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# Revenue Integrity Symposium

OCTOBER 16–17, 2018  
LITCHFIELD PARK (PHOENIX), AZ

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# RIS Revenue Integrity Symposium

## OVERVIEW

The **2018 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, patient status, denials management, appeals and Medicare Fair Hearings, 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 2019 OPPS proposed rule
- ✓ Develop strategies for enhancing your UR committee, using PEPPER and other analytics to strengthen internal audits and defend against external audits, and creating a revenue integrity workplan
- ✓ 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 physician advisors and compliance 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 designing a revenue integrity program, defining leadership, and setting and meeting revenue integrity goals

### 2018 HIGHLIGHTS:

- ★ Highlights of the 2019 OPPS proposed rule
- ★ Properly addressing National Correct Coding Initiative (NCCI) edits and Medically Unlikely Edits
- ★ Fundamentals of managing a compliance investigation and Medicare's 60-day overpayment provision
- ★ Impact of value-based reimbursement models on revenue
- ★ Reimbursement, documentation, and coding strategies for new technologies, laboratory tests, cardiac procedures, and joint replacements
- ★ PEPPER implications for audit, reimbursement, and denial management
- ★ Current payer audit targets and strategies to protect revenue
- ★ Links between ICD-10 and revenue integrity
- ★ Best practices for reducing payer denials using targeted data analytics
- ★ Understanding the impact of patient status and navigating payer regulations

# NAHRI

**JOIN NOW  
AND SAVE!**

The **National Association of Healthcare Revenue Integrity (NAHRI)** is dedicated to providing the hospital revenue integrity community the resources, networking, and training required to achieve efficiency, compliance, and optimized reimbursement for their organization. By becoming a charter member, you gain access to a vast body of revenue cycle knowledge, high-quality training programs, the latest tools and tactics, exposure to leading-edge thinking, and opportunities to interact with your peers. **NAHRI members save \$100 off the 2018 Revenue Integrity Symposium Registration fee.** Visit <http://hcmarketplace.com/national-association-of-healthcare-revenue-integrity> to register as a charter member today and save!

**REGISTER TODAY!** Call 800-650-6787 or visit [hcmarketplace.com/RIS2018](http://hcmarketplace.com/RIS2018)

7–8 a.m.

**REGISTRATION (WIGWAM FOYER) AND CONTINENTAL BREAKFAST (EXHIBIT HALL)**

8–9:15 a.m. – **General Session 1**

**REVENUE INTEGRITY PANEL: A LOOK AT 340B, NONCOVERED SERVICES, AND MEDICARE ADVANTAGE**

*Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS, Elizabeth E. Lamkin, MHA, Debra May, Terri Rinker, MT (ASCP), MHA, John Settlemyer, MBA, MHA, CPC, Angela Lynne Simmons, CPA*

Join a select group of revenue integrity experts as they discuss the latest trends impacting revenue. This roundtable discussion will use case studies to examine changes to the 340B drug program, Medicare Advantage, noncovered services, and more.

9:15–10:30 a.m. – **General Session 2**

**CMS' PROPOSED CHANGES FOR CY 2019 OPPS**

*Jugna Shah, MPH*

CMS' payment systems continue to evolve, and the OPPS/APC system is no exception. What's in store for CY 2019? Take a front-row seat for an analysis of the latest OPPS proposals and news. Session highlights will include the 340B drug program, site-neutral payment policies, the future of C-APCs, changes to drug pricing, and much more. Join us as we decode what CMS' rules will mean for your outpatient services next year.

10:30–11 a.m.

**NETWORKING REFRESHMENT BREAK (EXHIBIT HALL)**

11 a.m.–12:15 p.m. – **Breakout Sessions: Set 1**

**REVENUE INTEGRITY AND THE CDM: THE ROAD TO SUCCESS**

*Sarah L. Goodman, MBA, CHCAF, COC, CCP, FCS, and Kay Larsen, CRCR*

The chargemaster is your most vital tool. This session will dive into the structure and maintenance of the chargemaster with best practices for keeping it up to date. The audience will learn about the impact of common reimbursement methodologies, how to navigate the NCCI and other edit tools, how to identify charge capture strategies for common ancillary services, and tips for promoting revenue integrity in the facility setting.

