The Virginia AAHAM Insider

A Newsletter by and for the members of the Virginia Chapter of AAHAM

Fall 2014 Volume 32 Issue 1

The President's Message

Hello Virginia AAHAM Members!

I have so much to report from the AAHAM Board for all the activities that have happened or are in the makings right now. What an exciting time!

Most recently we just held our Fall Regional Conference at Fauquier Hospital. We had more than 70 of our friends and colleagues attend this fun and information packed day. I hope everyone enjoyed it as much as I did. Throughout the day we sold tickets for a raffle to benefit the Fauquier Free Clinic. Ticket sales came to an astounding $228.00, which was matched by the chapter. We will be donating $456.00 to the clinic this year on behalf of the chapter and its members. I wish to thank everyone that attended the meeting and participated in the charity raffle. We are so proud of these results and your generosity!

Mark your calendars! The Annual Meeting and Conference for the chapter will be held again this year at the Williamsburg Lodge from December 3rd thru the 5th. This location was hugely popular with our attendees last year due being located in the heart of the colonial section of town. The hotel and conference center are absolutely beautiful and the staff at the hotel are very friendly and attentive. Attendees can easily walk outside the hotel and be surrounded by all the history of this wonderful town. We are in the process of finalizing the agenda for this meeting, so keep an eye out for information to be coming out soon.

Just a few short weeks ago, our friend and fellow board member, Denise Martin resigned from the VA AAHAM Board to relocate to Florida to be closer to family. She will be missed by all of us at VA AAHAM and we wish her all the best. I am very pleased to report that Amanda Sturgeon has accepted an appointment to fill the vacancy of 2nd Vice President. Amanda has extensive experience with the chapter going back many years, to include a position of 2nd VP from 2004-2007. Welcome back Amanda, we are glad you will be joining us!

Are you attending the National AAHAM ANI? It's a great event held each year that attracts more than 500 folks from across the country to network and to learn all the latest in healthcare financial happenings. This year it's being held in San Diego, CA from October 15th thru 17th. If you are interested in going, you'd better hurry and register at www.aaham.org. If you are not able to go, than stay tuned as we will be sending back pictures and updates from the meeting. Also, wish us well at the ANI. Once again, VA AAHAM has entered to win an award for Chapter Excellence. Due to the efforts of all of us at the chapter, we have done well in the past and are hoping to continue to be one of the best in the nation. Other awards are also given out during this multi-day event and we will let you know how we do.

I want to wish all our chapter members who are sitting for one of the upcoming exams (CRCP, CRCS, or CCT) that will be ongoing from November 10th thru the 21st of 2014 the best of luck. We are behind you 100% and are proud of each of you for what you do.

Have a wonderful Fall season everyone and I look forward to seeing you at our Annual Meeting in Williamsburg, if not sooner!

David

David Nicholas, CRCE-I
President, Virginia Chapter of AAHAM

INSIDE THIS ISSUE:

The Virginia AAHAM Insider

2nd Place Winner for Excellence in Journalism

2012-2013 National Journal Award!

What's Next??? APR-DRG

Continued on next page

What's next? We have lived through many dynamic and drastic changes in healthcare that have had both positive and negative impacts on our facility payments and our physician payments. It seems that when CMS designs some methodology regarding services, it affects reimbursement. Over the course of a year or two, the third party insurance companies watch what happens in Medicare and, typically, if they see a reduction in payment streams, they adopt a similar if not the same methodology for many of their plans. CMS (the Center for Medicare and Medicaid Services), as a leader, has always sought ways to reduce facility and physician payments for services as "what they call" – A Reflection of Cost Adjustment.

In the 80's, they developed inpatient DRGs (Diagnosis Related Group) which is diagnostically based. Similar diagnosis have been grouped into estimates of days of care and tied to a national weight factor that supposed to represent the efficiency factor. This weight (geographically adjusted) is then multiplied by the hospital "base rate" that is derived from the Medicare cost report. Over the years, these weights and base rates have been adjusted as a 'reflection of improved efficiency'. Most third party insurance companies have adopted this same methodology for their inpatient reimbursement. In fact, recognizing that the Medicare DRGs did not appropriately address patients under 65, the development of AP-DRGs (All Patient-DRGs) was completed and used for reimbursement.

In the early 90's, CMS addressed the physician reimbursement situation in a similar manner. A study was undertaken regarding the three major components of a physician's practice, namely, malpractice insurance, office expense and physician's time. Each of these components were "weighed" for each CPT (Current Procedure Terminology) and HCPCS (Health Care Procedure Coding System). The weight of each component was added together and then multiplied by the professional fee standard established by geographic region as published in the Federal Register. This also was adopted by third party insurance companies and their "fee schedule" is typically a percentage of the Medicare fee schedule.

In the mid 90's, an outpatient methodology was developed by CMS known as APGs (Ambulatory Patient Group) which was a calculation based on both diagnosis and CPT/HCPCS code. This methodology was adopted by a number of states for their Medicaid programs. However, it was considered a little too cumbersome for national adoption, so further design was continued until the release of the methodology known as APCs (Ambulatory Payment Classification). This methodology grouped various CPT/HCPCS codes together and paid one price for the group. This was easier to implement and in August of 2000, this methodology was implemented. Some third party insurance companies adopted this methodology as well.

To further hinder our reimbursement but in the name of improved clinical service, quality measures were introduced into various methodologies to provide both an incentive and decrease in reimbursement standards based on these measurements. At the same time of these methodology discussions, the adoption and implementation of ICD-10 (International Classification of Diseases – 10th edition) was in progress. With some delays, I believe that CMS will definitely implement ICD-10 in October of 2015 (next year). We are all aware of the apparent changes involved with this new coding system but the simplest words to use in its description is documentation, detail and specificity. These three words will have a tremendous impact on both facility and physician reimbursement going forward. Of course, this is just my prediction but I ask you to consider this...

What's Next??? APR-DRG

Continued on next page

The latest reimbursement methodology that has been developed is known as APR-DRGs (All Patient Defined). The APR-DRGs incorporate severity of illness subclasses into the AP-DRGs. The APR-DRGs expand the basic DRG structure by adding four (4) subclasses to each DRG. The addition of the four subclasses addresses patient differences relating to severity of illness and risk of mortality. The four severity of illness subclasses and the four risk of mortality subclasses are numbered sequentially from 1 to 4 respectively, minor, moderate, major, or extreme severity of illness or risk of mortality. Illness severity of secondary diagnosis occurs through three steps: 1) eliminating secondary diagnoses associated with principal diagnosis; 2) assigning each secondary diagnosis its standard severity of illness level; and 3) modifying the severity of illness level based on age, APR-DRG and principal diagnosis or non-OR procedure.

Sound complicated…It really isn't complicated, it is scary!!!! Just ask yourself, how many claims do you submit with general or non-specific ICD-9 codes today. Ask your HIM department how many ICD-9 codes ending in either .8 or .9 do they put on your claims – both inpatient and outpatient. Ask your HIM department how many physicians add more than three diagnoses to the patient's record. Going forward, both POAs (Present on Admission) and secondary diagnoses are VERY important. I also believe that with the Affordable Care Act in place and the expansion of Medicaid in some states, the Case Mix in some facilities will change and this also has an impact on reimbursement. Let me show you a few graphs to further explain, after all a picture is worth a thousand words

	Future Methodology			APRDRG Weights			
MSDRG		Weight	APR #	1	2	3	4
470	Major joint replacement or reattachment of lower extremity w/o MCC	2.0613	313	1.0621	1.6254	2.8176	7.0611
313	Chest pain	0.5404	203	0.3586	0.451	0.6973	1.9656
392	Esophagitis, gastroent & misc digest disorders w/o MCC	1.6921	220	1.2027	1.9353	3.4738	7.5539
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	1.9121	175	1.4546	1.6351	2.4993	3.8994
885	Psychoses	0.8899	751	0.4768	0.5508	1.4403	1.4765

The above chart shows five (5) MS-DRGs (Medicare Severity) and their current assigned weights. It also shows the crosswalked APR-DRGs and their current assigned weights. Please note that the APR-DRG weights increase as defined – minor, moderate, major, and extreme. These new weights will effect a change to your Case Mix. See the chart below.

