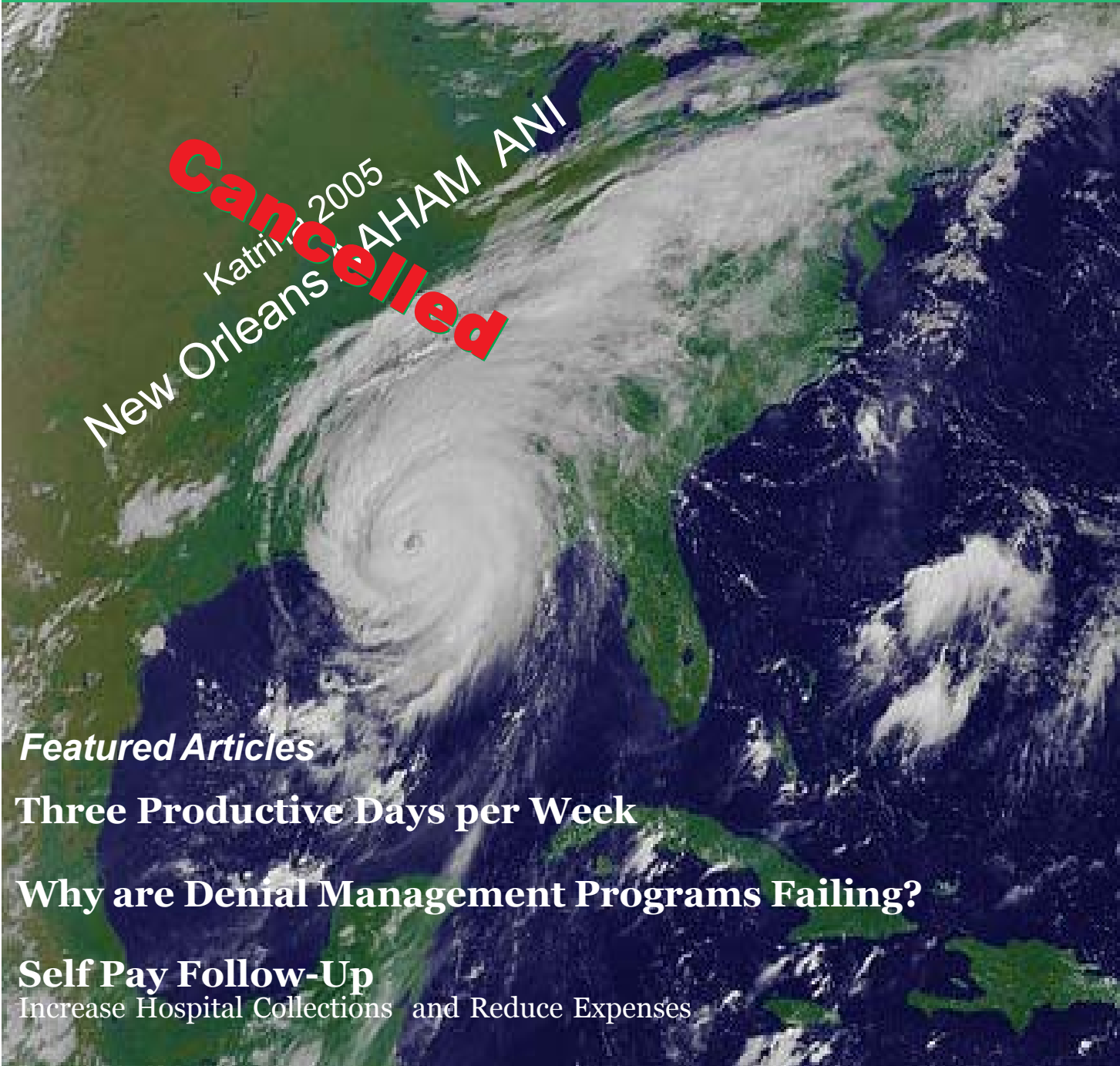


# THE LINCOLN LOG



*Award winning e-Magazine for the Illinois AAHAM Chapter*



## **Featured Articles**

**Three Productive Days per Week**

**Why are Denial Management Programs Failing?**

**Self Pay Follow-Up**

Increase Hospital Collections and Reduce Expenses

**Next Meeting December 8, 9**  
*Fall 2005*

# THE LINCOLN LOG

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*Veronica Modricker*

# President's Message

## Dear ILAAHAM Members,

I had such a list of items to address in my normal quarterly President's letter to all of you, but in light of the tragic events in our country, I thought those could wait until a later time.

These are such difficult times for the people of the United States Gulf Coast, and I know all of our thoughts and prayers are with them. Hopefully none of you have family, friends or loved ones who were in this area of destruction. If you have, I hope and pray that they are safe today and you have been able to contact them.

As you may have heard, our Annual National Institute has been cancelled and not rescheduled for this year. Our National Board will still be meeting at the same time to conclude our business for the year. The location has not yet been determined.

As I have been watching the television coverage's in the past few days, I did note a couple of agencies that need all of our help.

The Red Cross at 1-800-435-7669, and the Salvation Army at 1-800-725-2769 were shown as reputable firms for cash donations. They both have websites also to utilize which are [www.redcross.org](http://www.redcross.org) and [www.salvationarmy.org](http://www.salvationarmy.org). I have confirmed that 100% of your cash donation does go to the victims, specifically from the Salvation Army. I wasn't able to confirm this for the Red Cross. Of course, it saddens all of us to know that the scams are out there, also, so please be careful of whom you work with on these donations.

