The Virginia AAHAM Insider

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

Summer 2017 Volume 43 Issue 1

The President's Message

Greetings Virginia AAHAM Members and Friends!

As you know from my last letter, some of us from Virginia attended the Legislative Day on Capitol Hill May 1st and 2nd. I was joined by Brenda Chambers and Mary Prendergast and 84 of our other AAHAM friends from around the country. The three of us enjoyed visiting our Senator's and Congressman's offices and discussing with their staff about the topic; **Observation Stay; Improving Access to Medicare Coverage Act of 2017.** We were able to briefly see Rob Wittman and Tim Kaine during our time in their offices. That was icing on the cake for sure! Since that time, we were notified by National AAHAM that several additional lawmakers have signed onto the Bill that is currently with Congress. That's exciting news and we hope that it continues to gain momentum so it will be heard during the current legislative session.

While in DC, I also attended the AAHAM Board Meeting. Good information always comes out of these meetings. Such as national membership is up by 173 from this time last year to a total of 2740. The certification program is going very strong with 799 people scheduled to sit for the exams that are being given during the testing period of July 10th thru 21st. Also, two exciting things that National AAHAM has announced this year and we reviewed at the meeting are; The **certification webinars are now free** for AAHAM members. So, if you'd like to attend one of the upcoming webinars this summer, please visit aaham.org to sign up. The other exciting change this year was the announcement of **free memberships for full time students**. At the board meeting AAHAM executives told us about a marketing firm they have engaged who will be going out to educate universities and colleges all over the country to market to student who may wish to join AAHAM. As you may recall, the Virginia Chapter has also adopted a Free Student Membership policy in our Bylaws this year. Just in the past month we discovered we have 11 new National Student members that joined our chapter. I am very pleased to see that, and want to welcome all our newest members to the chapter.

Our Certification Committee, led by Leanna Marshall, is currently in the process of putting together our own Certification Webinar series. They plan to have these short and informative webinars available for free beginning in the Fall. We will be sending out information about dates, times and all the other detail when they are available so please watch your email, or check our website for more information later this year.

After our conference on June 9th in Richmond, we will have two others this year. They are the Fall Regional meeting which will be held in Fredericksburg, VA on September 22nd, and the Annual Meeting in Williamsburg VA at Kingsmill Resort December 6th thru 8th. Please visit our website at www.vaaaham.com and click on Communications & Calendar of Events to watch for agenda's and registration information.

Have a wonderful summer and I look forward to seeing everyone soon!

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

Inside this issue:

Booming Demand: How Urgent Care Centers are Impacting Hospital Operations

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The construction and use of urgent care centers in the health care industry has steadily increased over recent years. The growing popularity of urgent care centers presents an opportunity for hospitals to extend networks or expand partnerships in order to reach new clientele. Further, it offers an opportunity to enhance brand recognition in new and existing markets.

According to the Urgent Care Association of America (UCAOA), urgent care dates back to the late 1970s and was created with the intention of meeting a community's immediate health care needs. It was a slow but steady start for urgent care in the beginning, but the concept of seeing a physician without an appointment eventually began to gain popularity among patients. Over the past 20 years, the urgent care industry has continued to expand and earn the trust of those seeking a safe and affordable place to receive medical attention.

Today, urgent care centers are physician-staffed and typically offer extended hours (evenings and weekends), providing quality care without the costs and wait times associated with the average emergency room (ER) visit. Urgent care centers are best suited for situations that require more immediate attention; often times, this serves to be more practical than seeing a primary care provider, who can be challenged with offering consumers the hours or immediacy an illness or accident can demand.

Why the Increase in Popularity?

There are various drivers behind the recent growth of urgent care. The UCAOA estimates that growth has been steady the last several years, as between 300 to 600 urgent care centers are added per year, resulting in the current population of around 7,400 centers. Challenges on the supply side, such as difficulty in finding a primary care provider and the increase in costs associated with ER visits, are a factor in the increase. A larger demand by consumers for convenience, both in terms of proximity and hours, has also resulted in a need for more urgent care centers.

Booming Demand: How Urgent Care Centers are Impacting Hospital *Continued on next page*

More recently, lenders and investors have recognized the success of the urgent care model and have begun to look for opportunities to participate in the ongoing growth.

