The Virginia Chapter of AAHAM
American Association of Healthcare Administrative Management

THE VIRGINIA AAHAM INSIDER

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

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The President's Message

Katie Hughes, CPAM

Hello Virginia!

As we turn a seasonal corner and stow away our swim suits and flip-flop, I am eagerly awaiting the change in leaves that I am sure to see during my daily drive over Afton Mountain. What a beautiful place to call home!

As many of you know, the National AAHAM ANI is next week in Las Vegas, and I couldn't be more excited. Although with the excitement of winning so many awards in years past leaves me with a challenge to get them all home when my suitcase is already pushing the weight limit, it is a challenge that I welcome. I am excited for the education packed conference and the endless networking that is sure to take place during my attendance, but the biggest nail-biter for me will be during the Awards Banquet on Thursday evening. As in years past, I hope be able to send an email out to the chapter membership to let you know how we did!

Also on the horizon is the Virginia Chapter of AAHAM Board of Director election for the 2012/2013 term. You will see a ballot in your inbox sometime during the first two weeks of November. Although as a board member, this time means the end of a two year term, it also brings excitement for the future. We hope that you will all take part in voting for the best candidate to serve our chapter!

Save the Date!! → Be on the lookout for meeting notices for our Fall Regional Meeting on October 14, at Fauquier Hospital in Warrenton, Virginia and also for our Annual Meeting and Conference where we will be reconvening at the Fort Magruder in Williamsburg, Virginia from December 7 through December 9. The education committee is working hard on a big agenda for us all to enjoy!

Please let us know how we can enhance your membership, and as always....

Best Wishes,

Katie

INSIDE THIS ISSUE:

Watch for information on individual candidates to be announced soon!

Elections for of Virginia Chapter of AAHAM Officers for the two year term beginning January 1, 2012

In compliance with the Bylaws of The Virginia Chapter of AAHAM:

"Notice of the mailing of ballots to the membership shall be published in the official publication of the Chapter not more than sixty (60) days and not less than thirty (30) days prior to the mailing of the ballots."

Be sure not to miss this important opportunity to vote for your 2012-2013 AAHAM Chapter Officers. 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.

The Perfect Storm is about to Hit the Revenue Cycle!

By Rob Borchert, MBA, FHFMA, CPAM

We have always recognized that there has been some form of change in the healthcare industry over the last 50 years. The changes in our clinical areas have been miraculous in many cases with the control or elimination of some diseases and the expansion of technology to treat existing diseases and improve the life conditions of millions of people. The pharmaceutical industry has also added tremendous benefits to the healthcare industry and continues to conduct research for the betterment of mankind. We have almost doubled the life expectancy of people! These have all been positive changes to the healthcare industry. Each positive change costs money in research, technology, case studies, etc. and, so far, it appears that we have had the money to continue our advancement.

Once these positive changes have been approved for use, it is up to hospitals, physicians, nursing homes and other healthcare facilities and services to keep up by buying the technology and the pharmaceuticals for the betterment of their patients. In some cases, there is an allowable payment and sometimes, if considered "experimental", there is no payment. The problem in our healthcare system is not the advancement of positive scientific outcomes but the lack of reimbursement to support such advancements. Since the implementation of Medicare for senior citizens (and insurance companies following with supplemental policies), reimbursement has been more the focus of the government and insurance companies than 'paying for the appropriate level of quality care'. I remember the introduction of non-ionic, low osmolality agent for a radiologic procedure that reduces the risk of heart attack/heart failure during or post the procedure for patients with certain defined conditions. Aside from the clinical enhancement, the cost of the new non-ionic, low osmolality agent was $1200 a unit versus the ionic, high osmolality agent for $120 a unit. It took three years and continued case studies along with the full Board approval of Society of Anesthesiology and the Society of Radiology before Medicare would pay for it.

Reimbursement structures have also changed over the last 50 years trying to focus on cost and cost reduction…never mind the outlay for the new technology and pharmaceuticals. When Medicare was first introduced, the introduction of the Medicare Cost Report was implemented to identify a hospital's costs and then to adjust their reimbursement each year to provide for an approximate 2 to 3% profit above cost. What a great benefit! Most insurance companies, at that time, was paying a percent of charge and this was the only potential area to make a better profit and keep the facility (and staff) open. Over the course of time, the government has further introduced different reimbursement methodologies to try to match the cost for the clinical care of patients and (again) some slight profit margin. For inpatient methodologies, the government has developed Diagnostic-Related Groups (DRGs) which have now been refined to Medical Severity DRGs (MS-DRGs) and they seem to be moving toward a newer severity model known as All Patient Related DRGs (APR-DRGs) which address four level of severity for each standard DRG.

"The problem in our healthcare system is not the advancement of positive scientific outcomes but the lack of reimbursement to support such advancements."

The Perfect Storm is about to Hit the Revenue Cycle! —*continued from previous page*

By Rob Borchert, MBA, FHFMA, CPAM

The other inpatient standard is "per diem" reimbursement. On the outpatient side, we have Fee Schedules, Ambulatory Patient Categories (APCs), Ambulatory Surgical Units (ASUs), Case Rates, percent of charge and cost-plus for such things as DME (durable medical equipment). For the physicians, the beginning of a fee schedule has grown into the Resource-Based Relative Value System (RBRVS) which establishes a unit of ONE (1) for a particular CPT code based on office expense, malpractice cost, and professional involvement. Once established, all other CPT codes are allocated a relative value unit from the three resources, and then the payment is a multiplier from that CPT code by a base rate. There are other reimbursement methodologies for the other facets of healthcare, but you get the picture. It also has been a fact that once the government reimbursement protocols have been established, the healthcare insurance industry adopts and adapts to the reimbursement method – provided it makes an additional profit for them.

