The Virginia AAHAM Insider

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

Spring 2017 Volume 42 Issue 1

The President's Message

Hello Fellow Virginia AAHAM Members!

I am happy to report that we have just completed our Spring Regional Meeting in Charlottesville on Friday, March 10th. We had a wonderful turnout of 124 of our members and friends. The topics were very good, and you can find PDF's of the presentations on the Members Only section of our website if you'd like to download them or print them out. I wish to send my deepest gratitude to Leanna Marshall and Dushantha Chelliah for arranging this very successful meeting. Additionally, I also want to thank our annual corporate partners and the event sponsors that supported the meeting with their generous contributions. Your support helped make this an outstanding and affordable event for all who attended. To see a complete list of our annual partners please visit our website www.vaaaham.com and click-on Chapter Information. Also, when considering your next A/R need, please say thanks by contacting someone who supports VA AAHAM and our educational programs.
Additionally, during our time in Charlottesville, the Board of Directors met on Thursday afternoon and performed our annual review of the Chapter Bylaws and Constitution. We are recommending some changes to the Bylaws that will require a vote by our members. Soon these will be sent out via Constant Contact for a vote so please keep your eye out and place your vote soon so that we may update the approved changes. Thank you in advance for your assistance with this!

The National Office of AAHAM is hosting their Annual Legislative Day which will run May 1st and 2nd in Washington, DC. The topic in this year's visit to our Legislators is **Observation Stay; Improving Access to Medicare Coverage Act of 2017.** This is an important topic that currently has two bills in Congress that has broad support. AAHAM's support of these bills we hope will help move these forward. It's an exciting opportunity to get in front of our government leaders to discuss topics of importance. Please plan on joining me and other VA AAHAM members at this incredible event. To register, please visit http://www.aaham.org/Events/LegislativeDay.aspx
There is always so much news for me to report each quarter when I put out my letters to the members, and I could easily make this a multi-page long winded letter, but I will not. I will simply close today with a few items. One, please keep your eye on your email for notifications from us about upcoming events and a few surveys we have planned. The second, please mark your calendars for June 9, 2017 and plan to attend our meeting which will be held in Richmond this year. I know this will be another great event. And finally, I want to send thanks to all my friends and colleagues on the Board for all you do each week to insure the smooth operation of this wonderful Chapter. I appreciate every one of you!

Have a warm and enjoyable Spring. I look forward to seeing you or speaking to you sometime soon!

David

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

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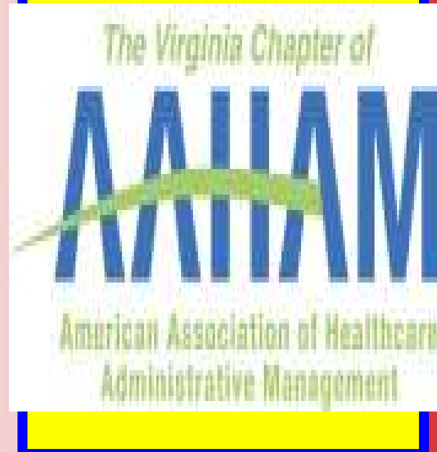

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Get a *Clue*! Eliminate All Timely Filing Adjustments

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In the popular board game *Clue*, players move about the board collecting information about a murder. As they find out what didn't happen – it wasn't Miss Scarlet, it wasn't with the rope, it wasn't in the Billiard Room – the winner eventually narrows it down to the only possibility: Professor Plum in the Conservatory with the Candlestick! (It isn't always in the Conservatory, but it somehow is ALWAYS Professor Plum!)

The game works because players can differentiate between the various locations, suspects, and weapons. It wouldn't work if every clue was the lead pipe.

Unfortunately, too many PFS shops treat their write offs like a bad game of *Clue*. When they find claims that are too old to bill, or when they perform regular cleanups of aged or low balance AR, they use adjustment codes like "Exceeds Filing Limits." In the process, they lose data that might otherwise give them insight and allow them to catch that dastardly Professor.

It is an unfortunate fact of running a revenue cycle that many claims will "die" of old age. Most often, the limit that is exceeded is actually an appeal limit triggered by multiple appeals which eventually exceed the deadline for appeal or a missed appeal window (60 or 90 days.) In a few cases, a bill will be held in the editor or at a clearinghouse past a filing limit. It is extremely rare that a bill simply sits in DNFB too long and once billed is denied simply because it was overlooked, forgotten, or somehow slipped through the cracks. In short, the vast majority of claims that deny for exceeding filing limits have *some other problem which caused the delay in billing*. Calling the write off a Timely Filing Adjustment not only fails to provide any insight into the upstream causes, it actually masks the real problem.

