October 23–24, 2014
Hyatt Regency Orlando
Orlando, Florida

Pre-Conferences:
October 22, 2014
Inpatient versus Outpatient:
A Soup to Nuts Menu for Success
8 a.m.–12 p.m.

Tricks of the Trade: Uncovering and
Optimizing Medicare Resources
1:30–5 p.m.

www hcmarketplace.com
The 2014 Medicare Compliance Forum is the only seminar that will teach you how to respond to the sweeping changes CMS implemented for inpatient and outpatient services. Learn how the changes impact operations from utilization review (UR) to billing and coding, and gain the information needed to predict the impact on your revenue stream for 2015.

The 2014 Medicare Compliance Forum pairs leading Medicare experts with practicing providers and hospital committee leaders from the field to provide a unique combination of solid regulatory guidance and practical solutions to enhance your organization’s policies and procedures.

Don’t miss out on this opportunity to learn strategies for strengthening the functions of your UR committee, appropriately assigning patient status, and protecting your organization from government audits.
What's New For 2014

This year's hot topics include:

• The latest changes to the IPPS and OPPS regulations and their impact on the audit landscape for hospitals
• What the 2-midnight rule means for patient status and medical necessity
• Changes to observation services and the impact of Condition Code 44 on revenue
• New guidance on Part A to B inpatient rebilling
• Implementing policies to receive accurate payment for packaged and separately billable labs
• An update on the current OPPS payment system and the impact of the new comprehensive APCs on Medicare claims
• Strengthening your UR committee by reviewing real-world examples of successful reviews and fully understanding the Conditions of Participation (CoP)
• Engaging your physician advisors to strengthen your UR committee determinations

Main conference – Price per person: $1145
Each pre-con – Price per person: $395

Attend both pre-conferences and the 2014 Medicare Compliance Forum!
$1,935 individual standard rate.

Team Program Discount: Send five for the price of four!

Please call 800-650-6787.

Cancellation Policy: Cancellations received by HCPro 30 days or more prior to the seminar are eligible for a credit or refund, less a $250 cancellation fee. The credit will be valid for up to six months from date of cancellation. Cancellations made 30 to 10 days prior to the seminar date(s) are not eligible for refunds but are eligible for payment transfer (credit) to another HCPro seminar, less a $250 cancellation fee. The credit will be valid. Participant(s) who cancel less than 10 days prior to the seminar date(s) will be considered as “no shows” and will not be eligible for refunds/credits. This policy is subject to change.

Who Should Attend:

- Case managers
- HIM directors and managers
- UR coordinators, committee members, physician advisors, and professionals
- CFOs, CMOs, CNOs, and VPMAs
- Compliance officers
- Revenue cycle directors
- Recovery audit coordinators
- Reimbursement managers
- Chargemaster coordinators
- Registered nurses
- Managed care directors
- Managed care staff
- Risk management professionals
- Patient financial services managers

Continuing Education Credits

Visit www.hcmarketplace.com/seminars for specific information about continuing education credits that will be provided for this program.
Overview & Benefits

Learning Objectives
At the conclusion of the conference, participants will be able to:

• Identify recent regulatory changes from CMS and their impact, including the 2015 IPPS Final Rule and 2015 OPPS Proposed Rule
• Discuss changes to patient status rules, including observation services and the 2-midnight rule
• Identify strategies for strengthening the efficacy of the UR committee and physician advisors
• Outline practical and innovative approaches to address important Medicare compliance concerns such as medical necessity, national and local coverage determinations, and custodial care
• Implement new and efficient approaches to address important Medicare compliance concerns such as Condition Code 44, Part A to B rebilling, the three-day payment window, and provider-based billing
• Examine several methods to prepare for and defend an audit
• Apply Medicare regulations and best practices to your UR process and chargemaster in two interactive, hands-on workshops

Benefits:

