American Association of Healthcare Administrative Management
MN Gopher Chapter

Gopher Tracks

Save the Date: Nov. 9-10, 2016

Featured Speaker:

Day Egusquiza

MN AAHAM Fall Conference/ St. Cloud, MN

Some topics to be discussed by Day Egusquiza include:

Top Audit Findings in Charge Capture and Patient Status

Updates and Lessons learned from Audits:

- Finding Lost Revenue
- Department Head Ownership
- Improving Documentation to Support and Keep In-Patients

CMS Audit Findings:

- Identify Common Problems with Documentation to Support In-Patients

Learning the 3-Steps for Ownership of Charge Capture at the Department Head Level

Lots of practical take aways will result from her sessions

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Marie Murphy

From the Desk of the President

Dear Minnesota AAHAM Members,

It is my distinct honor to begin these next two years with the support of some of the brightest in our healthcare industry. I am very excited about a brand new year with new possibilities. Our Board of Directors, chosen by the members, are also very excited to showcase their talents and propel us to a new level. I would like to take this opportunity to thank everyone who was able to attend the Installation of our new board in February.

Our National AAHAM theme for this year is “Raise the Level”. I am pleased to say we are on our way to raising the level to bring quality education to our members.

Education is a mission of our chapter that is of utmost importance to me. I am pleased to be hard at work with our present board members to bring quality education during these next two years.

We started this year with an excellent meeting back on April 13 – 14th, which was hosted by Mille Lacs Health System in Onamia. This was a great opportunity to meet with the payers and to network with our peers who experience similar struggles in their business offices. Ed Norwood continued to help us “Raise the Level” during our second day of boot camp education.

I wish everyone a safe and enjoyable summer, and look forwarding to seeing everyone in November.

Respectfully,

Marie Murphy

Marie Murphy and Rick Rogers were granted a special personal meeting with the presidential candidates and House Speaker during Leg Day in Washington DC to discuss healthcare issues as they pertained to Minnesota.

Fall Conference Nov. 9-10

Featured Conference Speaker

Day Egusquiza

Nationally recognized healthcare speaker, Day Egusquiza, will conduct a morning and afternoon session at the upcoming MN AAHAM Fall Conference in St. Cloud, MN. Ms. Egusquiza will be speaking on...

Finding HealthCare Solutions…together

Day Egusquiza brings over 30 years experience in health care reimbursement, hospital business office operations (20 years in an Idaho hospital), contracting and compliance implementation. Additionally, her experience includes eight years as a Director of a Physician Medical Management billing service which included completing an integrated business office between a hospital and a large multi-specialty physician clinic. She has been an entrepreneur in hospital and physician practice accounts receivable management and a leader in redesigning numerous organizations. Her work includes providing guidance as a compliance & reimbursement educator while providing operational insight on the revenue cycle impacts of RAC/Medicare Recovery Audit Contractors. Additionally, she has been instrumental in researching and preparing national education on the impact of the Prescription Drug Benefit. ICD 10 is also on the list of 'fun' projects with audit and boot camps. Day's strength is her ability to 'operationalize' complex regulations into teachable components.

Ms Egusquiza is a nationally recognized speaker on continuous quality improvement (CQI), benchmarking, redesigning, reimbursement systems and implementing an operational focus of compliance- both in hospitals and practices. She has been on the AAHAM National Advisory Council, HFMA National Advisory Council, is a past President of the Idaho HFMA Chapter & recently received the Lifetime Achievement Award. She has been highlighted in JCAHO's Six Hospitals in Search of Excellence, Zimmerman's Receivable Report, HFMA's HFM and Patient Account, AHIA Prospective, and numerous healthcare newsletters along with a contributing author to 2006 Health Law and Compliance Update. She received the Idaho Hospital Association "Distinguished Service Award" for her legislative work and training on new indigent law. Attendees at HFMA's ANI rated her in the top 25% for each year she has presented, earning her the 'Distinguished Speaker' award.

Her greatest accomplishments are her four wonderful children and her eight fabulous grandchildren.

What makes her unique? She has been in the trenches with us!

Points of Interest:

- AICPA: Planning Committee member for healthcare, Chair 2004-2011
Speaker at 14 annual conferences, board member 8 years
- AHIA: National conference key note speaker
- HFMA: National faculty member; presenter at ANI; national revenue cycle conference; two-day cluster; CFO Forums; regional conferences with continual evaluations in the top 25% -earning the Distinguished Speaker Award yearly.
- Instructor: College of Southern Idaho, continuing education program on "Understanding the Medicare Benefit."
- Board of Directors: Special Olympics of Idaho,2003-2007. Secretary 2004
- Contributing Editor; AAHAM Technical Certification Study Guide, revised March 2004; CPAT & CCAT exams
- Co-Chair of national RAC Summit (2009-current)

Conference Candids

Spring 2016 Conference
Payer Panel/ Boot Camp

By Dawn Huffman/ Mille Lacs Health System

On April 13 and 14, Mille Lacs Health System hosted the American Association of Healthcare Administrative Management (AAHAM) Minnesota Gopher Chapter, 2016 Payer Panel Meeting and Ed Norwood Boot Camp at the Holy Cross Center.

Representatives from many insurance payers, including NGS, Medicaid, Medica and HealthPartners provided updates with important changes and issues within their companies.

The Minnesota Gopher Chapter AAHAM is a membership-based association of administrative healthcare professionals working throughout Minnesota and across the country. They provide their members with the opportunity to pursue professional development as well as professional and technical certification. Through meetings and networking opportunities, members are connected with their peers throughout the area and with industry experts.

Additionally, the Minnesota Gopher Chapter AAHAM has become a skilled lobbying entity within the Minnesota legislature with lobbying efforts focusing on patient-centric billing and reimbursement issues, and the accompanying regulatory legislation.

Members network during the luncheon after the Charity Presentation.

A hospital employee describes the Mille Lacs Lake Area Operation Community Connect (OCC) during the Charity Presentation.

Above: Members take a break between sessions.

Top Left: Carrie Coan, Lake View Memorial Medical Center and AAHAM Chapter Newsletter and Photographer with Members of the Payer Panel.

Above Left: Nicole Weber, Ridgeview Medical Center with Kristopher Klinger from Preferred One.

Left: Members gather during the social at Eddy's.

First Time Attendees to a MN AAHAM Conference.

Lisa Wichterman, MN Dept.Labor & Industry and Gail Ahart with A Better Connection

Sherri Kremeier and Ashely Halverson, Riverview Health with Jean Roberts, NGS.

Above: Karla Langford and Bonnie Lawrence, St. Luke's; Rebecca Hardin, Blue Cross Blue Shield and Katy Vos, Rycan. Right: Ed Norwood with Erynn Johnson and Heather Elwood, Rice Memorial.

MN AAHAM

Benefits of AAHAM Certification

How does certification benefit an individual?

Earning an AAHAM certification demonstrates a high level of achievement and distinguishes you as a leader and role model in the revenue cycle industry. The certification validates your proficiency and commitment to your profession and can play an integral role in your career strategy. In many instances certification may help you secure the promotion or the job you desire.

Earning certification can help you by:

- Improving your earning potential
- Giving you a competitive advantage with current and prospective employers
- Granting you the recognition you deserve
- Providing access to the positions and promotions you seek and desire
- Building a network of peers in the influential group that shares your certification designation
- Continuing to expand your skills and expertise through continuing education

How does certification benefit an employer?

Earning an AAHAM certification demonstrates an individual's expertise. It shows they possess the knowledge to meet the industry's highest standards and the capacity to pass a rigorous certification examination. It shows commitment to their profession and ongoing career development. It also represents professionalism in the individual's pursuit of excellence to quality of service in their career and the healthcare industry.

