The Virginia AAHAM Insider

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

The President's Message

"There is an eloquence in true enthusiasm." ~ Washington Irving

My Dear Friends & Colleagues:

If there is anything we have learned from the pandemic it is this: we are resilient and we can adapt to most anything. Virginia AAHAM continued to thrive and grow while adapting to the COVID imposed restrictions and meeting the needs of our members. We were able to offer meaningful education at no cost. That was unheard of pre-pandemic. Our Board, Sponsors, Speakers and Members very willingly partnered together to make it all happen…and boy did it happen!

Virginia AAHAM by the numbers - 2020:

10 Board meetings, which included two strategic planning sessions.
$74,345.81 in checking account as of 12/31/2020, $1,029.68 in savings account as of 12/31/2020
238 national members at end of 2020
250 national members as of May 2021!
53 new national members as of May 2021
82% retention rate of existing members. This is the highest retention rate for chapters with over 200 members!
3rd largest chapter as of May 2021
36 student members
11 local only members
3 newsletters
23 webinars
92 attendees at our highest attended webinar
43 CRCE, 19 CRCP, 108 CRCS, 8 CRIP, 17 CCT certified members
17 corporate partners contributing $17,200 to support our chapter.
45 email communications from chapter to members

All of this during a year filled with lockdowns, work from home, virtual Zoom and Teams meetings, masks, social distancing, business closures and layoffs. We, as a collective group of enthusiastic healthcare professionals 'made it happen.' There is not only eloquence in enthusiasm, but also success. Thank you for sticking it out together, as we paddled our way through the pandemic. And as the song goes, "see you in September" for our first in-person conference since December of 2019. Details will be out soon. Until then be safe, enjoy life and march on with true eloquence and enthusiasm!

Yours in AAHAM,
Lin
Linda M. Patry, CRCE
President, Virginia Chapter of AAHAM

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Virginia Hospital Advocate Newsletter

What's Happening In Richmond

Virginia General Assembly to Reconvene April 7 for "Veto Session"

The Virginia General Assembly will meet on April 7 to consider amendments made by Governor Northam to legislation and the state budget bill passed in the 2021 Legislative Session. Governor Northam did not veto any bills approved by the General Assembly this year. The 2021 Legislative Session was successful for Virginia's hospitals and health systems, though VHHA has two outstanding budget priorities that have not yet been remedied: removing the Medicaid penalties on emergency department utilization, and securing a dedicated funding source for the Virginia Trauma Center Fund.

Governor Northam did not change language in the budget that gives the General Assembly the authority to allocate new federal relief funds. Virginia will receive approximately $6.8 billion from the American Rescue Plan Act that President Biden signed into law in March.

Conclusion of 2021 Legislative Session

With the conclusion of the 2021 Legislative Session, the General Assembly is now turning its attention to the commissions that meet year-round to review legislative proposals that have been referred for further study, among other key policy issues facing the Commonwealth. One such panel is the Joint Commission on Health Care (JCJC), to which VHHA Advocacy Team will deliver a presentation during a May 18 virtual meeting that will be live streamed and available to the public. The JCHC 2021 staff studies will include analyses of the impact of long-term care workforce needs on nursing facility care, health insurance affordability in the individual market, and strategies to support aging Virginians in their communities.

Significant Funding Requests Anticipated Ahead of To-Be-Scheduled Special Session

Advocates are honing their funding requests to the General Assembly ahead of a special session anticipated to be held in late July or early August to allocate the state's share of federal funding from the American Rescue Plan (ARP). Because the parameters of the ARP funds are broader than the past federal COVID-19 relief funds, it is expected that the General Assembly will consider significant and diverse budget requests. The VHHA Advocacy Team will also be finalizing budget priorities ahead of the special session – please make sure you are signed up for the VHHA grassroots action alerts to receive real-time updates!

Virginia Hospital Advocate Newsletter

What's Happening In Washington, D.C.

President Joe Biden addressed a joint session of Congress on April 28 to mark his first 100 days in office, as first-term presidents typically do. He focused much of his speech on the pandemic and health care, including the passage of the American Rescue Plan COVID-19 relief package, the delivery of roughly 230 million COVID-19 vaccinations to Americans, and the enrollment of 800,000 more individuals in Affordable Care Act health plans. Looking ahead, President Biden's infrastructure package – the American Jobs Plan – as well as his American Families Plan legislation on childcare and education are currently pending in Congress.

Virginia's U.S. Senators Mark Warner and Tim Kaine have reintroduced bipartisan legislation to expand coverage of telehealth services through Medicare and make permanent COVID-19 telehealth flexibilities.

Also on the health care front, Congressman Bobby Scott (VA-03), who is Chairman of the House Committee on Education & Labor, is carrying legislation that would allow the federal government to negotiate lower prescription drug prices, as well as a bill to improve maternal and infant health outcomes by strengthening partnerships between health care providers and local nutrition services.

Virginia Hospital Advocate Newsletter

What's Happening In Washington, D.C.

Virginia's U.S. Senators Work to Support Rural Health Care; U.S. Senate Extends Moratorium on Medicare Sequestration Cuts

Senator Mark Warner (D-Virginia) has introduced two bipartisan pieces of legislation to support rural health care providers in Virginia: the *Strengthening Rural Health Clinics Act of 2021* and the *Save Rural Hospitals Act of 2021,* which Senator Tim Kaine (D-Virginia) is also sponsoring. VHHA strongly supports both bills.

The *Strengthening Rural Health Clinics Act of 2021* would make a technical fix to protect existing rural health clinics from a sudden and unexpected Medicare payment rate change that was erroneously brought on by the December 2020 COVID-19 relief bill. A provision of the legislation has already been included in a bill that passed the U.S. Senate at the end of March.

The *Save Rural Hospitals Act of 2021* would fix a flawed funding formula that results in disproportionately low Medicare payments for hospitals in rural and low-wage areas. The bill would provide additional financial support for rural hospitals that are already operating on very thin margins and shutting down at record rates during the COVID-19 crisis.

In a news release, VHHA President & CEO Sean Connaughton noted, "It is critical that we protect rural hospitals so individuals and families in less populated communities in Virginia, and across the United States, can access essential medical services when they need them 24/7/365. The COVID-19 pandemic is a stark reminder of the importance of access to hospital-based acute care services at a moment's notice when seconds and minutes truly matter. Across the country, 180 rural hospitals have closed in the past 17 years, including two in Virginia since 2013. Senator Warner's Save Rural Hospitals Act of 2021 is a welcome proposal that recognizes the challenging conditions facing many rural hospitals and offers a common sense solution to appropriately adjust reimbursement rates so hospitals aren't unfairly penalized under an outdated payment methodology that fails to account for current realities."

Additionally, the U.S. Senate recently passed a bill that would postpone the planned two percent cut to Medicare payments, under a policy known as sequestration, until the end of 2021. The House is expected to consider the Senate-passed bill the week of April 11 when it returns to Washington D.C.

Virginia Hospital Advocate Newsletter

What's Happening In Washington, D.C.

VHHA-Supported "VOCA Fix Act" Passes U.S. House with Bipartisan Support

Legislation that would help sustain Virginia's Hospital-Based Violence Intervention Programs (HVIPs) recently passed out of the U.S. House of Representatives with overwhelming bipartisan support and will soon be considered by the U.S. Senate. Titled the "VOCA Fix Act" and co-sponsored by Virginia Representatives Jennifer Wexton (D-10) and Gerry Connolly (D-11), the bill would rebuild the Victims of Crime Act (VOCA) Crime Victim Fund that supports costs associated with caring for survivors and their families, including medical expenses and wraparound services.

Several Virginia hospitals in high-need areas receive these VOCA grants through the Virginia Department of Criminal Justice Services (DCJS) to maintain HVIPs that not only treat victims' trauma, but help provide short-term safety and long-term solutions to prevent recurring violence. The fund is paid for by penalties associated with criminal prosecution, not by taxpayers.

