Reimbursement and Payor Dispute Update

POLSINELLI REIMBURSEMENT TEAM NEWSLETTER

CMS Reimbursement FAQs — COVID-19

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Introduction

CMS has taken extensive measures to assist providers and promote access to care in light of the Public Health Emergency (PHE) related to the COVID-19 pandemic. The efforts taken have and continue to benefit providers and patients across the country, however, the influx of information and the pace at which CMS releases it can be overwhelming. As a result, Polsinelli has compiled a list of frequently asked questions and answers related to CMS waivers and flexibilities around reimbursement, coverage, and billing. Key topics include originating site fee, telehealth services, specimen collection and modifier use, among others. This guidance is current as of the date of this newsletter. As guidance is still shifting, we encourage providers to confirm nothing has changed prior to relying on the below.

Telehealth

When is it appropriate to report the Originating Site facility fee code Q3014?

HCPCS code Q3014 describes the Medicare telehealth originating sites facility fee. A hospital may bill the originating site facility fee when a physician who typically furnishes care in a hospital outpatient department furnishes telehealth to a registered outpatient of the hospital The code is appropriate when: (1) the patient is a registered outpatient, and (2) the service is furnished in the hospital or a provider-based department of the hospital.

As a result of the PHE the provider-based rules have been waived. Therefore, any location, including a patient's home, that is registered as a provider-based department is considered appropriate for meeting the condition that the service must be furnished in the hospital. If the service is furnished in the hospital and the patient is a registered outpatient it is appropriate to bill Q3014, the originating site facility fee.

What place of service (POS) code and modifiers should providers/suppliers use for telehealth claims?

Practitioners providing the professional component of telehealth services during the PHE should use the POS code that they would have otherwise reported had the service been furnished in person. Modifier 95 should be appended to all PHE telehealth claims.

COVID-19: What Your Business Needs To Know

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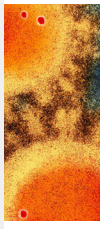

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Modifiers Related to Waivers

When is it appropriate to use condition code "DR?"

The DR condition code is required on all claims where Medicare payment is based on the presence of a formal waiver. The DR code is for institutional providers only and must be used at the claim level when all of the services/items billed on the claim are related to a COVID-19 waiver. If an institutional provider is receiving payment from Medicare due to a formal waiver issued as a result of the PHE, and all of the services billed are related to the waiver, the DR condition code should be applied to the claim. Medicare will not deny claims if the DR code is present but used inaccurately. Note: The DR condition code is not for telehealth services, even if those services are related to a COVID-19 waiver.

When is it appropriate to use modifier "CR?"

Similar to the DR condition code, the CR modifier is mandatory where Medicare payment is based on a formal waiver. However, unlike the DR condition code, the CR modifier is used by both institutional and non-institutional providers to identify Part B line item services/items that are related to a COVID-19 waiver. Medicare will not deny claims due to the presence of this modifier for services/items not related to a COVID-19 waiver. Note: The CR modifier should not be used for telehealth services, even if those services are related to a COVID-19 waiver.

When is it appropriate to use the "CS" modifier?

The CS modifier should be used by outpatient providers, physicians, and other providers and suppliers that bill Medicare Part B for COVID-19 testing related services. The services include: (1) Services that result in an order for or administration of a COVID-19 test, (2) Services that are related to furnishing or administering a COVID-19 test, or (3) Services for evaluation of an individual for purposes of determining the need for a test. Medicare beneficiaries should not be charged any co-insurance and/or deductible for these services. The CS modifier does not apply to inpatient services.

COVID-19 Specimen Collection and Testing

Can hospitals bill Medicare for the specimen collection fee (G2023 and G2024)?

Hospitals cannot bill using HCPCS codes G2023 or G2024, but there are limited instances when hospitals can perform and bill for specimen collection. G2023 and G2024 are used by independent laboratories to bill for specimen collection by trained laboratory personnel collecting samples from either homebound or non-hospital Part B inpatients (e.g., Part B SNF stay). Medicare also pays a travel allowance to laboratories performing specimen collection.