What's Next??? APR-DRG

Continued on next page

Future Methodology

MSDRG		Weight	APR #	APRDRG Weights 1	2	3	4
470	Major joint replacement or reattachment of lower extremity w/o MCC	2.0613	313	1.0621	1.6254	2.8176	7.0611
313	Chest pain	0.5404	203	0.3586	0.451	0.6973	1.9656
392	Esophagitis, gastroent & misc digest disorders w/o MCC	1.6921	220	1.2027	1.9353	3.4738	7.5539
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	1.9121	175	1.4546	1.6351	2.4993	3.8994
885	Psychoses	0.8899	751	0.4768	0.5508	1.4403	1.4765
		7.0958		**5.5548**	**8.1976**	**13.9283**	**25.9565**

Case Mix is a calculation of your total weights divided by the number of DRGs for a specified period. This simple chart indicates the possible change to Case Mix based on the new weights of APR-DRGs. If your diagnoses are not specific, you can end up with Level One calculations which lowers your payment ratio. Without an increased focus on detail and specification, most hospitals will probably fall between Level One and Two.

Now what does this mean for reimbursement? It means a lot. You can do the calculation yourself but as an example, the chart below indicates a hospital base rate of $5000.00. Taking the same MSDRGs, please take note of the wide various in reimbursement.

What's Next??? APR-DRG

		Future Methodology					
	Base Rate of $5000			APRDRG	Weights		
MSDRG		Weight	APR #	1	2	3	4
470	Major joint replacement or reattachment of lower extremity w/o MCC	2.0613	313	1.0621	1.6254	2.8176	7.0611
		$ 10,306.50		**$ 5,310.50**	**$ 8,127.00**	**$ 14,088.00**	**$ 35,305.50**
313	Chest pain	0.5404	203	0.3586	0.451	0.6973	1.9656
		$ 2,702.00		**$ 1,793.00**	**$ 2,255.00**	**$ 3,486.50**	**$ 9,828.00**
392	Esophagitis, gastroent & misc digest disorders w/o MCC	1.6921	220	1.2027	1.9353	3.4738	7.5539
		$ 8,460.50		**$ 6,013.50**	**$ 9,676.50**	**$ 17,369.00**	**$ 37,769.50**
247	Perc cardiovasc proc w drug-eluting stent w/o MCC	1.9121	175	1.4546	1.6351	2.4993	3.8994
		$ 9,560.50		**$ 7,273.00**	**$ 8,175.50**	**$ 12,496.50**	**$ 19,497.00**
885	Psychoses	0.8899	751	0.4768	0.5508	1.4403	1.4765
		$ 4,449.50		**$ 2,384.00**	**$ 2,754.00**	**$ 7,201.50**	**$ 7,382.50**

If your coding is consistently at Level One and Two, you will be losing a lot of money. I encourage you to take your top 10 or 15 DRGs and do this same test. Then meet with your HIM Director and talk about the current specificity occurring in your facility. Then, if you are at Level One and Two, make a plan NOW.

What today's physicians do not realize is that this reimbursement methodology of diagnostic specificity will be implemented for their reimbursement as well. Both diagnostic specificity support for the CPT/HCPCS assigned as well as quality measures will dictate their reimbursement in the future. Claims both denied and challenged will involve both the facility review and the physician review. If there is ever a time to thoroughly discuss the importance of documentation, detail and specificity, it is now. If you would like any assistance with this projected reimbursement analysis, please contact Best Practice Associates. Have Fun!!!!

Rob Borchert, Best Practice Associates
rob@bpa-consulting.com or (315) 345 5208

Tim Borchert, Practice Director
Altarum Institute
(703) 328-3953

Claims Payment Automation: How to Make an Educated Choice

Continued on next page

By Priscilla Holland, AAP, Senior Director, NACHA – The Electronic Payments Association

Many providers have found that claims paid by virtual card have increased this year. As a result, the fees they pay for card acceptance have skyrocketed. Does your practice have a planned response to virtual card claims payments? Do you know your rights under the Affordable Care Act (ACA) to a less expensive form of claims payment?

Under the ACA, providers have a number of electronic payment options available to them for claims reimbursements. Options can include the healthcare EFT standard via ACH, credit and virtual card payments, and wire transfers. Each payment type has unique attributes and associated costs, and providers have the ability to choose the payment type that best suits the needs of their practice.

The Healthcare EFT Standard

Similar to Direct Deposit, EFT via ACH enables health plan-to-provider payments that are processed over the ACH Network using the healthcare EFT standard, or the NACHA CCD+ Addenda. Payments made this way include a TRN Reassociation Trace Number, which is used to tie the ACH payment to the appropriate Electronic Remittance Advice (ERA). This allows for the automatic reconciliation of the EFT payment with the ERA.

Other EFT Payment Options

Health plans may offer other EFT payment options, including wire transfer or virtual cards, in addition to the healthcare EFT standard via ACH. Some health plans are replacing all check claims payments with virtual card payments without prior authorization from the provider. A virtual card is a single-use credit card transaction that must be manually entered into the provider's point of sale terminal and manually reconciled with an explanation of benefits (EOB).

Providers should make an informed decision on accepting virtual card claims payments, as these payments shift the cost of payment processing from the health plan to the provider. Credit card rules do not require a provider to accept virtual card payments just because they accept credit cards for patient payments.

Costs of EFT Payments

The costs associated with EFT payments can vary widely. With ACH payments, providers, as small businesses, generally pay their financial institutions a per-transaction fee for each ACH payment directly deposited to their accounts. The average per-transaction cost is $0.34, regardless of the payment amount.

Wire transfers and virtual cards are more costly. The fees associated with wire transfers vary, but the average provider will pay $10.73 regardless of the payment amount. With virtual cards, providers pay an average interchange fee of 3 percent plus a per-transaction fee to process the transactions. Some health plans are being incented by card issuers to switch from check to virtual card payments in exchange for a rebate of up to 1.75 percent of the interchange fee paid by the provider.

Comparing EFT Payment Options

	Healthcare EFT Standard (VIA ACH)	Virtual Card	Wire Transfer
Funds Availability (as measured from the time that a plan initiates payment)	Next day	2-3 business days, plus mail float	Same day
Average Cost to Provider On a $2,500 Claim Payment	$0.34	Percentage of total payment, plus a transaction fee Example: 3 percent average interchange fee on $2,500, plus a $0.10 transaction fee = $75.10	$10.73
Enrollment/Acceptance Process	One time with each health plan	Must have agreement with merchant card processing provider & POS processing system/terminal	One time with each health plan
Risk	Very low risk Financial Institutions can support additional account monitoring tools, such as debit filters or blocks	Higher risk Card numbers have information that can be used by anyone with the ability to accept card payments	Very low risk
Manual Processing	None	Each payment must be processed manually	None
Reassociation Trace Number (TRN)	Standardized inclusion of TRN with ACH payment	Not included with payments. Cannot receive HIPAA-compliant ERA with virtual card payments	No requirement to include TRN with wire transfer—but it can be included in remittance information

Educated Choice

While HIPAA requires health plans to make EFT via ACH available upon request, providers should be cognizant of any restrictions in payment methods when contracting with health plans. They should also avoid signing contracts with inflexible payment terms. Providers who don't wish to accept health plan virtual card payments should educate their office staff to recognize the difference between patient and health plan payments, in order to prevent undesired authorization of health plan virtual card payments.

