The Praxis Healthcare Solutions, LLC Press

THE PRAXIS DIFFERENTIAL:

We are a revenue recovery and integrity firm that utilizes clinicians, attorneys, coders, and financial experts to resolve problematic claims for our clients. Praxis believes that a combination of motivated staff, cutting-edge technology, and staying well-informed about the current healthcare environment will lead to effective receivables management. This newsletter is designed to assist you and your team in achieving that goal.

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Extras

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Affordable Care Act Update – How Will the Repeal of the ACA Affect Hospitals?

By Kristen Gurley, Esq., RN
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Everyone is keeping a watchful eye on President Donald Trump and his administration's plans to repeal the Affordable Care Act. We at Praxis have been staying abreast of the latest news to be aware any changes and how it might affect our hospital clients. Some experts fear an overhaul may create financial strain and issues in patient safety and overall health care quality. Two hot topics that appear to really have executives, experts, and analysts talking surround the provisions of Medicaid expansion (or, its reversal) and cost-sharing subsidies.

Medicaid Expansion

Medicaid expansion is one of the hot topics and analysts predict changes are likely to have the largest financial impact on hospitals. President Trump's first full budget proposal will include $3.6 trillion in spending cuts to balance the budget in the next decade. The proposed budget will include $610 billion in Medicaid cuts over 10 years. The reduction is in addition to the $839 billion pulled from Medicaid under the proposed American Health Care Act, the ACA repeal and replacement bill that phases out Medicaid expansion. "The Medicaid expansion was the clearest benefit to hospitals from the ACA. Those losses from the elimination of the Medicaid expansion could include $1.057 billion in revenue, which hospitals gained through an increase in Medicaid days of 1,057,730 at all hospitals from 2013 to 2015." Some experts estimate that reduced Medicare and Medicaid payments will present serious challenges to hospitals. Hospitals would have to absorb the cost of uncompensated care associated with these newly uninsured individuals who need and receive hospital care. Current estimates predict that the number of uninsured could rise by 22 million over approximately the next 10 years. Estimates of implications of an ACA repeal are based on the premise that the Medicaid expansion, premium tax credits, cost-sharing subsidies and penalties established under the ACA were the primary drivers of the reduction in the number of uninsured. Many individuals switched to subsidized Marketplace coverage and the Medicaid expansion that was adopted in 31 states and the District of Columbia also played a role. Therefore, if these provisions are repealed, health insurance coverage is likely to result in a loss of coverage for a large number of individuals who had only recently gained coverage under ACA implementation. The Congressional Budget Office score shows that 23 million fewer people will have insurance under the House GOP's plan and that premiums would rise for two years before beginning to fall.

In a recent PBS podcast, several healthcare executives discussed their concerns and fears. Some fear that if large numbers of people lose their insurance under the replacement plan, the hospital's finances would be at risk, especially in smaller and more rural areas. One executive finds it especially concerning since hospitals invested so much money and time in complying with the current health laws. Executives anticipate that a substantial amount of work and effort would be necessary to deal with the changes that may be required in going a completely different direction.

Cost- Sharing Subsidies

Another hot topic in recent headlines is cost-sharing subsidies. The subsidies are paid directly to insurers, and they help trim out-of-pocket costs like deductibles for customers with low incomes. As mentioned above, cost-sharing subsidies established under the ACA was a primary driver in the reduction in the number of uninsured Americans.

The federal government spent $7 billion on cost-sharing subsidies in 2016, however, many consumers aren't aware of this provision. Some health insurers, such as Blue Cross-Blue Shield insurer Anthem, have pressed President Trump and Congress to guarantee a crucial customer subsidy for the insurance exchanges. Months ago, Anthem threatened to leave the exchanges or raise their rates considerably if subsidies are halted. Just recently, Anthem announced that this lack of certainty on cost-sharing subsidy payments was a significant contributing factor in the company's decision to drop individual market insurance offerings in Ohio in 2018, which could leave more than 10,000 Ohio consumers with no individual market coverage options in local areas in 2018. In 2017, 58 percent of enrollees received cost-sharing subsidies. Without more assurances on the continuation of subsidy payments, there is a strong likelihood that other carriers may cease participation in the marketplaces in other states. As the filing deadlines approach very soon, carriers will likely continue to use their participation in the healthcare exchanges as bargaining chips.