The business model is based on low-margin, high-volume care, as the average visit costs $150 with a total visit time of under 60 minutes in 84% of cases, compared to an ER visit that averages $1,354 and consumes four hours of wait time. Costs are much lower in an urgent care setting, as detailed with some of the more commonly treated ailments shown in the chart below:

Condition	ER Cost	Urgent Care Cost
Sore Throat	$525	$94
Sinusitis	$617	$112
Urinary Tract Infection	$665	$112
Strep Throat	$531	$111

http://c.ymcdn.com/sites/www.ucaoa.org/resource/resmgr/Media/UCAOA-Infographic-UCvsER_FIN.pdf
https://www.debt.org/medical/emergency-room-urgent-care-costs/

An easy conclusion to reach would be that an urgent care center would draw lower-acuity patients away from emergency rooms, resulting in less overcrowding of the ER and improved efficiency. However, a study presented in April, 2016 by Grant Martsolf, et al, found that retail clinics opened near emergency departments are not associated with a material reduction in low-acuity emergency department visits. This data supports the notion that urgent care centers prompt patients to seek care for conditions that might have been treated at home or at a primary care office. Thus, urgent care centers may not be an avenue for reducing ER overcrowding, but may provide an opportunity for accretive revenue through partnership or expansion. This widening of a hospital network may increase referrals and retention of patients who will seek care through urgent care centers and might find themselves referred to physicians or testing facilities within the network.

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If a hospital invests in quality care and branding, the uniformity of care provided in an urgent care setting will enhance a patient's overall experience and may engender confidence in the entire health care system, prompting patients to utilize other services of the hospital.

How Hospitals are Getting Involved

For hospitals interested in expanding their network to include urgent care centers there are several options. Some hospitals have pursued partnerships with an existing provider of urgent care services. This allows the hospital to step into a relationship with an existing provider that has experience in managing the low-margin environment that demands a unique staffing approach. This partnership has benefits for both the urgent care provider and the hospital because the provider receives benefits from the local hospital's brand recognition and gains access to physicians employed by the hospital. In return, the hospital benefits from a reduction in initial investment requirements and receives another referral source. It is estimated that the majority of urgent care centers in the U.S. continue to be operated as free-standing facilities, while 20% are owned solely by hospitals and another 15% are structured as joint ventures. Hospitals that pursue the partnership model must be aware of the challenges that come with information sharing beyond their existing network.

Hospitals that opt to open urgent care centers have the ability to target neighborhoods and demographics that are either underserved or have a potentially advantageous payor mix. The hospital's brand recognition can provide immediate legitimacy to the start-up centers and these centers have the ability to share complete patient information, ensuring a seamless patient experience.

Hospitals pursuing this path must ensure that staffing and the scope of care provided do not tarnish the hospital's brand in the initial stages of the learning process. Traditional sources of financing for nonprofit hospitals, such as tax-exempt bonds, the U.S. Department of Housing and Urban Development (HUD)/Federal Housing Administration (FHA) Sec. 242 program, the U.S. Department of Agriculture (USDA) Business & Industry or Community Facilities program, or bank direct purchase financing, are typical options for financing these assets on a standalone basis, or as part of a larger strategic plan.

As demand for lower-cost alternatives to care that do not sacrifice quality continues to grow, opportunities for hospitals to expand into the urgent care center environment will continue to present themselves. Hospitals can act on these opportunities to grow market share and expand brand recognition, while simultaneously meeting patients' needs and providing quicker, lower-cost care than that offered in a typical ER setting.

http://www.annemergmed.com/article/S0196-0644(16)30998-2/abstract
http://www.modernhealthcare.com/article/20170125/NEWS/170129940

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When the earth moves under your feet: Medicaid and the Shift to Managed Care

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Nationally, the shift from traditional Medicaid and traditional Medicare to Managed Medicaid and Managed Medicare is both one of the hottest trends and one of the most difficult for hospital back offices to adapt to.

The traditional pain points in Revenue Cycle Management are amplified with these plans: eligibility and authorizations requirements, variation from standard CMS claims editing, working with third party administrators (TPAs), and new reimbursement methodologies. Many of the tried and true techniques to fine tune AR management remain the best approach, but the current environment requires a disciplined approach to seismic safety for the reimbursement infrastructure.

During an earthquake, the stress applied to the ground can cause a phenomenon known as soil liquefaction. Uncompacted, moist soil tends to compress under stress, leaving these particles "floating" between the remaining water particles which do not compress as easily. Structures tend to become highly unstable on the solid ground where they were built – and often topple as a result.

The changes going on in the Medicaid and Medicare markets across the US are causing a similar shifting of the ground beneath the feet of many providers. Managed Medicare and Medicaid are proliferating across the United States in the hope of bringing efficiencies to our healthcare delivery system.

The challenges posed by the increase in Managed Medicaid and Managed Medicare plans, while not outside of the usual set of problems, have a dramatically increased impact on the stability of the revenue cycle, and therefore are extremely daunting. Instead of dealing with a single Medicaid payer, providers now need to deal with upwards of eight to ten, all with varying degrees of adopting Medicaid regulations and levels of technology. If not responded to in an effective manner, they will likely have very significant Net Revenue and Cost-To-Collect impact. Organizations who had not adopted best practice processes before the payer mix shift need to act now, before they are toppled by the shift happening beneath their feet.