• NEW! Attend one of two new workshops that examine UR or chargemaster best practices. Participants are asked to bring their policies and procedures to work with peers and regulatory experts to identify areas for improvement.
• NEW! Ever wish you could be a fly on the wall in a room full of government auditors? We’ve got you covered. Get the inside scoop on what raises red flags for auditors—what you learn might surprise you!
• NEW! Denied claims are a problem for everyone, and sometimes the best solutions are lying right under your own roof. Leveraging clinical documentation improvement (CDI) specialists may be your solution to reducing medical necessity denials. Our CDI expert tells you exactly what to do to get on track.
• NEW! Electronic medical records (EMR) are often referred to as data rich and information poor, but it doesn’t have to be that way. Optimize your chargemaster so it captures valuable data, uncovers vulnerabilities, and opens the doors for compliant billing.
• Gain the skills necessary for predicting how changes outlined in the 2015 IPPS Final Rule and 2015 OPPS Proposed Rule may impact your revenue stream.
• Hear directly from Medicare experts who can explain what the new payment systems mean for your facility.
• Create action plans to budget for next year and to tackle reimbursement regulations.
• Discover practical and innovative approaches to address important Medicare compliance concerns.

Please note, in an effort to Go Green we will provide participants with the seminar presentation materials download link a week prior to the event and a thumb drive onsite. Participants will also receive a conference program guide, which will feature a section for note-taking during the event, but it will not include any of the seminar presentation materials.
### Inpatient versus Outpatient: A Soup-to-Nuts Menu for Success
**Price per pre-con per person: $395**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>7:00–7:55 a.m.</td>
<td>Registration with continental breakfast</td>
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<tr>
<td>7:55–8:00 a.m.</td>
<td>Introduction and welcome</td>
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| 8:00–10:15 a.m. | **Deborah K. Hale, CCS, CCDS**  
Changes to Level of Care Determinations for 2015  
- Defining observation  
- Inpatient admission definition and certification requirements  
- Coping with beneficiary perception of observation services  
  - Dealing with the increased publicity and misinformation from consumer groups  
  - Educating patients and families  
- Achieving accurate reimbursement when correcting inpatient admission order errors  
  - Condition Code 44  
  - Provider-liable Part A to B rebilling |
| 10:15–10:30 a.m. | Break                                                                  |
| 10:30 a.m.–12:00 p.m. | Strategies for Best Practice Utilization Review and Payment Accuracy  
- Establishing effective internal processes for achieving level of care accuracy  
- Key performance indicators for measuring level of care patterns  
  - Establishing benchmarks  
  - Current performance  
  - Evaluating data and determining action steps  
Fatal errors in observation billing |
| 12:00 p.m. | Adjourn                                                                 |
Agenda

Pre-Conference Workshops - WEDNESDAY, OCTOBER 22

Tricks of the Trade: Uncovering and Optimizing Medicare Resources
Price per pre-con per person: $395

12:30–1:25 p.m. | Registration

1:25–1:30 p.m. | Introduction and welcome

1:30–3:30 p.m. | Kimberly A. Hoy Baker, JD, CPC
Hierarchy of laws
  • Social Security Act, United States Code, and Public Laws
    – How do you find them and what’s the difference between them?
  • Regulations
    – Finding and interpreting Federal Register proposed and final rules, and other notices
    + Tackle those 1,000-page rules with confidence and learn to focus on what’s important
    – The Code of Federal Regulations and the eCFR—tools for compliance, learn how to use them

3:30–3:45 p.m. | Break

3:45–5:00 p.m. | CMS guidance
  • Paper-based and Internet-only Manuals
    – What’s in them and how to navigate them
  • CMS transmittals
    – Interpreting the dates and business requirements to help your organization proactively prepare for Medicare changes and billing requirements
  • MLN Matters articles
    – Leveraging these important educational tools and find out which ones you should pay special attention to
  • Where to find other important “sub-regulatory” guidance
    – Payment files, including OPPS Addendum A and B, Medicare Physician Fee Schedule, Laboratory Fee Schedule, DRG tables, etc.
    – Outpatient supervision levels and other important outpatient information
    – Inpatient medical review, the 2-midnight rule, order and certification clarifications
  • Coverage documents
    – Learn the best source for official NCDs, LCDs, and CEDs

