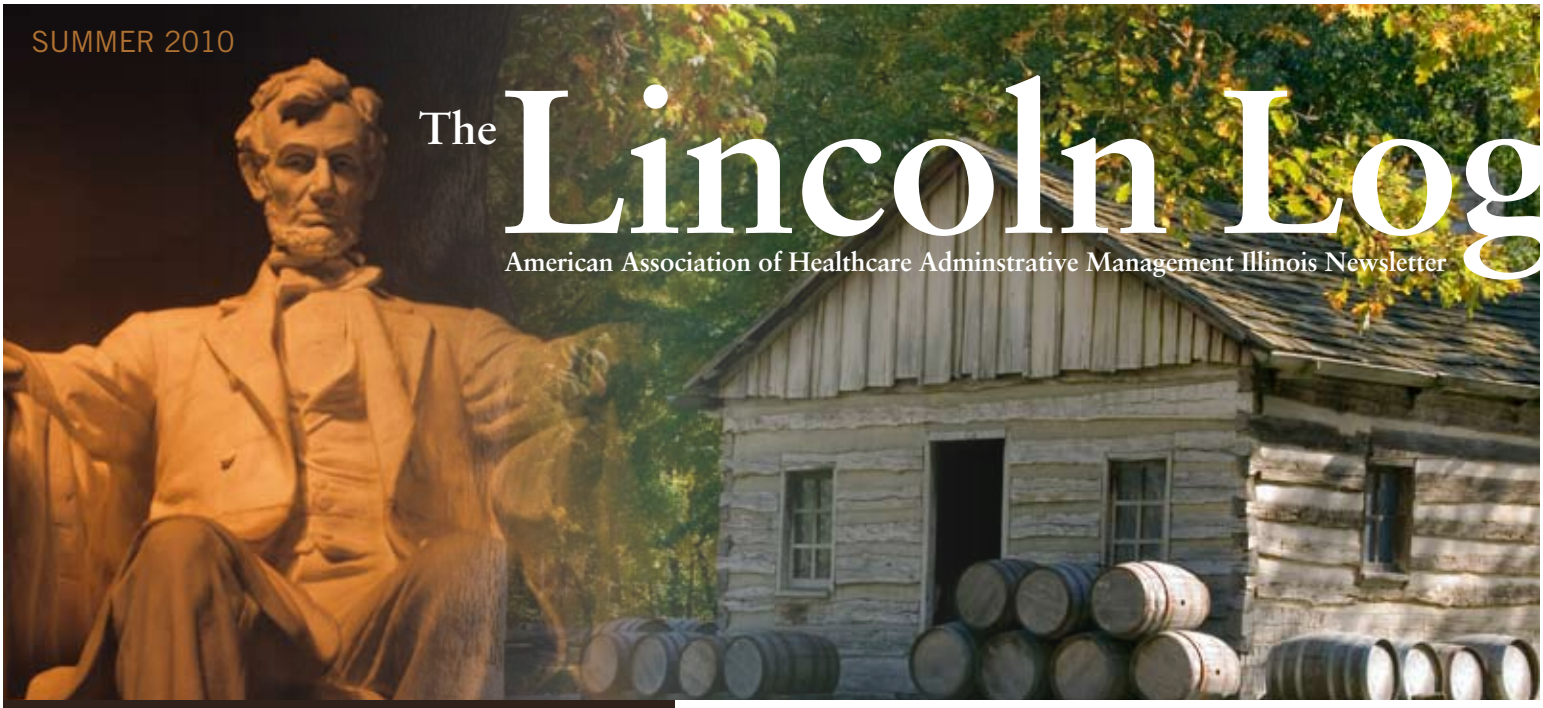
SUMMER 2010



The Lincoln Log

American Association of Healthcare Adminstrative Management Illinois Newsletter

FEATURED ARTICLES

DEPARTMENTS

AWARD WINNING EZINE

for the Illinois Chapter

1987 - 1990
2002 - 2009

LINCOLN LOG EDITORIAL POLICY & OBJECTIVES

The LINCOLN LOG magazine is published four times annually by the AAHAM ILLINOIS CHAPTER to update the membership regarding chapter and national activities as well as to provide information useful to health care administrative professionals. Opinions expressed in articles or features are those of the author(s) and do not necessarily reflect the views of the Illinois Chapter. AAHAM, the NATIONAL AAHAM organization or the editor. Reproduction and/or use of the format or content of this publication without the expressed permission of the author(s) or the editor is prohibited.

President's Message

President's Message – Lincoln Log Summer 2010

Wow! It's June already and my golf clubs have not yet seen the light of day. Unfortunately, that's not the only bad news on the horizon:

- BP still hasn't stopped the oil flow, at least as of June 1. Forget about buying fresh shrimp from the Gulf.
- Al & Tipper are splitting after 40 years of wedded bliss.
- Jack Bauer and "24" are never more…except for "24" The Movie.
- The FCC continues to attempt to make life more difficult for those companies and hospitals using autodialers to attempt to contact delinquent debtors. See ACA International for more details.
- The RAC attack continues.
- Self-pay revenue declines and insurance reimbursement on the increase…No Way!