By hiring AAHAM certified individuals and investing in AAHAM certification for your staff you can:

- Increase the competency of your staff
- Increase quality and productivity
- Build a strong team
- Promote ongoing education and training
- Reduce exposure to fraud and abuse
- Develop a career ladder for staff

Sandra Pawlek, MN AAHAM Certification

News and Updated Calendar

'06 Certification Edge

On behalf of the Gopher Chapter, we would like to thank everyone who recently proctored certification exams and congratulate the individuals examinee's who have passed their professional and technical exam. It takes hard work, determination and you, as individuals, have accomplished just that. Recognition for a job well done! We want to thank all employers who have encouraged and continue to support their staff in the importance of certification.

AAHAM certification options include:

- Executive Certification (CRCE I-P)
- Professional Certification (CRCP I-P)
- Revenue Integrity Professional
- Specialist Certification (CRCS I-P)
- Certified Compliance Technician

2016 Certification Calendar

Beginning in 2016 AAHAM will offer certification exams three times a year: March, July and November

March 14-25, 2016
March Exam period

April 15, 2016
Registration deadline for July 2016 Exam period

July 11-22, 2016
July Exam Period

August 15, 2016
Registration deadline for November 2016 Exam Period

November 7-18, 2016
November 2016 Exam Period

To become more knowledgeable in the different levels of certification visit the National AAHAM website at
www.aaham.org

Legislative Day 2016
Progress on Two Initiatives

Legislative Day 2016

AAHAM had another successful day on the Hill. We had many supporters across the states that would help sponsor our two initiatives this year. Medicare Audit Improvement Act and the Hospital Improvements for Payment (HIP) Act. We were lucky to have a beautiful sun shiny day in DC. Marie's Representative did offer to co-sponsor one of them!

It was really nice to have a speaker during our morning sessions from MN. Rep. Tom Emmer (R-MN) gave a wonderful presentation. The energy, optimism, and enthusiasm to invoke change to work together rather than the rhetoric we are all listening to with the criticizing of each party was refreshing. Lisa Grabert, Professional Staffer, House Ways and Means Committee was excellent as well looking at a middle ground for the IPPS and OPPS.

The two initiatives will more than likely take some time due to the election year and we all know change is slow, especially where Medicare is concerned. It is always a pleasure to interact with the staffers to discuss the Healthcare issues facing hospitals and clinics. The administrative nightmares of these programs has become so daunting and in most cases, the staffers are not even familiar with the issue, hence, our visits! It is very important for the Legislative Day to continue to get the word out on our concerns.

Hoping everyone survives the Presidential Election! Janet Curtis

Marie Murphy, Janet Curtis and Rick Rogers met with Representative Tom Emmer (R-MN) as part of their Leg Day activities.

Statement for the Record

National AAHAM Position Before the US Senate

STATEMENT FOR THE RECORD OF THE AMERICAN ASSOCIATION OF HEALTHCARE ADMINISTRATIVE MANAGEMENT BEFORE THE U.S. SENATE COMMITTEE on COMMERCE SCIENCE, AND TRANSPORTATION

WEDNESDAY, MAY 18, 2016

Chairman Thune, Ranking Member Nelson, and members of the Committee, thank you for the opportunity to submit this testimony for the record.

My name is Richard Lovich and I serve as National Legal Counsel for the American Association of Healthcare Administrative Management (AAHAM), which is the national organization actively representing the interests of healthcare administrative management professionals through a comprehensive program of legislative and regulatory monitoring and its participation in industry groups such as ANSI, DISA, WEDI and NUBC. AAHAM is a major force in shaping the future of healthcare administrative management.

I appreciate your holding this hearing today. As you know, the Federal Communications Commission recently ruled on over 22 petitions seeking changes to the current rules governing the Telephone Consumer Protection Act (TCPA). AAHAM was one of those groups that submitted a petition seeking clarification of how the FCC defines consent. Consent by definition may seem like something simple to answer, but we have found that consent does not mean the same thing to so many people and thus has caused our members to be sued over this issue. Healthcare providers cannot do their job effectively, efficiently, or in a cost effective manner without using technology today.

The TCPA was signed into law in 1991 and already is out of date, yet, the FCC seems unwilling to consider real modernization. Technology has advanced so rapidly since 1991and continues to develop at a pace the government cannot keep up with, yet agencies like the FCC, are unwilling to keep pace with these changes.

The TCPA was designed to protect consumers from receiving unsolicited telemarketing calls in their homes at all hours of the day and night. To prevent these intrusive calls, Congress restricted the use of "automatic telephone dialing systems", broadly limited the use of pre-recorded voice messages and prohibited outreach to mobile phones without "prior express consent" from the call recipient. Mr. Chairman, AAHAM supports that goal and mission of the TCPA. Nothing we or others have proposed would change that.

Twenty three years since its passage, the TCPA has become outdated. It restricts Americans from receiving customer service messages they want – including healthcare appointment reminders, credit card fraud alerts, notifications of travel changes, power outage restoration, UPS delivery information and more. Further, it prevents them from receiving these communications on the device they prefer, their mobile phones.

- At the time the TCPA legislation was passed, over 90% of U.S. households relied on their home or land-line phone. Only 3% of Americans had a mobile phone, they were truly the province of the elite. So much has changed since then.

- Today, the trend is away from landline phones, in fact nearly 2 in 5 American homes no longer maintain a land line and rely exclusively on wireless or cell technology.

- Since the enactment of the TCPA, a new form of communication, text messaging, has emerged. In 2012, more than 2.19 trillion text messages were sent and received. In 1991, legislators had no way of predicting the growth of the mobile market or the rapid adoption of text messaging as a critical form of communication.

To make matters worse, new laws and regulations have been passed that make compliance wiyth the TCPA even more difficult. The Affordable Care Act (ACA) as well as new IRS regulations dealing with charitable hospitals, place unfunded mandates on hospital providers the fulfillment of which is made difficult if not impossible by the current language and interptretation of the TCPA.

The ACA was passed in 2011, requires hospitals and outpatient clinics to perform post-discharge follow-up with patients to reduce the rate of readmission, a big contributor to the cost of healthcare. We know the reminders, surveys, and education that have proven to lower readmission rates, can be successfully and cost effectively conducted by phone.

However, under the TCPA, these calls place the hospital at high-risk of violating the statute and facing penalties and defense fees and costs where the patient's primary contact number is a mobile number and the patient didn't expressly

provide the mobile phone number for that purpose. The FCC's recent ruling helps by making some slight changes to the TCPA for healthcare related calls, but it just touches the surface and does not get to the root of the problem.

The IRS's 501(r) regulations create another another federal government unfunded mandate. These regulations require hospitals to call patients and orally inform them they may be eligible for financial assistance. A laudable endeavor and one hospitals are fully in favor of conducting. However, this is a process that could be more effectively, efficiently, and economically performed through the use of technology. The chilling effect of the ambuiguity of the TCPA has required hospitals to refrain from the use of auto dialers and contacting patients through the use of mobile technology. By requiring the use of more labor intensive methods to comply with the regulations, the TCPA adds unnecessary expense which requires diverting resources that could otherwise be dedicated to patient care.

President Obama has proposed "clarifying that the use of automatic dialing systems and pre-recorded messages is allowed when contacting wireless phones in the collection of debt owed to or granted by the United States. In this time of fiscal constraint, the Administration believes that the Federal Government should ensure that all debt owed to the United States is collected as quickly and efficiently as possible and this provision could result in millions of defaulted debt being collected…"

The practical impact on the care provider community is devastating. It is a significant financial strain on a hospital or any size, let alone a physician's office to try and determine if the phone number a patient left is a cell number or landline number. Then is it is a wireless number, determining if the provision of the number constituted express cpnsent to call them and for what purpose? In addition, when can a hospital vendor rely upon the level of consent provided to the hospital to gauge if their work on behalf of the hospital is protected at least to the limited extent that the hospital is protected.