Hospitals may perform specimen collection using personnel appropriately qualified under state law, and are doing so at main hospital locations, temporary expansion locations, and drive-thru testing sites. During the PHE, hospitals may bill for the specimen collection services as hospital outpatient services with new code C9803. Consistent with Medicare Outpatient Prospective Payment System (OPPS) policy, Medicare will only make a separate payment to the hospital for the specimen collection if it is furnished as a stand-alone service (i.e., not furnished with more significant services in the same encounter) or if it is furnished only with a clinical diagnostic laboratory test. Specimen collection related to Part A inpatient stays would be covered and paid for as part of the hospital's IPPS payment and there would be no separate collection reported.

Can hospitals and other non-lab provider-types bill Medicare for COVID-19 testing and, if so, what CPT/HCPCS codes should we use?

CMS guidance related to who can bill for COVID-19 testing itself has been complicated and we recommend seeking guidance as to whether your entity can perform and bill for COVID-19 testing and, if so, what CPT/HCPCS codes should be used.

In general, Medicare payment is available for COVID-19 testing performed by an entity that is (1) certified by CLIA, (2) licensed under state law to perform lab tests, if required, and (3) enrolled in Medicare as a provider or supplier qualified to bill for lab tests. For CLIA certification purposes, laboratory testing is divided into three categories: (1) waived tests, (2) tests of moderate complexity, and (3) tests of high complexity. There are a variety of COVID tests available in the market, and each test authorized for use by the FDA falls within one of those categories. To perform a particular test, an entity must be CLIA certified to perform the appropriate level of testing.

Assuming an entity meets the above requirements in order to bill for COVID-19-related testing, determining the appropriate CPT/HCPCS code depends on the type of test used. In general, Medicare pays for outpatient COVID-19 laboratory tests based on the Clinical Laboratory Fee Schedule. While

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pricing for some tests varies based on jurisdiction and is set by the MAC, through a CMS Ruling, CMS has decided to pay a uniformly higher amount ($100) for COVID-19 diagnostic tests involving "high throughput machines," meaning a testing platform that processes more than 200 specimens per day. CMS has created special codes to identify these tests, U0003 and U0004. Other codes are available for testing that does not use high throughput machines, including, but not limited to:

- 87635 (Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique);
- 86769 (Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]));
- 86328 (Immunoassay for infectious agent antibody(ies), qualitative or semi-quantitative, single step method (e.g., reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])); and
- 87426 (Infectious agent antigen detection by immunoassay technique, qualitative or semi-quantitative, multiple-step method; severe acute respiratory syndrome coronavirus (eg, SARS-CoV, SARS-CoV-2 [COVID19]).

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RHCs and FQHCs

Can RHCs and FQHCs bill for online digital evaluation and management services? What are the rates?

Yes, RHCs and FQHCs can bill for online digital evaluation and management services using HCPCS code G0071. The new payment rate is $24.76, effective March 1, 2020.

Hospital/Skilled Nursing Facilities (SNF)

Is additional payment available to hospitals that render care to SNF patients, requiring care at less than an acute level, that are unable to be transferred to a SNF due to the COVID-19 emergency?

Yes. If the initial patient admission was appropriate for Part A payment, Medicare will pay the DRG rate and any outlier costs for the entire stay until the patient can be moved to an appropriate facility.

Accelerated and Advanced Payments:

When will recoupment begin for the Accelerated and Advance Payment (AAP) program?

