal Decided in Favor of Hospital or RAC Withdrew†	0 (0.0%)	44 (91.7%)	123 (90.4%)	93 (93.0%)	260 (91.2%)	45 (36.3%)	83 (29.4%)	175 (36.6%)	252 (61.9%)	555 (43.0%)
Discussion Period and RAC Withdrawals	0 (0.0%)	38 (79.2%)	66 (48.5%)	44 (44.0%)	148 (51.9%)	0 (0.0%)	21 (7.4%)	146 (30.5%)	191 (46.9%)	358 (27.7%)
Level 1 Appeal	0 (0.0%)	2 (4.2%)	47 (34.6%)	34 (34.0%)	83 (29.1%)	10 (8.1%)	20 (7.1%)	11 (2.3%)	28 (6.9%)	69 (5.3%)
Level 2 Appeal	0 (0.0%)	4 (8.3%)	10 (7.4%)	15 (15.0%)	29 (10.2%)	22 (17.7%)	32 (11.3%)	18 (3.8%)	33 (8.1%)	105 (8.1%)
Level 3 Appeal‡	0 (0.0%)	N/A (N/A)	N/A (N/A)	N/A (N/A)	0 (0.0%)	13 (10.5%)	10 (3.5%)	N/A (N/A)	N/A (N/A)	23 (1.8%)

NOTE: Fields with N/A indicate no cases in a certain category have reached that level or have been decided yet, whereas a zero indicates that no cases exist at that level.

Abbreviations: HH, Johns Hopkins Hospital; RAC, recovery audit contractor; UWHC, University of Wisconsin Hospital and Clinics; University of Utah.

*All data are number and % unless otherwise specified.

¹There were 4 cases in 2012 at JHH that were withdrawn by the RAC and awarded to the hospital on technical issues. No other cases at the 3 institutions were RAC withdrawals.

²No appeals at JHH have reached level 3. No appeals at UWHC or UU have reached level 4 or 5.

for 31.3% (2536/8110) of Part A complex review cases requested, and the hospitals disputed 91.0% (2309/2536) of these assertions. None of these cases of alleged noncompliance claimed the actual medical services were unnecessary. Rather, every Part A complex review overpayment determination by all 3 RACs contested medical necessity related to outpatient versus inpatient status. In 2010 and 2011, there were in aggregate fewer audits (2282), overpayment determinations (680), and appeals or discussion requests (537 of 680, 79.0%), compared to audits (5828), overpayment determinations (1856), and appeals or discussion requests (1772 of 1856, 95.5%) in 2012 and 2013. The hospitals appealed or requested discussion of a greater percentage each successive year (2010, 78.0%; 2011, 79.3%; 2012, 94.1%; and 2013, 98.0%). This increased RAC activity, and hospital willingness to dispute the RAC overpayment determinations equaled a more than 300% increase in appeals and discussion request volume related to Part A complex review audits in just 2 years.

The 16.2% (374/2309) of disputed cases still under discussion or appeal have spent an average mean of 555 days (standard deviation 255 days) without a decision, with time in appeals exceeding 900 days for

TABLE 3. Estimated Workforce Dedicated to Part A Complex Review Medical Necessity Audits and Appeals at Three Academic Medical Centers*

	JHH	UWHC	UU	Mean
Physicians: assist with status determinations, audits, and appeals	1.0	0.5	0.6	0.7
Nursing administration: audit and appeal preparation	0.9	0.2	1.9	1.0
Legal counsel: assist with rules interpretation, audit, and appeal preparation	0.2	0.3	0.1	0.2
Data analyst: prepare and track reports of audit and appeals	2.0	1.8	2.4	2.0
Administration and other directors	2.3	0.9	0.3	1.2
Total FTE workforce	6.4	3.7	5.3	5.1

NOTE: Abbreviations: JHH, Johns Hopkins Hospital; UWHC, University of Wisconsin Hospital and Clinics; UU, University of Utah.

*All numbers are estimated full-time equivalents (FTE) based on hours accounting of one-quarter of CY 2012 updated to 2014. Nurse case manager FTE assisting physicians with concurrent status determinations and order changes is not included in this table.

cases from 2010 and 2011. Notably, the 3 programs were subject to Part A complex review audits at widely different rates (Table 1).

