OCTOBER 23–24, 2017

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PRE-CONFERENCE: October 21–22
POST-CONFERENCES (TWO OPTIONS): October 25–26, October 25–27

THE PERFECT CONFERENCE FOR YOUR ENTIRE REVENUE CYCLE TEAM!

hcmarketplace.com/RIS2017
OVERVIEW

The 2017 Revenue Integrity Symposium brings together training on Medicare billing and compliance, patient status, revenue integrity, case management, coding, and clinical documentation improvement (CDI), helping attendees ensure compliance and accurate billing and reimbursement across the revenue cycle. Unlike any other, this conference offers a wide range of exciting sessions on critical revenue integrity topics and the chance to learn from and network with trusted industry experts and revenue cycle professionals of all varieties.

Our expert speakers will cover critical topics essential to revenue integrity, such as IPPS and OPPS annual updates, chargemaster maintenance, the 2-midnight rule and condition code W2, denials management, payer audits, value-based purchasing, utilization review (UR), revenue cycle management strategies, and much more!

BENEFITS:

✔ Return to your facility armed with the tools to enhance revenue integrity and develop strategies for accurately documenting, coding, and billing patient encounters and stays
✔ Gauge the financial and operational impact of the 2018 IPPS final rule and OPPS proposed rule
✔ Develop strategies for strengthening your UR committee, correctly applying condition code W2, and understanding medical necessity
✔ Gain insight into billing and coding hot topics that may impact your facility’s financial performance, including injections and infusions, claim edits, and the inpatient-only rule

✔ Discover best practices for maintaining an up-to-date and compliant charge description master and learn to identify charge capture strategies for typical ancillary services
✔ Explore the role of CDI and case management in the overall revenue cycle and in a value-based model landscape
✔ Get the latest information on external auditors and learn new strategies for dealing with claim denials and appeals
✔ Learn strategies for breaking down revenue cycle silos and getting the right data in front of the C-suite

NEW FOR 2017:

★ National Association of Healthcare Revenue Integrity roundtable
★ Properly addressing National Correct Coding Initiative (NCCI) edits and Medically Unlikely Edits
★ Fundamentals of national and local coverage determinations
★ MACRA impacts on revenue integrity
★ Patient Safety Indicators, hospital-acquired conditions, and other value-based models

★ Contemporary approaches to PEPPER to support revenue integrity and reduce risk
★ Current OIG trends and strategies to protect revenue
★ Links between ICD-10 and revenue
★ Case management issues that impact revenue cycle
★ Moving from denials management to denials prevention

SOME OF THE HOT TOPICS WE WILL COVER INCLUDE:

➤ The latest changes to IPPS and OPPS regulations
➤ Internal and payer auditing
➤ Denial management and prevention strategies
➤ Reimbursement models
➤ Chargemaster maintenance and transparency
➤ The impact of ICD-10 on reimbursement
➤ The impact of case management on the revenue cycle
➤ The 2-midnight rule, patient status, and medical necessity
➤ The latest changes to inpatient-only procedures

➤ Changes to observation, including the NOTICE Act
➤ Injection and infusion coding and billing
➤ The National Correct Coding Initiative and Medically Unlikely Edits
➤ Contemporary approaches to PEPPER
➤ Efficient use of condition code W2
➤ Utilization review and utilization management
➤ On-campus versus off-campus provider-based entities and services rendered in these locations

REGISTER TODAY! Call 800-650-6787 or visit hcmarketplace.com/RIS2017
7:00–8:00 A.M.  CONTINENTAL BREAKFAST (PROVIDED) (EXHIBIT HALL OPEN)

8:00–9:15 A.M.  GENERAL SESSION 1

NATIONAL ASSOCIATION OF HEALTHCARE REVENUE INTEGRITY ROUNDTABLE
Valerie Rinkle, MPA; Kay Larsen; Denise Williams, RN, COC; Jugna Shah, MPH; John Settlemyer, MBA, MHA, CPC; Debbie Mackaman, RHIA, CPCO, CCDS; Elizabeth Lamkin, MHA; Ronald L. Hirsch, MD, FACP, CHCQM

Join select advisory board members from the National Association of Healthcare Revenue Integrity (NAHRI) as they kick off the 2017 Revenue Integrity Symposium with a discussion about the latest trends impacting the revenue integrity profession.