If your adjustment codes say everything looks like a lead pipe, it is awfully hard to know that it was really the candlestick, and if you don't know it was the candlestick, then it is harder to look for the right clues to who murdered the beautiful, innocent claim which now lies at your feet. In applied terms, if everything looks like a timely filing write-off, it appears that the problem is in billing and follow up. But unless something is seriously broken in PFS, the strong likelihood is that those timely filing write-offs are really a mix of authorization, medical necessity, billing error, and other denials. If, for example, most of your authorization denials are being buried in timely filing, you may not realize that authorizations are a problem: "*The auth write-off is small, so patient access must be doing its thing – these darn payer limitations are the real problem*."

But if those auth problems were broken out and categorized appropriately, the picture might be very different. It would be easy to identify the lack of authorizations as the root cause of the problem. **The answer is to eliminate all use of (or nearly all) Timely Filing write-off codes**.

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Get a *Clue*! Eliminate All Timely Filing Adjustments

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The conceptual solution in *Clue* is pretty simple – all the suspects and all the potential weapons are right there – just figure out which one is the murderer! A clear goal, but it takes some effort to achieve. Similarly, the conceptual approach of eliminating all Timely Filing adjustments seems simple, but it actuality it requires work to follow the clues and accomplish the task.

In some cases, posting logic is set to automatically adjust any Timely Filing denial. (In the worst case scenarios, those adjustments go to Contractuals rather than Denials. In those cases, all visibility into the size or shape of the denial problem is lost!) While this might seem like a time saver – *if the claim is past limits, the revenue is lost so why should we spend any time on it?* – but there really are two potential losses:

> First, the timely filing denials might not be legitimate. Perhaps a bill was sent or an appeal was filed but the payer didn't appropriately load it into their system. Or perhaps the bill was delayed for some legitimate reason that might lead a payer to make an exception. So a claim that could be recovered instead is declared dead.
>
> Second, even if the revenue is truly lost, it is likely the mistake will be repeated unless you can learn from this failure. Whether it is sizing the scale of the problem or localizing it by department or payer, appropriately maintained data is a key driver of improved performance. This is essential to keep recoverable claims alive in the future!

Revising the posting logic is a relatively easy step, but the next step is more challenging – if you haven't auto adjusted the claims but they still need to be written off the AR, then someone has to take the time to make the adjustment. The inclination from staff will likely be to look at the last denial and use that as the adjustment code – denied for Timely Filing, written off to timely filing – but doing that will only repeat the same error, just at greater expense.

Staff need to spend some time researching the claim (and need to be trained that expending the time is appropriate) to understand what caused the claim to deny in the first place, and using THAT adjustment code. It is more work and will take more time, but having an accurate reflection of the problems causing adjustments is vital to solving the problems. Even a careful AR manager may be surprised by how the distribution of adjustments changes when timely filing claims are re-distributed to more discrete, meaningful adjustment categories. And that AR manager may enjoy the side benefit of making themselves look good as adjustments shift from the PFS focused Timely Filing Codes to other codes that may be Patient Access or Coding related!

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Get a *Clue*! Eliminate All Timely Filing Adjustments

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Encouraging staff to move away from the use of timely filing may be difficult – their training and years of experience have likely built a strong tie between the last denial code and the adjustment reason – but there is one way to make a clean break: **Eliminate the Timely Filing adjustment codes**.

There are very few legitimate uses of the codes to begin with, when they are used they tend to mask the real problem, and staff tend to over- (or mis-) use them. It may mean there are a handful of claims that don't have an appropriate home, but the other benefits far outweigh this potential, minor cost.

Claims are going to die, for a variety of reasons, and the obvious cause of death might be a timely filing denial. But PFS managers should look beyond the obvious and take into account the root causes of those losses, which rarely are solely because of filing limits. Understanding root causes is an extremely valuable clue, which can lead to better understanding of adjustments, reduced write-offs, and ultimately increased collections.

Not to mention finally bringing Professor Plum to justice.

Peter Angerhofer is a principal at Colburn Hill Group www.colburnhill.com; he brings deep experience in operations, strategy and health policy to both the daily operations as well as long-term vision. Peter moves easily from working with line staff on performance improvement to C-suite discussions of strategic imperatives. Prior to forming Colburn Hill, Peter had been part of the original, pre-revenue start-up team of eight at Accretive Health, where he spent 10 years managing operations. Prior to Accretive, Peter worked for Deloitte Consulting and CSC/APM, as well as serving in health policy roles on Capitol Hill.

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Value Stream Mapping for Best Practice

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I have been around the Revenue Cycle for many years. In fact, I joined AAHAM in 1981 and my member number is the low four digits. Prior to getting into healthcare, I was in manufacturing and was familiar with "design". Design, in manufacturing, is a series of 'visions' that start at one initial point and through a series of re-drafting turns into a new design that the team is very comfortable in implementing. This is why I am so comfortable with 'value stream mapping' since we are able to start at the current state and move into the future state for a higher level of efficiency and effectiveness. Does this sound strange? How many times have you gone to the doctor's office or hospital and have to wait and while you are waiting you are looking around and identifying all the things you would improve to make the visit a better experience?