You have all been so generous with your contributions over the years, I know you will do what you can for the unfortunate. Thank you all for your cooperation, and please have a blessed and peaceful Labor Day Weekend.

I hope to see many of you in December at our ASI.

Veronica Modricker  
President  
ILAAHAM Chapter

# Why Are Denial-Management Programs Failing? 10 Common Problems — and Solutions

By Debra A. Schardt, RN, CPUR

For several years now healthcare leaders have been reading and hearing about the devastating financial effect of claim denials. In response, many providers have tried to develop or expand their denial-management efforts to recover lost revenue. In spite of these efforts, however, many initiatives are failing.

Why are these programs not delivering the expected return on the investments? Industry feedback shows that there are at least 10 good reasons why so many denial-management programs fail. These problems, and guidelines for resolving them, are provided below.

## Insufficient Program Plan

Traditionally, individuals or individual operational areas or departments within a facility have “owned” and “worked” denials. Usually, these individuals perform denial-specific tasks in conjunction with other job responsibilities.

However, the most efficient revenue-recovery programs are those that are entirely owned and worked by a designated facility-wide program planning team. The creation of a task force, as these teams are usually called, has been touted as a best practice for revenue recovery.

Once established, administrators *should* “charge” the task force to create a denial-management program and to “manage” the facility-wide revenue-recovery program.

In truth, however, many teams are not being properly guided, instructed and overseen.

One key problem is that the task force often confuses a denial-management program plan with policies and procedures. Without the proper information and direction they need, some task force members believe they are supposed to write and even manage departmental policies and procedures.

However, such micromanagement is not the charge of this group and, ultimately, leads to team discord. This, in turn, leads to objectives, goals and facility-wide processes that are not being developed and implemented efficiently.

It is important for the task force to understand that its charge is to develop a program plan—a tool, usually between one and

three pages, that will become the facility’s master revenue-recovery program. It should include a statement of understanding, outline objectives and goals, and establish long-term and short-term schedules. Most importantly, perhaps, is for facility administrators to give the plan their final approval and total support

An effective program plan will help task force members anticipate things like departmental changes and new software needed. The revenue-recovery plan should be coordinated with any master business plans that exist. It should also allow for progress assessments and changes to meet the program goals.

## Program Disorder

The success of any program begins with five steps: researching, assessing, educating, planning, and organizing. Many providers fail to develop sustainable denial-management programs because they do not follow through with these five basic program elements.

Failure results when task force team members do *not* do the following.

- Research the topic to gain a better understanding of the problem.
- Assess departmental and facility-wide processes or financial losses.
- Enhance their knowledge on the industry’s best practices (because they are not given the opportunity to do so).
- Plan out both facility and departmental program processes that improve revenue recovery.
- Organize themselves as a *team*, and work as one (instead of as individuals or individual departments).

The consequences of ignoring these important program elements are many, including chaotic implementation. The solution is for administrators to give task force members the guidance, tools and knowledge they need to ensure that the project meets the short- and long-term goals established.

Instead of focusing on whether overturned denials can be measured, hospital administrators should address how the five elements described above can be used to ensure revenue recovery.

Doing so can help guarantee that the efforts from a systematic and well-organized program result in financial recovery.

### Poorly Defined Objectives

In most cases, task force members must rely on previous “team program implementation” experiences, not all of which have been positive. For example, confusion inevitably reigns when the short- and long-term goals established are not compatible with master business operations and facility plans. Often, there is no distinction between short- and long-term goals, and many goals are often combined with multiple objectives.

Administrators who oversee the task force must be ready to instruct and direct the team about the objectives established for the revenue-recovery program. They also must ensure that the goals are facility-wide and not independent actions of departments or individuals.

The team should be coordinating a program that will successfully process, measure and prevent denials that cause declining reimbursement. The objectives and goals that are established should be obtainable and prioritized. In other words, they should not result in additional and overwhelming tasks. Here’s an example of an objective that is often overlooked or that fails because of inappropriate goals.

**Objective:** Determine how your team will categorize denials, appeals and outcomes.

#### Short-term goals:

- Collect current departmental definitions and outcome categories.
- Combine the above information.
- Eliminate duplicate categories of information, and add categories as needed.
- Create a master category list that’s “user-friendly” (one that every department will be able to use).
- Map the categories of denials to the root-cause area (source of the problem).
- Create outcome categories (overturned, denied, denied to second level, etc.).

#### Long-term goals:

- Evaluate and modify definitions and mapping on a predetermined schedule to meet the needs of the facility’s denial-management program objectives and tracking mechanisms.

- Create goals to utilize information to plan denial-prevention strategies.

### Implementation Chaos

Program disorder (summarized above) is not the same as implementation chaos. The program plans described previously provide the foundation for the next step of the process, which is, of course, implementation.

“Denial management” is commonly viewed as the impossible monster, so large that even the best of task forces cannot battle. This assumption is, quite frankly, wrong when the right plans are in place.

Strong and successful program processes must be executed in a systematic and orderly manner. Each step must lead to the next and build upon the previous one. While some tasks can be done simultaneously, strategies with goals that cannot be obtained should not be implemented. Here are a few examples to clarify this point.

- Denial and appeals data cannot be reported until an appropriate tracking mechanism is in place.
- Data tracking cannot be done without the proper software tools.
- Proper data-tracking tools cannot be used without suitable education.

To reiterate, implementation must be based on the program plans and the appropriate and approved priorities.