All of these changes have been introduced to us with some explanation as to the why and how as well as how it "may" affect a hospital or physician group, or another type of service. We have learned to live with this environment and adapt as best we can. At least, these methodologies have occurred over the last 50 years. We are now facing NEW impacts that will occur over the course of the next 5 years and, when reviewed, it appears that the Perfect Storm is coming…that we will either survive or thread water for a period of time or drown. Although, by the time you read this article, there will be other "waves"; in this article, I will try to present each of the 'known' impacts and their potential effect on your survival. The current Perfect Storm Waves are:

- EHR choice, implementation and value
- Moving from 4010 to 5010
- The beginning of Healthcare Reform
- Moving from ICD 9 to ICD 10
- Continuing Healthcare Reform
- ACOs and new Medicare Payment Plans
- Insurer-run Care in Retail Clinics
- Single Payor System

EHR choice, implementation and value

One thing that can be said about our industry is that we will try to get every "bag for our buck". In fact, there are time when our seeking for more CASH gets us in trouble. I am not talking about non-compliant behavior but more about making investments with the hope of gaining revenue. Buying the expensive MRI and waiting on the volume and reimbursement to reach some level of ROI for justification.

We all know the benefits of the electronic health record (EHR) . Well, with the announcement from the government of a financial incentive (bonus payment) to invest in, and implement the EHR, a deluge of sales people knock on everyone's door twice. Convincing a hospital or physician group to buy "their" system was the key objective of the numerous medical record companies. Showing the benefits to the "buyers" was sometimes a reality and sometimes "vapor ware". "Meaningful Use" became the tag line and we bought and lived with what we bought in order to make the deadline for the government incentive and get the bonus. I realize that the incentive goals are still in progress but the fact is that many chose a great system but did not or have not implemented it in the most advantageous manner. Meaningful Use criteria is driven by defined elements and those elements are the measurement for incentive. The measurement should not just be a check off box of IT success but a commitment on the part of the providers and the facility to enhance the flow of clinical information. Many had no physician input that represented the population of physicians in their network which has resulted in lack of trust in the system;

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The Perfect Storm is about to Hit the Revenue Cycle! —*continued from previous page*

By Rob Borchert, MBA, FHFMA, CPAM

many are buying additional portable hardware (notebooks, ipads, etc.) to entice the physicians to use the EHR; many are cutting back to the minimum requirements for the bonus and re-implementing the system…the right way.

This Perfect Storm wave is both good and bad. It is good in that the overall/final outcome should be something of great value to the hospital, hospital system, physicians, physician groups, etc. in the accurate and timely documentation of clinical services performed on a patient. The new legal document will be electronic will high standards of protecting PHI and therefore maximum benefit to a patient's personal history. There should be better exchange of information between providers and a drastic reduction in "pharmaceutical issues". If providers take the time to fully document in the EHR, then the quality of patient care will definitely improve. The bad part of this wave is IF the providers are not compliant to the requirements needed to optimize the EHR. If the push for this enhancement was driven more for financial gain than for patient quality, there could be a negative result from the implementation and the value minimized to the point that the facility does not make the goals and then a double whammy – lack of provider support and no additional funds. So the driving force should be "meaningful use" in the exchange of clinical information and not just slam dunk it in. Let's all do it the right way!!!

Moving from 4010 to 5010

January 1, 2012 is not far away! Many of us, as facilities and physician groups, have depended on our IT staff and our IT vendors to make sure that the 4010 to 5010 move goes smoothly. I understand how this environment appears to be totally based on IT functionality but think of all the internal applications that must be tested and not just the outside work of claim submission. We all know that the affected areas of health plans, clearinghouses and providers (both institutional and professional. By now, there should have been testing set up for the transmission and acceptance of claims from providers to health plans directly or through clearinghouses.

The Perfect Storm here is the co-existence and cooperation of various vendors in assuring that claims flow smoothly and that ALL of the fields in 5010 have been recognized and tested. Remember that 5010 is the required program for the ICD 10 activities as well. Testing of all of the HIPAA transaction sets is not an easy thing to do in a successful manner. There are many different scenarios that need to be tested in this exchange with the outside world. And let us not forget the inside world. The 5010 success story must not only address the external transmission but also the internal exchange of data in such areas as

- Medical Necessity
- Contract modeling
- Contract management
- Primary and secondary billing and claims
- Discharge planning
- Abstracting and coding
- Diagnosis-related groups
- Ambulatory payment classifications
- Chart deficiency, and
- Encoding

Each of these areas contain elements that are in the 5010 transmission set and we need to be confident that we are capturing and coordinating data elements for the size of the 5010 fields. As stated earlier, the 5010 is the required transmission source for ICD 10 and therefore we should be testing some of the ICD 10 requirements during this 4010 to 5010 experience. For example, have we tested for the alpha-numeric components from our environment to the acceptance of these components in the clearinghouse and the health plan and returned data back with the same alpha-numeric indicators. A recent MGMA survey indicated that 25% of the major physician practices in the survey were unaware of the conversion from 4010 to 5010. 75% were full aware and 15% had an impact analysis done. What is interesting is that one of the outcomes of the impact analysis is that 50% of those practices believe they will have to upgrade their Practice Management System.

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The Perfect Storm is about to Hit the Revenue Cycle! —*continued from previous page*

By Rob Borchert, MBA, FHFMA, CPAM

From a HIMSS survey, hospitals are a little better off with 52% having a project rolling but only 20% testing the first half of 2011. Without immediate focus this small thing that can turn into a huge Perfect Storm wave. If we only limit our 5010 testing to what we are doing now, we may find ourselves in a mess when we move forward and test ICD 10 in 2012 or 2013.

The beginning of Healthcare Reform

On March 23, 2010, the healthcare reform act was signed and the beginning of change was in the air. There are so many things in this law that no one article can begin to touch on it. My intent is to present what is in effect now and what may (or may not) be happening down the road. Under this law, things began to change in healthcare this year, 2011. Although many of us have not experienced any impact from this reform, others have and have initially benefited from it. The Wave right now is one of awareness to the small benefits that have occurred and the next Wave is to determine how great of an impact the law will have on our operations and quality of care.