It is important for providers to understand their rights under HIPAA and the ACA and make an educated decision on how their organization will be paid for claims reimbursements. Lack of understanding and transparency can have a significant impact on the bottom line of the practice.

To learn more, visit https://healthcare.nacha.org.

Priscilla Holland is the Senior Director of Healthcare & Industry Verticals for NACHA. As Senior Director, she leads NACHA's healthcare payments program and works on other payments and remittance information and standards projects. She has more than 20 years of experience in cash management, project management and product development and is an Accredited ACH Professional (AAP) and a permanent Certified Cash Manager (CCM).

Continued on next page

2015 OPPS Proposed Rule Detailed

***Steven Andrews, for HealthLeaders Media* , July 8, 2014**

The 2015 outpatient prospective payment proposed rule from CMS contains refinements to the previously introduced comprehensive ambulatory payment classification policy, significant packaging of ancillary services, and a change for inpatient certification requirements.

The 2015 OPPS proposed rule, released July 3 by CMS, is relatively short at less than 700 pages, but contains refinements to the previously introduced Comprehensive APC policy, significant packaging of ancillary services, and a change for inpatient certification requirements.

"In terms of the volume of changes, it's less than we normally see, but in terms of impact, it's on par with last year's big changes," says Kimberly Anderwood Hoy Baker, JD, director of Medicare and Compliance for HCPro, a division of BLR, in Danvers, Massachusetts.

Jugna Shah, MPH, president of Nimitt Consulting, agrees and encourages hospitals to begin assessing financial impact now in light of CMS' packaging proposals.

Comprehensive APCs

CMS has proposed implementing a concept it finalized in the 2014 OPPS final rule by introducing Comprehensive APCs for device-dependent APCs. With Comprehensive APCs, a single payment will be made rather than separate, individual APC payments, Shah says.

The 2015 OPPS proposed rule includes some lower-cost device-dependent APCs and two new APCs for other procedures and technologies that are either largely device dependent or represent single session services with multiple components. After additional consolidation and restructuring, CMS is now proposing 28 Comprehensive APCs for 2015.

The most significant change to the policy is a proposed "complexity adjustment." The adjustment is applied when a primary procedure assigned to a Comprehensive APC is reported with other specified procedures also assigned to Comprehensive APCs or with a specified packaged add-on code. When the facility reports one of these combinations, CMS will increase the payable APC to the next higher APC in the clinical group, similar to DRGs on the inpatient side.

"This is the first time in OPPS history where we have something like severity adjustment," says Baker.

Device-dependent edits

Instead of eliminating all device-dependent edits, beginning in CY 2015, CMS proposes to require that facilities report a device code for procedures currently assigned to a device-dependent APC.

Under CMS' proposal, the device claims edit would be met by reporting any medical device C code currently listed among the device edits for the CY 2014 device-dependent APCs, rather than reporting a particular device C code(s).

2015 OPPS Proposed Rule Detailed

Continued on next page

"It's nice that CMS heard commenters' concerns about the elimination of all device-to-procedure edits altogether and has instead proposed to retain some level of editing," says Shah. "This is critical to ensure that the agency receives completely coded claims for future rate-setting."

Packaging increases

The rule includes four proposals to continue expanding packaging, a common theme for the OPPS in recent years.

"CMS continues full steam ahead with packaging, and has added an interesting twist to how it's looking at packaging additional services, using a dollar threshold," Shah says.

CMS proposes to package add-on codes assigned to device-dependent APCs (paid separately in CY 2014) starting in CY 2015, since these device-dependent add-on codes will be paid under the Comprehensive APC policy. These codes are listed in Table 9 of the proposed rule.

CMS also proposes to conditionally package ancillary services that have a geometric mean cost of less than or equal to $100 (with some exceptions, including preventive service, counseling/psychiatry, and drug administration services).

Additionally, CMS proposes to eliminate status indicator X (ancillary services). This means that all CPT® codes currently assigned to status indicator X will either be reassigned to status indicator Q1 (conditionally packaged) or S (significant procedure, not discounted).

If finalized, ancillary services with status indicator Q1 will not generate separate payment when provided on the same date of service as another separately payable procedure with a status indicator of S, T (significant procedure, multiple reduction applies), or V (clinic or ED visit), but will generate separate payment if provided on their own.

Providers will need to carefully examine the proposed changes and assess the financial impact of the proposed packaging changes, which will require an examination of claims rather than individual CPT codes or line items, Shah says.

Finally, CMS proposes to package and change the status indicator from A (services furnished to a hospital outpatient paid under a fee schedule or payment system other than OPPS) to N (items and services packaged into APC rates) for all DMEPOS prosthetic supplies.

CMS says this is consistent with the change it finalized for CY 2014 for all non-prosthetic DMEPOS supplies (with the status indicator changed from A to N). If this proposed change is finalized for CY 2015, then all medical and surgical supplies would be packaged in the OPPS.

Physician certification of inpatient services

CMS is proposing several changes to requirements related to inpatient physician certification, according to Baker.

2015 OPPS Proposed Rule Detailed

Although CMS will continue to require a physician order for inpatient services, it will no longer require certification that the stay was medically necessary in most cases. CMS believes that in most cases the admission order, medical record, and progress notes contain sufficient information to support the medical necessity of an inpatient admission without a separate requirement of an additional, formal, physician certification, with two exceptions.

For stays of 20 days or longer and outlier cases, CMS believes physician certification is needed and therefore proposes to require formal physician certification beyond the admission order to substantiate the medical necessity for these cases.

E/M visits

CMS proposed no changes to E/M visit configuration or payment policy methodology in 2015, a year after CMS proposed replacing all E/M visit levels with three HCPCS Level II G-codes. CMS proposes to continue using the single visit G code and existing coding convention for Type A and Type B ED visits, though the agency says it plans on looking at different payment methodologies for the most costly ED trauma-type cases.

Additional proposals

CMS proposed the packaging threshold to remain at $90, the same as CY 2014, and for the average sales price plus 6% remains in effect for all separately payable drugs, biologicals, and radiopharmaceuticals. CMS proposed no changes to packaging of diagnostic radiopharmaceuticals and contrast agents, or the payment methodology of therapeutic radiopharmaceuticals or brachytherapy for 2015.

To better understand the frequency and type of services furnished in provider-based departments in off-campus locations, CMS proposes a new data collection requirement that, if finalized, would impact both physician and hospital reporting, according to Shah.

Specifically, CMS is proposing to collect this information beginning January 1, 2015, by requiring the use of a new HCPCS modifier that would be reported with every code for physician and outpatient hospital services furnished in an off-campus provider-based department of a hospital.

The modifier would be reported on both the CMS-1500 claim form for physician services and the UB-04 form (CMS Form 1450) for hospital outpatient services. CMS is asking for additional public comment on whether the use of a modifier is the best mechanism for collecting this service-level data.

"If providers do not like or support this option, they need to comment now, because this is the second time CMS has asked for comments and alternatives," Shah says. "If they are not provided, it seems very likely that CMS will finalize this."

