

The Lincoln Log

American Association of Healthcare Administrative Management Illinois Newsletter



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Award!!





The Illinois AAHAM Board of Directors would like to thank each one of you for your membership, support and participation!!

We look forward to another year of Awesome education and networking opportunities!

Doris, Kenny, Chris, Josh, Nancy, Tera, Julie, Maria, Rena, Bob, Dave, Donna and CJ



Inside this edition...

President's Message

Do It Well, Make It Fun—Ron Culberson

AHA Member Advisory

Legislative Day

Newly Certified Members

ASI 2013 Highlights

IHA Memorandum

AAHAM's Ask and Answer

Jodie Edmonds, HFS Bulletins

2014 Calendar of IL AAHAM Events

IL AAHAM Leadership

IL AAHAM Corporate Partners

IL AAHAM

Lincoln Log

Editor



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IL AAHAM 2nd Vice-President

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PRESIDENT'S

Message



*Kenny Koerner, CRCE
IL Chapter President*

A group of your Illinois AAHAM members attended Washington DC in April to participate with other AAHAM members from across the country in some grass roots lobbying on a couple of issues that are affecting our healthcare organizations. I have attended this the past 2 years and have really enjoyed learning about how our political process for this great country of ours works in practice. This year we had John Currier, Doris Dickey, CJ Tonozzi, Bill Carlson and myself representing Illinois in the National Legislative Day. When I am in Washington DC each year for this event, I am always reminded of the tremendous amount of service and sacrifice that has been given by those that walked before us. The monuments and the buildings take someone like me who just loves history back to the days of our forefathers and makes me think about the individuals that stepped up to lead in times of uncertainty.

This year, I was fortunate enough to get some great advice from my good friend Luke Gruber, who is currently the Iowa AAHAM chapter president. (For those of you that know Luke, I'm sure you just said out loud to yourself, Good Advice from Luke?) Luke said that a must see on the trip was the Library of Congress. I had been by the Library of Congress many times, but had never gone in for the tour. So a small group of us decided to take some time to take the tour at the Library of Congress one morning. The building was absolutely amazing architecturally. The detail to craftsmanship really stood out in addition to the feeling of amazement when you think of all the great historical figures that had been in the same building that you were standing in. While in the Library of Congress, we went to an exhibit area on the early maps of America. I love history, and I was fascinated with how some of the early map makers not only saw the World, but saw America. We were able to view maps that were produced at the initial onset of the colonies, prior to the time that the entire North American region of what is now known as the United States had been claimed by our settlers. These individuals that were able to visualize what would become the United States based upon stories and tales from others in order to come up with what they envisioned the land to the west of the Mississippi River to look like, were amazingly accurate in their depiction of the country and of the states and their boundaries.

I could go on and on about the experiences not only there, but throughout the trip to DC...but one thing that really stood out to me upon my return was the maps, and the early map makers drawing these maps based upon very little information and much uncertainty as to what the country really looked like...on the airplane ride home, I thought more about my time spent in the Library of Congress and began to think.....Isn't this similar to where we are with the revenue cycle in so many ways? We are entering uncharted territory with so much uncertainty and stories and tales about what our new world will look like in healthcare. Change is the only constant and our ability to visualize where everything will be at the end and to take that end game and to put together a plan and a map for our staff to follow will help us to step up, to lead, and to be successful in these times of uncertainty.

I hope each of you is enjoying the warmth that we've finally been blessed with! Here's to a great Summer for each of you and your families, can't wait to see you all at the Charles Garvin Memorial golf tourney this August!!!

Kenny Koerner MBA, CRCE



Do it Make it Fun® Well

Nice Shot! Golf and the Deepening of Relationships

At the risk of using yet another sports analogy for life, leadership, or teamwork, I'm going to use yet another sports analogy to discuss relationships. But luckily, I'm using the universally overused analogy of golf. The reason is that I just returned from a golf trip and there is nothing better than a recent life experience to spark an idea for a blog.

I'm not a great golfer since I only play about eight times a year. But I keep playing because I want to be able to participate in a sport when I'm 80 - and golf seems to be the most likely option. Especially since it's so hard to find a curling sheet (look it up) in central Virginia.



The destination of our recent trip was Ocean City, MD and my golf game was as bad as the weather was good. I've been going on this particular golf trip, give or take a few years, since 1996 when I accompanied two friends to Kiawah, SC on a coupon we received in the mail. After returning to Kiawah for a few years, we added a fourth person who was also the pastor of our church and a scratch golfer when he was in high school. He felt, as pastors often do, that this type of activity was an opportunity for other men in the church to enjoy fellowship while doing something fun. So the annual church golf trip was born.

A trip like this can be a wonderful relationship-building experience for men because we're not accustomed to inviting other men to dinner, for a walk, or to join us on a trip to the restroom. We will, however, invite other men to play golf, attend a baseball game, or paint a garage. So, it seems that we men tend to build relationships as a secondary component of an activity while women tend to build relationships first and the other activity becomes secondary.

As I pondered the value of my most recent trip, I was unable to prevent my brain from making the obligatory comparison between the golf terms we used and the relationship-building process. Don't worry, though. You don't have to know golf, or even like golf, to understand the comparison. But it's a lot more fun for me to write it this way!

