The Virginia AAHAM Insider

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

Fall 2013 Volume 28 Issue 1

The President's Message

Hello Fellow Virginia Chapter of AAHAM Members:

As we prepare for the next few years in healthcare, The Virginia Chapter of AAHAM is here to help you meet the challenges that are coming our way! Educational conferences/ workshops, newsletter articles, legislative updates, third party payer committee support and networking opportunities are just a few of the ways that we can assist facilities or individual providers in ensuring that they continue to have successful financial performance.

The Virginia Federal Healthcare Insurance Exchange was opened for enrollment to individuals and families on October 1, 2013. Even though this is a patient responsibility, we know that Healthcare providers will be asked to assisted patients as well many providers are being approved by CMS to assist patients with enrollment. The Virginia Chapter of AAHAM is here to support our membership. At our Fall Conference at Fauquier Hospital in Warrenton on October 11, 2013 we will provide details regarding the Federal Insurance Exchanges as well as overall Healthcare Reform. Plan to attend this vital conference that will also include Denial Management, ICD10, and a Palmetto Update.

I am hoping to see many of you at the AAHAM ANI which starts October 16 through October 18, 2013 in New Orleans. The agenda and activities planned are great and as usual The National AAHAM Conference will provide great educational opportunities.

The Virginia Chapter of AAHAM's Annual Conference this year will be at a new location, The Williamsburg Lodge. We are very excited about this new venue as it is in the middle of Colonial Williamsburg. The dates will December 4 through December 6. Save the Date!!! Our agenda will be as dynamic as the new location.

We look forward to seeing everyone at our upcoming events!!!!

Thanks,

Linda

Linda B. McLaughlin, CPAM

President, The Virginia Chapter of AAHAM

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The Virginia AAHAM Insider

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2011-2012 National Journal Award!

EAPG—By Heather Eavers, CPAT, CCAT

On November 1, 2013, Virginia Medicaid will implement a new reimbursement methodology for outpatient hospital services. EAPG stands for Enhanced Ambulatory Patient Groups. EAPG's are a patient classification system designed to explain the amount and type of resources used in a visit. This system was first implemented in 1994 with Iowa Medicaid. EAPGs are currently being used by Blue Cross/Blue Shield of Oklahoma, Massachusetts Medicaid, New York Medicaid, Wellmark BCBS, and Wisconsin Medicaid.

EAPG's are factored by CPT-4 procedure codes, HCPCS procedure code, and ICD-9-CM diagnosis codes. There are three types of procedures with EAPG's: significant procedures, ancillary tests and procedures, and incidental procedures. Using the EAPG grouping logic, patient encounters are first classified by CPT codes designated as significant procedures. If a significant procedure is absent but an E&M (medical visit) code is present, then the logic looks for diagnoses on a list of "major signs, symptoms and findings". The EAPG reimbursement is then determined by the EAPG weight assigned to each line and the provider-specific base rate.

Virginia Department of Medical Assistance Services chose to move to EAPG system because they felt like the current payment system is an outdated cost-based reimbursement methodology. Their goal with converting to EAPG is to develop a prospective payment system. DMAS even believes that the EAPG implementation will reduce both cost reporting and cost settlement activities for both DMAS and the provider.

What does this mean for us? Currently DMAS is proposing to transition to EAPG's over a 2.5 year period. They will implement a rate adjustment every six months and rebase annually for the first six years. This new system is complex enough that processing of large volumes of claims will be difficult to do manually. Therefore facilities and practitioners will need to ensure that their software vendors are prepared for the EAPG change.

With the focus of the industry shifting to the outpatient setting, both providers and payers are constantly looking at ways to maintain and improve revenue. Change is constant in this industry- EAPG's are just one of many.

Resources for additional information:

www.dmas.virginia.gov

hospitalEAPG@dmas.virginia.gov

www.3mhis.com

Heather Eavers, CPAT/CCAT, CHAA **is the Reimbursement Analyst at Augusta Health.**

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Back to Basics Workshop

Presented by Linda McLaughlin, CPAM

October 5, 2013

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American Association of Healthcare Administrative Management

Virginia Chapter of AAHAM

Fall Regional Conference

October 11, 2013 | 8:00 AM – 4:30 PM

Fauquier Hospital, 500 Hospital Drive, Warrenton, Virginia 20186

Agenda

- **How ICD-10 Will Impact Revenue Cycle Management** – Frank Carozzi from Quadax will walk through each step in the revenue cycle and provide a meaningful and in depth analysis of how ICD-10 affects each.
- **Denial trends by Virginia Payers** – A robust group discussion focusing on the current trends providers are facing with increasingly complicated denials. Join your peers from across the Commonwealth to help untangle the denial web and shorten the distance to payment.
- **Health Reform – Virginia Perspectives** – Combining a presentation on the shape reform has taken in Virginia with a panel discussion including payers, providers and vendors, this session will provide attendees with as clear a picture of reform that is currently available.
- **DMAS update on Virginia Medicaid program reform**
- **Medicare Update** - Pattie L. Miles, J11 Provider Outreach & Education, Palmetto GBA

The Future of Managed Care Contracting—How do You Measure a Winner? Part 1

By Rob Borchert & Tim Borchert

This could be called a 'generational' article since it is written by Father and Son who have different historical and current experiences with Managed Care Contracts. Part One of this article will touch on this history and how we measured success then and even now since we are in a 'moving environment' that will be taking Managed Care Contracts to the next level. Part Two of this article will address the future and the various methods of successful contracting that will either make us a winner or a loser.

