The Virginia AAHAM Insider

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

The President's Message

Dear Virginia AAHAM Members and Friends:

How are you? I realize that I ask this question, as I am staring at my laptop screen, not really expecting an answer from any of you! How often during a day, week or year do we ask this question of others? Do we really listen to the answer or is it just an acceptable social gesture that we have come to expect of others and ourselves?

Listening is a skill that not everyone possesses. We all know that one person who listens with the intent of responding rather than reflecting first. So where am I going with this, you ask? Our Chapter strives to bring you meaningful education and information and we need your help in determining what your needs are. Soon, you will be receiving a Membership Survey. Yes, we ask you to complete a survey every year and I know that surveys are not always fun to complete, other than the occasional "win this beautiful home on the beach" survey. (you know what I'm referring to). I do hope that you take a moment out of one of your busy days to answer a few questions for us. It is most helpful in planning our future for the Virginia Chapter of AAHAM, one that involves you.

At a recent board meeting, we talked about branching out to other parts of Virginia, in order to bring in more colleagues and expand upon our networking. We recently did that in traveling to Fairfax. That meeting was well-attended and the topics were on point. Please help us to steer this VA AAHAM ship into more directions in 2020. We look forward to hearing from you!

We are already midway into 2019 and I hope that you will add the following events to your calendars, if you have not done so already:

September 6th	Fall Conference – Mary Washington Healthcare's Fick Center, Fredericksburg, VA
October 9th-11th	AAHAM ANI – Caesar's Palace, Las Vegas, NV
December 4th-6th	Winter Annual Conference – Kingsmill Resort, Williamsburg, VA

Well, my friends this brings my message to a close. I wish you a great summer and look forward to seeing you in Fredericksburg on September 6th. Until then be well and let me know how you are doing…I'll be listening.

Yours in AAHAM,
Lin

Inside this Issue:

The Virginia Chapter of AAHAM

American Association of Healthcare Administrative Management

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Augusta Health-Interview with Matthew Painter, MSN, FNP-C

Why did you choose your specialty area?

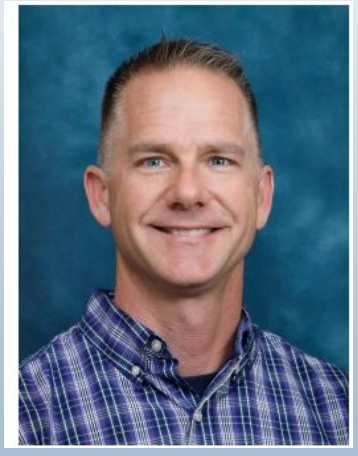
I have been an emergency provider/flight nurse for most of my career along with serving as a volunteer EMS provider. I have enjoyed my emergency work, but missed developing a relationship with patients since I was only involved in their care for a short period of time. Primary care allows the provider and patient to develop a partnership to assure health and wellness. I look forward to developing this health partnership with my patients and progressing into a new area of my career.

How do you spend your spare time?

I love to be outside spending time with my amazing family. Running and weight lifting are activities I enjoy to keep physically fit. I enjoy helping with activities at my church, as building my faith is a large part of my life.

What is the #1 health tip you can offer?

Exercise! Sitting has been branded the new smoking as inactivity results in a huge health risk from cardiovascular problems to even depression. So many people do not get enough exercise because they have a misunderstanding and fear of what it involves. You don't have to run a marathon to obtain health benefits from exercise. Exercise is the best "fountain of youth" medicine we can offer, and it is free.



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Being in primary care for several months now, how are you establishing a relationship with your patients on the first visit?

I like to set the tone of a relaxed atmosphere. People like to talk about what is wrong with them. You have to let them talk & listen. I tell most patients to think of our visit as we are having coffee and talking.

How are you adjusting to the structured schedule opposed to the more emergent trauma situations?

It actually is nice. I still work PRN on the Medevac-so it keeps me going in that regard. I like having time with people. Assess and devote time to figuring out the person's problems.