9:15–10:30 A.M.  GENERAL SESSION 2

WHAT’S ON THE HORIZON FOR CY 2018 UNDER MEDICARE’S OPPS/APC PAYMENT SYSTEM
Jugna Shah, MPH, and Denise Williams, RN, COC

CMS continues to refine changes to its payment systems, and the OPPS/APC system is no exception. We’ve seen more and more packaging over the years and the introduction of “outpatient mini-DRGs” called Comprehensive APCs. What’s in store for CY 2018? Have a front-row seat and get the information hot off the press. Session highlights include CMS proposals regarding the removal of additional services from the inpatient-only list, site-neutral payment for C-APCs and certain MS-DRGs, APC configuration changes, additional packaging, information related to both excepted and non-excepted off-campus provider-based departments, and much more. CMS’ rules never fail to amaze us. Join us as we highlight the key changes expected to impact your outpatient services for next year.

10:30–11:00 A.M.  NETWORKING REFRESHMENT BREAK (EXHIBIT HALL OPEN)

11:00 A.M.–12:15 P.M.  BREAKOUT SESSION 1

IT PAYS TO MONITOR ANNUAL IPPS CHANGES: THE FY 2018 IPPS FINAL RULE
Valerie Rinkle, MPA

Learn how to analyze the fiscal year 2018 inpatient prospective payment system (IPPS) final rule so you can evaluate the impact of the changes on your facility. This session will describe inflation and other program financial updates. It will review major MS-DRG grouping changes, including significant ICD-10 changes and the impact of significant declassification of 800 codes from OR to non-OR. An explanation of changes to DSH payment calculations, value-based incentives, and adjustment factors for hospital-acquired conditions and the Hospital Readmissions Reduction Program will be covered.

PROTECT REVENUE INTEGRITY BY BUILDING AN INFORMATION HIGHWAY
Elizabeth Lamkin, MHA

Value-based purchasing has put a spotlight on the need for patient-centered care. Ensuring systems for revenue integrity are in place results in better quality across the organization. This session will analyze the multidisciplinary components of the revenue cycle. Tools for measuring revenue cycle effectiveness and engaging staff in revenue integrity will be provided.

REIMBURSEMENT AT PROVIDER-BASED DEPARTMENTS: IT AIN’T WHAT IT USED TO BE
Kimberly A.H. Baker, JD, CPC

In recent years, CMS has been cutting into the revenue for provider-based departments with increased packaging of services, even unrelated ones. Now, new off-campus departments are no longer reimbursed under OPPS. This session will discuss the use and implications of modifiers -PO and -PN for off-campus provider-based departments. Case studies will be used to illustrate the changing reimbursement landscape for provider-based departments, comparing on- and off-campus and freestanding scenarios.

12:15 –1:30 P.M.  NETWORKING LUNCH (PROVIDED) (EXHIBIT HALL OPEN)
PUTTING DOLLARS AND SENSE BACK INTO OUTPATIENT OBSERVATION

Debbie Mackaman, RHIA, CPCO, CCDS

In theory, outpatient observation services should be a simple patient care concept that allows a physician or nonphysician practitioner the time to make a clinical decision about whether the patient should be discharged, transferred, or admitted as an inpatient. In reality, Medicare’s coverage, documentation, and payment requirements have made outpatient observation services very complex. With the addition of the MOON, hospitals need to find opportunities to work smarter rather than harder to comply with the regulations.

INJECTIONS AND INFUSIONS: TESTING YOUR KNOWLEDGE AND ADDRESSING FREQUENTLY ASKED QUESTIONS

Jugna Shah, MPH

This session will help participants test their coding, billing, and documentation knowledge related to facility reporting of drug administration (injection/infusion) services, including hydration, therapeutic, and chemotherapy injections. We will also cover new codes and/or reporting requirements for CY 2018 and the appropriateness of reporting a clinic visit code on the same day as drug administration. This will be an interactive session, with attendees responding to quiz questions and clinical scenarios.

CONTEMPORARY APPROACHES TO PEPPER: SUPPORT REVENUE INTEGRITY AND REDUCE RISK

William Malm, ND, RN, CRCR, CMAS

In this session, we will explore the overall basics of PEPPER and some nontraditional methods of using PEPPER. We will also discuss how PEPPER is relevant not only to coding but also to value-based reimbursement, as well as cover some organizational requirements for PEPPER and other data analytics.