Typically, recoupment of AAP payments will begin 120 days after issuance of the payment. The repayment timeline depends on provider type, however, with inpatient acute care hospitals, children's hospitals, certain cancer hospitals and critical access hospitals having one (1) year to repay the balance, and all other providers/suppliers having 210 days to repay. Repayment of the AAP amounts will happen automatically through a claims recoupment process. Thus, for a hospital, the MAC will begin offsetting claims payments to recoup the AAP amounts starting at 120 days from issuance. One year after the AAP issuance, the MAC will determine what amounts remain, if any, and will send a letter seeking direct payment of any remaining amounts, if necessary.

State Court Reverses Medicaid Overpayment Demands

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Providers are not liable for Medicaid overpayments based on imperfect or missing documentation alone according to the Supreme Court of Wisconsin in *Papa and Professional Homecare Providers, Inc. v. the Wisconsin Department of Health Services, 2020 WI 66, --- Wis. 2d ---, --- N.W.2d ---* (*Papa*). In the *Papa* case, Medicaid providers argued that the Wisconsin Medicaid Agency had repeatedly attempted to enforce a policy that medical records must be perfect in order for providers to retain payment for services furnished to Wisconsin Medicaid Beneficiaries. When auditors found imperfections in providers' records, Wisconsin Medicaid would recoup payments previously made for Medicaid services.

The *Papa* court rightly noted that Wisconsin Medicaid is required to abide by rules and regulations imposed by the federal government in return for federal funding for health care services.

> *"The State of Wisconsin has joined the federal Medicaid system, and has consequently committed itself to following the federal law governing that system."*
>
> -*Id.*, at ¶ 4
> (internal *quotations omitted)*

While Wisconsin Medicaid is required to audit Medicaid providers, and to recoup overpayments; the rules relied upon to recoup payments made to Medicaid providers did not support a requirement for perfect recordkeeping.

> *"The difference between imperfect records and no records at all is a significant one."*
>
> Id., at ¶ 38

Examples of imperfect records that did not create an overpayment or otherwise support recoupment from providers in Wisconsin included:

- Failure to counter-sign orders,
- Failure to bill other payors prior to billing Medicaid for Medicaid covered services, and
- Missing elements of a record when covered services were otherwise demonstrably furnished.

Medical records need not be perfect for providers to be paid and retain reimbursement for services furnished to Wisconsin Medicaid beneficiaries. Recoupment of Medicaid payments should occur only if the Medicaid program cannot verify from the provider's records that a service was actually provided or the amount claimed (or paid) was inaccurate or inappropriate. Though the *Papa* case only directly applies to Wisconsin Medicaid, providers across the country facing an overpayment demand or recoupment should carefully review the claims at issue to determine if an appeal could be successful.

Providers are not liable for Medicaid overpayments based on imperfect or missing documentation alone according to the Supreme Court of Wisconsin.

Unemployed and Uninsured: Can Hospitals Cover Patients' COBRA Premiums?

The economic impact of the COVID-19 virus has caused millions to lose their jobs and, along with it, their health insurance. Electing to continue coverage through COBRA is an option, but many times an option that is not affordable for people with no income. Hospitals can now expect to see a surge of patients that are in exactly this position. Can a hospital opt to pay the patients' COBRA premiums in order to assure payment for its services? The answer is that it depends on the circumstances.

Public hospitals that are the regional "safety net" hospitals are required to accept the patient regardless of the patient's ability to pay. If the patient has no insurance and is not able to pay, the hospital has options such as enrolling the patient in Medicaid if the patient is eligible, or including the patient in its indigent care program. For these hospitals, paying the patient's COBRA premium would not be an attempt to attract the patient to the hospital, since the patient must be accepted regardless of ability to pay. Instead, paying the COBRA premium would be just another way to assure that the hospital is paid for its services.

Further, once the COBRA coverage is in effect, the patient would be free to get treatment at any facility of his/her choosing, assuming the hospital did not condition payment of the premium on being the patient's exclusive provider. In fact, many hospitals openly make this their policy. There can, however, be concerns that paying a patient's COBRA premiums is a way of inducing the patient's patronage.