Traps or Bunkers. In golf, you're supposed to get a little ball into a hole, that's located anywhere from 100 to 600 yards away from the tee, using only 3-5 shots. It's amazing that it's even possible. As an aside, it isn't typically possible for me, but that's a topic for the what-we-learn-from-failure blog. But here's the kicker about golf - the course has obstacles in the way of your shots. There are trees, sand traps (or bunkers), tall grass, ponds, creeks, and hills. You not only have to hit the ball well, you have to maneuver around all this crap. And interestingly, that's the way life works. We have to maneuver around obstacles like challenges at work, complicated relationships, health problems, and death. In golf, it's much more fun to encounter the bunkers on the fairway when someone is there with you. In life, it's the same way. Our relationships don't make the barriers disappear but they make them more bearable.

Reading the Putt. If you're lucky enough to land your ball on the green, it's a good thing. But, the challenge of getting the ball in the hole is still not over because the green is not level. From up high, a green may look perfectly flat but when you get down on the ground, you will see that there are bumps, mounds, and hills to deal with. So, in golf, it's important to "read" the green before attempting a putt. Relationships are like that. We must read other people before we respond to them. A colleague may express frustration about the traffic coming into work but underneath, he may really be upset because of a marital problem or the death of a loved one. We must read the signs between and behind the words to truly understand others thus strengthening the relationship.

Muscle Memory. This is one of the coolest aspects of golf. It's like riding a bike. Even if I haven't played golf for a year, my body still remembers how to hit the ball. Now, muscle memory is great when your swing is correct but it's debilitating when your swing is bad because you will continue to do the wrong things automatically. It takes a long time to teach your body to move differently. Relationships are similar. We can easily get into bad habits in the way we treat other people. Often these habits were developed during our own upbringing but when they start to interfere with our relationships, we need to get a "swing adjustment" to change our muscle memory. By learning new ways of interacting, we can improve our relationships.

Nice Shot. The sweetest two words any golfer can hear is, "nice shot." It means that we put all of the components together and hit the ball well. It also means that someone else noticed and took the time to let us know. That's the best part of relationships as well. When we get supportive feedback from those around us, it builds our self esteem and helps us to tackle the next bunker in our life. And we must remember to offer a "nice shot" to others too as part of the mutuality of the relationship.

Maybe golf is not your bag (See how I did that? Golf...bag.) but I hope it won't prevent you from seeing the real message in this blog - the importance of having and maintaining relationships. Because just like my recent golf trip, it wasn't really about the golf.

Ron Culberson, MSW, CSP is a speaker, humorist, and author of "Do it Well. Make it Fun. The Key to Success in Life, Death, and Almost Everything in Between." His mission is to change the workplace culture so that organizations are more productive and staff are more content. Ron was also the 2012-2013 president of the National Speakers Association. For more information, please visit www.RonCulberson.com



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Member Advisory

May 9, 2014

MEDICARE ADVANTAGE SEQUESTRATION CUTS: NEW DEVELOPMENTS

AT A GLANCE

At Issue:

Hospitals have reported that some Medicare Advantage Organizations (MAOs), whose negotiated payments to hospitals rely on Medicare fee-for-service (FFS) rates as a reference point, are asserting that the 2 percent Medicare sequestration FFS reduction is a change in the payment rates and, as a result, should automatically be incorporated into how the MAO calculates the amount it owes a hospital under its contracts. The Centers for Medicare & Medicaid Services (CMS) recently confirmed that the 2 percent reduction in hospital payments required by sequestration does not change the Medicare FFS payment rates for hospitals. In a [letter](#) to the AHA, CMS stated: "We agree that the sequestration does not change the rates or fee schedule in the Medicare FFS program." The agency also quoted a Frequently Asked Question previously provided to Medicare Administrative Contractors that expressly states: "All [Medicare FFS] fee schedules, pricers, etc., are unchanged by sequestration."

Our Take:

Only payments made directly by the Medicare program are subject to the 2 percent sequestration cut – that is, FFS provider payments and capitation payments made to MAOs. CMS's guidance regarding the application of sequestration to hospitals, and its letter to the AHA, confirms that the 2 percent reduction applies only to the amount otherwise owed to hospitals by Medicare; it does not change the rates used to calculate what Medicare pays. As a result, any assertions by MAOs that reductions in their payments to hospitals are based on sequestration changes to the Medicare rates are not supported by the law and are contrary to explicit guidance from CMS. Providers should not experience a 2 percent cut to their MA payments on the basis that Medicare rates were changed. Any payment reductions during the course of a contract must be permitted under the terms previously negotiated under that contract.

What You Can Do:

Please share this advisory with your leadership team, legal counsel and those in your organization responsible for administering contracts with MAOs. Hospitals and their legal advisors now have the documentation needed to carefully evaluate the payment terms in their contracts and pursue any appropriate redress with MAOs and Part D sponsors.

Further Questions:

Further questions can be addressed to Ellen Pryga, AHA director of policy, at (202) 626-2267 or epryga@aha.org, or Maureen Mudron, AHA deputy general counsel, at (202) 626-2301 or mmudron@aha.org.