Those 'visions' are similar to the value streaming process. Within the full Revenue Cycle there are many different parts from scheduling through to account resolution. Each of these individual parts can be value streamed for best practice if you have the desire and commitment to do so. In fact, you do not even have to be manager to make the required changes (in some cases). Let's break some of this down.

- Emergency Room: From screening to triage; from triage to treatment room; from treatment room to registration; from registration to discharge (high level, non-critical)
- Outpatient Registration: From waiting room to registration; from registration to treatment area; from treatment area to discharge
- Inpatient Registration: From pre-registration to registration; from waiting room to registration; from registration to room; from registration to financial counselor; from financial counselor to room; from room to discharge
- Ambulatory Surgery: "you get the idea"
- Physician Office: " you get the idea"

From a high level standpoint, let us consider one of these for value streaming. Let's do physician office just for fun! This may be "overstated" regarding the actual situation but we want to emphasize a point.

A Patient's Office Experience

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Value Stream Mapping for Best Practice

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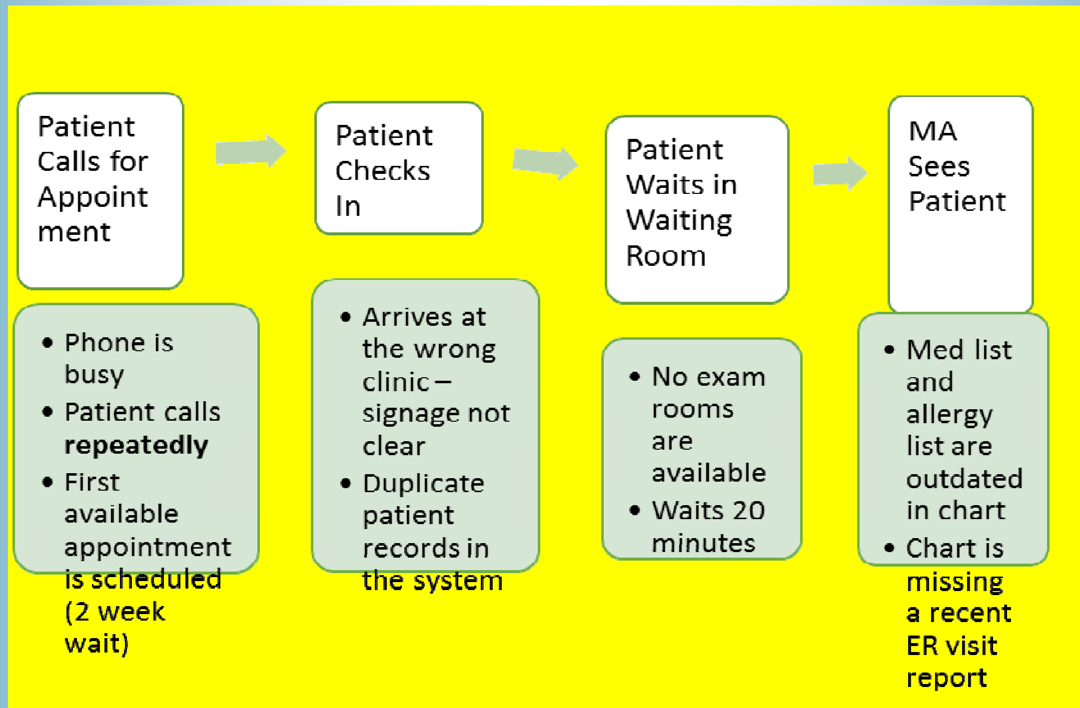