5:00 p.m. | Adjourn
Main Conference Day 1 - THURSDAY, OCTOBER 23

7:55–8:05 a.m. – Welcome

8:05–9:05 a.m. General Session

Regulatory and Audit Update: The Latest and Greatest From CMS, OIG, RACs, and More

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

In an industry where new information is available nearly every day, it is crucial to stay on top of regulatory guidance. Sometimes it helps to see things from another perspective. Learn to look at the most current Medicare regulatory proposals, guidance, and mandates that impact billing/reimbursement from an auditor’s standpoint.

Break: 9:05–9:15 a.m.

9:15–10:30 a.m.

TRACK 1: Strategies for Defending Audits and Appealing Claims

Taking Readmission Reduction Too Far: Stop Self-Denying and Start Billing

Deborah K. Hale, CCS, CCDS

Yes, you can bill for medically necessary readmissions! Discover strategies for complying billing for readmissions while demonstrating the impact of planned readmissions on the hospital’s overall rate. You can receive accurate reimbursements by understanding CMS instructions for billing readmissions, leaves of absence, and the risk adjustment process used to measure readmission rates. Examine CMS audit provisions for identifying premature discharges that result in readmission.

The Latest on the 2-Midnight Rule: Exceptions and Application

Kimberly A. Hoy Baker, JD, CPC

The requirements set forth by the 2-midnight rule changed the landscape for inpatient admissions. Compliance with the rule presents a challenge for many organizations, and keeping up with the latest CMS guidance compounds this task. Get familiar with the rule and its exceptions and how they can make it easier to determine patient status. Also, learn how providers and provider organizations have challenged the rule through proposed legislation and the courts.

Updates to the Outpatient Prospective Payment System APCs: How Comprehensive Can You Get?

Gina M. Reese, Esq., RN

Explore the impact of CMS’ adoption of 29 all-inclusive comprehensive Ambulatory Payment Classifications (APC), which will replace the 39 existing device-dependent APCs in 2015. Under this new payment system, CMS will package into the comprehensive APCs all "adjunctive services" provided during the delivery of the comprehensive service. This will result in a single prospective payment for all charges on the claim, excluding only charges for services that cannot be covered by Medicare Part B or that are not payable under the OPPS. In this session, we will furnish an overview of the basics of the current OPPS payment system and APCs, as well as detail the new comprehensive APCs.

Break: 10:30–10:45 a.m.

10:45 a.m.–12 p.m.

TRACK 1: Strategies for Defending Audits and Appealing Claims

Analytics Under IPPS: Data Support and Tracking

Ralph Wuebker, MD, MBA

Hospitals are expected to make data-driven decisions. Decision-making is always tricky, but so is gathering data to form and support conclusions. Without industrywide benchmarks, learn which metrics you should track locally to evaluate performance and uncover potential causes of shortfalls.

The Physician Advisor: Strategies That Affect the Success of This Key Player on Your UR Committee

Mark Michelman, MD, MBA

A UR committee is a team, and one of its integral players is your physician advisor. The success of a UR committee often hinges on the selection of the physician for this role. Learn how to appropriately select, train, and engage physician advisors to achieve optimal results for your UR committee. Challenges and barriers facing your physician advisors will be discussed along with measurable performance goals to avoid having ineffective advisors.

Peeling the Onion: The Layers of Medicare Coverage for Hospital Outpatient Services

Gina M. Reese, Esq., RN

The Medicare coverage requirements for hospital services are found in statutes, regulations, and national and local coverage determinations. It’s a lot to take in, but looking closely at common scenarios surrounding Medicare coverage can alleviate some confusion. Peel back the layers of these coverage requirements to better understand the conditions that must be met for coverage of outpatient diagnostic and therapeutic services, self-administered drugs, and laboratory services.