VHHA strongly supports the VOCA Fix Act. More information is included in an opinion-editorial authored by bipartisan attorneys general.

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Health Insurance Claim Denials: A Harsh Reality of Doing Business

Kelli Puffenbarger, CRCS

Katie Adams, CRCE, CRCS, CRIP, CCT

Due to increased scrutiny around the cost of healthcare paired with the complexity of insurance claims processing, health insurance claim denials in any healthcare system are a harsh reality – there is no immunity. Sure, health systems can (and should) implement techniques to track, trend, analyze and develop root cause analysis to address denials which could have been prevented. The truth is even when all the rules are followed and claims are filed "clean as a whistle", claims are still denied administratively from the payer, leaving the hospital to claw through the payer's obstacle course to achieve victory. Although the Administrative Simplification Act has regulated some consistency in this space, the payers still play by their own rulebooks. Health systems are left to crack the codes which can be very expensive and most egregiously, leave the health system unpaid for high cost services.

Deciphering between "Preventable Denials" and "Non-Preventable Denials"

One might think making the determination on what is preventable or not is an easy task, it's not. Insurance denials as communicated from payer to healthcare system are translated in CARCs (Claim Adjustment Reason Code) and RARCs (Remittance Advice Remark Code). The same CARC and RARC codes are used for claims denials whether those denials are preventable or non-preventable.

For example: CARC code 197 means "precertification/authorization/notification absent". This code can easily be placed in the "hospital didn't follow proper protocols" category. That's not always true. Hospitals and healthcare systems receive denials for this reason for services which were in fact authorized, the authorization number given by the payer was represented correctly on the electronic claim, and the claim is still denied. When called, payer representatives acknowledge there is indeed an authorization on file and will send it back for reprocessing. Without this action, the hospital doesn't get paid.

A widely used CARC code which gives little to no detail is CARC 16 "Claim/service lacks information which is needed for adjudication". What information is lacking? It requires research, leaving it up to the back-office revenue cycle to execute laborious research to discover what (if any) information is needed. Even if the health system is able to identify trends, payers won't allow for proactive submission of the requested information in order to prevent the denial from happening in the future. This code 16 in many cases is considered a delay tactic from the payer.

A CARC code which is not always categorized as a denial but is very crucial to a health system's financial success is CARC 97 "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated". This code is viewed as a routine contractual allowance, but can hide missed revenue opportunities if payment variances are not critically reviewed[a].

So how do health systems determine preventable vs. non-preventable? Spending precious and limited financial resources in technology systems; developing denial teams to analyze and lead denials taskforces to address trends; and conducting intense training of revenue cycle team members to be skilled to make the determination.

[a] Augusta Health was able to recover $786,000 in underpaid claims for CY 2020

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How to Manage Preventable Denials

Preventable denials are denials the health care system should be able to control. Although still expensive to manage, there are rules to follow; if not followed, hospitals should not expect to receive payment.

High performing healthcare systems develop denials taskforces to address categories of denials which have been identified as preventable. These taskforces gather resources beyond revenue cycle to implement preventative measures. The key to success is engagement from all levels of the organization, from frontline team members to hospital executive leadership.

Eligibility related denials are one of the most common preventable denials. To mitigate these denials, hospitals invest in Patient Access technology platforms to catch unintentional errors within registration processes. These systems use rules based engines to provide feedback to the registrar who can take real-time action on the identified issues. These systems also have electronic connectivity to the payer databases to confirm or deny what the patient has communicated upon registration[b]. Is it possible to achieve 0% denials in this area? Unfortunately not. It seems logical if eligibility is verified electronically on 100% of patients, no eligibility denials would occur. Even if that were the case, payers have what is called “retro disenrollment”. In these situations, the patient is legitimately classified as eligible on the date of service, claims are filed and paid, and months later the payer retracts payment as the patient was retroactively dis-enrolled. There are a number of reasons this can happen – but the key is the hospital had no indication it would later be denied and again are responsible for managing the denial.

How to Manage Non-Preventable Denials

In summary, react quickly and hold the payers accountable. If the appropriate amount of attention, time, and energy is given to implementing denials management technology, it will allow for swift identification, triage and delivery of the denial to the appropriate work queue. Upon delivery to the work queue, skilled team members begin greasing their elbows and take the appropriate action to attempt to get the denials overturned.

Over time, Revenue Cycle team members develop skillsets to navigate payer challenges, which are invaluable but can only be learned through experience. These include skills like multitasking while on hold for long periods of time, learning to speak payer specific terminology, development of detection tactics to determine the legitimacy of the information being given, development of thick skin and ability to debate and stand firm, and when the situations call for it, to be comfortable asking to be transferred to management if they feel they aren’t being heard or understood.

In addition to skilled team members, routine payer meetings are important to make progress but also to keep the payers to task. During these meetings, discussion and documentation of detailed issues occurs to make sure all key stakeholders and held responsible and have a shared understanding of the specifics of the topic, agree on a corrective action, and most importantly, issue resolution including who owns the action and when it will be completed.

It’s also important to understand, even though there are denials classified as non-preventable, that does not mean the dollars are ultimately lost. With persistence, time, and dedicated resources, it is possible to overturn these denials.

[b] Augusta Health recently underwent a change in their registration platform and was able to realize a 50% reduction in denials in less than 2 months.

Health Insurance Claim Denials: A Harsh Reality of Doing Business

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The cost of denials

Sample Spend Breakdown

Registration Quality	$	360,000
Claims Scrubber	$	240,000
Denial Management	$	360,000
Labor	$	250,000
Total	$	1,210,000

Although the cost of denials can vary widely, there are specific technology costs related to ensure passage of clean data through the revenue cycle, as well as managing, tracking, and overturning of denials when they occur. In addition to the cost of technology, there is an average labor cost associated with denials of $25 per denied claim, according to HFMA[c]. A significant amount of the labor costs is related to time spent on the phone with payer representatives[d]. Consolidating the costs of technology and labor, a health system can easily spend over a million dollars annually to prevent and react to denials alone.

A patient story

A 60 year old with coronary artery disease, hypertension, and congestive heart failure with a complete heart blockage, undergoes an insertion of a cardioverter-defibrillator. To bill for this service, the main procedures codes are 33249 - Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s); single or dual chamber and 33225 - Insertion of pacing electrode, cardiac venous system, for left ventricular pacing at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator. The patient's commercial insurance denies the entire claim as they state 33225 is experimental and investigational, therefore denying for medical necessity.

The denial is nonsensical. 33225 is inherent to the base procedure. Said differently, 33249 is the code representing the insertion of a device with leads. The 33225 is the procedure representing the lead insertion. By covering the base procedure, the lead insertion should have also been covered.

This particular case required 3 levels of appeal (including a letter of medical necessity written by the performing electrophysiologist) over the course of 10 months in order to get the original denial overturned. The effort involved, including pulling a very valuable organizational resource away from his clinical duties, is a waste of valuable and limited hospital resources.

Summary

As health insurance coverage continues to grow in complexity, so do the pre-service administrative requirements and the post-service denial recovery processes. Whether preventable or not, health systems will continue to remain responsible for working through the maze. With a dedicated and knowledgeable workforce, air tight identification processes, and energy to fight the good fight, financial exposure can be minimized.

[c] "Practical Tips for Maintaining Control Over the Revenue Cycle", by Eric Arnson (Feb 28, 2019)

[d] A recent review of Augusta Health's productivity identified an average of 22 minutes per phone call with a large national insurance carrier.

Health Insurance Claim Denials: A Harsh Reality of Doing Business

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About the Authors:

Kelli Puffenbarger, CRCS-I,P

Kelli is the Denials Manager at Augusta Health in Fishersville, Virginia. As the Denials Manager, she is responsible for monitoring, analyzing and developing prevention tactics for hospital related denials. Kelli is a Certified Revenue Cycle Specialist and active member of the Virginia Chapter of AAHAM. When she is not at work, she enjoys crafting, camping, and spending time with her grandkids.

