the forecast for RAC extrapolation: mostly cloudy

The recovery audit contractor extrapolation process could transform an overpayment demand from a few thousand dollars into a few hundred thousand dollars. Learn what action steps providers should consider.

Like weather forecasters, healthcare experts and providers are trying to predict the financial impact on the industry should Medicare’s Recovery Audit Contractor (RAC) program begin using extrapolation in future audits. Their concerns are justified: The potential for the use of extrapolation in audits puts substantial money at risk and limits providers’ ability to do anything about it.

Because extrapolation allows the RACs to calculate a total overpayment demand by applying overpayment findings from a sample of a provider’s claims to all of a provider’s claims, the process could transform an overpayment demand of a few thousand dollars into a demand of a few hundred thousand dollars or more. Worse, it could put some providers at risk for bankruptcy.

The rollout of the nationwide RAC program continues to bring significant anxiety to the healthcare industry. Providers are still uncertain about the extent of programmatic operations and audits. With many concerns, including the use of extrapolation, unanswered, providers are left questioning whether their organizations are completely prepared to comply with the program’s demands.

There are several steps providers should take to protect their rights—and their finances.

Past Might Show the Future

Unfortunately, the current statutory and regulatory guidance for RAC extrapolation is hazy at
best. The use of sample auditing by administrative entities is not a new concept. *Chaves County Home Health Services v. Sullivan* (931 F.2d 914, 923 (D.C. Cir. 1991)) shows the U.S. Department of Health and Human Services used the practice as early as 1972. And in 1986, the Centers for Medicare & Medicaid Services (CMS) issued CMS Ruling 86-1 to explain its authority to use statistical sampling, stating that claim-by-claim review is not feasible in cases involving a large amount of claims because of the administrative costs associated with record retrieval and review. Several federal courts have upheld CMS’s authority on the issue.

Although RACs were authorized to use the extrapolation process during the three-year demonstration period for the RAC program, they did not. To use the process, Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 requires the secretary of the U.S. Department of Health and Human Services (HHS) to determine that there existed a “sustained or high level of payment error” or that “documented educational intervention has failed to correct the payment error.”

Determination of a “sustained or high level of payment error” can be made based on error rate determinations by Medicare Review units, program safeguard contractors, zone program integrity contractors, probe samples, data analysis, provider history, the Office of Inspector General audits, as well as other means, according to the *Medicare Program Integrity Manual* (CMS, last modified June 29, 2011, www.cms.gov).

In addition, in determining whether to use statistical sampling instead of claim-by-claim review, a RAC can consider the total number of claims, the dollar amounts tied to those claims, available resources, and cost effectiveness of the sampling results.

What the guideline fails to explain is exactly what constitutes a “sustained or high level of payment error.” Tracing the legislative history of the MMA also offers little insight into the meaning of these terms. Additionally, in 2009, CMS declined to define the phrase. In response to concerns about the vagueness of these terms, CMS explained that it did not specifically define them because it believed that “contractors need the administrative flexibility to determine whether an error rate is ‘high level...or sustained’” (“Termination of Non-Random Prepayment Complex Medical Review.” *Federal Register*, Sept. 26, 2008). CMS further noted that a “variety of factors influence [their] determinations of such payment errors such as the scope of the problem, potential risk to the Trust Fund, the risk relative to other risks identified by contractor data analysis, and past history of the provider or supplier.”

Despite CMS’s apparent promotion of contractor flexibility, RACs cannot make the decision to extrapolate on their own. They must first receive CMS’s approval through the new issue review process. Marie Casey, deputy director of CMS’s Division of Recovery Audit Operations, told the Oklahoma Hospital Association during a question-and-answer session on RAC in 2009 that performing extrapolation is “actually a fairly difficult thing for RACs to do.”

So far, CMS has not approved any issues that can use extrapolation, leaving the threshold for obtaining CMS’s approval unclear.

**The Outlook**

It is clear, however, that once CMS does approve RAC extrapolation, it will be difficult for providers to challenge extrapolated demands. A major roadblock is the apparent inability to challenge the HHS secretary’s determination of a “sustained or high level of payment error” on appeal. A recent Medicare Appeals Council decision, involving Lakeside Foot Clinic of Cornelius, N.C., highlights this issue.

In the Medicare Appeals Council (MAC) decision *Lakeside Foot Clinic*, a Medicare program safeguard contractor selected a random sample of 60 claims from a podiatry clinic (to represent a universe of 8,455 claims) and determined that 13 percent of the sample claims were not covered...
based on lack of medical necessity (www.hhs.gov/dab/divisions/medicareoperations/macdecisions/lakeside_footclinic.pdf). This amounted to an overpayment of $319.02. The program safeguard contractor then extrapolated its findings to all of the claims, resulting in an overpayment demand of $23,656. On appeal, an administrative law judge reversed the overpayment finding, explaining that the program safeguard contractor failed to determine “a sustained or high level of payment error.” However, the MAC vacated and remanded this decision, holding that the administrative law judge erred in invalidating the program safeguard contractor’s sample. The MAC stated that neither the judge nor the MAC could review the HHS secretary’s decision to undertake statistical sampling.

