

Measure Results...Reduce Administrative Claims...Lower Administrative Expenses...Improve Denial Rates...Automate the Claims Process More Efficiently...Learn This and Much More at:

A World Research Group Healthcare Management Series Conference

HEALTHCARE CLAIMS MANAGEMENT SUMMIT

Successful Strategies to Measurably Reduce Cost, Time, and Lower Administrative Expenses While Improving Productivity Through Claims Processing Optimization

April 18-20, 2005 • Harrah's • Las Vegas, NV

Hear leading-edge case studies, proven strategies, and innovative methodologies from healthcare leaders how to drastically improve claims processing and cut costs! Learn how to:

- **Identify** data exchange to uncover Medicaid fraud, abuse and waste
- **Improve** denial rates and claims payment activity by analyzing the data available in the Claims Metric Report
- **Negotiate** best results for a healthcare claims outsourcing agreement
- **Identify** and **remedy** areas within your organization where HIPAA compliance may negatively impact your revenue from CMS
- **Lower** premiums with consumer-directed health care
- **Achieve** sustained compliance between the consumer and government agencies
- **Implement** simple steps to audit claims data to search for overpayments and recover overpayments
- **Develop** a marketing strategy that shows providers how EDI can save them money

Hear case-study driven strategies from these managed care leaders on how to cut costs while increasing productivity and auto-adjudication rates:

- Lessons Learned Transitioning From Manual Claims Processing to Auto-Adjudication
Colorado Access
- Overhauling a Claims Department From Redesign to Reengineering
Neighborhood Health Plan – Rhode Island
- Enterprise Wide Technology and Business Process Outsourcing Solutions to Minimize Administrative Costs
**Welborn Health Plans
ikaSystems**
- Vendor Consolidation – Promises and Pitfalls
Humana
- Streamlining Reimbursement for Provider Claims
Department of Managed Health Care of California
- Cost Containment in Claim Processing
Employee Benefit Management Services, Inc (EBMS)
- Medicaid Providers Billing and Paid for Services on Behalf of Deceased Recipients
Government of the District of Columbia
- Implementing and Managing a Business Process Outsourcing (BPO)
National Association of Managed Care Regulators
- Operational Efficiency Programs and Correlation to Constituent Satisfaction
Blue Cross Blue Shield of Massachusetts
- Crafting an Outsourcing RFP that Your Lawyer Will Love
WellPoint Health Networks Inc.
- Consumer-Directed Health Care: A Cause for Claims Function Re-Consideration
The ChangeArtist
- Implementing a Claims Quality Assurance Audit Function to Increase One Touch Processing
Neighborhood Health Plan
- Successful Strategies for Reengineering Claims Processes for Optimal Efficiency and Improved Provider Relations
Health Network Systems
- Up-Coding/Unbundling Edits – Threats and Opportunities
Health Alliance Plan
- Improving Productivity Within the Claims Department –
**PANEL DISCUSSION
Softheon
Employee Benefit Management Services, Inc (EBMS)
IntelliClaim**

DON'T MISS THE MUST-ATTEND IN-DEPTH WORKSHOPS!

- Enhance Your Claims Performance Through Rules-Based Adjudication – IntelliClaim
- How to Dramatically Improve Claims Quality Through Statistically Valid Audits – The ChangeArtist
- How to Capitalize on Waste, Abuse, and Fraud Programs in Healthcare – Allied Management Group

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Dear Healthcare Professional:

Can you continue to allow claims processing to languish as healthcare costs are skyrocketing?

If improved productivity and auto-adjudication are priorities for your plan, you are not alone. More and more health plans are relying on technology to improve efficiency. Today health plans are developing and implementing low-cost technology to achieve best work practices under real-life budgets and constraints.

This conference **The Healthcare Claims Management Summit: Successful Strategies to Measurably Reduce Cost, Time, and Lower Administrative Expenses While Improving Productivity Through Claims Processing Optimization** taking place **April 18-20, 2005 in Las Vegas, NV** will examine proven strategies and innovative methodologies that drastically improve claims processing while cutting administrative costs.

