The Virginia AAHAM Insider

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

Spring 2015 Volume 34 Issue 1

The President's Message

Greetings Virginia AAHAM Members and Friends!

It's a great time to be associated with AAHAM as I witness all the positive things happening around me. The Virginia Chapter held another successful Spring Regional Educational Conference in Charlottesville on March 13th. We had 114 people from around the state join us for the event. There were excellent topics and presenter's and the networking was off the charts. Everyone was chatting and enjoying each other throughout the day. The hotel did a fantastic job with the facilities and the food was delicious. I think this one will go in the record books as being one of our best 1-day meetings ever! Thank you to all the folks that made this possible, especially Leanna Marshall and Dushantha Chelliah for making many of the arrangements for this meeting. And thank you again to all of our corporate partners that sponsor these events and our chapter. You mean the world to us and we appreciate you!

Certification is always a hot topic for us at Virginia AAHAM and we have two exciting things to announce. First, we have our first CRIP (Certified Revenue Integrity Professional) in the chapter. Her name is Debra Hartley and she is from Parallon. We are so proud of her and excited to have our first one for the chapter. We also had several folks at the conference who were presented their CRCS or CRCP certificates. These certifications are quite an accomplishment and we know they will continue to solidify you in your careers. Keep up the great work and congratulations to you all! The second exciting piece of news is that VA AAHAM has received an anonymous donation in the amount of $1,200.00 that is specifically to be earmarked to assist national members of the Virginia chapter with their certification testing expense. The only thing asked of this donor is that it be used for the taking of the test for a person that has to pay this out of pocket themselves and is not sponsored by their employer. We are very thankful for this generous donation and hope that we get the opportunity to use it all up this year. Please contact me at david.nicholas@rmccollects.com if you wish to apply for a portion of this donation.

Keep your eye on your email. We will be sending out a ballot to you in early April to vote on the Bylaw changes that the board of directors is recommending after our recent review. Your vote matters to us and it will be a good reminder for you what the chapter is all about. Secondly, sometime later that month we will be sending out our annual chapter survey. We'd like to get your feedback on how you feel the chapter is running and whether there is more we can do for you as a member. Please watch for this important survey and be sure to give us your thoughts!

Our next meeting will be Friday, April 24th in Richmond VA. We are holding our Annual Payer Summit jointly with HFMA. We will have folks in from Medicare, Medicaid and some of our favorite commercial payers. Please plan on attending the meeting. For more information go to our website at www.vaaaham.com and click on Calendar of Events. I'm looking forward to seeing you all soon. Enjoy this beautiful weather!

David

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

INSIDE THIS ISSUE:

The Virginia Chapter of AAHAM American Association of Healthcare Administrative Management

The Virginia AAHAM Insider
2nd Place Winner for Excellence in Journalism
2014-2015 National Journal Award!

Is Meaningful Use– Meaningful??

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Do you all remember all of the excitement when the announcement about obtaining an "electronic health record" was released? Do you remember the dollar values of "reimbursement" was announced once the electronic health record (EHR) reached certain stages in development? Oh, what a consultant's dream to help hospitals and physicians choose the right system for their facility or practice! Oh, what a great revenue stream for the numerous companies who sold EHRs or were even in the development of one! What a boon!!!!!!

Along with this great announcement, but not emphasized, was the focus that physicians and those documenting into the EHR, were supposed to utilize the new tool to enhance their documentation and make the "picture" of the patient's condition and medical care more expandable. What did happen was that physicians complained about the length of time associated with the completion of the medical record during the "face-to-face" meeting with the patient. Other things that occurred during the initial year of the EHR were:

- the expansion of existing single point systems to multi-point systems without much testing;
- the introduction of "vaporware" companies who would sell their system and then develop the system at the client site;
- the quick growth of some established companies to the point that they would hire young men and women right out of college – train them in one specific functional area of their system and then send them to clients for implementation; and
- consultants who strived to implement systems that they had little to no knowledge of its various functions.

With all of this activity, it became fairly apparent that the real focus of obtaining and implementing an EHR system was the financial reward that the government would pay at certain stages of implementation and not the true purpose of increased documentation for better medical care and the interoperability of utilizing this medical information to offer enhanced care to the patient.

Where are you in all of this???? It may be too late for some of us but it would be nice if each of us could evaluate how meaningful is the use of the data in our medical records. The first thing that I remember is that many of the EHRs were "re-implemented" because the first time around, the outcome was not very good. Many of the "selling points" of the initial system did not work or were not user friendly; many of the dictionaries were standard with no advanced language to improve medical record information; many of the information hints that were supposed to increase the physician's documentation were not helpful or not used by physicians because it wasn't the way they would say it or it sounded 'dangerous' as documentation.

The reality point that a large number of already implemented systems had to be replaced or re-implemented told us that the focus was financial and 'patient-centered". Today, I think we have learned our lesson and have begun to turn the tide. There are two areas that we need to now focus in on to truly maximize meaningful use: physician documentation and interoperability. Both are very tough tasks and each have their own set of problems. Let's look at each:

Is Meaningful Use– Meaningful??