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May 9, 2014

MEDICARE ADVANTAGE SEQUESTRATION CUTS: NEW DEVELOPMENTS

BACKGROUND

On March 1, 2013, the president was required by law to issue a sequestration order directing a series of across-the-board reductions in federal spending that included a 2 percent reduction in Medicare payments to fee-for-service (FFS) providers and Medicare Advantage Organizations (MAO). In May 1, 2013 guidance on sequestration, MAOs were advised that whether and how sequestration might affect payment to their contracted providers was governed by the terms of the private contracts between the MAO and the provider. Guidance to the Medicare Administrative Contractors (MACs) who process payment to FFS providers advised that the reduction for FFS providers applies only to the final payment amount; all fee schedules, pricers, etc., were unchanged by sequestration.

AT ISSUE

Last summer, some AHA members and many state hospital associations advised the AHA that a significant number of MAOs were attempting to pass along their 2 percent Medicare Advantage (MA) plan payment reduction to network providers, regardless of the terms of their contracts. Specifically, in cases in which provider contracts use the Medicare rates as a reference point, the plans were treating the FFS sequestration reduction as a reduction in Medicare rates and automatically applying a 2 percent reduction to the rates the plan otherwise used in calculating payment.

While some plans were responsive to provider clarifications of the issue, many others refused to cease passing their sequestration cuts on to network providers whose payments were tied by contract to Medicare FFS rates. Consequently, on August 13, 2013, the AHA [wrote](#) to the Centers for Medicare & Medicaid Services (CMS), urging that the agency provide additional guidance to MA plans explaining that sequestration did not alter Medicare rates themselves and that CMS had not issued a "default Medicare rate" that incorporated the 2 percent reduction, as many plans claimed. In particular, we urged CMS to clarify that there is a distinct difference between Medicare rates and what Medicare "would otherwise pay." The AHA believed that an authoritative statement containing such clarification



would provide members and their legal advisors a document upon which they could rely on when pursuing discussion and resolution of contract disputes with MAOs. We pressed CMS to take action to avoid the growing likelihood that hundreds of private disputes between providers and plans would need to be resolved individually – disputes that could disrupt MAO enrollee access to services.

In a [letter](#) to the AHA dated April 17, CMS Administrator Marilyn Tavenner provided just such an authoritative statement, confirming that the 2 percent Medicare payment reduction under federal sequestration does not change Medicare FFS rates, fee schedules or pricers, but applies only to the final payment amount. The letter quoted an FAQ sent to MACs:

Question: Does the two percent payment reduction under sequestration apply to the payment rates reflected in Medicare FFS fee schedules or does it only apply to the final payment amounts?

Answer: Payment adjustments required under sequestration are applied to all claims after determining the Medicare payment, including application of the current fee schedule, coinsurance, an applicable deductible, and any applicable Medicare Secondary Payment adjustments. All fee schedules, pricers, etc., are unchanged by sequestration. Only the final payment amount is reduced.

The letter went on to say that CMS is prohibited from interfering in the payment arrangements between MAOs and contracted providers by statute. However, whether and how reductions to plan payments due to sequestration might affect a MAO's payments to its contracted providers are governed by the terms of the contract between the MAO and the provider. The letter also reiterated the guidance to MAOs and Part D plan sponsors that they must follow the prompt pay provisions in their contracts and pay providers under the terms of those contracts. Finally, the administrator encouraged any provider or hospital with additional questions about sequestration or provider payment provisions to contact the MAO or Part D sponsor with which they contract.

FURTHER QUESTIONS

Further questions can be addressed to Ellen Pryga, AHA director of policy, at (202) 626-2267 or epryga@aha.org, or Maureen Mudron, AHA deputy general counsel, at (202) 626-2301 or mmudron@aha.org.



SAVE THE DATES!!!

Insurance 101 Webinar--

July 29th!!

Fall Educational Meeting

August 20--

**Par-A-Dice Casino and
Hotel, East Peoria, IL**

**Charles Garvin
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Golf Outing--

August 19-

**Lick Creek Golf Course,
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**Watch for Details
and Registration
Information Soon!!**



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Best Wishes Ron!



Ron Thompson has been an IL AAHAM member for 12 years.

He is employed at Paris Community Hospital at the PFS Manager and will be retiring this spring.

(At least that's what we think. He told us, he would be done working by ICD10 implementation, so with the recent changes in the implementation date, maybe not)

Ron has been a stable attendee at IL AAHAM meetings for all of his 12 years of membership. He is a quiet, gentle man who's knowledge of PFS is recognized by many.

Ron has been a great resource for many of us. His knowledge of regulations related to IL Medicaid, Critical Access and Rural Healthcare are to be commended.

He will be greatly missed and we wish him success as he begins his next chapter in life.

Ron's hobbies and special interests will keep him busy. The ones we are aware of are:

He is active in prison ministries, he is a pilot, a superb vocalist, a good dancer once he decides to get on the floor and we know he once owned a pet squirrel.

We also know Ron married a younger woman, so he will start his retirement while his wife continues to work (at Paris Community Hospital). He's a lucky man.

Ron, we wish you success and happiness.