Benchmark Your Productivity

In order to gain efficiency in your claims operation, you need to remove bottlenecks and impediments and improve accuracy. Specifically, this conference will help forward-thinking health plans to:

- **Improve** denial rates and claims payment activity
- **Incorporate** a statistically valid audit into your claims operations
- **Improve** and **sustain** claims management quality by implementing key best practices
- **Eliminate** paper, mishandled claims and overpayments
- **Learn how to protect** your up-coding and unbundling savings as an asset
- **Negotiate** best results for healthcare claims outsourcing agreements

Managed Care Leaders Improve Bottom-Line Results

Learn specifically from these MCO industry leaders how to:

- **Identify** provider billing concerns and work with providers and interdepartmentally to resolve concerns and eliminate systemic issues
- **Optimize** the auto-adjudication process
- **Obtain** one-touch accuracy in claims processing
- **Capitalize** on data exchange that can identify patterns of provider abuse
- **Improve** the EDI process and get key stakeholder cooperation

Don't miss this must-attend high-quality information exchange and networking event of the year! Take the next step and register yourself and a team of key people today! Register 3 and the 4th attends free! Register early to take advantage of the best discounts.

Who Should Attend

Vice Presidents, Directors, and Managers of:

Claims • Case Management • Care Management • Medical Management • Operations
Utilization Management • Member Services • Customer Care • Provider Management
Service Operations • Network Management • Client Support
Decision Support • Quality Assurance

From:

Health Plans • Employer Plans • Payers • Insurers

**Team Participation is essential to improving claims administration.
Register 3 and the 4th is Free!**

Attention Association Members

In consideration of the worthwhile and valuable contribution that professional associations make to the world of managed care administration, World Research Group is offering a \$200 discount to members of certain qualified associations. To register and to see if your professional association membership qualifies, please call our Marketing Director, Vijay at 646-742-9763 ext 44 as soon as possible.

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Day 1: MONDAY, APRIL 18, 2005

7:30 Conference Registration and Continental Breakfast

8:00 Chairman's Opening Remarks

8:15 **Enterprise Wide Technology and Business Process Outsourcing Solutions to Minimize Administrative Costs**

CASE STUDY

In this wave of HMO consolidation, ikaSystems and US Healthcare Holdings are committed to work with small and mid-sized carriers to provide the technology and competitive advantages necessary to effectively challenge the larger established payers while minimizing upfront costs. ikaSystems central focus is providing Managed Care Organizations and TPA's with enterprise wide off-the-shelf technology, a single, comprehensive system that addresses all the key transactions in the managed care cycle. In this session, the partnership of ikaSystems and US Healthcare Holdings will present how small and mid-size managed care companies can leverage off-the-shelf technology coupled with proven efficient outsourced business processes for competitive operating and economic advantages necessary to effectively challenge larger established payers. This session will focus on accomplishing a sustainable advantage through the implementation of cutting edge, yet affordable technology, using proven efficient outsourced processes that will immediately create lower administrative costs resulting in more competitive premiums.

James Marzano

CIO

IKASYSTEMS

Chris Reef

CEO

WELBORN HEALTH PLANS

9:00 **Overhauling a Claims Department From Redesign to Reengineering**

CASE STUDY



This session will focus on how to obtain one-touch accuracy in claims processing. It is important to start with a new blank slate. When reengineering, you should spend 60% of your time on where you are going, 10% on where you are and 30% of your time on how to get there. Attendees will learn:

- Different approaches to claim reengineering
- How to analyze staffing, skill sets and create career paths and training
- To analyze processes from receipt through payment

Pamela Leite

Senior Director of Claims and Human Resources

NEIGHBORHOOD HEALTH PLAN – RHODE ISLAND

9:45 *Networking Break and Refreshments*

10:15 **Lessons Learned Transitioning From Manual Claims Processing to Auto-Adjudication**

CASE STUDY



Implementing a health plan claims auto-adjudication system brings significant challenges. In spite of this, the gains in operational efficiency from better automation far outweigh the trials and tribulations experienced up front. Health plans undergoing this transition must focus not only on the system implementation but also on the people and processes involved in order to realize the greatest return. Learn how business leaders at Colorado Access are succeeding today using auto-adjudication to

improve accuracy and reduce administrative expenses for their plan. This session will focus on:

- Re-engineering workflows to complement system design and optimize claims efficiency
- Developing people and processes to administer the system
- Measuring and managing results, including specific management tools and procedures that ensure the highest level of operational performance

Marie Steckbeck

Chief Operating Officer

Doug Bach

Chief Information Officer

COLORADO ACCESS

11:00 **Vendor Consolidation – Promises and Pitfalls**

CASE STUDY

Many organizations use multiple vendors to perform similar functions. This can often result in duplication of effort or double-dipping by vendors, which in turn increases costs and plan dissatisfaction with members and providers. By reviewing your vendor contracts and results from each, you may find you can consolidate services with fewer vendors resulting in reduced costs and increased efficiencies. This session will focus on:

- Consolidation of EDI vendors/clearinghouses – promises & pitfalls
- Impact on cost/ROI
- Increased auto-adjudication rates
- Consolidation of financial recovery vendors – promises & pitfalls
- Increased collections and reduced commissions
- Major steps needed in implementation
- Evaluating other services offered
- Ongoing support/service guarantees

Janna Meek

National Director Provider Connectivity Services

HUMANA

11:45 **Streamlining Reimbursement for Provider Claims - The California Approach**

CASE STUDY

This presentation will focus on the objectives and anticipate results of the Department of Managed Health Care's recent promulgation of regulations to streamline claims processing and to establish standards for dispute resolution. The goals of the regulations include: clarification of payment timelines, requirements and penalties; and ensuring that medical groups and IPAs are held to the same standards as health plans. Mr. Donohue will also focus on the Department's regulatory efforts to ensure that the mandates are appropriately implemented by payers. This session will highlight:

- The innovative ways that California has attempted to address claim payment issues (such as non-contracted provider reimbursement)
- How to address misplaced claims receipts and the failure to explain claims adjustments
- 20 demonstrable and unjust payment patterns that the Department has identified to improve claims timeliness and accuracy

Kevin Donohue

Senior Counsel for the Financial Solvency Standards Board

DEPARTMENT OF MANAGED HEALTH CARE OF CALIFORNIA

1:45 Cost Containment in Claim Processing



With health care expenses continuing to rise at double digit rates, payers are looking for additional ways to prevent excess spending through cost-containment initiatives. Ms. Kimmell will discuss procedures that can be utilized in your organization that will ensure that all payments are appropriate. Both internal and third party options will be discussed. Learning opportunities available in this session include:

- Efficient plan design
- Pre-payment review of billing practices against Medicare, AMA, and other billing guidelines
- Internal procedures to ensure appropriate fraud and abuse review
- Audit practices internally and externally
- Post-payment review for provider practices and overpayment recovery opportunities

Judi Kimmell
Director of Eligibility and Claims Operations
EMPLOYEE BENEFIT MANAGEMENT SERVICES, INC (EBMS)

2:30 Medicaid Providers Billing and Paid for Services on Behalf of Deceased Recipients: Lessons Learned



To reduce Medicaid fraud, abuse, and waste in the District of Columbia Medicaid Program, the Office of Program Integrity conducted a special initiative over the past several years. This session will focus on how two agencies, within the Department of Health, exchanged data and recovered over \$2 million and the tally keeps increasing. You will learn:

- How data exchange can uncover Medicaid fraud, abuse and waste
- How data exchange can expand and become routine
- How data exchange can identify patterns of provider abuse
- How to work smarter and wiser
- Provider self-audits

Jane Young
Chief, Office of Program Integrity
MEDICAL ASSISTANCE ADMINISTRATION
DEPARTMENT OF HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

3:15 *Networking Break and Refreshments*

3:45 Implementing and Managing a Business Process Outsourcing (BPO) Arrangement: Implementing BPO is Not Just Re-Redirecting Your Files



There is a massive amount of challenging work required when implementing BPO, but the effort can ultimately benefit your organization as a whole. Mr. Rod Moyer will highlight how to adjust the internal operations, business rules and data when implementing BPO. He will discuss the necessary steps required to properly manage the BPO. From this presentation, attendees will learn:

- What steps are essential to building an effective BPO component to your operations and why
- What you should expect in both activities and approaches
- How to assess the work performed and how to identify errors, glitches and gaps

- What are "Reference Claims" and how they can be employed
- How to prepare for a fallback plan that can reduce damage if something does go wrong