CURRENT OIG TRENDS AND STRATEGIES TO PROTECT REVENUE

John Settlemyer, MBA, MHA, CPC

Learn best practices in avoiding identified risks and protecting revenue by analyzing current trends in OIG Medicare compliance review. This interactive session will offer a deep dive into published 2016–2017 OIG Medicare compliance reviews as well as hospitals’ responses to the audits. Operational hurdles associated with resolving identified risks will be covered.

PLEASE NOTE that the program materials will be available via download and the conference app only. A download link will be provided prior to the event, but a printed book of the presentations will not be available on-site.
7:00–8:00 A.M.  CONTINENTAL BREAKFAST (PROVIDED) (EXHIBIT HALL OPEN)

8:00–9:00 A.M.  GENERAL SESSION 3

REVENUE CYCLE IDEAS PRESENTATION
Revenue Cycle Leadership Exchange members volunteer to share an innovation, an initiative, or a solution they have successfully implemented at their organization.

9:15–10:30 A.M.  BREAKOUT SESSION 4

NCD and LCD COMPLIANCE: THE ONCOMING STORM
Kimberly A.H. Baker, JD, CPC
Auditors from Recovery Auditors to the CERT program are focusing on compliance with requirements under national and local coverage determinations (NCD/LCD). Often, these requirements go beyond simple diagnostic information and include prerequisites that must be adequately documented, such as failed conservative treatment. In this session, you’ll learn how to find and analyze NCDs and LCDs as well as other related resources for compliance. This session will also review other important coverage resources, including the importance of National Coverage Analyses and Coverage With Evidence Development policies.

NAVIGATING MEDICAL NECESSITY DENIALS MANAGEMENT FOR ALL PAYERS
Steven Greenspan, JD, LLM, and Ralph Wuebker, MD, MBA
The inevitable reality of claims denials plagues every hospital. Managing denials and appeals processes can be a long and frustrating undertaking. As commercial and managed Medicare/Medicaid denials continue to grow and government denials become more uncertain thanks to QIO inquiries and the ALJ backlog, hospitals face serious threats to their financial health from revenue lingering in denials limbo. This presentation will provide best practices for managing medical necessity denials from all payers (commercial, managed Medicare/Medicaid, and government) and examples of how some facilities are addressing this growing threat to their revenue.

CURRENT AUDIT LANDSCAPE
William Malm, ND, RN, CRCR, CMAS
Facilities have focused on Recovery Auditor activity for a long time. Now facilities and providers need to be concerned again with payer line item audits (yes, they are back!) as well as documentation requirements for HCC and value-based reimbursement. This session will explore ways EMRs may be causing documentation deficiencies and methods by which auditors use data analytics to target claims. You’ll also receive guidance on internal reviews to target your deficiencies early.

10:30–11:00 A.M.  NETWORKING REFRESHMENT BREAK (EXHIBIT HALL OPEN)

11:00 A.M.–12:15 P.M.  BREAKOUT SESSION 5

CHARGEMASTER UPDATES AND BEST PRACTICES
Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS, and Kay Larsen
Gain a better understanding of the structure of a charge description master (CDM) and common reimbursement methodologies. This session will offer tips for maintaining an up-to-date and compliant CDM and provide guidance on identifying charge capture strategies for typical ancillary services.

MACRA IMPACTS ON REVENUE INTEGRITY
Diana Snow, CCS, CHC, CHPC, CHRC
The Quality Payment Program (QPP) established by MACRA significantly changes the way physicians are paid. Is your revenue integrity program ensuring your doctors are receiving incentives rather than penalties? This session will provide tips on how revenue integrity can help with the implementation of the QPP and provide insight on how payment reform will impact revenue integrity.

THE CONTRADICTION OF INPATIENT-ONLY PROCEDURES
Debbie Mackaman, RHIA, CPCO, CCDS
Inpatient-only procedures, according to CMS, are those that would not be safe or appropriate to perform on an outpatient basis and would fall outside the boundaries of acceptable medical practice. On the other hand, these procedures are within the boundaries of the 2-midnight rule, regardless of an inpatient’s length of stay. This session will explore the principles that surround the identification of and payment for inpatient-only procedures, while pointing out the paradoxical nature of the inpatient-only regulation.