This decision suggests that a high—even absolute—level of deference will be given to the secretary’s determination of a “sustained or high level of payment error.” From a financial and legal perspective, this could place providers at a significant disadvantage. Not only do providers lack clear guidance on what defines a “sustained or high level of payment error,” but they also appear to have no grounds to question it.

Furthermore, a case was filed earlier this year in the U.S. District Court for the District of Columbia challenging whether a Medicare contractor (in place of the HHS secretary) can determine whether there is a “sustained or high level of payment error” (see Gentiva Healthcare Corp. v. Sebelius, Civil Action No. 11–0438 [D.D.C.], filed Feb. 25, 2011). Here, a Medicare contractor used a subsample of 30 claims of a home health agency to extrapolate and calculate an overpayment. The home health agency filed for reconsideration and redetermination and then appealed to the administrative law judge, who upheld the contractor’s use of sampling and extrapolation. The Medicare administrative contractor affirmed, holding that the HHS secretary delegated her authority to the Medicare contractor to make the determination that there was a “sustained or high level of payment error.” The case is pending.

Losing this valuable appeal argument could potentially cause providers to feel that the battle has already been lost. Two defense strategies available to providers—challenging the statistical validity of the RAC’s extrapolation methodology and disputing individual overpayment determinations from the sample claims—present difficulties.

First, mounting a statistical challenge requires that the provider hire a statistical expert, which can be expensive and time-consuming. It also does not address the basic cause for the appeal nor dispute the extrapolated error. In addition, this type of appeal may be difficult to win since the provider has the burden of showing that the contractor’s sampling was invalid. Another complicating factor is that contractors are not strictly bound to using one type of sampling methodology. Although the Medicare Program Integrity Manual outlines specific sampling instructions, it states that a contractor’s failure to comply with its instructions does not necessarily affect the validity of that contractor’s sampling or its overpayment projection (Chapter 3, Sec. 3.10.1.1).

Second, disputing individual overpayment determinations also presents financial and logistical obstacles for providers. For example, the first obstacle in appealing the extrapolation demand from the Lakeside case on a claim-by-claim basis is cost. It may not be financially feasible for a provider to appeal each individual claim due to the low dollar-value of the claims (in Lakeside, about $40 per claim) in relation to the costs associated with record retrieval and review. It also may not be feasible if the records are no longer available or if there are not enough staff members to handle the paperwork.

RACs are not required to notify providers before starting reviews that could result in extrapolated overpayment demands, meaning providers may not even have enough time to plan and prepare appeal strategies.

So what is the forecast for RAC extrapolation? Although providers and healthcare professionals
cannot precisely predict when RACs might implement this process, Casey suggested to the Oklahoma Hospital Association that it will not be implemented immediately: “We don’t anticipate approving any issues in which the RAC would extrapolate on …at least initially. There would have to be some serious steps a RAC would have to take to even utilize extrapolation.”

**Action Steps for Providers**

Nevertheless, as the RAC program develops and becomes more organized, it will probably follow the lead of other Medicare contractors and begin to use extrapolation—especially considering that RACs will receive their full contingency fee for extrapolated claims. To allow providers a better opportunity to protect their rights—and their finances—Congress or CMS needs to announce more clear-cut guidelines about the extrapolation process.

As we have seen in the RAC demonstration, interpretations of CMS regulations and the RAC Scope of Work potentially allow for flaws in contractor behavior and performance. RAC errors have been overturned on Medicare appeal (The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration, CMS, June 2010). Although only 12.7 percent of the RACs’ overpayment determinations were appealed, 64.4 percent of those were favorable to the providers. In these appeals, multiple levels of safeguards were clearly defined and used by providers.

Moving forward, providers should not only understand the extrapolation forecast, but also be able to assess their extrapolation risk and their recourse through regulatory safeguards against contractor error.

Based on all of the open questions related to RAC extrapolation, we strongly recommend that providers be proactive. Providers should work with industry associations to get clarification from CMS on when extrapolation can be used and how a more meaningful appeal process can be established. They also should ask CMS to make the RAC financially liable if extrapolation is abused.

Finally, it is imperative that all providers aggressively appeal all incorrect RAC denials to minimize the potential impact of extrapolation. If providers follow this plan, perhaps RAC extrapolation can be minimized or at least be implemented without the potential for financial disaster for providers.

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