Continued on next page

Physician Documentation

Boy have we heard enough about this!!!! This is still the biggest complaint about physicians and among physicians. "Everyone wants more!" says one doctor; "The doctor will yell at me if I ask him for more information" says either a nurse or a medical record coder; "Denied, not enough information" says the insurance specialist; "Poor documentation is effecting our case mix and reimbursement" says the chief financial officer. We could go on and on but you get the point. Physician documentation is and has always been the key to successful patient care as well as the appropriate reimbursement. This is why physicians (and other providers) are always 'in question' when it comes to documentation.

When discussing documentation with physicians and providers, it is always best to recognize their knowledge base and their personal commitment to their patients. Under the new coding system, ICD-10 (International Classification of Diseases – 10th edition), we are very much aware of the new level of detail that is expected regarding patient care. This will be somewhat difficult for many physicians since they have the knowledge and keep it in their head but don't document it. Some of the best ways to enhance their ability to document the completeness of the patient's condition is to have some "experiential patient sessions" with the physicians of the same specialty. You can take some actual patients, redact their name and other information, or make up some patients with the typical language and conditions you usually see from that specialty area. Have one physician read the documentation as primary care physician and then ask if any happened to the primary care physician would any of the other physicians be able to immediately take over the care. Ask for comments regarding further description of the patient's condition and what other descriptions could be added to the medical record to make it more complete. If you think this is may be a good approach to further address the improvement of clinical documentation, then you should adopt this method and have the "clinical documentation improvement" team work with you for more focused sessions.

Physicians have a way of respecting data. They want data and respect it also. Therefore, this method also becomes valuable when dealing with claims that are reduced in payment or denied completely. Without mentioning the particular physician, this method can be extremely beneficial especially when, at the end of the session, you present the data representing the dollar value of these denials against the total dollars of revenue from that area. Additionally, we have found that when the physicians understand the level of documentation associated with these types of claims, they can add suggestions to either the electronic EHR to help with documentation or with other creative methods to help all of the physicians in their specialty. This has proven successful on more than one occasion. This is also a great way to express (gently) the incredible detail that ICD-10 wants. The more specific the documentation, the more specific the assignment of a code can be.

Oh, this level of specification regarding the assignment of an ICD code becomes even more important as the new APR-DRGs (All Patient Refined-Diagnosis Related Groups) are adopted by Medicare and all the other third party insurance carriers. If you read the article in the last issue, you will know that APR-DRGs have stratified each DRG into four classifications: minor, moderate, major or extreme. These are the codes that express the severity of the disease and the risk of mortality for that disease. As can be expected, each classification has its own set of weights in the Grouper and that the higher the classification, the greater the weight. The greater the weight, the larger the payment. Therefore, back to our subject...the depth of the documentation should bring about more specific assignment of medical record codes. The more specific and complete the codes are, the more likely the final assignment of the DRG will be above the moderate classification. Based on the information from the article, the only way to make any profit from these APR-DRGs is to have the assignment above moderate.

Is Meaningful Use– Meaningful??

Interoperability

The topic of interoperability has always been a topic that people really do not want to talk about comfortably. The electronic health record within a facility or practice can work well as an interoperable system. The internal IT staff of a facility or practice can usually "make it work" and have the availability of the EHR open to many work stations. Even a large health system, if they chose the right EHR system, can have it as a very productive asset in sharing a patient's medical history and current condition.

Interoperability is still a problem in most communities. The interoperability of the EHR across all systems through the HL7 protocols has not been accomplished. What is more, there is no significant focus on this aspect of the electronic medical record since entity revenue is still the major draw. Think about it… interoperability would have to be written, tested, cleared and then approved for another system to have the information from a patient. This is the goal of interoperability. We are still working on it and, I am confident, that we will get there someday. Meanwhile, we need to continue on enhancing both of the vital pieces to an electronic medical record: detail documentation and system interoperability.

If your physicians, whether at a facility or for a practice, can access and utilize the EHR from outside of the physical building, like from home or other location with a security code, then right steps are being taken toward accessibility and communication. Let me end with two quick personal experiences. The first experience is with my primary care physician (PCP) who I have been seeing for a number of years. He is in a multi-specialty practice and during one visit, we talked about a certain test that you should have done at a certain age. We agreed to have me referred to another member in his practice and as I was leaving, he told me he just sent this specialist my medical record and history so I do not have to repeat all of my health background. This is internal communication. The second experience is with the same PCP but the test/procedure that I needed was from a specialty that was not in his practice. He said that he would send my medical record over again. Well, I made my appointment and upon arriving, there was no medical record. I asked the specialist if he received my information and he checked and said no. He then proceeded to call my PCP and they faxed my information over. No interoperability here.

So let us do what we can…work with our physicians to obtain the highest level of documentation specialty for each patient and have the information technology people continue to work on making medical record systems interoperable.