Yearly RAC Part A Complex Review Overpayment Determinations Disputed by Hospitals With Decisions

The hospitals won, either in discussion or appeal, a combined greater percentage of contested overpayment determinations annually, from 36.0% (45/125) in 2010, to 38.5% (127/330) in 2011, to 46.1% (449/973) in 2012, to 68.0% (345/507) in 2013. Overall, for 49.1% (951/1935) of cases with decisions, the hospitals withdrew or rebilled under Part B at some point in the discussion or appeals process to avoid the lengthy appeals process and/or loss of the amount of the entire claim. A total of 49.9% (966/1935) of appeals with decisions have been won in discussion or appeal over the 4-year study period. One-third of all resolved cases (33.3%, 645/1935) were decided in favor of the hospital in the discussion period, with these discussion cases accounting for two-thirds (66.8%, 645/966) of all favorable resolved cases for the hospital. Importantly, if cases overturned in discussion were omitted as they are in federal reports, the hospitals' success rate would fall to 16.6% (321/1935), a number similar to those that appear in annual CMS reports.^{9,13,14} The hospitals also conceded 18 cases (0.9%) by missing a filing deadline (Table 2).

Estimated Workforce Dedicated to Part A Complex Review Medical Necessity Audits and Appeals

The institutions each employ an average of 5.1 FTE staff to manage the audit and appeal process, a number that does not include concurrent case management staff who assist in daily status determinations (Table 3).

CONCLUSIONS

In this study of 3 academic medical centers, there was a more than 2-fold increase in RAC audits and a nearly 3-fold rise in overpayment determinations over the last 2 calendar years of the study, resulting in a more than 3-fold increase in appeals or requests for discussion in 2012 to 2013 compared to 2010 to 2011. In addition, although "CMS manually reviews less than 0.3% of submitted claims each year through programs such as the Recovery Audit Program,"⁹ at the study hospitals, complex Part A RAC audits occurred at a rate more than 25 times that (8.0%), suggesting that these types of claims are a disproportionate focus of auditing activity. The high overall complex Part A audit rate, accompanied by acceleration of RAC activity and the hospitals' increased willingness to dispute RAC overpayment determinations each year, if representative of similar institutions, would explain the appeals backlog, most notably at the ALJ (level 3) level. Importantly, none of these Part A complex review denials contested a need for the medical care delivered, demonstrating that much of the RAC process at the hospitals focused exclusively on the nuances of medical necessity and variation in interpretation of CMS guidelines that related to

whether hospital care should be provided under inpatient or outpatient status.

These data also show continued aggressive RAC audit activity despite an increasing overturn rate in favor of the hospitals in discussion or on appeal each year (from 36.0% in 2010 to 68.0% in 2013). The majority of the hospitals' successful decisions occurred in the discussion period, when the hospital had the opportunity to review the denial with the RAC medical director, a physician, prior to beginning the official appeals process. The 33% overturn rate found in the discussion period represents an error rate by the initial RAC auditors that was internally verified by the RAC medical director. The RAC internal error rate was replicated at 3 different RACs, highlighting internal process problems across the RAC system. This is concerning, because the discussion period is not considered part of the formal appeals process, so these cases are not appearing in CMS or OIG reports of RAC activity, leading to an underestimation of the true successful overturned denial rates at the 3 study hospitals, and likely many other hospitals.

The study hospitals are also being denied timely due process and payments for services delivered. The hospitals currently face an appeals process that, on average, far exceeds 500 days. In almost half of the contested overpayment determinations, the hospitals withdrew a case or rebilled Part B, not due to agreement with a RAC determination, but to avoid the lengthy, cumbersome, and expensive appeals process and/or to minimize the risk of losing the amount of the entire Part A claim. This is concerning, as cases withdrawn in the appeals process are considered "improper payments" in federal reports, despite a large number of these cases being withdrawn simply to avoid an inefficient appeals process. Notably, Medicare is not adhering to its own rules, which require appeals to be heard in a timely manner, specifically 60 days for level 1 or 2 appeals, and 90 days for a level 3 appeal,^{6,20} even though the hospitals lost the ability to appeal cases when they missed a deadline. Even if hospitals agreed to the recent 68% settlement offer¹² from CMS, appeals may reaccumulate without auditing reform. As noted earlier, this recent settlement offer came more than a year after the enhanced ability to rebill denied Part A claims for Part B, yet the backlog remains.