Managed Care Contracts…when did they start? What was the payment method(s) before Managed Care? If managed care is all about the clinical care of a patient, why are the insurance companies running the show? If managed care is about clinical care, why hasn't acuity come into consideration? There are so many questions that are still being answered as we 'grow' in our patient care experience that we need to build a model where we, the providers, are in charge of 'negotiating' contracts and NOT the insurance companies. But how do we ever get there?

One thing we can say is that we do not want history to repeat itself. Before managed care, we had different methods of reimbursement from both the government and the insurance companies then we have today. In the 70's (ancient history), we had the government paying a certain percentage above a hospitals cost factors which was acceptable. We still file Medicare cost reports but they have a different purpose today when it comes to reimbursement. Cost plus was a fine reimbursement with separate grants for research and clinical study. Outpatient services were typically a percent of charge. No one complained about the volume of services you performed because healthcare was a wonderful benefit for the average working person. I, the Father, had most of our children in the 70's and the most it ever cost me was $460 for the birth of our first son. Insurance plans were 'fair' and paid by the employer with little or no deductible. Physicians were coming out of schools with high expectations of patient care and making a good living in doing so. So what happened to our healthcare environment?

In the 70's, our workforce was peaking and basically everyone had a job. Medicare population was a reasonable size and the ratio of working people to Medicare people was not in question. Our young people were healthy and many found jobs immediately after college or high school. But by mid-70's things began to change. The Viet Nam war may have been over (for the most part) but our veterans were not cared for appropriately when then came home. PTSD was unheard of, so many veterans wound up on the streets. Healthcare became more focused as new equipment, drugs, and research grew and grew. Other international economies grew and took American talent overseas by paying them more money. We became a global economy without knowing it as we tried to keep everything "normal" here at home. Also, as with the end of any war, an increase in births occurred and the health needs of the American population grew and grew. Insurance companies were paying in line with the government methodologies except they usually paid a per diem for inpatient care (no matter what specialty) based on the cost report information. With this combination of growth and increasing costs, changes were to be expected.

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The Future of Managed Care Contracting—*continued from previous page*

The actuarial accountants in the Federal Government began to realize this change in the 70's and began looking for ways to controls costs in healthcare as these costs were growing exponentially. Data are the key to any successful investigation to address trends and patterns. The Health Care Financial Administration (HCFA) began to study clinical patterns against cost across the country. They worked with senior staff from Yale to begin the study of the range of costs based on clinical patterns. Yale began to study these clinical patterns by specialty (Orthopedics, Cardiology, Obstetrics, Internal Medicine, etc.) from different databanks found in the coding application of the International Classification of Diseases (ICD-9) and from the billing data from the HCFA intermediaries across the country. Relative Value Units (RVUs) [also known as weights] were expanded based on the multiplicity of services being performed within all elements of healthcare. From Laboratory services to Radiology services, from Surgery services to daily Medical care, the Yale study found a 'central point' for the baseline of 1.000 and began to compute a weight distribution across health care services, both cognitive and surgical. This was the first introduction of Diagnostic Related Groups or DRGs. This was also the first introduction of how important documentation and proper and appropriate medical record coding is. Good documentation and good coders could provide for a higher paying DRG.

In 1983, the nation (except for two exceptions) adopted this new healthcare payment methodology whereby the weights associated with any inpatient service would be paid based on that specific weight and the baseline dollar value of cost derived from the annual Medicare cost report. Reimbursement for outpatient services basically remained the same. It was also at this time that such rules as the 72-hour rule became active in trying to control costs. This was the introduction of reimbursement by specialty patient care but it truly did not focus on the patient. The focus was cost control. With the introduction of this new methodology, there were also guidelines for average length of stay (ALOS) as well as cost outliers, for when the costs exceeded a defined threshold. What is most interesting about this new introduction of methodology is that HCFA wanted to focus on the quality of treatment to a patient toward a favorable outcome by only performing those tests, procedures and services necessary. The cost outlier, if justified, was there to cover services rendered to the patient that were necessary due to other patient diagnostic conditions. Our healthcare community and insurance companies focused on hiring the "best coders" to harass providers and get the best documentation so the facility received the best reimbursement. There was not a lot of focus on good patient care and positive outcomes. Our healthcare community also quickly realized that after the published ALOS for that DRG was reached, there would be no further payment. Therefore, discharges were a focus to get the patients out of the hospital. So you can see that starting in the early 1980's, the basic reimbursement structure financial interpretation was that if you discharged patients before the ALOS, you could make money. In fact, in those days, you would even get paid if the patient had to be re-admitted within 30 days. Insurance companies have always followed the lead of the government so, naturally, they did their own analysis and began to change the per diem contracts to DRG contracts. Aside from just changing the reimbursement method, the insurance companies realized that the DRG was a cap payment and therefore they would save money on not having to do Utilization Reviews on per diem patients. The burden of care (based on ALOS) was totally up to the facility.