Matthew Painter, MSN, FNP-C

Board Certifications: National Registered Paramedic; Certified Flight Registered Nurse

Professional Membership: American Academy of Nurse Practitioners

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The Virginia AAHAM Insider

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The Secret to Successful Cash Reconciliation

Tyler Kurasek and Peter Angerhofer, Colburn Hill Group

A journalist, covering a college golf match at Princeton, chanced upon Albert Einstein taking a walk on the golf course. Looking to make conversation with the man whose name is synonymous with genius, the journalist asked, "Mr. Einstein, do you play golf?" Einstein replied, "No, no. Tried it once. Too complicated. I quit." The journalist concluded if it was too complicated for Einstein, how could anyone else figure it out?

Even though provider Finance departments are populated with smart, capable people, they often struggle with cash reconciliation. Given the tools available in patient accounting systems, most resort to using spreadsheets and manual processes to match bank deposits and posting transactions. They spend most of their time confirming the deposits and transactions which match, and therefore don't have adequate time to work and resolve those that do *not* match. At some point, when the unreconciled amount is relatively small and the effort to close the gap is too great, those finance teams declare the process too complicated and following

Einstein's approach simply quit.

Especially in more complex operating environments, failure to appropriately reconcile cash can cause hours of rework, headaches with a variety of stakeholders (cash posters, follow up staff, and finance - not to mention auditors), and can leave uncertainty about whose cash is whose. To avoid unreconciled cash, organizations should understand the causes of the problem, avoid the common mistakes in cash reconciliation, and focus on adding one simple, though potentially hard to execute task: *track cash by deposits*.

When hospitals were generally one entity and had straightforward relationships with a small number of payers, cash reconciliation faced one relatively simple problem: Checks and remittances often arrived at different times. That disconnect, along with potential delays in cash posting processes, meant that cash in the bank had not necessarily been posted against the claims that had been paid with it.

The problem became slightly more acute when cash was received near the end of one month but the remittance was received or posted in the following month. But, during this simpler time, the imbalance of postings and deposits could be resolved with a simple comparison so Finance knew whether the cash associated with payment on an account had been deposited.

However, as hospital and payer environments have become more complex, so have the cash posting and reconciliation processes.

Owned physician groups should generally receive separate remittances, but payers often combine payments, delivering one check with a series of remittances. Hospital based billing arrangements add another layer of complexity, and a proliferation of payers with a variety of payment methods create a new set of challenges. Even the common experience of secondary or tertiary payments inserts ambiguity in the cash posting process.

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Additionally, the consolidation of administrative functions, including the growth in revenue cycle management outsourcing functions has added yet another layer of intricacy. For example, if a health system has moved from posting patient payments itself to doing so in a centralized function, payments commonly get batched up in ways that may make reconciliation more difficult. With more entities sending cash, receiving cash, and posting cash, reconciling payments has become more challenging. A single deposit may consist of multiple payments and those payments likely consist of multiple batches in multiple systems.

The constant flow of payments (including take-backs) and remittances have led hospitals to implement a variety of tracking mechanisms. In one hospital we worked with, the revenue cycle department used a highly manual, paper-based system to tie out deposits and postings. The process was so antiquated, the revenue cycle department had to contact multiple office supply vendors looking for a supplier of carbon paper, a key element in their reconciliation process!

Another hospital we helped had been attempting to track payments and reconcile via excel workbooks. Daily deposit sheets were kept for each day with separate workbooks for each payer, meaning the number of worksheets quickly ballooned into the tens of thousands. If a deposit was entered incorrectly or if someone needed to find a historical deposit, searching through dozens of files and thousands of worksheets was theoretically possible, but functionally impractical.

Given these challenges, too often hospitals choose to give up, accepting that their reconciliation efforts will fall a few thousand (*or a few hundred thousand*!) short of fully reconciling, and they accept the risk and costs of not being fully reconciled.

In our work with clients, we have found one key insight to shortcutting the reconciliation difficulties faced by so many in the industry: *use the deposit as the source of truth*. Deposits can be split into the various accounts where the cash belongs and can be posted into whatever systems or batches are appropriate. This layout quickly highlights the many-to-many complexities with today's deposits. However, while manually creating and managing a database of this structure is a viable option for reconciling cash, it does have limitations: it requires a significant amount of data entry, and entails all the risks associated with manual keystrokes.

