RAC: The Moving Target

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Vice President Business Development
Corporate Compliance Officer
Amphion Medical Solutions

Agenda
- Entities currently auditing hospital billing
- Region B RAC current focus – automated and complex
- Hospital experiences with RAC reviews (acute care and critical access)
- RAC record requests
- Tools to evaluate hospital’s exposure
- Observation status
- Resources required to manage RAC activities
- OIG Mandate to submit correct billing
- Consequences of incorrect billing

Current Environment

CMS update
- Over $1.3 Billion Dollars have been returned to Medicare because of over payments identified by demonstration RACs
- Latest update 06/2010 – 12.7% of claims appealed with 8.2% of claims overturned (66% of those denied)
- Permanent Medicare RAC Audit program has started in all 4 regions
Auditing Entities

RAC (Recovery Audit Contractor)
- Healthcare providers submitting Medicare Part A and B claims
- RAC reimbursement based on contingency fee
- 1% of average monthly claims q 45 days with cap of 300 claims q 45 days
- Appeal rights

Each of the 4 RACs have significantly different lists of MS-DRGs as approved issues

The 4 regions have received CMS approval to perform complex coding review of the following number of MS-DRGs:

As of 5/12/2010:
- Region A: 69 MS-DRGs
- Region B: 195 MS-DRGs
- Region C: 152 MS-DRGs
- Region D: 732 MS-DRGs

Region B RAC Reimbursement
- Paid totally on a contingency fee
- Region B = 12.5% of over and underpayments identified
- No changes = no revenues = out of business!
Auditing Entities

**ZPIC (Zone Program Integrity Contractor)**
- Replaces Program Safeguard Contractor
- Healthcare providers that submit Medicare claims
- ZPIC reimbursement based on set amount in contract
- Can review unlimited claims
- Appeal rights depending on type of finding
- Report findings to CMS, OIG DOJ, FBI

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**MAC (Medicare Administrative Contractor)**
- Healthcare providers that submit Medicare Part A and B claims
- Reimbursed by post-payment activities included within MACs' operating budget
- Can review unlimited claims
- Look back period 1 year without cause, 4 years with cause
- Appeal rights (rebuttal period)

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**CERT (Comprehensive Error Rate Testing)**
- Fiscal intermediaries, MACs or other carriers
- Reimbursed based on a set amount in contract
- Can review unlimited claims; however, claims are randomly selected and naturally limited by type
- Reviews 100,000 claims annually as a minimum
- Appeal rights
MIC (Medicaid Integrity Contractor)
- Healthcare providers that submit Medicaid claims
- Reimbursed on a fee-for-service model. Recouped monies may qualify MICs for bonuses
- Can review unlimited claims
  - AdvanceMed – ongoing review for Wisconsin
  - Health Integrity – audits for Wisconsin
  - No contract yet for education contractor
- Appeal rights (30 day period to review and comment)

Medicaid Integrity Program
- CMS has two broad responsibilities under the Medicaid Integrity Program:
  - To hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues
  - To provide effective support and assistance to States in their efforts to combat Medicaid provider fraud and abuse
  - [http://www.cms.hhs.gov/ProviderAudits/](http://www.cms.hhs.gov/ProviderAudits/)

Introduction
The fraud control game is dynamic, not static. Fraud control is played against opponents: opponents who think creatively and adapt continuously and who relish devising complex strategies; this means that a set of fraud controls that is perfectly satisfactory today may be of no use at all tomorrow, once the game has progressed a little. – Malcolm K. Sparrow

License to Steal: How Fraud Bleeds America’s Health Care System
Auditing Entities

Department of Justice:
“For every dollar spent on investigations, four dollars are recouped”

Region B RAC Current Focus

DRG and coding validation that includes:
- Principal diagnosis
- Major Complication/Comorbidities
- Complication/Comorbidities
- Operative procedure

Automated Review – black and white issues
- Began April 5, 2010
- 14 Issues including:
  - Blood transfusions (billing more than 1 unit per day)
  - Bronchoscopy (billing more than 1 unit per day)
  - IV Hydration (billing more than 1 unit per day)
  - Neulasta (billing in units rather than mgs)
Region B RAC Current Focus