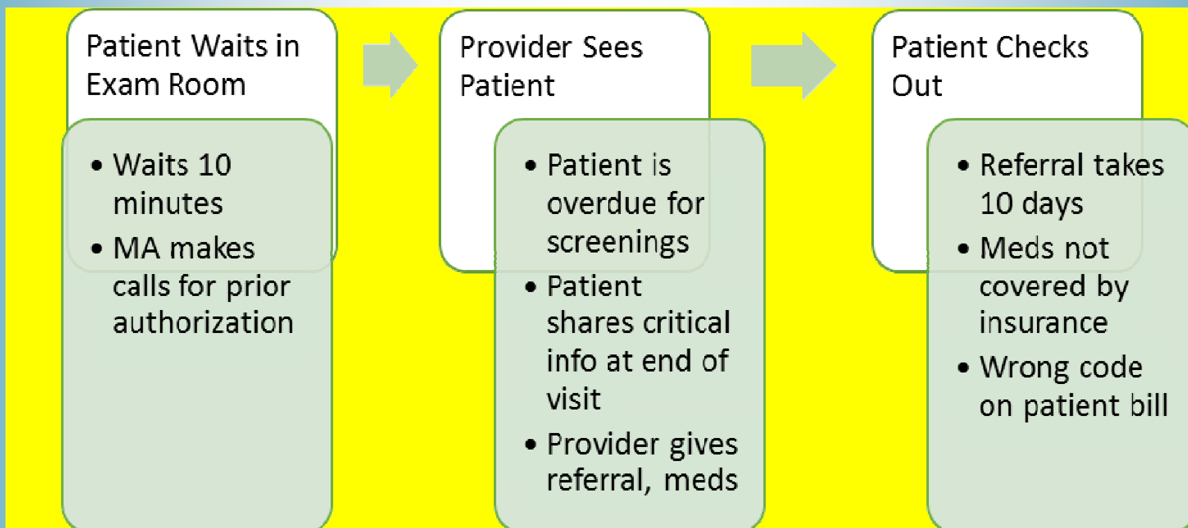

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Value Stream Mapping for Best Practice

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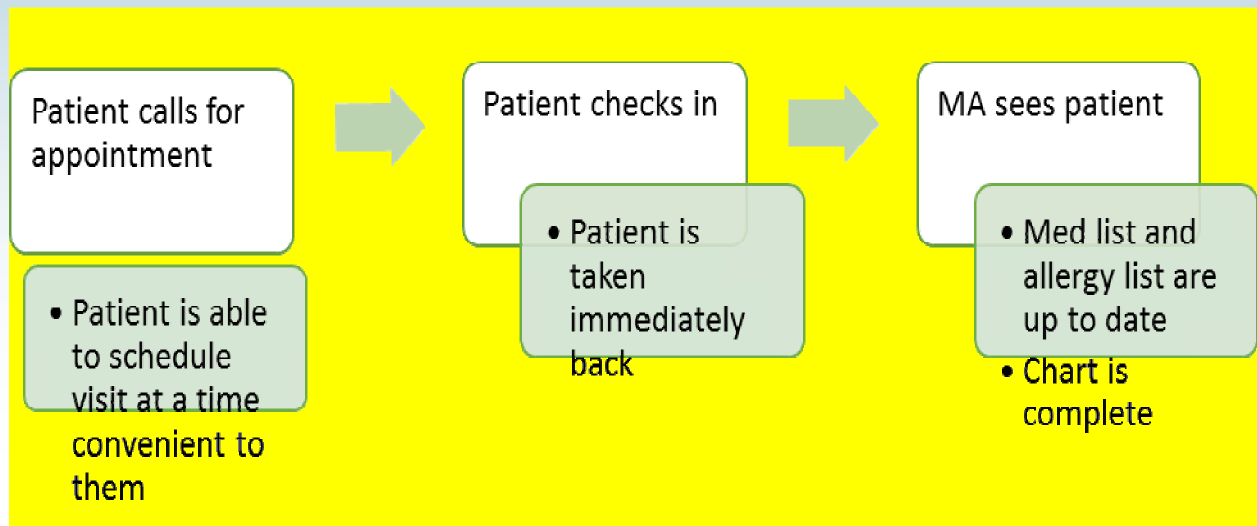
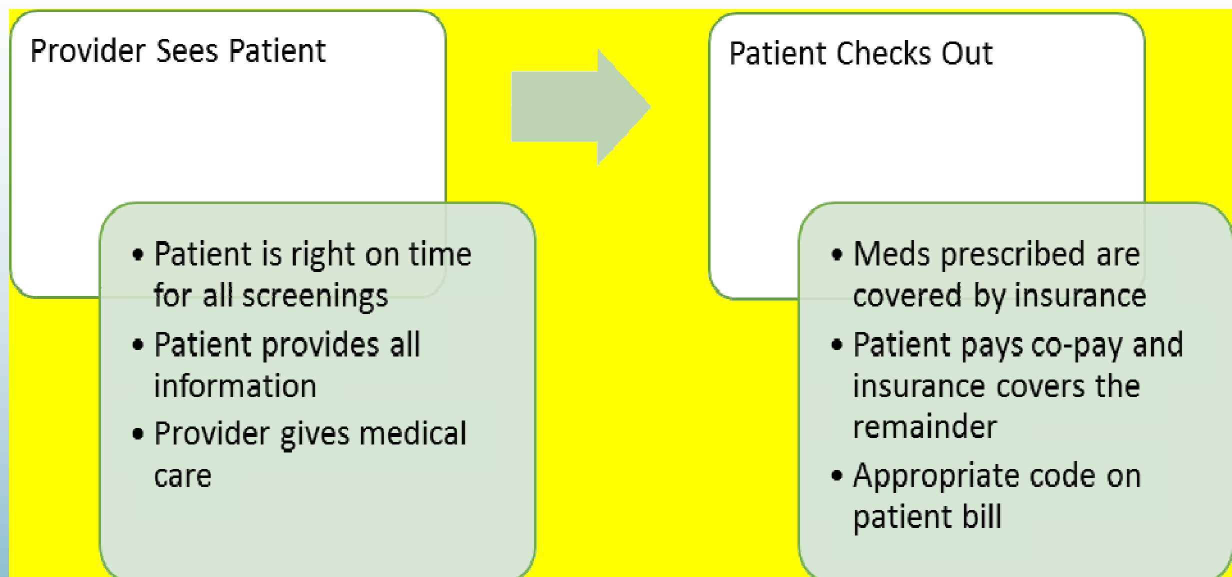
Well, maybe it is not as over stated as it seems. I have found the phone busy at times, I have been put on hold for 10 minutes, I have arrived on-time and sometimes early only to be told that the doctor is running late and then have to wait 30 minutes to see 'someone'. We can all share a tale or two about this kind of situation. With value stream mapping, we strive it identify the lags and gaps between process lines to see if anything can be done about these items of stress for the patient.