### Isolated Solutions

Hospital administrators and managers often favor independent departmental efforts, rather than interdepartmental efforts, for the simple reason that the processes being followed have been in place for a long period of time. Change, positive or not, is often met with employee resistance and discontent.

Many programs fail precisely for these reasons. Employees are not working together as a team but continue to work independently on denial-management issues, and they refuse to adapt to new processes.

Managers often overlook this because, on the surface at least, employees attend meetings, seem to have a genuine interest and concern, and share their thoughts willingly. Underneath, however, departmental personnel are not making process changes, sharing information or supporting implementation of a high-level program.

It is the administration's responsibility to ensure employee participation and cooperation. In addition to the factors already discussed, successful programs need the support of the executive team and the knowledge that everyone's contributions are essential to a profitable revenue-recovery plan.

A good program plan and implementation approach help to ease the transition. Combining strategies and procedures from different departments will result in a stronger, more efficient program for the entire facility and less work and frustration for the employees.

### **Inadequate Involvement**

Resourceful employees are the keys to the program's success. Unfortunately, many employees may not be adequately supporting the initiative and have difficulty collaborating. In many cases, the administration or task force do not get the attention, support, or assistance they need from employees due to lack of knowledge, executive support and empowerment.

Employees work better when they feel as though their contributions impact in a positive way, and they understand the intent behind the effort. While many employees "work" denials, many can't comprehend the true financial impact they can have or the results of their labor. The reason is, of course, that financial losses or revenue recovery have not been presented in a way that can be easily understood.

Administrators often overlook the value of educating employees charged with a difficult task, such as revenue recovery. Task forces should be given the responsibility to disseminate the knowledge that employees need and increase awareness of a facility-wide program.

This process begins by "training-the-trainer." Management should be arming task-force participants with information they can take back to departmental staff that allows and calls for ownership and "buy-in." The team must be given the authority to make decisions that allow for the continuation of individual departmental process. The decisions also must prove to be beneficial to the program and meet the stated goals and objectives.

Finally, administrators must empower employees to research best-practice processes, present ideas to the task force and initiate denial-management tactics. The point is to eliminate the barriers that make employees less likely to participate or

cooperate, and provide appropriate incentives, rewards and recognition.

### **Deficient Oversight**

Administrative management in the oversight and accountability of denial-management programs is a must. Lack of high-level management leads to failure. While task force members and departmental employees must participate and cooperate in the revenue-recovery program, executive officers must manage it, not just acknowledge its importance.

To ensure success, financial executives must do the following, although, in reality, they often do not.

- Participate in task force meetings.
- Champion team efforts.
- Provide input.
- Educate members of the task force.
- Maintain team accountability to meet goals and objectives.
- Acknowledge successes.

Involvement, support, education and clear communication of expectations—but not detail-level management—from the executive level can solve many problems. Their lack of participation in, and knowledge of, program progress does not lay a strong foundation nor guarantee the hoped-for return on investment. It will, in fact, lower the team's momentum.

### **Resources and Investments**

All too often task force members and employees cannot perform the functions necessary to meet program expectations because the resources and technology at their disposal are inadequate. Resources needed to achieve established goals include the following.

- Contract language
- Billing and payment information
- Access to current industry standards
- Knowledge of goals or expectations
- Assistance to balance responsibilities
- Denial-management and workstation tools

To get a return on an investment, facility leaders must first make an investment. Worthy investments include the following.

- Attending educational seminars
- Hiring outside experts to create and implement denial-management programs
- Developing a dedicated denials' team and hiring additional employees as needed to meet goals
- Purchasing and installing software and technology that are useful to, and used by, employees to full capacity

The most useful resources will require upfront costs to buy and to implement, but the result could be millions of dollars in recovered revenue. In the long-term, such investments will lead to timely and accurate reimbursement. For example, the purchase of automation tracking and reporting software directly contributes to improved revenue. Hiring a physician advisor as a liaison between the task force and the physician staff can be particularly helpful as can outsourcing certain tasks, such as appealing claims.

### **Data Collection and Reporting**

In spite of the attention it receives by industry publishers, providers often do not acknowledge payment denials. Denials are not easily detected or managed and are usually under-reported. Many providers simply write off denials as contractual allowances or make inappropriate administrative adjustments instead of noting loss revenue as bad debt. This leads to a misrepresentation of the actual revenue loss rate due.

It is important to assess a facility's loss rate against the loss rate being reported by the industry. If a facility is reporting a .5 percent denial rate (of net patient revenue) but has no denial-management program in place, it would be safe to assume that denials are being under-reported. The Advisory Board Company estimates the cost of denials to healthcare organizations can range from 3 to 7 percent of total revenue.

Staff members usually do not use the right data-management tools to track denied claims and appeals independently or into a central facility-wide database. The causes or impacts of denial problems cannot be ascertained without a central repository tool that tracks denials, appeals, overturn rates, root cause and payers.

Best-practice standards require the purchase or creation of an information system tool (such as independent denial-management software or software that is part of the current billing system). The task force can use this tool to accurately and efficiently assess, measure, manage, report and prevent denials throughout the organization.

### **Collection Required**

The bottom line of a denial-management program is, of course, revenue, and it must be documented as recovered in substantial amounts. However, is it actually being collected?

Several CFOs have verbalized their concern that, although staff has worked the denial and the revenue recovered has been documented on paper, there is no assurance that the funds were actually collected. The most commonly reported source of this problem is poor communication between a specific department or individual within a department and the patient accounting department personnel responsible for follow up and collections.