Katie Adams, CRCE, CRCS, CRIP, CCT

Katie Adams is the Director of Patient Financial Services at Augusta Health in Fishersville, Virginia. She is responsible for back-end revenue cycle operations including but not limited to, hospital billing and accounts receivables management, medical group billing and accounts receivables management, medical group coding and charge capture, system wide revenue integrity and denials management. Katie is a member of the Virginia Chapter of AAHAM and in her spare time enjoys spending time with her husband and four sons, raising chickens, drinking wine, and keeping bees.

Writers Wanted!

Newsletters are published quarterly. Don't miss your chance to be read, recognized, and rewarded for your writing talent! *Submission deadline for the Fall Newsletter is September 15, 2021.*

Submit articles or, express interest in participating on the Virginia AAHAM Publication Committee **HERE**.

Using Happiness To Drive Productivity

James A. Bush, PhD, MHA
Principal Product Trainer, nThrive
Adjunct Professor of Healthcare Sciences

One of my greatest joys as a vendor is visiting my client's office and, more specifically, being on the billing floor where the rubber meets the road. Revenue Cycle management teams have a unique culture separate from that of the rest of the facility they support. It consists of some of the most compassionate, caring, and analytical individuals you could ever encounter. And while each facility had its own personality, one thing remained consistent, and that was the theme of family and belonging. You are bound to find photos of adorable grandchildren, weddings, and graduations between keyboards and dual monitors. Cubicles personalized with choochkies, certifications, and greeting cards. The smell of an office potluck and your coworker's award-winning dish. I probably miss most the sounds of laughter and keystrokes blended with the mutilid phone calls to patients.

James Bush, PhD, MHA

Then with one e-mail, we all got sent home. We struggled at first between kitchen tables turned classrooms, bedrooms turned offices, and endless zoom meetings. Leadership had fears that productivity would fall and struggled with new policies from government agencies. As a consultant, I'm often asked about the dreaded P-word (Productivity) and ways to measure in their current systems. Often requesting data on the number of accounts touched, reviewed, billed, coded, and paid. And while leaderships eye light up as I explain productivity features, team members often overt their eyes at the dreaded p-word. But to everyone's surprise, the choppy waters settled, and it became smooth sailing. The anxiety of being out of your comfort zone faded and was replaced with a feeling of enjoyment. This "new normal" actually wasn't all that bad. Alarm clocks were replaced by face licks from family pets and the smell of freshly brewed coffee. The family photos on your desk hold no weight

Using Happiness To Drive Productivity

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to the real-life laughter of your little one playing in the next room. And with all that going on, you never missed a beat, a report, a conference call, or e-mail. In many instances, productivity for Revenue Cycle teams is maintained and or increased in areas.

> *"...happy employees were 13% more productive than their counterparts."*

Historically, being in the office has often been equated to a person's productivity. That if a person is not seen, then they couldn't possibly be working. While COVID-19 caused major logistical nightmares, it also revealed the importance of a work-life balance and that the notion of having to be in the office physically equated to increased productivity was false. As the world and our facilities began to open back up, Revenue Cycle leaders should remember that productivity is essential, but so is your employee's happiness. The working from home experiment for many worked because many employees found joy in their homes. A study conducted by Oxford concluded the happy employees were 13% more productive than their counterparts. The happy employees didn't work additional hours; they simply were more active and engaged in projects than the discontent employees. This notion of happiness supports the SHRM study that found 94% of employers stating that productivity was the same as or higher than before the pandemic, even with their employees working remotely. Undoubtedly our office culture will return, and desk will become occupied once more. However, revenue cycle leaders should consider the benefits of allowing flexibility in their team's ability to work remotely if needed. As a final thought, here is a quote by Alexander Kjerulf that says, "most people chase success at work, thinking that will make them happy. The truth is that happiness at work will make you successful".

Meet Maria Kelly, Founder of AMOR Healing Kitchen

Natalie Hefner, CRCE, Secretary VA Chapter of AAHAM

The AMOR Healing Kitchen is based in Charleston, South Carolina. They make and deliver nutritious, healthy food, using seasonal organic ingredients sourced from local and surrounding area farms, made with love by youth volunteers. On a weekly basis, Kitchen Mentors teach AMOR's Teen Chefs culinary skills who prepare delicious, nutritious meals for people undergoing or recovering from medical treatments such as Cancer, Diabetes, and HIV. These meals are delivered to those in need by AMOR's Delivery Angels every Friday. The Virginia Chapter of AAHAM, along with other National AAHAM chapters, have created a cookbook to support this wonderful organization. The cookbook features a selection of AMOR Healing Kitchen's recipes. Purchase yours today! Now, meet Maria Kelly, Founder of AMOR Healing Kitchen and former National Winner of Rachel Ray's Feed It Forward Competition!

Q. Tell us how AMOR Healing Kitchen was founded.

A. AMOR was founded in February 2018. I had been with my mom during her journey of a Colon cancer diagnosis and she was the one that instilled in me a love of cooking and healthy food. Growing up, no matter what we were doing or how busy everyone was, we always sat down together at the dinner table. I learned at an early age, that food connects us and heals us. I would often cook for my mom and take her food when she wasn't feeling well and I felt that was a little bit of comfort and strength that I could offer her during that time. I was a high school teacher in Charleston for 15 years so I have worked with youth for a long time and I know in my heart that they have so much to offer in shaping the future of our community. We have to include our youth and develop in them a sense of leadership, ownership and being connected (while being unplugged). When I learned about an organization in California that works with teens and serves people with health challenges, I just had this deep feeling of connection and that something similar could work in Charleston. We have an abundance of local, organic farms in our area and I believe that as a society getting back to the earth for our food will help cure us of so many of our chronic diseases. Once I started doing the research and really sitting with the idea, I knew it was something I had to do. Bringing people food in times of need is something we can all relate to. AMOR is bringing that to the table and offering it in a healthy way made with love.

Maria Kelly, Founder of AMOR Healing Kitchen

Q. How many people do you serve?

A. We average 25-30 clients and serve each one for a minimum of 12 weeks.

Q. How many teens do you estimate AMOR has mentored?

A. We have mentored approximately 60 teens.

Q. Name something about your journey that was pleasantly unexpected.

A. The fact that our volunteers for the most part, never leave! The level of dedication of service and belief in our Mission is extraordinary and I'm so grateful for their enthusiasm.

Q. What is one of your favorite recipes from the AAHAM Cooks! Cookbook?

A. Definitely the AMOR Amaze-balls! They are delicious, nutritious, easy to make, and a perfect treat!

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Meet Maria Kelly, Founder of AMOR Healing Kitchen

Q. What is your favorite way to celebrate after you have completed a demanding project?

A. Start the next one.

Q. What lesson (s) have you learned from the pandemic?

A. Adaptability is the name of the game.

Q. What is your favorite way to connect to nature?

A. My morning routine of meditation for 10-15 min. in my backyard with the morning songbirds.

Q. How do you manage work/life balance? How is it important to you?

A. Extremely important. I will work really hard in order to maintain my time for traveling with my husband. I make sure to leave my phone in the car when I'm spending time with my friends, or leave my phone in the other room in the evening when I eat dinner and spend time with my husband. I also make sure to take one day a week where I don't log onto my email (usually Sundays).

Q. What is your favorite quote?

A. "Life shrinks or expands according to one's courage." I'm not sure who said it, but I try to live my life by these words.