CMS will accept comments on the proposed rule until September 2, 2014, and will respond to comments in a final rule to be issued on or around November 1, 2014. The proposed rule will appear in the July 14 issue of the Federal Register.

Back

Credit Control Corporation

Financial Receivables Specialists

Cutting Edge Technology

Results

Customer Service

SERVICES

- Bad debt collections with credit reporting options
- Medicare bad debt collections with activity documentation
- Pre-collection programs supporting patient retention
- Budget account management
- 3rd party claims filing capabilities
- Full spectrum reporting
- Secure electronic data exchange
- Multiple skip tracing resources
- Convenient IVR/Web-based payment options available 24/7
- Premier customer and client service

HISTORY

- Extensive collection & accounts receivable management services since 1953
- Experienced collection and support staff
- Flexible programs designed to meet specific client goals
- Long-term client "partnering" relationships
- Engaged management teams

For more information, please contact
Terry Fuller or Rika Gripp at 1.800.723.5463

Ensuring Fair Health Care Collections

Continued on next

With medical debt on the rise and drawing scrutiny from legislators, regulators and consumers, there is a growing possibility of increased regulation of the collection process. Already medical providers and collection agencies have to comply with many federal and state laws governing medical debt, some of which can be confusing or even contradictor.

Section 501(r) of the Internal Revenue Code, which sets requirements for tax-exempt hospitals, as well as the Consumer Financial Protection Bureau's recent medical debt report, have cast a light on medical collections that will continue to change how providers and collectors approach medical debt.

In a May 2014 ACA International teleseminar, Tom Gavinski, vice president of healthcare for I.C. System in Saint Paul, Minn.; Lucia Lebens, director of federal government affairs for ACA International; and Mark Rukavina, principal for Community Health Advisors LLC in Chestnut Hill, Mass., discussed current best practices in fair health care collection and the wide- ranging consumer issues surrounding medical debt.

"Medical debt is seen as something different than other forms of debt," Lebens said. "People don't plan to get sick or have an accident. Medical debt is treated with more sympathy than other kinds of debt, which is why we're seeing more time spent on it from a legislative and regulatory perspective."

Proposed Legislation

As the spotlight on medical debt increases, health care providers should expect to see legislators and regulators continue to look for ways to rein things in.

Gavinski pointed to several consumer trends that have led to an environment ripe for legislative and regulatory action, including the increased use of high- deductible health insurance plans, tighter lending standards, nonstandardized account resolution processes in hospitals and challenges accessing financial assistance.

The Medical Debt Responsibility Act of 2013, which was introduced by Rep. Maxine Waters (D-Calif.), would require consumer reporting agencies to remove any information related to fully paid or settled medical debt from a consumer's credit report within 45 days. Though it is currently stalled in the House, cosponsors have increased since the CFPB's report on medical debt was released last spring.

Additionally, another bill introduced last year, the Accuracy in Reporting Medical Debt Act of 2013, would establish parameters for reporting medical debt to credit bureaus, ensuring medical debts are not prematurely reported before a consumer has time to resolve them

CFPB and Medical Debt

The CFPB has taken a clear interest in medical debt, and has been studying the impact of medical billing on credit scores since 2012.

In May 2014, the CFPB released a report examining how medical debt impacts credit scores. The report found that credit-scoring models might underestimate the creditworthiness of consumers who owe medical debt in collections.

The CFPB has excluded medical debts from much of its work to date. There also remains some question about whether medical debt falls within the bureau's scope under the Dodd-Frank Act..

Ensuring Fair Health Care Collections

You can bet the CFPB is going to further analyze the whole medical billing and collection process, and probably in a proposed rule will set some additional medical requirements relating to medical debt collection," Gavinski said.

501(r) Considerations

The Affordable Care Act added Section 501(r) to the Internal Revenue Service code in 2010. It imposes requirements on 501(c)(3) hospitals that must be followed to maintain their tax- exempt status. In light of these proposed billing and collection rules, hospitals should consider several issues:

- Does the hospital have billing, collection and financial assistance policies in writing? If so, have all parties reviewed the requirements?
- Do hospital policies satisfy federal and state laws?
- Have hospital policies been calibrated with the local marketplace? What kind of coverage is available under the local healthcare marketplace? For instance, did the state in which the hospital is located choose to expand its Medicaid program? If not, hospitals should take the Medicaid gap—and any other special situations in the hospital's marketplace—into account.
- Has the financial assistance policy been widely publicized? The rule says that the policy, a plain-language summary of the policy and an application for assistance should be available on the hospital's website.
- Are the financial assistance and billing and collection policies applied consistently? That means not only within the hospital's internal process, but also among the vendors it is using to collect accounts.
- Are safeguards in place to ensure that collection activity does not commence prior to making reasonable efforts to inform patients of financial assistance? Many hospitals and some collection agencies use different predictive models to determine patient financial need, and often will presumptively qualify them for financial assistance.

Though the provisions became law in 2010, some nonprofit hospitals may not yet realize they have to make changes now inorder to remain in compliance with the law.

"If hospitals haven't jumped on this bandwagon yet, they are behind the ball," Gavinski said. "They need to get this going so when the rules are finalized they will have the right processes in place."

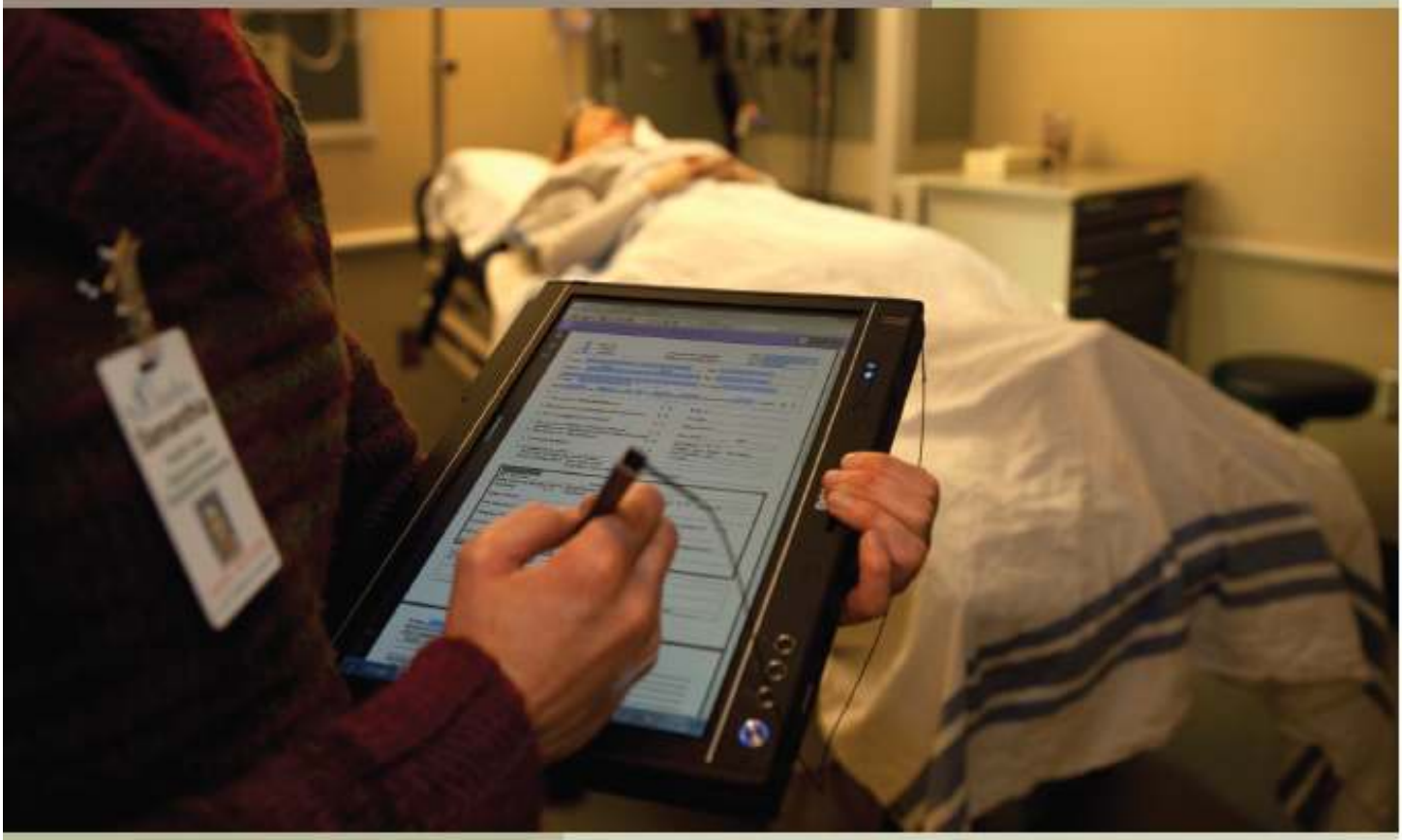
For more extensive coverage of this topic, see ACA International's August issue of *Collector* magazine at *http://www. digital- collector.com*.

