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LETTER FROM THE EDITOR

BY TESSA TINLEY

Breathe a sigh of relief, and clear the next 30 minutes of your calendar. The moment you've been waiting for since last November has finally arrived...

Welcome to the latest edition of the Three Rivers AAHAM Newsletter!

2021 has been dubbed "The Year of New Beginnings" by some (okay, by me). After the hot mess that was 2020, I think we are all ready to look ahead, move forward, and make the most of each moment that is to come.

And here's the best part... Three Rivers AAHAM can be a part of that! While a lot of things were in constant upheaval in 2020, your favorite local healthcare organization wasn't one of them. The board continued to meet monthly and plan virtual events, such as the joint webinar that occurred on March 17th. We are hopeful we can meet in-person later this year, but will be planning multiple educational and networking opportunities either way.

So, do yourself a favor – renew your Three Rivers AAHAM membership today! Or better yet, take it a step further, and join a committee. We are always looking for fresh, new ideas, and welcome all with open arms. Most of us don't bite (except Ken, but we're working with him on that). Reach out to any board member any anytime for more information on membership or joining a committee.

You'll also be pleased to know you'll be hearing from us more often. The newsletter is moving to a quarterly publication – and that means we'll need more content. Did you know? 98.5% of your colleagues have said that the most impressive accolade one can achieve both personally and professionally is having an article published in the Three Rivers AAHAM Newsletter*. If you'd like to submit something, please reach out to me personally.

Here's to a safe, vaccinated, optimistic 2021.

-Tessa

**This statistic has not been validated and may not be totally accurate.*

EDITORIAL POLICY

Opinions expressed in articles or features are those of the author and do not necessarily reflect the view of the Three Rivers Chapter, the chapter newsletter committee, or the national organization. The committee reserves the right to edit material and accept or reject contributions whether solicited or not. All correspondence is assumed to be a release of information for publication unless otherwise indicated.

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INTERESTED IN SPONSORSHIP FOR 2021? PLEASE CONTACT BRENDA FRAAS AT fraasbl2@upmc.edu FOR MORE INFORMATION!

PRESIDENT'S LETTER

BY CHRISTINE IFFT, CRCE CHAPTER PRESIDENT

Welcome to 2021! Things are changing yet still look the same if that is possible! However, we have hope – hope of everyone being vaccinated before the fall, hope that the virus is slowing down, hope that we will be able to finally get back to living our lives out of quarantine. That hope brings excitement to me! I am looking forward to a much better future. Maybe things will still be different than what we had become accustomed to prior to the pandemic, but I think we are on our way to a full "recovery" with a few minor side effects that we can really live with! Good things came out of all of this if you look at it with a different lens. Many of us are now working remote – being able to balance work and life. Being able to cut off the commute times and work around family emergencies. Some have become more efficient and productive. Some had time to step back and re-evaluate our processes in Rev Cycle. I know not everything is peaches and cream, but we have to take the good in every situation and focus more on that over the bad!

While we are not back to meeting in person, we have joined forces with our fellow Pennsylvania Chapters as well as the New Jersey chapter to bring you some great monthly webinars! We have a joint payer webinar planned for some time in April that will cover our major payors across the state. We recently had a panel of dynamic speakers that talked about their experiences in Rev Cycle with the COVID-19 crisis. It was interesting to see how each of them pivoted to make sure that their patients were still receiving the best care and being taken care of from the Revenue Cycle side of healthcare as well. The Three Rivers Education Committee is starting to gear back up to bring you even more education opportunities. Also, please check the National AAHAM site for other great offerings of free webinars.

In addition, I would encourage you to review our list of wonderful sponsors on our website and reach out to them in event that you would have a service that they could help you with! This is an excellent list of vendors that not only support our organization, but that have good reputations and are knowledgeable in our field of Revenue Cycle.

This paragraph will be a staple in my letters. I am going to ask you all to get engaged with our Chapter. To join a committee, sit in on a Board meeting, ask questions, make suggestions, and become certified. We would love to hear what you have to say, get fresh ideas, and have you involved!

Please make sure you follow Three Rivers AAHAM and National AAHAM on social media for up-to-date information. Three Rivers is on Facebook, Instagram and Twitter for your convenience.

I will close my letter this time with optimism to maybe be able to see many of you this fall in person! We have a lot of catching up to do!

Stay safe, stay well!