While the COBRA law is a federal law, COBRA insurance is not a federal health care program because no part of it is paid for by state or federal dollars. Therefore, the federal health care fraud and abuse laws that apply to Medicare and Medicaid are not applicable to COBRA. And neither CMS nor the OIG has adopted an express prohibition on the practice of hospitals paying patients' COBRA premiums.[1] The IRS has, in its 1999 Final Rule on Continuation Coverage Requirements Applicable to Group Health Plans, squarely addressed the issue by stating "Nothing in the statute requires the qualified beneficiary to pay the amount required by the plan; the statute merely permits the plan to require that payment be made." They go on to state that "any person may make the required payment on behalf of the qualified beneficiary."

To be clear though, this is only the position of the IRS and not other governmental agencies.

The issue may also depend on the state the hospital is in. States can have their own health care fraud and abuse laws that are applicable to commercial insurance. Local health care counsel should be consulted to determine if there are such laws and how they impact this practice. If faced with whether or not this would be permissible for your facility, considerations would include:

- Whether or not paying the COBRA premiums is intended to induce patient patronage as opposed to just assuring payment for services.
- Whether or not your facility accepts patients regardless of ability to pay.
- Whether or not your contracts with payers prohibit the practice.
- Any applicable state law.

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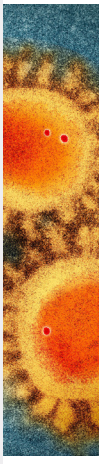

[1]Note that this article address payment of COBRA premiums under employer-sponsored plans. It does not address Federal Marketplace individual policies, which are federally funded.

CMS "Hospitals Without Walls" Flexibilities

New Opportunities and Risks

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One of the most frightening risks of the COVID-19 pandemic is the potential for health systems to become overwhelmed. Many regions of the country have seen rapid, often unpredictable increases of cases requiring intensive care and extended hospitalization, prompting serious concerns about bed capacity. In an effort to allow hospitals to maximize capacity and create more effective physical separation between COVID-19 and non-COVID-19 patients, CMS has authorized new regulatory flexibility to support "hospitals without walls" models. In theory, these models will allow hospitals to provide hospital-level care for patients in non-traditional settings including their homes. However, in practice hospitals should be aware of a number of open issues and regulatory complexities involved with delivering care in such locations.

In an interim final rule (CMS-5531-IFC, published at 85 Fed Reg 27550 on May 8, 2020) CMS used its special Pubic Health Emergency waiver authority under Section 1135(b) of the Social Security Act to authorize hospitals to provide care in "temporary expansion sites." This technically involves changes to several regulatory frameworks.

First, CMS waived a number of the hospital "conditions of participation" (or CoPs). These rules reflect the minimum standards hospitals must meet in order to receive Medicare reimbursement for hospital services. CMS did not waive all of the CoPs, but it waived important rules including provisions on the "physical environment" hospitals must maintain. Any location still must be consistent with a state's emergency preparedness or pandemic response plan.

Second, CMS used its waiver authority to create a number of changes to the rules on provider-based hospital locations. Last year, CMS finalized rules allowing temporary relocation of provider-based sites during traditional, time-limited emergencies (such as hurricanes). A hospital could apply to its CMS Regional Office (RO) for permission to temporarily relocate a provider-based location, although the RO had discretion to approve or deny such a request. For purposes of COVID-19, CMS builds on this flexibility to allow a broad expansion of hospital locations. Relocations of an on-campus or "excepted" provider-based off-campus department must still be approved by the RO, but a hospital may relocate an "unexcepted" provider-based off-campus department without any additional approval. (A provider-based department is "excepted" if it was established before January 1, 2017, and can bill a facility fee under the Hospital Outpatient Prospective Payment System) CMS also stated that inpatient departments can take advantage of this flexibility, although the agency was silent on any notice obligation.