During the planning stages, a way to assess communication is overlooked because it is assumed that employees working denials will automatically relay information to the patient financial services' division. This is not necessarily so. Ultimate collection efforts and accountability lie with patient accounts, but they can't collect what they don't know is available. Once a denial is worked and overturned, that information and all supporting documentation must go to the employees who can process correct payments.

Policies and procedures for communicating and collecting the financial information (such as denial and appeal outcomes, expected reimbursement, etc.) should be written. Be sure to track recovered revenue and report that in comparison to what has been collected. Program plans and departmental policies addressing final and correct payment processes need to be as clear and precise as the efforts to overturn the denial.

### **Summary**

Healthcare organizations can avoid failure and build successful and sustainable denial-management programs as long as they understand all of the unique aspects of revenue-recovery efforts outlined above. Program planning must be done strategically, the right investments and resources must be committed, and executive-level administration must be appropriately involved and oversee the process.

Successful programs are key to reducing and preventing denials. A thriving revenue-recovery program depends on the process, tools and employees put in place to manage, measure and ultimately collect overturned denied revenue.

*Debra Schardt is a healthcare revenue management specialist with Medical Learning, Inc. (MedLearn®), St. Paul, Minnesota.*



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## SELF-PAY FOLLOW-UP

### TO INCREASE HOSPITAL COLLECTIONS AND REDUCE EXPENSES

By: Robert V. Jacobs, CPAM

The procedures listed below have resulted in an increase to overall self-pay collections for the hospital and a reduction in expenses. In order to adopt these practices, one must have a thorough understanding of the self-pay cycle, and recognize the best opportunities to maximize collection returns.

The process should include the following steps:

- 1) Review your current business office practices in relation to how self-pay account balances are moved through the system.
- 2) Determine the number of FTE'S that are currently assigned to do the collection work and follow-up activity on the self-pay balances.
- 3) Analyze the time spent by your in-house staff dealing with the self-pay accounts, and what balance levels they are working.
- 4) Calculate the monthly cost for the business office mailings (letters/postage) and reassign this cost to the outside agencies.
- 5) If you are currently using a pre-collect/early-out collection firm to hand the true self-pay and self-pay after insurance balance, analyze the items listed below:
  - Time after discharge when the account is listed,
  - Amount of time the service vendor handles the account,
  - Current fee being charged for collections,
  - Type of program (flat fee or contingency),
  - Number of letters/phone calls being processed,
  - Collection results to date.
- 6) Do the same review (Step #5) with the hospital's bad debt collection agency.

#### UP-FRONT PRACTICES:

- 1) Emphasize to the admitting/registration staff the importance of collecting self-pay portions prior to, at or during the patient's stay.
- 2) Develop a standard cash realization form (on-line) that will allow the registration staff, including the emergency room clerks, to estimate the cost for services/treatments being offered.
- 3) Implement the use of financial counselors as a key to upfront collections. Their role is to handle all patient walk-ins, make payment arrangements, determine co-pays/deductibles/self-pay portions, make floor visits, review daily census, work with self-pay vendors and assist patients in obtaining state public aid qualification.
- 4) Create promissory notes for the self-pay patients that may qualify for payment arrangements based on the hospital's guidelines.

#### BACK-END PRACTICES:

- 1) Assign one (1) business office collector to monitor all self-pay payment arrangements.
- 2) Payments must be made directly to the hospital by the 20<sup>th</sup> of each month.
- 3) If a patient misses a monthly payment, a reminder letter should be sent as a final notification.
- 4) If the patient disregards the final notification, the account should be moved to bad debt at the end of the second month.
- 5) Validate that all payment arrangements follow the hospital's policy. If a payment is posted that does not follow the set guidelines, the patient will presume he is allowed to continue this process. The most effective hospital payment schedules are:
  - \$0-\$499 = 4 months
  - \$500-\$999 = 8 months
  - \$1000+ = 12 months

#### ***PRE-COLLECT SELF-PAY VENDORS***

Since self-pay amounts are somewhat difficult to collect, most hospitals are assigning the self-pay follow-up to an outside collection agency that specializes in these types of programs. To choose the most cost effective selection of agencies, the following criteria should be met:

- 1) The agency should include at least ten (10) hospitals in their clientele list,
- 2) The firm's service should be comprised of 75% healthcare organizations, since they are an extension of the hospital's business office,
- 3) To remain competitive in the changing market, the firm should offer their program at rates under 10%.

The best revenue cycle hospitals move all self-pay to an outside Pre-collect firm once the payment is posted for self-pay portion after insurance, and when the patient is discharged on true self-pay accounts. The most effective program should:

- 1) Utilize two (2) self-pay agencies and split up the alpha between both,
- 2) Allow them to work the account for a period not to exceed four (4) months,
- 3) Create the letters that you want sent, and designate the timetables for the agency to make the phone contacts.
- 4) Maximize the collection efforts from your firms by giving them weekly electronic placements, which will allow contacting the patient soon after discharge.

## **DISCOUNT LETTERS:**

The self-pay financial group is the only category for which contractual allowances are not given. The charges are gross and the patient assumes complete financial responsibility. This issue, added to the hospital's financial assistance (charity), has hospital management and the finance departments addressing this matter:

- 1) The For-Profit hospitals give discounts on self-pay bills, which has proven to be very cost effective.
- 2) The policy should be adopted to allow the patient an opportunity to pay his self-pay bill:
  - 40% discount – If paid in full.
  - 25% Write-Off - If a payment arrangement exists that follows the hospital guidelines.
- 3) The business office should prepare a notification letter, which will be sent to the self-pay population:
  - The letter is used by both the hospital staff, and the pre-collect self-pay vendors.
  - It should be patient friendly and written in both English and Spanish.
  - It should be sent upon discharge, allowing the patient thirty (30) days to accept participation in either discount program.