The bottom lin ei sthat healthcare providers must be able to effectively, efficeintlym and economicaly communicate with their patients. The TCPA robs our community of this fundamental aspect of the caerprovider- patoent relationship by imposing outdated and artificial restraints on effective communication. In addition, the TCPA prevents providers from fulfiliong statutory and regulatory mandates in an effective and efficient manner, all at eh expense of greater patient care.

Those in the healthcare sector aren't looking to inundate consumers with telemarketing calls. The great majority of the communication with patioents is care related and mandated by federal statute or regulation. Any government mandate in and of itself should provide a safeguard against unwarranted lawsuits against hospitals for fullfillment of the essence of the caregiver-patient relationship and to make calls they are required by law to make.

In today's technologogically burgeoning society, it makes no sense for the FCC to allow technology to be used to contact consumers via their landline phone, but not their cell phones. Almost 40% of homes today rely on their cell phones as the primary means of communication. This number is expected to continue to rise. With this the trend, the FCC is missing a golden opportunity to truly modernize the TCPA in a way that will have beneficial impacts on industry, while also safeguarding the protections consumers want.

Today the FCC is looking at the modernization the TCPA the wrong way. The FCC should be looking at meeting two mutually achievable goals-balancing the needs of consumers for obtaining healthcare and other information quickly and efficiently through their mobile devices, with maintaining the strong anti-telemarketing rules that already exist.

This is not a challenging endeavor. AAHAM has met with key members of the FCC several times and the message has been the same. AAHAM has explained in great detail what healthcare calls are and what, in the healthcare industry, would be considered (and prohibited) healthcare telemarketing calls. Yet, still getting the needed changes has been challenging.

We urge Congress to immediately modernize the TCPA to allow automated dialing technology to be used to text or call mobile phones, as long as these texts or calls are NOT for telemarketing purposes. These changes are critical to the future of care giver-patient communication.

Mr. Chairman and Ranking Member Nelson this is not a partisan issue, nor should it be. This is a simple issue of the need for government regulations to keep pace with the needs of today's consumers and businesses. This is an issue about government working to bring healthcare costs down for consumers, not drive them up by continuing to rely on outdated rules and regulations.

The TCPA is outdated and needs to be modernized immediately. The FCC's recent decision was disappointing and troubling for us in the healthcare industry. AAHAM's petition was very modest and simply asked for clarification on the definition of consent. The ruling did not effectively end this inquiry. This means that the care giver community, those upon which we all rely to provide effective healthcare to us, will continue to be subjected to costly lawsuits draining resources that would otherwise go to patient care.

Thank you for this opportunity and if you or your staff have any questions, please feel free to contact me. I would love to work with the Committee on real solutions to this very important issue.

National AAHAM Supports Dialoque

Congress Discusses Modernizing the TCPA

AAHAM Applauds Congress for Beginning Discussion of Modernizing the Telephone Consumer Protection Act (TCPA)

Fairfax, VA- The American Association of Healthcare Administrative Management (AAHAM) applauds Chairman John Thune (R-SD) and Ranking Member Bill Nelson (D-FL) for holding today's hearing The Telephone Consumer Protection Act at 25: Effects on Consumers and Business. Modernizing the TCPA is critical today and crucial to the ability for the healthcare sector to better reach and stay in touch with the patients they serve.

"We applaud today's hearing and look forward to working with the Committee and FCC on solutions that meet today's ever changing healthcare environment, but also meets the original intent of the TCPA of keeping people from unwanted telemarketing calls, a mission we support" said AAHAM President, John Currier, CRCE-I.

The TCPA restricts making telemarketing calls, using automatic telephone dialing systems and artificial or prerecorded voice messages (often referred to as robocalls), and sending unsolicited faxes. In his comments, Commissioner O'Reilly stated the TCPA has been a success. However, in enacting the TCPA he added, the Congress aimed to strike a balance between protecting consumers from unwanted communications and enabling legitimate businesses to reach out to consumers that wish to be contacted. Over time, as the FCC and the courts have interpreted the TCPA, business models and ways of communicating with consumers have also changed. As a result, the rules have become complex and unclear.

AAHAM believes the TCPA needs to be amended to improve the communication infrastructure between and among consumers and those service providers with which consumers choose to engage. "Proper communication between businesses, consumers, and patients is a vital component of a strong consumer protection environment. It ensures consumers are made aware of changes to the status quo that they may not otherwise be made aware of and provides them an opportunity to address pressing issues that stave off otherwise unavoidable, adverse financial action, such as foreclosure, negative credit reporting or litigation," Added AAHAM Legal Counsel, Richard Lovich, Esquire.

In the healthcare industry if a doctor needs to remind patients of their appointments or their medicine is ready, they have to have real people calling them to remind them of the appointment when in fact this could be done more efficiently and effectively with the use of technology. However, the TCPA prohibits all "person(s)" including healthcare providers or their agents from contacting consumers on their wireless phones by way of an auto dialer or prerecorded message. Notably, many of these same consumers do not even have landlines. Today 40% of homes do not have landlines and therefore healthcare costs continue to escalate because we cannot utilize technologies making it more effective for us to stay connected to our patients. Modernizing the TCPA would make clear that consumers who provide their wireless numbers to service providers with whom they have a relationship have granted the calling party consent to call them on their cell phone even if the communication is actually initiated by an auto dialer or provides a prerecorded message.

"The Affordable Care Act (ACA) requires hospitals and outpatient clinics to perform post-discharge follow-up with patients to reduce the rate of readmission, a big contributor to the cost of healthcare" stated AAHAM President John Currier, CRCE-I. "However, under the TCPA, these calls are high-risk if the patient's primary contact number is a mobile number and the patient didn't expressly provide the mobile phone number for that purpose. It is a financial strain on a hospital or doctor's office to try and determine if the phone number a patient left is a cell number or landline number. It also causes for increases in the healthcare system when a hospital and/or doctor's office cannot communicate with their patients, as now required by the ACA, using autodialer technology providing that these calls are not for telemarketing purposes and are not randomly generated," added President Currier.

Language included in the Affordable Care Act (ACA) requires hospitals and outpatient clinics to perform post-discharge follow-up with patients to reduce the rate of readmission, a big contributor to the cost of healthcare. AAHAM supports the reports that state reminders, surveys, and education that have proven to lower readmission

rates, can be successfully and cost effectively conducted by phone. However, under the TCPA, these calls are high-risk if the patient's primary contact number is a mobile number and the patient didn't expressly provide the mobile phone number for that purpose. The FCC's 2015 ruling does make some slight changes to the TCPA for healthcare related calls, but it just touches the surface and does not get to the root of the problem.

The healthcare sector also now has to deal with another federal government unfunded mandate through the IRS's 501(r) regulations, which require hospitals to call patients and verbally let them know they may be eligible for financial assistance. Again, this is a process that could be more effectively and efficiently done through the use of technology, but made more costly by the inability to utilize technology.

President Obama has proposed "clarifying that the use of automatic dialing systems and pre-recorded messages is allowed when contacting wireless phones in the collection of debt owed to or granted by the United States. In this time of fiscal constraint, the Administration believes that the Federal Government should ensure that all debt owed to the United States is collected as quickly and efficiently as possible and this provision could result in millions of defaulted debt being collected…"
The TCPA needs to keep pace with the rate at which technology is changing and how it is being used by businesses and consumers. AAHAM urges the FCC to begin a rule-making process that allows for modernization of an Act that is out of date. Regulations need to keep pace with the use of technology and this is one case where technology is clearly outpacing the intent of regulations.

ABOUT AAHAM

The American Association of Healthcare Administrative Management (AAHAM) is a national professional association of thirty-two chapters and over 3000 healthcare patient financial services professionals from hospitals, clinics, billing offices, allied vendors, physicians and multi physician groups. AAHAM members direct the activities of the thousands of people who are employed in the healthcare industry.