**PHYSICIAN ADVISOR: THE SILVER BULLET FOR REVENUE INTEGRITY**

*Elizabeth E. Lamkin, MHA*

This session will introduce participants to the role of the physician advisor (PA) and why it is so important. Participants will gain an understanding of how the PA fits into the revenue integrity continuum to lead and operationalize improvements along with how to measure the return on investment for the PA program. Sample tools and scorecards will be provided.

**WALK IN THE SHOES OF A COMPLIANCE INVESTIGATION**

*Melissa J. McCarthy, RHIT, CCS, CHC, and Greg Radinsky, JD, MBA, CHC, CCEP*

This session will help you understand how to manage difficult issues that arise in a compliance investigation, including attorney-client privilege, self-disclosures to government payers, and reporting compliance matters to management and the board. Through attending this session, you will also learn how to leverage publicly available CMS data to support your investigations and proactive compliance efforts. Attendees will also have the opportunity to walk through a case study to practice their investigatory skills.

12:15–1 p.m.

**NETWORKING LUNCH (PROVIDED—EXHIBIT HALL)**

1–1:30 p.m.

**XTEND HEALTHCARE SPONSORED SESSION**



1:30–1:45 p.m.

**TRANSITION BREAK (EXHIBIT HALL CLOSED)**

1:45–3 p.m. – **Breakout Sessions: Set 2**

### **PATIENT STATUS AND INPATIENT ADMISSION ORDERS: NEW DEVELOPMENTS FOR PART A PAYMENT**

*Kimberly A. H. Baker, JD, CPC, and Ralph Wuebker, MD, MBA*

Patient status continues to be a tricky determination. Although CMS' proposed changes to the inpatient-only list and proposed changes to inpatient admission order requirements might appear to ease some of these concerns, they open up new questions while leaving other long-term issues such as the two-midnight determination unresolved for providers. This session will cut through the confusion and provide the audience with expert analysis of the new patient status landscape and recommendations regarding the most recent regulations.

### **THE REVENUE INTEGRITY WORKPLAN: COLLABORATION, COMMUNICATION, COMPREHENSION**

*Marilyn Hart Niedzwiecki, MBA, CPA, RN, CPC, COC, CIRCC*

Revenue integrity is an essential component of an organization. This area has become very transparent in an organization, and the activities performed require collaboration, communication, and a comprehensive understanding of clinical, financial, and information systems. An annual workplan is essential to ensure that all areas of charge capture are reviewed on a regular basis. This presentation will provide an overview of how an annual workplan has been developed and implemented at Ann & Robert H. Lurie Children's Hospital of Chicago. It will demonstrate what is included in the workplan, complexities encountered, and the importance of collaboration, communication, and comprehension of the EMR in use.

### **AN INSIDER'S GUIDE TO MEDICARE FAIR HEARINGS**

*Alicia Kutzer, Esq., LLM, MHA*

This session will provide an inside look at the Medicare Fair Hearings process from a former Administrative Law Judge. Learn what to expect at a Fair Hearing, how to determine the value of a third-level appeal, and tips for presenting a persuasive argument. Attendees will come out of the session with best practices and strategies for navigating the appeals process wisely.

3–3:30 p.m.

### **NETWORKING REFRESHMENT BREAK (EXHIBIT HALL)**

3:30–4:45 p.m. – **Breakout Sessions: Set 3**

### **INJECTIONS AND INFUSIONS: TEST YOUR KNOWLEDGE AND GET ANSWERS**

*Jugna Shah, MPH*

This session will help participants challenge 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 2019 and will address the financial implications of series billing with respect to drug admin services as well as reviewing some frequently asked questions. This will be an interactive session, with attendees responding to quiz questions and clinical scenarios.