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Solving the Healthcare EFT Standard Enrollment Challenge for Providers

The HIPAA healthcare electronic funds transfer (EFT) standard for claims reimbursement is EFT via ACH (NACHA CCD+Addenda), which works similarly to Direct Deposit. Money is sent electronically from a health plan directly to the provider's bank account and is required to carry the TRN Reassociation Trace Number that allows for automated reconciliation of the EFT via ACH payment with the Electronic Remittance Advice (ERA). Providers will save an estimated $1.53 per EFT via ACH payment compared to check payments, according to the 2013 U.S. Efficiency Index Report. Other benefits include significant savings in staff time through automated reconciliation of the EFT and ERA and reduced risk by having payments directly deposited to your bank account instead of receiving a check. One large hospital group reported a 70 percent reduction in accounts receivable processing costs with EFTs via ACH when compared to checks through automated reconciliation and reduction in errors.

If EFT via ACH saves money, lowers risk, reduces errors through automated receivables posting, and allows staff to focus on secondary billing and improve cash flow, why haven't more providers moved from check to EFT via ACH? The answer: challenges with EFT enrollment.

EFT Enrollment Challenge

Enrollment for Direct Deposit of your payroll is simple. You complete one document, which takes about five minutes, return it to your Human Resources Department, and begin receiving your pay directly in your bank account. Enrollment for EFT via ACH with 25, 50 or 100-plus health plans requires more information, multiple forms and considerably more staff time and resources.

Making Enrollment Easier

Project Plan—Identify where most of your payment volume is coming from and start there. Prioritize your health plans by volume of payments received and have your office staff begin EFT enrollment with those organizations first. Then have your accounting/office staff continue enrolling with a specified number of health plans each week. Starting with the top 20 percent of your health plans will help move the majority of your claims reimbursements to EFT via ACH quickly. The rest can be moved as time allows.

Standardized Information—The Healthcare EFT & ERA Enrollment Operating Rules established a maximum set of data fields that can be used in the EFT & ERA enrollment process that must be used in a standardized order. So, if you are enrolling with multiple health plans, all of the information requested should be the same and in the same order. Once you or your staff has identified the appropriate information for EFT via ACH enrollment, you should be able to use it to enroll with additional health plans.

Solving the Healthcare EFT Standard Enrollment Challenge for Providers

Enrollment Databases—The Council for Affordable Quality Healthcare (CAQH) has developed a free EFT & ERA enrollment database tool that allows providers to enroll with multiple health plans through one online process. Providers complete the standardized enrollment form and select the health plans with which they do business. CAQH notifies the health plans of the enrollment, and the health plan can then access the provider's information. For additional information on the CAQH EFT & ERA Enrollment Utility, visit solutions.caqh.org.

Healthcare Clearinghouse—Many providers work with healthcare clearinghouses for a variety of services. One service that may be offered is EFT enrollment with health plans that the clearinghouse supports. Performance Pediatrics, a Plymouth, Mass.-based micro practice, was able to increase receipt of EFTs via ACH from 65 percent to 90 percent using their healthcare clearinghouse to assist with EFT enrollment.

Account Safeguards—With measures in place to protect the accounts of providers who accept the healthcare EFT standard, providers can be assured that health plans will not be able to debit their accounts in the event of overpayment. ASC X12 version 5010 835 TR 3 (Implementation Guide) expressly prohibits debiting a provider's account to recoup overpayments. Additionally, financial institutions have treasury services available to prevent debits from being processed to providers' bank accounts. Providers should work with their health plans to understand overpayment recovery procedures and discuss with their financial institutions any services that can provide additional bank account protections.

Acceptance of the healthcare EFT standard for claims reimbursement allows providers to improve the efficiency of their account procedures, reduce errors, speed up secondary and patient billing, and reduce costs of payments received. While enrollment with multiple health plans can be time consuming and providing bank account information can be concerning, there are resources available to assist providers in the EFT & ERA enrollment process and measures in place to safeguard accounts. In the end, providers will find that the benefits of EFT via ACH will offset initial challenges and concerns with enrollment.

Priscilla Holland is the Senior Director of Healthcare & Industry Verticals for NACHA. As Senior Director, she leads NACHA's healthcare payments program and works on other payments and remittance information and standards projects. She has more than 20 years of experience in cash management, project management and product development and is an Accredited ACH Professional (AAP) and a permanent Certified Cash Manager (CCM).

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Room to Grow: How Small and Critical Access Hospitals Are Financing Expansion

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Almost one fifth of the U.S. population lives in a rural area. Small and critical access hospitals play a vital role in rural areas and are likely to offer services that otherwise would not be accessible to residents. As a result, these hospitals may be required to expand and/or renovate their facilities in order to provide additional service lines, adjust the amount of outpatient and inpatient services and improve operational efficiencies and patient amenities.