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The Future of Managed Care—*continued from previous page*

So what about outpatient? Well, as we know, the implementation of DRGs and their variations over the years has pushed more services to the outpatient environment. The interesting part is that after the 1980s experience of inpatient, HCFA began focus on physicians. The same type of logic for RVUs and weights was accomplished in various studies resulting in the introduction of a new physician reimbursement methodology know as Resource-Based Relative Value Units (RBRVS). In 1992, after another University study, RBRVS was implemented and the physicians had to learn something new. Unlike, DRGs where the reimbursement is based on the ICD-9 codes, RBRVS is based on the Current Procedural Terminology (CPT) codes. Each CPT code used by a physician has a series of three components to equal the final or total unit/weights. This total unit was then multiplied by a geographic dollar factor based on where the physician practiced. The three components are (1) professional time; (2) office expense; and (3) malpractice insurance cost. This dynamic table comprised all of the CPT codes that are produced by the American Medical Association (AMA). So, guess what, insurance companies began to utilize this methodology as well. Oh, I almost forgot, some insurance companies began to get smart on their own and thought if DRGs work and RBRVS is working, maybe there was a way to further limit their reimbursement or at least cap their reimbursement as in a single DRG. Oh, I forgot to mention that by this time – 1990s – insurance companies developed plans called "managed care" and therefore used these various methodologies to "manage" the care of their members when the reality is that they are managing the payouts to try to reduce them as much as possible. So, in order to try to put a cap on physician services, they introduced "capitation". Capitation is very simple in its definition. It is the monthly dollar payment by the insurance company to a primary care physician or primary care group that is based on the number of members in the managed care plan AND the 'mutual risk' is that the physician or group would get this monthly payout whether or not they saw member patients. These primary care physician were also known as the 'gatekeepers' since no member, under this managed care plan, could see a specialist without the referral of the primary care physician. On the other side of the coin, if the number of members seen by the physician or group increased to the point that the cost of the care exceeded the monthly payout, so be it. There was no extra money.

!970s, 1980s, 1990s, what is next? Oh, 2000 and the introduction of the Ambulatory Patient Classification (APC) system. As the government gets more data (and smarter), it recognizes that since 1983, the DRG methodology has matured with more specific coding and not much could be done with reducing fund layout there. With the 1992 RBRVS methodology, nothing much can be done with reducing this fund layout either. What is next…outpatient services! If the same type of actuarial accounting structure can work in the physician environment, why not in the outpatient service area. But APCs also added the ancillary service charges into the reimbursement method as well as outpatient surgery services so there would be one combined payment for treating one patient's clinical condition in any outpatient environment. Wow! Let's see, since the 1970s where things were not a problem in the healthcare environment through the 1980s, the 1990s and the 2000s, we have touched every healthcare environment and provided changes and challenges to the provider community in striving to provide quality healthcare within some very prohibitive reimbursement methodologies.

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The Future of Managed Care—*continued from previous page*

Insurance companies, in the form of managed care contracts, have followed in the government's footsteps and have used the same reimbursement methodology approaches. Managed care plans have not only changed from having little to no co-pays or deductibles to having very large co-pays and deductibles. Managed care plans have restricted services in some areas or types of plans offered to the public and have expanded their coverage requirements in the form of required pre-authorizations for some services.

This change over the last 40 plus years is totally based on data. Data gathered both nationally and regionally. Data generated by the healthcare community and used by the Managed Care companies to reduce and/or restrict their payments. Data that has been used to assist the Managed Care companies to make tremendous profits for their shareholders and senior executives. Data that has been continually used for financial reasons and not for any patient care/quality reasons. We think that we, in the provider community, have lived with this approach because we believed that "they" had all the data and knew what was best and even allowed us to challenge and win some battles but never the war. Today, data used by the government and Managed Care companies have provided us with the following types of plans and methodologies that THEY bring to us to sign:

- Prospective DRG inpatient care plans
- Inpatient per diem plans for specialized services
- Prospective DRG skilled nursing plans
- Prospective DRG rehabilitation plans
- Case Rates
- APC reimbursement plans (Ambulatory Payment Groups [APGs] are another form
- High deductible plans
- Pre-authorization plans
- Capitation
- Per diem contracts, and
- Others that we have not listed here.

In the healthcare industry, we, as providers, have usually measured the success or failure of the impact of these various types of plans by our ability to monitor their contractual terms, their percent of denials, their days in accounts receivable, the timeliness of their payment, and other points that are of concern in the Revenue Cycle. We use our 'hind-sighted' data to do most of this measuring.