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12:15–1:15 P.M.

LUNCH (PROVIDED) (EXHIBIT HALL OPEN)
XTEND HEALTHCARE LUNCH AND LEARN SESSION: 12:30–1:00 P.M.

BREAKOUT SESSION 6

UTILIZATION REVIEW COMMITTEE: BEST PRACTICES AND STRUCTURE
Steven Greenspan, JD, LLM, and Ralph Wuebker, MD, MBA

The utilization review (UR) process and committee are important drivers of hospital policy, directly influencing both revenue and compliance. This session will focus on the relationship between the physician advisor and case management, the importance of a strong admission review process, the composition of an effective UR committee, and the role of the physician advisor in UR.

THE GLOVES ARE OFF WITH ICD-10: HOW TO PROTECT YOUR REVENUE CYCLE
James Dunnick, MD, FACC, CHCQM, CPC, CMED, and R. Scott Dunnick, BSM, MBA

This session will explore the reasoning behind the ICD-10 transition and describe the potential value of the data collected through this code set. Clinical examples will illustrate how revenue may be lost through ICD-10 and how this can be avoided through physician motivation and education. Payer concepts and expectations will also be covered.

DRIVE POSITIVE IMPACTS ON PSI, HAC, AND OTHER VALUE-BASED MODELS
Steven Robinson, MS-HSM, PA, RN, SSBB, CDIP

Appropriate documentation supporting quality measure mitigation has become an important part of clinical documentation improvement (CDI) programs’ concurrent review responsibilities. When expanding CDI programs to cover Patient Safety Indicators (PSI) and hospital-acquired conditions (HAC), proper case identification and prioritization is critical. CDI specialists must know which cases to review and what criteria to use. This session will discuss the foundation of quality initiatives and tools to aid in documentation mitigation, including prioritization of review, understanding excluded and included criteria, and post-review audit priorities.

1:15–2:30 P.M.

2:30–2:45 P.M.

NETWORKING REFRESHMENT BREAK (EXHIBIT HALL OPEN)

2:45–4:00 P.M.

BREAKOUT SESSION 7

CONDITION CODE W2: STRATEGIES FOR REIMBURSEMENT FOR NON-COVERED INPATIENT STAYS
Kimberly A.H. Baker, JD, CPC

Condition code W2 provides an alternative to condition code 44 to obtain reimbursement under Part B for inpatient cases that do not meet requirements for Part A payment. This session will discuss advantages to using condition code W2 while maintaining Part B reimbursement that is nearly identical to condition code 44. Strategies for promoting efficiencies for the UR department and minimizing the impact on billing and coding will be discussed.

2017 CASE MANAGEMENT ISSUES THAT IMPACT REVENUE CYCLE
Ronald L. Hirsch, MD, FACP, CHCQM

The revenue cycle team is often unaware of the work and tasks of the case management and utilization review teams. This session will review the issues that benefit most from these teams understanding each other’s work. Commercial contracts, patient notices, and the 2-midnight rule will be covered.

MOVING FROM DENIAL MANAGEMENT TO DENIAL PREVENTION
Tracey Tomak, RHIA

Start breaking down silos related to denials. This session will identify key data elements to regularly report to the C-suite. It will include a discussion about key players to engage in process improvement to identify root causes for denials. Strategies for developing process improvement initiatives to prevent future denials will also be covered.

4:00 P.M.

ADJOURN

Agenda and speakers subject to change

REGISTER TODAY! Call 800-650-6787 or visit hcmarketplace.com/RIS2017
**Pre-Conference**
**OCTOBER 21–22, 2017**

**Medicare Boot Camp®—Utilization Review Version** is an intensive two-day course focusing on the Medicare regulatory requirements for patient status and the role of the utilization review (UR) committee.

Managing patient status plays a critical role in proper compliance, correct reimbursement, and stabilizing inpatient payments for the hospital. Don’t leave money on the table—ensure the UR committee is ready to implement and leverage the regulatory requirements.

**Medicare Boot Camp—Utilization Review Version** also answers all your questions about navigating the CMS website and finding Medicare requirements. You will be able to find answers to your questions long after the Boot Camp is over.