Automated Review – black and white issues
- Transmittals R5610TN, R5710TN, R5730TN allows the RAC to mass deny “similar claims and/or service types” automatically in the Medicare Claim System

Region B RAC Future Focus

Complex reviews scheduled for CY2010 including:
- DME Medical Necessity
- Medical Necessity (within the month)
  - Coding and DRG assignment in critical access hospitals will likely determine which cases are requested by the RAC
- Also, physicians and Parts C & D will begin later in 2010

Hospital Experiences with RAC Reviews

6 hospitals of a hospital system
- 30 charts requested
  - 21 no findings
  - 3 “underpayments”
  - 5 “overpayments”
  - 17% denial rate

1 community hospital
- 10 ventilator cases requested
  - 8 no findings
  - 2 “overpayments” = $36,000
  - 20% denial rate
Hospital Experiences with RAC Reviews

2 hospitals of a hospital system
- 6 charts requested
  • 5 no findings
  • 1 “overpayment” = $18,000
- 17% denial rate

1 community hospital
- 10 charts requested first time
  • 8 no findings
  • 2 “overpayments” = $36,000
- 20% denial rate
- 158 charts requested second time!

RAC Record Requests

CMS 2010 Institution Guidelines for Additional Documentation Limits for RAC Program
• Limits will be set by each RAC on an annual basis to establish a cap per campus on the maximum number of medical records that may be requested per 45-day period
• A “campus unit” may consist of one or more separate facilities/practices under a single organizational umbrella
• 1% of all claims submitted for the previous calendar year (2008) divided into eight periods (45 days)
• Limits will be applied across all claim types, including professional services

RAC Record Requests

2 caps for FY2010
• Through March 2010 the cap will remain at 200 additional documentation requests per 45 days for all providers/suppliers
• April through September 2010, providers/suppliers who bill in excess of 100,000 claims to Medicare (per Tax Identification Number) will have a cap of 300 additional documentation requests per campus unit, per 45 days
CMS will allow RACs to request permission to exceed the cap
- The expanded cap will not be automatic
- RACs must request approval from CMS on a case-by-case basis
- Affected providers will be notified prior to receiving additional requests

A 25 bed critical access Wisconsin hospital
- Annual 2008 Medicare encounters under campus umbrella
  - Inpatient: 750
  - Outpatient: 39,000
  - Clinic Encounters: 31,500
  - Rehab Visits: 3,750
- Total: 75,000
- x 1% = 750
- ÷ 8 = 94 records q 45 days

A 25 bed critical access Wisconsin hospital
- Annual 2008 Medicare encounters under campus umbrella
  - Inpatient: 807
  - Outpatient: 23,585
  - Clinic Encounters: 0
  - Rehab Visits: 3,183
- Total: 26,768
- x 1% = 268
- ÷ 8 = 33 records q 45 days
RAC Record Requests

A 204 bed Wisconsin community hospital
- Annual 2008 Medicare encounters under campus umbrella
  - Inpatient: 1,602
  - Outpatient: 8,812
  - Clinic Encounters: 52,116
  - Rehab Visits: 3,542
- Total: 66,074
  \[ \times 1\% \]
  \[ \div 8 \]
- 83 records q 45 days

Tools to Evaluate Hospital's Exposure

Has a RAC audit committee been formed?
- What have you done thus far to prepare?
  - Benchmark analysis?
  - Risk analysis?
  - Any conclusions reached?

What are you doing to prepare for audit?
- Medical necessity screening process?
- Coding audits?
- Chargemaster reviews?

Tools to Evaluate Hospital's Exposure

One Day Stays

XX Hospital
Distribution of Medicare Discharges by Length of Stay
1/1/2007-12/31/2009