Expansions and/or renovations to existing facilities can be an ideal option when the costs are below that of a replacement facility or when the economic, financial or political climate is not conducive for a new construction project. To better understand how small and critical access hospitals are able to fund their capital needs, it is helpful to review some real life financings from the past year.

Private Placement

Golden Valley Memorial Healthcare (GVMH) is a nonprofit health care organization that operates a 56-bed acute care hospital, a home health service, and physician and outpatient clinics located in west central Missouri. Although it is a district hospital, GVMH does not currently receive any tax support and is primarily self-funded through operations.

GVMH had experienced a significant increase in the demand for outpatient services and was looking to fund an approximately 100,000 square foot expansion to accommodate that demand as well as future growth. In addition, the hospital wanted to renovate a significant portion of existing space and fund the acquisition of two medical office buildings that it leased.

After considering multiple financing options, GVHM's board and leadership team chose to issue privately placed, tax-exempt bonds to fund the expansion and renovation. This financing option provided several benefits, including: a low fixed interest rate, a 25-year amortization, the ability to incorporate a drawdown structure and a significant reduction in interest expense during construction.

The $36.2 million financing allowed GVMH to add over 100,000 square feet and to acquire the two medical office buildings it had been leasing. The transaction allowed GVMH to improve all outpatient services including new surgery suites, emergency department, outpatient treatment center, cardiac rehabilitation and an expansion of imaging services. The funding allows the hospital to modernize its current facility to properly address and handle the growth within outpatient services.

FHA Sec. 242 and FHA Sec. 241(a)

Fall River Health Services (FRHS) operates a 25-bed critical access hospital (CAH) in Hot Springs, S.D. FRHS provides emergency, acute and long-term health care to the communities in Fall River County as well as Buffalo Gap in Custer County.

Room to Grow: How Small and Critical Access Hospitals Are Financing Expansion

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Prior to 2010, Fall River Hospital and Castle Manor, its long-term care (LTC) facility, were housed in the same century-old facility. For a number of years, it was apparent that the rural area needed new health care facilities to keep up with modern medical standards. In order to obtain funding in 2007, as the financial crisis unfolded, FRHS leadership decided to build in three phases to make the project financially feasible: fund the construction of a new hospital, fund the expansion of that hospital and then fund the construction of a new LTC unit.

For the first phase, FRHS set up Castle Manor as a separate entity that would stay in the original building for the time being. FRHS then obtained a taxable, fixed-rate $16.7 million mortgage note insured by the U.S. Department of Housing and Urban Development (HUD)/Federal Housing Administration (FHA) Sec. 242 mortgage insurance program for its long-term, fixed-rate debt. That loan, coupled with approximately $600,000 contributed from the hospital and the local community, would fund construction on a 15-bed hospital.

In late 2009, to fund the second phase, FRHS closed on a supplemental $2.3 million loan through the FHA Sec. 241(a) program to expand the hospital by an additional 10 patient rooms, bringing it to the CAH maximum of 25 beds. The 42,000 square foot hospital opened in the spring of 2010.

Four years later, FRHS proceeded with phase three of the project. To finance the new LTC unit that would replace Castle Manor, FRHS used the Sec. 241(a) program to obtain a $4 million supplemental loan. The hospital then contributed $2.2 million in equity to fund the replacement facility. By constructing the entire project in stages, FRHS was able to keep its overall risk to prudent levels. In addition, the drawdown feature of the structure is saving the hospital considerable interest expense because funds are allocated at each construction phase instead of being funded entirely at the project's start.

USDA Community Facilities Loan Program

Box Butte General Hospital (BBGH) is an acute-care provider located in Alliance, Neb., that serves six counties via a network of clinics. BBGH is not taxpayer supported and approximately 65% of inpatient revenues are from Medicare and Medicaid patients. As a result of its CAH status, BBGH can be reimbursed for most of the allowable Medicare and Medicaid costs, including interest and depreciation expenses. The favorable reimbursement environment positioned BBGH to improve its facilities in pursuit of the organization's mission.

The campus needed to undergo renovation and an expansion in order to keep up with advancing medical technology and meet the shifting demand from inpatient to outpatient services. After community buy-in and approval by the board of a two-story addition and 17,000 square foot renovation, the total project cost totaled $40 million.

Room to Grow: How Small and Critical Access Hospitals Are Financing Expansion

BBGH obtained two U.S. Department of Agriculture (USDA) Community Facilities Program direct loans for the project, totaling $28.8 million at a fixed interest rate of 3.5% for 40 years. In addition, the hospital secured a low interest rate construction loan consisting of tax-exempt, variable-rate bonds with a three-year final maturity that were privately placed with a large commercial bank. This series of bonds will be replaced with permanent funding provided by the USDA direct loan upon substantial completion of construction. The drawdown feature of this structure is particularly cost effective as bond proceeds are only drawn as necessary, saving the hospital considerable interest expense.