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Shifting Payer Mix

Nationally, there is a trending payer mix shift. Traditional Medicare patients are electing enrollment in Managed Medicare Plans, and many states are electing to outsource management of their Medicaid populations to commercial Managed Medicaid Plans. In theory, the financial motivation behind these changes is that these commercial health plans can more efficiently manage the business, thus drive reduced administrative costs and achieve better health outcomes. In practice, health systems experience higher administrative burdens, increased revenue leakage from denials and underpayments, and lower net reimbursement.

New Reimbursement Methodologies

Another national trend is experimentation with new reimbursement methodologies. In aggregate, there is population health risk sharing and incentive programs based on various quality measures.

The most difficult reimbursement methodology to understand is the adoption of Enhanced Ambulatory Patient Groups (EAPGs), a model similar to – but distinctly not identical to – the Medicare APC (Ambulatory Payment Classification) method. Outpatient services are grouped into logically associated groups which carry specific reimbursement values that are multiplied by provider-specific weights to calculate reimbursement. On top of this, there are various rules for combinations of EAPGs and specific diagnoses that affect which EAPG some CPT Codes map to.

In an already complicated world, EAPGs inject an entirely new level of complications. Monitoring payer compliance administering contractual rates requires implementing expensive proprietary technology – on top of any contract management software already implemented – at significant cost and complexity.

Almost all managed Medicare and Managed Medicaid plans generally say that they follow CMS processing rules, but in the details, they tend to pick and choose which rules they adopt. Each payer publishes (annually, quarterly, and even monthly) updated guidance on non-covered services and changes to bundling rules.

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Eligibility and Authorizations

Managed Medicare and Managed Medicaid plans put additional burdens on the Patient Access functions, particularly the insurance verification and authorization processes. First, many of the patients who have elected (or been assigned to) a Managed plan continue to tell schedulers and registrars that they have "Medicaid" or "Medicare". When the staff performing those functions are pressed for time, they often just pull forward whatever insurance was on the last registration.

In this new world of managed care, detailed insurance verification is critical. Verifying Medicare or Medicaid often returns a "positive" check – because the patient does have those benefits – however, the staff needs to read all of the details of the verification, particularly the Coordination of Benefits section that would indicate if the patient has elected (or been assigned to) a managed plan. Further, additional audit steps need to be implemented to ensure the correct Plan Code configured in the registration system is selected. Many providers bill traditional BCBS to one electronic payer ID and Managed Medicaid BCBS to a different electronic payer ID. Just picking the most common BCBS Plan Code on the system can often result in downstream eligibility denials. Alternatively, picking a generic Medicare and Medicaid HMO plan code may cause delays in processing and timely filing issues.

Authorizations are even more complicated. Managed Medicaid and Managed Medicare payers have the most restrictive authorizations rules of any payers. They also make more frequent changes to policy than commercial plans and are the least forgiving (in terms of retro-authorization) on appeal. In the old world, Patient Access could rely on Medicare's National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) and a relatively small list of procedures requiring authorization for traditional Medicaid.

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Today, that single Medicaid list is split into as many as eight to ten separate Managed Medicaid Plans, each with their own nuances. Now, the team needs to balance a very significant and volatile matrix of plans and procedures requiring various forms of notification, authorization, and precertification.

Use of TPAs

Over the past ten years, outsourcing has been a common way for insurance companies to reduce their administrative costs. With the complex nature of Managed Medicare and Managed Medicaid plans and the significant differences between these plans and their core commercial products, even the largest payers have begun to rely on third party administrators (TPAs).

Unfortunately for many providers, these TPAs do not provide the service level normally associated with large commercial insurance companies. This causes a variety of difficult problems. Many do not provide standard Electronic Data Interchange transactions for claim status or remittance processing. Some do not even provide online portals for basic services, and their call centers performance levels are notoriously poor.

How Providers Can Respond

The problems associated with Managed Medicaid and Managed Medicare plans are daunting. But the good news is that none of these problems are new. Providers have always faced insurance verification, authorization, payment compliance, and poor claims processing problems.

The solution is simply to do everything you've always done . . . just do it better, more comprehensively, and more precisely.

Failing to adapt to the new challenges puts revenue in peril. Organizations who had not adopted best practice processes before the payer mix shift need to act now. The following are some practical actions providers can take to raise their performance level.