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Value Stream Mapping for Best Practice

Now this is a perfect world!!! Can this be done? Is this an exaggeration? Do we even dare to try? Identifying all the lags and gaps in the first diagram can and should lead you to the second diagram. Can we get there? One does not know but if we don't try, we will never know!

Some of us may think that this value stream mapping is a little too much outside of reality so let's make it real. Not in the physician's office but in some of the revenue cycle functions that we are more familiar with. Let me try to bullet point some of the lags and gaps that may occur in these areas and if I miss any that you are familiar with in your own situation, so be it.

Scheduling an outpatient ancillary service:

- Current schedule may not be correct as the tech did not update it. Therefore, the patient waits
- Service has not be pre-approved by the insurance company and the patient has to wait to see if the service is approved
- Service is not approved by the insurance company based on the diagnosis
- There is a backlog of patients at the outpatient site and therefore a long wait for service
- The patient is informed of a deductible/co-pay that is due at this time (for the first time)

Inpatient admission:

- Patient shows up and there is a wait (no triage here)
- Patient's admitting diagnosis is not valid for an admission
- Physician does not have admitting privileges
- Insurance verified on site and a large deductible is found and presented to the patient
- No financial counselor available to discuss payment arrangements
- Language barrier with patient and no translator available
- Admitted as "observation" since no admission diagnosis present
- Patient not told observation status and receives a large bill

Patient Financial Services:

- Large DNFB with no discussion of resolution
- Large volume of a specific (or 2) billing edit is not communicated upfront to stop
- Initial claim submission return (277) is not worked at all
- Back-up information from HIM not responsive until after 7 days
- Secondary bills over 30 days old from initial payment
- Wrong primary payer

The list for each area could be expanded but we will let you do that expansion. The point is that value stream mapping can assist each RCM area to improve operationally and/or systematically. With my 30 years of experience, I invite you to send me your situation and I will value stream map it (as you describe it) and provide some recommendations for improvement. This will not only help you but prove to me that some people read these articles in the Journal.

Sincerely,
Rob Borchert
rob@bpa-consulting.com
(315) 345 -5208

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Member Spotlight……

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Member Spotlight

Karen Griffin – Augusta Health Care

What is your birthplace? Baltimore, MD

Marital status? Married

Favorite hobby? Spending time with my husband of 37 years and my mom. Favorite past time is gambling

Current occupation/position? Physician Billing Supervisor

What is the hardest part of your job? Keeping up with all of the healthcare changes

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Member Spotlight...

Number of years in Healthcare? 23 years

What AAHAM certifications have you earned? (4 total) CRCE, P-I; CRCS, P-I

How do you see Healthcare evolving in future state? "I see a lot more change coming regarding healthcare on a financial state. Hospitals are already seeing that more care is involved with less reimbursement. This is a growing concern working in the Revenue Cycle. Payer contracts need to be reviewed in a more complex manner to ensure that reimbursement is at a maximum. I also see hospitals becoming much more competitive with procedure saving vouchers and advertised savings on procedures. We really have to get savvy on how to get patient's to our facility while retaining those patients, and still providing the best care possible.

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New Revenue Procedure Is Here To Stay

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Out with the old and in with the new? A recent revenue procedure change is catching the attention of health care providers with facilities financed through tax-exempt bonds. The good news is, the changes allow for greater flexibility and revised safe harbor guidelines.

The Internal Revenue Code (IRC) provides that interest on bonds issued by governmental or 501(c)(3) organizations may be exempt from tax if, in addition to satisfying other requirements, not more than 10% of the proceeds of the debt issuance for governmental entities (5% for 501(c)(3) organizations) are utilized in a private business use (a private party such as a medical practice or for-profit service provider may qualify as a private business use). As a result, traditional service agreements between hospitals and medical practices and other arrangements to manage segments of hospitals' businesses may be considered management agreements and could cause financings to fail the private business use test. This would result in interest on bonds being taxable.