Q. You have an unexpected day off. What do you do?

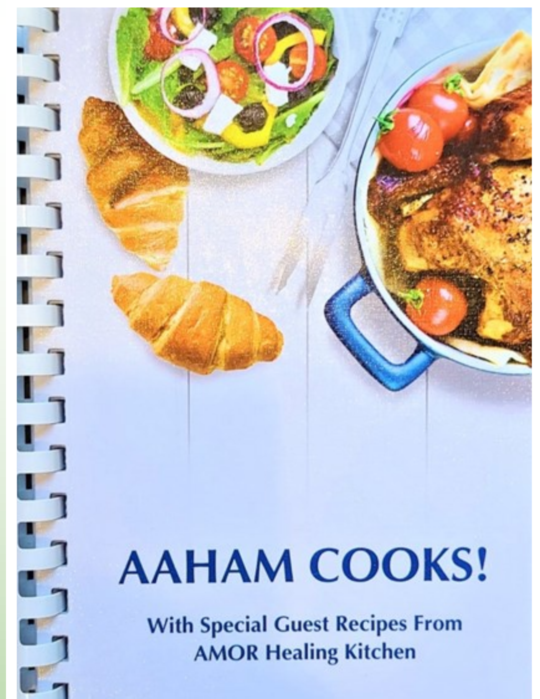
A. Surf when there are waves, work in my garden when there aren't.

Q. What might someone be surprised to know about you?

A. I will spontaneously bust into a dance party if there is a call for it.

Q. How can people donate to your cause?

A. Via our website www.amorhealingkitchen.org



The members of the Carolina, Georgia, Keystone, Maryland, Philadelphia, Three Rivers and Virginia Chapters of AAHAM along with AMOR culinary staff created the cookbook to support the AMOR Healing Kitchen. **The cookbooks can be purchased at AMOR Healing Kitchen's website.**

Palmetto GBA: GY and GZ HCPCS Modifier Use

The Center for Medicare & Medicaid Services (CMS) created two modifiers that allows you to distinguish between services that are statutorily excluded, or otherwise not a Medicare benefit because Medicare does not consider them "reasonable and necessary." Statutorily excluded refers to Medicare benefits that are never covered according to law. "Statutory" refers to written law. Medicare does not pay for all health care costs. Certain items or services are program or statutory exclusions and will not be reimbursed by Medicare under any circumstances. Medically necessary services are defined as "health care services or supplies that are needed to diagnose or treat an illness, injury, condition, disease or its symptoms, and that meet accepted standards of medicine." If the services billed do not meet the criteria, then it is not considered reasonable and necessary.

HCPCS Modifier GY: service provided is statutorily excluded from the Medicare program. The claim will deny whether or not the modifier is present on the claim. Adding the GY HCPCS modifier to the CPT code indicates that an "item or service is statutorily excluded or the service does not meet the definition of Medicare Benefit." This will automatically create a denial and the beneficiary may be liable for all charges whether personally or through other insurance. For example, when a beneficiary wants new eyeglasses and wants to get a denial through Medicare for secondary payer purpose, the claim should be submitted with GY HCPCS modifier. This way the claim may be processed faster than it would be without GY HCPCS modifier. Advanced Beneficiary Notices (ABNs) are not acceptable for statutory exclusions.

Appropriate Usage:

- Services provided under statutory exclusion from the Medicare program, the claim would deny whether or not the modifier is present on the claim
- It is not necessary to provide the patient with an ABN for these situations
- Situations excluded based on a section of the Social Security Act
- Modifier GY will cause the claim to deny with the patient liable for the charges

Inappropriate Usage

- Do not use on bundled procedures
- Do not use on add-on codes

Continued, next page

Palmetto GBA: GY and GZ HCPCS Modifier Use

HCPCS Modifier GZ: item or service expected to be denied as not reasonable and necessary.

Medicare will auto-deny services submitted with a GZ HCPCS modifier. The denial message indicates that the patient is not responsible for payment; deny provider liable.

Use this modifier to report when you expect that Medicare will deny payment of the item or service due to a lack of medical necessity and no ABN was issued.

Use when the provider expects denial due to a lack of medical necessity based on an informed knowledge of Medicare policy.

This modifier is an informational modifier only. An informational modifier is a medical coding modifier not classified as a payment modifier. Another name for informational modifiers is "statistical modifiers." Payment modifiers are modifiers that have an impact on payment of the claim. An example of this is adding the 50 CPT modifier for bilateral services. When the 50 CPT modifier is added, the code billed gets reimbursed at 150 percent of the Medicare allowable amount.

Medicare contractors, including Palmetto GBA, will automatically deny claim line(s) items submitted with HCPCS modifier GZ, using Claim Adjustment Reason Code CO-50. (These services are non-covered services because this is not deemed a "medical necessity" by the payer.)

Do not submit both HCPCS modifier GZ and HCPCS modifier GA or GY on the same claim line.

The GA HCPCS modifier indicates that there is an ABN on file.

The GY HCPCS modifier indicated that an item or service is statutorily non-covered or in not a Medicare benefit.

Do not add the GZ HCPCS modifier to a corrected claim (XX7 UB) if you are correcting a charge and putting it as non-covered. This causes the line to deny because lines with the GZ HCPCS modifier are automatically denied.

Medicare will adjudicate the service just like any other claim.

If Medicare determines that the service is not payable, denial is under "medical necessity." The denial message will indicate that the patient is not responsible for payment.

If either the beneficiary or provider requests a redetermination, the modifier indicated that an ABN was not given, and this could aide in completing the review quickly.

Source: Palmetto GBA Jurisdiction M Part A, Last Updated: 06/06/2021

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"Code Calamity" with Transitional Care; Chronic Care And Remote Patient Monitoring

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rob@bpa-consulting.com

Caring for a patient today has become more complicated than ever before. We all know what we might call "traditional" care, meaning that the patient (or someone) contacts the physician and makes an appointment. Then, the patient shows up, completes the information required for becoming part of the physician practice, including insurance and financial information. Moving on, the patient gets to meet the nurse and now the clinical information is entered into the patient database. With the clinical and social and family history collected, the patient "waits" to see the physician. Once the physician arrives, the patient basically repeats everything the nurse has collected regarding the clinical, social, and family make-up to better understand the patient. Once all of this dialogue is completed, the patient gets to state the reason why they came to see the physician.

All of this is encompassed in what we call, today, 'Evaluation and Management" (E&M) codes as found in the Current Physician Terminology (CPT) manual. These codes have certainly matured over the course of their initial introduction to the physician community back in 1992 era. Now, over the course of the last 30 years, these codes have been redefined, clarified, modified, expanded, etc. and have become a dictionary for members of the medical practice (from multiple specialties) to try to determine which code is the correct and best code to assign toward a patient's care. As the accessibility of healthcare has expanded, as well as the level of diagnostic specificity, the Centers for Medicare and Medicaid Services (CMS) has also expanded the various situations regarding the proper care of a patient through documentation requirements and code specificity. So now, we have codes for Evaluation and Management situations onsite, we also have codes for off-site situations using 'Place of Service" codes and proper modifiers for 'Tele-medicine' patients. In many rural situations, telemedicine care has become a wonderful way to care for and monitor elderly patients, sickly, chronic patients and provide a method to quickly identify if more acute care may be needed for many patients. Especially during this pandemic situation, the ability to care for patients through tele-communications has become vital to saving many lives.