Further, a single department may now be split between multiple locations, so that a hospital could theoretically extend the enrollment of one of its hospital outpatient departments to cover multiple patients' homes. These flexibilities raise

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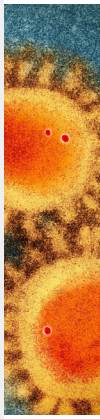

the exciting possibility of providing hospital-level care in patients' own homes, potentially reducing infection risk, preserving hospital capacity for the highest-acuity patients, and improving patient satisfaction. However, a number of legal and operational risks continue to exist in this model. The appropriateness of care provided at home will depend on the clinical needs of each patient — patient acuity, co-morbidities, or the nature of required services may make in-home care inappropriate for some patients. As with any departure from traditional practices, a hospital's decision to provide care in a patient's home or other non-traditional location will likely be scrutinized in any future medical malpractice action. CMS's waiver authority also does not affect state law and, in fact, the waivers are expressly conditioned on compliance with state law. Hospitals should carefully review their state licensing rules and other standards to determine whether these rules (including any special Executive Orders or emergency regulations applicable during the pandemic) allow in-home care. Many state laws remain silent on this possibility, but state officials may be willing to work with hospitals to align rules with CMS standards.

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Further, hospitals should be aware that CMS has only waived some — not all — of the CoPs. Medicare still requires hospitals to comply with important rules including requirements around providing 24-hour nursing care and discharge to a "safe environment." The applicability of certain CoPs may depend on the nature of the services to be provided in patients' homes, and a hospital may need to work with CMS to obtain additional clarity on the specific rules applicable to their desired use case.

Finally, the "hospitals without walls" rules are built on the Public Health Emergency waivers, and CMS has not suggested it may extend these rules further. These regulatory considerations will also guide a number of operational considerations. Hospitals may be required to revise staffing obligations, invest in additional technology (particularly telehealth technology), and amend supply agreements to serve a variety of new locations.

While the "hospitals without walls" model may be attractive for certain locations and some kinds of patients, hospitals should be aware of the significant policy, legal, and operational considerations necessary to operate such a model. Working with competent legal counsel will be essential to implementing this kind of structure successfully.

So You Got Your CARES Check, What's Next?

Preparing for Potential Audits Under Provider Relief Fund Awards

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In the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Congress allocated $175 billion in funding for hospitals and other health care providers that are fighting COVID-19. Of that amount, the Department of Health and Human Services (HHS) has allocated $50 billion for the Provider Relief Fund.

That money has been distributed to providers in two tranches: HHS paid the first $30 billion based on the provider's Medicare fee-for-service payments received in 2019; HHS started paying the remaining $20 billion based on an allocation to ensure that a provider's total allocation of the $50 billion fund is proportionate to its 2018 net patient revenue. All providers who received Medicare fee-for-service reimbursements in 2019 were eligible for the distribution of funds, even those who ceased operations as a result of the COVID-19 pandemic. Although providers did not have to apply for funding under the initial $30 billion tranche and the funds are not considered loans, the receipt of funds did come with **Terms and Conditions** (T&Cs). Providers are required to attest to having received Provider Relief Fund payments and accept the T&Cs.

Providers receiving funds under the second tranche of payments are required to accept T&Cs that are nearly identical, and should be prepared for auditors to ask questions some day about their compliance with these T&Cs.

Among the T&Cs applicable to all Provider Relief Funds is a statement that: "Recipient agrees to fully cooperate in all audits the Secretary, Inspector General, or Pandemic Response Accountability Committee conducts to ensure compliance with these Terms and Conditions." While neither HHS nor any Inspector General (IG) or other oversight body has yet issued guidance on the form or substance of any planned audit activity, providers should start preparing now for the possibility that they will be audited. Such preparation should involve a provider:

- Understanding the requirements under the T&Cs and recognizing the areas of compliance most likely to be audited; and
- Ensuring that it has documented compliance with the requirements.

