HAWKEYE HIGHLIGHTS

AAHAM
American Association of Healthcare Administrative Management

FALL 2005

President's Message

Dear AAHAM Member:

Do you ever feel like you don't know where to turn when you are trying to get a claim paid, looking for compliance resources, or just trying to determine Medicare payment systems? It's likely most of you have, at one point or another in your career. In the March 2005 *Health Professional Work Force Survey Trends*, conducted by the Iowa Hospital Association (IHA), business office staff were rated fifth highest in terms of health care professional shortages.

Recognizing the need to attract Iowans to patient financial careers—and the lack of a concentrated education track for this specialty—the Hawkeye AAHAM chapter decided at its fall board meeting to work in conjunction with IHA to develop concentrated curricula on AAHAM certification and better prepare our members for a continued, challenging career in health care. We will begin the education track in April at our spring meeting, with continued programs throughout the year. For those of you unfamiliar with certification, I've provided some highlights below. There are also many certified AAHAM members who could share their own personal experiences and the benefits they have received through certification.

The Certified Patient Account Manager (CPAM) and Certified Clinic Account Manager (CCAM) exams are every bit as challenging for patient account managers as the CPA and bar exams are for their respective fields. Sitting for this exam takes commitment and dedication. That's one of the reasons it is so prestigious in our industry. For over 25 years the Professional Certification exam has set the standard of excellence in patient accounting. It is offered twice a year, on the last Saturday of April and September. The sections for the CPAM exam are admissions/registration, billing, credit/collections, and accounts receivable management. The CCAM sections are patient communication/registration, billing, credit/collections, and accounts receivable management.

Technical Certification was developed in 1992 as a direct result of the dramatic changes in the health care industry. AAHAM developed the Certified Patient Account Technician (CPAT) and Certified Clinic Account Technician (CCAT) examinations to test the proficiency of individuals involved in the collection of patient accounts and to prepare them for the many changes to come. The Technical Certification exam is second only to the Professional exam in terms of difficulty and time needed to prepare for it. Successful completion of the exam should indicate to a prospective employer that an individual has mastered the common body of technical knowledge required of an employee in the patient accounts department. Certification designation affords benefits during job search or promotional opportunities.

Looking forward to another great year in 2006!

Respectfully,
Heather Hulscher

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Hawkeye Highlights is published three times a year by the Hawkeye Chapter of AAHAM. The statements and opinions expressed represent the attitudes of each author. Readers are encouraged to express their opinions of the written articles. Articles and letters to the editor are subject to editing and condensing.

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From Zero to Hero:

Seminar Pays Off for Mahaska Health Partnership Emergency Room Collections

By Pam Brindley, CCAE, CHFP, CPAT
MedPay Management Systems/H&R Accounts, Inc.

When Joyce Vonk attended a leadership training seminar, little did she know that it would literally pay off for her hospital, the Mahaska Health Partnership (MHP) in Oskaloosa, Iowa.

From May through September, money collected for Emergency Room treatment totaled $21,406. The prior amount was a grand total of $0. This revenue stream was all due to implementing the "Eight Stage Process of Creating Change," outlined in the book *Leading Change* by John P. Kotter, which was featured at the seminar Joyce attended.

Joyce was first introduced to this method of collections during the Fall 2004 AAHAM Conference. Mary Clouse of St. Luke's, Laurie Gaffney from Buena Vista Regional Medical Center, and Luke Gruber of AAMS put on the program "Collecting Co-Payments in the ER."

The AAHAM program and the Kotter seminar sparked Joyce into action. She returned to MHP, where she is the Business Office Director, and in March 2005 began meeting with the admitting staff for weekly training and policy work with the goal of increasing cash collections. Training included role playing and attending outside collection seminars throughout March and April.

Staff input proved to be huge part of this success story, resulting in the administration's approval of two admitting staff—one registration clerk and one financial staff member—to be available in the ER during high traffic times, Monday – Friday from 3 p.m. – 9 p.m. The goal was for these two staff members to work with guarantors and collect the money due after treatment, while the patient was still at the hospital.