Transitional Care Management (TCM) codes have been established allowing for the care of patients moving from one care situation to another. These codes (services) are for established (E&M) patients whose medical and/ or psychosocial problems require moderate or high complexity medical decision

"Code Calamity" with Transitional Care; Chronic Care And Remote Patient Monitoring
Rob Borchert, S.M.E., MBA, CRCE, FHFMA

making during transitions in care from an inpatient hospital setting (acute, rehab, or long-term), partial hospital, observation status either in a hospital or skilled nursing facility, to the patient's community setting (home, domiciliary or assisted living). What is interesting is that the TCM codes require a number of criteria that are similar or the same as Chronic Care and Remote Monitoring. The TCM codes comprise one face-to-face visit within 29 days and also consists of various communication situations with patient, family members, guardian, etc. that can be via telecommunication venues. Also, other E&M codes can be utilized during this time with proper, medically necessary criteria and documentation. The TCM codes do not include any form of a data collection device for patient care. So now we have the patient "off-site" and want to provide services to them. Also, the patient may need a device to monitor their clinical condition. There are usually two types of patients that need to be monitored for clinical care. One type are the chronic care patients whose conditions are expected to last at least 12 months. The other type are patients, both chronic and acute, who require monitoring of their condition on a daily basis. For chronic care patients, there needs to be at least two or more chronic conditions to last at least 12 months or until the death of the patient and that place the patient at significant risk of death, acute exacerbation/ decompensation or functional decline. Some examples of chronic conditions that meet these criteria are:

Alzheimer's disease and related dementia
Arthritis (osteoarthritis and rheumatoid)
Atrial fibrillation
Cancer
Cardiovascular Disease
Chronic Obstructive Pulmonary Disease
Depression
Diabetes
Infectious diseases such as HIV/AIDS

Remembering that these patients are established patients, there is a code (G0506) that is an "add-on" code that indicates a "comprehensive assessment and care planning" service that includes additional reimbursement in setting up this chronic care patient. Once this patient is set-up, there are specific Chronic Care Management (CCM) codes that are utilized for the care plan for this type of patient. These codes are defined in the CPT manual and range from non-complex service rendering to complex service. These services are also performed by the clinical staff under the supervision of the provider and

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cover various periods of time over the course of the monthly billing. Each of these various services require specific documentation of both the services rendered both directly associated with the plan of care, as well as any additional services that will be documented and later reviewed by the provider. One must note that this documentation is not only the clinical conditions but also the specific time associated with the service. This time is cumulative over the billing period but must be noted in very specific terms. Again, all of this documentation is reviewed and signed off by the provider of the patient.

So now we have patients who start off with E&M codes (and there is a continuous pattern) and some patients transition into a different element of care and are documented with TCM codes. Moving further along our pattern of life, there are some patients who will be served best in a chronic care setting and therefore are documented using CCM codes for the period of time needed. We must note that all patients are treated and cared for with the greatest respect and tenderness that caregivers are blessed with. We, who are typically the billers of these services, should also respect these clinical staff personnel and hold them in high regard and thank them for their gift of care.

There are also patients who have conditions, both chronic and acute, who can be placed in home settings that require a medical device and constant monitoring of their condition electronically. Some devices are utilized by the patient 24 hours a day and some have periodic monitoring requirements. Some patients have hypertension and provide their provider with daily blood pressure measurements electronically. Some patients have additional conditions that require such items as pacemakers, diabetic monitors, breathing machines, etc., to report their data on a regular basis to the provider and/or the clinical staff. These patients are not in the chronic care arena necessarily, but in such a condition that there is a defined need to monitor their care for an enhanced life.

In order to address these type patients, CMS has developed codes to reimburse providers regarding care for remote patient monitoring. These codes are an outgrowth of the beginning of telemedicine services and the recognized need for these services. Add onto this need, the current environment of this COVID-19 pandemic environment and we now have services that can be provided for both acute and chronic patients who, through the technology of medical devices, are able to receive good medical services in their home or domicile and the providers/clinical staff can also receive some reimbursement for these services.

Remote Patient Management (RPM) services provide patients with the medical device(s) they need

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for the monitoring of their care. These devices are described in section 201(h) of the Federal Food, Drug and Cosmetic Act and basically consist of items such as an apparatus, implement, machine, contrivance, implant, in vitro reagent, etc. which is recognized in the official National Formulary; intended for use in the diagnosis of disease, treatment, prevention, etc. or intended to affect the structure or any function of the body of man and not achieve its primary intended purpose through chemical action and is not dependent upon being metabolized for the achievement of its primary intended purpose(s).

Sounds complicated but in simple terms, the approved medical device must digitally and automatically upload patient physiological data for purpose of monitoring the patient's condition and, electronically, notifying providers of both steady conditions as well as any changes that may affect the condition. There is also a code for the initial setup and patient education on the use of the device as well as the code for continual monitoring and reporting. As with the other monitoring codes, there are specific guidelines regarding time and documentation. These are monthly billing codes, so the timeline guidance is for services throughout the month as well as add-on codes if the monitoring requires a more extensive time period. Documentation in the patient's medical record is critical for the proper use of these codes and the sign-off process by the provider is also critical to timing. By this I mean that the clinical monitoring can indicate a basic change in the patient's condition that may require action, but if the provider does not read/sign-off on the documentation for a day or two later, the patient's condition may have become more severe than if reviewed the day of documentation.

So, now we have E&M codes, TCM codes, CCM codes, RPM codes and lots of diagnostic codes. For a biller, and even a health information management coder, there can be "code calamity" if there are indicators to bill multiple codes that require a knowledgeable review. For TCM codes, certain other codes cannot be billed with them. Such codes involving education and training, analysis of data, chronic care coordination services, etc. are not appropriate to bill together. Some RCM and CCM codes can be billed with TCM and certainly with E&M codes. Some codes are immediate flags for CMS to question the billing of the patient. While there are no flags to tell you that you can bill some additional codes to Medicare that you forgot to utilize. A biller of these services may need to review the medical documentation themselves or work closely with a health information management person to review the documentation to arrive at the correct and most accurate billing scenario. A biller must also recognize there is a specific "place of service" code for telemedicine and off-site patient care. There are also code modifiers associated with this type of billing. All of this is fun, right? Why else we would choose a profession with such simple scenarios that make everything black and white! Life is short…live it well!

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Meet Amy Beech, CRCE

Amy Beech, CRCE is the First Vice President of the VA Chapter of AAHAM

Amy Beech, CRCE and family

Q: Where do you work and what is your role?

A: I am the Patient Financial Services Manager at Augusta Health. I have been here for 12 1/2 years.

Q: Tell us about yourself!

A: I live in Stuarts Draft, Virginia with my husband and two sons who are 19 and 15. My favorite thing to do is go to the beach!

Q: How did you get involved with AAHAM?

A: I got involved in AAHAM in 2010 by starting out helping on a committee. From 2014-2017 I was the Secretary and from 2017-2021 I have served as the First Vice President for the Chapter.

Q: Name something you feel you excel at.

A: I feel like I have a very strong connection with people and I enjoy going to the extra mile to make connections with people. I have found in my years of leadership that making time to get to know things that are important to people go a very long way to helping make them successful in their career.

Q: Do you have a favorite way to relieve stress?

A: I find the ultimate stress relief for me is being able to go to the beach. The ocean brings me a sense of peace that I cannot find anywhere else. I can put my mind at ease and fully relax!

Q: Name something you can't live without.

A: Most who know me well know that I am not a morning person, so everyone always makes sure that I have had my cup of coffee to start my day before they talk to me!

Q: What book is on your nightstand?

A: Anything by Nicholas Sparks.

Q: What might someone be surprised to know about you?

A: I love British cars.

If you would like to be interviewed for our newsletter, please contact the Publications Committee!

Bill Spare National AAHAM Recognition Award Nominations

The Bill Spare National AAHAM Recognition Award is presented to a National AAHAM member to acknowledge and honor significant, commendable and long-standing contributions to the AAHAM organization. The award is named in honor of Bill Spare, CRCE, who served as the National AAHAM President from 1996-1998. Bill demonstrated integrity and leadership in every role he served within the organization and provided support and encouragement for so many of its members.

Eligibility: Candidates for award consideration must be National AAHAM members in good standing.

Criteria: A nomination for the AAHAM National Recognition Award may be made for:

- a single exceptional contribution
- a sustained contribution, or
- a lifetime of exceptional service

Nomination Process & Requirements: Nominations may be submitted to the National Office by current National AAHAM members and must include the following:

- At least one letter of reference outlining the specific contributions the nominee has made, including examples of their having demonstrated leadership in professional advancement, actively supported the AAHAM mission and contributed as a volunteer in the advancement of AAHAM
- A brief biographical sketch of the nominee
- A concise description of the aspects of the nominee's contributions that cause him / her to be worthy of special recognition by AAHAM.

The nomination deadline is July 31, 2021.