What is interesting as we move forward in the reimbursement arena, the government has realized that they can't really come up with any new reimbursement methodologies based on numbers. They have now turned to such situations as quality factors, utilization management measurements, personal quality of life situations, etc. What the government and others are stating is that if there is nothing more than can be done with numbers, let's look at documentation and patient's conditions and quality of care if we want any further effect on reimbursement. This is too become the new reimbursement methodologies so now the question for us is do we let THEM tell US about the quality of OUR CLINICAL DATA or DO WE TELL THEM HOW WE WANT OUR CONTRACTS TO LOOK LIKE IN THE 2010s.

This concludes Part One. Part Two will address these new contractual approaches and how to measure them and, more importantly, how to LEAD the discussion with the payor rather than having the payor lead the discussion with you.

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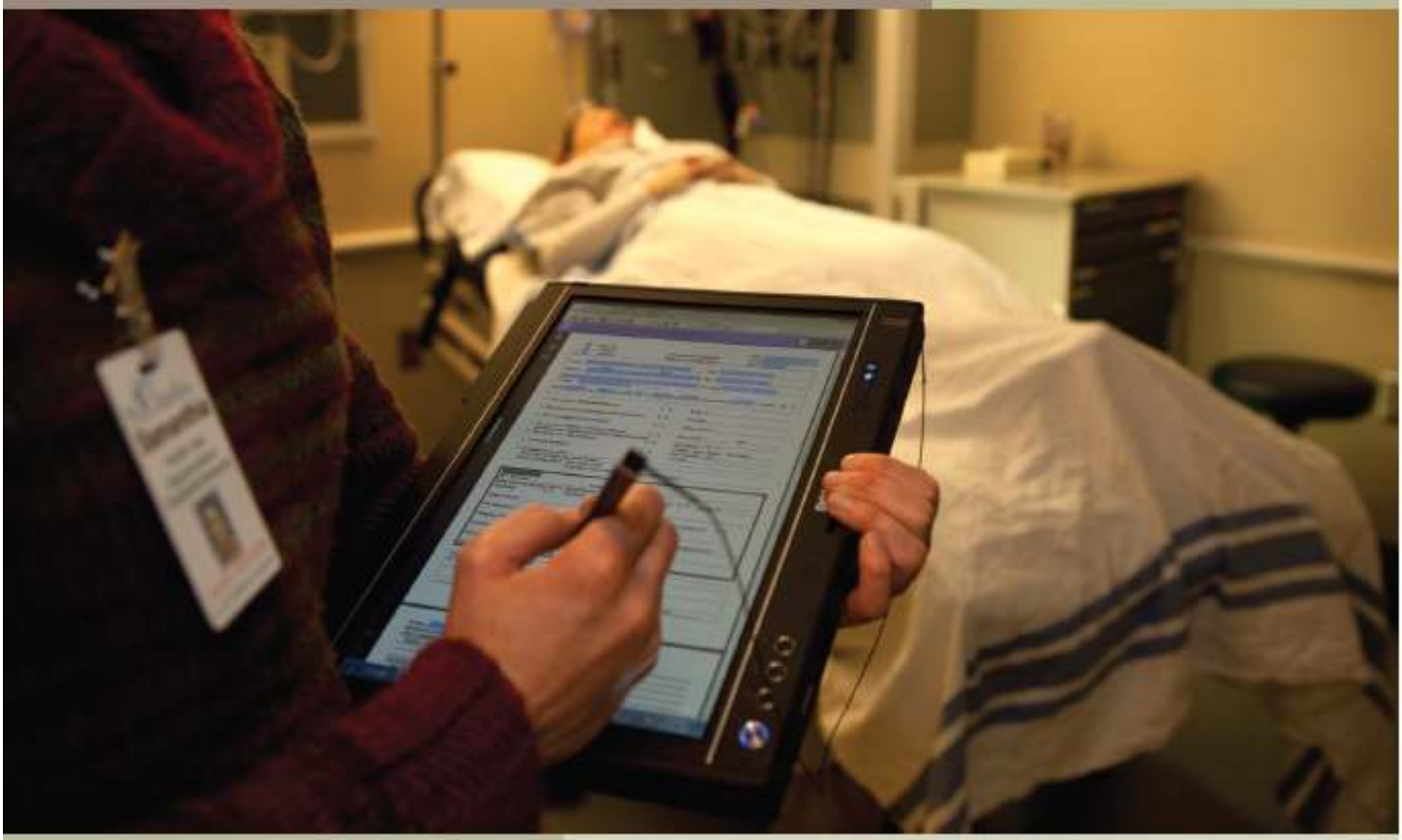

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Lone Ranger Leadership
By Jim Grigsby CPAM, CHCS

As a life-long Lone Ranger fan, I find it amazing that the phrase; "He (or she) is a Lone Ranger" is derogatory, denoting a rebellious or individualistic person, someone who is not a "team player". A closer inspection of the life and actions of the Masked Man reveals an ethical, result-oriented leader. Maybe healthcare and business would benefit from *more* Lone Rangers.