To fund the remainder of the project, the commissioners of Box Butte County approved issuance of $8 million of limited-tax, general obligation bonds. The commissioners then loaned the funds to BBGH, which will make debt service payments on the county's behalf to avoid levying taxes. In addition, the hospital was able to take advantage of the lack of new supply of municipal bonds and strong investor demand to lock in an exceptionally low interest rate while also making tax-exempt bonds available to local investors, raising the remainder of funds necessary for the project.

The 93,000 square foot, two-story addition includes a new 25-bed patient care unit, surgery department and other ancillary medical services. Additionally, 17,000 square feet of the existing building will be renovated into a wellness center for rehabilitation and fitness. The project improves the patient experience and privacy with multiple waiting areas, expanded pre- and post-operative rooms and separate labor and delivery rooms. BBGH broke ground in early October 2013 and the entire projected is expected to open in early 2016.

Small and critical access hospitals perform a vital role in the national health care system and are an economic anchor for thousands of small communities, serving 19% of Americans. Above, we have examined three instances where hospitals used diverse funding methods to expand their facilities in order to better serve their populations.

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Scabs of Honor – Another Mom Moment

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I'm driving in the car with my son and we're singing songs and playing the "I Spy Game".

Okay, so we weren't really singing. He had on his headphones (we're going on a fourteen hour record) and the only game we were playing was let's see how quickly Mom can lose her temper over the guy in front of her who's driving like he's in a coma.

All of a sudden that little munchkin shrieks in this really loud voice (the same voice he used the time he got trapped in the back seat with a fly) and says, "Look Mom! A new scab!" And there he his, his big smile breaking through the tough façade of a nine-year-old who thinks he should be a rapper. Those stolen moments that moms get all too rarely – when their children actually become children again, and not walking smirks. He's got that same look of awe I got when I saw those animal print cowboy boots. I swear I heard angels.

"See this scab?" he points to a red mark in the middle of thirteen other red marks. Apparently this one was new. "I got this riding my skateboard. Remember that day when Jason and me skateboarded? Before the ice cream truck came? The time I got the red white and blue popsicle with the red bubble gum eyes? Yeah. That day." And he rubbed his scab lovingly and beamed while reflecting on his precious memory.

You see, my son has a story for every scar. And for every bruise. And for every scrape. They are his badges of honor - or rather his scabs of honor. To him, they represent courage, accomplishment, friendship, and ice cream.

And being a motivational speaker, I couldn't help but relate this moment to life – life in the real world, or rather the world of big people who long ago stopped listening for the ice cream truck.

Scabs of Honor – Another Mom Moment

And being a motivational speaker, I couldn't help but relate this moment to life – life in the real world, or rather the world of big people who long ago stopped listening for the ice cream truck.

While my son spends countless hours checking his body for scars, I spend many hours trying to hide mine. The wrinkles. The bulges. The scars. The old age spots. The signs of a life well lived – or rather, lived well.

And suddenly this freckled kid with the buzz cut and weird smell, is making me see my scabs in a whole new way. This scar that came the day my son was born. This scab that came the time I tried to show my little sister that we could fly. These wrinkles around my eyes that came from laughing so much. And the gray hairs that frame my face and represent every moment I spent on my knees. And who could forget the muf-fin top – that represents all the good food and memories that came with each meal.

Today my son made me see my scars through his eyes – as badges of honor – as memories of a life well lived.

I think I'll try that again tomorrow.

Kelly Swanson

Motivational Speaker, Comedian, Author of "Who Hijacked My Fairy Tale?
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For more about Kelly go to www.kellyswanson.net