### **UTILIZATION MANAGEMENT COMMITTEE: ENHANCING VALUE IN YOUR HOSPITAL**

*Edward P. Hu, MD, CHCQM-PHYADV*

The utilization management (UM) committee is little more than a regulatory checkbox at many hospitals. However, it can and should be so much more. This session will review how to set up an effective UM committee and provide a detailed process map with real-world examples demonstrating how this committee can reduce clinical variation, enhance efficiency, and cut costs.

### **MACRA, MIPS, ALTERNATE PAYMENT MODELS, ACOs: WHERE ARE WE HEADED WITH VALUE-BASED CARE?**

*William L. Malm, ND, DNP, CRCC, CMAS*

Confusion reigns among providers about required reporting for the QPP and MIPS. As the stakes rise and the threshold increases, providers need to deploy analytics to avoid sizable penalties. This session will discuss the necessities of reporting and how providers can improve their reporting methods. The audience will be given detailed information on how to use analytics to score more points and transform their organization for success under new payment models.

4:45 p.m.

### **ADJOURN**

4:45–6 p.m.

### **NETWORKING RECEPTION (EXHIBIT HALL)**

**HCPro**  
**GO GREEN**

**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.

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7–8 a.m.

**CONTINENTAL BREAKFAST (EXHIBIT HALL)**

8–9:15 a.m. – **Breakout Sessions: Set 4**

**NEXT GENERATION TECHNOLOGIES: PRACTICAL GUIDANCE FOR SUCCESS**

*Jugna Shah, MPH, and John Settlemeyer, MBA, MHA, CPC*

Providers struggle with how to report and price new, innovative, and sometimes very expensive therapies for drugs, devices, and procedural services. An example is CAR-T, especially if no codes exist and when there are debates on what charges should be included given the product code description. This session will walk providers through coding, charging, and billing strategies as well as Medicare's rules/citations on appropriate charging practices and the impact on the outlier and new technology add-on payment (NTAP). We will show how provider charges fundamentally impact the ability or inability to generate an NTAP or outlier payment.

**BEST PRACTICES TO DECREASE MANAGED CARE DENIALS**

*Steven A. Greenspan, JD, LLM, and Ralph Wuebker, MD, MBA*

Managing denial and appeal processes can be a long and frustrating undertaking. Hospitals face serious threats to their financial health from revenue lingering in denial limbo. This session provides best practices for managing medical necessity denials from managed care payers, as well as examples of how some facilities are addressing the growing threat to their revenue from medical necessity denials. The session will feature case presentations and a facilitated question-and-answer period.

**MEDICARE'S SECONDARY PAYER PROVISIONS: WHAT EVERY PROVIDER NEEDS TO KNOW**

*Alicia Kutzer, Esq., LLM, MHA*

Take a look at how the Medicare Secondary Payer (MSP) provisions can impact your organization and learn how to prepare for major changes that will hit hospitals hard. This session will give attendees an overview of MSP and will break down how CMS interprets and applies the complex and far-reaching regulatory language. By tying payments from programs such as workers' compensation, liability insurance, no-fault insurance, and other non-group health plans to all future treatment related to the injury, hospitals could find themselves facing major overpayment recoupment actions. As provider organizations more frequently report diagnoses attributable to past injuries and conditions in risk-adjusted reimbursement models and recent legal action has opened the door to aggressive MSP recoupment, organizations must be prepared. This session will help attendees comply with regulations and avoid/combat targeted recoupment.

9:15–9:30 a.m.

**TRANSITION BREAK (EXHIBIT HALL CLOSED)**

9:30–10:45 a.m. – **Breakout Sessions: Set 5**

**NCCI/MUE PROCESSES: REDUCE EDITS BY CONFRONTING AND ELIMINATING OBSTACLES**

*Valerie A. Rinkle, MPA, and Denise Williams, COC*

This session will provide a review of the background of NCCI and MUE edits and why they were established. Scenarios will be used to demonstrate how to apply the NCCI and MUE edits. There will be a discussion of strategies to mitigate edits, appeal appropriate scenarios, protect revenue integrity, and meet the requirements to charge every patient in the same way.