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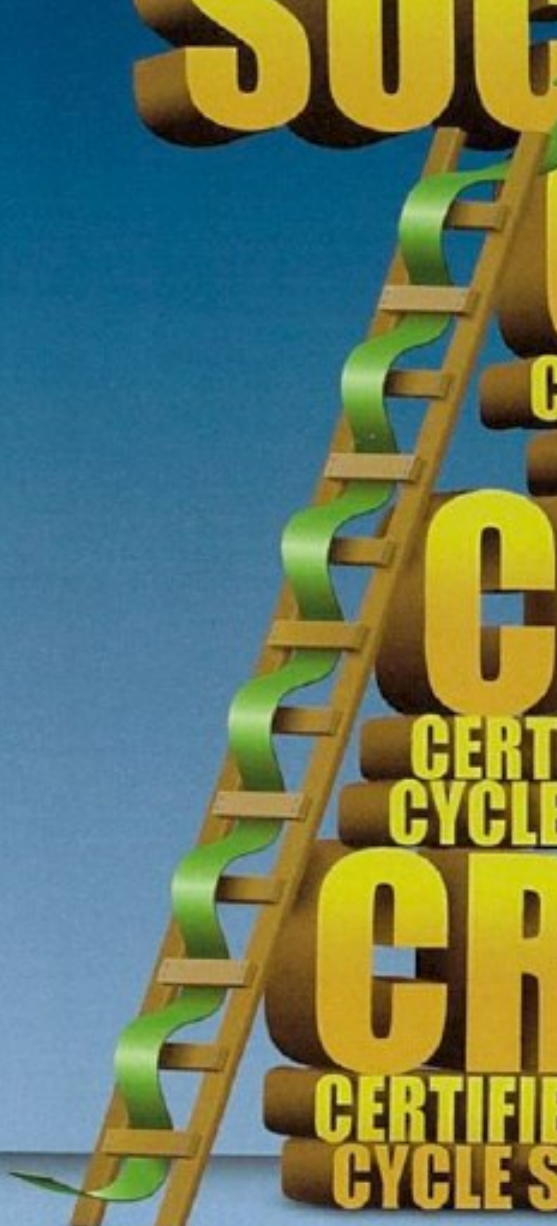


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Mary Garbe CRCP-I PRESENCE HEALTH

Certification Schedule

March 3, 2014 - Deadline for May
2014 Exam Period (May 12-23, 2014)

June 2, 2014 - Deadline for August
2014 Exam Period (August 11-22,
2014)

September 2, 2014 - Deadline for
November 2014 Exam Period
(November 10-21, 2014)

December 1, 2014 - Deadline for
February 2015 Exam Period



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Great Spring Meetings!!

April 3-4 in Bloomington, IL





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Joint Meeting with IL AAHAM and ICAHN

May 6-Springfield, IL



IHA Memorandum

February 4, 2014

ILLINOIS HOSPITAL ASSOCIATION MEMORANDUM

TO: Chief Executive Officers, Member Hospitals and Health Systems
Chief Financial Officers
Patient Financial Services Managers

FROM: Maryjane A. Wurth, President & CEO
Tom Jendro, Senior Director, Finance

SUBJECT: **2014 Federal Poverty Level Guidelines Effective January 22**

The Dept. of Health and Human Services published its annual revisions of the federal poverty guidelines in the Jan. 22, 2014 *Federal Register*. These income limits reflect a 1.5% increase from the 2012/2013 amounts. The guidelines are used as an eligibility criterion in a number of federal programs, including the Hill-Burton Uncompensated Services Program. The effective date of the guidelines is the date of publication (Jan. 22), unless an office administering a program using the guidelines specifies a different effective date for that particular program. The *Federal Register* can be viewed at: <http://www.gpo.gov/fdsys/pkg/FR-2014-01-22/pdf/2014-01303.pdf>.

This notice includes updated poverty income guidelines for families of one through eight persons.

Size of Family	Unit Poverty Guideline
1	\$11,670
2	15,730
3	19,790
4	23,850
5	27,910
6	31,970
7	36,030
8	40,090

For families with more than eight members, add \$4,060 for each additional member. If you have any questions, please feel free to contact Tom Jendro at: 603-276-5516 or tjendro@ihastaff.org.





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ASK Illinois AAHAM?????

ASK:



Dear Illinois AAHAM,

Will a Medicare beneficiary be impacted financially if we fail to meet all certifications of the two midnight rule & self-report the case to Medicare requesting Part-B reimbursement?



ANSWER:



Yes, the beneficiary will become responsible for his/her 20% co-insurance, up to the cap set at the level of the inpatient hospital deductible.

<http://www.gpo.gov/fdsys/pkg/FR-2013-12-10/pdf/2013-28737.pdf>



Have a question that you think IL AAHAM might be able to answer?? Please go to our website at www.illinoisaaaham.org, click on the Q&A tab, and ask away!



ASK Illinois AAHAM?????

Page 79

Impact on Beneficiary Payments

Under the comprehensive service APCs, instead of paying copayments for a number of separate services that are generally, individually subject to the copayment liability cap at section 1833(t)(8)(C)(i) of the Act, beneficiaries can expect to only pay a single copayment that is subject to the cap.

This will likely reduce beneficiary overall liability for most of these claims.

Comment: Several commenters agreed with CMS that, due to the inpatient deductible cap on beneficiary copayments, net beneficiary coinsurance would decrease under the proposed change. One commenter was concerned that beneficiary out-of-pocket costs may still be higher for any individual beneficiary. The commenter

was particularly concerned that new cost-sharing with beneficiaries for laboratory services would be contrary to statute and congressional intent. The commenter objected to a proposal that would impose new beneficiary cost sharing requirements in order to cut total projected Medicare spending for outpatient services.