For the Wave right now, some benefits have occurred. These could be considered positive to healthcare providers as well as to the beneficiaries. Waving pre-existing conditions allows for more coverage for a patient and more revenue to a provider; coverage up to age 26 under a parents plan whether they are working or not is another good thing for the patient and for the provider; the right for a patient to appeal a denial at all levels can bring more coverage benefits and more revenue to the provider if the patient wins. These are a few of the positive outcomes of the law and a positive Wave. Other things such as creating various state options for extended coverage's; for profit firms must contribute 50% towards their employee's premium; imposing a $50,000 penalty for non-profit hospitals who do not meet the non-profit requirements are examples of the negative Wave. As with most government laws and regulations, the monitoring of compliance to these statutes are always a problem of timing and with potentially more on the horizon, the negative Wave could be higher and more powerful than the positive Wave.

Moving from ICD 9 to ICD 10

Full compliance with ICD 10 CM and ICD 10 PCS is the law…effective October 1, 2013. It sounds like we have plenty of time but this is far from the truth. With the implementation of Meaningful Use and the preparation for 5010, the impact of ICD 10 has not been realized. Most providers, hospitals and physician groups, are sort of in a daze regarding the impact and that in itself can be a very negative Wave. CMS has stated over and over again the potential impact of this "upgrade" (so that we join the rest of the world) since it has a dynamic impact on all systems, all operations, all documentation and therefore all reimbursement. CMS has presented a timeline expectation for this process.

As we can see, most of us are behind. Education and training will be key to success in this new environment. As it has always been in the U.S., coding has determined reimbursement. A simple example in Sports Medicine of the distinction between documenting a patient encounter in ICD 9 and one is ICD 10 is as follows:

Hit by a ball – Sports Medicine
Today, the diagnostic code is ICD-9-CM code: E917.0
Tomorrow, the same event will require documentation that will determine the ICD-10-CM possible code

- W21.00 – Struck by hit or thrown ball, unspecified type
- W21.01 – Struck by football
- W21.02 – Struck by soccer ball
- W21.03 – Struck by baseball
- W21.04 – Struck by golf ball
- W21.05 – Struck by basketball
- W21.06 – Struck by volleyball
- W21.07 – Struck by softball
- W21.09 – Struck by other hit or thrown ball

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The Perfect Storm is about to Hit the Revenue Cycle! —*continued from previous page*

By Rob Borchert, MBA, FHFMA, CPAM

As only one could imagine this could be the Perfect Storm Wave that turns the boat over and loses everything. Many of you remember the Y2K era when every system that had a date within its components had to be identified and assessed for potential shutdown. Well, this can be equated to a similar situation. Every system and module that contains an ICD 9 code must be identified and assessed as to its ability to handle an ICD 10 code. One must remember however that not only has the size of the code changed from 5 digits to 7 digits but it has gone from a numeric code to an alpha-numeric code. For some systems, the current ICD 9 structure is only numeric and could mean that you have to replace the system.

Another element of this Wave is the size of the impact and the fact that specific documentation will be the ONLY way that one will ever be able to reach the true and accurate ICD 10 code. The size of the impact can be stated that today there are approximately 13,000 clinical diagnosis codes in ICD 9 and there will now be 68,000 clinical diagnosis codes. For inpatient services, today in ICD 9 there are 11,000 procedure codes and now, in ICD 10 there will be 87,000 procedure codes. This training alone is enough to make some certified coders retire. Speaking of certification, ALL currently ICD 9 certified coders MUST take a new test to be certified in ICD 10. This is a budgeted expense that you need to be aware of so that the financial impact is not all at once. Aside from the coder education and training, think of the physicians and their requirement for documentation that will allow a coder to reach the specificity required. How many providers do you know that would ask "what kind of ball hit you?" in the examination. It may come up in casual conversation but it is a requirement for proper coding. If the physician does ask and document these kinds of questions, then it will be up to the clinical staff or even the front office staff…more training.

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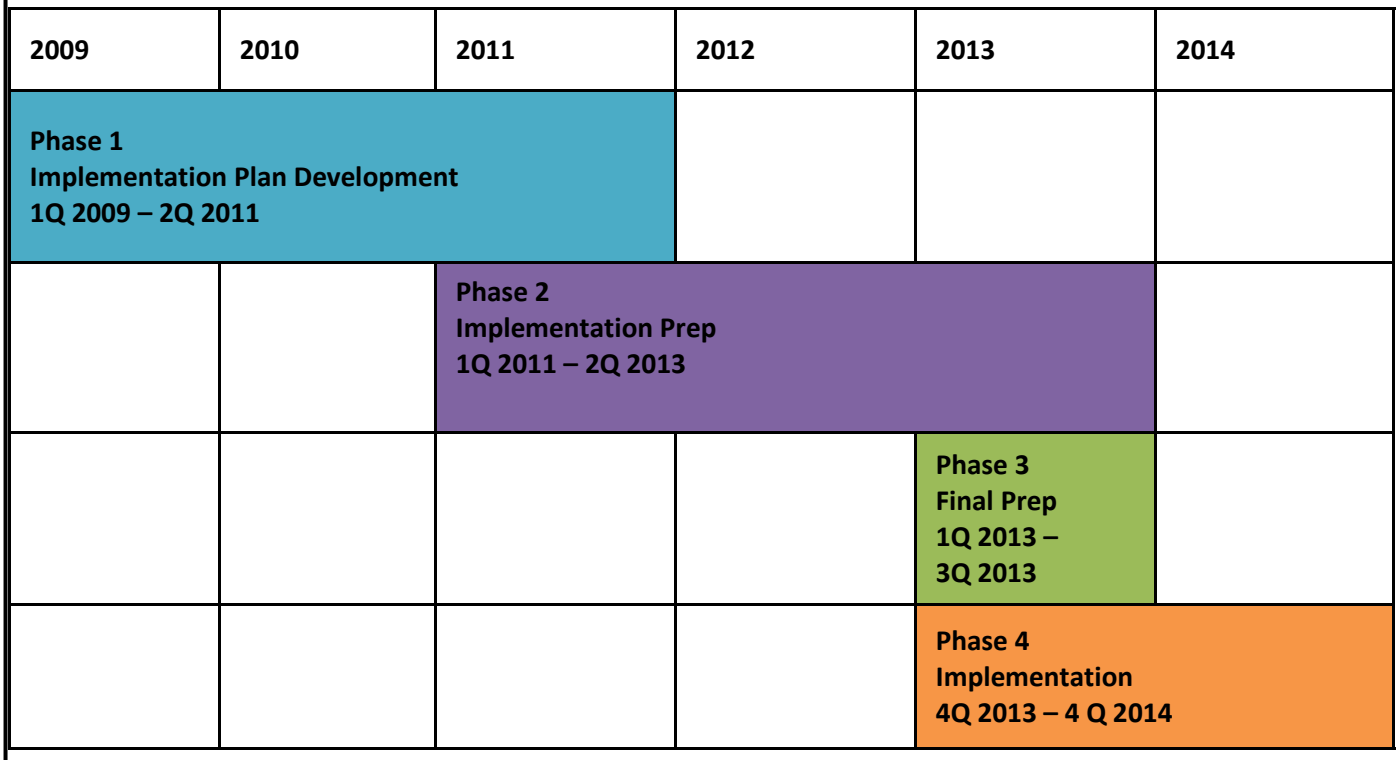