**PEPPER IMPLICATIONS FOR AUDIT, REIMBURSEMENT, AND DENIAL MANAGEMENT**

*William L. Malm, ND, DNP, CRCC, CMAS*

PEPPER is a critical but frequently overlooked benchmark that is significant to clean claim submission. This session will provide an overview of PEPPER and will walk the audience through how to use PEPPER to improve revenue integrity and reduce risk. We will illustrate how to create sustainable audit processes using PEPPER and will use case studies to demonstrate how to put PEPPER to work for your organization.

**MEDICARE BENEFICIARY NOTICES: OPTIMIZE DELIVERY AND REDUCE BURDEN**

*Judith L. Kares, JD*

This session will focus on primary patient notice responsibilities of hospitals and staff while providing guidance on implementing common practices for effective delivery of notices. We will also discuss consequences of noncompliance, including the impact of notices on billing and reimbursement, particularly where occurrence codes 31 and 32 are concerned.

10:45–11:15 a.m.

## NETWORKING REFRESHMENT BREAK (EXHIBIT HALL)

11:15 a.m.–12:30 p.m. – **Breakout Sessions: Set 6**

### REVENUE INTEGRITY AUDITS: IT'S NOT JUST ABOUT CODING ACCURACY

*Diana Snow, CCS, CHC, CHPC, CHRC*

It is easy to think about coding accuracy and clinical documentation improvement when thinking about revenue integrity auditing, but there are many other areas of the revenue cycle where revenue leakage can occur. This session will explore how one organization began auditing from the beginning to the end of the revenue cycle and will discuss experiences in design, implementation, and execution of the program.

### JOINT REPLACEMENTS AND CARDIAC PROCEDURES: A CLINICAL AND FINANCIAL REVIEW

*Ronald L. Hirsch, MD, FACP, CHCQM*

The removal of total knee replacement from the Medicare inpatient-only list may mark the start of a quantum shift of procedures traditionally performed as inpatient to the outpatient setting and even to ambulatory surgery centers. Furthermore, the application of the 2-midnight rule to these patients has created tremendous confusion and financial consternation. This session will review the regulations and financial considerations applicable to total knee replacement and discuss the clinical and financial implications of the shift of orthopedic and cardiac procedures from the hospital to the surgery center that is anticipated to accelerate.

### BASICS OF HIERARCHICAL CONDITION CODING AND VALUE-BASED CONTRACTING

*Becky Cook, CPA, MHA*

Using risk factor scoring in financial management is a new skill needed to thrive with shared savings, Medicare Advantage, managed Medicaid, ACO contracts, and other value-based payment methods. Learn how risk scoring may be used to stratify patient populations, project cost of care for those patient populations, and manage the reimbursements required to care for your patients. Examples using risk scoring in contracting decisions, operational decisions, benchmarking, and communications with physician leadership will be presented.

12:30–1:15 p.m.

## NETWORKING LUNCH (PROVIDED—EXHIBIT HALL)

1:15–1:45 p.m.

## CHARTWISE MEDICAL SYSTEMS SPONSORED SESSION



1:45–2:00 p.m.

## TRANSITION BREAK (EXHIBIT HALL CLOSED)

2:00–3:15 p.m. – **Breakout Sessions: Set 7**

### A PRACTICAL GUIDE TO THE OUTPATIENT CODE EDITOR

*Kimberly A. H. Baker, JD, CPC*

CMS has substantially revised its specifications and is now publishing many code lists only with the OCE quarterly updates. Understanding the OCE is vital to keeping up with edits and quarterly changes, including retroactive changes that allow rebilling. This session will provide a practical look at how to use the OCE files and track OCE updates to keep your organization on top of CMS quarterly changes.