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Primary Compliance Requirements Under the T&CS

Certification of Eligibility to Receive Funds

By accepting the funds, a provider certifies that it is eligible under the requirements, and specifically that it: billed Medicare in 2019; has provided testing or treatment after January 31, 2020, to actual or prospective COVID-19 cases; is not excluded from participation in Medicare or other federal healthcare programs; and does not have its Medicare billing privileges revoked.

Use of Funds

There are broad parameters around the use of the Provider Relief funds and, generally, a provider may use funds only "to prevent, prepare for, and respond to" COVID-19 and to reimburse the provider for losses attributable to COVID-19. Some examples of coverable expenses are: building or construction of temporary structures, leasing of properties, medical supplies and equipment including personal protective equipment and testing supplies, increased workforce and trainings, emergency operation centers, retrofitting facilities, and surge preparation. The T&Cs specifically state that a provider may not use the funds to recover on losses that another source has, or is obligated to, reimburse.

There is also a prohibition on balance billing, and providers should not balance bill any patient for COVID-19 related care or bill for more than the patient would have been charged by an in-network provider. Implicitly, providers may also not use the funds for a purpose wholly unrelated to COVID-19 (e.g., personal use; transferring the funds to a third party for non-COVID-19 purposes).

Reporting

The T&Cs require that a provider submit reports as required by the Secretary of HHS. Therefore, the nature and timing of provider reporting is subject to further guidance. However, the T&Cs specify what appears likely to be the primary reporting mechanism: quarterly reporting from providers that receive more than $150,000 in COVID-19-related relief funding. Within 10 days after the end of each calendar quarter, such provider is required to submit a report to the Secretary of HHS and the Pandemic Response Accountability Committee, detailing: the amounts it has received and spent or obligated; and a list of all projects and activities on which funds were spent or obligated. The provider must also describe each project or activity, and report the number of jobs it has created or retained (if applicable) and detailed information on the sub-contracts and sub-grants that the provider awarded using the funds, including the information required under the Federal Funding Accountability and Transparency Act of 2006.

Recordkeeping

A provider that receives Relief Fund payments is required to maintain its records and financial documentation in accordance with specified provisions of the HHS grant regulations: 45 C.F.R. §§ 75.302 and 75.361-75.365. Though the full details of those financial documentation requirements are beyond the scope of this article, they generally require that federal award recipients: separately identify federal money received and expended, and the associated programs; accurately account for the financial results of each federal award; keep records that adequately reflect the source and use of funds under federal awards; establish an effective system of control over federal funds; track expenditures versus budget on each program; and establish written procedures for payments made under the federal award and determination of allowable costs.

A federal award recipient generally must maintain all required financial and other documentation relating to the award for a period of at least three years. A recipient must allow HHS, Inspectors General, and the Comptroller General to access all records relating to the award for audit or other examination purposes as long as the records are maintained.

Unless qualified by subsequent HHS program instructions, providers should operate on the assumption that all financial documentation and recordkeeping requirements of 45 C.F.R. §§ 75.302 and 75.361-75.365 apply to their receipt and use of the Provider Relief funds.

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Preparing for Potential Audit

A provider that accepts Provider Relief payments should prepare for potential audits by HHS or other oversight bodies by:

- Closely tracking the requirements associated with the funds and
- Ensuring that it has documented its compliance with those obligations.

From a financial management standpoint, a provider will need to provide accountability for the use of the funds to ensure compliance with the conditions imposed on the payment. In order to ensure that it has an auditable trail, each provider should:

- Segregate funds from an accounting perspective to track the direct and indirect and application of the funds to the Provider Relief program;
- Separate the Provider Relief payments from other sources of payments or funds for similar services to ensure they are segregated and avoid potential overlap;
- Set up separate general ledger codes for each funding program or each grant for each entity tax ID number;
- For direct expenses, identify separate cost centers for losses and other costs attributable to COVID-19;
- For indirect expenses, identify and document an appropriate allocation methodology to distribute indirect departmental expenses to COVID-19 accounts;
- Develop and document a methodology to identify lost revenue as a result of COVID-19, including:
  - Accounting for known cancellations of elective procedures or visits;
  - Determining revenue based on decreased admissions;
  - Reviewing year-over-year revenue decrease; and
  - Understanding any trends in recent revenue to determine if there was an increase or decrease that was occurring before COVID-19.