The staff asked patients with no insurance for a $100 deposit and commitment to a payment arrangement. Those with Blue Cross/Blue Shield and other commercial insurances were required to pay $50, unless they knew their specific co-payment amount. They did not requirement payment from Medicare, Medicaid, or workers compensation patients. In all cases, the staff stayed true to the MHP Collection Policy, which states that "all patients being treated in the Emergency Room are treated fairly in regards to their ability to pay. Mahaska Health Partnership will make its best effort to collect the patient co-payments or establish payment arrangements only after the completion of treatment."

As with any system, there will always be collection challenges. If a patient claimed not to have their checkbook or credit card, Joyce's staff gave them a specially marked envelope and told them to send payment within five days. This system has worked particularly well for the hospital, according to Joyce. The installation of a credit card machine in the ER has also proven to be quite effective in increasing cash collections.

To help motivate employees working with this new system, the hospital offered a kick-off incentive during the first two months, with the highest individual collector receiving MHP apparel. It is an ongoing challenge to keep up the momentum.

Looking toward future improvements, Joyce would like to see registration move to the front of the ER. However, that would involve some construction costs, so all options are on the table. In the meantime, congratulations to the MHP staff for a great job performance in keeping their hospital a viable part of the community.

Critical Access Decision & Transition

By Liz Baptist, CPAM, CHFP

What is the Critical Access Program?
Originally designed for hospitals in remote and/or mountainous areas, the Critical Access Program is part of the Federal Government's initiative to ensure the viability of the rural safety net. The Federal criteria specify that a Critical Access Hospital (CAH) be at least 35 miles from another hospital, or 15 miles in mountainous areas or on secondary roads, or designated by the State as a "necessary provider."

In a mainly rural state like Iowa, many communities are less than 35 miles apart, so each of the CAHs in Iowa used the state designation as a "necessary provider" to become a CAH. To be eligible for this designation, the state requires that the hospital be located in an area with an elderly population (65 years or older) percentage greater than or equal to the state average; have a motor vehicle accident rate or farm injury rate greater than or equal to the state average; and be an emergency medical services (EMS) provider or demonstrate a cooperative relationship with the local EMS provider. These and other criteria have been crucial in identifying 71 Iowa hospitals as necessary to their communities.

However, the Federal Government is eliminating the necessary provider exemption on January 1, 2006. Thus, it's now or never for most small, rural hospitals deciding whether to become a Critical Access facility.

Why Go Critical Access?
Reimbursement, reimbursement, reimbursement. A CAH is paid 101% of reasonable Medicare costs. For our hospital, this was the key in moving from a $1.5 million loss in 2003 to a $1.3 million profit in 2005. Instead of operating under negative margins, most rural hospitals have been able to make an operating profit for the first time in many years.

You will receive interim rates—a daily rate for inpatient and swing days, and a percentage of charges for most outpatients. The Fiscal Intermediary will adjust these rates every year, and many CAHs choose to file interim cost reports to minimize any differences between the interim and final payments. (Reference lab and screening mammograms are still paid via fee schedule.)

Other important considerations include your community needs, your case mix, and your average length of stay (LOS). Many hospitals changed to Critical Access soon after the program began in 1998. Originally a CAH was limited to 15 beds and a 3-day LOS per admit. However, this was soon changed to a 96-hour average LOS. In January 2004, the bed limit increased to 25 beds, including swing beds. Twenty-five is an actual literal limit on the number of hospital beds your facility can have in use. An observation patient may not count in the census or length of stay, but the bed he is in counts toward the bed limit. If, like mine, your hospital's census is often near or above 25, the decision must be carefully considered. Good Care Management is imperative because as a weighted average, LOS is hard to affect. It takes 20 one-day stays to balance every 10-day stay.

It was invaluable to us to visit other nearby hospitals, particularly ones that had recently made the transition to Critical Access. We gained insight into the process and were able to learn from the problems they had already gone through. Our internal evaluation consisted of several items beyond reimbursement. We manually monitored our daily census for about year. This monitoring included designating patients that could have been swing or observation. This provided concrete proof that we would be able to function within the census limitations. We assessed our discharge processes including room turn-around time. Again, it is important to have a solid Care Management process in place. Patients need to be assessed daily to ensure care is provided at the most appropriate level.