### TARGETED PROBE AND EDUCATE AUDITS AND OTHER CMS INITIATIVES

*Diane Weiss, CPC, CPB, CCP*

CMS seems to be retooling its audit programs and medical review initiatives. This presentation will review the Targeted Probe and Education initiative as well as other CMS/MAC audits. During this presentation you will learn how to understand the scope of an audit, what documentation is actually required, the method for replying, and how to appeal if there are unfavorable findings.

### TICK TOCK YOU'RE ON THE CLOCK: THE 60-DAY PROVISION

*Jennie Bryan, MBA, RHIA, CCS, and Kim Cusson, CCS, CPC*

This session will provide a general overview of CMS' final rule implementing the Affordable Care Act's 60-day report and return provision for self-identified overpayments, which became effective May 14, 2016. The session will examine how to use CMS' guidance to determine when an overpayment is identified for the purpose of the 60-day requirement as well as analyze the look-back period and explain how to report and return overpayments.

3:15–3:45 p.m.

## NETWORKING REFRESHMENT BREAK (EXHIBIT HALL)

3:45–5:00 p.m. – **Breakout Sessions: Set 8**

### IMPLEMENTING THE NEW OUTPATIENT LAB DOS EXCEPTION

Valerie A. Rinkle, MPA

The 2018 OPPTS final rule changed the current clinical laboratory date of service (DOS) policies for outpatient molecular pathology tests and advanced diagnostic laboratory tests (ADLT), since they are now excluded from the OPPTS packaging policy for laboratory tests. Although CMS has not yet designated any tests as ADLTs, it is critical for facilities to begin working through operational and reference lab contracting issues to implement the required changes for molecular pathology tests. This session will explain the changes to the clinical laboratory DOS policies and describe the reasons for the change as well as outline next steps for implementing changes associated with the new DOS policies.

5:00 p.m.  
**ADJOURN**

### DENIAL PREVENTION: ADDRESSING ROOT CAUSES THROUGH DATA ANALYTICS AND A TEAM-BASED CULTURE

Tracey A. Tomak, RHIA, PMP

This session will highlight the differences between denial reason codes and root causes as well as define root causes that will allow for effective process improvement activity. Key players that must be involved to facilitate a team-based approach to denial prevention will be covered as well as ways to mitigate denials.

### ONE SIZE DOES NOT FIT ALL: REVENUE INTEGRITY PROGRAM DESIGN OPTIONS

Caroline Rader Znaniec

This session will describe the varied approaches to the design of a revenue integrity program. As one size does not fit all, the audience will be introduced to approaches seen nationwide. The session will describe the pros and cons to each approach and will address leadership and buy-in, roles and responsibilities, and staffing models.

*Agenda and speakers subject to change*

**SAVE 15% WHEN YOU REGISTER FOR BOTH THE 2018 REVENUE INTEGRITY SYMPOSIUM AND A PRE-CONFERENCE OR POST-CONFERENCE BOOT CAMP!**

## Pre-Conference OCTOBER 14–15, 2018

### Medicare Boot Camp®—Utilization Review Version

**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. In 2018, CMS made significant changes to the inpatient-only list and continues to change its strategies for auditing patient status. Don't become a target or leave money on the table—ensure the UR committee is ready to implement and leverage the regulatory requirements.



## Revenue Integrity Leadership Exchange

**EXCLUSIVE FORUM  
JUST FOR REVENUE  
INTEGRITY 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 and HCPro have added the **Revenue Integrity Leadership Exchange**, an exclusive, small-group opportunity within the **2018 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 NAHRI leadership and featuring only revenue Integrity vice presidents or above
- ★ Collaborate with revenue Integrity 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 Andrea Kraynak at [akraynak@hcpro.com](mailto:akraynak@hcpro.com) with "Revenue Integrity Leadership Exchange" in the subject line.

## Post-Conference OCTOBER 18–19, 2018

### 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 changes to off-campus PBDs, understand the effects of the recent increased packaging of services for all PBDs, and know how to handle other recent changes, such as modifiers -PO and -PN and modifier -JG.

## Post-Conference OCTOBER 18–20, 2018

### Case Management Boot Camp

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.