"Nowhere in the pages of history is there a better champion of law and order in the Old West. Return with us now to those thrilling days of yesteryear."

John Reid was Texas Ranger, serving under his brother, Captain Dan Reid, when Butch Cavendish's gang ambushed six Rangers as they passed through a box canyon. Tonto found the badly injured John Reid, the only survivor, and cared for him. Restored to health, Reid hid his identity with a mask and became "The Lone Ranger". His quest was to avenge the death of his brother and fellow Rangers, but he did not focus on revenge; instead, he vowed to pursue and capture the entire Cavendish gang.

The gang separated, so it took two years for him to capture all of them, but he did. Each time he captured one of them, he did not exact "prairie justice", instead, he arrested them and trusted the justice system. All gang members were prosecuted and hanged.

Once his mission was complete, Reid realized this was his calling. He sacrificed his wealth (half ownership of a prosperous silver mine) and traveled the West, with Tonto, protecting people from injustice. The Lone Ranger was known throughout the West as a man of integrity, someone who helped those in need and worked tirelessly for justice. If you look beyond the superficial elements - the mask, powder blue suit, shiny boots, and pure white horse, you find 12 leadership lessons that you can apply to your professional and personal life.

1. Think through the problem

Most problems are more complex than they appear; there is usually a root cause or an impetus that requires more than surface-level thought. The Lone Ranger did not make snap judgments; instead, he delved into the problem. He thought and observed, identifying the other facets of or the true cause of a problem. Then he acted, decisively and properly.

As managers and leaders, we need to emulate this approach –think, observe, and then act.

2. Listen

A second important skill demonstrated by the Lone Ranger is listening – listening with the intent to learn, not waiting for a chance to respond. He listened to whomever was speaking – victims, witnesses, children, family members, and total strangers. Because he listened, he *learned*. He gathered information that helped solve the crime.

Successful mangers listen with intent to learn, and then implement the best possible plan.

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Lone Ranger Leadership—*continued from previous page*

3. Shoot to wound, not to kill

The former Texas Ranger, a highly skilled shooter, did not need gratuitous bloodshed to solve crimes; he shot the gun out of the bad guy's hand or nicked his wrist. He used enough power or force to solve the problem, no more. This simple act of common sense placed the crook in the hands of the justice system, not the grave.

As managers, we need to understand the proper use of power and make sure we use our authority properly, not abuse it.

4. Protect the dignity of people

The Masked Man never uttered an unkind word, rather he spoke well of people. He even applied that standard to ex-cons, "he paid is debt to society, give him a chance to make a new life." He encouraged people to do the right thing without preaching, he protected the weak, and he expressed genuine gratitude for assistance and kindness.

Professional managers treat everyone with courtesy – people they work for, work with, and who work for them. The exceptional ones take it a step further and extend that courtesy to whomever they encounter.

5. Have a diverse team

The Lone Ranger was accepted by everyone – he was welcome in Native American territory, by Mexican families, ranchers, sheepherders, farmers, the military and settlers. He was polite, spoke the local language and respected various cultures.

Reid and Tonto met as boys. Reid found Tonto injured and nursed him to health, when others ignored him. Years later, Tonto returned the favor by nursing the nearly dead John Reid back to health. *Kemo Sabe* – trusted friend.

Build a team of professionals who complement you, respect their culture and background, and learn from them.

6. Model honesty and integrity

In one episode, the Lone Ranger was incorrectly jailed by an overzealous young deputy, who did not understand that the "mask was on the side of the law". Another deputy recognized the Lone Ranger, unlocked the cell, and indicated he was leaving and no one would be there to prevent an escape. The Lone Ranger did not leave; he stayed behind bars because the deputy had placed him there - he respected the law. When the sheriff learned that the Masked Man did not escape, he said, "That is the real Lone Ranger. He would never break the law."

Ethics is not a part-time trait; it must be at the core of all decisions.

Our reputations require full time ethics, not ethics of convenience.

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Lone Ranger Leadership—*continued from previous page*

7. Work hard

Our hero was not a spectator; he was actively involved in capturing the bad guys. The Lone Ranger not only chased horse thieves and bank robbers, he went undercover; roped cattle, mined, and worked on ranches to gather information to identify the villains. Nothing will win the admiration of your staff and management team more than rolling up your sleeves and working to overcome a challenge.

Demonstrate a willingness and ability to work and people will follow you.

8. Work with people

John Reid's background as a Texas Ranger taught him the value of building a team and of teamwork. His career is an example of working with people to accomplish a goal – establish justice in an untamed era.

He and Tonto were a team; they trusted, respected and depended on each other. Together they traveled the West, teaming with countless local law officers and citizens to prevent or stop criminal activity.

Create a cohesive team and nurture it.

9. Communicate clearly and concisely

In every episode, the Lone Ranger needed to communicate a plan or idea to Tonto, lawmen, or other characters. His directions were always clear, concise, and, most importantly, understood. There was never confusion or crossed signals.

One of the essential qualities of a leader is the ability to communicate her or his vision clearly.