AAHAM is the preeminent professional organization for revenue cycle professionals and is known for its prestigious certification and educational programs; professional development of its members is one of the primary goals of the association. AAHAM is also recognized for its quarterly journal, The Journal of Healthcare Administrative Management and its Annual National Institute, held each fall. AAHAM actively represents the interests of its members through a comprehensive program of legislative and regulatory monitoring and participation in industry groups such as WEDI, ASC X12, NUBC and NUCC. For more information regarding AAHAM and its programs, please visit www.aaham.org or contact AAHAM, 703.281.4043.

AAHAM
American Association of Healthcare Administrative Management

Paul Miller

Observation Stays
Medicare Beneficiaries

OBSERVATION STAYS DENY MEDICARE BENEFICIARIES ACCESS TO SKILLED NURSING CENTER CARE

SUPPORTED BY

AAHAM
American Association of Healthcare Administrative Management

AARP

ACMA
American Case Management Association

Aging Life Care Association

AHCA
American Health Care Association

AJAS
Association of Jewish Aging Services

Alliance for Retired Americans

American College of Emergency Physicians

AMDA
The Society for Post-Acute and Long-Term Care Medicine

Catholic Health Association of the United States

Center for Medicare Advocacy

The Coalition of Geriatric Nursing Organizations

Emergency Nurses Association

The Jewish Federations of North America

Justice in Aging

Leadership Council of Aging Organizations

LeadingAge

LSA
Lutheran Services in America

Medicare Rights Center

n4a
National Association of Area Agencies on Aging

NAELA
National Academy of Elder Law Attorneys, Inc.

NAHCA
National Association of Health Care Assistants

NASL
National Association for the Support of Long Term Care

NASOP
National Association for State Long-Term Care Ombudsman Programs

NCAL
National Center for Assisted Living

National Committee to Preserve Social Security & Medicare

The National Consumer Voice for Quality Long-Term Care

SHM
Society of Hospital Medicine

Special Needs Alliance

Medicare beneficiaries are being denied access to Medicare's skilled nursing facility (SNF) benefit because acute care hospitals are increasingly classifying their patients as outpatients receiving observation services, rather than admitting them as inpatients. Patients are called outpatients despite the fact that they may stay for many days and nights in hospital beds and receive medical and nursing care, diagnostic tests, treatments, medications, and food, just as they would if they were inpatients. Under the Medicare statute, however, patients must have an inpatient hospital stay of three or more consecutive days, not counting the day of discharge, in order to meet Medicare criteria for coverage of post-acute care in a SNF. As a result, although the care received by patients in observation status is the same as the care received by inpatients, outpatients who need follow-up care in a SNF do not qualify for Medicare coverage. Hospital stays classified as observation, regardless of their length and the type or number of services provided, are considered outpatient. These hospital stays do not currently qualify patients for Medicare-covered care in a SNF; only inpatient time counts.

Hospitals' use of observation status and the amount of time patients spend in observation status are both increasing. A study* found a 34% increase in the ratio of observation stays to inpatient admissions between 2007 and 2009, leading the researchers to conclude that outpatient observation status was becoming a substitute for inpatient status. The same study also documented increases in long-stay outpatient status, including an 88% increase in observation stays exceeding 72 hours.

Support for counting time spent in observation status toward the three-day prior inpatient stay continues to grow. In July 2013, the Office of the Inspector General reported that hospitals varied widely in their use of observation stays and, in calendar year 2012, that beneficiaries had 617,702 hospital stays that lasted at least three nights, but that did not include three inpatient nights. These beneficiaries did not qualify for SNF services under Medicare. The report was supportive of counting observation days towards the three-day inpatient stay minimum requirement. In addition, in September 2013, the congressionally created Long Term Care Commission recommended that the Centers for Medicare & Medicaid Services (CMS) count time spent in observation status toward meeting the prior three-day stay requirement.

The NOTICE Act and the two-midnight rule do not resolve this problem of observation status for patients. Beginning August 2016, the NOTICE Act requires hospitals to inform patients who are receiving observation services as an outpatient for more than 24 hours that they are outpatients, not inpatients. While receiving written and oral notice informs patients of their status, the law -- which is a positive step forward -- does not give patients hearing rights or count the time in the hospital for purposes of SNF coverage.

The two-midnight rule establishes time-based criteria for inpatient hospital status, and most importantly, authorizes physicians to order inpatient status if they believe their patient is likely to be hospitalized for two or more midnights. A revision to the rule in 2015 allows physicians, on a case-by-case basis, to order inpatient status for patients who are likely to be hospitalized for only a single midnight. While the rule and its revision reflect CMS' concerns about long outpatient stays, hospitals are unlikely to change their practices when CMS provides no meaningful guidance on when an inpatient stay of fewer than two midnights is appropriate. Physician decisions about patient status continue to be reviewed by hospitals under the same standards as before: short inpatient decisions are prioritized for review by Quality Improvement Organizations (QIOs); and the specter of audits by Recovery Auditors (still known as RACs) remains. A RAC's determination that a patient has been incorrectly classified as an inpatient requires the hospital to return most of the Medicare reimbursement for the patient's stay, despite the fact that the services were medically necessary and coverable by Medicare.

Both the NOTICE Act and the two-midnight rule reflect recognition of the problem of observation status for Medicare patients, but they are not sufficient to address the impact on SNF eligibility for beneficiaries in observation. Legislation introduced this Congress with bipartisan support would create a full and permanent solution. **The Improving Access to Medicare Coverage Act of 2015 (H.R.1571/S.843)**, introduced by Representatives Joe Courtney (D-CT) and Joe Heck (R-NV) and Senators Sherrod Brown (D-OH), Susan Collins (R-ME), Bill Nelson (D-FL), and Shelley Moore Capito (R-WV) would help Medicare beneficiaries who are hospitalized in observation by requiring that time spent in observation be counted towards meeting the three-day prior inpatient stay.

*Zhanlian Feng, Brad Wright and Vincent Mor, Sharp Rise In Medicare Enrollees Being Held In Hospitals For Observation Raises Concerns About Causes And Consequences, Health Affairs, 31, no.6 (2012):1251-1259

Observation Stays Deny Medicare Beneficiaries Access to Critical Skilled Nursing Care, Cost Thousands

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Justice in Aging

Leadership Council of Aging Organizations

LeadingAge

LSA
Lutheran Services in America

Medicare Rights Center

n4a
National Association of Area Agencies on Aging

NAELA
National Academy of Elder Law Attorneys, Inc.

NAHCA
National Association of Health Care Assistants

NASL
National Association for the Support of Long Term Care

NASOP
National Association for State Long-Term Care Ombudsman Programs

NCAL
National Center for Assisted Living

National Committee to Preserve Social Security & Medicare

The National Consumer Voice for Quality Long-Term Care

SHM
Society of Hospital Medicine

Special Needs Alliance

The Issue

Medicare requires beneficiaries to be hospitalized for medically-necessary inpatient hospital care for at least three consecutive days before covering post-hospital care in a skilled nursing care center. Yet, patients often remain under observation status in the hospital for several days. These days are considered outpatient, and therefore, do not count toward Medicare's three-day inpatient stay requirement.

The Effort

The Observation Stays Coalition, consisting of 28 national organizations, has launched an effort to collect stories that put a face on this critical issue that leaves millions at risk of getting stuck with high medical bills – or foregoing needed care – because of their observation status in the hospital.

The Coalition continues to support bipartisan legislation that would count observation stays towards the three-day stay requirement. Senators Sherrod Brown (D-OH), Susan Collins (R-ME), Bill Nelson (D-FL), and Shelley Moore Capito (R-WV) along with Representatives Joe Courtney (D-CT) and Joe Heck (R-NV) have introduced the Improving Access to Medicare Coverage Act of 2015 (S. 843/H.R. 1571) to count all hospital days spent in observation towards the three-day stay requirement.