In addition to adopting a "deposit as the source of truth" mentality, providers struggling with reconciliation should seek or build a technology solution that integrates a relational database with exception based workflow management. This approach eliminates the tedious and human error prone process of manually matching deposits and posted transactions, allows for far faster and more comprehensive reconciliation, and provides a variety of management reporting functionalities that are difficult to replicate in even the most elaborate excel spreadsheet.

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For many Finance departments, reconciliation is a headache that rears its ugly head at the end of each month. While the cash posting process is often highly automated and supported by significant technology, cash reconciliation has not received the same level of attention. As a result, it is highly manual, often overlooked, and extremely complicated. It is no wonder so many operations reach a point where they deem it too complicated and simply give up and say, "I quit." Fortunately, if you focus on deposits as the source of truth and make use of available tools, you do not have to be an Einstein to complete your cash reconciliation.

Tyler Kurasek is a principal at Colburn Hill Group, and is the inventor of a Software as a Service (SaaS) application which allows hospital and physician groups to manage deposits, posting, and reconciliation of insurance and self-pay cash.

Peter Angerhofer, MBA, is also a principal at CHG; he brings experience in operations, strategy and health policy to both the daily operations as well as long-term vision.

Colburn Hill Group is a revenue cycle management firm which offers solutions through tech-enabled tools such as Robotic Process Automation as well as operational consulting. www.colburnhill.com

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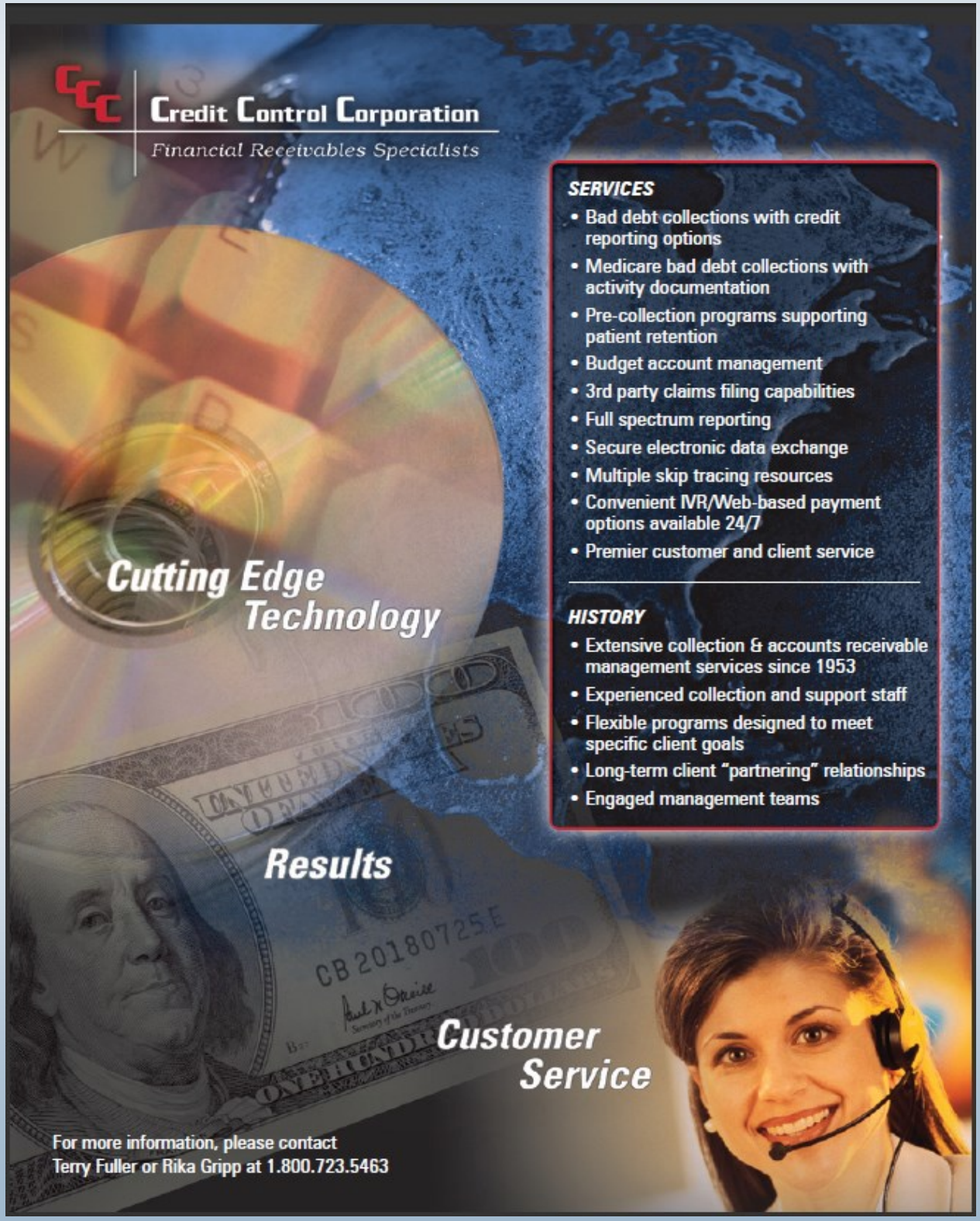