<table>
<thead>
<tr>
<th>Length of Stay</th>
<th># Medicare Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day</td>
<td>27</td>
</tr>
<tr>
<td>2 days</td>
<td>54</td>
</tr>
<tr>
<td>3 days</td>
<td>21</td>
</tr>
<tr>
<td>4 days</td>
<td>18</td>
</tr>
<tr>
<td>5 days</td>
<td>11</td>
</tr>
<tr>
<td>6 days</td>
<td>6</td>
</tr>
<tr>
<td>7 days</td>
<td>5</td>
</tr>
<tr>
<td>8 days</td>
<td>2</td>
</tr>
<tr>
<td>9 days</td>
<td>3</td>
</tr>
<tr>
<td>10 days</td>
<td>1</td>
</tr>
<tr>
<td>11 days</td>
<td>2</td>
</tr>
<tr>
<td>12 days</td>
<td>1</td>
</tr>
<tr>
<td>13 days</td>
<td></td>
</tr>
</tbody>
</table>
Tools to Evaluate Hospital's Exposure

One Day Stays
- MS-DRG 69: Transient ischemia
- MS-DRGs 190, 191, 192: Chronic obstructive pulmonary disease w MCC, w CC, w/o CC/MCC
- MS-DRGs 291, 292, 293: Heart failure and shock w MCC, w CC, w/o MCC/CC
- MS-DRG 313: Chest pain
- MS-DRGs 391-392: Esophagitis, gastroenteritis & misc digest disorders w MCC, w/o MCC
- MS-DRGs 551, 552: Medical back problems w MCC, w/o MCC

Tools to Evaluate Hospital's Exposure

Two day stays discharged "home" with no scheduled follow-up
- MS-DRG 69: Transient ischemia
- MS-DRG 70: Chronic obstructive pulmonary disease
- MS-DRG 190: Chronic obstructive pulmonary disease w/w CC/MCC
- MS-DRGs 301-320: Other unspecified medical/surgical procedures
Tools to Evaluate Hospital’s Exposure

**Observation**

**Trending % of XX Hospital’s Medicare Obs Patients to Inpatients**

<table>
<thead>
<tr>
<th>Date</th>
<th>% Medicare Obs Patients to Inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/2007</td>
<td>16.0%</td>
</tr>
<tr>
<td>03/31/2009</td>
<td>18.0%</td>
</tr>
<tr>
<td>10/01/2007</td>
<td>20.0%</td>
</tr>
<tr>
<td>03/31/2009</td>
<td>20.0%</td>
</tr>
<tr>
<td>10/01/2007</td>
<td>16.0%</td>
</tr>
<tr>
<td>03/31/2009</td>
<td>18.0%</td>
</tr>
<tr>
<td>10/01/2007</td>
<td>20.0%</td>
</tr>
<tr>
<td>03/31/2009</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

**Trending LOS (in hours) for XX Hospital’s Medicare Observation Patients**

<table>
<thead>
<tr>
<th>Date</th>
<th>Average LOS in hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/07</td>
<td>34.8 34.8 35.2 36.2 37.1 37.2 38.1 38.4 38.8 39.4 39.6 40.1 40.4 41.3 42.2</td>
</tr>
<tr>
<td>03/09</td>
<td>34.8 34.8 35.2 36.2 37.1 37.2 38.1 38.4 38.8 39.4 39.6 40.1 40.4 41.3 42.2</td>
</tr>
</tbody>
</table>

**What is Observation?**

- Observation Status is an ongoing short-term period for active treatment, assessment and reassessment to allow time to decide if a patient should be admitted to inpatient or be discharged.
Why Use Observation:

- The Federal Government has determined that many one day stays did not meet inpatient criteria and should have been placed into the observation status.
- Wisconsin is above the National average for the number of one day stays.
- CMS is monitoring hospitals' one day admits to determine if the admission was appropriate. Correct status is necessary to be compliant and to receive payment for the service.
  - Center for Medicaid & Medicare Services (CMS)

How to determine the correct status:

- CMS and many insurance companies utilize a criteria set to determine the patient’s admission status. It is based on:
  - Severity of Illness (SI) How sick is the patient?
  - Intensity of Service (IS) What did we do for the patient?
- Region B will be using InterQual criteria as well as NCDs and LCDs
- Complete clinical documentation by attending physician is the key to correct determination of status

Who should be assigned to observation?

- Patients who need further assessment to determine if inpatient status is appropriate or if after assessment they could be discharged. Examples might be R/O MI, abdominal pain, dizziness.
- Patient with unexpected prolonged recovery after surgery. An ambulatory patient who needs pain control, develops nausea & vomiting, bleeding, etc.
- Observation status is not for the convenience of the patient, family or physician.
Observation Status

How long can I keep someone in observation?