Woodrow Samuel Annual Scholarship

To be eligible for this annual scholarship award, you must be a Virginia AAHAM member employed full time in a healthcare related field or a child of a Virginia AAHAM member enrolled in an accredited college or school. For more information on how to apply and to obtain a copy of the scholarship application, logon to the Members Only page of the Virginia AAHAM chapter website.

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Upcoming Events

Virginia AAHAM

- **June 22-24, 2021** **The 2021 AAHAM Virtual Legislative Day** The Virginia Chapter supports National AAHAM Legislative Day. Earn up to 12 AAHAM CEUs!
- **September 24, 2021** **State Legislative Day** Please join the Virginia Chapter as we host our very first State Legislative Day! This will be an in-person meeting in Charlottesville, Virginia. Email registration coming soon! Topics will include the **Balance Billing Regulation** and speakers from the Virginia Bureau of Insurance will be in attendance.
- **October 2021** **The 2021 AAHAM ANI** will be held virtually. Stay tuned for dates. Attend every day or just one day and earn your AAHAM CEUs.
- **October 2021** **VA AAHAM to host Certification Webinars** Earn AAHAM CEU's by attending a certification webinar. Watch for an email blast with dates!
- **November 30, 2021-December 3, 2021** **VA AAHAM Annual Winter Conference** Join us in-person at Kingsmill Resort in Williamsburg, Virginia and Earn AAHAM CEU's!

Upcoming Certification Exam Dates and Registration Deadlines

Certification Exams are now available each month. Applications to take an exam are due in to the National AAHAM office 30 days prior to a testing period.

- July 19-23, 2021 July 2021 Exams
- August 16-20, 2021 August 2021 Exams
- September 20-24, 2021 September 2021 Exams
- October 18-22, 2021 October 2021 Exams
- November 15-19, 2021 November 2021 Exams
- December 13-17, 2021 December 2021 Exams

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Spotlight: The AAHAM Certified Revenue Cycle Executive

The **CRCE** exam is intended for all senior/executive leaders in the revenue cycle industry, to help equip you for strategic management of the business. This certification possesses the highest level of difficulty combining content knowledge of the business with critical thinking and communication skills. The Executive Revenue Cycle Certification demonstrates a high level of achievement and distinguishes you as a leader and role model in the revenue cycle industry. The certification validates your proficiency and commitment to your profession and can play an integral role in your career strategy. In many instances certification may help you secure the promotion or the job you desire. In the healthcare revenue cycle industry, the Executive Revenue Cycle Certification is comparable to earning a CPA or passing the bar exam. Passing the CRCE designates a mastery of the art of revenue cycle management. Visit the AAHAM Certification webpage for more information.

VA AAHAM Board Member in the News!

Timothy Breen Earns AAHAM CRCE Designation

Washington, DC - The American Association of Healthcare Administrative Management (AAHAM) has awarded **Timothy Breen**, the prestigious designation of Certified Revenue Cycle Executive (CRCE). The CRCE certification signifies that **Timothy Breen** has completed a rigorous professional competency examination addressing the complex areas of Patient Access, Billing, Credit & Collections, and Revenue Cycle Management.

By achieving the CRCE designation, individuals demonstrate that they possess not only the knowledge base required to pass the 8-hour examination but also a dedication to excellence and the advancement of their profession. This level of knowledge and commitment is highly valued by healthcare executives and certification is frequently a pre-requisite for patient account management positions.

Successful management of the revenue cycle operation is critical for the financial well-being of a healthcare institution, clinic or physician’s office. A mark of excellence for more than 30 years, the CRCE certification process measures the technical and functional knowledge necessary to achieve this success.

To maintain AAHAM Executive certification, Timothy Breen will be required to earn 40 continuing education units every two years in activities such as attending educational seminars, authoring articles and giving presentations, and coaching others for certification exams.

AAHAM is a national association of more than 2,500 healthcare administrative management professionals with 30 chapters across the U.S and in India. A resource center for information, education and advocacy, AAHAM is the premier professional organization in healthcare administrative management, providing education, communication, professional standards and certification.

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Meet Timothy Breen: Virginia's Newest Certified Revenue Cycle Executive

Timothy Breen, CRCE is the Chairperson of the VA AAHAM Linda B. McLaughlin, CRCE Communications Committee.

Q: Where do you work and what do you think other people should know about this organization?

A: I work for UVA Health as their Managed Care Supervisor for outpatient accounts. UVA Health continuously represents a fun work environment that empowers their employees. The presence of mentors at UVA Health has had such a significant role in my development and motivated me to reach for more and achieve my goals, including passing this exam to obtain the CRCE.

Q: How many years have you been involved with VA AAHAM?

A: I became a member in July 2019 following the passing of my CRCS exam, however I was introduced to the VA AAHAM in Fall of 2018.

Timothy Breen, CRCE with daughter

Q: What does your VA AAHAM Membership mean to you?

A: My membership means a great deal to me. I gain so much value in the webinars, networking, certification opportunities, and overall support from VA AAHAM and National AAHAM.

Q: What would you say to someone thinking about becoming AAHAM [CRCE] certified?

A: Do it! BUT, make sure you study hard for the exam. I spent a lot of late nights up on a couch reading the material and had a few study sessions with former exam takers leading up to the exam.

Q: What does being an AAHAM CRCE mean to you?

A: This means a lot, as I have looked up to others that are on the VA AAHAM Board and at UVA Health whom have their CRCE. Knowing I am moving up to those ranks makes me feel motivated to strive for excellence and do what I can to improve the healthcare administration industry in Virginia.

Q: Do you have any tips for studying for the CRCE?

A: Read the manual several times, attend certification webinars, and grab a study partner. I must have read the manual over 10 times, front to back, since this year presented a combo of physician and facility billing material. By reading each word in the manual and not skipping anything helped me soak in the information. As I was approaching the actual exam, I did gain extra value by attending the VA AAHAM certification webinars, plus I got a great opportunity to work with Leanna Marshall as a study partner. Thanks, Leanna!

Meet Timothy Breen: Virginia's Newest Certified Revenue Cycle Executive

Q: Tell us about the moment you learned of your CRCE designation. How did you celebrate?

A: After months of waiting for the e-mail to surface to confirm my scores, I was surprised and excited by the way I found out. The update on my score had also been shared with Leanna Marshall (Certification Chairperson for VA AAHAM) wherein she shared the great news with the VA AAHAM Board, and then Dushantha Chelliah (my boss at UVA Health) shared that information with UVA Health management. When I looked through my e-mails, I was happy to see my peers and mentors giving me congratulatory e-mails, so it made the day one of my favorite Fridays of all time. I am so appreciative to have such great people surrounding me in both organizations and can't thank them enough for helping me on my journey and for celebrating my accomplishment.

Q: What trends are you seeing right now?

A: Being the Managed Care Supervisor for UVA Health I see new trends each year with the ongoing updates for amendments. This year has had a unique trend surrounding our non-contracted payers though, since there is the new balance billing law requirement. I would say properly analyzing this trend was a big scenario for our hospital and most hospitals in Virginia, so I bring mention to the hard work that went into it by UVA Health to properly align with the new requirements, while always keeping the patient's well-being into consideration while we adjusted our practices to meet these needs.

Q: Name something you feel you excel at in your role.

A: I believe that my ability to analyze large groupings of data, spotting trends, and then using big projects to rectify any underpayments is something I have excelled at with my current role. There is immense satisfaction with knowing my work is resulting in the patient's insurance covering the charges while also reducing the patient's responsibility and earning the hospital money.

Q: You have an unexpected day off. What do you do?

A: Enjoy time with family! Time with my daughter, wife, and two dogs can fill up a day pretty fast. Going for walks outside or finding a place to go fishing with them will make for a nice substitute to the typical work day.

Q: What might someone be surprised to know about you?

A: I am a "happy camper", which is funny because nobody uses that term without there being a lot of sarcasm. My family and I really enjoy these moments to bond and relax. Plus, since my house is a log cabin, we enjoy these camping trips to allow us to "rough it" for a few days.