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Technology-Enabled Services In Health Care

Bradley Granger

Popular media in numerous industries—including health care—are abuzz with the potential of artificial intelligence (AI). Although it can be hard to separate the signal from the noise in such coverage, there are indeed positive trends in AI that are immediately applicable for organizations.

However, the concept of AI is a broad one, and its applications are myriad. It is therefore helpful to classify what it is and is not. Broadly, AI falls into two areas in modern health care: clinical and operational. The former often provides flashier headlines, promising independent robots who can diagnose and treat illness. However, it is on the operational side that more promising developments already exist. These come in the form of automation and optimization of existing practices, such as billing and patient coding. It is with these technology-enabled services—to borrow a term used by the Centers for Medicare and Medicaid Services (CMS)—that the potential to cut costs and increase quality of care is a more immediate reality.

Why Transition?

The "why" behind a transition to a particular technology can be the same as it is for a timely refinancing or much-needed renovation: desiring to increase quality of care and/or pressures from higher costs or shifting regulatory pressures. In addition, changes to payment processes that either affect or are affected by health care services that technology can support can provide ample reason for a technology upgrade.

CMS is beginning to recognize these needs as well, and is creating new and more nuanced reimbursement rules that will benefit proactive organizations.

Perhaps most importantly, technology-enhanced services have the potential to increase quality of care. Below, we will discuss several technologies that currently exist which fulfill this purpose. As these examples prove, clearly the universe of potential applications is growing at a staggering and encouraging rate.

A recent study by Accenture notes: "Growth in the AI health market is expected to reach $6.6 billion by 2021—that's a compound annual growth rate of 40 percent." That is a clear sign that operators are heeding a similar call to maximize their efficiency through technology-enhanced services.

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Efficiency Through Technology

What are the most promising current technologies that are helping organizations stay focused on patient care? Below, we highlight several prominent technologies currently in use.

Automating Patient Insurance Verification. Administrative costs as a share of total health care spending have reached 8% in the U.S. In other countries, the number is 1 to 3%. This is work that, by its very nature, is not directly related to quality of care. Instead, inefficiencies in this area can result in increased denial rate, longer wait times for walk-in patients and overtime for overworked staff. Automating these processes through AI can result in significantly reduced wait times, often reducing them from hours or even days to mere minutes.

- **Electronic Health Records (EHRs).** EHRs are one of the more well-known technology-driven changes in the industry. However, many organizations do not realize the full extent of their potential. Thorough analysis of records and record-keeping—then applying those results to operational and clinical change programs—can create a holistic system of tracking and care that consolidates and refines practices. This can make these record systems a catalyst for change instead of merely a regulatory necessity.

Telemedicine. Generally, telemedicine refers to either video conferencing with patients or various forms of remote patient monitoring. The former increases access to care. The latter removes some of the strain that can be placed on smaller facilities or facilities in areas with a diffuse population. Numerous studies have found that telemedicine can lower costs and improve patient outcomes.