Christine Ifft, CRCE
Three Rivers AAHAM Chapter President

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Net Worth - As of 2/23/2021 As of 2/23/2021

Account	2/23/2021 Balance
ASSETS	
Cash and Bank Accounts	
Checking	24,818.78
TOTAL Cash and Bank Accounts	24,818.78
TOTAL ASSETS	24,818.78
LIABILITIES	
Other Liabilities	
Sales Tax	0.00
TOTAL Other Liabilities	0.00
TOTAL LIABILITIES	0.00
OVERALL TOTAL	24,818.78

THREE RIVERS AAHAM STUDENT MEMBER SPOTLIGHT:



Three Rivers AAHAM Vice President Ken Kreiger presented a check to the Greater Pittsburgh Area Food Bank from our 'Virtual Happy Hour' event.



Name:

Lauren Gutterman

Hometown:

Macungie, PA

Current Job:

Administrative Intern at University of Pittsburgh SHRS Wellness Pavilion

Career Aspirations:

I am interested in working in operations, quality improvement, and patient satisfaction in an acute care or outpatient setting.

Why you chose Pitt's Master of Health Administration Program:

The MHA program at Pitt is comprehensive and high ranking. I was looking for a challenging program that provided internship opportunities.

What you hope to gain out of your AAHAM membership:

I want to network with members and learn new skills.

Fun fact about you:

I enjoy reading in my free time.

AAHAM CERTIFICATION

BRENDA FRAAS

Newly Certified Members:

CRCP- Kristin Berkeybile - St. Clair Hospital

CRIP - Lori Lawther – Allegheny Health Network

The American Association of Healthcare Administrative Management (AAHAM) is the premier professional organization in healthcare administrative management. Your one-stop resource center for information, education and advocacy in the areas of reimbursement, admitting and registration, data management, medical records, patient relations and so much more.

Did you know professional development of its members is one of the primary goals of the association. Publications, conferences and seminars, benchmarking, professional certification and networking offer numerous opportunities for increasing the skills and knowledge that are necessary to function effectively in today's health care environment. See below for more information on AAHAM's certification options and the importance of earning certification.

AAHAM certification options include:

- The AAHAM Certified Revenue Cycle Executive (CRCE)
- The AAHAM Certified Revenue Cycle Professional (CRCP)
- The AAHAM Certified Revenue Integrity Professional (CRIP)
- The AAHAM Certified Revenue Cycle Specialist (CRCS)
- The AAHAM Certified Compliance Technician (CCT)
- The importance of earning an AAHAM certification

AAHAM certification is an investment in your personal growth and your professional future. For over forty years, AAHAM's elite certification program has set the standard of excellence in patient financial services and the revenue cycle.

It doesn't matter whether you are new to the healthcare revenue cycle or are a seasoned veteran, our family of AAHAM certification examinations offer a complete career ladder beginning with the Certified Revenue Cycle Specialist and culminating with the Certified Revenue Cycle Executive. We have a certification that will help advance your career.

Plus, the learning doesn't stop once you have obtained certification. Our certifications are maintained through a continuous education process. This assures you stay abreast of the important changes and updates that continually occur in our rapidly changing healthcare environment.

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

Certification Exam Schedule

March 8-19, 2021
March 2021 exams

April 15, 2021
Registration deadline for July 2021 exams

July 19-30, 2021
July 2021 exams

August 16, 2021
Registration deadline for November 2021 exams

November 8-19, 2021
November 2021 exams

December 15, 2021
Registration deadline for March 2022 exams

For those of you who are already certified, you can earn 2 AAHAM CEU's for each session you attend. For more information on the webinars or to register, please visit www.aaham.com

RULE EASING PATIENT CARE AUTHORIZATION PULLED FROM HHS WEBSITE

AMY GARCIA, GOVERNMENT RELATIONS CHAIR

A Trump administration rule aimed at making it easier to approve medical procedures was removed from the Department of Health and Human Services website, the agency confirmed.

The final rule, which the Centers for Medicare & Medicaid Services announced Jan. 15, "was removed from the CMS website as it falls under the White House's Regulatory Freeze," the HHS press office said in an email. The final rule was never published in the Federal Register. Only the proposed rule (RIN: 0938-AT99) from Dec. 18, 2020, was published.

President Joe Biden has ordered his administration to halt many Trump-era rules that were issued late in the last administration until they can be reviewed to ensure they don't undermine the Affordable Care Act or harm coverage in the new president's view. The prior authorization rule is one of those actions.