The Stories

The following real patient stories highlight how Americans in need of skilled nursing care have been forced to pay out-of-pocket costs because of Medicare's current observation status policy.

CONNECTICUT

After a car accident left him with a neck fracture, Angelo Verdini, a 90-year-old North Haven resident, was shocked to receive a $7,700 bill for the weeks he spent in a rehabilitation center. The Connecticut man was rushed to an emergency room after the accident where he was subjected to a battery of tests. He spent five days in the hospital room and felt like an admitted patient. Verdini told NBC 4 New York, "I couldn't tell the difference, and I don't know if anyone else who has experienced it could tell the difference." But there was a huge difference. He later discovered that he was "under observation" and not admitted. As a result, Medicare did not cover post-hospital care. After several appeals, Angelo Verdini fears he will have to fight Medicare until his death. Read more about Angelo Verdini's story on NBC 4 New York's website at www.nbcnewyork.com/investigations.

DISTRICT OF COLUMBIA

On November 22, Mary, a resident of the Lisner-Louise-Dickson-Hurt (LLDH) Home in Washington, D.C., was sent to the hospital after a fall that left her unable to walk. From the emergency room, Mary was transferred to the general medicine floor where she was unknowingly kept under observation status and not admitted as an inpatient. During that time, she learned her degenerative joint disease in her back and legs had become worse. The physical therapist at the hospital recommended Mary return to the skilled nursing center for intensive rehabilitation, but because Mary was not admitted as an inpatient to the hospital, the center could not access her Medicare Part A benefit. On November 25, after four days in the hospital under observation status, Mary returned to the skilled nursing center where she was required to apply for Medicaid in order to pay for her stay.

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Joe Courtney
Congress of the United States
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May 5, 2016

The Honorable Sylvia M. Burwell
Secretary of Health and Human Services
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Observation Coding / Two Midnight Rule

Dear Secretary Burwell:

I am writing to follow up on our frequent dialogue on the harmful impact of the observation rule, particularly in light of your Department's recent decision to abolish the Two Midnight rule.

As verified by the Medicare Inspector General's office, hundreds of thousands of long-term elderly patients in hospitals each year are routinely ensnared by the coverage gap created by observation coding. As you know from our previous conversations, when patients are coded as 'observation' after presenting at the hospital, that determination typically costs Medicare beneficiaries thousands of dollars per year out of pocket because medically prescribed orders to go to a Skilled Nursing Facility post-discharge are not covered by Medicare.

As the Inspector General confirmed, observation has disrupted post-discharge care into nursing homes by removing patients from the traditional three day pathway. This is why I continue to work, year after year, with a large coalition of Members of Congress and outside stakeholders to restore the long-established Medicare coverage for discharged patients.

In the past, when my office has engaged with you on this issue, I have asked the Department for help in fixing the unintended, but well documented, consequences of observation determinations. Unfortunately, each time I write to you, I have received responses insisting that the Two Midnight rule was a 'solution' to the problem. However, per the most recent CMS proposed rule (CMS 1655 P) published on April 18 2016, it is clear that the Department now concedes that the Two Midnight rule was ineffective in changing hospital determination behaviors, not to mention the fact that it did nothing to help patients.

Though I am pleased that the Department has recognized that the Two Midnight rule is ineffective, I am frustrated that simply rescinding the rule still fails to provide any relief for patients, or change hospital determination behavior. As such, I would appreciate revisiting past

conversations with you regarding this issue, and would ask for your support of my legislation, the *Improving Access to Medicare Coverage Act of 2015* (HR 1571). As you know, this measure would enable observation determinations to be counted toward inpatient stay requirements for the purposes of Medicare coverage for patient discharge into a skilled nursing facility.

As we have discussed, providers attest that the difference between patients coded as inpatient versus observation is nominal – physicians may order the same tests for both inpatients and observation patients, and both may receive the exact same level of care. Therefore, I fail to see why the Department will not support a common sense restoration of the three day rule (whether coded as observation or inpatient) that had been in place for over forty years.

As part of the rule, I note that the Department moved forward with implementation of the Notice Act, which is a well-intentioned measure adding transparency to this confusing process for patients. Many states, such as Connecticut, enacted similar provisions in recent years, and of course I voted in support of passage of the Notice Act. However, as we know in Connecticut, the Notice Act has not solved the barriers created by observation coding for patients with three day stays or longer. Providers and patient advocates in states such as mine, which have had Notice Act requirements, are still reporting huge numbers of coverage problems for Medicare patients.

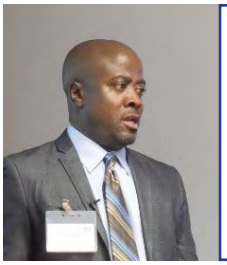
Once again, I want to applaud the Department for recognizing that the two midnight rule was an ineffective response to the collateral damage created by observation coding for longer stay patients. Our responsibility as legislators and regulators is to improve laws and regulations in order to create a more efficient health care delivery system while also doing our best to protect patients. Hopefully, this new development will provide a 'fresh look' by your office at my bill. The bill has tremendous bipartisan support of 118 members of the House and 22 Senators, as well as over 55 front-line provider groups and patient advocacy groups from all across the country.

As always, thank you for your attention to this important matter and I look forward to your response.

Sincerely,

Joe Courtney

JOE COURTNEY
Member of Congress



Ed Norwood

Conference Speaker Discusses

Timeframe for Filing Claims

Dear MN Alumni Provider Membership:

Last week, I spoke with Pam Gergen, Audit Director at the Enforcement Division of the Minnesota Department of Commerce regarding the timeframes to file claims under §62Q.75 Subd. 3, which states:

Claims filing. Unless otherwise provided by contract, by section 16A.124, subdivision 4a, or by federal law, the health care providers and facilities specified in subdivision 2 must submit their charges to a health plan company or third-party administrator within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later. A health care provider or facility that does not make an initial submission of charges within the six-month period shall not be reimbursed for the charge and may not collect the charge from the recipient of the service or any other payer. The six-month submission requirement may be extended to 12 months in cases where a health care provider or facility specified in subdivision 2 has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. Any request by a health care provider or facility specified in subdivision 2 for an exception to a contractually defined claims submission timeline must be reviewed and acted upon by the health plan company within the same time frame as the contractually agreed upon claims filing timeline...."

I explained to Ms. Gergen that the term: "Unless otherwise provided by contract," appears to permit a health plan company to set their rates anywhere between 30-180 days at their discretion and use a "take it or leave it" approach in contracting with emergency safety net providers.

Ms. Gergen confirmed that, under existing law, plans may set timely filing deadlines in contracts less than the 180 days stipulated above and that if our provider membership is uncomfortable signing contracts with short claims filing deadlines, they should not sign them.

We then sent Ms. Gergen two California regulations to discuss with her policy unit, as a basis for suggested law reforms that can protect providers in contracting:

28 CCR §1300.71 (b) (1) states:

“Neither the plan nor the plan’s capitated provider that pays claims shall impose a deadline for the receipt of a claim that is less than 90 days for contracted providers and 180 days for non-contracted providers after the date of service, except as required by any state or federal law or regulation. If a plan or a plan’s capitated provider is not the primary payer under coordination of benefits, the plan or the plan’s capitated provider shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than 90 days from the date of payment or date of contest, denial or notice from the primary payer.”

28 CCR §1300.71 (b)(4) adds:

A plan or a plan’s capitated provider that denies a claim because it was filed beyond the claim filing deadline, shall, upon provider’s submission of a provider dispute pursuant to section 1300.71.38 and the demonstration of good cause for the delay, accept, and adjudicate the claim according to Health and Safety Code section 1371 or 1371.35, which ever is applicable, and these regulations.