Response: We believe that this proposal decreases the liability for almost all beneficiaries receiving primary procedures assigned to comprehensive APCs in CY 2015

because the inpatient deductible cap, mandated by statute to apply to single services, will now apply to the entire hospital claim, as it is now considered a single service or procedure. We agree with the commenters that there may be some isolated beneficiaries who may have a higher beneficiary liability than they would have had we not proposed comprehensive APCs. In many instances, and for these device-related procedures in particular, beneficiaries will no longer make copayments for

individual ancillary services. Because the device insertion procedures that we have proposed as comprehensive services are universally very expensive, the cap will apply to the majority of claims reporting services assigned to comprehensive APC. We received many public comments on our proposal to package laboratory services and address those comments and concerns in our discussion of that final policy in section II.A.3.c.(3) of this final rule with comment period.

Page 86

For CY 2015, we are treating all individually reported procedures that are assigned to status indicator "J1," which will appear in the CY 2015 Addendum B to the proposed rule, as representing components of a comprehensive service characterized by a primary service, and we will make a single payment for the comprehensive

service. We will be making a single all inclusive payment for each comprehensive service reported on a claim with that payment subject to a single beneficiary copayment, up to the cap set at the level of the inpatient hospital deductible, as provided at section 1833(t)(8)(C)(i) of the Act.

Page 360

We proposed in section II.A.2.e. of the OPSS proposed rule to create 29 comprehensive APCs for CY 2014 to prospectively pay for device-dependent hospital outpatient services associated with 121 HCPCS codes. We proposed to define a comprehensive APC as a classification for the provision of a primary service and all adjunct services provided to support the delivery of the primary service. For services that trigger a comprehensive APC payment, the comprehensive APC would treat all individually reported codes on the claim as representing components of the comprehensive service, resulting in a single prospective payment



Have a question that you think IL AAHAM might be able to answer?? Please go to our website at www.illinoisaaaham.org, click on the Q&A tab, and ask away!





Illinois Healthcare & Family Services (HFS) Bulletin

Jodie Edmonds, Vice President, Medicaid Revenue Consultant
May 2, 2014

eQHealth Frequently Asked Billing Questions

Illinois Medicaid policy has always stated that hospitals can change an inpatient admission to observation, prior to billing the claim to Medicaid.

eQHealth recently revised their "Frequently Asked Billing Question" pertaining to this policy, without notification to the hospitals.

*1g) Can an inpatient admitting order be changed to an order for observation prior to billing? **No, the HFS OIG does not permit retroactive orders or the inference of orders. Instances where an inpatient admission is ordered, and the physician chooses to change the patient status to outpatient observation should be addressed on the claim level using the appropriate condition code.***

On April 23, 2014, the Office of the Inspector General met with Medicaid and eQHealth Solutions. The result of the meeting was that the policy should not have been changed and Medicaid will release a provider notice to clarify that hospitals can change an inpatient admission to observation prior to billing the claim to Medicaid.

The Incarcerated & the Affordable Care Act

Federal law prohibits Medicaid coverage for incarcerated persons, unless they require inpatient hospitalization away from the facility and the person is otherwise eligible.

Medicaid will cover only those costs associated with the inpatient hospitalization.

Inpatient Cost Outliers

89 IL Administrative Code, Section 148.130 in the IL Register on 3/21/14 eliminates these types of cost outliers effective with discharges on July 1, 2014 and after. These cost outliers were for the per diem children's hospitals, which will now be reimbursed based on the APR DRGs.

eQHealth Prepayment DRG Reviews(Attachment D)

With the implementation of the APR DRGs, HFS will soon release a new listing of APR DRGs that will be reviewed by eQHealth.

Hospital Rate Reform Implementation July 1, 2014

3M Enhanced Ambulatory Patient Groups (EAPGs) – Version 3.7

Users of Nebo's eCare CMS or ClaimSource solutions will be given the option to receive a file containing contractual adjustments derived by running submitted claims through the EAPG grouper.

Solutions are also available to providers who are not one of our claims customers.

The output will be a file that providers can upload into their system that will provide the expected EAPG's and reimbursement.

I recently met with HFS staff regarding several questions that I had pertaining to the EAPG implementation.

- 1) Paper Remittance Advices & 835s
 - a. The EAPGs that result in a payment will not be reported on the paper remittance advices, only the 835s.
- 2) Modifiers
 - a. All modifiers will be accepted and the EAPG assignment will be based on the AMA guidelines for "Coding with Modifiers."
- 3) Base Rates & Relative Weights
 - a. The hospital specific base rates and 3M national weights will soon be released by HFS.
- 4) The National Correct Coding Initiative (NCCI) edits will be applied to the EAPG process.
- 5) Observation Services
 - a. I have requested that HFS add HCPCS Code G0378 to the APL/EAPG Listing and eliminate the requirement that observation services be billed with CPT Codes 99218, 99219, 99220, 99234, 99235 and 99236.
 - b. This would eliminate the need for hospitals to report two revenue code service lines for one observation service.

Prior Authorization Review for Coronary Artery Bypass Graft and Back Surgery Procedures

Effective with elective general inpatient admission dates beginning April 1, 2014, all ICD-9-CM procedures identified on new Attachment F will be subject to prior authorization review.

If a hospital bills a claim that has multiple procedures identified on Attachment F, as long as one of the procedures billed matches the prior authorization from eQHealth, the claim will not be rejected.

IlliniCare to Operate the CountyCare Program, Effective July 1, 2014
Federal CMS has granted an extension of this program until June 30, 2014.