Don't dispair fellow AAHAM'ers; there is good news in the Heartland –

- At the urging of Congress, the FTC has pushed back, once again, the Red Flag Rules enforcement date to December 31, 2010. Irrespective of the enforcement date, having policies and procedures in place to recognize and eliminate identity theft is a good thing.
- As of the May 6 report from National, your Illinois AAHAM Chapter has 171 members – our highest membership in many years. Congratulations!
- Julie & Tim have published their second Lincoln Log and are working better together than Al & Tipper. Great job!!
- Mark your calendars for September 16 & 17 in Bloomington for the Charles Garvin Golf Outing and Fall Education Meeting. No skill required, golf or otherwise. Just for fun.
- Make plans now to attend this year's ANI, October 13-15 at the Marriott Harbor Beach Resort in Fort Lauderdale. You can't catch the rays on the beach in Peoria in October.
- The best news is that Illinois AAHAM and your peer network of healthcare professionals have the answers and support you need to be successful every day. We're here for you.

Last but certainly not least, how about this comforting little gem (with thanks to Louise Johnson and Veronica Modricker for passing it along to me):

Mark Fowler, FCC Chairman "If somebody has a bad heart, they can plug this jack in at night as they go to bed and it will monitor their heart throughout the night. And the next morning, when they wake up dead, there'll be a record."

Have a great summer and I'll see you in Bloomington in September.

Bill Carlson
CPAM

EDITOR'S CORNER

Illinois AAHAM members are amazing. This is not news—there are charitable organizations throughout the state that know this to be true. There are members who have benefitted from the chapter's education who already know this is the fact. We have members who network consistently who value each other's expertise and willingness to help out their peers . We are a strong chapter filled with dynamic professionals.

Now, I have a new perspective as the co-editor of The Lincoln Log on the depth of your amazing abilities. I've joined a small group who knows that the entire chapter really gets credit for the creation of the newsletter. It is not just two people, it is not just a committee, nor is it the board that works alone in this project. I've had members send me emails for inclusion in a newsletter. No one has turned down an opportunity to author an article when I've asked. Members have offered their support as I've bounced off ideas regarding the newsletter. The Lincoln Log truly is the result of our amazing membership's efforts.

Tim and I look forward to your continued feedback, your submissions and your volunteerism. If you are new to the chapter and willing to be the topic of Spotlight on a New Member, please send your name to Julie at jvanpelt@hraccounts.com. If you read an article that makes you stop and think or you put it in the "Keep Forever" file of your personal library, please send it to us. If there's something that you would love to broadcast to the chapter, please share it.

This is your communication tool. Let it reflect the vibrancy of its membership.

Professional Certification Corner

Doris Dickey, IL AAHAM Professional Certification Chair

Professional Exams were held the week of April 26, 2010

The Illinois chapter had three IL AAHAM members sitting for the exam this period Thanks to my co-chairs for assisting in proctoring exams. John Currier and Carol Hoehn were gracious enough to open their own PFS office space to allow a testing site for individuals and I did one exam in Rochelle. Good luck to all examinees, hopefully results will be in from the national office soon.

If you have questions about the professional exam, need study tips or general information, contact me and I'll help anyway I can. ddickey@rcha.net or 815-561-1620.

CPAM/CCAM Study Guide

Our brand new, official AAHAM Professional CPAM/CCAM Exam Study Manual will be ready for you to order on the website in the next few weeks. Our manual has been written and designed specifically to help you study for the professional exams, we are very excited about it and know you will be too. There are other guides out there but remember, this is the only study guide written by AAHAM for AAHAM exams, specifically to assist you in studying for AAHAM's certification programs. The manual costs $279 for members and $399 for non-members.

Listed below are the current IL AAHAM members who are professionally certified:

Robert Anderson
Sandra Beimfohr
Randall Bounds
Betty Marschang
William Carlson
John Currier
Steven Dennis
Doris Dickey
Mary Farmer
Carol Hoehn
Kenny Koerner
Judith Lines
Joanne Schnabel
Sandra Kay Senesac
Pat Tucker
Rene Willey
Debra Wilson

MLN Matters® — Information for Medicare Fee-for-Service Health Care Professionals

News Flash – The April 2010 Edition of the Medicare Learning Network (MLN) Catalog of Products is now available and may be accessed at http://www.cms.gov/MLNproducts on the CMS website. The MLN Products Catalog is an interactive downloadable document that lists all Medicare Learning Network products by media format. The catalog has been revised to provide new customer-friendly links that are embedded within the document. All product titles and the word "download" when selected, will link you to the online version of the product. The word "hard copy" when selected, will automatically link you to the MLN Product Ordering page. To access the catalog, click on the link called MLN Product Catalog.

MLN Matters® Number: MM6960

Related Change Request (CR) #: 6960

Related CR Release Date: May 7, 2010

Effective Date: January 1, 2010

Related CR Transmittal #: R697OTN

Implementation Date: October 4, 2010

Systems Changes Necessary to Implement the Patient Protection and Affordable Care Act (PPACA) Section 6404 - Maximum Period for Submission of Medicare Claims Reduced to Not More Than 12 Months

Provider Types Affected

This issue impacts all physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, durable medical equipment Medicare administrative contractors (DME MACs), fiscal intermediaries (FIs), Part A/B Medicare administrative contractors (A/B MACs), and/or regional home health intermediaries (RHHIs)) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is updating edit criteria related to the timely filing limits for submitting claims for Medicare Fee-for-Service (FFS) reimbursement. As a result of the PPACA, claims with dates of service on or after January 1, 2010 received later than one calendar year beyond the date of service will be denied by Medicare. Further details follow in this article. Make sure your billing staff is aware of these changes.