The legality of cost-sharing subsidies is being determined in the case now named House v. Price. In 2016, a district court judge sided with House Republicans, ruling that the cost-sharing subsidies were illegal and could not continue. However, the ruling was stayed to allow the Obama Administration to appeal, which they did. For the time being, the lawsuit over cost-sharing subsidies has been put on pause. HHS has been noncommittal on the issue. However, cost-sharing reduction money has continued to flow from HHS to health insurers across the country. Ongoing funding of cost-sharing reductions is still uncertain, and that uncertainty is a great determining factor as insurers look toward 2018.

These are all just estimates of the impact, and we won't truly know the impact on hospitals until a new plan is revealed and passed, which is expected to happen very soon. One thing is for certain: healthcare overhaul will remain an urgent legislative priority of 2017, and we all will continue to keep a watchful eye.

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Success is walking from failure to failures with no loss of enthusiasm

-Winston Churchill

Strategies for Identifying Appeals Processes and Filing Limits

By David Blakeley, Esq.
Senior Attorney for Praxis

Provider Account Representatives must always be aware of appeals deadlines and must not allow them to pass without submission of a formal appeal. In many instances failure to submit a timely appeal will be an absolute bar to recovery of an outstanding claim. This crucial deadline can often be missed by Account Representatives who are attempting to resolve denied claims through phone conversations with the payer. Provider appeals are limited and precious in the modern payer environment, and it is laudable to try to preserve formal appeals through more informal means; however, too often we make call after fruitless call to a payer, trying to save that appeal, until the day arrives when we realize that timely filing for any appeal has passed.

The first crucial element to avoiding missing an appeals deadline is simply to know what it is. There are two questions we need to answer to determine a timely filing deadline – the measure of time the payer allows for appeals, and the point from which that time begins to run. Payers have been steadily shrinking window for submitting appeals. Where once a year seemed to be the standard, now providers may only have ninety or even sixty days to submit appeals. Adding to the uncertainty, the clock for timely appeals can begin to run from different points – usually either from the date of service or from the date of the previous adverse determination.

The second element to avoid missing deadlines is to understand the payer's appeal process. Often, payers will have an informal level of appeal, call a "reconsideration" or "reprocessing," and a formal appeal, variously called "appeals," "claim disputes," "grievances," etc. Account Representatives must be very careful to ensure we understand the terminology of the payer with whom we are working. Payers sometimes treat their informal review process as a first level appeal. Many times, the informal review can be requested multiple times. Also, be aware that different levels of appeal may have different deadlines.

There are a number of ways to obtain the information pertaining to these two issues. Payer representatives will typically be able to answer these questions when we call the payer; however, we do need to treat this information with caution. Payer representatives can, and do, make mistakes. Sometimes we may want to make a second call to reconfirm the information. You should also always ask for call reference numbers from the representatives. A better resource is your managed care database or "payer matrix." We can also review the payer's Provider Manual on its website.

If a payer offers an informal review process prior to formal appeal, by all means, take advantage of it, but always bear in mind that the informal review process often involves only limited review and usually does not toll the period allowed for formal appeals. In my experience, timely filing denials are among the most difficult to overcome. Even where it can be done, you have only added an additional hurdle to overcoming the original denial. So, it is very important that we do not miss the opportunity for a thorough review that a formal appeal provides. To make sure we don't lose that appeal, we must understand the payer's appeals process, including its terminology and number of levels, and know the associated time limits.

Things to Consider When Collecting on Patient Responsibility to Help Your Hospital's Bottom Line

By Brittany Coleman, Esq.
Staff Attorney for Praxis

Our goal at Praxis Healthcare Solutions is to help your facilities recover revenue from insurance companies to help your bottom line. In addition to reviewing your claims and spotting denial trends with insurance companies, we also want to offer

helpful tips or pointers to aid your facilities to collect on patient responsibility portions of your claims.

Does your facility have a pre-payment policy in place?