A CMS press release from Jan. 15, which no longer is on the agency's website, said the final rule "builds on the efforts to drive interoperability, empower patients, and reduce costs and burden in the healthcare market by promoting secure electronic access to healthcare data in new and innovative ways."

The rule would have allowed insurers, health-care providers, and patients to have electronic access to pending and active prior authorization decisions. Under prior authorization processes used by insurers, doctors must get approval before procedures such as operations can be covered. Health-care providers complain the process is too burdensome.

America's Health Insurance Plans President and CEO Matt Eyles blasted the rule in a statement when it was announced. "This shabbily and hastily constructed rule puts a plane in the air before the wings are bolted on by requiring health insurance providers to build these technologies with incomplete and untested instruction manuals," Eyles said. "Despite rushing the rule, this Administration requires insurance providers to build expensive IT bridges to nowhere by failing to establish comparable requirements for providers or their IT vendors to use the technologies," he said.

It's not clear when the final rule would have taken effect. Rules that went into effect before Biden took office can be reviewed by his administration because the Congressional Review Act calls for 60 days between a rule's publication and its effective date.

Another Trump administration rule that would clarify employers' responsibilities under the Affordable Care Act when they help employees buy ACA plans also appears to have been deleted from the government's website. The Internal Revenue Service issued the final rule Jan. 13 (RIN 1545-BP17), but the Federal Register only shows the proposed rule from Sept. 30, 2019.

The rule said employees enrolled in Obamacare plans through health reimbursement arrangements (HRAs), or are eligible for HRAs that provide ACA benefits, can't get premium tax credits that help pay for the plans.

ELIMINATE ALL TIMELY FILING ADJUSTMENTS

PETER ANGENHOFER

Unfortunately, today too many PFS shops write off claims which they find are too old to bill, or when they perform regular cleanups of aged or low balance AR. Frequently, adjustment codes like “Exceeds Filing Limits” are used. However, as of this process, valuable data is lost which might otherwise give them valuable information about a larger issue.

It is an unfortunate fact of running a revenue cycle that many claims will “die” of old age. Most often, the limit that is exceeded is actually an appeal limit that is triggered by multiple appeals which eventually exceed the deadline for appeal or a missed appeal window (60 or 90 days.) In a few cases, a bill will be held in the editor or at a clearinghouse past a filing limit. It is extremely rare that a bill simply sits in DNFB too long and once billed is denied simply because it was overlooked, forgotten, or somehow slipped through the cracks.

In short, the vast majority of claims that deny for exceeding filing limits have some other problem which caused the delay in billing. Calling the write off a Timely Filing Adjustment not only fails to provide any insight into the upstream causes, it actually masks the real problem.

If everything looks like a timely filing write-off, it appears that the problem is in billing and follow up. But unless something is seriously broken in PFS, the strong likelihood is that those timely filing write-offs are really a mix of authorization, medical necessity, billing error, and other denials. If, for example, most of your authorization denials are being buried in timely filing, you may not realize that authorizations are a problem: “The auth write-off is small, so patient access must be doing its thing – these darn payer limitations are the real problem.”

But if those authorization problems were broken out and categorized appropriately, the picture might be very different. It would be easy to identify the lack of authorizations as the root cause of the problem. The answer is to eliminate all use of (or nearly all) Timely Filing write-off codes.

The conceptual approach of eliminating all Timely Filing adjustments seems simple, but in actuality it requires work to follow the clues and accomplish the task.

In some cases, posting logic is set to automatically adjust any Timely Filing denial. (In the worst case scenarios, those adjustments go to Contractuals rather than Denials. In those instances, all visibility into the size or shape of the denial problem is lost!) While this might seem like a time saver – if the claim is past limits, the revenue is lost so why should we spend any time on it? – but there really are two potential losses:

First, the timely filing denials might not be legitimate. Perhaps a bill was sent or an appeal was filed but the payer didn't appropriately load it into their system. Or perhaps the bill was delayed for some

legitimate reason that might lead a payer to make an exception. The results? A claim that could be recovered instead is declared dead.

Second, even if the revenue is truly lost, it is likely the mistake will be repeated unless you can learn from this failure. Whether it is sizing the scale of the problem or localizing it by department or payer, appropriately maintained data is a key driver of improved performance. This is essential to keep recoverable claims alive in the future!