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Financial Clearance Processes

- Coordinate with Managed Care Contracting and put together a detailed list of the Managed Medicaid Plans that are contracted with your health system and the associated plan codes to select during registration. Build a training package that outlines which payers are contracted, what their insurance cards look like, and what services require special attention. This list needs to be maintained quarterly at a minimum.
- Review with all staff that perform insurance verification the particular screens/sections to review the Coordination of Benefits section of the eligibility check result (271 transaction). Run a check of a patient that has Managed Medicaid on your insurance verification platform and take a screenshot of the section showing the plan the patient has been assigned to.
- Implement a 1st of the month process to re-verify all in house patients with Managed Medicaid plans to catch any cases that have eligibility cut over between plans between months.
- Build an authorization matrix that the staff can use as a job aid to quickly refer to, instead of going from memory. The monthly process of updating the job aid serves as a training aid itself. Managers who walk the floor and check all the workstations for an updated authorization matrix will quickly know if the staff are up to date on authorization requirements.
- Implement a specific process for how to handle newborn Medicaid cases. Each Managed Care payer likely handles adding a baby to the plan differently. Having a process in place to systematically ensure every newborn is covered either through traditional Medicaid or Managed Care Medicaid is crucial, especially given that these cases are often higher dollar.

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Claims Processing

- Nationally there are very few billing editors and regionally there are even less. Ensure your claims editor is configured to handle Managed Medicare and Managed Medicaid claims as their own claims class. Simply following the commercial claims edits or even just the Medicare or Medicaid edits is not sufficient. Often edits need to be run in a specific sequence to ensure the right outcome is achieved on the final bill.
- In addition, many Medicaid HMO payers have implemented strict front-end edits to ensure specific encounter data is present and accurate so that they can in turn have all encounter reporting requirements to submit to the state. Examples of these include taxonomy codes, National Provider Identifier (NPI) validation, and National Drug Code (NDC) requirements. Looking at billing throughput by payer is key to ensuring edits are being worked, and all claims are reaching the payer in a timely manner.
- Many of the payers who use TPAs to process their claims will accept claims through the editor, but then have a separate set of edits to accept those claims into their adjudication system. Claims may pass through the clearinghouse edits and be marked as received (and even assigned a trace number – DCN), but then never get processed for payment. When you call the payer call center, the representative may say something like "*we never received that claim*." Instruct your team to have the trace number handy and to not allow the representative to simply state that, "*the claim is past the filing limit*."

Underpayments and Denials Management

- The reimbursement rules are so complicated and volatile that it is almost certain payers are making underpayments errors. If contract management software is over-budget, or IT cannot handle another project, find a vendor who can do these recoveries for you on a contingency basis. Manage them actively and be sure to capture the themes, so you can work with the payers to systematically stop the underpayments and avoid excess vendor fees.

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- Managed Medicare and Managed Medicaid tend to have significantly higher rates of initial denials (remittances denying line items or entire claims) than commercial or government payers. Tracking these denials in details is critical. Build a denials management scorecard and a cross-functional team to implement process changes to prevent denials in the future.
- Hold payers accountable for non-descript denials such as non-covered, lacks information, or payment included as a part of another service. As an example, "lacks information" can be used as a general catch all for more specific information the payer is looking for on the claim including NDC codes, NDC units, and missing procedure codes to name a few.

As the potential impacts of soil liquefaction have become better understood, building techniques have been adjusted to minimize damage. Active efforts to compact soil and the injection of stabilizing materials can greatly reduce the impacts -- but these efforts come at an additional cost.

The problems posed by the increase in Managed Medicare and Managed Medicaid plans are not new, but they can have very significant Net Revenue and Cost-To-Collect impact if not aggressively managed. For example, the need for denials analysis and payer management starts to increase exponentially; business offices are no longer working with a single payer - Medicaid (or Medicare) - as now there are upwards of 10 payers for each, all holding significant volume, with varying processing issues.

The techniques we recommend are tried and true, but they need to be executed to a whole new level of performance. Facilities need dedicated resources who specialize in this payer mix to help manage the new complexities introduced. This trend will cause additional administrative costs, and revenue cycle executives need to decide whether those expenses are in the form of increased performance level of the revenue cycle operation, or in the form of revenue leakage from failing to adapt.

APPENDIX A

Most Managed Medicaid Payers are contractually required to process 90% of claims within 30 days, and 99% of claims within 90 days of submission. Measuring this performance is very difficult, but provides visibility to a part of the process the billing staff cannot control or influence.