Under 62Q.75, there appears to be a similar good cause exception written as follows:

"…providers and facilities specified in subdivision 2 must submit their charges to a health plan company or third-party administrator within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later.

However, if 1.) You have a contract deadline less than 180 days or 2.) Your contract is silent to any timeframes permitted to bill from the date you became aware of the responsible plan/TPA, we may need to fight for even stronger protections.

As you know, many managed care plans just won't negotiate with providers. Contracts are an important and growing part of medicine and essential components to a viable healthcare delivery system. However, in cases of adhesive contracts – form contracts that can't be negotiated- this can often injure the less advantaged parties (providers) with provisions that are unfair or unconscionable.

Our provider members in Minnesota simply need stronger laws that set minimum claims filing deadlines plans can use in contracts to protect residents from being forced to pay large amounts of money when they arrive in an altered state, unconscious, intubated, placed in a coma, or seen in the ER, and simply do not pass the insurance along until receiving a bill months later.

Perhaps additional language that states: "If the provider can demonstrate good cause, the plan shall accept and adjudicate the claim per MS 62Q.72 Subd. 2."

Lastly, I explained to Ms. Gergen that we would begin escalating trend timely filing complaints, where we could demonstrate good cause for the delay or if no apparent prejudice occurred from the late filing.

If you can trend timely filing denials by payors where good cause exists for the late filing as shown above, please email us to request inclusion of your cases in a formal trend complaint to the Minnesota Department of Commerce.

Also, where plan hold times are excessively long (60-80 mins) and their failure to provide timely status determination results in violation of prompt payment timeframes, the State would like to see those.

Please contact us with a list of any problem payors who repeatedly fail to reimburse claims within 30 days as required by MN Statutes §62Q.75.

Best,

Ed Norwood
President
ERN/The National Council of Reimbursement Advocacy

714-995-6900 ext. 6926 bus 714-995-6901 fax
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Success Stories from Ed Norwood Boot Camp

Does anyone else have any results from using information that Ed Norwood shared? After the meeting, a facility was able to get some action with the VA using the Federal Prompt Payment Law and got over $90K in timely filing auth denials overturned.

Be prepared to share any success stories at the upcoming MN AAHAM Fall Conference in November or contact me with any information. No names or contact information will be used.

Pam Brindley/ pbrindley@avadynehealth.com

Priscilla Holland / Senior Director of Healthcare Payments, NACHA

Switching to the Healthcare EFT Standard:

4 Ways to Ease the Transition

Healthcare electronic funds transfers (EFTs) via ACH – the Healthcare EFT Standard - can make practice management easier and more affordable—and switching doesn't have to be difficult.

Compared with other payment methods, providers can save up to $7.21 per payment using EFTs via ACH in combination with electronic remittance advice (ERA), according to the 2014 CAQH Index. EFT via ACH payments, which transfer funds electronically from the insurer's account to the provider's account, are also faster than other methods, with funds available the same day they're received.

Additionally, going electronic also has security and efficiency benefits. Because they're transferred digitally, EFTs via ACH come with lower fraud risk than, for example, paper checks, which often change hands multiple times. And, with most practice management systems, reconciliation between EFT and ERA can be fully automated.

Best of all? It's not difficult to switch. Thanks to the implementation of the Healthcare EFT Standard effective Jan. 1, 2014, which requires insurers to deliver EFT payments via ACH upon request, it's easier to transition than ever, especially if you use the following tips.

1. Enroll the easy way. CAQH offers an enrollment hub that's free to all providers. Entering your information into the secure database just once allows you to enroll with multiple participating health plans, simultaneously. For plans that aren't participating in the enrollment hub, providers should rank them according to payments volume. In most practices, roughly 80 percent of payments come from 20 percent of insurance providers. It makes sense, then, to enroll with the largest payments providers first to reap maximum benefit right away. Then, gradually work your way down the list until you've enrolled with all insurers.

2. Don't forget ERAs. EFTs via ACH produce more savings for practices when they're used in conjunction with ERAs. ERAs allow for the automatic reconciliation and posting of payments to patient accounts, saving your staff time as well as eliminating manual posting errors. It's easy to set up ERAs: in most cases, they can be requested at the same time as EFTs via ACH. If your practice uses a clearinghouse, contact them for additional assistance.

3. Talk to your vendors. Communication and cooperation between all parties involved in the EFT process—practices, banks, clearinghouses, practice management systems—is essential to a smooth transition. Your bank is required by NACHA Operating Rules, which govern the ACH Network through which healthcare EFT standard transactions are processed, to deliver ACH remittance data to your practice. If you've requested ACH data and your bank won't provide it, contact NACHA immediately. Additionally, while most clearinghouses and practice management systems can support EFT/ERA reconciliation and auto posting, make sure yours can and, while you're at it, ask about any set-up help or services they might provide.

4. Address staff concerns. Change can be uncomfortable for staffers who are used to tried-and-true processes or who might be concerned about being replaced by technology. In truth, transitioning to EFT/ERA simply reduces staffers' time spent on reconciliation and posting. This allows them to handle a larger volume of claim payments or frees them up to focus on other important tasks and patients. Prior to transitioning, get ahead of staff concerns and make sure everyone understands the EFT/ERA process and its benefits.

Switching to EFTs via ACH is one of the easiest ways to dramatically simplify your practice management and reduce costs. For more resources and tips on how to make the transition a smooth one, visit https://healthcare.nacha.org/ProviderResources

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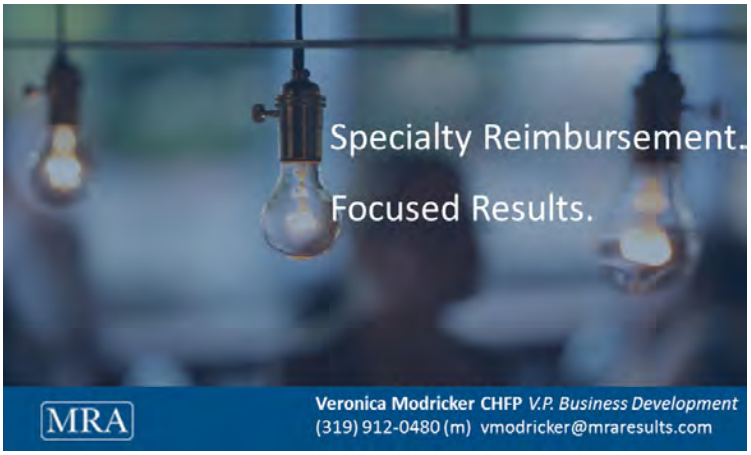

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Minnesota Department of Human Services

Minnesota Health Care Programs (MHCP)
American Association of Healthcare Administrative Management (AAHAM)
April 13, 2016

Responses to AAHAM Provider Questions

1. What is your current approximate wait time when providers call in. Is there a regulation on how long the wait time can be? Currently BCBS can be up to 60 minutes. – Mille Lacs Health System

   Answer: Wait times on the MHCP Provider Call Center have averaged less than 10 minutes through the end of March and the beginning of April. Around the beginning of the year, wait times were higher due to increased call volume related to member eligibility renewals.

2. We had a change for CPT 90853 to be billed as G0410 for Medicare on 8/1/15. This is a facility charge I am questioning as I believe the professional CPT will remain as 90853. Do the Medicare Replacement plans want us to use G0410 for facility or should we use 90853? Same thing with G0463 and 99214. – Lakewood Health System

   Answer: MHCP accepts 90853 on both the professional and facility claims. However, we accept G0410 on facility claims only when Medicare has paid this code and the prior payment is listed on the claim.

   Effective January 1, 2014, MHCP implemented Medicare's change to require G0463 on facility claims in place of the following codes, 99201–99205 and 99211–99215.