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**REVENUE CYCLE LEADERSHIP EXCHANGE**

Presented by: HealthLeaders Media

**NEW THIS YEAR! EXCLUSIVE FORUM JUST FOR REVENUE CYCLE LEADERS**

Are you a vice president, director, or senior finance leader accountable for the direction of your hospital or health system’s revenue cycle enterprise?

HealthLeaders Media and HCPro have added the Revenue Cycle Leadership Exchange, an exclusive, small group opportunity within the 2017 Revenue Integrity Symposium. Selected leaders will be able to share ideas on a range of challenges, including patient-friendly billing strategies, understanding changes in the payer market, and driving high-level operational efficiency.

Benefits include:

- Share ideas in two small-group roundtables, moderated by HealthLeaders Media editors and featuring only revenue cycle vice presidents or above
- Collaborate with revenue cycle leaders in custom workgroups, where you identify the topic, challenge, or opportunity you want to explore
- Join your fellow leaders in an exclusive off-site dinner with members and sponsors
- Attend with no registration fee, a value of $1,099

This opportunity is limited to senior revenue cycle leadership. For more information on qualifications and to request an invitation, please email Exchange@HealthLeadersMedia.com with “Revenue Cycle Leadership Exchange” in the subject line.

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**Post-Conference**
**OCTOBER 25–26, 2017**

**Medicare Boot Camp®—Provider-Based Departments Version**

The **Medicare Boot Camp—Provider-Based Departments Version** provides education on attestations, on- and off-campus determinations, enrollment, billing, and reimbursement. This Boot Camp will provide brand-new insight for understanding hospital outpatient department billing and reimbursement in an ever-changing regulatory landscape.

This Boot Camp will break down billing, coding, compliance, coverage, qualification, and other issues. It will help attendees gauge the financial impact of the Bipartisan Budget Act of 2015 (Section 603) on off-campus PBDs, understand the effects of the recent increased packaging of services, and know how to handle other recent changes, such as now-mandatory use of modifiers -PO and -PN.

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**Post-Conference**
**OCTOBER 25–27, 2017**

**Case Management Boot Camp: Strategies for Enhancing the Continuum of Care**

The **Case Management Boot Camp** focuses on arming case managers with knowledge of best practices on topics such as discharge planning, collaborative practice, and utilization management so they can go back to their hospitals, set goals to meet best practices as closely as possible, and raise the bar. It includes strategies for defining the role of case managers and selecting the models that may work best at your facility, in addition to offering practical advice on measuring outcomes related to patient care.

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Kimberly A. H. Baker, JD, CPC, is the director of Medicare and compliance for HCPro. She is a lead regulatory specialist for HCPro’s Revenue Cycle Advisor and is the lead instructor for HCPro’s Medicare Boot Camp®—Hospital Version, Medicare Boot Camp®—Utilization Review Version, and HCPro’s Medicare Boot Camp®—Provider-Based Department Version. She is a former hospital compliance officer and in-house legal counsel and has over 25 years of healthcare experience, including 10 years of experience teaching, speaking, and writing about Medicare coverage, payment, and coding regulations and requirements.

James Dunnick, MD, FACC, CHCQM, CPC, CMDP, is a physician, board certified in internal medicine and cardiology. Dunnick has 25 years of clinical practice experience specializing in preventive cardiology, chronic disease management, and heart disease in women. Dunnick is the CEO and founder of SESEDN, LLC, and The Dunnick Group, LLC, and now works full time helping physicians and hospitals with coding, compliance, best practice algorithms, quality, utilization, and cost of care.

R. Scott Dunnick, BSM, MBA, is the director of business affairs for The Dunnick Group LLC. He has experience in project operations, practice management, and electronic health record transitioning and training. He has been with the Dunnick Group since 2013, working in provider contracts, practice acquisitions, and revenue protection.

Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS, is president/CEO and principal consultant for SLG, Inc., in Raleigh, North Carolina. She is a nationally known speaker and author on the charge description master (CDM), outpatient facility coding, and billing compliance, and has more than 30 years’ experience in the healthcare industry. Goodman has been actively involved and held leadership roles in a number of professional organizations on the local, state, and national levels, including NAHRI.