% of Claims Adjudicated Within 30 Days Claim Date Payer Name	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2017-01
Payer #1	68%	77%	75%	74%	76%	72%	75%	76%	74%
Payer #2	66%	75%	74%	73%	75%	71%	76%	77%	75%
Payer #3	69%	78%	77%	76%	78%	74%	79%	80%	78%
Payer #4	72%	77%	76%	75%	77%	73%	78%	79%	77%
Payer #5	67%	72%	71%	70%	72%	68%	73%	74%	72%
Payer #6	70%	75%	74%	73%	76%	72%	77%	78%	76%

% of Claims Adjudicated Within 90 Days Claim Date Payer Name	2016-05	2016-06	2016-07	2016-08	2016-09	2016-10	2016-11	2016-12	2017-01
Payer #1	76%	85%	83%	82%	84%	80%	83%	84%	82%
Payer #2	74%	83%	82%	81%	83%	79%	84%	85%	83%
Payer #3	77%	86%	85%	84%	86%	82%	87%	88%	86%
Payer #4	80%	85%	84%	83%	85%	81%	86%	87%	85%
Payer #5	75%	80%	79%	78%	80%	76%	81%	82%	80%
Payer #6	78%	83%	82%	81%	84%	80%	85%	86%	84%

Formula -- # of claims adjudicated (paid or denied)/# of claims submitted

APPENDIX B

Understanding the complete impact of denials can be difficult, and tracing denials back to their root causes takes time, diligence, and skill. However, measuring the complete process – including claim errors detected by the claims scrubber and all line item and claim level denials on payer remittances – is the best way to identify controllable sources of revenue leakage.

Formula 1 -- # of claims that have errors, rejections, or transmission failures in claims editor/# of claims that pass through editor

Clean Claim Rate	Claim Date				
Payer Name	2016-09	2016-10	2016-11	2016-12	2017-01
Payer #1	65%	68%	71%	74%	77%
Payer #2	67%	70%	73%	76%	79%
Payer #3	55%	58%	61%	64%	67%
Payer #4	78%	81%	84%	87%	90%
Payer #5	81%	84%	87%	90%	93%
Payer #6	33%	36%	39%	42%	45%

Formula 2 -- # of claims with a denial/# of claims remitted

Denial Rate						
Payer Name	2016-08	2016-09	2016-10	2016-11	2016-12	2017-01
Payer #1	11%	12%	12%	11%	13%	11%
Payer #2	13%	14%	11%	12%	14%	12%
Payer #3	14%	15%	12%	13%	15%	14%
Payer #4	16%	17%	11%	14%	16%	15%
Payer #5	17%	18%	12%	15%	17%	17%
Payer #6	11%	12%	12%	11%	13%	11%

Jeff Means and Sara Roberts are with Colburn Hill Group; we work with providers at their operations level to solve their Revenue Cycle challenges. For more info, please visit www.ColburnHill.com

Highlights from the Richmond VA. Meeting……

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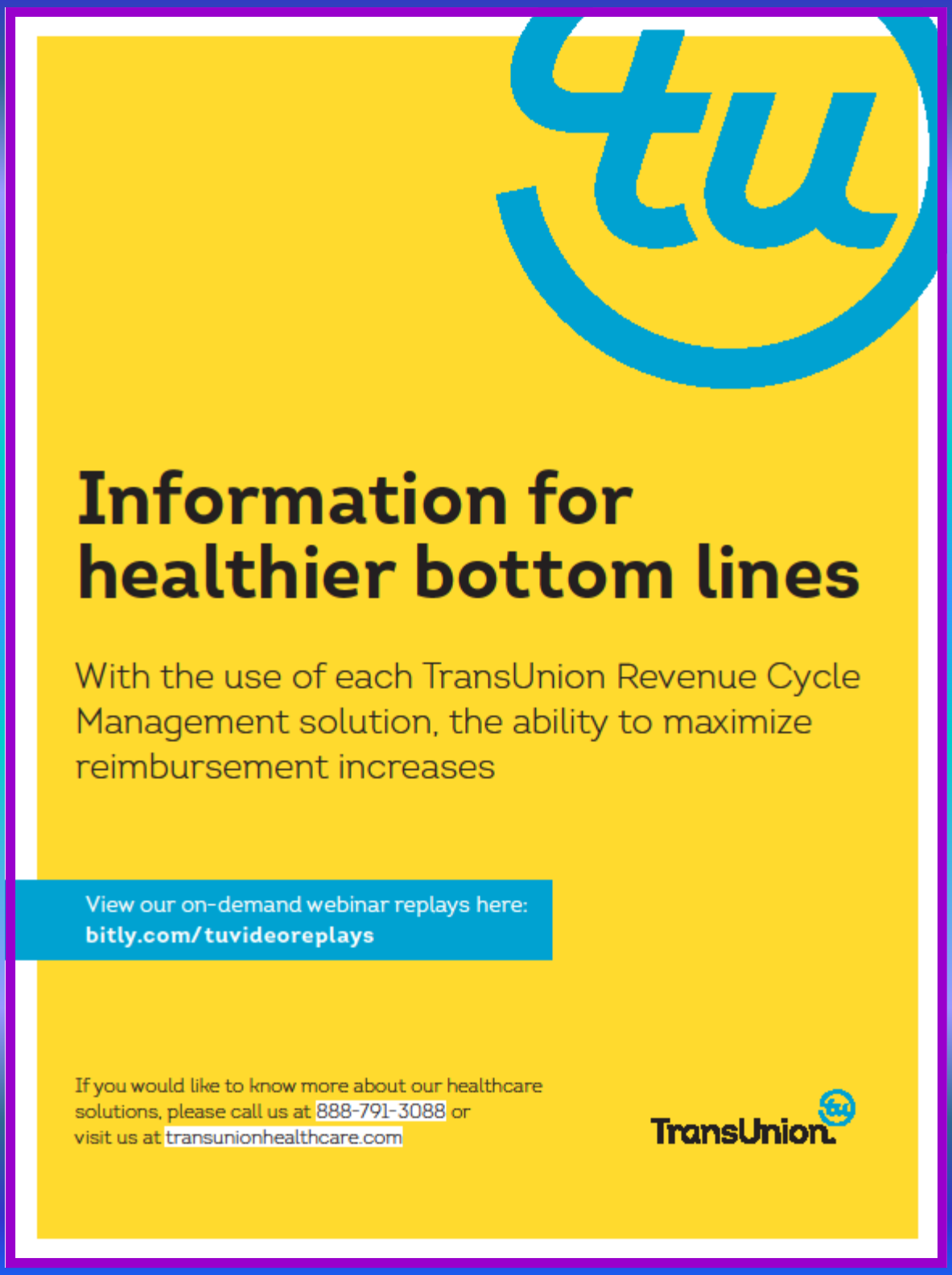
Information for healthier bottom lines
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Terry Fuller or Rika Gripp at 1.800.723.5463