Under the Radar Possibilities. New technologies are constantly being tested, trialed and improved, then rolled out into various markets. Some, like smartphone apps for first responders, have shown promising results in patient outcomes, as they facilitate better communication between first responders and partnered hospitals. Similar initiatives, like a signal preemption system that was implemented in Savannah, Georgia, reduced average EMS response times by five to seven minutes.

While topics like telemedicine and EHRs have dominated technology discussions in health care, this list is still far from complete. It behooves operators to understand their options and what those options could mean for care outcomes.

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Support From CMS

The Medicare Shared Savings Program (MSSP) is a good example of institutional support for technology-enabled services. The MSSP is an alternative payment model that recognizes telemedicine services as a clinical practice improvement activity, which is a component required for incentive payments. Through this program, there are waivers available for physicians who provide patients with free equipment for remote monitoring services.

Unfortunately, uniform coverage of telemedicine under Medicaid remains elusive. Policies and decisions related to such reimbursements are determined on a state level. However, telemedicine has been reimbursed in some form since 1997, and various forms remain eligible to this day. Since CMS defers to states to define reimbursement qualifications, it is important to know what they are before any adjustment is made to current practices.

Another interesting development is that some states have begun to adopt separate payment structures for "technology-enabled services." By listing these services as distinct from telemedicine, they are able to expand their benefits in regard to technological costs, thereby reducing costs for facilities.

Examples of eligible technologies include remote monitoring of physiological parameters (weight, blood pressure, etc.) through apps or smart watches, as well as clinician-to-clinician consultations that help to share information and practices among and between health systems. Understanding your state's policies surrounding documentation, billing and approval of technology-enabled services is crucial to maximizing their benefits.

Where to Start

Fears around the implementation of new technologies can be warranted. A good first step is to talk to other facilities—either within your care network or through other channels—to gauge the effectiveness of certain technologies. It also is important to speak with partners whose clinical and operational experiences work together with sound financial strategies, in order to wisely build a facility's technological infrastructure. Blindly trusting a large, new system or industry report can lead to frustrations or, worse, a failed implementation of a system that might not be the best fit for your organization. There can be a risk in not investing in new technologies as well, but gathering relevant and trusted information will help to avoid missteps.

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Once a decision has been made on a new system, a clear vision from leadership that is disseminated to employees can help to mitigate anxiety over systemic changes or job security. Ideally, any change is one that strengthens focus on care and is not disruptive to the workforce.

The previously mentioned Accenture study notes: "By 2026, AI can create $150 billion in annual savings for the U.S. healthcare economy." Another study published in MIT Technology Review states that "more than half of early stage and mature-stage users of AI say their efforts have resulted in demonstrable ROI."[1]

With such widespread acceptance and implementation, it is clear that while health care leaders need not be experts in AI or other technologies to reap their benefits, to ignore their effectiveness is a potential hazard to the long-term stability of an organization. Deliberately seeking out and adopting the most useful technologies can and should be a priority for those looking to create efficiency and reduce costs while increasing quality of care.

[1] MIT Technology Review Insights and Google Cloud, "Machine Learning: The New Proving Ground for Competitive Advantage," MIT Technology Review, March 16, 2017.

Bradley Granger is a vice president, operational and clinical underwriting with Lancaster Pollard Mortgage Company, a financial services firm based in Columbus, Ohio, that specializes in providing capital funding to the health care and senior living and sectors. LPMC is a division of ORIX Real Estate Capital, LLC. Securities, Investment Banking and Advisory Services provided through OREC Securities, LLC, Member FINRA/SIPC

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DRG Downgrades, Cost Outlier Reviews and Retroactive Takebacks

Brandon Holland, Principal, Triage Consulting Group

WHAT TO LOOK FOR

Tips for identifying, preventing, and recovering DRG and Cost Outlier Denials

Where are the requests being sent within your facility? *Make sure your various teams and departments (HIM, PFS, Managed Care, etc.) are looking out for and responding to these requests.*

Who is the payer and who is the third party reviewing the claim? *Make sure you are following the appropriate steps to answer their specific request. Sometimes requests include much more than just a subset of Medical Records.*

Pay attention to older claims. *Hospitals are experiencing takebacks > 1 year from initial payment leading some of these to slip through the cracks.*

Reply quickly. *Either respond directly to the payer/third party review company's request by sending the requested documents, or go straight to you payer representative to dispute the process if it is not in line with the contract you have in place.*