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Now begin to think about the next step…payment for services rendered under ICD 10. The billing impacts can be extremely powerful on a facility or physician practice. The potential challenge by every insurance company regarding the specificity of the diagnosis as applicable for the services that were rendered can be constant. What a wonderful way for an insurance company to delay payments!!! The backlog in HIM could grow by a factor of 10 in trying to obtain the most specific diagnosis possible for record quality as well as the payment component.
We know it will take at least three years of inpatient data to be gathered and analyzed to develop a new DRG Grouper and then there are the weights associated with the new Grouper and the payment methodology behind it. The government will do the Grouper development for you and then the insurance companies will jump on top of that with new rates and criteria. How many denials will occur for inpatient, outpatient and physician services due to poor third party insurance computer systems or a series of claim reviews by insurance company staff that may or may not have been officially trained in ICD 10. This is definitely a Wave that can kill you.

Continuing Healthcare Reform

I wanted to put a break between the Healthcare reform components that have already gone into effect and those that are pending. We all realize that in today's political environment that after the national elections of 2012, this reform law could have some significant changes made to it whether it be total repeal or modifications based on budget or modifications based on some set of realities not addressed yet. At any rate, I will present many of these potential 'waves' to our environment so that you have some knowledge and recognition of what could happen.

- Require drug manufacturers to provide a 50% discount on brand-name prescriptions for the Medicare Part D program
- Provide a 10% bonus payment to PCPs and surgeons in health professional shortage areas – this is actually happening now
- Create an Innovation Center within CMS charged with the development and implementation of new programs that will improve and update the national delivery system and experiment with new strategies to test these programs
- Reduce Medicare payments to those hospitals that have a high re-admission rate
- Establish a hospital value-based purchasing program in Medicare and the expand it to SNFs, HHAs, and ambulatory surgery centers
- Establish a pilot program for the payment of ONE flat rate for all providers for one patient's 'episode of care'
- Establish an Independent Payment Advisory Board of 15 members to submit legislative proposals to reduce the per capita rate of growth in Medicare spending.

There are more but I think you get the idea that this law can have a tremendous effect on the way we do business today. I think that the future of this law will be part of the 2012 national campaign since the baby boomers will be impacted by whatever may be implemented. For instance, requiring drug manufacturers to provide a discount on brand-name prescriptions can be a good thing for providers, insurance companies and the patient's co-pay. As you know, today you can go to Walmart and get certain prescriptions (some brand names) for $10 for a 90 day supply. This would be a similar expansion of purchasing benefits and the patient can go to any pharmacy. Other items like the creation of an Innovation Center within CMS seems like just another environment of 'disaster planning' in the experimentation of new strategies. I think these potential new strategies could conflict with or totally support any proposals coming from the Independent Payment Advisory Board. I can also see a new deluge of lobbyists in DC effecting any proposal from this Board and therefore we have another group with internal conflicts and not capable of implementing positive changes to our healthcare system.

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The Perfect Storm is about to Hit the Revenue Cycle! —*continued from previous page*

By Rob Borchert, MBA, FHFMA, CPAM

Other components such as the reduction of payment rates to hospitals with high re-admission rates is potentially a reality check on the quality being provided but the ONE flat rate for an 'episode of care' is one that could cause a lot of discussion among the healthcare community. If the physician base for patients is employed then the discussion could be favorable and attract more patients to that health system. Just remember that what tends to succeed within CMS flows over to third party insurance companies so successful negotiations with them must be based on some level of profitability drawn from the ONE flat rate with CMS. On the other hand, if the physician base in a community is mostly independents, one could find a higher level of patients moving to a physician-owned ambulatory care center rather than the hospital as well as a continual discussion regarding the appropriate "split" of the ONE flat rate between physicians and the hospital. These experiments are not only in discussion today but some experiments are actually happening today. We will see what the size of this Wave will be in the future!!!!

ACOs and a New Medicare Payment Plan

The structure of an Accountable Care Organization is characterized by the integration between physician partners and the reimbursement model coordinated with the Medicare Shared Savings Program (MSSP). It is one of the new Waves of trying to contain costs by having an incentive to those organizations (ACOs) who meet and beat the 'benchmarks' that will be defined under this program. All of the requirements have not been fully defined and yet there is a lot of discussion and activity due to the 'incentive'.