## **SELF-PAY PATIENTS FILING FOR MEDICAID STATE PROGRAMS:**

This category also impacts the self-pay accounts receivable balance by those patients who have not been approved by the Public-Aid office.

- 1) The self-pay patient who files for Medicaid coverage has to meet the requirements of the application process, and have a specific diagnosis under the state program regulations.
- 2) The application should originate while the patient is in an inpatient setting.
- 3) The financial counselor or the outside public aid vendor (depending on the number of self-pay patients filing for the P.A. program,) must obtain the necessary documents to support the claim.
- 4) The inter-city approval rate is usually between 50% - 60% of applications filed, the approval rate for rural medial centers is between 60%-70%.
- 5) Most cases denied are a result of the patient's lack of cooperation or the individual is not actually disabled.
- 6) These accounts need to be moved directly to bad debt collection agencies, once the denial from the state is received.
- 7) The monitoring of these cases both internally and externally is critical to your self-pay balance percentage level.

## **CHARITY CARE – UNCOMPENSATED CARE POLICY:**

Every hospital must adopt and implement a Charity Care Policy. Most hospitals are following the AHA standards, including using the Federal Poverty Guidelines.

- 1) Once it is determined that the patient does not have any active healthcare insurance, the financial counselor or intake/registration clerk needs to begin the charity process.
- 2) The patient needs to complete an application and provide documentation to validate the approval for the charity write-off.
- 3) The business office must monitor these cases. The patient should be allowed thirty (30) days to complete the application.
- 4) All applications must be submitted to the bad debt committee for approvals or denials in compliance with auditing reviews.
- 5) Once a decision has been made, the patient must be notified in writing within five (5) business days, the outcome of his review.
- 6) These cases must be diligently handled since some may be moved to bad debt rather than classified as charity care.

## **BAD DEBT COLLECTION AGENCIES:**

The bad debt collection agency is yet another vital selection to be made, as it impacts your accounts that have been written-off to bad debt. Many healthcare consulting firms and hospitals believe the agency chosen should service only healthcare accounts. Depending on the hospital's volume, utilizing two (2) agencies is the most beneficial choice. This will allow you to compare collection results on a monthly basis. The following criteria should be used in selecting an agency:

- 1) Do not choose an agency based strictly on the percentage the company is going to charge the hospital.
- 2) Call the hospital references that use their services.

- 3) Perform an on-site review of the firm to examine their collection techniques, calling patterns, and the collection letters that they send.
- 4) Most hospitals prefer firms to notify the patient/debtor within the first twenty (20) days after listing.
- 5) The collection agency needs to file the debt with the local credit bureau.
  - This practice will allow the credit bureau to receive calls from patients who are seeking credit, as they will consequently need to address the delinquent hospital bill.
  - Some hospital facilities are also allowing the agency to send a discount letter to the patient following proper notification. They offer up to a 25% reduction for payment in full.
- 6) The on-going rate for bad debt agencies is now between 15%-18%.
- 7) The accounts should be listed on a monthly basis and are the self-pay returns received from the pre-collect firms.
- 8) In most cases, the hospital should establish a time frame during which time the account remains with the agency. This practice lets the agency know they have only a set period of time to work and resolve the account; rather than the old practice of leaving the account open for years. Most aggressive hospitals follow the time period below:
  - 0 – 4 months – Pre-Collect Self Pay Companies
  - 4 - 12 months – Bad Debt Collection Companies
- 9) This schedule allows the hospital to either second place the account with a different vendor, or sell the receivable on the market, as the receivable is now less than 5% collectable.

### **FOLLOW-UP REVIEW STEPS:**

- 1) Make sure monthly reports are sent to the hospital by the 5<sup>th</sup> business work day.
- 2) Allow the agencies to make settlements on the accounts when they are talking to the patient/debtor as most opportunities to get the account paid are time sensitive.
- 3) Have quarterly meetings with all outside collection firms, and go over their findings and suggestions for process improvement. An on-site review has always been a good practice as you can witness first hand the collection process of the hospital accounts.
- 4) The Director of Patient Financial Services, Manager of Billing/Collection, Admitting/Registration Manager, and the Financial Counselors must fully understand the internal and external self-pay program. They should meet monthly to review any issues, concerns or problems associated with the self-pay accounts.

### **CONCLUSION:**

The program and follow-up steps outlined above are not the only practices to improve cash flow. They are definitely important steps to implement when trying to improve the cash flow for the hospital in relation to the self-pay population. These procedures will increase cash flow on a monthly basis and in turn reduce the bad debt expense. ■

### **ABOUT THE AUTHOR:**

*Robert V. Jacobs has over twenty (20) years of healthcare experience. He began his healthcare career at a large inter-city unionized medical center. While working in a Catholic Hospital, his success for the financial turnaround was featured in a healthcare magazine. He had worked at a behavioral health hospital before joining a Hospital Consulting/Revenue Cycle Agency, which incorporated process improvements at over thirty (30) hospitals in Indiana. In 2000, he joined one of the largest hospital chains and was highlighted in a leading receivable magazine as having one of the ten best hospitals in revenue cycle practices within the U.S. Currently, he is working at a for-profit hospital as the Patient Accounts Director. He is an active member of the HFMA, AAHAM and NAHAM health state organizations.*

## Survey Finds Workers Average Only Three Productive Days per Week

Ineffective meetings, unclear objectives and lack of team communication are some of the top time wasters that workers say make them feel unproductive for as much as a third of the workweek. According to a new online survey by Microsoft, respondents also said that they struggle with the need to work longer hours while seeking better balance in their lives. They found that they rely on technology tools to assist in personal and professional productivity.