Background

Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act as well as the Code of Federal Regulations (CFR), 42 CFR Section 424.44 specify the timely filing limits for submitting claims for Medicare Fee-For-Service (FFS) reimbursement. Prior to PPACA, the regulations stated the service provider or supplier must submit claims for services furnished during the first nine (9) months of the calendar year on or before December 31st of the following calendar year. For services rendered during the last quarter of the calendar year, the provider or supplier must submit the claim on or before December 31st of the second following year.

Section 6404 of PPACA amended the timely filing requirements to reduce the maximum time period for submission of all Medicare FFS claims to one calendar year after the date of service. Additionally, this section mandates that all claims for services furnished prior to January 1, 2010 must be filed with the appropriate Medicare claims processing contractor no later than December 31, 2010.

What You Need to Know

Medicare contractors are adjusting (as necessary) their relevant system edits to ensure that:

- Claims with dates of service prior to October 1, 2009 will be subject to pre-PPACA timely filing rules and associated edits;
- Claims with dates of service October 1, 2009 through December 31, 2009 received after December 31, 2010 will be denied as being past the timely filing deadline and;
- Claims with dates of service January 1, 2010 and later received more than 1 calendar year beyond the date of service will be denied as being past the timely filing deadline.

NOTE: For claims for services that require the reporting of a line item date of service, the line item date is used to determine the date of service. For other claims, the claim statement's "From" date is used to determine the date of service.

Section 6404 of PPACA gives CMS the authority to specify exceptions to the one (1) calendar year time limit for filing claims. Currently, there is one exception found in the timely filing regulations at 42 CFR section 424.44(b)(1), for "error or misrepresentation" of an employee, Medicare contractor, or agent of the Department that was performing Medicare functions and acting within the scope of its authority. If CMS adds additional exceptions or modifies the existing exception

to the timely filing regulations, specific instructions will be issued at a later date explaining those changes.

Additional Information

If you have questions, please contact your Medicare FI, Carrier, DME MAC, A/B MAC and/or RHHI at their toll-free number which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

The official instruction (CR6960) issued to your Medicare FI, Carrier, DME MAC, A/B MAC and/or RHHI is available at *http://www.cms.gov/Transmittals/downloads/R697OTN.pdf* on the CMS website.

Don't Let Your Practice Bury Its Head in the Sand

Without proper ICD-10 implementaion, revenue comes to a grinding halt.

By Deborah Grider,
CPC, CPC-I, CPC-H, CPC-P, CPMA, CEMC, COBGC, CPDC, CCS-P

We are seeing very little movement by physicians and physician's groups in the industry regarding ICD-10-CM preparation. Health plans and government payers are working on their implementation plan and hospitals are beginning the process, but physician and physician groups of varying sizes continue to wait. It is somewhat understandable in many respects. With the current state of health care reform, it's unknown how this will affect them. President Obama's Stimulus Plan, which includes incentives for physicians to move to electronic health records (EHRs), makes ICD-10 seem like just another mind boggling and overwhelming task in health care.

One thing is for sure, the message from the U.S. Department of Health and Human Services (HHS) is clear. The final rule, published more than 16 months ago, and ICD-10 are a reality. Get moving and begin the implementation process, as there will be NO delay.

Reluctance Brings Financial Ruin

To put the impact of delaying into perspective, here is a scenario that can happen if the necessary steps aren't taken to implement ICD-10:

It's Dec. 1, 2013 and Sarah Reid's practice has not received payment from any of her payers since ICD-10 implementation occurred on Oct. 1. Because Sarah's medical group did not take the time to properly implement ICD-10, many payers now ask for documentation and every claim submitted is either suspended or denied. Sarah's medical group relied on their vendor for software and did nothing else. The vendor mailed Sarah the software but never tested it end-to-end, so now many of the claims are bouncing all over the place.

An impact analysis wasn't done and hardware wasn't upgraded, so now Sarah's practice management system is so slow it takes 10 minutes to pull up a patient in the system. The insurance carrier policies weren't reviewed, and the staff wasn't trained. For the past two months everyone has been guessing in regards to the codes. Ironically, every code the doctors select are unspecified codes. For claims the payers did receive, countless requests for documentation are piling up on Sarah's desk. Why? The use of the unspecified codes triggered a pattern of misuse and overutilization, which is one of the reasons for migration to ICD-10—detail and specificity. The entire office is a mess. The practice is now financially strapped and the physicians have told the staff they might have to close.

Don't let this to happen to your practice. Without payment from your payers, the financial health of your practice is at risk. How long will you or your medical practice survive without revenue?

Have a Firm Process in Place

I can't reiterate this enough: ICD-10 implementation is not just a software update or a software fix. Systems and processes need to be in place and functional. This will take a few years to accomplish, and YES this will be expensive, for which we must budget carefully. Otherwise, your practice just might end up like Sarah's—financially devastated and a real mess!