Discussion has been both positive and negative in this arena and part of that is due to the undefined elements of the program. Having sophisticated information systems for both clinical and administrative processes is a 'no-brainer' but their output and outcome have not fully been explained. There are commitments that the government is asking of ACOs such as PCPs that can accommodate at least 5,000 beneficiaries each as well as a commitment to this new program for at least 3 years. The proposed rules set out 65 proposed measures for establishing quality performance standards that ACOs must meet for the incentive from shared savings.

Again, these measures have not been fully defined and they cover a vast and sometimes complex situation for evaluating the benchmark criteria. Although there will be a benchmark amount of benefit to each ACO, the benchmark criteria is currently too generic to provide actual measurements. Who will define and accept the definition for evidence-based medicine outcomes, the 'quality' of patient care and involvement in their care as well as the interaction with other medical professionals in the coordination of patient-centered care. With everything else that is going on today, cost reduction or cost containment measures may only be achieved through the expense of improved technology. This model is receiving a lot of attention now and we will have to watch how big this Wave gets since we will have to make the decision to be an ACO and work within our benchmarks or lose money.

In connection with this whole ACO consideration and cost reduction measurements, Medicare will soon track spending on millions of individual beneficiaries and propose to reward hospitals that hold down costs and penalize those whose patients prove most expensive. This is different from the ACO process because there is not commitment made to the government regarding participation in a program where there are accepted benchmarks and therefore goals to be reached. What Medicare is doing now is gathering data to come up with a factor known as "Medicare spending per beneficiary". This new measure consists of costs generated during a hospital stay, the 3 days before it and the 90 days afterward.

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The Perfect Storm is about to Hit the Revenue Cycle! —*continued from previous page*

By Rob Borchert, MBA, FHFMA, CPAM

If you remember the national study that came up with DRGs, this could be considered as a similar type study. The DRG study looked at both the national charge factor as well as the information found in the annual Medicare cost reports. The outcome of the study was a measurement that established "weights" based on associated clinical factors and also established a cost rate for each hospital that there weights are multiplied by to result in a payment. Well, this similarity here is now the study is only based on overall cost BUT there is an expansion of cost factors in the consideration of patient activity 3 days prior to admission and for the 90 days after discharge. As we know already, any services pertaining to the admission of a patient that occur within 3 days of admission are put on the inpatient bill today. What a hospital cannot control is any activity that may occur during the 90 days after discharge. In the DRG grouping system and in the RBRVS physician reimbursement system, there are 'outlier' days that follow the clinical condition of a patient. In the DRG system, these days pertain to a length of stay for the condition and in the RBRVS system; these days pertain to the follow up care for a patient. Two different concepts now trying to be merged into one element. Having no control over the post discharge care of a patient by a physician is one major concern; the other major concern is the distinction between after care for one diagnostic condition and then the patient realizing another (different) diagnostic condition during the follow up period. What will be the outcome of payment then? Will all of these post discharge encounters be denied and then have to be appealed due to the different clinical condition? No one has answers yet, just a lot of questions. Of course, the final question is what is the incentive if I am below the national expenditure for that clinical condition as well as what will be the penalties if I am over the benchmark? This is certainly a Wave that needs more study OR it could be tied to the ONE flat rate per episode of care approach.

Insurer-run Care in Retail Clinics and a Single Payor System

Over the last few years, many providers have tried community outreach projects such as Urgent Care Centers. Some have been successful and some have failed. Well it appears that some insurance companies are seeing benefit in the "patient care center" approach and we have experienced some recent growth in Insurer-run Care in retail clinics. At last count, there are nearly 1,200 retail clinics in strip malls across the country. They are owned by insurance companies and have been established based on their market penetration. The focus is one of offering both Urgent Care and Family Care in one building. Advantages to this trend are beneficial to the insurance company because they can not only market to their base but also attract new patients to become members and talk about the advantage of 'one stop shopping' since these new clinics usually offer radiology and laboratory under the same roof. This actually provides better cost control for the insurance company and better service for the patient. Other advantages that they offer to the community are flexible hours for scheduling staff and extended hours for patients. This is taking away from the already established hospital volume of outpatient services as well as the local physician's market of patients. We need to watch this Wave very closely as we do not want to lose any market share.

"Well it appears that some insurance companies are seeing benefit in the "patient care center" approach and we have experienced some recent growth in Insurer-run Care in retail clinics. At last count, there are nearly 1,200 retail clinics in strip malls across the country."

The Perfect Storm is about to Hit the Revenue Cycle! —*continued from previous page*

By Rob Borchert, MBA, FHFMA, CPAM

The last Wave that I want to mention is the recent passage into law of the first state-financed single-payor system. On May 26, 2011, the state of Vermont signed bill H.202 into law. This law creates a 5 member board to be established by October 2011 whose task it is to implement a single payor system in the state by 2014. The various elements included in this law are to establish a state run health benefit exchange program; establish a medical malpractice reform program; establish a program to modify the insurance rate review process and to create a statewide drug formulary. This single payor system will be known as "Green Mountain Care" and in direct line with the health care reform law. This will be very interesting to watch as things move along since this law has gone into effect no matter what happens to the national law going forward. The new financing plan is due for release on January 15, 2013 and I am sure that we will all be watching this new Wave.

I know that I have only touched on the tip of the iceberg regarding the Perfect Storm Waves but we don't want to run into an iceberg either (remember the Titanic). I will try to keep writing articles on more specific Waves (and any new Waves) and hope that this information will be helpful. Please feel free to contact me with any questions.

This article is written by Rob Borchert, President of Best Practice Associates, LLC.
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Eligibility Enrollment Services

Customized solutions that streamline screening and enrollment. Because APA's knowledge and understanding of programs is unmatched in our industry, we leave no stone unturned in connecting patients to the coverage they need and maximizing payment remittance for our clients. Our comprehensive solutions streamline the screening and enrollment process for higher participation.