In order to prevent such a result, hospitals with outstanding tax-exempt debt historically sought to fit management and service agreements into one of a multitude of complex and often burdensome private use safe harbors under the Internal Revenue Service (IRS) Revenue Procedure 97-13 (Rev. Proc. 97-13). These safe harbors were tied to the length of the agreement and the type of compensation provided to the service provider. If a safe harbor was satisfied, then the agreement would not qualify as a private business use.

Because the safe harbors were extremely technical and complex, on August 22, 2016, the IRS issued Revenue Procedure 2016-44 (Rev. Proc. 2016-44) as a replacement to Rev. Proc. 97-13. Rev. Proc. 2016-44 has been lauded in the industry as providing greater flexibility for management and service agreements to qualify for private use safe harbors. Gone are the rigorous tests of the past that tie modes and forms of compensation to the length of agreements.

However, in the health care context, while the modes of compensation and lengths of agreements have been liberalized, there are a few provisions in Rev. Proc. 2016-44 that are likely to be viewed as more restrictive than Rev. Proc. 97-13 and may be viewed by clients as unnecessary or prohibitive in securing needed physician services. There are also numerous outstanding questions caused by the vagueness of the safe harbor as it relates to typical health care contracts.

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New Revenue Procedure Is Here To Stay

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New Safe Harbor Provisions

For a management or service agreement to fit within Rev. Proc. 2016-44, the following elements must be satisfied:

- **Reasonable Compensation**: The compensation paid to the service provider must be "reasonable" for the services rendered. Instead of analyzing whether the compensation methodology is a periodic fixed fee, per unit fee or percentage of revenue or expense fee, now, the compensation must only be reasonable.

- **No Net Profits or Losses**: As before, compensation cannot be tied to the net profits or net losses of the hospital or any service line or department of the hospital. Importantly, for purposes of many alternative payment methodologies and accountable care organization (ACO) activity, incentive compensation based on meeting quality, performance or productivity standards is not considered to be based on net profits. Likewise, compensation tied solely to revenue or expenses, but not both, may be permissible. However, provisions that delay or subordinate payment of fees to profitability or availability of funds can be viewed as a "net profits" arrangement.

- **Risk of Loss**: The service provider cannot bear the risk of loss due to damage or destruction of the hospital or managed property.

- **Term**: The term of the agreement may be no greater than the lesser of 30 years or 80% of the weighted average of the reasonably expected economic life of the property subject to the agreement. This is a significant lengthening of the typical safe harbor contract terms relied upon by hospitals under Rev. Proc. 97-13. However, as further described below, this provision can be a significant impediment if the property being financed is older or otherwise close to the end of its useful life, which may be the case in many refinancings.

- **Control of Property**: The hospital must control the financed property. This means that the hospital must retain authority over matters such as approval of budgets, capital expenditures, disposition of property, rates charged for use of the property, and the general nature and type of use of the property.

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- **Relationship of Parties**: The safe harbor requires that there be no circumstances (on a fact and circumstances basis) that would effectively prevent the hospital from exercising its rights under an agreement. Rev. Proc. 2016-44 states that safe harbors that provide an arrangement will not be viewed as violating this term so long as:

o No more than 20% of the voting power of the hospital's board rests with directors, officers, shareholders, employees, etc. of the service provider;

o The chief executive officer (CEO) or chairperson of the service provider does not sit on the hospital's board; and

o The CEO of the service provider is not also the CEO of the hospital or any related parties of the hospital.

Potential Road Blocks

While Rev. Proc. 2016-44 does make some substantial improvements over Rev. Proc. 97-13, there remain a few significant outstanding questions.

To maintain control of the property, hospitals must approve of the rates charged for use of the property. Under Rev. Proc. 97-13 there was a well-known split of opinion over whether hospitals were required to actually approve of the fees charged by physicians to patients. However, within the confines of Rev. Proc. 97-13, that issue only mattered insomuch as the hospital needed to use a "per unit" fee safe harbor. Under Rev. Proc. 2016-44, to receive protection of the safe harbor, an agreement must provide that the hospital approves the rates charged by the service provider (physician). This applies to any service agreement needing safe harbor protection, regardless of whether the compensation is a periodic fixed fee, per unit fee, or no fee at all. In the past, many split-bill arrangements only gave hospitals the right to review and potentially object to the physician's fees, if any rights were given at all. Express approval by the hospital is now required.

Further, while the potential length of permissible management contracts has been significantly extended, a question remains over the usefulness of this safe harbor for new management or service agreements that are entered into later in the useful life of the financed property. For example, if a hospital has bond-financed assets that are well into their useful lives (say the facility is 35-years-old and has a useful life of 40 years) and the radiology group wants to enter into a five-year agreement, the arrangement would technically not satisfy the safe harbor since the limit would be 80% of the remaining useful life (four years).