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Hospital Spotlight.....

Bath Community Hospital

Bath County Community Hospital is a not-for-profit critical access hospital located in Hot Springs, Virginia. The hospital has 25 beds for acute or skilled care, and they provide 24hr emergency services.

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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

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

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Certification

2017 Certification Schedule

July 10-21, 2017
July 2017 Exam Period

August 15, 2017
Registration deadline for November 2017 Exam Period

November 6-17, 2017
November 2017 Exam Period

December 15, 2017
Registration deadline for March 2018 Exam Period

A Tribute to Shirley Clatterbaugh…..

When Shirley came to work in the Credit Office (now PFS) in the early seventies I met not only a co-worker but I met a friend for life. Shirley was a caring and friendly person. She was smart , intelligent, dependable, honest and very compassionate. She took a lot of pride in her work and was very dedicated to her job. She worked in the collection department and went to court to obtain judgments. She was well adverse in the collection laws It didn't take long for Shirley to move into a Supervisor position. She stayed in that position until she had to quit work due to medical problems. After being away for a period of time she returned to PFS as a Medicaid claims processor and remained in that position until she had to retire due to health issues. She was very knowledgeable regarding billing of third party payers. She was employed for UVA Health Systems for over thirty years.

Shirley joined AGPAM (now AAHAM) and became very active in the organization. She was certified as CPAM(now CRCE-I) in 1992 . Shirley received the Leslie Hample award (Now the Certification Excellence award) for the highest score on the professional exam. Shirley was Secretary of the Virginia chapter in 1994-1995. She also served on several committees with AAHAM. Shirley and I attended many National and Local Chapter AAHAM meetings together.

Some of my fond memories of Shirley is the fun time our two families had at Virginia Beach together. The hayride and cook out we had at her house when she lived in Scottsville, Va. there are so many more I could mention.

Shirley made many friends over the years and she had a heart of gold she always thought of others and would help out anyone that needed it .I thank God that he brought Shirley into my life she was a blessing me.

Written by: Leanna Marshall

Switching For Sustainable Success

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Today in our daily healthcare business transactions, we still experience the same "complaint" that I have heard for over 35 years…'If only Registration would get it right, we would not have all of this re-work'. Does this sound familiar to anyone! Well there are some considerations for the reality of this statement. According to various studies, the section of the Revenue Cycle known as 'Patient Access' is one of the departmental areas that has a high volume of turnover.

Some studies have indicated that this turnover can range around 70 to 80% during one year. Another factor within this department is that it is open 24 hours a day 7 days a week (if closed, registration is through the Emergency Department). With this open schedule, there are many part-time positions needed to cover the various shifts with some members only working weekends and some working four hour shifts. This is a tremendous hindrance in striving for accuracy, completeness and clarity. A third factor is if your facility is not "officially" opened 24/7 but utilizes the Emergency Department for registration during these down times. Staff within the Emergency Department (usually clinical) are not familiar with all the elements required for a complete registration. In fact, some facilities have a "short" registration for the clinical staff. Now I am not making excuses for the Patient Access Department but just talking the reality of today's world. People tend to believe that with today's efficient software, there is no reason for errors in collecting patient data.