Rod Moyer
Independent Consultant
NATIONAL ASSOCIATION OF MANAGED CARE REGULATORS

4:30 Operational Efficiency Programs and Correlation to Constituent Satisfaction



This session will focus on the three specific programs BCBSMA uses to continually improve the operational efficiency of the claims adjudication process. You will see how the three programs complement one another toward the goal of improving the internal measures of claims timeliness and accuracy. Most importantly, you will see the connection between these initiatives and constituent satisfaction measures – member, provider, and associate. This presentation will focus on:

- EDI claims submission outreach process
- BCBSMA Peak Performance Program – as applied in Claims Operations
- Improving first pass rate by source of input analysis

Ted Burke
Director of Claims Operations Division
BLUE CROSS BLUE SHIELD OF MASSACHUSETTS

5:15 p.m. – 6:15 p.m.
Cocktail Reception for Delegates and Speakers



Day 2: TUESDAY, APRIL 19, 2005

7:50 *Chairman's Remarks*

8:00 Consumer-Directed Health Care: A Cause for Claims Function Re-Consideration



Consumer-Directed Health Care (CDHC) has been the darling of government and employers as a means for keeping health care premiums down. The new benefit plans do this by placing the consumer in control of many of the first care-dollars spent; by combining high deductible benefits designs with a variety of health care accounts from which to draw funds to pay for care. In addition to placing the consumer in charge of spending health care dollars, the implementation of these plans requires coordination of benefits administration claims payment with the use of these other health care funding sources. The upshot for claims administration includes requirements for additional claim system functionality, claim system database redesign, operational changes in claims work flow, and policy decisions with respect to accessing health savings account funds and provider reimbursement rates. The presentation will explore these new requirements, and suggestions for ways to address them. This session will focus on:

- Additional claims system functionality required to coordinate claims payment with access to other healthcare funding sources

- Additional claim system fields required to track use of other healthcare funding source balances
- Workflow considerations with respect to payment of claims at point-of-service
- Policy considerations with respect to provider reimbursement rates

Robert S. Eichler
Principal
CHANGEARTIST

9:00 **Implementing a Claims Quality Assurance Audit Function to Increase One Touch Processing**

CASE STUDY

This session will focus on how to put processes in place to perform quality audit reviews, claims testing, identification of provider billing concerns and a post-audit of system modifications. This presentation will focus on the collaboration of departments to ensure the transactional system is working efficiently and the tools necessary to perform quality audits. The presenter will highlight:

- Upfront involvement with contractual language before agreement is signed
- Testing processes of claims configuration for contractual agreements and benefits
- Identification of provider billing concerns and working with providers and interdepartmentally to resolve specific concerns and eliminate the systemic issues
- Post-payment audits
- Medical chart audits against claims submissions
- Retrospective adjustment policies and procedures

Jane Russo
Manager, Quality Assurance Claims
NEIGHBORHOOD HEALTH PLAN

10:00 *Networking Break and Refreshments*

10:30 **Successful Strategies for Reengineering Claims Processes for Optimal Efficiency and Improved Provider Relations**

CASE STUDY

Payors are experiencing a plethora of concerns in this area. Is your auto-adjudication rate less than 70%... 50%... or even 20%? How many duplicates do you have in your provider database? Are you paying the right facility the correct contracted rate? What is your 'touch' rate for your physician, ancillary and facility claims? and what are the associated costs?

Studies show that health plans are struggling with inefficiencies and inaccuracies that directly impact member satisfaction and provider relations. This presentation will examine the challenges associated with the claims payment process and identify proven solutions for reducing medical and administrative expenses through:

- Improving management of provider data
- Automating complex claim pricing
- Effectively reducing claims rework
- Accurately pricing claims consistently and accurately
- Predictive contract modeling

Meridith Herdes
Chief Operating Officer
Nancy Wohlhart
Assistant Vice President, Reimbursement Services
HEALTH NETWORK SYSTEMS

11:30 **Up-Coding/Unbundling Edits – Threats and Opportunities**

CASE STUDY



This session will focus on the continuing controversy between payers and providers over up-coding and unbundling edits, their validity, and legislative actions to reduce their impact on physician reimbursement.