With responses from more than 38,000 people in 200 countries, the Microsoft Office Personal Productivity Challenge, rated workers productivity based on responses to 18 statements about their workplace. Some of the U.S. findings:

- Employees work an average of 45 hours a week; 16 hours are considered unproductive.
- Approximately 16% of participants relate their productivity directly to their software.
- Over 66% said that they don't have work-life balance.
- Only 31% said they are using proven scheduling tools and techniques.
- Women had an average productivity score of 70% while men were at 68%.
- Workers said they receive an average of 56 e-mail messages per day.
- The most common productivity problems are procrastination, 42%, lack of team communication, 39%, and ineffective meetings, 34%.

The results of the survey come as no surprise to many employees. Procrastination occurs when information is not clear, or the employee does not feel comfortable with the task. Workers frequently complain that objectives are muddy and information is not communicated effectively.

“Runaway meetings” are identified as the biggest time waster by more than a quarter (27 percent) of workers polled in a recent survey by Office Team, a staffing service specializing in skilled administrative professionals. Many companies continue to conduct meetings in the same format as years ago; inviting large groups of people, allowing excessive time, and often with no clear leadership of the meeting. With today's lean staffing levels, there is a need to restructure meetings for greater efficiency.

Workers in Microsoft's survey reported that they rely on technology tools to stay on task. Here are some things you can do in your workplace for better efficiency:

- **Train staff how to proactively use technology instead of reactively responding.** One reason that “time saving” devices often don't save time is that we react to them

rather than structuring their use. Plan your day with specific times to answer phone calls, check messages, and read e-mails. You lose efficiency when you rapidly move from one task to another.

- **Use a system to find electronic documents quickly and efficiently.** Use folders to organize your documents and important files. Make sure that the document names are descriptive and easy to find.
- **Make sure all computer users back up important documents and programs.** Don't forget to back up programs on a regular basis. Back up on the hard drive as well as an external storage (CD's, floppys) for extra safety. Nothing will slow you down quicker than a crashed system.
- **Staff should be trained in basic computer maintenance such as cleaning up disk space and defragmenting to increase computer efficiency.** These routine tasks do not need to be done by IT personnel or a tech person. Each user can easily be trained to program and monitor these routine operations.
- **Establish spam filters and sorters to help manage e-mail more effectively.** There are increasingly sophisticated programs to filter e-mails and protect machines. Initiate a company wide filter and add one for your home computer.
- **Set company guidelines on how e-mail is to be used.** One of the most common complaints of employees these days is “too much e-mail.” Set procedures on who needs to be copied and on what. Train staff on e-mail protocol including appropriate length, content, and tone.
- **Train all staff in time management including a priority system.** While employees may have had some training in time management, it needs to be refreshed on a regular basis to be effective. Make sure that employees at all levels know how to establish a priority system and time accountabilities.

Remember, time is the one non-renewable resource.

**Barbara Bartlein, is The People Pro and President of Great Lakes Consulting Group, which helps businesses sell more goods and services by developing people. She can be reached at 888-747-9953, by e-mail at:**

**barb@thepeoplepro.com**

**or visit her website at [www.ThePeoplePro.com](http://www.ThePeoplePro.com).**

# ASK... P.A.M. PATIENT ACCOUNT MANAGER

## WHO IS P.A.M.?

*If you have a question for Dear P.A.M., please email it to the editor of this publication and it will be considered for future Lincoln Log publications. This is for fun as well as educational. (trace.manning@st-johns.org)*

**Dear P.A.M.:** Help – when and how did working in the Business Office as a biller become my career? – BILLER

**Dear Biller:** According to Webster a career is your life's work. It sounds to me as though you have overdosed on HCPC's way too long. I suggest you try getting certified through AAHAM and broaden your horizons. There is more to life than transaction code sets and revenue codes. Your local AAHAM chapter is only a phone call or a few clicks away on line. They also have coaches that will help you prepare for the test. There is a whole new world out there in the Patient Accounts department. Wake up and get your head out of your UB.

**Dear P.A.M.:** What is the difference between a HMO and a PPO? - CONFUSED

**Dear Confused:** One is a scum sucking bottom dweller and the other is...no, I think that was a lawyer joke. No wonder you are confused, these two confuse a lot of people. The differences between them are many dependent upon if you are a biller, collector, CFO, in Contract Reimbursement, lawyer etc. I will speak to the collection side since the big push for Patient Accounts people is to get the money in the door. Both are contracted insurances but the HMO (Health Maintenance Organization) is the one that you cannot bill the patient until the HMO tells you what amount you can bill the patient for. You cannot call the patient to encourage his involvement in getting the bill paid and you cannot send him bills until the HMO has adjudicated the claim. The PPO (Preferred Provider Organization) patient, on the other hand, usually can be billed XX days after billing even if his insurance has not paid. Each contract is a bit different but most state that the account must be paid by the insurance in 30 – 45 days after billing. Be sure you have copies of all of your contracts so you know what the rules are. I hope you are diligent about payment tracking to ensure you get the proper reimbursement according to contract AND that your contracts state that you can deny the discount if the clean claim is not paid within the time frame in your contract.