Here are a series of reality situations within the Patient Access Department:

- I forgot my insurance card!
- Yes, nothing has changed (but it truly has changed)
- I am divorced so my husband should pay (and use his insurance)
- Birthday rule in the collection of who has primary coverage
- I don't know when the pain started…a few days ago

I am sure that there are others that you can think of but this can give someone an idea of what this staff goes through in gathering data. There are typical claim denials that, once identified, recognized that they are initiated by different departments. The most common denials, coming from different departments are:

- Claim not specific enough regarding the specificity of the diagnosis code to the services rendered;
- Missing information on a claim such as date of accident, date of onset, etc.
- Timely filing of the claim to the insurance carrier
- Incorrect patient identifier information
- Wrong ICD code for services rendered
- Duplicate billing
- Upcoding or unbundling
- Medical necessity
- Referral or prior authorization required
- Services not covered/coverage terminated/'cap'reached

As we can see there are other Departments that are involved with denials in the Revenue Cycle and that includes clinical departments that have access to certain modules of the system. However, we will not consider those departments in this article. The express point of this article is to focus on a sustainable practice that has proven successful in the reduction of denials and a high percentage of clean claim submissions. This practice can be implemented now and incorporated with your facility's overall education/training program. Let's put this practice into the form of a policy and procedure.

Switching For Sustainable Success

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Policy: It is the policy of this facility that all personnel directly involved with the Revenue Cycle Process be given education and training in the fundamental procedures of each facet of the patient's experience. This education and training will be given to all new personnel* prior to their assigned role. There will also be additional education and training associated with those personnel who desire to advance and achieve a certification. (This policy for certification can involve payment by the student first and then reimbursed by the facility when certification is achieved or any variation of this).
*This education and training can occur with current personnel over a planned period of time.

Procedure: Under the authority and responsibility of the Director/Manager of Patient Financial Services and with the full cooperation of both the Director/Manager of Patient Access and Health Information Management, education and cross-training of Revenue Cycle Staff with occur over a designated period of time (e.g. two months (minimal) or more). The personnel from each department will directly report to their appropriate Director/Manager during this time but follow all of the associated protocols in this education and training procedure. There will be a general knowledge questionnaire at the end of this education/training to be given to their direct supervisor and placed in their Human Resources file.

For Health Information Management personnel:

- After completing the formal introduction to the facility's policies and instructions from the Department of Human Resources, they will report to their Department supervisor;
- The Department Supervisor will introduce the staff person to the 'particulars' of the Department of Health Information Management regarding daily responsibilities and accountable tasks;
- The new staff person will spend approximately one month in their newly assigned position before moving into the cross-training program;
- When scheduled, the new staff person will begin training in the Department of Patient Access under the supervision of an assigned 'mentor';
- The training will consist of system familiarity, basic data collection requirements to include
  - Verified demographic information
  - Third party insurance information that requires verification on-site
  - Physician order review for service/diagnostic information which will require some personal study of referral requirements and prior authorization requirements as well as medical necessity information.
- The total training period for this program should be about one month. Note, there should be an exchange of personnel between the new staff person and someone from Patient Access.
- After completing two weeks in this Department, the new staff person will move to the Patient Financial Services Department. The Patient Access person in Health Information Management will return to their original position and someone from Patient Financial Services will be the exchanged member.
- NOW, in the Patient Financial Services Department, the new staff person should work with the area that handles denials. There should be a report that indicates the top 10 denials for the system from all payors and this should be reviewed and highlighted regarding the denials directly due to diagnostic coding;
- The new staff person should be allowed to work as many of this type of denials as possible for at least two weeks (with a month-long program, there would be two weeks in Access and two weeks in Patient Financial Services).
- Upon completion of the program, the new staff person should be given an 'experience' test combining both Access and Patient Financial Services questions. This test is not a qualifier for employment but is a retention test to assess the understanding of both Departments and how the Health Information Management Department can affect the clean claim process.

Switching For Sustainable Success

Continued on next page

For Patient Access and Patient Financial Services Departments:

NOTE: *Distinctions are in italics*

- After completing the formal introduction to the facility's policies and instructions from the Department of Human Resources, they will report to their Department supervisor;
- The Department Supervisor will introduce the staff person to the 'particulars' of the Department of Patient Access/Patient Financial Services regarding daily responsibilities and accountable tasks;
- The new staff person will spend approximately one month in their newly assigned position before moving into the cross-training program;
- When scheduled, the new staff person will begin training in the Department of Patient Access or Patient Financial Services under the supervision of an assigned 'mentor';
- The training will consist of system familiarity, basic data collection requirements *for Patient Access* to include
  - Verified demographic information
  - Third party insurance information that requires verification on-site
  - Physician order review for service/diagnostic information which will require some personal study of referral requirements and prior authorization requirements as well as medical necessity information.