10. Solve the problem

The Masked Man's goal was to solve a crime or prevent another; solving problems was his focus. Whether he worked alone, with Tonto, or in conjunction with others he never lost his focus or let his sense of purpose drift.

Exceptional managers are problem solvers.

11. Share the spotlight

The Lone Ranger shied away from the spotlight, deflecting praise to someone who may not have appeared deserving.

Share the glory and credit, especially when one of your staff played a crucial role. They will bask in the glory and work even harder for you.

12. Know when to leave

Every episode ended with the Lone Ranger and Tonto leaving town after placing criminals behind bars or restoring justice to yet another Wild West town. The Lone Ranger's final words were always, "Adios. My work here is done."

There comes a time when you need to move on and allow someone else to take the reins. Will you recognize it and move on? A leader prepares a successor, knowing she can leave to accept new challenges.

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Lone Ranger Leadership—*continued from previous page*

CONCLUSION

Based on these twelve leadership points, being called a Lone Ranger is a positive label. Perhaps one of these Lone Ranger Leadership Points will help you improve as a leader. One of the heroes of our youth can help adults advance their careers.

The Lone Ranger's calling card was a silver bullet and people knew it represented ethics, justice, and a friend who would help them. Is your calling card a silver bullet? When people hear your name, do they associate it with positive characteristics? Are you a Lone Ranger?

About the author

Jim Grigsby CPAM, CHCS, is president of Jim Grigsby Consulting, a revenue cycle and management consulting firm and a 25-year AAHAM member. You can contact him at either jgrigsby@jimgrigsbyconsulting.com or 772-539-1990.

Member Spotlight—

By Tammy Shipe, CCAT, CPAT, CCT

Karen has been a member of AAHAM since 2010 and currently serves on the Scholarship Committee. Her career in healthcare began in 1990 and joined the Augusta Health team in 2002 as an Accounts Receivable Specialist in the department currently known as AMG (Augusta Medical Group). She was promoted to Physician Biller and soon after became Team Lead of that group. During her time serving as Team Lead, she earned her CCAT and CPAT certifications. In 2012, she was promoted supervisor of the AMG Central Business Office which not only includes Physician Billers, but also Accounts Receivables Specialists, Credentialing, and Refund Personnel. During her role of supervisor, she has obtained her CPAM and CCAM certifications.

Karen is also NextGen certified which greatly assists in her job duties such as maintaining and updating the NextGen libraries through chargemaster and provider

set-up. She also serves as a liaison to AMG clinics which to date has 129 providers.

In addition, she provides support for physicians outside AMG that currently use the NextGen system.

When asked what she likes best about being a member of AAHAM, she states " I enjoy being a part of a group that is so dedicated to continuing education. This is demonstrated through the conferences and WebEx that this group provide each year. This information is most helpful in my daily work duties. Another great example of dedication to continuing education is Leanna Marshall. Leanna has coached me through a CCAT, CPAM and CCAM exam. She gives freely of her time and knowledge, and I find this so commendable. We also have the privilege of free seminars by Linda McLaughlin. Again, she freely shares her time and knowledge and makes education fun. This is what I find most exciting about AAHAM, along with the friendliness of the group".

In her spare time, Karen loves to shop and spend time with her family.

Karen Griffin
CCAT, CPAT, CPAM, CCAM
Augusta Health—AMG Billing Supervisor
kgriffin@augustahealth.com

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!

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—

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

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.

CPAM & CCAM 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 CPAM/CCAM designation after your name.

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

Leanna Marshall, CPAM

PFS Consultant

UVA Health System (Retired)

Phone: (434)293-8891

Fax: (804)977-8748

814 Montrose Avenue

Charlottesville, VA 22902

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

Newly Certified…

First Name	Last Name	Certification	Facility
Laura	Brady	CCT	Augusta Health
Diane	Cramer	CPAT	Mary Washington Home Health
Robin	Hatcher	CPAT	Mary Washington Healthcare
Sharon	Hobbs	CPAT	Mary Washington Healthcare
Evelyn	Morris	CPAT	Mary Washington Healthcare
Renee	Morris-Taylor	CPAT	Hunter Holems McGuire VA Med Ctr
Porsche	Samson	CCAT	Inova Health System
Tammy	Shipe	CCT	Augusta Health
Gimena	Ugarte-Revollo	CCAT	Inova Health System
Adele	Vogt	CPAT	Mary Washington Healthcare

Congratulations!

We are proud of you!!