Since Medicare is the biggest payer for most rural hospitals, most of those hospitals have already made the decision. Even so, all hospital staff should know about the reasons for deciding to become Critical Access. The financial benefits should be stressed, but don't forget that there will be fears of layoffs and unit closures. More likely, the CAH program will allow hospitals to replace old and outdated capital assets and relieve the financial pressures that can affect hiring decisions. Physicians may be resistant, particularly about the LOS and bed limits.

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They may feel it *can't* work and resent the implication that their judgment will be overruled. It's even possible that physicians may talk about sending patients to other hospitals, but in the end they usually are fine with the decision.

You may decide to use Method II billing for outpatient services because you'll receive 115% of the fee schedule amount for professional fees billed on the UB. You can choose which physicians, but you must make your decision at the beginning of each fiscal year. Each physician must fill out an 855R to reassign benefits to you, and you must bill *all* outpatient services by the chosen physicians. For example, if your family doc sees patients in the ER and you bill for that under Method II, you must also bill any other outpatient visit he performs in your hospital. Doctors don't like that part.

If you choose Method II, you might also be entitled to receive Health Professional Shortage Area (HPSA) bonuses, a 1% incentive payment, and Physician Scarcity Area (PSA) bonuses, a 5% payment. Your ZIP code might entitle you automatically (see http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0449.pdf). You must keep records of all this so you can pay the physicians correctly, because you will receive all the checks.

The Conversion

Once you have notified your licensing board of your intent to convert to Critical Access, you will be surveyed. You may have deficiencies to correct and then you will be approved. You will receive a new Medicare provider number, and you will want to have a clean way to separate the old and new accounts for easy cost reporting. In our system, the provider number is tied to the insurance plan, so we created all new Medicare plans. It was a clear way for everyone to recognize the change. This also allowed the revenue to tie to new GL accounts.

Series patients should be discharged and readmitted with new accounts. This can be done beforehand to make the paperwork burden lighter.

When you make the change to CAH, any patient currently in-house will need to have a new account number, because you will be billing two different stays. All documentation prior to the conversion will need to stay with that account number. This required us to have a team of IT, Nursing, Pharmacy, and BO staff come in at midnight and convert the current patients. Our conversion went off with out any problems.

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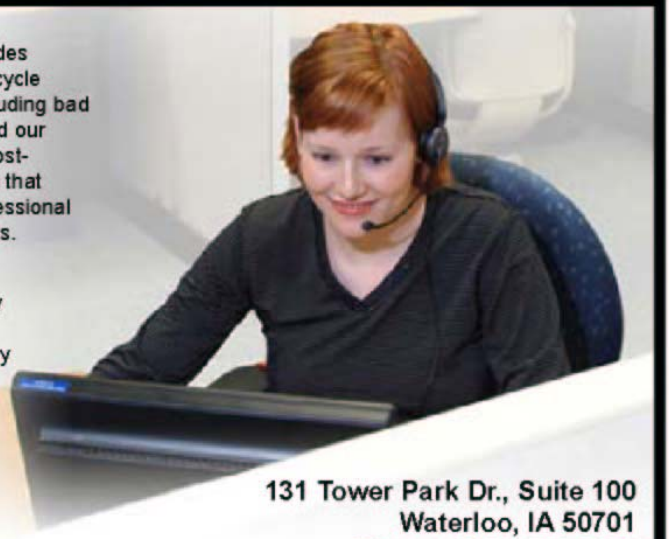

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Within several days of converting, our census climbed and remained high. Several times we were at 25, and we had to adjust our room turn-around process. On admission, we asked patients about transportation needs and encouraged them to make arrangements prior to discharge. Our Social Service folks helped arrange transportation. We held patients in the ED until a bed opened up—this was quite a change. Most patients were only in the ED for 2 – 3 hours before going CAH, although when beds are tight it was 4 – 6 hours. These patients received treatment and meals as appropriate.

Communication between nursing, Case Managers, and physicians became extremely important. In the beginning there were challenges, but as the physicians began to realize they could not admit patients if we did not have beds, the team effort became apparent.