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Many hospitals include physician members on their boards. One instance where this could be a problem is when a physician who is the head of a practice group with which the hospital has a contract is elected to the hospital's board after the agreement is executed. Likewise, it could arise where the chief of staff has an *ex officio* position on the hospital board and the newly elected chief of staff has a leadership role with a contracted group. These circumstances do not in and of themselves eviscerate the Rev. Proc. 2016-44 safe harbor, but they remove the "substantially limiting the exercise of rights" safe harbor and move the analysis to a facts and circumstances test.

These outstanding questions affect health systems and their counsel as they work to contract with physicians and physician groups for needed services. They also impact due diligence and review standards for bond counsel and underwriters as hospitals seek to go to market. While Rev. Proc. 2016-44 does lessen the structure surrounding management safe harbors in some very important ways, it also may make contracting with physicians and physician groups more burdensome than before.

Andrew D. Kloeckner is a partner at Baird Holm Attorneys at Law. He can be reached at akloeckner@bairdholm.com.

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Highlights from Annual Spring Meeting… Charlottesville, VA.

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Hospital Spotlight……..

Riverside Doctors' Hospital Williamsburg

Riverside Doctors' Hospital Williamsburg sits on a beautifully landscaped campus in Williamsburg, VA. The campus is over 25 acres. This facility opened in May 2013 and is licensed for 40 private rooms (which consists of 33 Medical/Surgical rooms and 7 ICU rooms). They have a full service Emergency Department, and their Surgical Service features 2 operating rooms. In addition to the 2 OR's, they have an additional 8 private patient pre-op and recovery rooms.

They are a 501c(3) tax exempt, non-profit organization dedicated to improving health and saving lives. They are governed but a voluntary Board of Directors.

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Certification… why bother?

You may wonder why you should bother with obtaining your certification. After all, it's a lot of work—Let us enlighten you! Certification is an investment in your personal growth and your professional future.

Benefits of obtaining AAHAM certification:

- Professional development
- Individual enrichment
- Employer awareness
- Recognition by industry and build a network of connections in the elite group that shares your designation
- Personal challenge and satisfaction
- National recognition
- Recognition and access to the positions and promotions you seek and deserve

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An AAHAM certification demonstrates your:

Commitment—to your field and your ongoing professional development.

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CRCE-I & CRCE-P exams are considered to be the best indication of knowledge in our field. Set a goal or make a promise to yourself to pass the exam. It will be gratifying to prove to yourself that you can pass this difficult exam, and that your years of experience and hard work will be evident to all by the CRCE-I/CRCE-P designation after your name.

Study guides are loaned out to members. You do not have to purchase your own study guide.

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

Leanna Marshall, CRCE-I

PFS Consultant

UVA Health System (Retired)

Phone: (434)293-8891

Fax: (804)977-8748

814 Montrose Avenue

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

Certification

2017 Certification Schedule

April 17, 2017
Registration deadline for July 2017 Exam Period

July 10-21, 2017
July 2017 Exam Period

August 15, 2017
Registration deadline for November 2017 Exam Period

November 6-17, 2017
November 2017 Exam Period

December 15, 2017
Registration deadline for March 2018 Exam Period

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2016 Membership Application

Please enter your data below, and then send this form, along with the $30.00 annual dues to the address below to join or renew your membership with the Virginia Chapter of AAHAM.

Take advantage of these important benefits…

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Please mail the completed form with our dues payment of $30.00 to the following address:

Treasurer, Virginia AAHAM
Linda Conner
2204 Wilborn Ave.
South Boston, VA 24592

-OR-

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

Virginia AAHAM Tax ID: 54-1351774

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dale.brumbach@penncredit.com

The Virginia Chapter of AAHAM Executive Board 2016-2017

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(Chapter of Excellence Committee)

Linda McLaughlin, CRCE-I

Director, Director Finance and Governmental Services

VCU Health System

PO Box 980227, Richmond, VA 23298-027

Office—(804)828-6315 Email– linda.b.mclaughlin@gmail.com

President

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

David Nicholas, CRCE-I

President, Mercury Accounts Receivables Services

Office - (703) 825-8762

Email— David@Mercury.ARS.com

First Vice President

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

Linda Patry, CRCE-I

Director, Patient Financial Services

Mary Washington Hospital

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Office—(540)741-1591 Email– Linda.Patry@mwhc.com

Second Vice President

(Committee Chairperson: Education Committee; Government Relations Committee)

Dushantha Chelliah

2212 Greenbrier Dr.

Charlottesville, VA, 22901

Office - (434)924-9266

Email- DC5P@hscmail.mcc.virginia.edu

Secretary

(Committee Chairperson: Publications Committee; Scholarship Committee)

Amy Beech, CRCE-I

Patient Accounting Supervisor

Augusta Health

PO Box 1000, Fishersville, VA 22939

Office—(540)245-7216 Email—abeech@augustahealth.com

The Virginia Chapter of AAHAM Executive Board 2016-2017

Treasurer

(Committee Chairperson: Vendor Awards Committee)