Help is Here

AAPC has developed a couple of really valuable ICD-10 tools available at www.aapc.com/ICD-10/, which are at no cost, and very few people are using them:

Benchmark Tracker, as shown in **Figure A**, is a guide to help you with implementation. It lists the steps necessary for implementation based on your practice size and/or health plan.

ICD-10 Code Translator, as shown in **Figure B**, is a simple electronic version of the General Equivalency Mapping (GEM) files from the Centers for Medicare & Medicaid Services (CMS). You can enter an ICD-9-CM code and it will list all the possible ICD-10-CM codes. You also can enter an ICD-10-CM code and it will map backwards to ICD-9-CM. This is helpful for implementation, especially if you continue to use a superbill to see code choices in ICD-10. Payers can use these files to map their systems and policies, as well.

These tools were developed to assist AAPC members and their providers with successful implementation.

Educate Now for the Future

Attend an ICD-10 Implementation Bootcamp, offered by AAPC. The first day of the boot camp focuses on coding to help you get the documentation in your office up to speed and the second day focuses on implementation.

Take the ICD-10 Implementation distance learning course and webinar. Distance learning does the same as bootcamp, only in the comforts of your personal computer. Either method is a good first start in getting your practice ready for the future.

Don't let what happened to Sarah's practice happen to you. Get up from your desk and have a good heart-to-heart with your doctors now, and bring ammunition with you when you go. Don't forget to show them the final rule, articles on ICD-10, and share with them what the impact could be if they decide to bury their heads in the sand. So get going!

Deborah Grider, CPC, CPC-H, CPC-I, CPC-P, CPMA, CEMC, COBGC, CPC-D, CCS-P, is the AAPC's vice president of strategic development and the former AAPC National Advisory Board president. Deborah is the author of *ICD-10-CM Implementation Guide, Make the Transition Manageable*, American Medical Association Press, 2009.

ILLINOIS CHAPTER

2009 - 2010 Corporate Partners

The Illinois AAHAM Chapter would like to thank our Corporate Partners for their continued support and dedication to the Chapter. Their partnership and generous financial support enable us to provide quality educational and networking opportunities throughout the year.

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Danielle Miller – dani@rmacollections.com

The CBE Group, Inc.
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Lindy Winterscheidt – lkwinterscheidt@cbegroup.com

State Collection Service, Inc.
www.statecollectionservice.com
Brad Taylor – bradt@stcol.com

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Healthcare Financial Resources, Inc.
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UCB, Inc.	Doug Headman – daheadman@ucbinc.com

For additional information regarding the Illinois AAHAM Corporate Partners program please contact Cheri Lockhart, 1st Vice President at clockhart@essex1.com

CHARLES GARVIN MEMORIAL GOLF OUTING

September 16, 2010
Weibring Golf Club
at Illinois State University
800 West Gregory Street
D. A. Weibring Drive
Normal, Illinois 61790
309-438-8065
Tee off Time: NOON
Cost: $50.00

To reserve your tee time and/or 4-some, please contact:

Al Staidl
alanstaidl@yahoo.com
630-724-1197

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Resolution Manager

A true resolution workflow tool with full transparency - not simply worklisting - comes completely pre-integrated with eCare® CMS. Automatically identify the NEXT most important account to work, reduce denials by a proven 30% and increase net revenue 3-5%.

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Automate the task of manually posting information back into your host system. Our posting technology is fully customizable with your business rules and uses keystroke emulation scripting, or file normalization logic to save time and improve data accuracy.

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Avoid technical denials and preserve your appeal rights on every claim overpayment identified by a RAC audit with our internal claims monitoring system. Our audit control center allows providers to define the facility type, audit types and reporting period for submission to AHA's RACTrac.

Claims Consulting & Outsourcing

Our claims professionals provide the resources and expertise to improve claims submission and follow-up, significantly increasing reimbursements. Outsourcing projects can be very focused and short-term or more comprehensive and long-term determined entirely by your needs.

PAC NEWS

Fear of not being reelected has seemingly paralyzed the Illinois General Assembly. They appear to be unwilling to do almost anything. As a result there is little to write about.

At some point government is going to go to work again and since it is such a big budget item, healthcare will surely be a big focus. So, in the mean time we must be informed and ready to act.

To that end, we have been working with other groups that share the concerns of Illinois AAHAM. Hopefully, many of us took time to post a comment to the FCC regarding the proposed rules for contacting cell phones with automatic dialing equipment. The first alert about this came from the American Collectors Association government action committee. Illinois AAHAM forwarded the alert and the national AAHAM legislative action committee also placed the alert on its listserve.

Howard Peters and Sandy Kraiss of the Illinois Hospital Association asked that we share this link with the Illinois AAHAM membership. It highlights issues for advocacy on hospital issues. The link is Protect Illinois Healthcare, which can found by just entering it on your browser. There is an email list that we can access to receive direct updates.

Sandy will be sending more "inside and technical alerts" directly to us. We should visit the Illinois Hospital Association web site to access information on legislative issues. We need to be informed and ready to help.

Rena Willey has been forwarding alerts important to Critical Access Hospitals. All of us need to join together to support healthcare. What is bad for any of us will be bad for all of us eventually.