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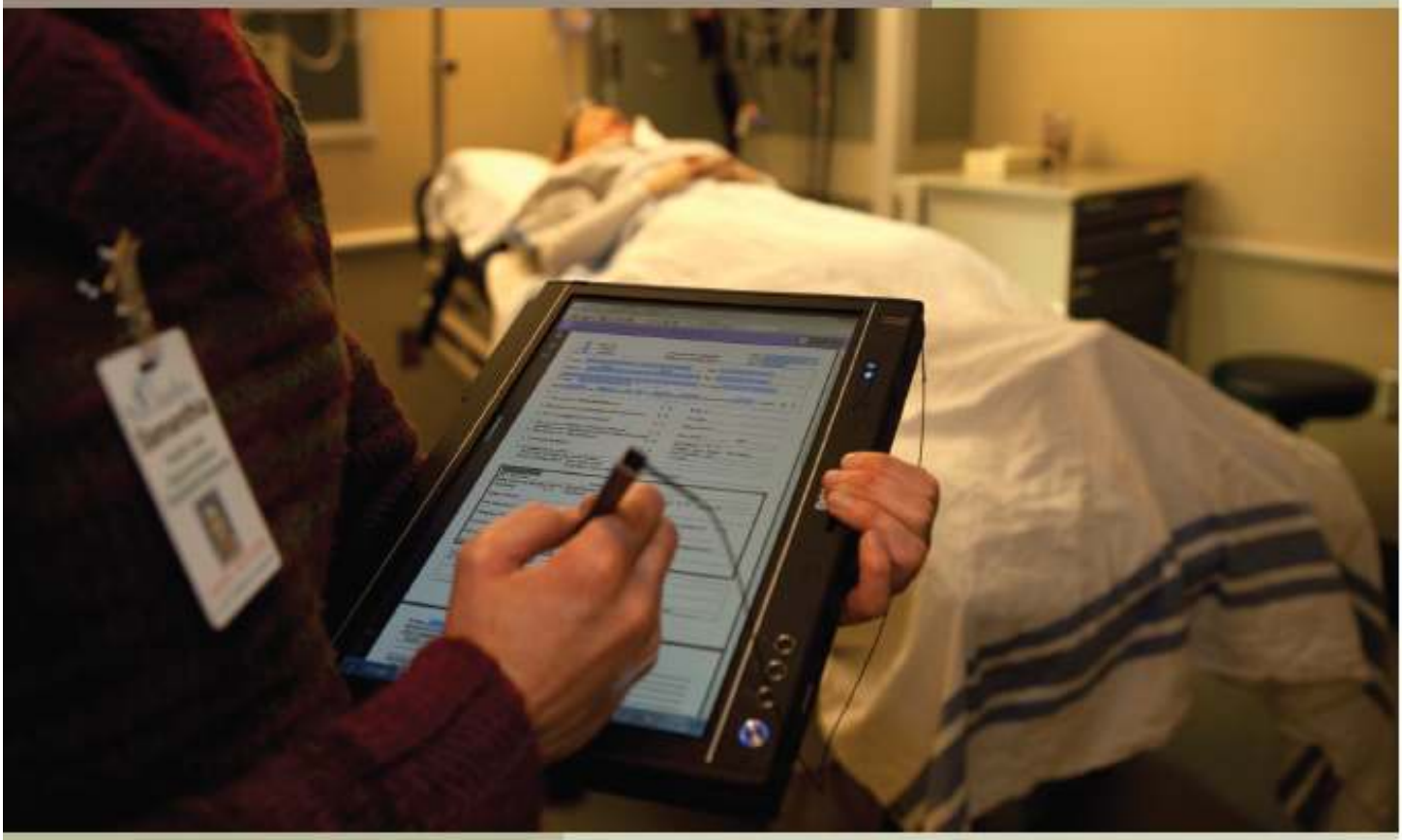

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Highlights … Spring Meeting, March 13, 2015 Charlottesville, VA.

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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

—AND—

An AAHAM certification demonstrates your:

Commitment—to your field and your ongoing professional development.

Expertise—you possess the knowledge to meet the industry's highest standards and the capacity to pass a rigorous certification examination.

Professionalism—your pursuit of excellence supports the quality of service in your career and in the healthcare industry.