# Speakers



**KIMBERLY A. H. BAKER, JD, CPC**, is the director of Medicare and compliance for HCPro. She is a lead regulatory specialist and lead instructor for HCPro's Medicare Boot Camp®—Hospital Version and Medicare Boot Camp®—Utilization Review Version. She is also an instructor for HCPro's Medicare Boot Camp®—Critical Access Hospital Version. Baker is a former hospital compliance officer and in-house legal counsel, and has 10 years of experience teaching, speaking, and writing about Medicare coverage, payment, and coding regulations and requirements.



**JENNIE BRYAN, MBA, RHIA, CCS**, is a healthcare risk client-based associate manager for CHAN, a subsidiary of Crowe Horwath, in Clayton, Missouri. Bryan has more than 30 years of audit, consulting, compliance, and acute care coding and documentation experience. She has also held positions as director of corporate compliance and HIPAA privacy, inpatient and outpatient consulting manager, and health information management director. Bryan has served as a board member of her state and local professional associations.



**BECKY COOK, CPA, MHA**, is a healthcare financial leader with extensive experience with employed and independent physician networks. Competencies include basics of practice management, billing and revenue cycle management, revenue strategies, physician compensation plan development and implementation, data analytics design and management, and managed care contracting including gain-sharing and other risk arrangements.



**KIM CUSSON, CCS, CPC**, is a healthcare risk client-based associate manager for CHAN, a subsidiary of Crowe Horwath, in Clayton, Missouri. Cusson has more than 30 years of healthcare experience including more than 20 years of experience in auditing, hospital postacute care consulting, and physician coding and billing. She has also held positions as billing director, healthcare compliance manager, and outpatient coding manager. Cusson has served as board member of her local professional association.



**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 the National Association for Healthcare Revenue Integrity. Goodman and Kay Larsen have been client/colleagues for more than 15 years, and have worked on a number of CDM, charge capture, and revenue integrity projects together.



**STEVEN A. GREENSPAN, JD, LLM**, is vice president of regulatory affairs at Optum 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 of R1 RCM in Chicago. He is a general internist and HIV specialist. Dr. 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 the National Association of Healthcare Revenue Integrity (NAHRI).



**EDWARD P. HU, MD, CHCQM-PHYADV**, is the current president of the American College of Physician Advisors. He completed his medical education at Washington University School of Medicine in St. Louis, Missouri, and went on to complete his residency in internal medicine at Duke University Medical Center in Durham, North Carolina. Dr. Hu is board-certified in internal medicine and healthcare quality and management, with a subspecialty certification as a physician advisor. He practiced as a hospitalist for 14 years and served as a medical director of case management at UNC Rex Hospital in Raleigh, North Carolina. Currently, he serves as the UNC Health Care System executive director of physician advisor services, supporting the development of physician advisor programs at 10 system hospitals. His areas of interest include Medicare regulations, revenue cycle, compliance, patient safety and quality, and risk adjustment.



**JUDITH L. KARES, JD**, is an expert in Medicare rules and regulations and is an instructor for HCPro's Medicare Boot Camp—Hospital Version®. She spent a number of years in private law practice, representing hospitals and other healthcare clients, and then as in-house legal counsel prior to beginning her current legal/consulting practice. She is also an adjunct faculty member at the University of Phoenix, where she teaches courses in business and healthcare law and ethics.



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**ALICIA KUTZER, ESQ., LLM, MHA**, is an adjunct instructor for HCPro's Medicare Boot Camp®—Audits, Appeals, and Denials Version and Medicare Boot Camp®—Hospital Version. Kutzer is a licensed attorney in the state of Pennsylvania and is a managing partner of Kutzer Law Firm, LLC, located in the Wilkes-Barre/Scranton area, founded in 2011. She served as an

Administrative Law Judge in more than 1,000 Administrative Fair Hearings for Federal Hearings and Appeals Services, Inc., from August 2016 through February 2017. Prior to that, Kutzer was a post-adjudication appeals officer, appeals officer, and subject matter expert for MAXIMUS, Inc., a Medicare Qualified Independent Contractor (QIC), from April 2012 through November 2015.