Understanding OBS criteria is also very important. Since OBS patients placed in hospital beds counted toward the 25, we opted to purchase electric stretchers, which most OBS patients use unless it is unsafe.

Having an OB/GYN unit presented additional challenges. We originally designated six OB/GYN beds. After 4 months we realized that this was too many beds. Many times these beds were empty and the Med/Surg/ICU beds were at capacity. We now have four OB/GYN beds, of which two are designated as "float" beds that can be moved to Med/Surg should census warrant it.

The Center for Medicare & Medicaid Services (CMS) states that you can continue to bill under old numbers and balance at the end of the year. This did not work at all—our Fiscal Intermediary required us to cancel and rebill all the accounts after we got our new provider number. If I were to do this again, I would wait for the new number, even though cash flow would be affected. But when *will* you get the numbers? Generally it only takes about 4 – 6 weeks. However, not carefully following the submission instructions can subject you to painful delays. You should follow up regularly. When you get the numbers, you need to inform Blue Cross, Medicaid, Medicare Advantage payers in your area, and Tricare of your new status. Most other insurances want you to continue billing as you always did and will not require provider number or other changes.

There are some important billing differences between PPS and Critical Access. Acute inpatient billing does not change, but outpatient is significantly different. 85X is the typical outpatient bill type: X-ray, ER, observation, and recurring. The 14X is the reference lab: samples taken outside your facility (true for any specimen collected outside the facility, even if drawn by your lab techs). Screening mammograms are no longer billed on a 14X, even for OPPS. The 18X is for swing beds.

As a general rule, a CAH should follow the same billing criteria as an OPPS hospital. Sometimes this is not possible because a rule specifically gives the CAH other instructions. For example, the rules for billing LOCM are different for a CAH. Even though CPT/HCPCS codes are not "required" except for fee schedule items, you should continue to use them for several reasons: 1) it gives you more internal data, 2) it is difficult to determine medical necessity without CPT, and 3) you may decide to return to OPPS one day, and your system will be a lot closer to ready!

Importantly, the 3-day rule—which was never 3 days anyway—does not apply to CAHs. You will no longer have to check for prior accounts, but outpatient services *must* be billed separately from inpatient stays. If a patient starts in ED or Observation, the charges for that portion of the encounter go on an outpatient bill. You must decide whether creating a new account at time of admission is easier than creating it later. Neither is an ideal option. And the Medicare beneficiary ends up paying both an inpatient deductible and outpatient co-insurance, which is 20% of charges, not the lower APC co-insurance rates.

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Most hospitals set up a new account at the time the patient becomes an inpatient, but this requires effective education of clinical staff to ensure data is not lost and changes happen in a timely fashion. It is important to verify that charges are posted on the correct account.

You may decide to use Method II billing for outpatients. For the professional fees, you will use revenue codes 963 anesthesiologist MD, 964 CRNA, 972 diagnostic radiology, 973 therapeutic radiology, 975 OR, 981 ER, 982 Outpt, 983 clinic, 985 EJG, 960, 970, 980 general. You might have to make system adjustments, as these codes are not typical on the UB. You may also need modifiers you are not accustomed to using. Some secondary payers may need education on the unfamiliar bill types and revenue codes.

The biggest challenge we faced in the Business Office was lack of direction from CMS about Critical Access. Most of the transmittals that are issued do not address whether CAHs should make changes or not. The Hospital Manual speaks mostly about the differences between Standard and Method II billing. However, networking with fellow members was and still is an invaluable way to find answers.

Don't Forget AAHAM!

If you've recently had a change to your personal contact information, please let AAHAM know. If we aren't able to contact you, we can't keep you informed of all the great benefits AAHAM has to offer. So please, keep us in mind as your life changes and let us know how to reach you.