2012 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…

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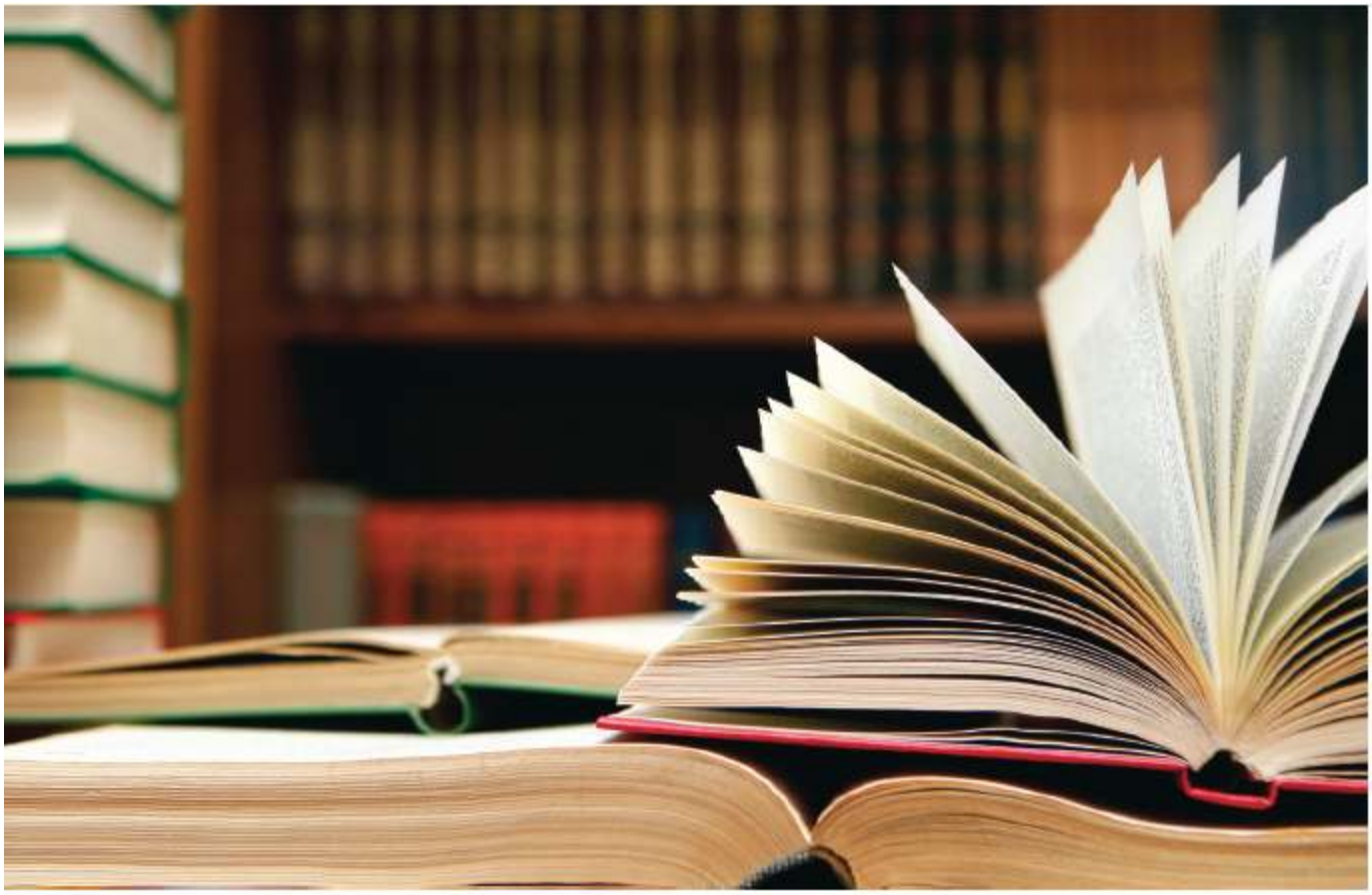

Ethics & Billing

By Heather Eavers, CPAT, CCAT

Medical billers are kept on their toes by a constant flow of information. They serve as the interpreter between providers and the insurance companies. Billers work closely with confidential patient information and are a key part to the collection abilities. Because of this, billers must display ethical practices to protect patients and providers.

The Patient Bill of Rights was first adopted by the American Hospital Association in 1973. Key points in the Bill of Rights state that the patient has the right to respectful and considerate care and a right to privacy. Hospitals utilize the rights set forth by the Patient Bill of Rights to ensure that the community is receiving satisfactory care.

It is therefore the biller's responsibility to protect private patient information. Billers have access to the private details of patient records and in order to remain compliant with HIPAA, billers must insure that this sensitive information remain protected. The consequences of violating HIPAA regulations include civil and criminal penalties.

Billers should also consider neutrality. All billers should be unprejudiced and impartial. This means to remain free of conflicts, rewards or kickbacks. A biller should not let personal gains impair their ethical duties.

Honesty is another worthy quality to have as a biller. Billers need to be trustworthy so as to not fraudulently submit claims. Knowingly unbundling a procedure (charging for related products and services separately, rather than as a unit) is fraudulent.

Integrity (professionalism to patients and coworkers) is another key aspect of a biller. Billers should maintain a normal speaking voice, refrain from shouting, and avoid the use of profanity at all times. Avoid biased or derogatory remarks or any generalizations, examples, or jokes that affirm or perpetuate negative stereotypes.

This Code of Ethics was created by the American Medical Association in 1980, called Principles of Medical Ethics. It was set up as a standard for behavioral conduct; however, there is no enforcement. The government created Health Insurance Portability and Accountability Act (HIPAA). If a violation of HIPAA transpires, fines and sanction can be imposed.