Follow Up Often. *These denials are difficult to overturn*

Many hospitals are experiencing an uptick in denials and recoupments related to DRG downgrades and charge validation. Commercial payers use a variety of Third Party Review companies (Equian, Cobius, Med Review, Ceris, etc.) to dispute charges and the validity and order of specific codes on claims leading to reimbursement recoupments and refund requests. In many cases, payers remit full reimbursement for the billed DRG and then recoup payment months (or years…) later once a downgrade is determined or a charge/outlier review is requested. While these reviews and requests may be in line with payer policies, the number being submitted and the reimbursement at stake makes this a high priority issue that warrants hospitals' attention.

The first steps in disputing a DRG downgrade are determining if medical records were reviewed by the payer, which code triggered the downgrade, and whether or not the codes are supported by the medical records or are related to a payer policy or clinical bulletin. You may also receive letters requesting sign off on the downgrade as a clinical review should be required to 'agree' with the downgraded coding. If these letters are not being signed off by designated expert on your team, it may warrant a discussion with your payer representative.

Additionally, payers and their third party review companies may target outlier claims for your Medicare Advantage population by reviewing and denying charges, thus reducing reimbursement. These requests are often line item specific and usually require a detailed review from HIM staff or Nurse Auditors to overturn. Because these reviews involve outlier claims, the reimbursement impact to your organization can be significant and the time it takes to resolve them is substantial. Timeliness is key, so keep an eye out for any payer requests on outlier claims and reply quickly either with official responses or by pushing back on any requests that go against the contractual policies you have in place.

If you find this is occurring at your facility, first try to get an idea of the volume of claims that are impacted. Many times it is easier to work directly with the payer and their third party review company to resolve the recoupments in bulk rather than spending time disputing each account separately. Keep in mind that while you may not see this happening now, providers should continue to monitor for this issue as we have observed this practice nationwide. Please contact Brandon Holland at brandonh@triageconsulting.com with any questions.

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Stepping Into The Future By Reviewing The Past

Rob Borchert, MBA, CRCE-I

I have just returned from giving two presentations to my "original" AAHAM chapter, Hawthorn chapter in Missouri. It was a wonderful experience and stepped into the future by reviewing the past. I am a past president of the Hawthorn chapter so when a past member, friend and now, president called and asked me to speak, I was thrilled. We talked about various subject matter and decided on two focus points…"Benchmarking…" and "A Walk thru the Revenue Cycle".

Now, many of you are thinking…Oh! These are old topics…what can we learn from them? It is true that most of us would consider these to be old topics, but we can always learn from the past. As I was putting the presentations together, I was thinking just that…these subjects have been presented before so what would be the best way to present them to an audience of people wrapped up everyday in the revenue cycle? Well, let's first start with the audience itself. The typical AAHAM audience consists of people from both the hospital and the physician environments of healthcare. They are revenue cycle managers/supervisors; patient accounting managers/superiors and staff; have some health information management managers/supervisors/staff; and vendors from various healthcare support areas. I am sure that each chapter and each meeting has its own mixture environment and it is always nice for a speaker to know what the audience mixture will probably be.

I am proud to say that I been a member of AAHAM (AGPAM) for almost 40 years (joined at a very young age). I am also proud to say that I was president of the Hawthorn Chapter many years ago and that relationships have maintained themselves over the course of time. This is why the current president of Hawthorn called me to speak…we have a historical relationship and I would not let my old chapter down. In fact, when I arrived at the meeting place, there were two other long-time relationship friends there and another who arrived the next day. It was a wonderful sense of 'reviewing the past and moving to the future'.