The presenter will provide current information on:

- The most common coding disagreements between providers and payers
- Protecting your up-coding/unbundling savings as an asset
- Facing the provider relations challenge
- Legislative developments
- Meeting edit disclosure requirements

Don Kiefiuk
Associate Vice President of Claim Operations
HEALTH ALLIANCE PLAN

12:30 *Luncheon for Speakers and Delegates*

1:45 **Improving Productivity Within the Claims Department - PANEL DISCUSSION**

This interactive roundtable discussion will focus on how to improve productivity, cut costs, and optimize the overall processing of claims. This session will highlight the challenges that need to be faced and how to deal with these challenges in the most efficient way.

Robert L. Beaver
Healthcare Practice Leader
SOFTHEON

Judi Kimmell
Director of Eligibility and Claims Operations
EMPLOYEE BENEFIT MANAGEMENT SERVICES, INC (EBMS)

Kathleen Connolly
President
INTELLICLAIM

2:45 **Crafting an Outsourcing RFP that Your Lawyer**



Will Love
This session will focus on how WellPoint Health Networks Inc. has crafted an RFP process that provides a predictable, enforceable outsourcing agreement. Mr. Zeiss will discuss key areas of the process, including goals and timing, key document contents, negotiation strategies, and dealing with consultants and counsel. Risk mitigation strategies will be modeled and discussed in detail.

The session will highlight:

- Goal-setting and level-setting
- Negotiation strategies
- Building an effective team with your consultants and counsel
- Service level agreements
- Risk mitigation strategies

Gary Zeiss
Senior Counsel
WELLPOINT HEALTH NETWORKS INC.

3:45 *End of Day 2*

A NOTE FROM WRG ABOUT THE WORKSHOPS

In addition to learning first-hand information from the experts we have provided for you during the conference, past attendees often tell us that they come with the hopes of taking home valuable solutions that can be implemented immediately. In order to do this, WRG has organized essential workshop experiences. They are guaranteed to give you a much deeper grasp of the key issues of Healthcare Claims Management.

These vital sessions are designed to give the A-Z roadmap approach for tackling the challenges you face and making the most of opportunities as they present themselves. Workshop sessions are designed to allow for a high degree of interactivity and assurance that they will cater to your specific needs.

SPECIAL, IN-DEPTH EVENING WORKSHOP

Workshop A • TUESDAY, APRIL 19, 2005 • 4:15 p.m. – 7:15 p.m.

Enhance Your Claims Performance Through Rules-Based Adjudication

Every payor struggles to improve their service delivery by increasing the speed, accuracy and consistency of claim payments. Often, barriers to achieving greater efficiency in paying claims arise due to the complexity and proprietary nature of product benefits, provider contracts and payment policies. These issues stretch the capability of current systems and often increase the need for manual intervention to interpret claims payment rules.

Rules-based support for adjudication enhances the ability to automate claim processing logic. This involves complex reasoning related to the many claim, member and provider attributes applicable, and can efficiently use large amounts of historical claims data to make real-time claim processing more intelligent.

Rules-based adjudication also allows health plans to adjudicate claims and resolve issues more quickly, easily and efficiently, resulting in higher levels of medical and administrative savings coupled with greater customer satisfaction due to the speed, accuracy and consistency of claim payments.

This in-depth workshop and discussion will help attendees answer critical questions when analyzing opportunities for claims performance improvement in their current environment:

- What are the causes for claims to fail auto-adjudication and require manual intervention?
- What are the specific reasons why claims are not paid correctly?
- What plan design or contracting options have been delayed because of claim processing system constraints?

Attendees will learn:

- How to meet the demands of employer groups, members and providers, while lowering administrative and medical costs
- The techniques and benefits of scenario testing capabilities and quality assurance routines
- The technology components required for rules-based adjudication support
- How rules-based adjudication can maximize resources by increasing auto-adjudication rates
- How to improve consistency and quality of claim output and claims performance

ABOUT YOUR WORKSHOP LEADER:



Sandy Slowik - Senior Vice President of Client Services at

INTELLICLAIM, a provider of technology solutions for health plans, has over 20 years of healthcare and managed care experience. In her position, Ms. Slowik works with IntelliClaim clients to help them maximize the IntelliClaim technology in order to gain the full benefits of optimal claims performance. She also consults with the clients on utilizing IntelliClaim solutions for their broad claims efficiency needs. Her career started in the clinical arena as a registered nurse. Ms. Slowik joined Aetna Health Plans in 1986 where she later headed the Medical Management Unit for their Small Business Market. She has also served as Vice President of Operations for a Medicaid managed care organization where her responsibilities extended from member enrollment to claim adjudication. Her experiences have all focused on quality processes and operational improvements.