It is essential that medical billers remain consistent in their ethical practices. Not only will that prevent fines, it will display to your patients that your facility is one they want to return to. Billers should display absolute accuracy in their duties along with following the rules. And unquestionably, ethics must drive their practices.

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– Administrator, Inpatient Psychiatric Facility

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– Administrator, Ambulatory Surgery Center

Today I'll Be Afraid of Heights

Another Motivational Moment with Kelly Swanson (www.kellyswanson.net)

I was riding home on the plane when I overheard a little boy say to his mother, "Mommy, today I think I will be afraid of heights. I haven't decided, but I'll let you know." That precious comment made me laugh, but it also made me think. There is a lot of truth in that statement – not just for children, but for adults. Because how often do we choose our fears instead of our fears choosing us? Or better to say, how often do we carry around a rational fear long past its expiration date? Just follow me for a minute.

Most of our fears are rational, learned through an experience that taught us to be afraid. Burning my hand taught me to be afraid of fire. Getting lost in the mall taught me to be afraid of abandonment. Dodgeball taught me to fear athletics. Dating that guy I'll call Skip, taught me to be afraid of guys who bring their mothers along on the first date. I'm just saying. Life teaches us to be afraid of things. And if we're lucky, we learn how to move past that fear so that it doesn't own us. But sometimes we carry it around forever to the point where we are actually making the choice to be afraid. And often we don't even know it. Let me give you an example.

Being the bullied kid in school (not whining, it's just a fact) was an experience that taught me to be afraid of not fitting in. I was afraid nobody would like me - mainly because they didn't – so the fear was pretty valid. So I carried around this fear that I didn't belong. While it may have been true and valid at the time – and while it really shouldn't have mattered anyway – it was the way I felt. And it was real. Well, at some point it was not true anymore. At some point, I did have friends who liked me. I did belong. But I still kept carrying around that fear of not being accepted because I never really held it up to a light and assessed whether it was still a rational valid fear. Maybe I still haven't, and this is my chance.

What's wrong with carrying around a fear or belief about yourself that isn't true? It owns you. You become defined by it, and you start making decisions and choices based on that fear. It affected my relationships with men as I acted out of a desperation to be included and liked, instead of expecting to be treated with respect. It affected job interviews. When you are scared of not fitting in, you don't put out an air of confidence, you put out an air of neediness – and when I wasn't convinced I should be included, neither were they. It affected my business in many ways, like sales. It's hard to sell yourself when you don't really believe that you have something worth selling.

I finally reached the point (just recently actually) where I had to look this fear in the face – acknowledge it, and ask myself if it was valid, or if I was choosing this fear. Turns out it was no longer valid (just because I felt it, didn't make it true) – and turns out that I was choosing that fear. So I let it go. It wasn't easy. And it didn't happen in one step. And I think I'm still not quite there. But I'm reprogramming. I'm changing the things I say to myself on a daily basis. And I will fake it until I wake up one day and believe it.

So what about you? Is there a fear that is owning you and affecting your choices, and therefore blocking your way to a more peaceful and productive life? Isn't it time to let it go? Are you willing to change your behavior and look in the mirror and see yourself as you truly are, not who you are afraid you are? Or will you keep choosing to be afraid of heights? It's your choice. Let me know if I can help you reframe the way you see yourself. It would be my pleasure. I promise that you are so much more wonderful than you think you are.

Until we meet again – stay on the funny side of life and when you look in the mirror, love who you see!

National News— www.aaham.org

Important Dates for 2013:3

- **2013 ANI—October 16-18, 2013 at the Sheraton New Orleans in New Orleans, LA**

Visit the website for more information
http://www.aaham.org

2013 Certification Schedule

October 28—November 2, 2013 Fall CPAM/CCAM exams

November 11-22, 2013—CPAT/CCAT/CCT exam period

December 2, 2013—Registration deadline for February 2014 CPAT/CCAT/CCT exams

2013 PAM Week

This year's PAM Week will be held October 13-19, 2013. The theme is "Feel the Power" which addresses recognition of exemplary work that is conducted by healthcare administrative management teams in hospitals, physician practices and health care related industries.

Visit our web site for more information and to order products.

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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 also benefits from the financial support that many organizations provide. I hope that you will consider supporting Virginia AAHAM this year.

—Denise Martin, Vendor Sponsorship / Corporate Partners Chair

dmmart515@aim.com

Mark you calendars!

Upcoming VA AAHAM events:

- **October 11, 2013** **Fall Regional Conference, Warrenton , VA**
- **October 16-18, 2013** **Annual National Institute, New Orleans, LA**
- **December 11-13, 2013** **Annual Meeting and Conference, 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, CPAM

President, The Virginia Chapter of AAHAM

Jack Pustilnik

Second Vice President, The Virginia Chapter of AAHAM

Watch our web site for details:

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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 2013. Submit articles to Chris Fisher cfisher@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**

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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.