Lunch (provided): 12–1:30 p.m.

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<td>1:30–2:45 p.m.</td>
<td>Leverage CDI Specialists to Reduce Medical Necessity Denials</td>
<td>The New UR Committee: Best Practices for Successful Reviews</td>
<td>Jeopardy of Non-Validated Charge Capture Within Your EMR</td>
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<td>Cheryl Ericson, MS, RN, CCDS, CDIP, AHIMA-Approved ICD-10-CM/PCS Trainer</td>
<td>Kimberly A. Hoy Baker, JD, CPC, and Zachary Fainman, MD</td>
<td>William Malm, RN, ND, CMAS</td>
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<td>Collaboration between UR and CDI specialists can potentially decrease denials due to medical necessity. Objective findings don’t often translate into coded diagnoses and can make a claim vulnerable to denial. To avoid this, it is crucial to gain an understanding of why the patient is being admitted. Organizations should leverage CDI specialists to improve provider documentation so it reflects the condition that is the focus of treatment.</td>
<td>The role of the UR committee is evolving with the introduction of the 2-midnight rule and changes to inpatient Part B billing requirements. To ensure admissions and billing are appropriate, organizations must have a firm grasp on UR CoP. Learn the CoP requirements and how to leverage them for proper reimbursement. Real-world examples from a successful UR committee will be examined.</td>
<td>Is your chargemaster optimized to capture all of the information from an EMR? EMRs are often used to automate billing functions, but this is hardly useful unless an organization determines whether its system is capturing data and applying it to the billing rules. Learn how to run tests that uncover revenue vulnerabilities and develop and apply compliant billing rules that ensure you receive accurate reimbursement.</td>
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<td>Break: 2:45–3 p.m.</td>
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<td>3–4:15 p.m.</td>
<td>From the Front Line: An Auditor’s Perspective</td>
<td>Rise to the Challenge of Medicare’s “Inpatient-Only” Procedure List</td>
<td>Inpatient Orders and Certification: A Compliance Trap for Hospitals</td>
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<td>William Malm, RN, ND, CMAS</td>
<td>Deborah K. Hale, CCS, CCDS</td>
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<td>Ever wish you could be a fly on the wall in a room full of auditors? We’ve got you covered. Take an inside look at the role and perspective of auditors to understand what raises their red flags. Find out how auditors approach records, what situations lead to a closer look, and how to ensure you’re prepared to survive their scrutiny. Learn how to use this insider’s tips to perform self-audits.</td>
<td>The rules surrounding reimbursement for inpatient-only procedures can be tricky to comply with because not all scheduled procedures play out as expected. Gain valuable insight that will help your organization comply with the requirements for preoperative inpatient admission orders. Learn to address challenges associated with these procedures by reviewing strategies for coping with unplanned procedures, postoperative transfers, or intraoperative death.</td>
<td>New regulations require an inpatient order and a separate certification for hospitals to receive payment for inpatient admissions under Medicare Part A. These regulations go beyond normal order requirements, setting up compliance pitfalls for hospitals. CMS has further complicated matters by issuing clarifying guidance that sets up a new “initial order” for inpatient care with its own separate requirements. Explore the regulations and extensive clarifying guidance and learn the ins and outs of compliance with these new requirements.</td>
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<td>8–9 a.m.</td>
<td>An Inside Look at the Probe and Educate Audits of Inpatient Claims</td>
<td>Custodial Care and Placement Issues: Use Notices to Improve Compliance and Patient Satisfaction</td>
<td>Secrets for Success: Billing for Lab Services in a Rapidly Changing Environment</td>
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<td>Zachary Fainman, MD, and Ralph Wuebker, MD, MBA</td>
<td>Kimberly A. Hoy Baker, JD, CPC</td>
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<td>CMS has extended its probe and educate audits of prepayment inpatient claims, underscoring the importance of complying with the latest guidance for inpatient admissions. The preliminary results of these reviews will be discussed to serve as a teachable moment for healthcare professionals and assess compliance with the 2-midnight rule. Real-world examples of denied claims will be reviewed.</td>
<td>Case managers have long struggled with Medicare patients who need placement in lower levels of care or are simply unsafe to discharge back home. The new 2-midnight rule has put a spotlight on these issues with its requirement to identify patients that need hospital care versus other types of care. Learn how to identify custodial care patients and how to use advance beneficiary notices to better track charity care, garner goodwill, and improve throughput of patients experiencing delays in discharge. Explore the limited “safe discharge” benefit for inpatients.</td>
<td>Just when you think you have the hang of billing for outpatient lab services, CMS releases new regulations, causing hospitals to suffer billing headaches. Don’t try to work through the changes alone. Discover strategies for effectively billing for separately payable and packaged labs, selecting appropriate modifiers, and selecting the most appropriate type of bill.</td>
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### 9:15–10:30 a.m.