Unsurpassed program knowledge. Our highly trained professionals know the intricacies of all local, state and federal programs and use their insight to quickly and efficiently connect patients with the coverage option that best meets their healthcare needs. APA goes above and beyond to generate highly accurate applications and prompt payments, without compromise.

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- Medicaid
- Medicare dual-eligible assistance
- Crime victims
- COBRA
- Newborns
- Workers comp
- Liability
- Nursing home (SNF) applications
- Charity
- Social Security Disability Insurance (SSDI)
- Social Security Income (SSI)

Point-of-Service Operations

Maximize your up-front collections. APA utilizes its best-of-breed processes and unmatched knowledge of programs to improve your existing point-of-service collections and elevate the number of emergency department patients screened. Our advocates:

- Utilize unique workflow processes designed to integrate with your existing collection protocols and practices
- Integrate solutions into your existing front-end process to ensure a seamless patient experience
- Educate patients about all options available to them
- Work with centralized registration units to focus on pre-registration screening where applicable

Disability Services

Simplify the complexity of applying for disability benefits—for both providers and patients. APA's dedicated team of attorneys, paralegals and disability specialists represent every claimant through all levels of appeal to ensure the fastest approval. Our approach and documented results have been recognized by national research organizations.

Other Solutions

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Member Spotlight

It was a pleasure talking with Nancy who is a healthcare veteran and long time employee of Augusta Health. She has certainly seen some changes over the years and I think you will find her story interesting.

Nancy Hinton, CCAT, CPAT

So, tell me about your healthcare career. How long have you been in healthcare and where did you start?

"I've been in healthcare in one aspect or another since 1971. I worked in the snack shop at Kings Daughters Hospital and the Administrator at that time and the Business Office Director agreed to let me try working in the Business Office. That's all it took – I've been in healthcare ever since. I've done billing, customer service, cash posting, collections, and back to billing which is where I am currently."

I'm sure with that many years in the healthcare field you have seen a lot of changes. What has been the most challenging change in healthcare over the years?

"The most challenging changes for me have been computer system updates and changes. The most beneficial change however was the UB – that was a great change to healthcare billing!"

What was your favorite healthcare related job?

"I really enjoyed working for Blue Cross. I was able to work directly with a factory in the area helping their employees with questions regarding their coverage. I found that very rewarding and enjoyable."

"I would definitely recommend healthcare. It is constantly changing and as far a job security it would be a good field to get in to. A pointer would be to get as much education as possible. I see healthcare requiring more and more as far as education and certification and the more education you have the better off you will be."

Would you recommend healthcare as a field for the younger generations and what would be your biggest pointer to them?

"Yes, I would definitely recommend healthcare. It is constantly changing and as far a job security it would be a good field to get in to. A pointer would be to get as much education as possible. I see healthcare requiring more and more as far as education and certification and the more education you have the better off you will be."

Member Spotlight—Nancy Hinton, CCAT, CPAT—*continued*

How long have you been a member of AAHAM?

"About a year."

What is your favorite part of being an AAHAM member, and what benefits has it brought to you in your career?

"I enjoy the meetings and workshops. It gives me a certain pride just to be part of the organization. The knowledge that I've gained going through the certification process has given me more confidence in myself in doing my job."

What is your biggest motivator (professionally and/or personally)?

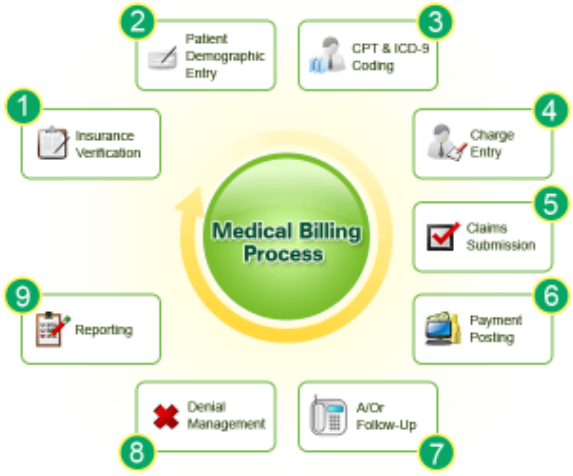
"The feeling of a job well done! I also feel that our Director helps motivate me as well as all the staff here by promoting certification and allowing us to be a part of AAHAM. It was something that we had not had in the past and it makes us feel valued as employees."

What do you feel is your biggest accomplishment?

"Definitely my CCAT and CPAT certifications."

Are there any other fun facts about yourself that you think our audience would be interested to know about you?

"I love decorating. Whether it is a wedding or my home or just my dining table I am drawn to making it beautiful. I'm constantly rearranging my home."



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> — Jerry Davis
> Senior Director Clinical Operations
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Scholarship Information

Did you know?

Virginia AAHAM offers a yearly $1,000 scholarship award to it's membership. Following is the information about that award as well as the application. If you have any questions, please feel free to contact one of your board members.

Purpose:

The Virginia State AAHAM Scholarship Award was established with the primary purpose of educating its membership in the management of health care receivables. As the chapter increased in membership and cash equity, the concept of a scholarship program was initiated by the Executive Board of Directors and was first offered in the fall of 1987.

The Executive Board of Virginia AAHAM has continued to make the scholarship program available as it is believed educational funds are a benefit to individual members, the Chapter and dependents of our members. In 2007, the name of the scholarship was changed to the Woodrow Samuel Scholarship Award to recognize a lifetime member of the VA State AAHAM organization.