August 2014 – Vol. 30 No. 8

Published for Health Care Providers by ACA International

www.acainternational.org

You see
uncompensated care shortfalls.



We see
proven paths
to eligibility
and enrollment.

Chamberlin Edmonds® eligibility and enrollment track record is the most productive in the nation. Our custom-tailored services examine the widest spectrum of uninsured and underinsured patients, including inpatient, outpatient and emergency department cases. The advanced technology of our web-based system is built on the unique experience and expertise of the most qualified professionals in the industry – our people. By gathering and analyzing information faster and more accurately, we are even more patient-centric and more effective in securing reimbursement for the hospitals Chamberlin Edmonds serves. For more information, contact Robert Meyer at 800.255.0953, ext. 5108.

Medicaid Eligibility (Inpatient, Outpatient, ED) | Social Security Disability - SSDIB
Supplemental Security Income - SSI | State Disability | Charity Care | Crime Victims Assistance

APS Advanced Patient Search OnPoint

800.255.0953 | www.chamberlinedmonds.com

ChamberlinEdmonds
Optimizing Eligibility & Enrollment

Highlights … Fall Meeting, Sept. 26, 2014, Warrenton, VA.

Highlights … Fall Meeting, Sept. 26, 2014, Warrenton, VA.

Legislative Update

The General Assembly reconvened the Special Session on Thursday, September 19, to address the budget shortfall, appoint judges and debate Medicaid expansion. Delegate Tom Rust (R-Fairfax) introduced a bill titled the "Virginia Health Care Independence Act," which sought to make coverage available to newly eligible adults under 133 percent of the federal poverty level and pursue comprehensive reform of medical assistance programs. That bill failed on a vote of 33 to 64.

The General Assembly also took action to address the budget shortfall by passing a bipartisan bill to amend the budget and filled several judicial vacancies through appointments and approval of funding. The budget amendments do not include any further reductions in Medicaid provider payments and it appears the Governor's targeted investments under his Healthy Virginia plan remain in place. Budget cuts affecting the Department of Medical Assistance Services are administrative in nature.

Also as part of the Special Session, Senator Bill Stanley (R-Moneta) introduced several bills aimed at piecemeal efforts to support indigent care and safety net providers, including bills seeking to develop regional care organizations and accountable care organizations, pilot telemedicine, establish a patient-centered medical home advisory panel and make available medical scholarships for students attending schools outside Virginia. All of the bills have been referred to Senate committees and will be considered in upcoming committee meetings. The Senate Finance Committee has already heard one of the bills, which was referred to the Joint Legislative Audit and Review Commission for a fiscal impact analysis.

If you have questions or would like additional information, please feel free to contact Paul Speidell at pspeidell@vhha.com.

Written by Paul Speidell

SENTARA
RMH Medical Center

Hospital Spotlight by Heather Eavers

Sentara RMH was originally Rockingham Memorial Hospital. It opened its doors in 1912 serving seven counties including Rockingham County. In May 2010 they partnered with the Sentara Healthcare System. Sentara RMH has 238 beds and is a general medical and surgical hospital.

Sentara RMH offers the following services:

- Heart and Vascular Center: a comprehensive program offering cardiothoracic surgery, interventional cardiology, electrophysiology, heart disease prevention and screening programs.
- Hahn Cancer Center: Providing the latest technologies in cancer-fighting care, medical and radiation oncology, palliative care, counseling and nutrition services
- Orthopedics and Sports Medicine: Joint replacement surgery, spine surgery, sports medicine, concussion programs, rehabilitation
- Funkhouser Women's Center: Digital mammography, bone health and heart health screening programs. Home to a breast surgeon and breast health navigators.
- Behavioral Health, individual and family therapy, addiction services, partial hospitalization program, bereavement
- Center for Sleep Medicine, fully accredited, offering diagnosis and treatment of sleep disorders
- Family Birthplace, offering comfortable, extra-large birthing rooms, birthing classes, Doula program, nurse home visits, lactation consultation
- Image Recovery Center, restoring cancer patients' appearances
- Imaging Services
- Inpatient Physicians, providing inpatient care for patients whose primary care physicians do not admit to the hospital
- Rehab Services, physical, occupational, and speech therapy in both inpatient and outpatient settings
- Wellness Center, a premier fitness facility

Emergency Room- treats more than 71,000 patients per year

In 2014, Healthgrades awarded them with Distinguished Hospital Award for Clinical Excellence, Women's Health Excellence Award, America's 100 Best Hospitals for Pulmonary Care Award, and the Critical Care

Member Spotlight by Sara Quick

Tracie has been a member of AAHAM since 2010. Her career in healthcare began in 1996 where she started out as a Customer service representative for the Business Office, handling calls and inquiries from patients regarding their accounts. She then moved on to a floater position and was utilized in many different facets of the office before finding her niche. She now holds a position where she primarily does follow-up and billing of commercial insurance payers.

She became dually certified in both CRCS-I and CRCS-P. When asked what she likes best about being a member of AAHAM, she stated that she is proud of the fact that she works for an organization that gives her the opportunity for further education, and gives her the opportunity to gain the necessary knowledge about healthcare changes and challenges that we are faced with today.

In her spare time, she enjoys spending time with family and her 2 grandchildren, as well as shopping and vacationing at the beach.

Certification… why bother?

You may wonder why you should bother with obtaining your certification. After all, it's a lot of work—Let us enlighten you! Certification is an investment in your personal growth and your professional future.

Benefits of obtaining AAHAM certification:

- Professional development
- Individual enrichment
- Employer awareness
- Recognition by industry and build a network of connections in the elite group that shares your designation
- Personal challenge and satisfaction
- National recognition
- Recognition and access to the positions and promotions you seek and deserve

—AND—

An AAHAM certification demonstrates your:

Commitment—to your field and your ongoing professional development.

Expertise—you possess the knowledge to meet the industry's highest standards and the capacity to pass a rigorous certification examination.

Professionalism—your pursuit of excellence supports the quality of service in your career and in the healthcare industry.