Revising the posting logic is a relatively easy step, but the next step is more challenging – if you haven't auto-adjusted the claims but they still need to be written off the AR, then someone has to take the time to make the adjustment. The inclination from staff will likely be to look at the last denial and use that as the adjustment code – denied for Timely Filing, written off to timely filing – but doing that will only repeat the same error, just at greater expense.

Staff need to spend some time researching the claim (and need to be trained that expending the time is appropriate) to understand what caused the claim to deny in the first place, and using THAT adjustment code. It is more work -- and will take more time -- but having an accurate reflection of the problems causing adjustments is vital to solving the problems. Even a careful AR manager may be surprised by how the distribution of adjustments changes when timely filing claims are re-distributed to more discrete, meaningful adjustment categories. (And that AR manager may enjoy the side benefit of making themselves look good as adjustments shift from the PFS focused Timely Filing Codes to other codes that may be Patient Access or Coding related!)

Encouraging staff to move away from the use of timely filing may be difficult – their training and years of experience have likely built a strong tie between the last denial code and the adjustment reason – but there is one way to make a clean break: Eliminate the Timely Filing adjustment codes.

There are very few legitimate uses of the codes to begin with, when they are used they tend to mask the real problem, and staff tend to over- (or mis-) use them. It may mean there are a handful of claims that don't have an appropriate home, but the other benefits far outweigh this potential, minor cost.

Claims are going to die, for a variety of reasons, and the obvious cause of death might be a timely filing denial. But PFS managers should look beyond the obvious and take into account the root causes of those losses, which rarely are solely because of filing limits. Understanding root causes is an extremely valuable clue, which can lead to better understanding of adjustments, reduced write-offs, and ultimately increased collections.

Peter Angerhofer is a principal at Colburn Hill Group www.colburnhill.com; he brings deep experience in operations, strategy and health policy to both the daily operations as well as long-term vision. Peter moves easily from working with line staff on performance improvement to C-suite discussions of strategic imperatives. Prior to forming Colburn Hill, Peter had been part of the original, pre-revenue start-up team of eight at Accretive Health, where he spent 10 years managing operations. Prior to Accretive, Peter worked for Deloitte Consulting and CSC/APM, as well as serving in health policy roles on Capitol Hill.

THE FEDERAL “NO SURPRISES ACT” ARRIVES JANUARY 1, 2022

CHARLES HILTON

The Consolidated Appropriations Act 2021 was signed into law on December 27, 2020 (“COVID Relief Bill”). The “No Surprises Act” contained therein specifies that patients will only be required to pay in-network cost sharing amounts for out-of-network emergency care and care provided from out-of-network providers at in-network facilities without the patient's informed consent. Many of the sections of the new law will go into effect on January 1, 2022. At the federal level, the Department of Health and Human Services, the Department of Labor and the Treasury Department will be promulgating regulations in furtherance of the Act.

The No Surprises Act pertains to surprise bills from doctors, hospitals, and air ambulances for out-of-network emergency care and for care provided by out-of-network providers at in-network facilities without the patient's consent. The Act will prevent these providers from billing patients who have health coverage for unpaid balances for these types of services. Instead, providers will have to work with the group health or health insurer to determine the appropriate amount to be paid by the plan or issuer under a methodology provided in the Act. The Act's methodology limits what patients can be billed for out-of-network services to a fee that is based on in-network services.

The Act further requires insurers and medical providers who cannot agree on a payment rate to utilize an outside independent arbitrator to decide. The arbitrator will determine a fair amount, based, in part, on what other doctors and hospitals are typically paid at the median in-network rate for similar services, in addition to other criteria set forth in the Act. Significantly, the No Surprises Act prohibits the arbitrator from taking into consideration the rates paid by governmental payers, such as Medicare and Medicaid, which often pay less than the cost of providing care, but are many times utilized by payors as benchmarks for reimbursement.

Regulations by the applicable federal agencies are currently being promulgated so that a large portion of the Act will be effective January 1, 2022. The federal No Surprises Act will not pre-empt existing state law for those states who have previously enacted surprise billing prohibitions with frameworks for dispute resolution processes. However, for state regulated health plans in those states which do not have a surprise billing law, such as Pennsylvania, as well as federally regulated ERISA employer sponsored health plans, both types of plans will be subject to the jurisdiction, protections, and dispute resolution process set forth in the new No Surprises Act. Stay tuned!

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