3. Electronic claims front end rejections from insurance payers.
   When a Provider submits an electronic claim to the wrong insurance payer in error. An example would be, some payers will send the claim back electronically with a claim response message (possibly called a 272 - patient is not eligible for dos) on why the electronic claim cannot be processed and why the claim is being sent back electronically to the provider. So it's a front end edit that rejects the claim at a header level vs. full adjudication. Will providers see more of these front end claims rejections? – St. Luke's Duluth

   Answer: When providers send claims to MHCP for patients who are not covered under an MHCP program, we fully adjudicate the claim and return the denial information on the provider's remittance advice. MHCP rejects files on the front end only for syntax errors. In these situations, the provider will receive a rejected 999 or TA1 response for the batch file.

4. Do you foresee in the future of possibly adding a condition code to the claim form when additional documentation/medical notes are required for the reprocessing of the claim? – St. Luke's Duluth

Answer: When additional documentation is required to process a claim, MHCP requires providers to send a claim attachment and indicate an attachment control number on the claim.

5. Electronic PWK for Health insurance plans.
With the recent laws regarding Workers Compensation under Minnesota State Statues 176.135 subdivision 7a states that beginning 07.01.2016 the provider must submit medical notes electronic through the PWK segment and insurance payers must accept an electronic PWK segment. Do you see these same laws being applied to the health insurance industry? – St. Luke's Duluth

   Answer: The statute in question does not specifically apply to MHCP claims. However, MHCP does accept information in the PWK segment when providers submit a claim attachment type code and attachment control number on the claim.

6. We've had 4 situations where DHS says they sent a renewal form to the patient however, they have not received it. The patients' coverage then gets termed out 1/31/16. All of these happene in January. DHS states that a mass load of letters went out in January. Did these actually go out? - Fairview Range

   Answer: Over 130,000 Medical Assistance and MinnesotaCare cases were up for renewal in January, 2016. To date, DHS and county servicing agencies have processed all January renewals that were returned on time. Many cases were closed because the renewal or the requested verifications were not returned. Enrollees can still submit the necessary information bu may experience a gap in coverage. They can also reapply.

   Renewal notices were mailed to all cases selected for renewal. It is possible the case record included an incomplete or outdated address. If members have any questions about their renewal, please encourage them to call their county servicing agency or the MHCP Member Help Desk at 651-431-2700 or 800-366-5411.

7. Medicaid NCCI edits. We recently were directed to the Medicaid specific NCCI edit information on the MHCP website after one of our calls on a denial was escalated to a supervisor. We did not know that there were separate, unique NCCI edits for Medicaid, and had looked at the MHCP website and searched multiple times. The information isn't within the regular provider/billing information. It would be very beneficial to educate all provider call center staff so they can direct providers to this information and also post educational information related to this in a provider communication. – Rice Memorial

Answer: Refer to the MHCP NCCI FAQ web page under Billing Resources on the MHCP Enrolled Providers Homepage (www.dhs.state.mn.us/providers). This page has information abo how MHCP applies Medicaid NCCI edits and links to the Medicaid.gov page. The MHCP Provid Call Center has been informed of these resources.

8. DME: Medicare claims processing as primary and crossing over as a secondary to MA; MA is denying entire claim for inappropriate modifiers or incorrect/incomplete HA0 notes on misc HCPCs. MA should be processing as a secondary payer according to how Medicare paid, we shouldn't have to rework the secondary claim according to MA guidelines. – Rice Memorial

   Answer: In most cases, when Medicare has made prior payment for MHCP covered services, w may pay the Medicare applied coinsurance and deductible up to the MHCP or Medicare allowab amount for the service, whichever is less. We are not aware of any broad issues related to use modifiers or notes on the claim. Please submit claim examples through the Provider Call Center at 651-431-2700 or 800-366-5411.

9. We have been told for Physician Credentialing for MN MA they are just working on early Octobe applications, wondering why the back log and this is causes claim rejections and us to have to hold claims. What steps are being taken to resolve this backlog? We shouldn't have to wait 6 months to submit claims for services provided. – Rice Memorial

   Answer: Processing of some of the provider types are behind due to the volume of applications received. This volume has also increased due to required provider revalidation efforts. MHCP Provider Enrollment is working hard to process applications as quickly as possible, in order of th date they received them for both revalidation and new enrollment. Staff have been working overtime and we have added three new staff to our team. We are hoping this will reduce the delays in processing.

If you have a client access issue and you have waited more than 30 days for a new provider enrollment application to be processed, call the Provider Call Center at 651-431-7462 or 800-36 5411. Request a work order to Provider Enrollment due to an access issue for the client. The Call Center will need the name, NPI and date and time the application was faxed to create the work order.

AAHAM 2016 Payer Panel – Q & A PreferredOne

1. What is your current approximate wait time when providers call in? Is there a regulation on how long the wait time can be? Customer Service/Provider Services call center wait time is under one minute. Wait time can vary by product line as each of our products has its own call center phone number. Some product line wait times are under 30 seconds.

2. We had a change for CPT 90853 to be billed as G0410 for Medicare on 8/1/2015. This is a facility charge I am questioning as I believe the professional CPT will remain as 90853. Do the Medicare Replacement plans want us to use G0410 for facility or should we use 90853? Same thing with G0463 and 99214. PreferredOne generally follows CMS coding guidelines so even though we're fully commercial with no Medicare or Medicare Replacement plans offered we would follow CMS guidelines for these coding changes.

3. Electronic claims front end rejections from insurance payers. When a provider submits an electronic claim to the wrong insurance payer in error. An example would be, some payers will send the claim back electronically with a claim response message (possibly called a 272 – patient is not eligible for DOS) on why the electronic claim cannot be processed and why the claim is being sent back electronically to the provider. So it's a front end edit that rejects the claim at a header level vs. full adjudication. Will providers see more of these front end claims rejections? Yes, I believe as EDI front end edits become more defined the likelihood of these header level edits will increase. If the claim does end up making it through the front door & into full adjudication a remittance would post with an ST denial code indicating the subscriber policy is termed/not eligible for this DOS. However, I would say the goal is to decrease the need to adjudicate & submit a remittance for these instances so that an instantaneous rejection can be sent back to the clearinghouse & in turn to the provider when a member is no longer eligible under a policy.

4. Do you foresee in the future of possibly adding a condition code to the claim form when additional documentation/medical notes are required for the reprocessing of the claim? The NUBC does accept recommendations for consideration to adding new condition codes. Any uniformity that can be brought to the claims submission experience would be welcomed, but at this time PreferredOne isn't actively pursuing the addition of such a condition code. At this time if a line descriptor is insufficient & records are needed PreferredOne will send a letter to the provider requesting the required records.

5. Electronic PWK for health insurance plans. With the recent laws regarding Workers Compensation under Minnesota State Statutes 176.135 subdivision 7a states that beginning 7/1/2016 the provider must submit medical notes electronic through PWK segment and insurance payers must accept an electronic PWK segment. Do you see these same laws being applied to the health insurance industry? Industry-wide everything appears to be moving towards become electronic whether that's care provided to members via telemedicine providers, EMR systems being implemented, claims submissions requiring electronic submission vs paper submission, etc. I would imagine that electronic submission of medical notes/records

would follow suit in that the industry would eventually move towards that as a standard just as it did for claims submissions, at least within the state of Minnesota.

PreferredOne Question:

1. Is there a way to know which policies go through the Medicare edits and how we can tell by the insurance card? Yes, any tribal member who has access to Medicare-like rates/edits would have a unique identifier on their insurance ID card. You'll want to look for 2 things on the insurance ID card to identify these members. You'll see both the tribe's logo along with the phrase ***Contract Health Services***.

National Government Services, Inc., per CMS, requires that all initial inquires be made to our Provider Contact Center. If the inquiry is something can be answered by our Interactive Voice Response (IVR) system, then the J6 Part A (includes all Minnesota Part A providers) provider should first contact the IVR at: 877-309-4290.