CountyCare coverage of ACA Adults will not end on June 30, 2014. The end of the waiver will not change the operation of the plan. CountyCare will continue as a Managed Care Organization.

IlliniCare Health Plan Inc., a division of St. Louis-based Centene Corp. that already manages health care programs for the state of Illinois, was chosen to operate the CountyCare Program.

HFS MEDI/REV Messages

Incorrect eligibility messages are being returned by HFS. The examples that have been provided to me pertain to Cook CountyCare clients with the 90 day retroactive eligibility period.

HFS has identified this as a system problem and they are working on resolving the issue.

The Illinois Health Women (IHW) Program

The Illinois Healthy Women Program is being phased out over the next several months, ending December 31, 2014.

Effective January 1, 2014, the ACA requires everyone to have health insurance covering a defined package of health benefits including family planning services. Because IHW coverage is limited to family planning and related services, it is not considered minimum essential coverage.



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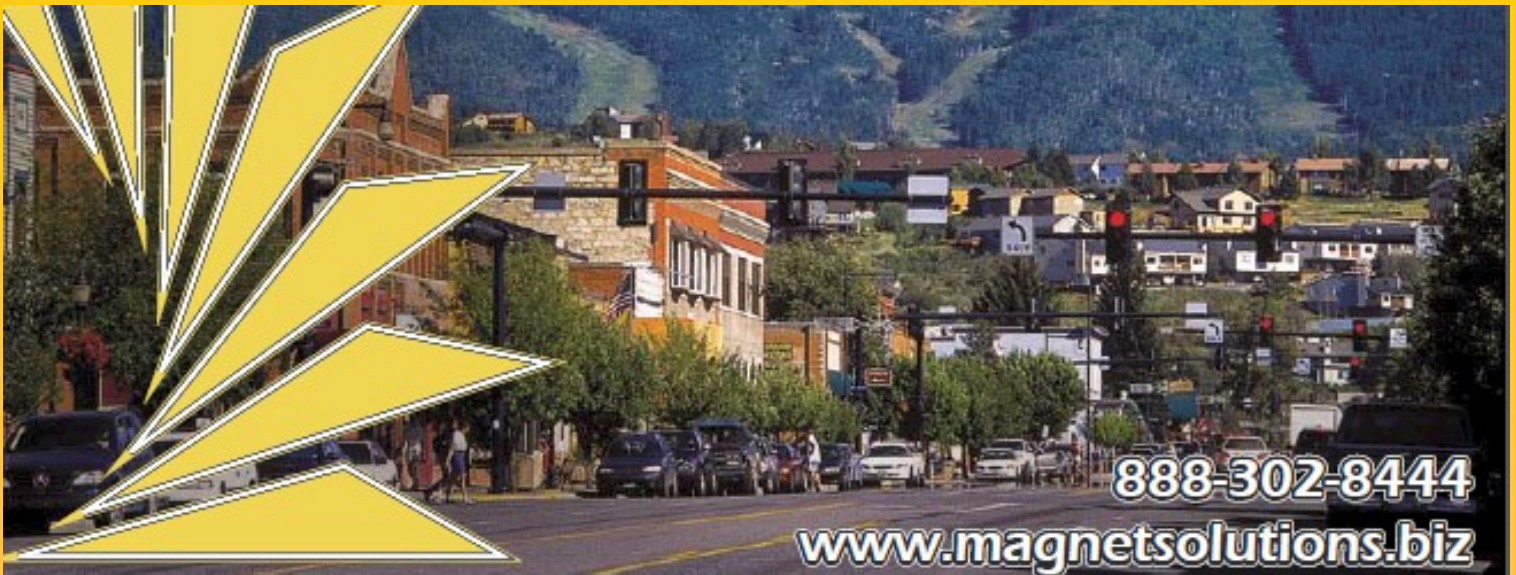


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May 30, 2014

Illinois HFS Bulletin



Jodie Edmonds, VP Medicaid Revenue Consultant

Resending today's bulletin to correct one **date** below. It appears correctly in the article but it was wrong in the heading. We apologize for the confusion.

This is a special bulletin for Medicaid information in Illinois. The author, **Jodie Edmonds**, worked for the State of Illinois Healthcare & Family Services for 33 years and is now the VP, Medicaid Revenue Consultant for Nebo Systems. If you would rather not receive this information, please click the unsubscribe link at the bottom of the page.

Illinois Medicaid MEDI/REV Messages Incorrect

Erroneous K40 (Services not covered by CountyCare) Rejections

IL Medicaid does not have an estimated completion date established for this fix.

Hospital Rate Reform Implementation **July 1, 2014**

54 Service Lines Restriction

The following policy has always existed for IL Medicaid when billing institutional claims because of their system restrictions.

Current Revenue Code guidelines – IL Medicaid will consolidate revenue codes so that total for each claim does not exceed 54 codes. HFS strongly recommends that providers roll-up the revenue codes to create a claim with 54 or less lines.

It is important that hospitals report all services rendered for each visit and do not consolidate revenue code lines based on the service line EAPG assignment/reimbursement.

Medicaid has not yet determined how they will handle claims that exceed 54 service lines.

Inpatient APR DRGs

IL Medicaid will be implementing on July 1, 2014 the Patient Discharge Status Codes (FL-17) that were approved by the NUBC effective October 1, 2013.