When you are not paid promptly by the HMO you may think your only option is to continuously call the HMO and beg on every little account just to get it off your books. Either quantify those problems and give regular feedback to the CFO or ask the bottom dweller in your organization that signed the contract to call a few times on the larger accounts.

**Dear P.A.M.:** Would you have suggestions on how to handle staff members who wear too much perfume? Too short skirts? Too low cut blouses? – BILLING BORDELLO

**Dear Bordello:** You are obviously a female Patient Accounts Manager. The first thing you should do is to check with your HR department about the dress code and your ability to devise one that is suited to your department. Unless you want an all out war, you should enlist a small but diverse committee of employees to decide what image they want the public to have of them when a patient walks into the office. The dress code should flow from there. Try not to get too precise or you will be re-writing the code every six months when the new fashions come out. Be sure to address the men's dress code as well as the women's. After the effective date, if there is an infraction, quietly and discretely let the person know he or she is not in the agreed to office attire and the next time they appear at work without being dressed according to office code, they will be sent home to change. You will only have to send one person home one time and you will never have another problem. It is also probably time for you to go shopping for something other than that frumpy black ankle length suit you have been wearing every day.

**Dear P.A.M.:** Help, there are too many dark suits running around my facility. How can I tell a doctor from a CEO from the local State Representative? – CAN'T TELL THEM APART

**Dear Can't:** Even though it is a state law that we all wear our badges in the facility, we would not be able to tell who the person really is unless the badge was billboard sized. The doctor is the one that goes to the head of the lunch line, the CEO is the one that goes to the cafeteria as they are closing and the State Representative eats before or after he is at your facility. However, I wonder why you believe you have the need to tell them apart. Would you treat one differently from the other? Why not just put on your best smile and great everyone with a pleasant "Hello". Who knows, you may even become known as a friendly place!

**Dear P.A.M.:** What are your suggestions for reward and recognition? I am all for it if it keeps morale up but I am having a difficult time finding something that everyone likes. The people in my office are male and female ranging in age from 20 – 60. - R&R

**Dear R&R:** I am assuming that the R&R in your name does not stand for rest and relaxation. If it does, you do not work in Patient Accounts. One thing I have found that absolutely everyone

Continued on page 12

# ASK P.A.M.

## PATIENT ACCOUNT MANAGER

likes is something our office calls “Spring Day” and “Fall Day”. The first day in the spring time that gets to the upper 60’s and everyone has spring fever, we make a surprise announcement to the troupes that it is “Spring Day”. Half of them can leave two hours early and get paid for it. They decide among themselves which ones will go early and the rest man the phones and the fort. Those that stayed behind get to go early on “Fall Day” which is that nice Indian summer day after the first frost and before the snow begins to fly. You may modify this in any manner that will suit your morale in the office or reward and recognition. R&R with pay. You will never get a complaint.

**Dear P.A.M.:** When a meeting agenda reads Business Casual, what does that really mean? - CASUAL

**Dear Casual:** Business attire has changed dramatically in the past 15 – 20 years. Gone are the days of suits and ties for most male managers and suits and heels for women managers. Normal business attire now is very often a collared shirt and Docker type slacks for men and for women it could be a skirt, dress or slacks with flats. Dress codes for the employees are often times even more lenient. My employees asked me if they could have a “dress down day”. I asked if it meant they would be wearing their housecoats and slippers. I mean, how much more “dressed down” can they get? What used to meant by “business casual” now is “business norm” for most. If the agenda reads “business attire” I would think it means the men wear a suit and tie and the women wear a suit. However, these types of meetings are few and far between anymore. And I do not miss them.

**Dear P.A.M.:** Do you have suggestions on achieving harmony between Patient Accounts, Patient Access and Health Information Systems? - THREE IN WORLD WAR

**Dear WWII:** No problem. As soon as I get finished with world peace, I’ll get right back to you. Actually, the problem in your case is not much different than a war in the fact that you all are working towards different and conflicting goals. Your goals are usually handed down to you from Administration: register the patients as quickly as possible, code the charts deeply and get the bill out the door and the money in as quickly as possible. The wise administrator will develop a common goal for you all to work towards. It could be measured by dollars delayed because of incorrect or incomplete registration information, dollars not yet diagnosed, dollars not billed and dollars not collected. Perhaps days outstanding per department would work better for your facility instead of dollars but you get the idea. Now, see if you can make it your boss’s idea.

**Dear P.A.M.:** What suggestions do you have for a new manager when coming from a good busy biller to a Manager in the same office? – RISING FROM THE RANKS

**Dear Rising:** Run out and buy a suit of armor or develop thick skin fast. There will be those in the office that think you are now stuck up because of your position, some will believe that if they are your “best” friend they will get favors, some will be jealous and some will just sit back and wait to see if you stumble. However, the really great employees will be glad for you and help you. Understand that most of your time will be spent in meetings and your “normal” work will be done nights and weekends. In addition, you will now have responsibilities that never before entered your head such as budgets, hiring and firing. You must absolutely understand how to present problems and solutions to your CFO in his or her language which is in “percentage speak” and you must learn to love graphs and charts as much as the CFO does. Goals are a huge thing for success. What are your goals as far as your boss is concerned? What are your goals for yourself and for your department? What do your employees believe your goals should be? Then strive to exceed each of those goals, walk on a little water and success will be yours.

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# FIRST TIME ATTENDEES

## August 2005



First time AAHAM attendees were presented with a AAHAM portfolio at the August meeting in Peoria, IL. Attendees pictured above are from left to right Joe Schueler CGH Medical, Erin Carlson Carle Foundation, Mary Leslie OSF St. Joseph, Terry Roesch Gibson Area Hospital, Kay Taylor Healthware Systems, and Diann Winger Carle Foundation.