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<td><strong>Administrative Law Judges: Case Studies</strong></td>
<td><strong>The Move From Concurrent Review to Post-Discharge Review: Properly Using Condition Codes W2 and 44</strong></td>
<td><strong>Strengthen the Revenue Cycle With Interdepartmental Collaboration</strong></td>
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<td>Ralph Wuebker, MD, MBA</td>
<td>Kimberly A. Hoy Baker, JD, CPC</td>
<td>Cheryl Ericson, MS, RN, CCDS, CDIP, AHIMA-Approved ICD-10-CM/PCS Trainer</td>
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<td>Gain valuable insight by walking through Administrative Law Judge case studies to understand strategies for effectively moving forward. Featured examples are based on real-life lessons learned, including major Recovery Auditor targets, Recovery Auditor readiness recommendations, and process and reporting guidelines.</td>
<td>Changes to Part B inpatient billing requirements have given many facilities the opportunity to move to post-discharge reviews billed with condition code W2, instead of concurrent reviews billed with condition code 44. To maximize resources and ensure appropriate payment, organizations must understand when concurrent review is not necessary for full Part B payment. This can allow for the redeployment of resources to tackle crucial problem areas like inpatient-only procedures or custodial cases. Requirements for and payment of cases using condition codes W2 and 44 will be reviewed along with strategies for achieving optimal reimbursement.</td>
<td>Learn to speak the language of IPPS reimbursement methodology. Participants will dissect the anatomy of an MS-DRG, discussing the importance of the principal diagnosis and the relevance of secondary diagnoses (e.g., CCs and MCCs) on determining expected length of stay. Armed with a better understanding of MS-DRGs, you can implement strategies to maximize efficiency by leveraging MS-DRGs assigned by CDI specialists to help minimize avoidable days.</td>
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### 10:30–10:45 a.m.

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<td><strong>The Ins and Outs of Appeals: From Process Building to Appeal Writing</strong></td>
<td><strong>Engage Physicians and Drive Revenue: We Know You Don’t Like the Rules, but You Must Follow Them</strong></td>
<td><strong>Provider-Based Clinics: What You Need to Know, From the Basics to the Nuances</strong></td>
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<tr>
<td>Steven A. Greenspan, JD, LLM, and William Malm, RN, ND, CMS</td>
<td>Zachary Fainman, MD, and Ralph Wuebker, MD, MBA</td>
<td>Kimberly A. Hoy Baker, JD, CPC</td>
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<td>This session will identify optimal strategies for reviewing and writing medical and coding appeals. Key components of successful appeals will be discussed to help attendees apply best practices to their own appeals writing.</td>
<td>Physicians are busy professionals who don’t often take the time to stop and listen to every rule in the book. However, it is crucial for them to learn how to think through the 2-midnight rule and the certification requirements and to document properly. This allows organizations to correct revenue and reduce denials, thereby allowing for quality patient care. Learn how one hospital implemented a physician education program to change physician behavior.</td>
<td>Provider-based clinics and physician practices must comply with a complex set of Medicare regulations. Even after meeting those requirements, they face a separate set of complex billing and coding challenges. Recognize the requirements for a provider-based clinic, the unique coding rules and nuances for these clinics, and how payment differs from a freestanding clinic owned by a hospital. The impact of new bundling rules and a review of CMS solicitation of comments on provider-based departments will also be covered.</td>
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### Agenda