- 69 - Discharge transferred to a designated disaster alternate care
- 81 - Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission
- 82 - Discharged/Transferred to a Short Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission
- 83 - Discharged/Transferred to a SNF with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission
- 84 - Discharged/Transferred to Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission
- 85 - Discharged/Transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission
- 86 - Discharged/Transferred to Home Under Care of Organized Home Health Organization with Planned Acute Care Hospital Inpatient Readmission
- 87 - Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission
- 88 - Discharged/Transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission
- 89 - Discharged/Transferred to a Hospital -based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission

- 90 - Discharged/Transferred to an IRF including Rehabilitation Distinct Part of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
- 91 - Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission
- 92 - Discharged/Transferred to Nursing Facility Certified by Medicaid but not Certified by Medicare with Planned Acute Care Hosp IP Readmission
- 93 - Discharged/Transferred to Psychiatric Hospital or Psychiatric Distinct Part of a Hospital with a Planned Acute Care Hosp IP Readmission
- 94 - Discharged/Transferred To a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission
- 95 - Discharged/Transferred to Another Type of Health Care Institution not Defined in this Code List with a Planned Acute Care Hosp IP Readmission

Senate Bill 741 – Comprehensive Medicaid Package

This bill did pass through the House and the Senate this week.

Medicaid package in this bill:

1. \$19M being added to the transitional pool to ensure that no general acute care hospital will face a reduction with the implementation of the new Medicaid Hospital Rate Reform.
2. The most significant part of the bill would extend the hospital assessment program, in which Illinois hospitals pay a tax to the state to leverage an additional \$1 billion-plus each year in additional federal Medicaid matching funds for a variety of health-care providers.
 - o The extension would generate \$1.6 billion in federal match for the state. The total includes \$400 million for hospital services in fiscal 2015 for the 385,000 adults expected to be added to the Medicaid program by July 2015 because of the federal Affordable Care Act.
3. Requires Managed Care providers to pay at least the Medicaid fee-for-service equivalent rate for out-of-network emergency hospital services and post-stabilization services provided until the patient is transferred to an in-network provider.
4. The bill would also reverse restrictions imposed in 2012 with the SMART Act.
 - o Adult dental services that were cut from the state's Medicaid program two years ago would be restored.
 - o Medicaid patients needing anti-psychotic drugs would be exempt from the state's current four-drug policy

eQHealth Frequently Asked Billing Questions

Illinois Medicaid policy has always stated that hospitals can change an inpatient admission to observation, prior to billing the claim to Medicaid. eQHealth recently revised their "Frequently Asked Billing Question" pertaining to this policy, without notification to the hospitals.

1g) Can an inpatient admitting order be changed to an order for observation prior to billing? (HFS OIG updated answer 5.19.14)

No. The OIG does not permit an order to be retroactively changed. If a hospital determines that an inpatient admission was not medically necessary, a new order for the appropriate level of care should be written by the physician responsible for the patient's care, or by another physician who has knowledge of the patient's care and who is authorized to do so by the responsible physician or by the hospital's medical staff.

The Office of the Inspector General (OIG) is in the process of discussing this policy with their attorneys.



G67 (Prior Authorization Review for Coronary Artery Bypass Graft and Back Surgery Procedures) Erroneous Rejections

Effective with elective general inpatient admission dates beginning April 1, 2014, all ICD-9-CM procedures identified on new Attachment F will be subject to prior authorization review.

If a hospital bills a claim that has multiple procedures identified on Attachment F, as long as one of the procedures billed matches the prior authorization from eQHealth, the claim will not be rejected.

IL Medicaid is rejecting claims erroneously for the G67. They are working on correctly the programming problem.

Care Coordination Enrollment for Children, Families and ACA Adults

Medicaid must move at least 50% of Medicaid beneficiaries into care coordination by January 1, 2015.

There are four forms of Care Coordination entities: including Managed Care Organizations (MCOs), Managed Care Community Networks (MCCNs), Accountable Care Entities (ACEs) and Care Coordination Entities for Children with Special Needs (CSN CCEs). The notice also includes how providers will need to bill for services depending on the type of entity in which a beneficiary is enrolled.

This roll out will cover children, their family members, and the newly eligible Affordable Care Act (ACA) adults who reside in one of five managed care regions.

The five mandatory managed care regions are: the Greater Chicago Region, the Rockford Region, the Central Illinois Region, the Metro East Region and the Quad Cities Region.

It is imperative that providers check Department electronic eligibility systems regularly to determine beneficiaries' enrollment in a plan and to ensure your Medicaid patients can continue care with you. The Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS), and the Medical Electronic Data Interchange (MEDI) system will identify the care coordination plan in which the beneficiary is enrolled.