Now, we first chose the topic of 'benchmarking' for a couple of reasons. First, it is an excellent way to monitor any project or environment surrounding the revenue cycle. Benchmarking, today, is more than just aged bucket percentages and clean claim submission percentages and denial percentages, etc. These are normally a part of your daily 'dashboard'. My belief, my opinion, my strong recommendation is that revenue cycle people, like us, become much more involved with areas of the full revenue cycle that, through benchmarking, can add tremendous value to your facility. With this belief (etc.), I put my presentation together to show the audience some areas what benchmarking can truly add value. Aside from the 'regular' benchmarking areas mentioned above, we discussed other areas (out of the box) where the data generated from our various revenue cycle systems (and other associated systems), one can generate benchmarking data for:

- Discharged-not-final-billed by department based on the various types of charging, i.e. charge at time of service, charge at time of result, charge at time of supervisor approval, etc.
- Percentage calculations from the general ledger accounts for 'revenue by payor' vs. 'adjustments by payor'; denials by type, by payor vs. appeals by payor, etc.
- Contracted rates by payor regarding charge/allowed/collected…compare this information across all of the payors in one spreadsheet
- Contracted rates by type of contract by payor for allowed percentages of common services to access the 'winners and losers'

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- Contracted rates by payor by clinical service area to assist with future contract negotiations
- Denials by type, by payor across all payors to assist with future contract negotiations (one should do both initial denials and resolved (positive) denials.

We had other discussions regarding other areas, but these were valued discussions to get revenue cycle people involved with other areas of the facility. We also had audience attendance from physician office and many of these discussion points apply to their environment as well.

When it comes to 'A Walk thru the Revenue Cycle…", I tried to present the revenue cycle areas with both the old points of discussion as well as 'out of the box' discussion points. It was very interesting to hear that feedback regarding the out of the box discussion points were responded with "they would never do this OR they would never let me do this!" I know that many of you would probably disagree with either their comments or the 'out of the box' approach to a revenue cycle area but an open mind is always a good thing when striving to improve any area. During the presentation, we talked about the initial contact with the patient (scheduling) is usually done by the physician office. Many appointments for ancillary services as well as ambulatory surgery or inpatient admission is done by the nurse or admin person in the physician office. If surgery is involved, there is typically 'two' areas for scheduling…surgical and then administrative. Is this true for you also??? If so, we discussed the potentially different reasons for the patient's admission to either outpatient or inpatient. The surgical area may clarify the patient procedure clearly while the administrative area may just get a very general reason for the service. Does this matter? Yes, it does since detail diagnostic information is the focus for service and reimbursement. So scheduling is a point of discussion.

Other areas such as pre-registration and registration are very good areas for discussion. The audience did discuss that they do pre-registration via phone to the patient to gather both demographic and financial data. However, they do not know (or do not tell) the patient if there is a deductible or co-pay associated with the visit/admission. One point of discussion was that most of the inpatient admissions comes through their Emergency Room so data capture is at a minimum. Lots of discussion in this area regarding capturing full demographic and financial data like sending someone to the patient's room or asking a 'support person' to give us the data prior to the patient going to their room. We know that this is a sensitive area due to various emotions but one thought was to have a 'admission/welcome' package. These packages would be based on the critical, diagnostic nature of the admission and would include items like a toothbrush/toothpaste; deodorant; pack of cards; description/history of the facility and other creative items. This breaks the potential tension of collecting demographic and financial data. Moving into the clinical areas where the charging and coding takes place, we talked about concurrent review and the pros and cons of this activity and how it influences the patient's account. We talked about how doctors (radiologists) change the 'ordered' test because they believe that it is 'better' for the patient but it may not have been 'authorized' by the payor. We even talked about pathologist and doing a 'study' on the extended length of time waiting for the pathology charge to complete the bill versus charging at time of order and the potential crediting and debiting for a claim re-submit if the pathologist changes the ordered test.

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We then continued and talked about billing and, of course, denials. We discussed the recent study basically showing that the top ten denials have not changed in over 30 years. Yes, everyone agreed with the study and we discussed having the denial team actively addressing each denial since they are generated by various departments. We ended by showing the denial and resolved rate graphic by payor as an example of benchmarking, success rate, and meeting with the payor to challenge the rate of initial denial if there is a high percentage of resolution from the first follow-up encounter. We also discussed the use of this data in negotiating payor contracts.

What was significant about this conference, unlike others I have attended and/or presented at, the vendors stayed for each presentation and even participated with examples from their own client base. I think that this is a wonderful environment where vendors, consultants and revenue cycle members can all participate and share their experiences to better improve each other. Even after all of my many years of consulting, interim management and conferences, I still find that I am able to "Step into the Future by Reviewing the Past." Thank you AAHAM.