**ELIZABETH E. LAMKIN, MHA**, is CEO of PACE Healthcare Consulting, LLC, in Hilton Head, South Carolina. She has 20 years of hospital CEO experience. She is a nationally known speaker and author on billing compliance, including CMS Recovery Auditors. Lamkin serves as an advisory board member for NAHRI.



**KAY LARSEN, CRCR**, 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 client/colleagues for more than 15 years, and have worked on a number of CDM, charge capture, and revenue integrity projects together.



**WILLIAM L. MALM, ND, DNP, 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.



**DEBRA MAY** is the interim vice president of revenue cycle for Renown Health in Reno, Nevada. She oversees the revenue cycle for two acute care hospitals, one inpatient rehabilitation hospital, a children's hospital, and all the integrated health network's urgent care, medical group, and specialty locations. Renown Health is the only not-for-profit healthcare system in Northern Nevada. Previously,

May served as Renown Health's director of revenue integrity, with a focus on developing a team to cover all aspects of revenue integrity. May has over 25 years' experience in both the hospital and professional revenue cycle, is a certified Transformational Health Care leader involved in process improvement projects across the health network, and is an active member of the HFMA Nevada Chapter.



**MELISSA J. MCCARTHY, RHIT, CCS, CHC**, is the assistant vice president and deputy chief corporate compliance officer for Northwell Health in Great Neck, New York. Previously, McCarthy worked as the regional manager for information on demand and was manager of records design and retention for the Penn State Milton S. Hershey Medical Center in Hershey, Pennsylvania,

where she was responsible for electronic medical record forms design and policies as well as hybrid medical record processes. McCarthy

was also previously employed as an assistant director in the health information management department of Glen Cove Hospital in Glen Cove, New York.



**MARILYN HART NIEDZWIECKI, MBA, CPA, RN, CPC, COC, CIRCC**, is the director of revenue integrity at Ann & Robert H. Lurie Children's Hospital of Chicago, where she is involved in chargemaster maintenance along with other revenue cycle initiatives. Previous employment was focused in the clinical side until Niedzwiecki discovered the revenue cycle after obtaining her accounting degree.

She has published several articles related to the revenue cycle and is also frequently involved with nationally recognized organizations related to chargemaster research and best practices webinars and speaking engagements. Niedzwiecki also serves as a subject matter expert for articles related to strategies and complexities of the charge description master.



**GREG RADINSKY, JD, MBA, CHC, CCEP**, is the senior vice president and chief corporate compliance officer of Northwell Health, the largest private employer in New York. Prior to joining Northwell, he served as a vice president and assistant general counsel at a leading healthcare procurement company. Before that, Radinsky was an attorney for Medtronic, where he also held marketing and consulting positions. He began his career

as a fraud and abuse attorney in the Office of Inspector General (OIG) for HHS. The OIG honored Radinsky with its Exceptional Achievement Award and Cooperative Achievement Award. Furthermore, the Ethisphere Institute named him as an Attorney Who Matters in the ethics/compliance fields for 2014, 2015, and 2016. Radinsky received his MBA from Northwestern University's Kellogg School of Management, his JD, magna cum laude, from Saint Louis University School of Law, and his bachelor's, magna cum laude, from Tufts University.



**TERRI RINKER, MT (ASCP), MHA**, is the revenue cycle director at Community Hospital Anderson in Anderson, Indiana, an affiliate of the Community Health Network. She was awarded her organization's award for innovation in 2012. In the past 20+ years she has worked to find creative ways to bridge the gap between the clinical side and the financial side of healthcare. She has a Bachelor of

Science degree in Medical Technology from Indiana University and is board-certified by the American Society of Clinical Pathologists with a specialty certification in Laboratory Management. She worked as a laboratory manager before completing her Master of Health Administration at Indiana University. She is chair of the Provider Round Table, an HFMA member, and a Court Appointed Special Advocate volunteer. She currently volunteers with the United Way and was the recipient of the 2015 Madison County United Way Volunteer of the Year award.