Lastly, while the PAC has needed to spend very little to this point, that could change in a heartbeat. Please consider sending a contribution to the Illinois AAHAM PAC today. Send it to our treasurer, Veronica Modricker. That way when we need to activate, we will be ready.

John McGlasson
2nd Vice President and Legislative Action Chair

Cost Containment - Doing My Part: "Paying for My Care"

Submitted By:
Shawn Steffen, Iowa HFMA Treasurer
Mercy Hospital Cedar Rapids, IA

I wrote the following article for my Hospital's newsletter. The goal was to help educate our employees on why it is important to help us in this endeavor.

How many of us have been asked to pay our co-pay at the physician office? Or pay for our prescription medicine at Target, Wal-Mart, or Walgreen's?

Why did these providers of care switch to collecting at the time of service? They did so to reduce their administrative burden on collections. Sending out statements, making phone calls, going to court, etc., are very expensive options to collecting for a service that has been provided.

On average, many patients will receive a minimum of three statements and one phone call to resolve payment on their account. If an average statement costs $1.25 between printing and postage and an average phone call conversation will cost $5.00 to $10.00 to discuss and resolve, we are looking at an additional expense of $8.75 to $13.75. If we can save this for every account we work by collecting the funds at the time of service, how much better off will we be at the end of the year?

Answer: We see on average 320,415 outpatient patients a year. Let's assume half of these patients have some form of co-payment or deductible due at the time of service. Using the above statistics, we could potentially save over $1 million per year on paper, postage and labor costs.

Have you ever heard one of these comments from a patient or used one yourself?

"I've never had to pay for this upfront before.I thought my insurance paid for everything! I did not bring my checkbook. I don't have the money with me. Doesn't my insurance pay for my bills? I am turning this into my flex account and won't pay until then! I don't have any money with me. I was not expecting to have to make a payment today. I cannot pay today, I do not have my wallet/purse with me. I am an employee and should not have to pay for this today."

All are common responses. Yet how many of us travel without our purse or wallet? How many of us do not have some form of payment in our belongings (check, cash or credit card, or our employees' ability to payroll deduct)? How many of us would expect to receive goods or service from any other entity and not expect to pay for it at the time of service? Flex accounts are a choice of individuals to maintain. The delay it takes to reimburse oneself from these accounts is the responsibility of the patient and not the provider. Yet many individuals do not see anything wrong to not pay and wait to be reimbursed from their own personal account. None of us, personally, would expect to not be paid for our services on a timely basis.

As part of Mercy's overall efforts to control costs, we are now collecting from the following areas at the time of service: Emergency Department, Physical Therapy, Radiology, Joslin Diabetes Center, Sedlacek and Fit for Life. How do we know what an individual will owe? Depending on the service, insurance plans will have set copayment or coinsurance amounts that an individual will owe. For other services, we have to confirm an individual's benefits and then calculate the benefit amount. These are all estimates based on the information shared by that individual's insurance company.

What can YOU do? Help us in our endeavor to become great financial stewards for (Place your Facility Name Here).

When you seek care, pay for your service at the time you receive care. There are many forms of payment that can be made: cash, check, credit card or payroll deduct. Additionally, for the departments we are already working with to provide upfront cash collections, encourage your patients to stop and pay for their service today. Let them know we greatly appreciate their support and effort to help us reduce healthcare costs.

If you have questions or comments, please do not hesitate to let me know.

2010 Meeting Dates & Sites

Save These Dates for Illinois AAHAM

September 16, 2010
Charles Garvin Memorial Golf Outing
Bloomington, IL

September 17, 2010
Education Meeting
Bloomington, IL

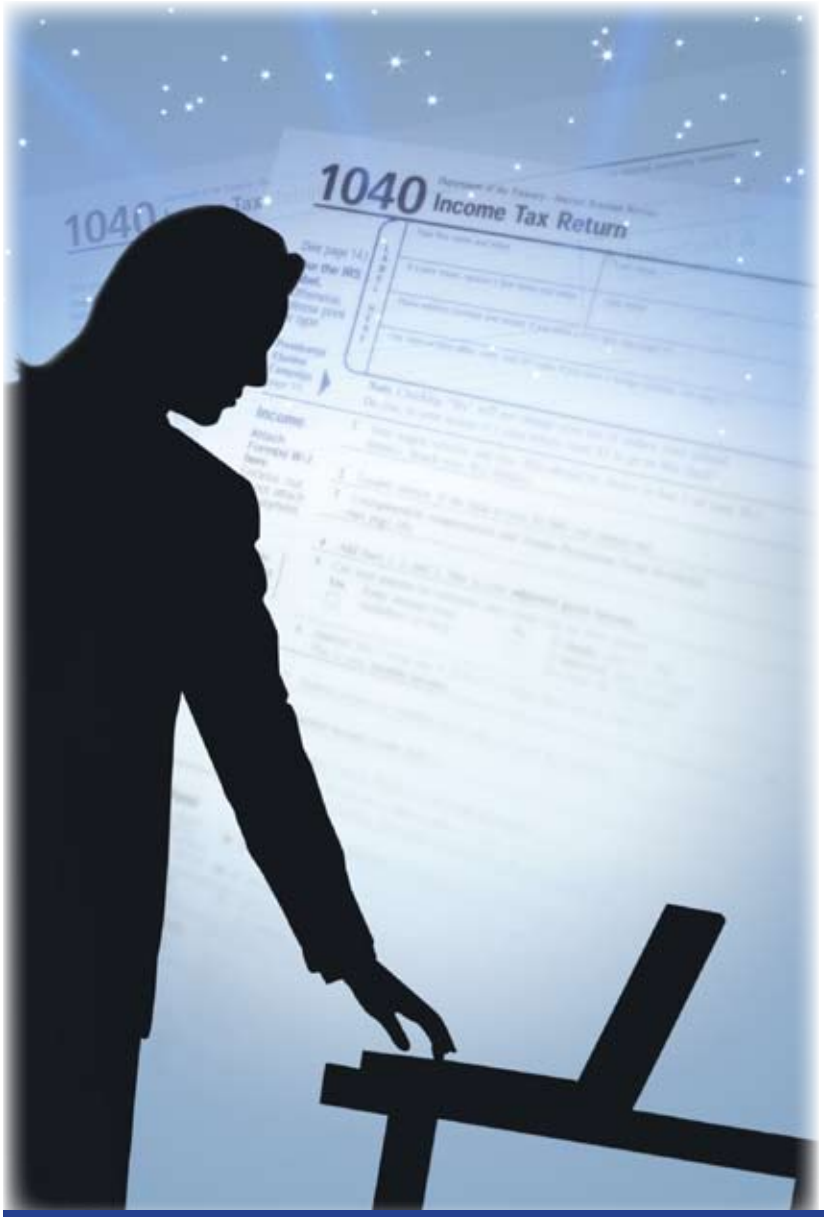
December 2-3, 2010
Annual State Institute
Bloomington, IL