A provider should also have a documented recordkeeping and record-retention policy that is applicable to payments received and obligated or expended. All staff who are responsible for receipt, obligation, and spending of the funds should be trained on the basic compliance obligations under the T&Cs and the recordkeeping and record-retention requirements applicable to financial and other documentation.

Anticipating Provider Relief Fund Audits

Though HHS has not yet provided guidance on the form, frequency, or strategy for audits under the program, there are certain possibilities that can be anticipated at this stage. On one hand, HHS or an Inspector General may target audits based upon the information provided in quarterly reports and focus on, for example, the largest recipients, the recipients who have potential reporting anomalies, or some combination thereof. If HHS has more widespread concerns about fraud or misuse of funds, it could also enact a form of random auditing that would reach a wider range of providers. Given the fairly broad latitude that providers have been given regarding the use of funds, it may be the case that HHS will only audit where it has actionable concerns about egregious violations of the T&Cs — and given the size and scope of the program, HHS' resource constraints may dictate that approach.

A final issue to consider is the potential role of whistleblowers in enforcing the requirements of the T&Cs. Especially if accepting Provider Relief funds may serve as a predicate for liability under the civil False Claims Act (an issue that will no doubt be litigated in the near future), private party enforcement may be a major element in identifying potential cases of non-compliance. If that occurs, a provider receiving an audit request may not know whether the inquiry is routine, or has more serious potential concerns behind it.

Click **here** for additional information about the terms and conditions. Retention of the funds beyond 30 days constitutes acceptance of the terms of conditions. Should you have additional questions, please contact the authors of this article.

ABOUT POLSINELLI'S HEALTH CARE PRACTICE

The Polsinelli Health Care practice represents one of the largest concentrations of health care attorneys and professionals in the nation. From the strength of its national platform, the firm advises clients on the full range of hospital-physician lifecycle and business issues confronting health care providers across the United States.

Recognized as a leader in health care law, the firm was ranked as the 2018 "Law Firm of the Year" in Health Care by *U.S. News & World Report*'s "Best Law Firms" for the second time in four years, and continues to hold the national Tier One ranking in Health Care Law. The practice is currently ranked by the American Health Lawyers Association as the largest health care practice in the nation (*AHLA Connections*, 2019), and is nationally ranked by *Chambers USA* 2019.

As one of the fastest-growing health care practices in the nation, Polsinelli has established a team that includes former in-house counsel of national health care institutions, the Office of Inspector General (OIG), and former Assistant U.S. Attorneys with direct experience in health care fraud investigations. Our group also includes current and former leaders in organizations such as the American Hospital Association. Our strong Washington, D.C., presence allows us to keep the pulse of health care policy and regulatory matters. The team's vast experience in the business and delivery of health care allows our firm to provide clients a broad spectrum of health care law service.

Understanding the nuances of Medicare, Medicaid, private and other payor reimbursement is one of the greatest challenges that providers face in today's quickly changing health care world. The Reimbursement Institute's Advisors help organizations clear those hurdles in aim of providing the best care possible.

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Upcoming Webinars

Health Care Private Equity Basic Training
Tuesday, August 4

Digital Health Series Part 1
Thursday, September 17

Digital Health Series Part 2
Thursday, October 8

Medical Staff Quarterly Update
Wednesday, October 21

Healthcare Dealmakers Quarterly Market Update
Wednesday, October 28

Digital Health Series Part 3
Thursday, October 29

Digital Health Series Part 4
Thursday, November 19

Stay tuned for more information on **Polsinelli's 2021 Reimbursement Summit.**

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