According to The Advisory Board Company Financial Leadership Council (the "Advisory Board"), this is best method for maximizing your facilities' point-of-service ("POS") collections efforts. You can require a minimum payment of $20 up front from your patients so that you start receiving revenue on claims as soon as possible. Collecting this from all of the patients at your facility can help reduce your bad debt to less than 4% of your net patient revenue ("NPR").[1]

Do you know if your facility provides services to a large number of patients with high deductible health plans?

The Advisory Board recommends that you "know your market" and we agree. Why? Because its analysis of 400,000 patient claims showed that the higher the deductible on a patient's plan, the less likely that the patient will pay on his or her portion of his or health insurance claims. This trend held steady regardless of the patient's income level.[2] Given this trend, your facilities should consider having a modest pre-payment policy in place to help with POS collections reduce the amounts your facility has to absorb or write off.

Is most of your facility's bad debt due to bad debt on outpatient claims?

If the answer to this question is "yes", then your facility should consider methods such as a modest pre-payment policy to help increase revenue for those claims. Per the Advisory Board, outpatient POS collections reflect the largest source of bad debt for facilities as a percentage of NPR.[3]

Does your facility have an installment plan in place for patients to reduce bad debt and assist in your patient responsibility collection efforts?

In "10 things to know about healthcare collections and patient responsibility 2017," author Morgan Haefner writes that more facilities are providing their patients with installment plans for outstanding balances.[4] The article points to Novant Health, which is headquartered in North Carolina, as a successful example facility featured in an April 13, 2017 Reuters article. Reuters reported that after Novant Health offered zero-interest loans to maintain financial stability that Novant Health's patient default rate fell from 32 percent to 12 percent.[5] Providing patients with options to pay their outstanding balances allows patients more time to pay and it allows your facility to collect more revenue on those claims.

Does your facility provide an online payment option or mobile payment systems for medical bills?

In her article, Haefner points out that over 75% of consumers use online payment channels to pay their online bills many patients still receive healthcare bills in the mail. Facilities should consider providing patients with online payment option and/or a mobile payment system, like Apple Pay or Samsung Pay, so that facilities can collect more patient payments.[6]

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Revenue Recovery

U O T I Q B K O A A H W I N M	RECOUPMENT
X X I T Z R R U D E P R C W E	EOB
U B D I B E T N X C E E G J A	REMITTANCE
Y J U Y L S N R B N C S O M D	MEDICARE
X V A W L O E E C A N C V P J	COMPLIANCE
Z E Q Z T L M U R T A I Z Y U	DENIAL
A C O E X U P C U T I N B Y S	APPEAL
A O T X P T U R K I L D K F T	RESCIND
R N U T A I O V A M P E B E M	RESOLUTION
A T A B F O C D J E M N F O E	AUDIT
P R L L F N E C Y R O I K B N	ANALYSIS
P A S U Y A R U A P C A Z D T	CONTRACT
E C B D K S M W E C R L X A B	ADJUSTMENT
A T O W W K I M E D I C A R E	
L W E O Z H P S H I C O T O I	

The DOJ, OIG, and You

By Joyce Varughese, Esq.
Staff Attorney for Praxis

The Department of Justice (DOJ) and the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services are coming down hard on health care facilities that are in violation of the Anti-Kickback Statute. The federal Anti-Kickback Statute 42 U.S.C. § 1320a-7 is a criminal statute that prohibits the exchange or offer to exchange anything of value in an effort to induce referral of services or items that are paid for by a federal health care program, such as Medicare and Medicaid. Furthermore, claims submitted to federal health care programs in violation of the Anti-Kickback Statute also violate the False Claims Act 31 U.S. Code § 3729. The Anti-Kickback Statute applies to all federal health care programs. As this is a very broad statute, the Department of Justice has substantial latitude in determining whether to enforce it against a person or entity.