Rated a
4.8 out of 5 at
our last Claims
Summit!

SPECIAL, IN-DEPTH POST-CONFERENCE WORKSHOP

Workshop B • WEDNESDAY, APRIL 20, 2005 • 8:00 a.m. – 11:00 a.m.

How to Dramatically Improve Claims Quality Through Statistically Valid Audits

In order to establish the accuracy rates of claims processing, the most precise method of measuring accuracy would be to review every claim, determine its correctness with respect to measurable criterion of accuracy, and develop a score for the processing of all claims. However, reviewing every claim for accuracy is an unfeasible proposition. It would be an administrative burden, and it would cost too much. Fortunately, the science of statistics provides an alternative means for determining the accuracy of a Universe set of claims with relative precision by selecting and auditing only a sample set of claims from that Universe.

This lively interactive session will include a primer on statistically valid samples, exercises in the application of statistics, and an opportunity to examine your auditing practices with your colleagues and the presenter for opportunities for improvement.

You will learn:

- The difference between a statistically valid claims audit and a focused claims audit – and the difference in actionable results from each
- Claims to include in audits – and why
- Appropriate sample size
- Statistically valid sampling techniques for claims audits
- The three measures of claims accuracy, including industry norms
- The use of statistical equation to determine sample relevancy to Universe of claims
- Methods for extrapolation of overall financial impact of claims paid in error based on sample findings
- Actionable items that come from claims audits
- How to incorporate the statistically valid audit into your claims operations

ABOUT YOUR WORKSHOP LEADER:



For 18 years, **Mr. Robert S. Eichler**, Principal, **The ChangeArtist**, has boosted the bottom line for managed health care businesses by improving information flow, designing effective resource allocation, functionally analyzing system applications and evaluating and designing system strategies. His talents in system analysis, conversion and operations re-engineering are combined with an ability to communicate technical concepts in layman's language. Mr. Eichler is an expert in managed care claims systems, claims workflow operations and adjudication, business requirements, system functional specifications, statistically valid auditing techniques, and available managed care systems. He enjoys solving business puzzles and synthesizing the findings to develop new opportunities for business effectiveness.

TO REGISTER, PLEASE CALL 1-800-647-7600 OR 1-781-939-2438 • Fax 781-939-2490 or

WORKSHOP C • WEDNESDAY, APRIL 20, 2005 • 12 noon – 3:00 p.m.

How to Capitalize on Waste, Abuse, and Fraud Programs in Healthcare

Waste, Abuse, and Fraud programs (WAF) reflect the principles, values, and priorities of a healthcare organization. A WAF program should ensure the fair and correct payment of claims as well as the identification, investigation, and possible recrimination and prosecution of parties involved in occurrences of fraud.

This session will focus on increasing healthcare fraud awareness, maintaining a process of fraud identity, developing educational programs, deterring fraud, and reporting. You will examine:

- Definition of waste, abuse and fraud
- Detecting potential waste, abuse, and fraud
- Protected health information
- Data matching, trending, and statistical analysis

- Claims data analysis
- Public databases
- Investigation guidelines and procedures
- Medical records review
- Provider and insured/member educational programs
- Documentation and closing a case
- Funds recovery

ABOUT YOUR WORKSHOP LEADER:



Lori Lewis, Executive Vice President, Chief Operations Officer, at **Allied Management Group**, has over 30 years experience in the health insurance and managed care industry. She has developed and managed over 20 provider networks throughout the United States including

medical, prescription drug, optical, and dental. Ms. Lewis organized and developed six managed care organizations, two health maintenance organizations (medical), and four third party administrators (TPAs).