Can Healthcare Reform Impact Your Tax-Exempt Status?

Public Law 111-148, Patient Protection and Affordable Care Act (PPACA) will establish compliance requirements relating to billing practices and financial assistance that must be satisfied in order for a hospital to retain its tax-exempt status. In addition to provisions calling for periodic assessments of community health needs, hospital executives also need to be concerned about the detailed operational processes and procedures for patient billing that will be required to be implemented on the front lines. This article addresses the implications for hospitals of the patient billing requirements of PPACA.

Section 9007 of PPACA establishes a new Internal Revenue Code section 501(r) which imposes the following new operational requirements on the billing practices of tax-exempt hospitals:

- Development, implementation and communication of a Financial Assistance Policy
- Limitations on charges for services
- Billing and collection requirements related to patients



Hospitals will need to comply with these requirements by the start of their next fiscal year after March 23, 2010. This may create some challenges, since regulations governing this legislation have not yet been developed by the Secretary of Treasury and may not be finalized prior to the required implementation date.

Here are the specific requirements that will need to be met:

Financial Assistance Policy that must include:

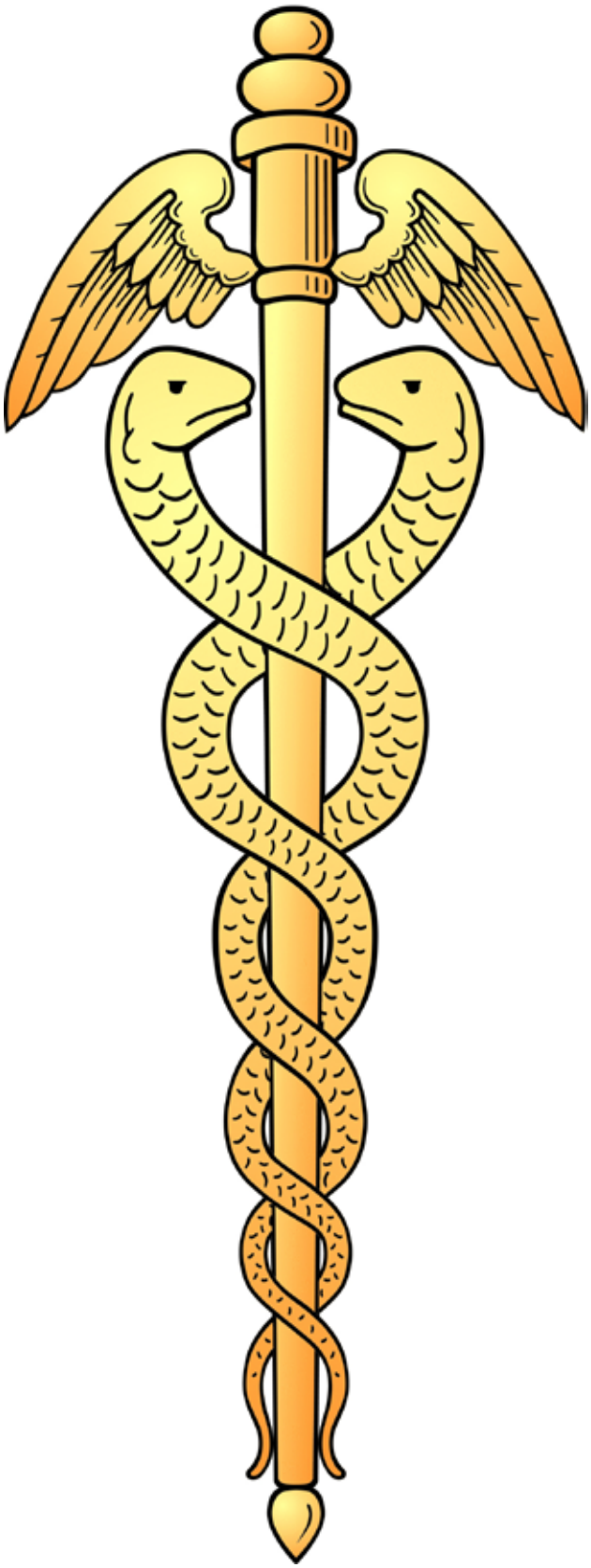
- Eligibility criteria to qualify for assistance
- The basis for calculating amounts to charge patients
- The method for applying for financial assistance
- Measures established to widely publicize the policy within the hospital's service area