Linda Connor, CRCE-I

Manager of Patient Financial Services

Sentara Halifax Regional Hospital

Office: (434) 517-3433

Email: linda.conner@halifaxregional.com

Appointed Board Member

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

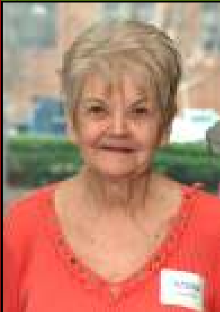
Brenda Chambers, CRCE-I,P

Revenue Integrity

HCA - RSSC Capital Division

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

Richmond, VA 23225 Office—(804)267-5790 Email—Brenda.Chambers@hcahealthcare.com



Appointed Board Member

(Committee Chairperson: Certification Committee)

Leanna Marshall, CRCE-I

UVA Health System (Retired)

814 Montrose Avenue, Charlottesville, VA 22902

Phone—(434)293-8891 Fax—(434)977-8748

Email—ayden1@embarqmail.com

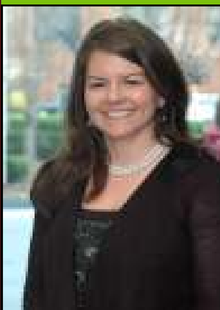
Honorary Board Member

Michael Worley, CRCE-I

Revenue Cycle Consultant

1807 Mount Vernon Street, Waynesboro, VA 22980

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



Appointed Board Member

(Committee Chairperson: Communications Chair)

Katie Creef, CRCE-I

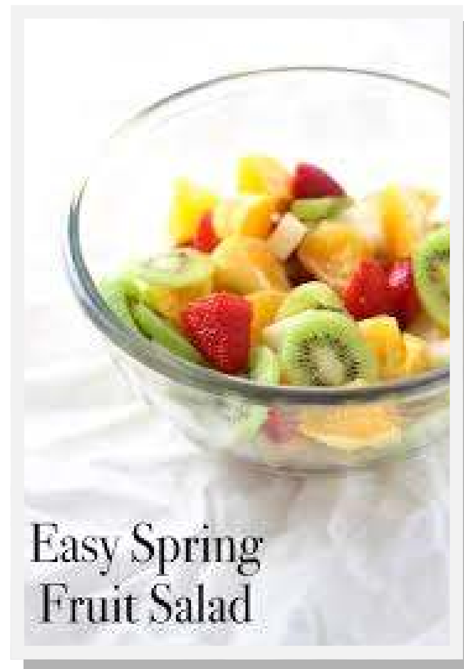
Director of Patient Accounting

Augusta Health

P.O. Box 1000 Fishersville, VA. 22939

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

On the lighter side of things........



3 kiwi, peeled and sliced

2 navel oranges, peeled and cut into 1 inch sizes

2 cups strawberries, halved

2 green apples, cut into small cubes

2 tbsp honey

1 tbsp lemon juice

Combined all fruit into a large bowl. Dress with honey and lemon juice. Serve chilled.

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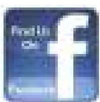
National News— www.aaham.org

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

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

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

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



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National News— www.aaham.org

JOIN US ON LEGISLATIVE DAY

The 2017 Legislative Day is May 1-2, 2017 at the

Hyatt Regency Washington on Capitol Hill, Washington, D.C.

National News— www.aaham.org

The 2017 Annual National Institute will be held at the

Opryland Resort in Nashville, Tennessee

October 18-20, 2017

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The Virginia Chapter of the American Association of Healthcare Management (VA AAHAM) exists to provide or facilitate professional education, promote professional excellence, provide opportunities for sharing management strategies and tactics through professional networking. You and your organization are important to this mission. Virginia AAHAM benefits by drawing on the experience and education that you and your organization can bring to the activities and efforts of our association. Virginia AAHAM's mission. I hope that you will consider supporting Virginia AAHAM this year. —***Dale Brumbach,***

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Volume 42, Issue 1

Mark your calendars!

Upcoming VA AAHAM events:

2017 Summer Regional Conference, Richmond, VA.

June 9, 2017

2017 Fall Regional Conference, Fredericksburg, VA.

Mary Washington Hospital September 22, 2017

2017 Annual Meeting and Conference, Williamsburg, VA.

35th Anniversary, Dec. 6-8, 2017

Go to our web site for more information and registration:

www.vaaaham.com

Some other important dates. . . . .

May 14, 2017

May 29, 2017

June18, 2017

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Contest for Newsletter Articles!

Writers Wanted!

The Virginia Chapter of AAHAM will award **$100** to the author of the best article submitted to the Publications Committee during 2016. Submit articles to Amy Beech abeech@augustahealth.com. Newsletters are published quarterly. Don't miss your chance to be read, recognized, and rewarded for your writing talent.

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

Amy Beech, CRCE-I

abeech@augustahealth.com

Sara Quick, CRCS-I,P

squick@augustahealth.com

What is AAHAM?

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

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