2014 Events Calendar

- March 20** IL AAHAM Certification Coaching Webinar
- April 3** IL AAHAM Board Meeting, Parke-Regency, Bloomington, IL
April 4 IL AAHAM Spring Education Meeting, Parke-Regency, Bloomington, IL
- April 23-24** Legislative Day
Hyatt Regency Capital Hill
Washington, DC
- May 5** IL AAHAM Board Meeting
May 6 Joint Meeting with ICAHN, Northfield Inn & Suites, Springfield, IL
- July 29** Webinar—Insurance 101
- August 19** IL AAHAM Board Meeting – Lick Creek, Pekin, IL
August 19 Charles Garvin Memorial Golf Outing –
Lick Creek Golf Course, Pekin, IL
August 20 Fall Education Meeting –
Par-a-dice Hotel and Casino, East Peoria, IL
- December 3** Board Meeting –
Vendor Reception
East Peoria, IL
- December 4-5** Annual State Institute –
East Peoria, IL



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APPLICATION FOR NATIONAL MEMBERSHIP

NAME: _____ TITLE: _____

EMPLOYER/ORGANIZATION NAME: _____

PRIMARY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____ LOCAL CHAPTER: _____

E-MAIL ADDRESS: _____ WEBSITE: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ HOME PHONE: _____

How did you hear about AAHAM? Colleague Publication Website LinkedIn

If referred by AAHAM member, please give name: _____

Membership Type: National Member Student Member

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.

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.

PAYMENT OPTIONS

For Credit Card Payment: Amex Visa MasterCard

Card Number: _____ Exp: _____

Name as it appears on card: _____

Signature: _____

Billing Address, if different from above: _____

Please allow two weeks for processing after your application is received at the national office. Dues are not tax deductible as a charitable contribution, but may be as a business expense.

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

For Check Payment:

Please make checks payable to AAHAM and send application with your payment to:

AAHAM Membership
11240 Waples Mill Road, #200
Fairfax, VA 22030
Fax: 703-359-7562
AAHAM Tax ID: 23-1899873

YOUR PAYMENT TOTAL:

NATIONAL DUES: _____

LOCAL DUES: _____

TOTAL ENCLOSED: _____

AAHAM Providing Excellence in the Business of Healthcare
Certification, Compliance, Leadership Development, Networking, Advocacy



ILLINOIS
AAHAM



Local Chapters: AAHAM has 31 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	Please Check the Appropriate Codes in Each Category Below
Aksarben #01	Nebraska	\$0.00	Years in Healthcare: <input type="checkbox"/> 0-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-25 <input type="checkbox"/> 25+ Certification: <input type="checkbox"/> CHAM (NAHAM) <input type="checkbox"/> CHFP (HFMA) <input type="checkbox"/> FHFMA (HFMA) <input type="checkbox"/> CHCS (ACA) <input type="checkbox"/> Other (please list) Employer Type: <input type="checkbox"/> Vendor/Corporate Partner <input type="checkbox"/> Billing <input type="checkbox"/> Collection Agency <input type="checkbox"/> Consulting <input type="checkbox"/> Outsourcing <input type="checkbox"/> Software/IT <input type="checkbox"/> Provider <input type="checkbox"/> Law Firm <input type="checkbox"/> Other (please list) Position: <input type="checkbox"/> CFO <input type="checkbox"/> Vice President <input type="checkbox"/> Partner, Principal, Owner <input type="checkbox"/> Executive Director <input type="checkbox"/> Consultant <input type="checkbox"/> Director <input type="checkbox"/> Manager <input type="checkbox"/> Supervisor/Coordinator <input type="checkbox"/> PFS Representative <input type="checkbox"/> Patient Access Representative <input type="checkbox"/> Other (please list) Responsibility: <input type="checkbox"/> Accounting <input type="checkbox"/> Administration/Operations <input type="checkbox"/> Admitting/Access <input type="checkbox"/> Audit <input type="checkbox"/> Benefits <input type="checkbox"/> Budget <input type="checkbox"/> Compliance <input type="checkbox"/> Business Development, Sales, Marketing <input type="checkbox"/> Information Services/Technology <input type="checkbox"/> Managed Care <input type="checkbox"/> Medical Records <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> PFS, Patient Billing & Collections <input type="checkbox"/> Reimbursement <input type="checkbox"/> Third Party Administration <input type="checkbox"/> Other (please list)
Florida Sunshine #03	Florida	\$40.00	
Carolina #04	North & South Carolina	\$30.00	
Evergreen #05	Washington State, West of the Mountains	\$30.00	
Gopher #06	Minnesota	\$40.00	
Hawkeye #07	Iowa	\$0.00	
Hawthorn #08	Missouri	\$45.00	
Illinois #09	Illinois	\$25.00	
Inland Empire #10	Washington State, East of the Mountains	\$25.00	
Keystone #11	Central Pennsylvania	\$25.00	
Maryland #13	Maryland	\$20.00	
Mountain West #14	Utah	\$30.00	
New Jersey #16	New Jersey	\$35.00	
Western Reserve #18	Ohio	\$0.00	
Northeast PA #19	North East Pennsylvania	\$30.00	
Rocky Mountain #21	Colorado	\$40.00	
Pine Tree #22	Maine	\$25.00	
Rushmore #23	North & South Dakota	\$0.00	
Western Region #26	Arizona and California	\$0.00	
Virginia #27	Virginia	\$30.00	
Philadelphia #29	Philadelphia, Pennsylvania	\$35.00	
Mid-York #31	New York	\$40.00	
Georgia #33	Georgia	\$30.00	
Connecticut #34	Connecticut	\$35.00	
Three Rivers #37	Pittsburgh, Pennsylvania	\$30.00	
Texas Bluebonnet #40	Texas	\$50.00	
Indiana #42	Indiana	\$25.00	
Wisconsin #44	Wisconsin	\$25.00	
Chennai #49	Chennai, India	\$0.00	
Music City #53	Tennessee	\$25.00	
Michigan #55	Michigan	\$0.00	

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