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- ⇒ **9/13 A/R Management**
- ⇒ **9/20 Billing Part I**
- ⇒ **9/27 Billing Part II**
- **VA AAHAM Fall Conference 9/6/19**
- ⇒ **Mary Washington Healthcare-Fick Center**
- **VA AAHAM Winter Annual Conference 12/4-12/6/19**
- ⇒ **Kingsmill Resort Williamsburg VA**

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Mindy	Truong	Inova Health System
Jessica	Galberth	Inova Hospital
Diane	Cramer	Mary Washingon Healthcare
Holly	Dobson	Mary Washingon Healthcare
Claudette	Foster	Mary Washingon Healthcare
Stephanie	Hilgris	Mary Washingon Healthcare
Donna	McHugh	Mary Washingon Healthcare
Samantha	Lundin	Mary Washington Healthcare
Lynn	Rafferly	Mary Washington Healthcare
Michele	Noel	Mary Washington Hospital
Kellie	McBride	Whitman Walker Health

The Virginia AAHAM Insider

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

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.

The webinars that were held on credit & collection; Patient access and Billing are out on the web site.. Also a practice test is out there and the power points from the three webinars are on the web site. You have to be a Va AAHAM member to access this information. If

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

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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The Virginia AAHAM Insider

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Woodrow Samuel Scholarship

Congratulations to our 2019 recipient, Cecilie Elliott!

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.

Please submit all applications to Pam Cornell by email at pam.cornell@mwhc.com or mail the application to Pam Cornell 2300 Fall Hill Ave Suite 313 Fredericksburg, VA 22401 no later than January 31st. Awards will be presented at the March AAHAM meeting to be held in March 2020 in Charlottesville.

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Receivables Management Consultants, Inc.

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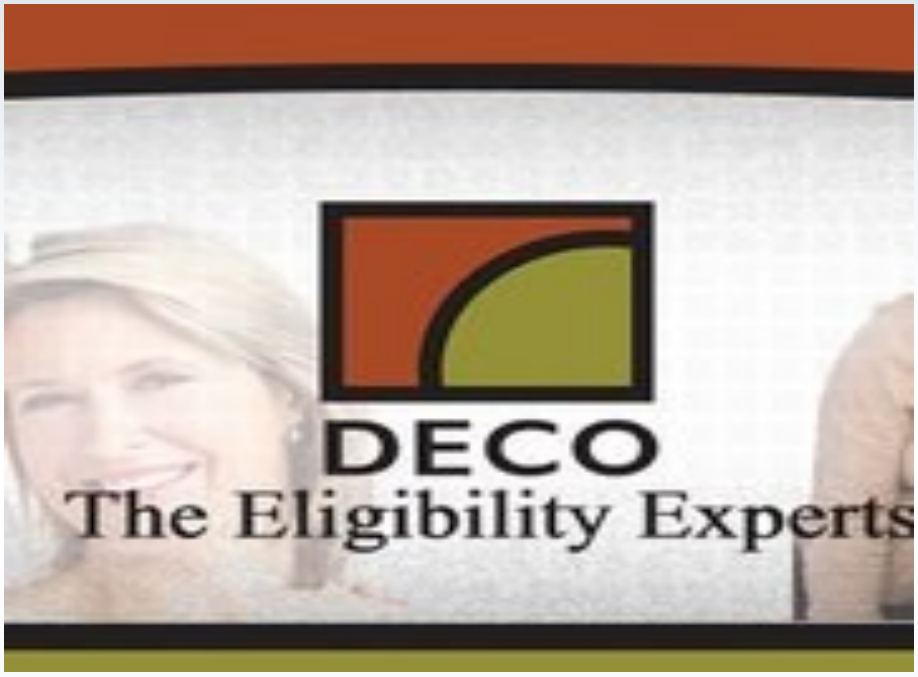

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Michael Good
VP National Business Development
617.965.2000 ext. 2478
mgood@ccsusa.com

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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 2018. Submit articles to Pam Cornell at pam.cornell@mwhc.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**

Pam Cornell, CRCE-I

Secretary

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.

I ❤ Virginia