Steven A. Greenspan, JD, LLM, is vice president of regulatory affairs at Executive Health Resources (EHR) in Newtown Square, Pennsylvania. He is responsible for overseeing regulatory research and hospital advocacy efforts, and collaborates closely with EHR’s appeals management teams to offer support on complex Medicare, Medicaid, and commercial appeals matters. During his 18-year career, Greenspan has overseen the adjudication of more than 200,000 appeals and personally authored more than 10,000 appeal decisions. Prior to joining EHR, he served as vice president and project director for MAXIMUS Federal Services, Inc., overseeing the company’s Part A East QIC project.

Ronald L. Hirsch, MD, FACP, CHCQM, is vice president at AccretivePAS® Clinical Solutions in Chicago. He is a general internist and HIV specialist. Hirsch was the medical director of case management at Sherman Hospital in Elgin, Illinois. He is certified in healthcare quality and management by the American Board of Quality Assurance and Utilization Review Physicians. In addition, he is a member of the American Case Management Association, a member of the American College of Physician Advisors, and a fellow of the American College of Physicians. Hirsch serves as an advisory board member for NAHRI.
Elizabeth E. Lamkin, MHA, ACHE, is CEO of PACE Healthcare Consulting, LLC, in Hilton Head, South Carolina. She has more than 20 years of experience as a single and multi-hospital hospital chief executive officer at teaching, community, and investor-owned hospitals. Lamkin now consults on operational effectiveness and is a national speaker and author on operations, quality, utilization, and billing compliance. She serves on the advisory board and Government Affairs Committee for the American College of Physician Advisors and as an advisory board member for NAHRI.

Kay Larsen is a revenue integrity specialist at Glendale Adventist Medical Center (soon to be Adventist Health Glendale) in Glendale, California. She has enjoyed 17 years working in healthcare, including many years as a CDM coordinator. Larsen’s favorite part of her job is working with departments maximizing revenue through education and charge review. In her years of work, she has experienced standardization projects, extensive price reviews, and conversion of financial systems and still is passionate about revenue integrity. Larsen serves as an advisory board member for NAHRI. Larsen and Sarah Goodman have been colleagues for more than 15 years and have worked on a number of CDM, charge capture, and revenue integrity projects together. This is their first time presenting as a team.

Debbie Mackaman, RHIA, CPCO, CCDS, is the developer and lead instructor for HCPro’s Medicare Boot Camp®—Critical Access Hospital Version and Rural Health Clinic Version and an instructor for the Hospital Version and Utilization Review Version. She has over 24 years of experience in the healthcare industry, including inpatient and outpatient prospective payment systems; and coding, billing, and reimbursement issues for hospitals, critical access hospitals, and rural health clinics. Mackaman has served as compliance officer and director of health information services for healthcare systems. She serves as an advisory board member for NAHRI.

William L. Malm, ND, RN, CRCR, CMAS, is a managing director at Health Revenue Integrity Services. He is a nationally recognized author and speaker on topics such as healthcare compliance, chargemasters, and CMS recovery audits. Malm brings over 25 years of experience with a combination of clinical and financial healthcare knowledge that encompasses all aspects of revenue integrity. Previously, Malm played a key role in providing revenue integrity and data expertise for Craneware, Inc., the market leader in revenue integrity software solutions. He also serves as the secretary/treasurer for the Certification Council of Medical Auditors. He has extensive experience with all postpayment audits, having previously worked as a systems compliance officer at a large for-profit healthcare system.

Valerie A. Rinkle, MPA, is a lead regulatory specialist and instructor for HCPro’s Revenue Integrity and Chargemaster Boot Camp®, as well as an instructor for HCPro’s Medicare Boot Camp®—Hospital Version and Medicare Boot Camp®—Utilization Review Version. Rinkle is a former hospital revenue cycle director and has over 30 years in the healthcare industry, including over 12 years of consulting experience in which she has spoken and advised on effective operational solutions for compliance with Medicare coverage, payment, and coding regulations. Rinkle serves as an advisory board member for NAHRI.