Ms. Lewis has designed and developed a payor and network management system including claim processing software for HMOs, TPAs, insurance carriers, and self-funded groups servicing multiple plan types while incorporating EPO, PPO, and POS products. She has developed prescription PBM and compounding pharmacy system. Ms. Lewis has also designed and developed the AMGSIU fraud detection system including correct claim coding, investigation tracking, compliance reporting, analysis and statistical reporting, monitoring, and recoveries.

Sponsors



Health Network Systems is a network transaction management company that helps payors, HMOs and TPAs improve the quality and cost effectiveness of the claims reimbursement function. Leading payors rely on HNS as a business partner with the expertise and technology to achieve dramatic improvements in network transaction performance. HNS addresses the need for accurate, consistent and timely claims payment through a powerful repricing application and provider database that complement existing systems. These automated solutions are proven to significantly reduce administrative and medical costs, and improve provider and customer relations. Please call 630.845.1800 or visit www.hnsconnect.com for more information.



Computer Sciences Corporation, one of the world's leading consulting and IT services firms, helps clients in industry and government achieve strategic and operational results through the use of technology. The company's success is based on its culture of working collaboratively with clients to develop innovative technology strategies and solutions that address specific business challenges. CSC's Health Plan Solutions application software, and ASP and BPO services support more than 300 healthcare clients representing 30 million covered lives and 150 million claims annually.



Antares Management Solutions provides business process and information technology outsourcing for the insurance and healthcare industries. Business process services include: claims processing, call center, premium billing/collections, commissions processing, enrollment, eligibility & membership, financial administration & banking, benefit/policy administration. Antares' IT services include: data center, hardware/software support, help desk, network management & communication, disaster recovery



IntelliClaim is a technology solutions company that helps healthcare payor companies cut costs and increase the performance of claims processing using a powerful combination of technology, services and industry knowledge. IntelliClaim offers payors sophisticated and effective solutions that produce immediate medical and administrative savings. IntelliClaim reviews over \$24 billion in healthcare claim decisions annually for healthcare payor organizations, covering 20 million lives, including some of the country's largest health plans.



Softheon is a leading provider of Business Process Software Solutions that drive bottom line benefits in healthcare firms, empowering them to improve competitiveness and comply with regulations. Softheon's award-winning Softheon6 Process Optimization Framework combines imaging and document management, workflow, business process management and analysis, data integration and aggregation, and reporting software. Softheon has been awarded with KM World's "Trend Setting Product" award and named one KM World's "100 Companies that Matter" along with Deloitte and Touche's "Technology Fast 50" award for the past four years. Softheon is the only Business Process Software developer recognized as an "AHIP Premier Solutions Partner."



ikaSystems central focus is providing Managed Care Organizations and TPA's with enterprise-wide off-the-shelf technology, a single, comprehensive system that addresses all the key transactions in the managed care cycle. ikaEnterprise, our flagship product, is comprised of five self service web portals (ikaPortals) that are tightly integrated with the ikaClaims core administrative system. ikaEnterprise enables automation of key business process across the organization that health plans have been struggling for years to implement. Key advantages include swift time-to-market, adaptability, modularity, and the ability to replace or communicate with existing systems, resulting in increased efficiency and reduced cost.

Media Partners



Keep on top of the latest strategic moves of managed care organizations, proposed and pending legislation, and what other organizations are doing to successfully trim healthcare costs with *The Executive Report on Managed Care*. With things changing so rapidly in the managed care industry you need this twice-a-month briefing to find out what's happening in Washington, D.C., and within the insurance industry. You'll get concise and timely details on the most pressing issues affecting managed care so that you can plan efficient strategies to bring your healthcare costs under control. Sign up for a free no-risk trial subscription today. Call The Managed Care Information Center (888) 843-6242 or visit www.themcic.com/14norisk.htm.



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HEALTHCARE CLAIMS MANAGEMENT SUMMIT

Successful Strategies to Measurably Reduce Cost, Time, and Lower Administrative Expenses While Improving Productivity Through Claims Processing Optimization

April 18-20, 2005 • Harrah's • Las Vegas, NV



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| Conference and 2 workshops | \$1895 | \$2195 | \$2195 | \$2495 |
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Fee includes continental breakfast, lunch, refreshments, and conference documentation. Please make checks payable to WRG Research, Inc.

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