Deputy Assistant Attorney General Joyce R. Branda for the Civil Division states "The payment of illegal remuneration to induce patient referrals interferes with health care providers' independent judgment when they make referral decisions for their patients… We will continue to pursue health care providers that engage in such conduct, which undermines public confidence in our health care system.[1] Violation of the Anti-Kickback Statute and False Claims Act may result in extremely steep penalties. Conviction for a single violation under the Anti-Kickback Statute may result in a fine of up to $25,000 and imprisonment for up to five (5) years. *See* 42 U.S.C. § 1320a-7b(b). In addition, conviction results in mandatory exclusion from participation in federal health care programs. 42 U.S.C. § 1320a-7(a). Absent a conviction, individuals who violate the Anti-Kickback Statute may still face exclusion from federal health care programs at the discretion of the Secretary of Health and Human Services. 42 U.S.C. § 1320a-7(b). The government may also assess civil money penalties, which could result in treble damages plus $50,000 for each violation of the Anti-Kickback Statute. 42 U.S.C § 1320a-7a(a)(7). Although the Anti-Kickback Statute does not afford a private right of action, the False Claims Act permits individuals to bring qui tam actions alleging violations of the Anti-Kickback Statute. *See* 31 U.S.C. §§ 3729–3733. When a private citizen sues on behalf of the Federal government and is successful, they receive a percentage of the ultimate recovery for their "whistleblower" efforts.

In April of this year, U.S. Attorney John Parker of the Northern District of Texas announced International Tutoring Services, LLC and Curo Health Services agreed to pay $12.2 million to settle such claims.[2] These allegations were first brought to the attention of the federal government by whistleblowers, who now stand to be compensated heavily for their efforts. Health care facilities should err on the side of caution to avoid such claims. In *United States v. Greber*, the landmark case regarding the scope of the Anti-Kickback Statute, the U.S. Court of Appeals for the Third Circuit established the "one purpose" test. Under the "one purpose" test, "if one purpose of the payment was to induce future referrals, the Medicare statute has been violated."[3] This test has also been adopted by the Fifth, Ninth, and Tenth Circuits and is an effective method to avoid kickbacks.

There are certainly Safe Harbor regulations in place under 42 CFR 1001.952 that protect business practice that could otherwise potentially implicate the Anti-Kickback statute. It is important to ensure the legal and compliance departments are constantly monitoring all practices that could be considered a kickback are protected under these safeguards. The OIG's website, currently located at www.oig.hhs.gov, provides the most up to date information on fraud detection, prevention, Anti-Kickback Statute safe harbors, fraud alerts, and advisory opinions to assist with this process. Take action now to ensure compliance or pay for it later!

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Be the change that you wish to see in the world

-Mahatma Gandhi

Go Bananas with Bananas

With summer fast approaching, it's time to beat the heat with something cool, sweet, and VEGAN!

Banana "Ice Cream"

Step 1: Freeze peeled and sliced bananas overnight (2-3 whole bananas).

Step 2: Add frozen bananas to a blender or food processor and blend.

Step 3: Optional, add berries or other flavor enhancers of your choice like honey, nuts, and/or vanilla bean.

Step 4: Blend until the base turns creamy.

Step 5: Enjoy your tasty treat with none of the guilt!

Low Calorie Banana "Pina Colada"

Step 1: Puree the following: 2 bananas, 1 cup diced pineapple, 1 cup pineapple juice, ½-1 cup coconut milk, and 3 cups of ice cubes.

Step 2: Divide among 4 glasses and garnish with pineapple wedges.

Step 3: Voila! Your waist and taste buds will thank you!

WATCH OUT!

With the Affordable Care Act in the news, scammers are on the prowl to obtain financial information through phone calls, emails, texts, and mailing letters. These scams include: charging for assistance with obtaining new insurance coverage and medical discounts, posing as insurance agents to obtain personal and financial information from consumers, and contacting consumers under false pretenses concerning their Medicare cards. Never give your personal and financial information unless you can verify the identity of the person who contacted you. Furthermore, it is illegal to charge you for assistance with obtaining health insurance. You do not need a new Medicare card and will not lose coverage for refusing to update your information over the phone. Call 1-800-MEDICARE before you give out any information.

REPORT ANY SCAMS YOU SEE TO THE FEDERAL TRADE COMMISSION:

Call 1-877-FTC-HELP (1-877-382-4357) or go to ftc.gov/complaint.