CRCE-I & CRCE-P exams are considered to be the best indication of knowledge in our field. Set a goal or make a promise to yourself to pass the exam. It will be gratifying to prove to yourself that you can pass this difficult exam, and that your years of experience and hard work will be evident to all by the CRCE-I/CRCE-P designation after your name.

Study guides are loaned out to members. You do not have to purchase your own study guide.

If you are interested in testing your knowledge and gaining the recognition that comes with certification, contact Leanna Marshall for additional information.

Leanna Marshall, CRCE-I

PFS Consultant

UVA Health System (Retired)

Phone: (434)293-8891

Fax: (804)977-8748

814 Montrose Avenue

Charlottesville, VA 22902

CRCE-I Study Sessions will be conducted by Leanna Marshall on the third Saturday of the month from 9:00am until approximately 3:00pm.

Virginia AAHAM offers a certification payment reward for passing the professional exam. AAHAM will reimburse the member for the cost of the exam.

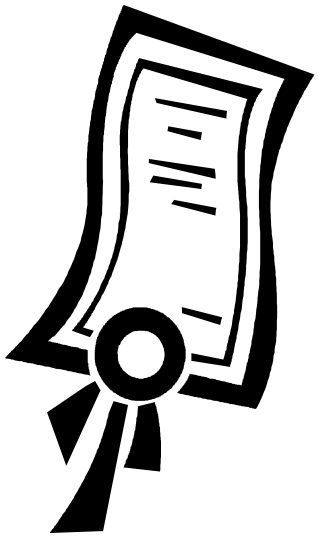
Newly Certified…

First Name	Last Name	Certification	Facility
Amy	Garnett	CRCS-I	Mary Washington Hospital
Sharyn	Jenkins	CRCS-I	Mary Washington Hospital
Deborah	Hill	CRCS-I	Mary Washington Hospital
Linda	Dotson	CRCS-I	Mary Washington Healthcare
Priscilla	Biggs	CRCS-I	Inova Health System
Brandy	Wildman	CRCS-I	Davis Health System
Patricia	Deacon	CRCS-I	Centra Health
Brigette	Bardeaux	CRCS-I	Mary Washington Healthcare
Sunee	Bunyasrie	CRCS-I	Mary Washington Healthcare
Marsha	Kent	CRCS-I	Mary Washington Healthcare
Michelle	Maxwell	CRCS-I	Davis Health System
Michelle	Lane	CRCS-I	Augusta Health
Amanda	Gunnoe	CRCS-P	Inova Healthcare Services
Diane	Van Luven	CRCS-P	Salem Medical Billing Company

2014 Certification Schedule

September 2, 2014—Deadline for November Exam Period (November 10-21, 2014)

December 1, 2014– Deadline for February 2015 Exam Period



The Virginia Chapter of AAHAM American Association of Healthcare Administrative Management

2014 Membership Application

Please enter your data below, and then send this form, along with the $30.00 annual dues to the address below to join or renew your membership with the Virginia Chapter of AAHAM.

Take advantage of these important benefits…

- Problem solving and solution sharing with your associates
- Membership directory
- Reduced fees for chapter education events
- Educational seminars & workshops
- Chapter newsletter
- Interaction & networking with peers
- Access and preparation assistance for certification tests that demonstrate your professional skills

Please enter your information below.

First Name:	Last Name:
Certification:	Employer Name:
Job Title:	Mailing Address:
Day Phone #:	City:
Fax #:	State & Zip Code:
E-Mail:	

MEMBERSHIP RECOMMENDED BY: _____

For additional information contact Chris Fisher @ 540-332-5030 or via email at: cfisher@augustahealth.com

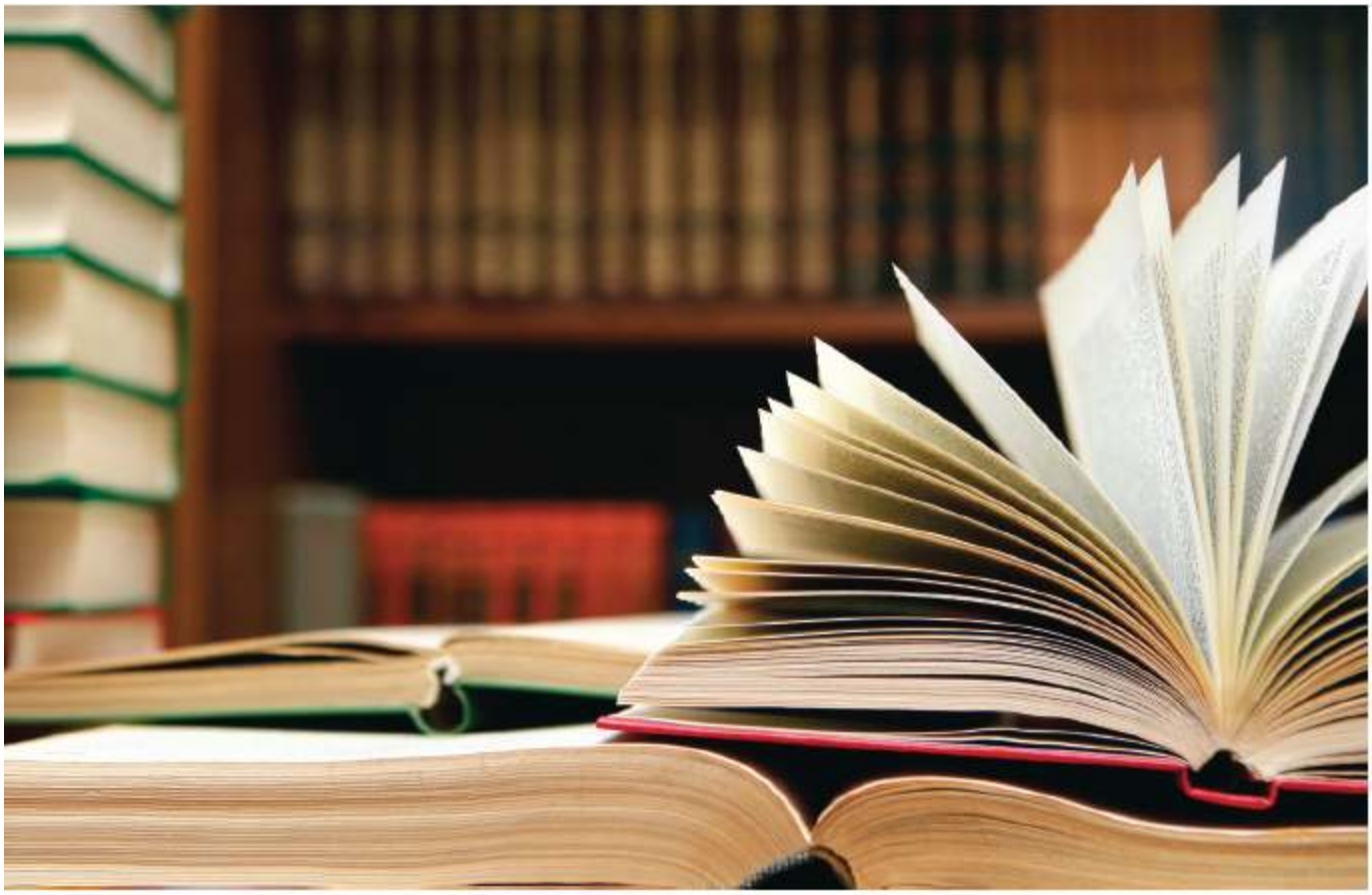
Please mail the completed form with our dues payment of $30.00 to the following address:

Treasurer, Virginia AAHAM
Dushantha Chelliah
2212 Greenbrier Dr
Charlottesville VA 22901

-OR-

Take advantage of our online membership application and payment options. Visit our website at http://www.vaaaham.com/Membership_Application.html

Virginia AAHAM Tax ID: 54-1351774



Woodrow Samuel Annual Scholarship Application

Purpose:

The Virginia State AAHAM Scholarship Award was established with the primary purpose of educating its membership in the management of health care receivables. As the chapter increased in membership and cash equity, the concept of a scholarship program was initiated by the Executive Board of Directors and was first offered in the fall of 1987. The Executive Board of Virginia AAHAM has continued to make the scholarship program available as it is believed educational funds are a benefit to individual members, the Chapter, and dependents of our members. In 2007, the name of the scholarship was changed to the Woodrow Samuel Scholarship Award to recognize a lifetime member of the VA State AAHAM organization.