- Usually 24 hours. A determination to admit or discharge should be made within that time frame. Medicare patients may be in observation for 48 hours. An active treatment plan is required.
- Observation begins when the order is written and ends with the discharge order. The time a patient is waiting for transportation cannot be billed. Document the time in the notes when the patient is ready for discharge.

Observation Status

What needs to be documented?

- A physician order—timed & dated to admit/assign to observation
- The reason for the observation status noted by the physician
- Results of treatments/diagnostics performed
- Frequent documentation by nursing (approx. every four hours) throughout the stay demonstrating the medical necessity for the care
- Physician discharge order must be timed & dated

Observation Status

- Patient status can be changed to inpatient at any time if condition warrants it
- If a Medicare patient does not meet inpatient criteria, the status can be changed to observation status if the patient is still in the hospital and the physician agrees (Documentation must support the changes)
- Observation cannot be ordered before a procedure/surgery
Use of Condition 44 code:
- The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;
- The hospital has not submitted a claim to Medicare for the inpatient admission;
- A physician concurs with the utilization review committee’s decision; and
- The physician’s concurrence with the utilization review committee’s decision is documented in the patient’s medical record.

Resources to Manage RAC Activities
Internal options:
- Multi-disciplinary RAC team
  - Finance
  - Nursing
  - Case management
  - HIM
  - ER
  - OBS
  - Medical staff representation

Resources to Manage RAC Activities
Internal options:
- RAC Coordinator
  - Serves as hospital contact for RAC
  - Responds to all RAC requests
  - Tracks each RAC request and status
  - Coordinates appeals internally and externally
  - Submits RAC data to AHA’s RACTrac
Resources to Manage RAC Activities

- Internal options:
  - American Hospital Association
    - Free web-based survey open to all hospitals regardless of AHA membership
  - Purpose
    - To gather data to quantify the impact the RAC program is having on hospitals
    - [http://www.aha.org/aha/issues/RAC/index.html](http://www.aha.org/aha/issues/RAC/index.html)

Resources to Manage RAC Activities

- WHA support
  - WHA encourages Wisconsin hospitals to participate
  - Data analysis will identify what is happening nationally as well as specifically in Wisconsin
  - WHA will share aggregated information with Wisconsin hospitals

Exploring the Impact of the RAC Program on Hospitals Nationwide

Results of AHA RACTrac Survey, January - March 2010

June 22, 2010
Methodology (cont.)

- AHA Survey: RACTrac: Ongoing Monitoring of RAC Impact on Hospitals
  - 2010 first quarter data were collected from April 1 through April 22, 2010
  - 853 responses were received: 437 reporting activity, 210 reporting no activity
  - Respondents included general medical/surgical acute care hospitals, including critical access hospitals and cancer hospitals, long-term acute care hospitals, inpatient rehabilitation hospitals, and other types of hospitals.
  - 90% were non-teaching hospitals
  - 31% of hospitals were rural
  - 57% of hospitals had a bed size of less than 200

Executive Summary (cont.)

- 64% of responding hospitals report that their RAC impacted their organization in the first quarter of 2010—whether they experienced RAC reviews or not
  - 49% of responding hospitals reported increased administrative costs
  - Managing the RAC process is spread across many types of hospital staff creating significant administrative burden
  - Clerical and other types of staff, including RAC coordinators, spent the most time responding to RAC activity
  - Hospitals are using both internal and external resources to prepare and manage RAC activity
  - 17% of hospitals using external resources reported spending an average of $97,636 to hire an external utilization management consultant

Participation in RACTrac was generally consistent with hospital representation in each of the RAC regions.

<table>
<thead>
<tr>
<th>Hospitals Participating in the RACTrac Survey by RAC Region, 1st Quarter, 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region</td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>B</td>
</tr>
<tr>
<td>C</td>
</tr>
<tr>
<td>D</td>
</tr>
</tbody>
</table>

Region C also had the highest amount of dollars targeted in medical record requests, over $72 million.