To update your local chapter records please contact Kristina Gursky, membership chair:

Phone: (800) 685-0595 ext. 6987
E-mail: kgursky@icsystem.com

To update your national file, please log on to www.aaham.org, click on Members Only, and after logging in, click on "Click Here to Update Your Contact Information." You may also fax your change of information to AAHAM, attn: Debra Fernandez, fax # (703) 359-7562, or you may mail information to:

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A Bit of Humor:

Heaviest Element Ever Discovered

The element, tentatively, named Administratium, has no protons or electrons and thus has an atomic number of 0. However, it does have one neutron, 125 assistant neutrons, 75 vice neutrons and 111 assistant vice neutrons, which gives it an atomic mass of 312. These 312 particles are held together by a force that involves the continuous exchange of meson-like particles called morons. It is also surrounded by vast quantities of lepton-like particles called peons.

Since it has no electrons, Administratium is inert. However, it can be detected chemically as it impedes every reaction it comes in contact with. According to the discoverers, a minute amount of Administratium causes one reaction to take over four days to complete when it would have normally occurred in less than a second. Administratium has a normal half-life of approximately three years, at which time it does not decay, but instead undergoes a reorganization in which assistant neutrons, vice neutrons and assistant vice neutrons exchange places. Some studies have shown that the atomic mass actually increases after each reorganization.

Research at other laboratories indicates that Administratium occurs naturally in the atmosphere. It tends to concentrate at certain points such as government agencies, large corporations, and universities. It can usually be found in the newest, best appointed, and best maintained buildings. Scientists point out that Administratium is known to be toxic at any level of concentration and can easily destroy any productive reaction where it is allowed to accumulate. Attempts are being made to determine how Administratium can be controlled to prevent irreversible damage, but results to date are not promising.

HAWKEYE CHAPTER OF AAHAM

TREASURER'S REPORT FOR PERIOD ENDING 9/9/05

BALANCE SHEET

ASSETS:	
Cash in Bank	$12,570.10
Certificate of Deposit	$7,500.00
TOTAL ASSETS	$20,070.10
LIABILITIES:	$0.00
Payables	
EQUITY:	$20,070.10
TOTAL LIABILITIES AND EQUITY	$20,070.10

OPERATING STATEMENT

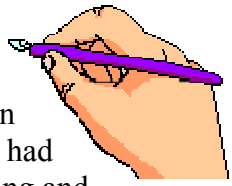
REVENUES:	
Corporate Sponsors	$3,950.00
Interest Income	$22.75
State Dues	$125.00
Professional/Technical Exams	$3,750.00
Spring Meeting Registrations	$6,545.50
TOTAL REVENUE	**$14,393.25**
EXPENSES:	
Travel	$2,446.63
Professional/Technical Exams	$2,609.22
Miscellaneous	$1,350.65
Spring Meeting Expenses	$6,404.68
Regional Meeting Expenses	$550.00
TOTAL EXPENSES	**$13,361.18**
NET INCOME (LOSS)	**$1,032.07**
BEGINNING CASH BALANCE	$11,538.03
ENDING CASH BALANCE	$12,570.10
OTHER (INCREASE OR DECREASE IN CASH) FUTURE PAYABLES	$0.00
ACCRUED CASH BALANCE	**$12,570.10**

Respectfully Submitted,
Val Gifford, Treasurer

Report from the National President's Meeting

Scottsdale, AZ
September 22 – 23, 2005

By Luke Gruber



A major topic of discussion at the National President's Meeting was the cancellation of the ANI in New Orleans. National AAHAM had purchased insurance on the meeting and will receive the equivalent of the revenue they would have earned. Without this insurance, national would have had a large loss for the year.

Attendees also discussed how to handle certification CEUs because of the ANI cancellation. The recommendation to the board was to extend the renewal from two years to three years.

Legislative day 2006 was discussed and the recommendation to the board was to make this a three-day event so those attending can visit both House and Senate representatives, as well as a day of education.

Attendees discussed why only 20% of the membership voted for national officers. The board is working on ways to get more people to vote. Since the ANI was cancelled, the annual awards were given out at a dinner on Thursday night.

Corporate Sponsors

The Hawkeye Chapter wishes to thank its Corporate Sponsors. Their generous financial contributions help ensure our chapter meets its goals and objectives, and allow us to provide educational programs, social functions, training programs for member certification, and the *Hawkeye Highlights* newsletter.

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