  Basic data collection requirements for Patient Financial Services to include
  - *Various data element requirements from the different third-party payors including Medicare and Medicaid and other government programs*
  - *Data element edits that prevent a clean claim submission*
  - *Items that need re-verification from Patient Access*
  - *Denials that occur due to lack of complete or wrong information coming from the Patient Access Department and Health Information Department.*
- The total training period for this program should be about *six weeks*. Note, there should be an exchange of personnel between the new staff person and someone from *Patient Access/Patient Financial Services*.
- *For the new staff person from both Patient Access and Patient Financial Services, the education/ training in Health Information Department will be for two weeks and will consist of understanding the information that is provided from Patient Access for initial clarification of the patient's diagnosis as well as the interpretation of the physician and other clinician notes that further detail the reason (s) for the services rendered.*
- After completing *two weeks* in Health Information Management Department, the new Patient Access staff person will move to the Patient Financial Services Department. The Health Information Department person in Patient Access will return to their original position and someone from Patient Financial Services will be the exchanged member.
- NOW, in the Patient Financial Services Department, the new staff person should work with the area that initialing handles the submission of clean claims as well as the area that handles denials. There should be a report that indicates *the percentage of clean claims that are submitted daily and another report that indicates the top 10 denials* for the system from all payors and these should be reviewed and highlighted regarding the denials directly due to diagnostic coding;
- The new staff person should be allowed to work as many of *the* denials as possible for at least two weeks *and the final week learn about the various billing requirements for the different payors.*
- *NOW for the new staff person from Patient Financial Services completing their time in the Health Information Department, they will move to the Patient Access for three weeks. The exchange of staff will occur as the program continues.*

Switching For Sustainable Success

- *NOW, in the Patient Access Department, the new staff person should learn all the protocols for collecting data upon registration. If there is a manual, it should be read at the beginning of the exchange experience.*
- *Working with a mentor in this Department, the new staff person should learn the screen formats and the various questions posed to the patient prior to any service/admission.*
- *During this experience, the new person should be allowed (under supervision) to register patients with different coverage, e.g. Medicare, Medicaid, Blue Cross, self-pay, other insurance.*
- Upon completion of the program, the new staff person should be given an 'experience' test combining both *Health Information Management and Patient Financial Services/Patient Access* questions. This test is not a qualifier for employment but is a retention test to assess the understanding of both Departments and how *they can affect the clean claim process.*

This program creates a sustainable environment of best practice training as well as an indicator regarding the future career path of the new staff person. All things involve an investment. This is an investment in time and talent but the outcome is an improved process within the Revenue Cycle.

Rob, formally President of Best Practice Associates, is now a principal with Federal Advisory Partners. For any questions, Rob, formally President of Best Practice Associates, is now a principal with Federal Advisory Partners. For any questions, Rob can be reached at 315 345 5208 or rob@bpa-consulting.com

The Virginia Chapter of AAHAM
American Association of Healthcare Administrative Management

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Director of Patient Accounting

Augusta Health

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

On the lighter side of things.....

- Fresh Strawberries
- Red Seedless Grapes
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- Blueberries
- Large Marshmallows

Wash and dry fruit & remove pits from cherries. Grab your wooden skewers, and simply alternate fruit and marshmallows in fun patterns.

I ❤ Virginia

National News— www.aaham.org

AAHAM announced a new mid-level certification at the 2014 Annual National Institute (ANI) in San Diego, CA, the Certified Revenue Integrity Professional (CRIP). This certification is intended for individuals in the revenue cycle to help ensure that facilities effectively manage their facilities charge master, and bill and document appropriately for all services rendered to a patient. This certification requires an in-depth, working knowledge of various revenue cycle areas and proper skill sets needed to increase revenue and reimbursement for facilities. It also ensures that proper charging takes place to maintain compliance within the insurance payer programs. 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**

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/



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National News— www.aaham.org

The 2017 Annual National Institute will be held at the

Opryland Resort in Nashville, Tennessee

October 18-20, 2017

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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. I hope that you will consider supporting Virginia AAHAM this year. —***Dale Brumbach,***

I ❤ Virginia

Mark your calendars!

Upcoming VA AAHAM events:

2017 Fall Regional Conference, Fredericksburg, VA.

Mary Washington Hospital September 22, 2017

2017 Annual Meeting and Conference, Williamsburg, VA.

35th Anniversary, Dec. 6-8, 2017

Go to our web site for more information and registration:

The Virginia Chapter of AAHAM American Association of Healthcare Administrative Management

www.vaaaham.com

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Some other important dates. . . . . .

August 26

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 2017. 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

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.