If you would like to be interviewed for our newsletter, please contact the Publications Committee!

Recently Certified in Virginia

VA AAHAM would like to congratulate those who earned the following designations this spring. Congratulations to:

Certified Revenue Cycle Executive

Timothy Breen, CRCE

Certified Revenue Cycle Specialist

Kayla Conner, CRCS
Haily Day, CRCS
Georgina Dinarte, CRCS
Bianca Doakes, CRCS
Sachet Fields, CRCS
Sandy Duong, CRCS
Jhane Glenn, CRCS
Cassandra Johnson, CRCS
Gimena Ugarte-Revollo, CRCS
Tatiana Vanegas Jurado, CRCS
Hannah Sawn, CRCS
Ngoc Truong, CRCS
Sierra Miller, CRCS
Kaitlyn Ward, CRCS

Certified Revenue Cycle Professional

Catherine Price-Campbell, CRCP

Certified Revenue Integrity Professional

Logan Rexrode, CRIP

New AAHAM Certification Exam Schedule

AAHAM now offers all of our certification exams on a **monthly basis**, enabling our test takers to have more flexible scheduling options to become certified when the time is right for them. All certification exams will now be offered on the third week of each month.

The certification exams will continue to be delivered either remotely online through ProctorU, or with a local in-person proctor. AAHAM will work with examinees to assist in making the necessary proctoring arrangements for their exams. All exam registrations will need to be submitted at least 30 days prior to the scheduled exam date, and there are no changes to the exam registration fees. The 30-day registration deadline now applies to both new exams and section retakes, offering a faster track to becoming certified for those who are ready to take an exam for the first time.

The new certification exam calendar, registration links, and information about ProctorU can be found on the AAHAM Certification page.

VA AAHAM hopes that you will consider sitting for at least one certification exam in 2021. Please reach out today to let us help you reach your career aspirations!

If you are interested in testing your knowledge and gaining the recognition that comes with certification, or wish to request individual study sessions, contact Leanna Marshall for additional information.

Leanna Marshall, CRCE
Phone: (434) 962-8508

Did you know? VA AAHAM loans out Hard-Copy study guides to members. You do not have to purchase your own study guide.

Earn Your AAHAM CEU's!
AAHAM Presents Free All New 2021 Certification Webinar Series

The Virginia Chapter of AAHAM would like to share the National AAHAM announcement of FREE On-demand videos of the new 2021 AAHAM certification webinar training series and quizzes to reinforce your knowledge! To access these amazing resources, go to the AAHAM Info Hub website and click Webinars. The CRCS and CCT webinars are publicly available for anyone to view; the CRCE, CRCP and CRIP webinars are only available to current National members, so please note that members will need to be logged in to access. Whether you are planning on taking any of the AAHAM Certification examinations, preparing for the future, or need the education to enhance your job performance, you will benefit from participating in this webinar program. Statistically, **those who have participated in our webinars have a higher exam pass rate** than those who did not. The CRCS, CRCP and CRCE webinars include multiple sessions covering each section of the exam. The CRIP and CCT webinars are one single session covering the entire exam.

You can earn 3 AAHAM CEUs for each webinar that you view. In order to receive credit for the CEUs, you will need to take a brief online quiz and answer 5 multiple-choice questions related to the webinar that you watched. You can then use the CEU submission form at https://www.aaham.org/Certification/RecertForm.aspx to earn your CEU credits. The quiz can be taken more than once if necessary, which will help to ensure that you have a thorough understanding of the topics covered.

Brenda Chambers Certification Scholarship Program

Did you know? Virginia AAHAM has earmarked funds for the AAHAM Certification Programs. The money is to be used by Virginia AAHAM National members who wish to apply for these funds to pay for the testing fee at AAHAM and will be applied on a first come first serve basis. Once these funds run out, money won't be available until 2022. This scholarship is meant for people that are truly interested in becoming AAHAM Certified but would have difficulty paying for it on their own and are not receiving funds from their employer for this purpose. This would be for any of the AAHAM Certification programs that AAHAM offers (CRCS, CRCP, CRIP, CRCE or CCT).

In order to qualify for reimbursement of the expense of taking the exam you should meet these simple requirements:

- Be a member in good standing with both Virginia AAHAM and National AAHAM for 2021 if taking one of the Professional Exams: CRCP, CRIP or CRCE
- Be a member in good standing with Virginia AAHAM as a State Only member for 2021 if taking one of the Technical Exams: CRCS or CCT
- Be someone who is not receiving reimbursement from their employer for the exam fee
- Must register for and take exam of one of these programs in 2021: CRCS, CRCP, CRIP, CRCE, CCT. Visit www.aaham.org to view exam schedule and register
- Must reside in or be employed in the Commonwealth of Virginia
- To apply, Contact David Nicholas, Chairman of the Board VA AAHAM **HERE**

Virginia AAHAM will reimburse your expense for your registration if you have a need and request it.

Once these funds run out then the program will automatically end, so please don't hesitate to register and apply for these funds if you need them!

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CERTIFICATION KNOWLEDGE CHECK!

FILL IN THE BLANK

Find answers on page 49!

Dual Eligible are individuals who are entitled to	M________________ M________________
Three Consumer Reporting Agencies	T________________ E________________ E________________
A Private Health Insurance policy	M________________
Durable Medical Equipment Includes	W________________ O________________ H__________B_____ W________________
Outpatient Analog of DRG's	A________________
Levels of Patient Care	O________________ I________________ R________________
Verbal Telephone Orders from Referring Physicians can be accepted by	P________E_______ R________N_______
Four Types of Medicare Advantage Plans	H________________ P________________ S________________ M________________
What is MSN	M________________
Two Items not covered by original Medicare plan	H________A_______ C________S_______
Ways to Become Eligible for Medicare	A________________ D________________ E________________
Three Laws that Determine When Medicare is Primary	D________________ T________________ O________________

2021 VA AAHAM Membership Application

We are growing!

The Virginia Chapter of AAHAM has 250 members as of May! We are thrilled to be growing our chapter. Visit our online membership application and payment options to join or renew your membership with the Virginia Chapter of AAHAM!

Take advantage of these important benefits…

- Problem solving and solution sharing with your associates
- Educational seminars & workshops
- Conference presentation materials
- Membership directory
- Chapter newsletter
- Reduced fees for chapter education events
- Interaction & networking with peers
- Preparation assistance for certification tests that demonstrate your professional skills
- Certification Training webinar slides and recordings
- Job Postings board

Join Today!

Notice of Elections of Officers of The Virginia Chapter of AAHAM for the Two-year Term Beginning January 1, 2022

Your vote is very important, so watch for the ballot and participate in this important event in the life of The Virginia Chapter of AAHAM. Be sure not to miss this important opportunity to vote for your 2022-2023 AAHAM Chapter Officers.

Guided by the Chapter By-Laws and Regulations, the Nominating Committee will follow established nominating and voting procedures. The President of the Chapter has appointed a Nominating Committee. The Committee will nominate persons for the offices of President, First Vice President, Second Vice President, Secretary, and Treasurer. The Committee will also nominate any member who is qualified to hold office for nomination endorsed by a minimum of ten members in good standings.

The Committee will report the names of the candidates for nomination to the President by October 1, 2021; and ballots will be sent to members on October 15, 2021. Voting will be open until November 15, 2021. The elected officers will take the oath of office at the Annual Meeting in December in Williamsburg.

Members in good standing have the right to vote with the exception of Student Members or Retired Members who are not an appointed board member. All ballots will have provisions for write-in votes for each office. Election of the nominees shall require a simple majority of those voting.

Additional information regarding nominations and voting can be found in the Chapter By-Laws and Regulations available in the Member Information on the Members-Only section of the Chapter website.