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

Eligibility:

Eligible nominees must:

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

Nomination Procedure:

Nominees must:

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

Continued on next page

Scholarship Information—*continued from previous page*

Submission:

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

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

Review Process:

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

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

Section A—Application

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

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip Code _____

Daytime Telephone _____ Evening Telephone _____

Date of Birth _____ E-mail address _____

Present Place of Employment or Accredited School _____

Address of Employer or School _____

_____

Dollar Amount of Scholarship Being Requested _____

Continued on next page

Scholarship Information—*continued from previous page*

Section B—Education

Current School/College You Plan to Attend _____

Section C—Essay and Reference Letter

For Virginia members, please write an essay in 250 words or less on how the healthcare field has benefited you and the reason you would like to further your education. For dependent's of Virginia State AAHAM members, please write an essay in 250 words or less on the reason you would like to further your education and the reason you have chosen your career field major. Feel free to list any education experiences which have influenced your life and your goals for the future. Include an explanation on why winning this scholarship is important to you. Submit your answer on a separate sheet that includes your full name in the upper right hand corner.

A reference letter must accompany the application. It must state the reason why they feel the candidate deserves to win the scholarship.

Section D—Signatures

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

_____ _____

Applicant's Signature Date Application Submitted

Section E—Submission and Deadlines

Applications must include all signatures and titles. It must also include your written essay and reference letter. Submission deadline is January 31, 2012. The application is to be submitted to:

Chris Fisher
Augusta Health Business Office
PO Box 1000
Fishersville, VA 22939
(540)332-5030
cfisher@augustahealth.com

Please do not write below this line.

Date Application was received _____

Scholarship Committee Chair Signature _____

Scholarship Approved or Awarded? _____ YES _____ NO

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Third Party Payer Update—by Bonita Brubaker CPAT/CCAT & Tammy Shipe CPAT/CCAT

In the fast paced, demanding world of healthcare, it is essential to stay abreast of new developments and changes that may have an impact on your office or facility. We have compiled a list of some of the changes and notices from several major payers below. Please check each payer's website or latest newsletter for additional details.

Anthem

- Effective September 1, 2011, Anthem Observation room billing policy has changed. Check your individual agreement with Anthem to determine what observation services are covered in your contract.
- Reminder that the Utilization Management pilot for outpatient imaging services for Department of Correction inmates will not be implemented at this time. This change was announced in May 2011.
- A Voice Self Service tool is now effective for FEP programs as of August 22, 2011.

Medicare

- The new Medicare Physician Fee Schedule is available for download on October 3, 2011. Per the September newsletter provider types affected are, "physicians, non-physician practitioners, and providers submitting claims to Medicare contractors (Carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for professional services provided to Medicare beneficiaries that are paid under the Medicare Physician Fee Schedule (MPFS). Affected providers should be aware that Medicare contractors will only adjust claims brought to their attention".
- Changes in Inpatient Rehabilitation Facility Prospective Payment System will be released and effective October 1, 2011. The September newsletter notes that the IRF PRICER software package "will contain the updated rates that are effective for claims with discharges that fall within October 1, 2011, through September 30, 2012".

Southern Health

- The Southern Health website states "Coventry Health Care Inc. has contracted with Aperture Credentialing Inc. , an Optum Insight Company, to assist us with the primary source verification component of the credentialing process. Aperture/Optum Insight is located in Louisville, KY". The website also advises that providers may begin to receive correspondence from Aperture/Optum Insight requesting documentation or completion of forms pertaining to the credentialing process.
- According to the Southern Health website, as of August 21, 2011, "Remittance Advices have been enhanced to provide access to remits for Coventry members with Health Reimbursement Accounts/HRAs and Flexible Spending Accounts/FSAs. Previously, remits for these members were not available via directprovider.com".

Virginia Medicaid

- Per a memo from Medicaid dated September 19, 2011, changes have been made to the Virginia Family Planning Service Program known as Plan First effective October 1, 2011. The memo states "The 2011 Appropriations Act authorized Virginia to request a state plan amendment to transition Plan First from a family planning waiver program to a state plan option". Other areas of change include eligibility income, retroactive eligibility, individuals with other health insurances can be eligible and also transportation can be provided to family planning services for these individuals.
- Per a memo dated September 14, 2011 titled "Coverage of Medicaid-Fee-Service Compound Drugs" DMAS "will begin paying for the active pharmaceutical ingredients and the excipients of medically necessary compounded prescriptions for members enrolled in the Medicaid Fee-For-Service Program". This change goes into effect October 1, 2011.

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Certification… why bother?

You may wonder why you should bother with obtaining your certification. After all, it's a lot of work—Let us enlighten you!

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.

Contact Leanna for more information on CPAM certification or study sessions.

Newly Certified:

Congratulations
to the following members for successfully passing their CPAM, CCAM, CPAT or CCAT exams! We are so proud of you!

Pamela Banks, CPAT
Brigette Bardeaus, CPAT
Pamela Day, CPAT
Marjorie Duncan, CPAT
Amy Garnett, CPAT
Shannon Graham, CPAT
Sharyn Jenkins, CPAT
Leann Judd, CPAT
Marsha Kent, CPAT
Shannon Lannoye, CPAT
Peggy Lawrence, CPAT
Amanda Maynard, CPAT
Georgia McKnight, CPAT
Lisa Morgan, CPAT
Anita Myers, CPAT
Caroline Pagan, CPAT
Porsche Samson, CPAT
Vivian Shomo, CPAT
Deborah Sinsel, CPAT
Dawn Skinner, CPAT
Deborah Sullivan, CPAT
Irene Watson, CPAT

CPAM/CCAM and CPAT/CCAT examinations have set the standard of excellence in patient account and have defined new levels of professionalism in the healthcare administrative field. The exams are symbols of mastery of the art of patient account management. Congratulations to those who have successfully passed the certification examinations. This is an outstanding achievement!

Join VA AAHAM

Membership applications are on the next page. If you pay by the end of this year your membership will be good throughout 2012

2012 Membership Application

Please enter your data below, and then send this form, along with the $25.00 annual dues to the address below to join or renew your membership with The Virginia Chapter of AAHAM.

Take Advantage of these important benefits…

*Problem solving and solution sharing with your associates;
*Educational seminars and workshops
*Reduced Fees for Chapter Education Events
*Access & prep. assistance for certification tests that demonstrate your professional skills;
*Interaction & Networking with Peers
*AAHAM Membership Directory
*Chapter Newsletter
*Educational scholarship opportunities
*Membership Directory

Please enter your information below.