Dollar Value of Medical Records Requested from Responding Hospitals, through 1st Quarter 2010, in Millions

Number of Medical Records Requested from Responding Hospitals With RAC Activity, through 1st Quarter 2010

...and the majority of RAC activity during the first quarter of 2010 was medical record requests.
The average dollar value of an automated denial was $709 and the average dollar value of a complex denial was $6,542.

Average Dollar Value of Automated and Complex Denials Among Hospitals Reporting RAC Denials, through 1st Quarter 2010

87% of denied dollars were complex denials.

Percent and Dollar Amounts of Automated Denials Versus Complex Denials, through 1st Quarter 2010

Hospitals are also spending on external resources to deal with RAC activity and 17% of hospitals using external resources reported spending an average of $91,536 to hire an external utilization management consultant.

Percent of Hospitals Using External Resources by Type and Average Dollars* Spent this quarter, 1st Quarter 2010

Source: AHIMA Procedure Coding System

Source: AHIMA Procedure Coding System

Source: AHIMA Procedure Coding System

Source: AHIMA Procedure Coding System
The administrative burden of RAC is spread across all types of hospital staff. Clerical and other types of staff, including RAC coordinators, spent the most time responding to RAC activity.

Average Hours of Staff Time Spent Per Responding Hospital* on RAC by Staff Type, 1st Quarter 2010

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/Pharmaceutical Management</td>
<td>21</td>
</tr>
<tr>
<td>Registration</td>
<td>15</td>
</tr>
<tr>
<td>Financial/Cost</td>
<td>14</td>
</tr>
<tr>
<td>Admit/Cod</td>
<td>14</td>
</tr>
<tr>
<td>Lab/Cust</td>
<td>13</td>
</tr>
<tr>
<td>Case Management</td>
<td>12</td>
</tr>
<tr>
<td>Cath/Monitoring</td>
<td>10</td>
</tr>
<tr>
<td>Cath/Intensive Care</td>
<td>12</td>
</tr>
<tr>
<td>Orth/Patient</td>
<td>8</td>
</tr>
<tr>
<td>Social Services</td>
<td>6</td>
</tr>
<tr>
<td>Other*</td>
<td>3</td>
</tr>
</tbody>
</table>

*Includes responding hospitals with and without RAC activity

84% of responding hospitals reported that RACs impacted their organization during the first quarter of 2010 and 49% reported increased administrative costs.

Impact of RAC on Responding Hospitals* by Type, through 1st Quarter 2010

<table>
<thead>
<tr>
<th>Type</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard administrative change</td>
<td>56%</td>
</tr>
<tr>
<td>Standard administrative errors</td>
<td>40%</td>
</tr>
<tr>
<td>Unpaid administrative change</td>
<td>18%</td>
</tr>
<tr>
<td>Unpaid administrative errors</td>
<td>10%</td>
</tr>
<tr>
<td>Additional administrative change</td>
<td>1%</td>
</tr>
<tr>
<td>Additional administrative errors</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Includes responding hospitals with and without RAC activity

Nearly all hospitals reporting complex denials experienced denials for inpatient coding errors.

Percent of Responding Hospitals with RAC Activity Experiencing Complex Denials by Reason, 1st Quarter 2010

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Coding</td>
<td>50%</td>
</tr>
<tr>
<td>No Documentation</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>

Source: AHA (May 2010), RAC Activity Survey

AHA analysis of survey data collected from 800 hospitals, 407 reporting activity, 20% reporting activity, 31% reporting inactivity, from January to March 2010. Data were collected from general hospitals, psychiatric hospitals, and teaching hospitals. Data from nonacademic hospitals were excluded.
Resources to Manage RAC Activities

Internal options:
- RAC tracking software
  http://www.aha.org/aha/content/2010/pdf/10ractracvendors.pdf

External resources:
- Concurrent or retrospective review of coding and UM
- Focused review
- Denial and appeal process management
  - Letter writing assistance
- Ongoing review of benchmarks
- Education & training for coders and UM staff
- Updating Chargemaster

OIG Mandate to Submit Correct Billing

HIPAA Regulations:
  Public Law 104-191 August 21, 1996
  - Privacy and Confidentiality
  - Insurance portability
  - Subtitle A – Fraud and Abuse Control Program
    - To coordinate Federal, State and local law enforcement programs to control fraud and abuse of health plans
    - To conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States
Office of Inspector General:

- HIPAA Compliance Guidance for Hospitals published in the Federal Register February 23, 1998 and January 31, 2005 strongly recommends auditing billing accuracy prior to bill submission
  - No single “best” hospital compliance program (per OIG guidelines?)
  - The guidelines = OIG’s suggestions on how a hospital can best establish internal controls and monitoring to correct and prevent fraudulent activities.