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

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

Charlottesville, VA 22902

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

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

Newly Certified…

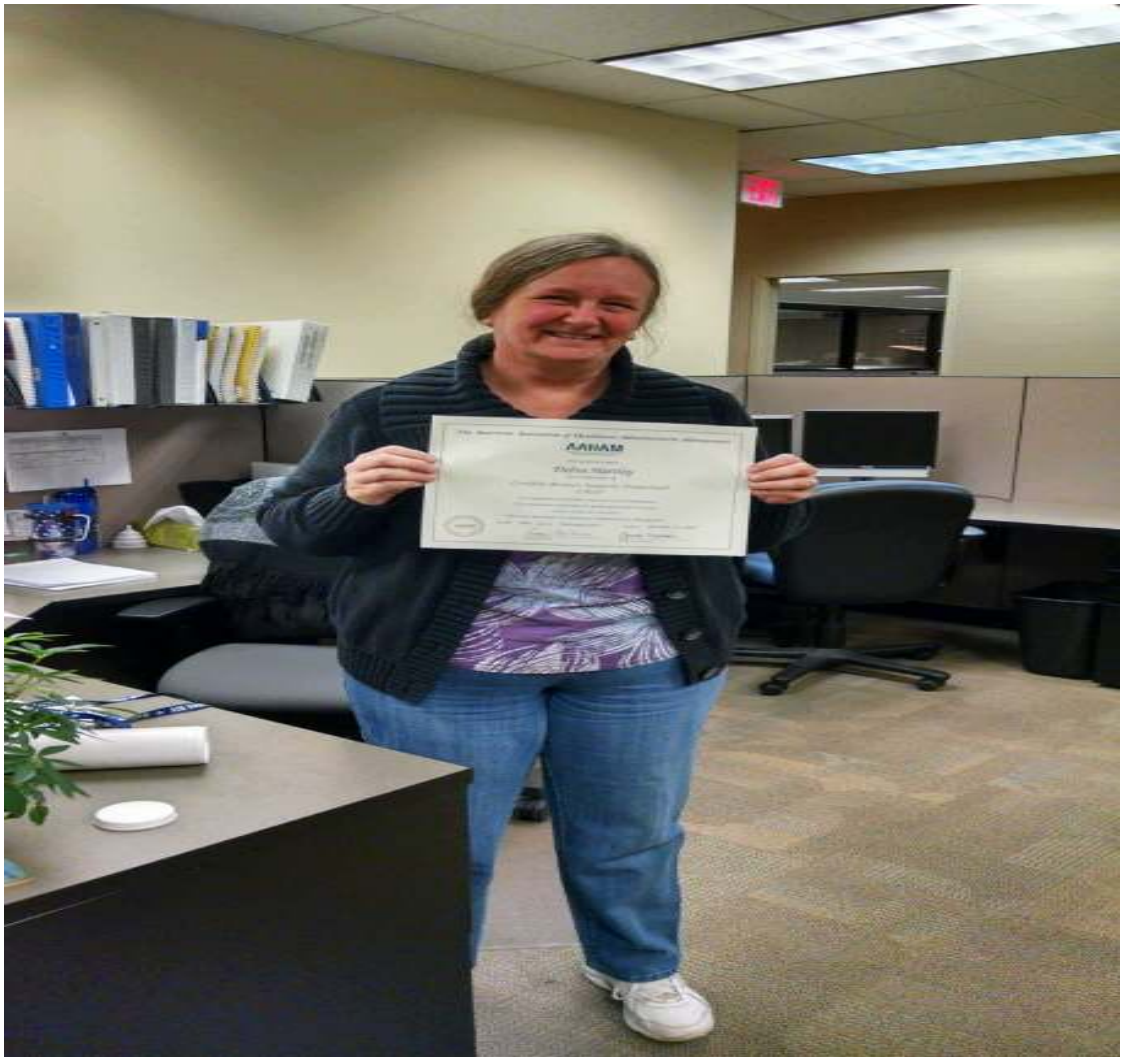
First Name	Last Name	Certification	Facility
Stacy	Anderson	CRCS-I	Mary Washington Hospital
Kathleen	Brunette	CRCS-I	Mary Washington Hospital
Angela	Fields	CRCS-I	UVA Medical Center
Amanda	Gassaway	CRCS-I	Mary Washington Hospital
Donna	McHugh	CRCS-I	Mary Washington Hospital
Dana	Mims	CRCS-I	Medicorp
Noelia	Morris	CRCS-I	Inova Health System
Rhynhardt	Rademeyer	CRCS-I	UVA Medical Center
Erika Renee	Simpkins	CRCS-I	UVA Medical Center
Logan	Wilson	CRCS-I	UVA Medical Center
Jeanette	Wright	CRCS-I	Riverside Health Systems
Stephanie	Agar	CRCS-I	
Anna	Gilchrist	CRCS-P	Centra Health
Catherine	Ingram	CRCS-P	Centra Health
Holly	Bradley-Carter	CRCP-I	University of Virginia Medical Center
Beth	Horn	CRCP-I	UVA Medical Center
Marcia	Parrish	CRCP-I	University of Virginia Health System
Debra	Reese	CRCP-I	University of Virginia Health System

Congratulations!
We are proud of you!!

2015 Certification Schedule

March 2, 2015 - Registration deadline for May 2015 Exams
May 11□22, 2015 - Exam period
June 1, 2015 - Registration deadline for August 2015 Exams
August 10□21, 2015 - Exam period
September 1, 2015 - Registration deadline for November 2015 Exams
November 9□20, 2015 - Exam period
December 1, 2015 --Registration deadline for February 2016 Exams

Newly Certified…



Congratulations to Debra Hartley, she is the first person in the state of Virginia to successfully pass her CRIP certification.

The Virginia Chapter of AAHAM American Association of Healthcare Administrative Management

2014 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…

- Problem solving and solution sharing with your associates
- Membership directory
- Reduced fees for chapter education events
- Access and preparation assistance for certification tests that demonstrate your professional skills
- Educational seminars & workshops
- Chapter newsletter
- Interaction & networking with peers

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 Chris Fisher @ 540-332-5030 or via email at: cfisher@augustahealth.com

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

Treasurer, Virginia AAHAM
Dushantha Chelliah
2212 Greenbrier Dr
Charlottesville VA 22901

-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

Medical Claim Insurance Recovery

P | S

9821 Katy Freeway, Suite 850
Houston, TX 77024
T. 800.872.1818 Ext. 116
C. 713.252.4876 F. 713.470.7243

Julie@ParrishShaw.com

The Virginia Chapter of AAHAM Executive Board 2014-2015

Chairman of the Board

(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 Fax—(804)828-6872

Email—lmclaughlin@mcvh-vcu.edu

President

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

David Nicholas, CRCE-I

Director of Operations RMC, Inc.