#### Main Conference Day 2 - FRIDAY, OCTOBER 24 (cont.)

**Lunch (on your own): 12–1:30 p.m.**

**Workshops (Pick one workshop to attend)**

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<th>Time</th>
<th>Workshop</th>
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| 1:30–4 p.m. | **Chargemaster Essentials to Ensure Accurate Claim Submission**<sup>**</sup>  
William Malm, RN, ND, CMAS  
The chargemaster is essential to the functions of a successful hospital revenue cycle. During this workshop, attendees will collaborate with each other to analyze the services and procedures on their chargemasters such as ED, respiratory therapy, and pharmacy. A chargemaster expert and former auditor will help attendees apply strategies to develop and maintain an optimal chargemaster. Attendees are encouraged to bring a summary of their chargemaster to compare with that of other organizations to enhance accuracy and efficiency of claim submission.  
**This workshop does not offer ANCC contact hours** |

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| 1:30–4 p.m. | **Practical Strategies for Enhancing Your UR Committee**  
Kimberly A. Hoy Baker, JD, CPC; Steven A. Greenspan, JD, LLM; Deborah K. Hale, CCS, CCDS; Gina M. Reese, Esq., RN; and Ralph Wuebker, MD, MBA  
The key to an effective UR committee is teamwork. During this interactive workshop, attendees will work alongside one another and industry experts to develop strategies for strengthening their UR process and plans. Presentation and discussion will help attendees gain a better understanding of UR determinations and notices to patients while exploring goals for interacting with other hospital departments. Attendees are encouraged to bring UR policies and plans from their organization to refine and analyze during the workshop. |

### Location

**2014 Medicare Compliance Forum**

**Hyatt Regency Orlando**

9801 International Drive  
Orlando, Florida 32819

Conveniently situated in the center of International Drive, Hyatt Regency Orlando brings you within minutes of world-famous theme parks while allowing you to escape in upscale accommodations and premium amenities. [http://orlando.regency.hyatt.com/en/hotel/home.html](http://orlando.regency.hyatt.com/en/hotel/home.html)

**Hotel Cutoff Date:** September 22, 2014  |  **Hotel Reservations Number:** 888-421-1442  
**Hotel Direct Phone Number:** 407-284-1234  |  **Discounted Room Rate:** $179

For the discounted room rate, reservations must be made by September 22, 2014. Be sure to mention HCPro to receive the discounted room rate. Rooms are available on a first-come, first-served basis and often sell out before the September 22 cutoff date. Make your hotel reservations immediately to guarantee rate and availability.
Kimberly A. Hoy Baker, JD, CPC, is the director of Medicare and compliance for HCPro, a division of BLR, in Danvers, Massachusetts. She is the lead instructor for HCPro’s Medicare Boot Camp®—Hospital Version and Medicare Boot Camp®—Utilization Review Version, as well as an instructor for Medicare Boot Camp®—Critical Access Hospital Version. Baker has experience conducting billing, compliance audits, and internal investigations.

Cheryl Ericson, RN, MS, CCDS, CDIP, AHIMA-Approved ICD-10-CM/PCS Trainer, is the associate director of education for the Association of Clinical Documentation Specialists (ACDIS) at HCPro, a division of BLR, in Danvers, Massachusetts. Ericson is responsible for developing and implementing CDI education for HCPro, including the CDI Boot Camp, ICD-10 for CDI Boot Camp and the Advanced CDI Boot Camp. She has been an InterQual Trainer and managed the UR department at a large, academic medical center.