Limitations on Charges:

- Cap on amounts charged for emergency or medically necessary care to patients eligible for financial assistance to no more than the amounts generally billed to individuals with insurance coverage
- Prohibition on the use of gross charges, regardless of a patient's eligibility for financial assistance

Billings and Collection Requirements:

- Prohibition against extraordinary collection efforts until reasonable efforts have been made to determine if a patient is eligible for financial assistance



The legislation constitutes an amendment to the Internal Revenue Code and will be administered by the Department of Treasury. Reviews are required to be conducted not less frequently than once every third year.

The Secretary of Treasury is authorized to issue regulations and guidance as may be necessary to carry out the provisions of the legislation. The Secretary is specifically directed to provide guidance as to what constitutes "reasonable efforts" for a hospital in determining the eligibility of a patient under a financial assistance policy. The timing of any such regulations and guidance, however, remains uncertain. Typically the Secretary of Treasury issues regulations in preliminary form, followed by a comment period in which interested parties have an opportunity to provide written submissions raising issues, concerns or questions about the proposed language, after which final regulations are promulgated. This process can sometimes take many years. Nonetheless Congress specified that new code section 501(r) applies starting with a hospital's next fiscal year following the enactment date, regardless of whether definitive regulations and guidance have been issued by such date.

What does new IRC Section 501(r) mean to hospitals?

Hospitals must meet the requirements of new IRC Section 501(r) in order to maintain 501(c)(3) tax-exempt status. While many hospitals may already operate in a manner largely consistent with the intent of this new legislation, it is critical that the detailed operational aspects of the legislation as well as the related regulations are met. Compliance will be ruled on very specific criteria that differ from previous tax-exemption criteria and state chartered charity designations.

Financial Assistance Policies. Financial Assistance Policies will need to be reviewed and revised as appropriate to include specific criteria for eligibility as well as how amounts will be calculated and the method for a patient to apply for financial assistance. Hospitals will also need to specify, either in the Financial Assistance Policy or in a separate billing and collections policy, the actions they may take in the event of non-payment, including collections action and reporting to credit agencies. The method for communication will also be more extensive than what was customary in the past for many hospitals, in order to satisfy the requirement to "widely publicize" the Financial Assistance Policy within the community.

Limitations on Charges. Gross Charges. Any hospital whose current practice is to impose "gross charges" for services rendered to patients who are not otherwise entitled to a contractual allowance with an insurance company or other third-party payer will need to adopt a new pricing approach in order to take into consideration the blanket prohibition on that practice. Since the legislation is silent as to the amount of allowance necessary to satisfy the new requirement, it will be important to monitor guidance from the Secretary of Treasury

regarding acceptable levels. Irrespective of whether any such guidance is provided, hospitals must eliminate "gross charges" before the start of their next fiscal year.

Patients Eligible for Financial Assistance. A second limitation relates to amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the hospital's Financial Assistance Policy. In these cases, the hospital may charge only "amounts generally billed to individuals with insurance coverage." The determination of "amounts generally billed" is not further clarified in the legislation. Presumably a charge for any given medical procedure that reflects roughly the mid-point of the range of prices agreed to between a hospital and the insurance companies with whom it has contractual arrangements would satisfy this test. Whether amounts that are higher than the mid-point but still reasonably within the range of contractual pricing would also satisfy the test remains unclear. The Secretary of Treasury may (but is not required to) provide further guidance on this calculation.

In order to comply with this additional rule affecting eligible patients, a hospital must either (1) unilaterally adjust all patient bills receiving emergency or medically necessary care to reflect amounts which satisfy the "generally billed" test, regardless of financial need, or (2) affirmatively determine patient eligibility for financial assistance and adjust the bills only of those patients. If the latter, an open question remains as to the actual mechanism for making the adjustments. For example, must a hospital contact all patients prior to the sending out any statements in order to ensure that no eligible patient receives a bill showing more than the "generally billed" amount? Or is it sufficient to include a blanket disclaimer in all patient statements advising them of their right to a further discount if they meet eligibility requirements for financial assistance, and to then make adjustments only on those statements where eligibility has been determined by subsequent communications initiated by the patient? While the latter interpretation might seem reasonable, the legislation is not clear on this point. Again, the Secretary of Treasury may (but is not required to) provide further such guidance.