Office - (703)321-8633 Fax- (703)321-8765

Email— **David.Nicholas@RMCcollects.com**

First Vice President

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

Chris Fisher, CRCE-I

Patient Access Coordinator

Augusta Health

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Office—(540)332-5030

Email—cfisher@augustahealth.com

Second Vice President

(Committee Chairperson: Education Committee; Government Relations Committee)

Amanda Sturgeon, CRCE-I

Director of Payer Relations

500 Hospital Dr., Warrenton, VA 20186

Office phone—(540)316-4313 Email—sturgeona@fauquierhealth.org

Secretary

(Committee Chairperson: Publications Committee; Scholarship Committee)

Amy Beech, CRCE-I

Patient Accounting Supervisor

Augusta Health

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

The Virginia Chapter of AAHAM Executive Board 2014-2015

Treasurer

(Committee Chairperson: Vendor Awards Committee)

Dushantha Chelliah

2212 Greenbrier Dr.

Charlottesville, VA, 22901

Office - (434)924-9266

Email: DC5P@hscmail.mcc.virginia.edu

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

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(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

Honorary Board Member

Michael Worley, CPAM

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...by Sara Quick

Do you have exciting news or a special announcement you would like to have shared in the next newsletter? Please, let us know!

squick@augustahealth.com

Peeps S'mores

1 (11 1/2oz) package of chocolate chips
3 (16oz) packages of marshmallow peeps
1 (14 1/2oz) package of graham crackers
****

- Take apart all Peeps & break graham crackers into 48 fourths
- Place graham cracker pieces onto cookie sheets lined with wax paper
- Melt ¾ of the bag of chocolate chips
- Dip the bottom of each peep into the chocolate & place on a piece of graham cracker
- Place the cookie sheets of Peeps in the fridge for 15min so the chocolate can harden
- Melt the remaining chocolate in a Ziploc bag
- Cut a tiny piece off the corner and drizzle the chocolate over each Peep
- Place in the fridge until ready to serve.

Peeps S'mores can be eaten at room temp or heated in the microwave for 8-10 seconds.

RMC
Receivables Management Consultants, Inc.

Receivables Management Consultants, Inc.
6800 Versar Center; Suite 400
Springfield, VA 22151
Phone: (703) 321-9400
Fax: (703) 321-8765
www.RMCcollects.com

"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

OUR SERVICES ARE CUSTOMIZED TO MEET THE NEEDS OF OUR CLIENTS

> Business Office Outsourcing – Total or Partial
From billing through collections, follow-up, appeals, and recovery, RMC has the commitment and experience to be your trusted business partner.

We're ready to provide a total outsourcing solution, or assist you with any segments that are difficult or costly to manage internally:

- Acute Care Hospital
- Specialty Department (Psychiatric, Rehab, Hospice)
- Ambulatory Surgical Centers
- Home Health

> Insurance Billing – Follow-Up – Recovery

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

> Revenue Recovery Projects for Underpayments

> Denials Management

> Clean-Up Projects for Very Aged or Backlogged Receivables

> 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

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

And calendar of upcoming events.

Calendar of Events:

2015 Legislative Day, Hyatt Capital Hill from March 30-31, 2015.

2015 Annual National Institute
Walt Disney World Swan and Dolphin - http://www.swandolphin.com/
Orlando, Florida

October 14-16, 2015

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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Sponsorship

Platinum Sponsorship - $1,500

- **Exhibit space available at <u>both</u> the May & December Conference**
- **Full-page ad in <u>ALL</u> newsletters**
- **Full-page ad distributed at <u>ALL</u> meetings**
- **Free Registration at <u>BOTH</u> the May & December educational conference for four (4) sponsor employees**
- **Plus much more...**

Gold Sponsorship - $1,200

- **Exhibit space available at <u>both</u> the May & December Conference**
- **Full-page ad in <u>ALL</u> newsletters**
- **Full-page ad distributed at <u>ALL</u> meetings**
- **Plus much more...**

Silver Sponsorship - $1,000

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

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.

—Saurabh Sharma, Vendor Sponsorship / Corporate Partners Chair

Saurabh.sharma@rycan.com

Mark your calendars!

Upcoming VA AAHAM events:

- **April 24, 2015 Joint with HFMA Payer Summit, Richmond, VA.**

Go to our web site for more information and registration: www.vaaaham.com

The Virginia Chapter of AAHAM American Association of Healthcare Administrative Management

To: All Virginia Chapter of AAHAM Members:

The Virginia Chapter of AAHAM Education Committee, in an effort to provide our members with "Back to Basics" training is looking for interested parties to conduct a 30-45 minute webinar series. The web series would focus on professional development for operational level staff or first time managers. Presenters can share their professional experiences in networking, positioning yourself to grow in your organization, establishing yourself as a leader and a go-to person, etc. Please contact Gio Naranjo at gnaranjo@claimlogic.com or 405-548-1492 if you can assist in this education opportunity.

Linda McLaughlin, CRCE-I

Chairman of the Board, The Virginia Chapter of AAHAM

Amanda Sturgeon, CRCE-I

Second Vice President, The Virginia Chapter of AAHAM

Watch our web site for details:

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 2014. 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.