OIG Mandate to Submit Correct Billing

http://oig.hhs.gov/authorities/docs/cpghosp.pdf

A. Benefits of a Compliance Program

In addition to fulfilling its legal duty to ensure that it is not submitting false or inaccurate claims to government and private payers, a hospital may gain numerous additional benefits by implementing an effective compliance program. Such programs make good business sense in that they help a hospital fulfill its fundamental caregiving mission to patients and the community, and assist hospitals in identifying weaknesses in internal systems and management.
At a minimum, comprehensive compliance programs should include the following seven elements:

1. The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas; and

Some of the special areas of OIG concern include:

- Billing for items or services not actually rendered
- Providing medically unnecessary services
- Upcoding
- DRG creep
- Outpatient services rendered in connection with inpatient stays
- Teaching physician and resident requirements for teaching hospitals
- Duplicate billing
- False cost reports

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Inspector General
OIG Supplemental Compliance Program Guidance for Hospitals
AGENCY: Office of Inspector General (OIG), HHS.
ACTION: Notice.

pp 4858-4876
• Includes but not limited to:
  • Medical necessity of every service including lab, radiology, and DME
  • Appropriateness of setting (IP, OBS, SDS, ER)
  • Units of service
  • Coding
    • ICD-9-CM
    • CPT/HCPCS
    • E/M
    • Chargemaster

Myth: “We are not paid based on coding; therefore, the RACs won’t be looking at critical access hospitals’ coding.”

Fact: RACs will likely identify critical access hospital cases for medical necessity review based on codes assigned and MS-DRG assignment!
Consequences of Incorrect Billing

Substantial economic impact to hospital
- Significant revenue at risk
- Cost to hospital to manage denials
- Cost to hospital to educate coding, utilization management and billing staff
- Increased stress on those performing coding and billing
- Rate of denials can trigger increased scrutiny by the RAC and other entities

Which hospital is the RAC more likely to request the maximum records from in 45 days?
Hospital A:
- RAC requests 10 One Day Stays
- RAC changes 5 of 10 cases to OBS
- RAC denies 5 days’ per diem
  - $1,459 x 5 = $7,295

Hospital B:
- RAC requests 10 One Day Stays
- RAC changes 1 of 10 cases to OBS
- RAC denies 1 days’ per diem
  - $1,459 x 1 = $1,459

Corporate Integrity Agreement (CIA) Work Plans
Focus may include completing an annual report to the OIG that includes:
- Implementation of hospital coding policies and procedures
- Turnover of certain hospital management and coding personnel
- Existence of internal quality assessment monitoring program
- Coding staff fulfillment of continuing education requirements
Consequences of Incorrect Billing

Office of Inspector General

Listing of current CIA's (several hundred)

http://oig.hhs.gov/fraud/cia/cia_list.asp

<table>
<thead>
<tr>
<th>Provider</th>
<th>City</th>
<th>State</th>
<th>Effective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saint Barnabas Healthcare System</td>
<td>West Orange</td>
<td>NJ</td>
<td>06-14-2006</td>
</tr>
<tr>
<td>Saint Elizabeths Hospital</td>
<td>Washington</td>
<td>DC</td>
<td>07-18-2008</td>
</tr>
<tr>
<td>Saint Joseph's Hospital of Atlanta, Inc.</td>
<td>Atlanta</td>
<td>GA</td>
<td>12-19-2007</td>
</tr>
<tr>
<td>San Mateo Medical Center</td>
<td>San Mateo</td>
<td>CA</td>
<td>03-06-2009</td>
</tr>
</tbody>
</table>

The RAC – A Moving Target
Thank you for the opportunity to speak with you today.

If you have questions please contact me at mterlep@amphionmedical.com
715-358-3842 (direct line)