A maximum of $1,000 scholarship award will be given.

Eligibility:

Eligible nominees must:

- Be a Virginia AAHAM member or a child of a Virginia AAHAM member as of January 1 of the current year.
- Eligible nominees can apply for the scholarship award on an annual basis.
- Members must be employed full time in a healthcare related field and dependents must be enrolled in an accredited college or school.
- Chapter dues of the member must be paid prior to the acceptance of requested scholarship applications.
- Classes taken must be taken during the current school year.

Nomination Procedure:

- Nominees must:
- Complete the application form
- Include at least one letter of reference.
- Include or attach any documentation you would like to have considered.
- Include an essay on why winning the scholarship is important.

Submission:

The form will be completed and returned to the address listed at the end of the application. This application will be postmarked no later than January 30th of the year the application is submitted to the Virginia State AAHAM Scholarship Chairman.

All application materials and supporting documentation will be reviewed by the Virginia State Scholarship Committee. After all applications are reviewed, the applicant will be notified if they have been selected as a Scholarship recipient by the Chair of the Scholarship Committee.

Review Process:

All applications will be reviewed and scored by the Scholarship Committee. Points are awarded based on the following criteria:

- Active in school related organizations (e.g. Honor Society, FFA, Ecology Club, Science Club, Beta Club, Student Council, etc.)
- Elected leadership position in school or community related clubs or organizations
- Demonstrates community involvement (e.g., membership in Scouts, 4-H, civic group/club, volunteer work)
- References
- Essay (Explains why _____is important to the applicant and/or his/her family.)
- Awards received for school or community involvement

Section A—Application

Type or print all answers clearly. Fill in all information completely. Use a blank sheet of paper to continue answers, and number them to correspond with the question number (for example, D—Goals).

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip Code _____

Daytime Telephone _____ Evening Telephone _____

Date of Birth _____ E-mail address _____

Present Place of Employment or Accredited School _____

Address of Employer or School _____

_____

Dollar Amount of Scholarship Being Requested _____

Section B—Education

Current School/College You Plan to Attend _____

Section C—Essay and Reference Letter

For Virginia members, please write an essay in 250 words or less on how the healthcare field has benefited you and the reason you would like to further your education. For dependent's of Virginia State AAHAM members, please write an essay in 250 words or less on the reason you would like to further your education and the reason you have chosen your career field major. Feel free to list any education experiences which have

this scholarship is important to you. Submit your answer on a separate sheet that includes your full name in the upper right hand corner.
A reference letter must accompany the application. It must state the reason why they feel the candidate deserves to win the scholarship.

Section D—Signatures

I certify that the information on this application is correct and represents the candidate to the best of my knowledge.

_____ _____

Applicant's Signature Date Application Submitted

Section E—Submission and Deadlines

Applications must include all signatures and titles. It must also include your written essay and reference letter. Submission deadline is January 31, 2015. The application is to be submitted to:

Amy Beech, CRCE-I
Augusta Health Business Office
PO Box 1000
Fishersville, VA 22939
(540)332-5030
abeech@augustahealth.com

Please do not write below this line.

_____

Date Application was received _____
Scholarship Committee Chair Signature _____
Scholarship Approved or Awarded? _____ YES _____ NO

The Virginia Chapter of AAHAM Executive Board 2014-2015

Chairman of the Board

(Chapter of Excellence Committee)

Linda McLaughlin, CRCE-I

Director, Director Finance and Governmental Services

VCU Health System

PO Box 980227, Richmond, VA 23298-027

Office—(804)828-6315 Fax—(804)828-6872

Email—lmclaughlin@mcvh-vcu.edu

President

(Committee Chairperson: Nominating Committee; Accounts Receivable/Third Party Payer Committee)

David Nicholas, CRCE-I

Director of Operations RMC, Inc.

Office - (703)321-8633 Fax- (703)321-8765

Email— **David.Nicholas@RMCcollects.com**

First Vice President

(Committee Chairperson: Membership & Chapter Development:Chapter Awareness)

Chris Fisher, CRCE-I

Patient Access Coordinator

Augusta Health

PO Box 1000, Fishersville, VA 2293

Office—(540)332-5030

Email—cfisher@augustahealth.com

Second Vice President

(Committee Chairperson: Education Committee; Government Relations Committee)

Denise Martin

P.O. Box 1324 Duxbury, MA 02332

Phone—(774)454-9993 Email—dmmart515@aol.com

Secretary

(Committee Chairperson: Publications Committee; Scholarship Committee)

Amy Beech, CRCE-I

Patient Accounting Supervisor

Augusta Health

PO Box 1000, Fishersville, VA 2293

Office—(540)245-7216 Email—abeech@augustahealth.com

The Virginia Chapter of AAHAM Executive Board 2014-2015

Treasurer

(Committee Chairperson: Vendor Awards Committee)

Dushantha Chelliah

2212 Greenbrier Dr.

Charlottesville, VA, 22901

Office - (434)924-9266

Email: DC5P@hscmail.mcc.virginia.edu

Appointed Board Member

(Committee Chairperson: Finance Committee; Constitution & By-Laws Committee; Historical Committee)

Brenda Chambers, CPAM, CCAM

Revenue Integrity

HCA - RSSC Capital Division

7300 Beaufont Springs Drive; Boulders VIII – 2nd Floor;

Richmond, VA 23225

Office—(804)267-5790 Fax—(804)267-5791

Email—Brenda.Chambers@hcahealthcare.com

Appointed Board Member

(Committee Chairperson: Certification Committee)

Leanna Marshall. CPAM

UVA Health System (Retired)

814 Montrose Avenue, Charlottesville, VA 22902

Phone—(434)293-8891 Fax—(434)977-8748

Email—ayden1@embarqmail.com

Honorary Board Member

Michael Worley, CPAM

Revenue Cycle Consultant

1807 Mount Vernon Street, Waynesboro, VA 22980

Office—(540)470-0020 Email—mworley@ntelos.net

Appointed Board Member

(Committee Chairperson: Communications Chair)

Katie Creef, CRCE-I

Director of Patient Accounting

Augusta Health

P.O. Box 1000

Fishersville, VA. 22939

Office- (540) 332-5159 Email– kcreef@augustahealth.com

On the Lighter Side...by Trista McGuire

	2	5						
3		6			7		1	
9	7			6		8		
7			9		1		8	
8		1				2		7
	5		4		8			1
		9		1			3	8
	1		6			9		2
						1	6	

Do you have exciting news or a special announcement you would like to have shared in the next newsletter? Please, let us know!

tmcguire@augustahealth.com

Looking for a lighter lunch?