Extraordinary Collection Efforts. A hospital must make "reasonable efforts" to determine whether a patient is eligible for financial assistance before it engages in "extraordinary collection actions." Once again the language of the statute alone leaves room for interpretation, although the Secretary of Treasury is specifically mandated to define the phrase "reasonable efforts." "Extraordinary collection efforts" almost certainly is intended to preclude lawsuits, arrests, liens, or similar actions prior to satisfaction of the "reasonable efforts" standard, but it may well encompass other collection practices as well, such as reporting to consumer credit agencies, threats of legal action or credit reporting, or referring delinquent accounts to an outside collection agency. What is clear is that traditional billing and collection protocols that place the burden on the patient to request or avail themselves of financial assistance will no longer be allowed. Simply sending a patient a series of statements and thereafter commencing aggressive collection efforts is likely to violate the statute. Instead hospitals will need to demonstrate that they have tried in good faith to make a determination of financial assistance eligibility prior to resorting to extraordinary collection efforts. Satisfactory documentation of these efforts will also be well-advised, if not required.

What steps do hospitals need to take?

1. Review current policies for financial assistance, billing and collection and make necessary revisions to comply with the new regulations.
2. Establish Financial Assistance Policy communication protocols for wide publication.
3. If gross charges are currently used, establish a discount policy applicable to patients without insurance or other third-party coverage.
4. Determine what amounts will be charged to patients qualifying for financial assistance.
5. Establish protocols and procedures for screening patients for eligibility for financial assistance, including a documented process meeting the "reasonable efforts" test.
6. Review staffing levels and quality metrics in patient billing area, adding internal or external resources as necessary to ensure compliance.

For further information regarding the billing and collection implications of new IRC Section 501(r) for your institution, please contact Stephen M. Chrapla (phone number: 847-395-7655. E-mail: schrapla@revenuecyclepartners.com).

About Revenue Cycle Partners

Revenue Cycle Partners LLC (www.revenuecyclepartners.com) provides a comprehensive suite of account resolution management services to hospital clients throughout the United States, focusing particularly on non-delinquent patient accounts and third-party follow-up.

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Local Chapter (see page 6, left, for name and fees) _____

Membership Type: (See back for details & dues) o National Member o Student Member

How did you hear about AAHAM? o Colleague o Publication o Website

o Other (Please list) _____

If referred by AAHAM Member, Give Name: _____

Please allow 2 weeks for processing once your application is received at the AAHAM National office.

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National Membership - The fee to become a National member is $175. If you join anytime between July 1st and August 31st, the dues are $140 for the rest of the current year. If you join between September 1st and December 31st, the fee is $210 for the rest of the current year and all of the following year.

Please note, membership is on an individual, not institutional basis, and is non-transferable.

Student Membership - The student membership fee is $50. If you join between July 1st and August 31st, the pro-rated dues are $35, and if you join between September 1st and December 31st, dues are $65 (for 15 months of membership). To qualify for student membership you must currently be taking 6 credit hours per semester. Student members receive all the benefits of membership with the exception of voting, eligibility for professional certification, and cannot be a proxy for a chapter president at any national board meetings.

Please Check the Appropriate Codes in Each Category Below.

Years in Healthcare:

o 0-5
o 6-10
o 11-20
o 21-25
o 25+

Certification:

o CPAM/CCAM
o CPAT/CCAT
o CHAM (NAHAM)
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o FHFMA (HFMA)
o CHCS (ACA)
o Other (please list)

_____

_____

Employer Type:

o Vendor/Corporate Partner
  o Billing
  o Collection Agency
  o Consulting
  o Outsourcing
  o Software/IT
o Provider
o Law Firm
o Other (please list)

_____

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Position:

o President, Administrator, Executive
o Director, CEO
o Partner, Principal, Owner o CFO/Controller, COO, CIO o Vice President
o Assistant VP/Assistant Administrator
o Director, Manager, Supervisor
o Technician
o Clinical
o Academic
o Other (please list)

_____

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Responsibility:

o Accounting
o Administration/Operations
o Admitting/Access
o Audit
o Benefits
o Budget
o Business Development, Sales, Marketing
o Compliance
o Information Services/Technology
o Managed Care
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o Medicare/Medicaid
o PFS, Patient Billing & Collections
o Reimbursement
o Third Party Administration
o Other (please list)

_____

_____

AAHAM
American Association of Healthcare Administrative Management

Local Chapters

AAHAM has 37 chapters throughout the US and India. Local chapters offer you more opportunities for education and networking. Please see the listing of local chapters below to help you decide which chapter you should belong to along with your National membership:

Name of Chapter	Geographic Location	Chapter Dues
Aksarben #01	Nebraska	**$0.00**
Greater Florida Buccaneer #03	Tampa/Orlando, Florida area	**$40.00**
Carolina #04	North & South Carolina	**$30.00**
Evergreen #05	Washington State, West of the Mountains	**$30.00**
Gopher #06	Minnesota	**$35.00**
Hawkeye #07	Iowa	**$0.00**
Hawthorn #08	Missouri	**$35.00**
Illinois #09	Illinois	**$25.00**
Inland Empire #10	Washington State, East of the Mountains	**$25.00**
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Philadelphia #29	Philadelphia, Pennsylvania	**$35.00**
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Tennessee #32	Tennessee	**$30.00**
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Texas Blue Bonnet #40	Texas	**$50.00**
Indiana #42	Indiana	**$25.00**
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Chennai #49	Chennai, India	**$0.00**
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