This study also showed that a large hospital workforce is required to manage the lengthy audit and appeals process generated by RACs. These staff are paid with funds that could be used to provide direct patient care or internal process improvement. The federal government also directly pays for unchecked RAC activity through the complex appeals process. Any report of dollars that RACs recoup for the federal government should be considered in light of their administrative costs to hospitals and government contractors, and direct costs at the federal level.

This study also showed that RACs audited the 3 institutions differently, despite similar willingness of the hospitals to dispute overpayment determinations and similar hospital success rates in appeals or discussion, suggesting that hospital compliance with Medicare policy was not the driver of variable RAC activity. This variation may be due to factors not apparent in this study, such as variable RAC interpretation of federal policy, a decision of a particular RAC to focus on complex Medicare Part B or automated reviews instead of complex Part A reviews, or RAC workforce differences that are not specific to the hospitals. Regardless, the variation in audit activity suggests that greater transparency and accountability in RAC activity is merited.

Perhaps most importantly, this study highlights factors that may help explain differing auditing and appeals numbers reported by the OIG,⁴ CMS,^{9,13,14} and hospitals.^{15,16} Given the marked increase in RAC activity over the last 4 years, the 2010 and 2011 data included in a recent OIG report⁴ likely do not represent current auditing and appeals practice. With regard to the CMS reports,^{9,13,14} although CMS included FY 2013⁹ activity in its most recent report, it did not account for denials overturned in the discussion period, as these are not technically appeals, even though these are contested cases decided in favor of the hospital. This most recent CMS report⁹ uses overpayment determinations from FY 2013, yet counts appeals and decisions that occurred in 2013, with the comment that these decisions may be for overpayment determinations prior to 2013. The CMS reports also variably combine automated, semiautomated, complex Part A, and complex Part B claims in its reports, making interpretation challenging. Finally, although CMS reported an increase in improper payments recovered from FY 2011¹⁴ (\$939 million) to FY 2012¹³ (\$2.4 billion) to FY 2013⁹ (\$3.75 billion), this is at least partly a reflection of increased RAC activity as demonstrated in this study, and may reflect the fact that many hospitals do not have the resources to continually appeal or choose not to contest these cases based on a financial business decision. Importantly, these numbers now far exceed recoupment in other quality programs, such as the Readmissions Reduction Program (estimated \$428 million next FY),²¹ indicating the increased fiscal impact of the RAC program on hospital reimbursement.

To increase accuracy, future federal reports of auditing and appeals should detail and include cases overturned in the discussion period, and carefully describe the denominator of total audits and appeals given the likelihood that many appeals in a given year will not have a decision in that year. Percent of total Medicare claims subject to complex Part A audit should be stated. Reports should also identify and consider an alternative classification for complex Part A cases the hospital elects to rebill under Medicare Part B, and also detail on what grounds medical

necessity is being contested (eg, whether the actual care delivered was not necessary or if it is an outpatient versus inpatient billing issue). Time spent in the appeals process must also be reported. Complex Part A, complex Part B, semiautomated, and automated reviews should also be considered separately, and dates of reported audits and appeals must be as current as possible in this rapidly changing environment.

In this study, RACs conducted complex Part A audits at a rate 25 times the CMS-reported overall audit rate, confirming complex Part A audits are a particular focus of RAC activity. There was a more than doubling of RAC audits at the study hospitals from the years 2010 - 2011 to 2012 - 2013 and a nearly 3-fold increase in overpayment determinations. Concomitantly, the more than 3-fold increase in appeals and discussion volume over this same time period was consistent with the development of the current national appeals backlog. The 3 study hospitals won a greater percentage of contested cases each year, from approximately one-third of cases in 2010 to two-thirds of cases with decisions in 2013, but there was no appreciable decrease in RAC overpayment determinations over that time period. The majority of successfully challenged cases were won in discussion, favorable decisions for hospitals not appearing in federal appeals reports. Time in appeals exceeded 550 days, causing the hospitals to withdraw some cases to avoid the lengthy appeals process and/or to minimize the risk of losing the amount of the entire Part A claim. The hospitals also lost a small number of appeals by missing a filing deadline, yet there was no reciprocal case concession when the appeals system missed a deadline. RACs found no cases of care at the 3 hospitals that should not have been delivered, but rather challenged the status determination (inpatient vs outpatient) to dispute medical necessity of care delivered. Finally, an average of approximately 5 FTEs at each institution were employed in the audits and appeals process. These data support a need for systematic improvements in the RAC system so that fair, constructive, and cost-efficient surveillance of the Medicare program can be realized.

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