Zachary Fainman, MD, is the co-medical director and physician advisor of care management, as well as the co-chair of the UR committee at Advocate Lutheran General Hospital in Park Ridge, Illinois. He has been a physician advisor for more than 14 years and serves as the chair of the physician advisor committee for the Advocate Healthcare System. Dr. Fainman had been in a general internal medicine private practice at the hospital for more than 21 years. He is also a member of the business conduct committee for the Advocate Healthcare System.

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 17 year career, Greenspan has overseen the adjudication of more than 200,000 appeals and personally authored over 10,000 appeal decisions. Prior to joining EHR, Greenspan served as vice president and project director for MAXIMUS Federal Services, Inc., overseeing the company’s Part A East QIC project.

Deborah K. Hale, CCS, CCDS, president and CEO of Administrative Consultant Service, LLC, in Shawnee, Oklahoma, has more than 30 years of experience in healthcare management including administration, health information management, clinical documentation improvement, resource outcome management, and UR. For the past 29 years, she has provided clinical documentation improvement, utilization management, coding, and billing consultation for hospitals throughout the United States.

William L. Malm, ND, RN, CMAS, is a senior data project manager for Craneware, based in Edinburgh, Scotland, with offices in Atlanta. He has more than 25 years’ experience in a combination of clinical and financial healthcare. He specializes in operations surrounding chargemasters, including education, audit, and post-implementation reviews. Malm has performed more than 250 CDM analysis engagements. His specialty is auditing with a focus toward proactive operational changes based on auditing.

Mark Michelman, MD, MBA, is vice president of medical affairs at Morton Plant Mease Health Care in Clearwater, Florida. He is board certified in internal medicine, hematology, and quality assurance, and UR. He also serves as medical director of quality management, utilization management, and case management, and as advisor to coding and CDI.

Gina M. Reese, Esq., RN, is an expert in Medicare rules and regulations and 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, in addition to serving as in-house legal counsel, prior to beginning her current legal/consulting practice. Reese is also a certified mediator, as well as an adjunct assistant professor at the Glendale College School of Law, where she teaches courses in legal writing.

Ralph Wuebker, MD, MBA, is chief medical officer for EHR in Newtown Square, Pennsylvania. Dr. Wuebker is board certified and continues to practice three to four days per month. He currently serves as a member of EHR’s physician education and audit team. He 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, UR, denials management, and length of stay.
REGISTRATION FORM  
MEDICARE COMPLIANCE FORUM | OCTOBER 23-24, 2014 | HYATT REGENCY ORLANDO

INDIVIDUAL PROGRAM DISCOUNTS:
Medicare Compliance Forum | October 23-24
- $1,145 individual standard rate

PRE-CONFERENCE—Event #1: Inpatient Versus Outpatient:  
A Soup to Nuts Menu for Success | October 22
- $395 individual standard rate

PRE-CONFERENCE—Event #2: Tricks of the Trade: Uncovering and Optimizing Medicare Resources | October 22
- $395 individual standard rate

REGISTER FOR BOTH PRE-CONFERENCES AND THE MEDICARE COMPLIANCE FORUM:
- $1,935 individual standard rate

TEAM PROGRAM DISCOUNTS:
Register a team of 4 and your 5th member attends FREE!
Call for special team discounts!
- $4,580 team of five (regular standard rate)

NAME OF ATTENDEE: (Seminar confirmation will be sent via email.)

Name: 
Title: 

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Organization: 

Street address: 

City: 
State: 
ZIP: 

Tel: 
Fax: 

Email: 

CONTACT PERSON NAME: (If different from attendee)

Name: 
Email: 

SELECT YOUR METHOD OF PAYMENT: (Payment is due immediately upon receipt.)

- Check enclosed (Payable to HCPro)
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