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

MEMBERSHIP RECOMMENDED BY:_____

For additional information, contact Miguel Wilkens @ 410-227-3051 or via email @ mwilkens@medical-account.com .

Please mail the completed form with your dues Payment of $30.00 to the following address**:**

Treasurer, Virginia AAHAM
Al Payne
142 Bambi Drive
Ruckersville, Virginia 22968
-OR-

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

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Virginia AAHAM Executive Board 2010-2011

Chairman of the Board

(Chapter of Excellence Committee)

Michael Worley, CPAM

Revenue Cycle Consultant

1807 Mount Vernon Street, Waynesboro, VA 22980

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

President

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

Kathleen Hughes, CPAM

Director of Patient Accounting

Augusta Health

PO Box 1000, Fishersville, VA 22939

Office—(540)332-5159 Fax—(540)332-4616

Email—k1hughes@augustahealth.com

First Vice President

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

Miguel Wilkens

Sale and Marketing Associate

Medical Account Management, Inc.

1220-A E Joppa Road, Towson, MD 21286-5811

Office—(410)227-3051

Email—mwilkens@medical-account.com

Second Vice President

(Committee Chairperson: Education Committee; Government Relations Committee)

Linda McLaughlin, CPAM

Director, Finance and Governmental Services

VCU Health System

PO Box 980227 Richmond, VA 23298-0227

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

Email— lmclaughlin@mcvh-vcu.edu

Secretary

(Committee Chairperson: Vendor Awards Committee)

Chris Fisher, CPAT

Chargemaster Specialist

Augusta Health

PO Box 1000, Fishersville, VA 2293

Office—(540)332-5030 Email—cfisher@augustahealth.com

Virginia AAHAM Executive Board 2010-2011

Treasurer

(Committee Chairperson: Vendor Awards Committee)

Al Payne, CPAM

Martha Jefferson Hospital

PO Box 2556, Charlottesville, VA 22902

Office—(434)982-7249

Email—albert.payne@mjh.org

Appointed Board Member

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

Brenda Chambers, CPAM, CCAM

Revenue Integrity

HCA - RSSC Capital Division

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

Richmond, VA 23225

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

Email—Brenda.Chambers@hcahealthcare.com

Appointed Board Member

(Committee Chairperson: Certification Committee)

Leanna Marshall. CPAM

UVA Health System (Retired)

814 Montrose Avenue, Charlottesville, VA 22902

Phone—(434)293-8891 Fax—(434)977-8748

Email—ayden1@embarqmail.com

Appointed Board Member

(Committee Chairperson: Corporate Partners Committee; Community Service/Member Relations Committee)

Jack Pustilnik, CPAM

Director of Employee & Professional Development

Advanced Patient Advocacy

1025 Boulders Parkway; Suite 400, Richmond, VA 23225

Phone—(804)327-6899 Email—jpustlnik@apallc.com

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

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> Insurance Billing – Follow-Up – Recovery

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

> Revenue Recovery Projects for Underpayments

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> Credit Balance Audit and Resolution

> Interim Management

> Training

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

National News— www.aaham.org

We are honored to present the candidates for 2011-2012 AAHAM Executive Offices:

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Christine L. Stottlemyer, CPAM

1st Vice President
Victoria DeTomaso, CPAM

2nd Vice President
Virginia Berney, CPAM, CCAM
John D. Currier, CPAM, CCT
Satish Kumar Thangavadivelu, CPAM, CCAM

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Bruce J. Scheller, CPAM

Secretary
Kia Earp, CPAM
Eileen Mary Froelich, CPAM, CCAM
Amy Mitchell, CPAM
Katherine Sandora, CPAM
Kim E. Sharif, CPAM, CHAM



Important Dates for 2011:

- October 3—AAHAM Officers Meeting—Las Vegas, Nevada, The Wynn
- October 4—AAHAM Officers & Committee Chairs Meeting—Las Vegas, Nevada, The Wynn
- October 4-5—AAHAM Board of Directors Meeting— Las Vegas, Nevada, The Wynn
- October 5-7—2011 ANI—Las Vegas, Nevada, The Wynn
- October 18 —National Patient Account Management Day
- October 24-29—Fall CPAM/CCAM exam period
- December 1—Registration deadline for February 2012 CPAT/CCAT/CCT exams

Stay up-to-date on Administrative Simplification and other healthcare Legislative issues of interest by visiting the National AAHAM web site:

https://www.capwiz.com/aaham/home/

Sponsorship

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.

—Jack Pustilnik, Vendor Sponsorship / Corporate Partners Chair

jpustilnik@apallc.com

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- **Plus much more...**

Silver Sponsorship—$1,000

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

Mark you calendars!
Upcoming AAHAM events:

2011 ANI — October 5-7
at the Wynn in Las Vegas Nevada.

Watch for details coming soon on the National web site
www.aaham.org

Linda McLaughlin and the Virginia AAHAM Education Committee are diligently working on informative and exciting agendas and networking events . Save the dates below and join us—you are sure to have a blast along with earning valuable CEUs.

October 14

Fall Meeting

Fauquier Hospital

December 7-9

Winter Meeting and Conference
Williamsburg, VA

Watch our web site for details:
www.vaaaham.com

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 2011. 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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cfisher@augustahealth.com

David Nicholas, CPAM
david.nicholas@rmccollects.com

Bonita Brubaker, CCAT
bbrubaker@augustahealth.com

Tracie Hirtriter, CPAT
thirtriter@augustahealth.com

Tammy Shipe, CCAT
tshipe@augustahealth.com

What is AAHAM?

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

COMMITTEES

- Third Party Payer
- Government Relations
- Publications
- Chapter Awareness
- Website Development
- Membership
- Education
- Scholarship
- Finance
- Chapter of Excellence

If you are interested in serving on a committee contact one of the Board Members.