**VALERIE A. RINKLE, MPA**, is a lead regulatory specialist and instructor for HCPro's Medicare Boot Camp®—Hospital Version, Medicare Boot Camp®—Utilization Review Version, and Medicare Boot Camp®—Critical Access Hospital Version. Rinkle is a former hospital revenue cycle director and has over 30 years of experience

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.



**JOHN SETTLEMAYER, MBA, MHA, CPC**, is an assistant vice president, revenue cycle with Carolinas HealthCare System with a focus in 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 25 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 Nimit 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.

Shah serves as an advisory board member for NAHRI.



**ANGELA LYNNE SIMMONS, CPA**, is vice president of revenue and reimbursement at Vanderbilt University Medical Center in Nashville, Tennessee. A Texas Certified Public Accountant, she brings more than 30 years of experience in healthcare operations and finance, and public accounting for healthcare entities.

Simmons has expertise in healthcare policy, reimbursement principles from government programs (Medicare and Medicaid), as well as healthcare financial analysis and cost accounting. Much of her focus throughout her career has been on identifying revenue opportunities and pursuing those through improving hospital operations and by Medicare filings and appeals. Prior to relocating to Vanderbilt, she was the director of clinical revenue and reimbursement for University of Texas M.D. Anderson Cancer Center, where she was responsible for Medicare and Medicaid reimbursement, cost accounting, revenue and rate-setting, financial analysis, and clinical decision support reporting.



**DIANA SNOW, MJ, CCS, CHC, CHPC**, 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, PMP**, is the director of project management and client engagement at Intersect Healthcare in Towson, Maryland. She has more than 20 years of experience in revenue cycle with a focus on hospital coding, charge capture, and denials management. In her current role, Tomak is responsible for coordinating project implementation of Intersect Healthcare's Veracity software. She works directly with clients

to ensure that they are fully utilizing the Veracity software to effectively manage commercial and government audits and denials. Tomak is an active member of IHIMA, serving as the Nominating Committee Chair for the 2018-2019 year.



**DIANE WEISS, CPC, CPB, CCP**, is the vice president, reimbursement, for RestorixHealth (formerly Wound Care Specialists). Weiss joined RestorixHealth in Metairie, Louisiana, in June 2011, which facilitated the formation of the New Orleans office revenue cycle team. Previously, Weiss managed a general surgery practice for 10 years in the Greater New Orleans area, where

she served as practice manager and was also the in-office medical assistant. In 1995, her career moved to the payer side. She became the provider education representative for Pinnacle Medicare Services, providing CMS Medicare Part B provider education and denial management for providers throughout Louisiana and other states within the MAC jurisdiction. For those 12 years with Medicare, Weiss conducted provider education workshops and seminars, and spoke to a variety of specialty societies, coding groups, and medical manager associations. She provided information and assistance with claims submission issues and denial management, and effectively communicated CMS' annual changes regarding reimbursement and coverage for Part B providers. She also served as Ochsner Health System's internal medicine consultant for five years before joining RestorixHealth.



**DENISE WILLIAMS, 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.



**CAROLINE RADER ZNANIEC** is the owner and consulting lead of Luna Healthcare Advisors LLC in Denton, Maryland. In the past, she held various positions both within consulting and the industry. Znaniec was the national revenue integrity lead for Grant Thornton LLP (Baltimore), associate director of charge integrity at Navigant Consulting (Baltimore), corporate compliance officer at Anne Arundel Health System (Annapolis, Maryland),

senior consultant of the national CDM practice of KPMG LLP (Baltimore), clinical operations manager at Children's National Medical Center (Washington, D.C.), business operations manager of Halpern Eye Care (Dover, Delaware), and physician billing representative at Peninsula Regional Medical Center (Salisbury, Maryland). She holds a Bachelor of Science in Corporate Health as well as a Master of Business Administration and Master of Science Management in Healthcare Administration.

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