Chicken Caesar Salad Wraps

-1/4 cup light mayo
-1/4 cup parmesan cheese
-2 tablespoons lemon juice
-1 tablespoon Worcestershire sauce
-1 tablespoon Dijon mustard
-1 garlic clove, finely minced
-1/4 cup olive oil
-3 cups shredded cooked chicken
-1 romaine heart, torn into bite size pieces
-4 large tortillas or wraps

- In a large bowl, whisk together the mayo, parmesan, lemon juice, Worcestershire, Dijon mustard, and garlic
- Gradually whisk in olive oil until fully incorporated
- Toss with chicken and lettuce until coated
- Divide into tortillas or wraps and enjoy!

Yields 4 servings

RMC
Receivables Management Consultants, Inc.

Receivables Management Consultants, Inc.
6800 Versar Center; Suite 400
Springfield, VA 22151
Phone: (703) 321-9400
Fax: (703) 321-8765
www.RMCcollects.com

"I couldn't be happier -- RMC has collected over $2 million in outstanding A/R for us, reducing A/R days by 49% and decreasing outstanding A/R by 52%. At one time we had considered bringing billing and follow-up back in-house, but they're doing such an outstanding job we decided to continue outsourcing."
– Administrator, Inpatient Psychiatric Facility

OUR SERVICES ARE CUSTOMIZED TO MEET THE NEEDS OF OUR CLIENTS

> Business Office Outsourcing – Total or Partial
From billing through collections, follow-up, appeals, and recovery, RMC has the commitment and experience to be your trusted business partner.

We're ready to provide a total outsourcing solution, or assist you with any segments that are difficult or costly to manage internally:

- Acute Care Hospital
- Specialty Department (Psychiatric, Rehab, Hospice)
- Ambulatory Surgical Centers
- Home Health

> Insurance Billing – Follow-Up – Recovery

- Medicare Deductible & Coinsurance
- Medicaid
- Managed Care
- Workers' Compensation
- Blue Cross
- Commercial Insurance

> Revenue Recovery Projects for Underpayments

> Denials Management

> Clean-Up Projects for Very Aged or Backlogged Receivables

> Credit Balance Audit and Resolution

> Interim Management

> Training

"We're very pleased with the level of collections coming in, and with how RMC works to build the team. They've given us much better coordination; it's like they're part of our staff. In addition to billing and follow-up they helped implement our new computer software system, setting up billing protocols and helping us make processes more efficient."
– Administrator, Ambulatory Surgery Center

National News— www.aaham.org

The renaming of our renowned certifications was announced at the Annual National Institute (ANI) in New Orleans, LA. The new AAHAM designations now accurately reflect the scope of knowledge and skills required to secure these prestigious certifications. The names are designed to more accurately reflect current job and industry titles and reinforce the association's growth and continued focus on healthcare revenue cycle professionals. Also unveiled was news regarding a new mid-level certification, the CRCP, Certified Revenue Cycle Professional. This new exam is designed for mid-level managers and tests the participant's knowledge of the revenue cycle. With the addition of this new certification, AAHAM now offers a complete career ladder, beginning with the CRCS and culminating with the CRCE.

Visit the website for more information
http://www.aaham.org
And calendar of upcoming events.

Calendar of Events:

Manchester Grand Hyatt in San Diego, California from October 15-17, 2014.

The ANI is attended by nearly 500 National members and over 75 exhibitors. Each year, the members of AAHAM come together to exchange ideas, renew old friends, make new ones, and further their knowledge and education in the field of Patient Account Management.

2015 Legislative Day, Hyatt Capital Hill from March 30-31, 2015.

National Patient Account Management Week
October 18-25, 2014
"Our Team Spirit is Key"

Stay up-to-date on Administrative Simplification and other healthcare Legislative issues of interest by visiting the National AAHAM web site:
https://www.capwiz.com/aaham/home/

CORPORATE SPONSORSHIPS

Platinum Sponsors:

Chamberlain Edmonds/Emdeon
Receivables Management Corporation
HFMI
Credit Control Corporation

Gold Sponsors:

Rodney Napier
Penn Credit

Silver Sponsors:

Life Credit/Portfolio Recovery Assoc.
SSI Group
NHI Billing
Deco

Sponsorship

Platinum Sponsorship - $1,500

- **Exhibit space available at <u>both</u> the May & December Conference**
- **Full-page ad in <u>ALL</u> newsletters**
- **Full-page ad distributed at <u>ALL</u> meetings**
- **Free Registration at <u>BOTH</u> the May & December educational conference for four (4) sponsor employees**
- **Plus much more...**

Gold Sponsorship - $1,200

- **Exhibit space available at <u>both</u> the May & December Conference**
- **Full-page ad in <u>ALL</u> newsletters**
- **Full-page ad distributed at <u>ALL</u> meetings**
- **Plus much more...**

Silver Sponsorship - $1,000

- **Exhibit space available at <u>EITHER</u> the May <u>OR</u> December Conference**
- **Half-page ad in ALL newsletters**
- **Half-page ad distributed at <u>BOTH</u> meetings**
- **Plus much more...**

The Virginia Chapter of the American Association of Healthcare Management (VA AAHAM) exists to provide or facilitate professional education, promote professional excellence, provide opportunities for sharing management strategies and tactics through professional networking. You and your organization are important to this mission. Virginia AAHAM benefits by drawing on the experience and education that you and your organization can bring to the activities and efforts of our association. Virginia AAHAM's mission also benefits from the financial support that many organizations provide. I hope that you will consider supporting Virginia AAHAM this year.

—Saurabh Sharma, Vendor Sponsorship / Corporate Partners Chair

Saurabh.sharma@rycan.com

Mark your calendars!

Upcoming VA AAHAM events:

- **December 3-5th, 2014 Winter Annual Meeting, Williamsburg, VA.**

Go to our web site for more information and registration: www.vaaaham.com

The Virginia Chapter of AAHAM American Association of Healthcare Administrative Management

To: All Virginia Chapter of AAHAM Members:

The Virginia Chapter of AAHAM Education Committee, in an effort to provide our members with "Back to Basics" training is looking for interested parties to conduct a 30-45 minute webinar series. The web series would focus on professional development for operational level staff or first time managers. Presenters can share their professional experiences in networking, positioning yourself to grow in your organization, establishing yourself as a leader and a go-to person, etc. Please contact Gio Naranjo at gnaranjo@claimlogic.com or 405-548-1492 if you can assist in this education opportunity.

Linda McLaughlin, CRCE-I

Chairman of the Board, The Virginia Chapter of AAHAM

Denise Martin

Second Vice President, The Virginia Chapter of AAHAM

Watch our web site for details:

Contest for Newsletter Articles!

Writers Wanted!

The Virginia Chapter of AAHAM will award **$100** to the author of the best article submitted to the Publications Committee during 2014. Submit articles to Amy Beech abeech@augustahealth.com. Newsletters are published quarterly. Don't miss your chance to be read, recognized, and rewarded for your writing talent.

This publication is brought to you through the collective efforts of the **Publications Committee**

Amy Beech, CRCE-I
abeech@augustahealth.com

Sara Quick, CRCS-I,P
squick@augustahealth.com

Heather Eavers, CRCS-I,P
heavers@augustahealth.com

Trista McGuire, CRCS-I, P
tmcguire@augustahealth.com

What is AAHAM?

AAHAM is a premier professional organization for healthcare administrative management. Our goal is to provide quality member services and leadership in the areas of education, communication, representation, professional standards and certification. Virginia AAHAM was founded in 1982 as the American Guild of Patient Account Management. Initially formed to serve the interests of hospital patient account managers, AAHAM has evolved into a national membership association that represents a based constituency of healthcare professionals.