The Virginia Chapter of AAHAM 2021 Nominating Committee:

David Nicholas, CRCE, Chairperson

Leanna Marshall, CRCE, Member

Michael Whorley, CRCE, Member

Virginia AAHAM Executive Board 2021

Chairman of the Board
(Chapter of Excellence Committee)

David Nicholas, CRCE
President, Mercury Accounts Receivables Services

Office: (703) 825-8762

Email: David@MercuryARS.com

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

Linda Patry, CRCE, Director, Patient Financial Services
Mary Washington Healthcare
2300 Fall Hill Ave. Suite 311 Fredericksburg, VA. 22401

Office: (540) 741-1591

Email: Linda.Patry@mwhc.com

First Vice President
(Committee Chairperson: Membership & Chapter Development: Chapter Awareness)

Amy Beech, CRCE
Augusta Health PO Box 1000, Fishersville, VA 22939

Office: (540) 245-7216
Email: ABeech@AugustaHealth.com

Second Vice President
(Committee Chairperson: Education Committee; Government Relations Committee)

Pam Cornell, CRCE
Mary Washington Healthcare

Office: (540) 741-3385

Email: Pam.Cornell@mwhc.com

Virginia AAHAM Executive Board 2021

Secretary
(Committee Chairperson: Publications Committee)

Natalie Hefner, CRCE
Mercury Accounts Receivable Services

Office: (571) 620-0141

Email: Natalie@MercuryARS.com

Treasurer
(Committee Chairperson: Vendor Awards Committee)

Jeffrey Blue
UVA Health System
4105 Lewis and Clark Drive Charlottesville, VA 22911

Office: (434) 297-7477

Email: Jrb2re@virginia.edu

Appointed Board Member: SPONSORSHIP COMMITTEE
Thomas Perrotta, Vice President of Client Relations, CCCO

Penn Credit

Office: (888) 725-1697

Email: Tom.Perrotta@penncredit.com

Appointed Board Member: CERTIFICATION COMMITTEE

Leanna Marshall, CRCE, Retired

Charlottesville, VA

Phone: (434) 962-8508

Email: ayden1@embarqmail.com

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Virginia AAHAM Executive Board 2021

Appointed Board Member: FINANCE COMMITTEE CHAIR

Dushantha Chelliah
UVA Health System
2212 Greenbrier Dr. Charlottesville, VA, 22901

Office: (434) 924-9266

Email: DC5P@hscmail.mcc.virginia.edu

Appointed Board Member: COMMUNICATIONS CHAIR

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Virginia AAHAM Executive Board 2021

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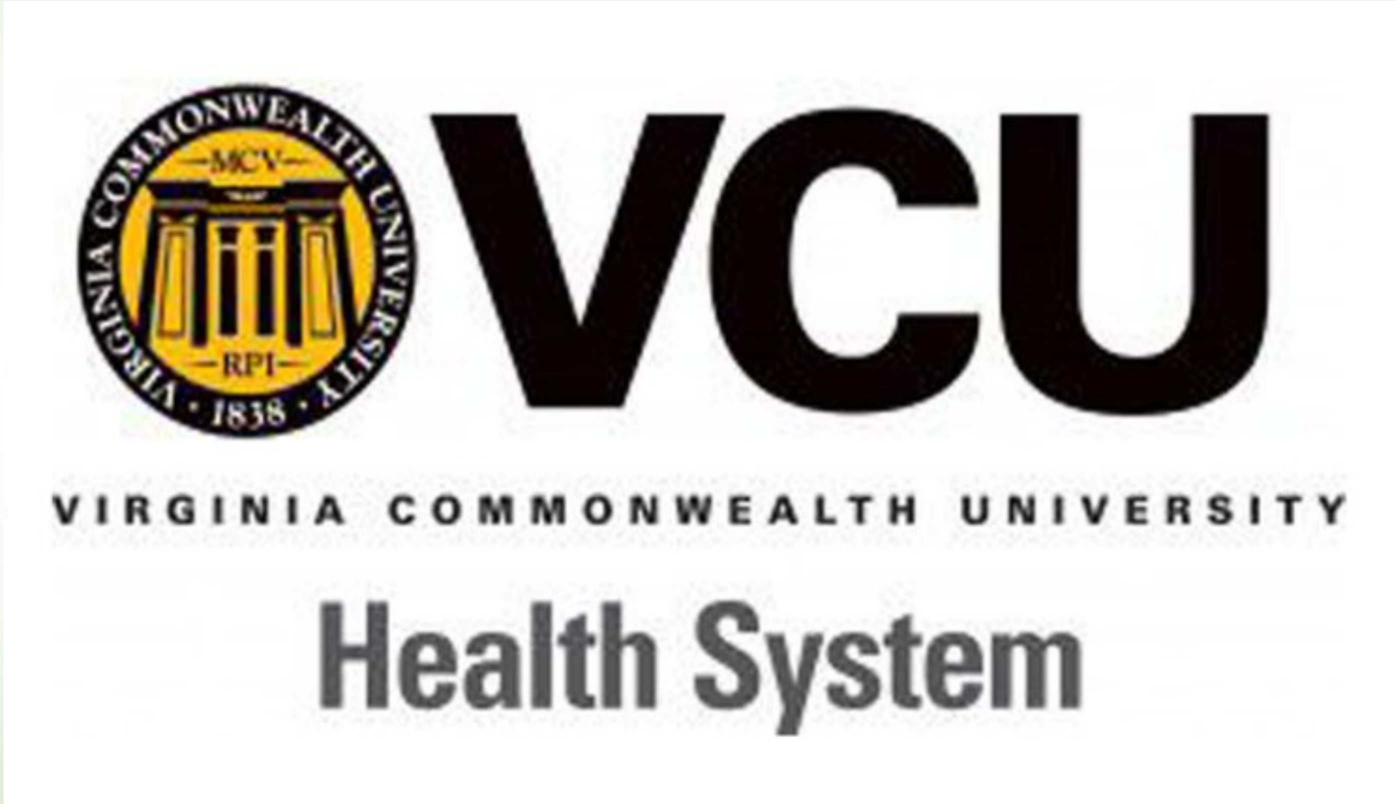

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CERTIFICATION KNOWLEDGE CHECK!

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Dual Eligible are individuals who are entitled to	Medicare & Medicaid
Three Consumer Reporting Agencies	Transunion, Experian, Equifax
A Private Health Insurance policy	Medigap
Durable Medical Equipment Includes	Wheelchair, Oxygen, Walker, Hospital Bed
Outpatient Analog of DRG's	APC's (Ambulatory Payment Classification)
Levels of Patient Care	Outpatient, Inpatient, Recurring
Verbal Telephone Orders from Referring Physicians can be accepted by	Physician Extender, Registered Nurse
Four Types of Medicare Advantage Plans	HMO, PPO, Special Needs Plan, Medical Savings Account
What is MSN	Medicare Summary Notice
Two Items not covered by original Medicare plan	Hearing Aids, Cosmetic Surgery
Ways to Become Eligible for Medicare	Age, Disability, ESRD
Three Laws that Determine When Medicare is Primary	DEFRA, TEFRA, OBRA

The Virginia AAHAM Insider

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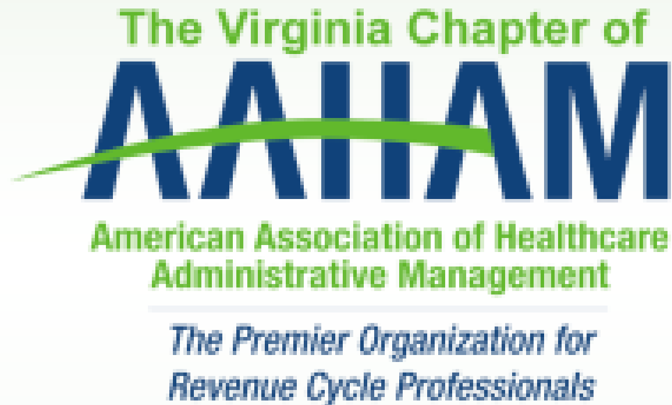
This publication is brought to you through the collective efforts of the Publications Committee.



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.