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# Editors' Corner



## 2004 National Journal Award

Trace Manning



August AAHAM Speakers

Day Equisquiza

Ray Swisher



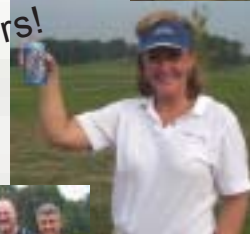
Grill Masters Steve & Betty grilled outstanding ribs for the AAHAM members and guest at the Texas Bar-B-Cue.



2005 Chuck Garvin Winning Group  
Jim Knepper, Adam Garvin, Gregg Winbrow, Steve Smith & John Rademacher



Cheers!



Golf Prizes were plentiful



2005 Chuck Garvin Golf Outing  
Lick Creek, Pekin, IL



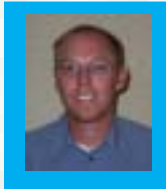
Steve Dennis, CPAM

CPAM  
CCAM  
CCAT  
CPAT

# CERTIFICATION CORNER

## Congratulations

### New Illinois AAHAM Professional Examinees



#### **Kenneth Koerner, CPAM**

IL AAHAM Board - Membership  
Director Patient Accounts  
CGH Medical Center  
Sterling, IL

*(Ken passed all 4 sections on his first attempt!)*



#### **Richard M. Wyrwal, CCAM**

IL AAHAM Chairman of the Board  
Allied Business Accounts, Inc.  
Vice President  
Clinton, IA 52732

In August 2005, there were examinee's sitting in Chicago, Gibson City & Springfield for the Technical exam. Early responses indicate there are at least 9 new CPAT's. Final results will be announced once notification is released by the National Office.

#### **DATES TO WATCH**

The CPAM/CCAM Professional Exam will be Saturday, October 8, 2005. Illinois AAHAM has one confirmed member sitting for the CPAM exam.

Technical exams will be given for the last time in 2005 during the last two weeks of November. Currently Illinois AAHAM has 37 applicants sitting or the CPAT Exam. Locations include Springfield, Chicago & Sterling Illinois.

#### **OTHER NEWS**

Members of AAHAM can go to the Members Only section of the national website and by looking under the "Toolkits" link, will find practice tests for CPAT/CCAT sections.

Illinois AAHAM is reviewing the possibility of adding additional Practice Tests for CPAT/CCAT. If you are interested in submitting practice Test Questions, please contact Steve Dennis, CPAM at [dennis.steve@mhsil.com](mailto:dennis.steve@mhsil.com)

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Family House was again the recipient of the AAHAM fund raiser held at the August Meeting in Peoria.

## **ANI Refunds** **Registration Fees**

We will be refunding the amount you paid the same way you paid it, i.e., credit card payments will receive a credit card credit, payments by checks will be receiving a refund check. Please be patient, we plan on having all refunds & credits out within 60 days.

## **ANI Refunds**

### **Exhibitor & Sponsor Fees**

We will be refunding the amount you paid the same way you paid it, i.e., credit card payments will receive a credit card credit, payments by checks will be receiving a refund check. Please be patient, we plan on having all refunds & credits out within 60 days.

**National**  
**Patient Accounts Week**  
**Oct 16 - 22**

## **Lincoln Log** **Deadlines** **for Articles**

**Winter 2005 - Nov 15**

**Spring 2006 - March 15**

**Summer 2006- May 15**

# 2005 / 2006

## MEETING SCHEDULE & SITES

**RESERVE THESE DATES FOR IL AAHAM**

*September 21-23*

*Annual National Institute  
New Orleans, LA.*

**CANCELLED**

*October 8*

*CPAM/CCAM exam*

*October 16-22*

*National Patient Account  
Management Week (PAM Week)*

*December 8 & 9*

*Annual ASI  
Crown Plaza, Springfield*

Jodi Edmonds, IDPA

Linda Schafer, National AAHAM President

Rick Hamilton, IHA

Robert Greer

Jeanne Scott

Awards Program and Banquet

*For more information contact: ILLINOIS CHAPTER - AAHAM*

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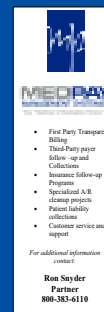
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<b>2 Certification</b> 1 CPAT 2 CCAT 3 CHAM (NAHAM) 4 CHFP (HFMA) 5 FHFMA (HFMA) 6 CHCS (ACA) 7 CPA 8 Other	<b>4 Position</b> 1 President/Administrator 2 Partner/Principal/Owner 3 CEO/Exec Dir/Exec VP 4 COO 5 CFO/Controller 6 CIO	<b>5 Responsibility</b> 1 Accounting 2 Administration 3 Admitting/Access 4 Audit 5 Benefits 6 Billing 7 Budget	8 Business Development/Sales 9 Compliance 10 Collections 11 Finance 12 Information Services/Technology 13 Managed Care 14 Marketing 15 Materials Management 16 Medical Records 17 Medicare/Medicaid 18 Operations 19 Patient Financial Services 20 Provider Services/Relations 21 Reimbursement 22 Third Party Administration 23 Utilization Review 24 Underwriting 25 All Other (not listed above)

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National Dues are \$150 for the year. Prorated dues amount for July 1 to September 30: \$115  
 For October 1 to December 31: \$185  
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Please allow 2 – 4 weeks for processing once your application is received at the AAHAM National Office.

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