Steven Robinson, MS-HSM, PA, RN, SSBB, CDIP, is the vice president for clinical revenue integrity (CRI) at RecordsOne, where he helps clients incorporate a fully functioning revenue cycle platform to facilitate clinical communication effectiveness and exceptional documentation, physician, and patient outcomes measurements. He is clinically experienced with a forte in clinical documentation and quality leadership. As a physician assistant and registered professional nurse, he primarily practiced in the arenas of intensive care and orthopedics, and in perioperative administration, before transitioning into a consulting career in the early 1990s.
John Settlemyer, MBA, MHA, CPC, is an assistant vice president, revenue cycle with Carolinas HealthCare System with a focus on chargemaster (CDM) compliance, charge capture, and revenue integrity. He has direct oversight or consulting oversight of the CDM for 39 hospitals and their associated outpatient care locations, such as healthcare pavilions and freestanding emergency departments. Settlemyer has more than 20 years’ experience in healthcare finance and reimbursement and is expert-level in Medicare OPPS coding and billing. He is a charter member and past chair of The Provider Roundtable, a national group of providers whose focus is providing comment to CMS on the operational and financial impact of OPPS proposed rules. He has made a number of presentations to the Medicare Advisory Panel on hospital outpatient payment. Settlemyer serves as an advisory board member for NAHRI and is also a member of the North Carolina HFMA chapter.

Jugna Shah, MPH, is the president and founder of Nimitt Consulting, Inc., a firm specializing in case-mix payment system design, development, and implementation. She has 15 years of experience working with providers on the ongoing clinical, operational, financial, and compliance implications of Medicare’s OPPS based on APCs. Shah has educated and audited numerous hospitals on their drug administration coding and billing practices. She has contributed to several books and numerous OPPS/APC articles and is a contributing editor of HCPro’s Briefings on APCs. Shah serves as an advisory board member for NAHRI.

Diana Snow, CCS, CHC, CHPC, CHRC, is the director of revenue integrity and quality for the University of Utah Health Sciences System. Prior to this position, Snow was the senior director of the billing compliance office and the clinical research compliance and education office for the University of Utah Health Sciences System. Snow brings a unique blend of knowledge of the revenue cycle and regulatory expertise to her current position to assist with efficient implementation of payment reforms and maintenance of alternative payment models within the revenue cycle.

Tracey A. Tomak, RHIA, has nearly 20 years of experience in revenue cycle with a focus on hospital coding, charge capture, and denials management. In her current role as director of clinical denial prevention and revenue cycle compliance at St. Vincent, Tomak is responsible for overseeing all external charge capture, coding and medical necessity audit functions. This work includes oversight for the RAC process, response to internal and external audits such as CERT, probe, OIG, and Medicaid audits, chart to charge audits performed by third-party payers for outlier claims, pre-billing medical necessity audits, as well as coordinating monthly denial prevention meetings for each of St. Vincent’s facilities.

Denise Williams, RN, COC, is senior vice president of the revenue integrity division and compliance auditor at Revant Solutions (formerly Health Revenue Assurance Associates, Inc. (HRAA)) in Ft. Lauderdale, Florida. She has more than 30 years of healthcare experience, including a background in multiple areas of nursing. For the past 20 years, Williams has been in the field of coding and reimbursement and has performed numerous E&M, OP surgical, ED, and observation coding chart reviews from the documentation, compliance, and reimbursement perspectives. She serves as a contributing author to articles published in HCPro’s APC Insider and Briefings on APCs and is a nationally recognized speaker on various coding and reimbursement topics. Williams is also an AHIMA ICD-10 Ambassador and serves as an advisory board member for NAHRI.

Ralph Wuebker, MD, MBA, is chief medical officer for EHR in Newtown Square, Pennsylvania. He is board certified and currently serves as a member of EHR’s physician education and audit team. Wuebker regularly visits EHR’s client hospitals to provide medical executives and staff members with ongoing education on a variety of topics, including Medicare and Medicaid compliance and regulations, medical necessity, Recovery Audit Contractors, utilization review, denials management, and length of stay.

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October 21–22, 2017

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October 25–27, 2017

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• Cancellations made 30 to 14 days prior to the event are not eligible for refunds but are eligible for payment transfer (credit) to another H3.Group event, less a $250 cancellation fee. The credit will be valid for up to six months from date of cancellation.
• Registrants who cancel less than 14 days prior to the event will be considered “no shows” and will not be eligible for refunds/credits.
• Registrants who do not cancel and do not attend are liable for the full registration fee.
• Please notify the conference registrar at 800-650-6787 with any requests for changes.

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HOTEL

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