If the question is beyond the capabilities of the IVR, then the provider should contact the NGS Provider Contact Center at 1-877-702-0990 (TTY: 888-897-7523). The provider should be prepared to provide (per CMS requirements) their NPI, PTAN, and the last 5 digits of their TIN as well as any information necessary for a claim specific inquiry.

For additional information, please go to www.NGSMedicare.com and select J6 Part A – then look under the search bar for the "Contact Us" link.

For education requests, please contact us via the following email box: J6.provider.training@anthem.com

Local Chapters: AAHAM has 32 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
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	$25.00
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	$20.00
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	$30.00
Georgia #33	Georgia	$30.00
Connecticut #34	Connecticut	$35.00
Three Rivers #37	Pittsburgh, Pennsylvania	$50.00
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
Twin States #56	Vermont & New Hampshire	$25.00

Please Check the Appropriate Codes in Each Category Below

Years in Healthcare:
□ 0-5 □ 6-10 □ 11-20 □ 21-25 □ 25+

Certification:
□ CHAM (NAHAM) □ CHFP (HFMA)
□ FHFMA (HFMA) □ CHCS (ACA)
□ Other (please list)

Employer Type:
□ Vendor/Corporate Partner □ Billing
□ Collection Agency □ Consulting
□ Outsourcing □ Software IT
□ Provider □ Law Firm
□ Other (please list)

Position:
□ CFO
□ Vice President
□ Partner, Principal, Owner
□ Executive Director
□ Consultant
□ Director
□ Manager
□ Supervisor/Coordinator
□ PFS Representative
□ Patient Access Representative
□ Other (please list)

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

MN Gopher *AAHAM* Chapter Scholarship Program

Eligibility

- ♦ Local Gopher Chapter member must be a member for 1 year before running for scholarship.
- ♦ If not a National member, the member will be responsible to pay national dues if wins.
- ♦ The President & Chair of the Board are ineligible.
- ♦ The winner of the scholarship award is ineligible for the next 3 years.
- ♦ The scholarship year runs from the day after the summer meeting the current year until after the summer meeting the following year.
- ♦ Points need to be turned in within 30 days of the qualifying event to be accepted. July points need to be turned in by the summer meeting.

Points

10 points	**25 points**	**50 points**	**75 points**	**100 points**
♦Assisting with seminars ♦Recruiting a local member ♦Articles not written by the member but published in the Gopher Tracks or the National Journal (max 2 per issue) ♦Conducting coaching sessions outside regular meetings	♦Setting up speaker for meeting ♦Serving on a Gopher Chapter task force or special committee ♦Representing AAHAM on a committee (ex. AUC) ♦Proctoring for technical certification(max 50 pts./day) ♦Representing AAHAM as a speaker for an organization ♦Presenting at a Gopher Chapter meeting ♦Attending MN Leg Day	♦Sitting for technical certification (1 sitting) ♦Passing technical certification ♦Articles you wrote that are published in the Gopher Tracks or National Journal (max 2 per issue) ♦Attending Chapter meetings ♦Attending ANI ♦Attending Nat'l Leg Day ♦Chairing a Gopher Chapter committee ♦Serving on a National Committee ♦Presenting at ANI ♦Attending **all** Chapter meetings for year	♦Recruiting a National Member ♦Grading CPAM/CCAM ♦Proctoring for prof certification	♦Sitting for CCAM, CPAM, or CHCS **(Max 100 pts per certification)** ♦Passing the CCAM, CPAM, or CHCS

Name: _____ Phone: _____ Email: _____

Address: _____

Signature: _____ Date: _____

DATE	QUALIFYING ACTIVITY	COMMITTEE CHAIRPERSON	POINTS

Send to:
Janet Curtis
Fairview Range Regional Health Services
Revenue Cycle Manager
Hibbing, MN
218-362-6240
jcurtis1@range.fairview.org

CONSTITUTION

American Association of Healthcare Administrative Management
Gopher Chapter

ARTICLE I – NAME

The name of this organization shall be the American Association of Healthcare Administrative Management (AAHAM), Gopher Chapter.

ARTICLE II – MISSION

Our mission is to be the premier professional organization in healthcare administrative services. Through a national organization and local chapters, we provide quality member services and leadership in the areas of education, communication, representation, professional stan-dards and certification.

ARTICLE III – PURPOSE AND OBJECTIVES

The purpose of the American Association of Healthcare Administrative Management, Gopher Chapter shall be to:
Promote and encourage recognition of Patient Account Management as an integral part of healthcare financial management.
Encourage the implementation of effective and efficient business and receivables management, policies, and procedures in the healthcare industry.
Stimulate and encourage an exchange of information among the membership.
Develop and encourage the implementation of programs for the purpose of furthering the education and increasing the knowledge of the membership of the healthcare industry.
Develop and implement such programs as may add to the knowledge and encourage the development of persons new to the healthcare industry.
Establish standards of performance for persons who participate in, or are involved with, the management of healthcare patient accounts.
Cooperate with other healthcare organizations, institutions, and other related agencies.

ARTICLE IV – MEMBERSHIP

A member shall be an individual associated with healthcare administrative services.
Membership shall be on an individual basis and not on an institutional basis.
One member from each institution must be a national AAHAM member. Other members from that institution may be Gopher Chapter (local) members only.
In the event the National AAHAM member leaves the institution, local only members may continue their membership for the remainder of the membership year.

ARTICLE V – MANAGEMENT

The Executive Committee shall direct the affairs of the American Association of Healthcare Administrative Management, Gopher Chapter.
The Executive Committee shall consist of the Officers and Board of Directors of the American Association of Healthcare Administrative Man-agement, Gopher Chapter. The powers and duties of the Executive Committee are defined in the Bylaws.

ARTICLE VI – PERSONAL LIABILITY OF OFFICERS AND DIRECTORS

An Officer or Director of the AAHAM, Gopher Chapter shall not be personally liable to the Association or its shareholders for monetary dam-ages as such including, without limitation, any judgment, amount paid in settlement, penalty, punitive damages or expense of any nature (including, without limitation, attorney's fees and disbursements) for any action taken, or any failure to take the action, unless the Officer or Director has breached or failed to perform the duties of his or her office under this Constitution, the Bylaws of the Association, or applicable provisions of the law and the breach or failure to perform constitutes self-dealing, willful misconduct or recklessness.

ARTICLE VII – MEETINGS

Annual or special meetings of the American Association of Healthcare Administrative Management, Gopher Chapter shall be held as pro-vided for in the Bylaws.

ARTICLE VIII – BYLAWS

The Bylaws of the American Association of Healthcare Administrative Management, Gopher Chapter may be amended, repealed, or added to in the following manner:
Any of the membership of the American Association of Healthcare Administrative Management, Gopher Chapter may propose a change to the Constitution.
The Board of Directors shall, by a majority vote, determine if the proposed change shall be submitted to the membership for a vote.
Notification shall be in writing and shall inform the members of the Article or Articles to be changed.
The Article or Articles to be changed shall be submitted to the membership in their existing form and in the form of the proposed change.
Voting on any change shall be by mail ballot submitted to the membership. A two third (2/3) vote of the members voting shall be required to adopt the said change.
Approved by the Board of Directors 5/7/97. Approved and adopted by a majority vote of the membership 11/5/97.
Changes approved and adopted by a majority vote of the membership 11/6/02 and 7/21/03
Reviewed and Approved by Board of Directors 7/21/10 and 11/2012

National AAHAM Membership Application

For those interested in becoming a National AAHAM Member, this application can be found at www.aaham.org

AAHAM
American Association of Healthcare Administrative Management

2015 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 $190. If you join anytime between July 1st and August 31st, the dues are $150 for the rest of the current year. If you join between September 1st and December 31st, the fee is $230 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 and submit proof with this application.** 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