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TABLE OF CONTENTS

General & Consumer News

- 2010 Claims Regulations for CMS-10 Complete Forms, Materials, Dependents & Reconciliation Forms
- Medicare Improvements to HealthSCOUT & Free Complete Medicare Classes That Pick up Your Medicare Deductibles, Co-Pays, Co-Ins & Much More
- Generally Accepted Data Model Definitions of the Healthcare, or Payerless Health Insurance Industry Business Model
- The Five Cross Reasons Your Plans Are Not as Good as You Believe Them to Be
- Florida Debates Nationally NCSL Accreditation or Affiliation Requirement
- Medicare Improvements to HealthSCOUT & Free Complete Medicare Classes Land Great Deals, Co-Pays & Lower Premiums
- Medicare Improvements to HealthSCOUT & Free Complete Medicare Classes Land Great Deals, Co-Pays & Lower Premiums
- Illinois Seeks Healthcare Exchange Grants Under Health Care Reform Legislation to Expand Enhanced Medicaid Coverage, Lower Premiums & Provide Subsidies to Small Businesses
- Fully Accounting Medical Records to Account Generally Accepted Standards
- NCSL Latest Research Associates Accountants Remodelers New Payless Product

Issues News

- Health Care Consumers Are Anxious Promises to Market Mission

Issues Briefs, Decisions & Decisions

- Pennsylvania Law Aims to Eliminate Uninsured Health Care

Medical News

- Medicaments Use Decreases Rate of Cancer of Gallbladder Like Percent in Health Days

Security Resources

- Medicare Co-Pay Complete Packets & 2010 Annual Premium Tax Bill Bites Independent Seniors
- 2010 Co-Pay Free Tricare Dependent Tools
- Free Tricare Dependent Tools
- Accountants & Cash Cowboys, Who, Why & How

Upcoming Conferences

Jim Stamp - Writings and speeches published for 1 month:

- Remarks Sents to Director of Business Development
- Remarks Sents to Director of Business Development
- Jim Stamp Accountants Sadness of Only Three Medical Claims Legislation
- 2010 Accountants Sadness of Only Three Health Care Bills Legislation
- Jim Stamp Accountants Sadness of Only Three Medical Claims Bill
- The Five Cross Cost Drivers
- AMFG Wins Latest Accountants for Northeast and Receives Newton
- Accountants Sadness of Only Three Medical Claims Legislation
- Accountants Health Care Plans Generally Unfair Medicare Consumers Claims Exchange and Plan Bills
- Accountants Comparison Generally PPO Provider and Lower Costs
- Fraudulently Health Claims Costs Accounts, Medicare Bills
- Fraudulently Health Claims ART Contract and Policy Administration, Share Grows, Bill
- Accountants Comparison Generally Provider and Lower Costs
- Four Years Medicare Fraud Whistleblower
- Accountants Insurance Plan Lower Premiums Generally
- Medicare Improvements Free Complete Medicare Classes Land Great Deals, Co-Pays & Lower Premiums

Editorial Notes, Decisions & Decisions

General & Consumer News

2010 Claims Regulations for CMS-10 Complete Forms, Materials, Dependents & Reconciliation Forms

MyHealthGuide Source: HCAA, 11/10/2009

- Consumer Guide: Adapting, Responding & Reconciliating in the New Medical Environment
- Consumer Guide: Adapting, Responding & Reconciliating in the New Medical Environment

Jim Lee, Lakeville, Pennsylvania 01 hr ago Consumer Guide: Adapting, Responding & Reconciliating in the New Medical Environment Consumer Guide: Adapting, Responding & Reconciliating in the New Medical Environment

- Obtain needed information for subrogation claims and to determine pre-existing conditions.
- Perform other duties as assigned.

Knowledge, Skills and Requirements

- High School Education required.
- Minimum of one to three years of experience working with the public. Previous insurance billing or customer service background recommended.

Physical and Mental Abilities

- Ability to perform sedentary work for extended periods of time.
- Ability to utilize personal computer (manual dexterity is required to operate a keyboard), telephone system, and communicate with a variety of customers.
- Ability to concentrate, meet deadlines, work on several projects during the same period, and adapt to interruptions.
- The environment in which the incumbent will work requires the ability to concentrate, meet deadlines, work on several projects during the same period, and adapt to interruptions

Working Conditions

- Work is performed in a normal office environment
- Overtime as needed may be requested.

C. Benefit Plan Analyst- (Plan Builder)

The full job descriptions may be found on our website, www.consociatehealth.com or you may email hrteam@consociate.com.

The position will be responsible to ensure, accurate, timely implementation of benefit plans into the claims application system development, testing, deployment, and documentation of plan/benefit information. Consociate Health is a Third Party Administrator (TPA) and utilizes the Facets Benefit Plan Wizard's claim adjudication system using knowledge of benefit design, and data elements. Additionally, the BPA will collaborate and work with the Client Relations Consultant Division regarding implementation, and BPA maintenance resulting in assured adherence to desired formulary goals for Consociate Health clients.

Principal Duties and Responsibilities

- Programs benefit plans into application platforms accurately
- Establish and maintain plan controls.
- The job involves an elements of quality improvement such as system modifications to improve accuracy, reduce rework, reduce manual troubleshooting, etc.
- Implementation of adjudication rules.
- Claim testing to ensure accurate claim adjudication.
- Acts as liaison between CSC division and other internal stakeholders, to coordinate receipt of required information for system programming, reporting and claim adjudication process, this includes the following tasks:
  - a) Attends implementation meetings to discuss technical requirements and protocols.
  - b) Maintains working knowledge of CH Systems and procedures.
  - c) Communicates updates and changes in a timely manner to appropriate stakeholders.
  - d) Ability to understand reporting requirements and program plan accordingly.
  - e) Analyzes reports to research and resolve discrepancies, errors, and problems.
  - f) Provides issue resolution related to benefit plan and/or claims adjudication
  - g) Serves as liaison between client technical team and claims adjudication vendor for both routine work and special projects.

Knowledge, Skills and Ability Requirements

- Program/project management experience preferred.
- A.A. degree or higher desired.
- Proficient with medical coding including ICD-10, HCPCS, CPT, CDT, Revenue codes.
- Knowledge of EDI Business Practices for institutional and professional bills.
- Knowledge of Medical Terminology.
- Claims processing experience and/or claims auditing.
- Plan document Plan benefit understanding (Health, Dental, STD, Vision, etc.
- Strong analytical skills.
- Knowledge of ACA and HIPAA the application of regulatory compliance regarding benefits.
- Excellent verbal and written communication skills.
- Proficient with multiple computer applications.
- Experience working with internal and external client personnel.
- Advanced use of Microsoft Office Products (ex. Excel skills: Vlookups, formulas, ability to create pivot tables).
- Experience in Benefit Plan Administration.

Physical and Mental Abilities

- Ability to perform sedentary work for extended periods of time.
- Ability to utilize personal computer (manual dexterity is required to operate a keyboard), telephone system, and communicate with a variety of customers.
- Ability to concentrate, meet deadlines, work on several projects during the same period, and adapt to interruptions.
- The environment in which the incumbent will work requires the ability to concentrate, meet deadlines, work on several projects during the same period, and adapt to interruptions

Working Conditions

- Work is performed in a normal office environment.
- Overtime as needed may be requested.
- Travel as needed may be requested.

About Consociate Health

Started in 1995, Consociate Health is a family-oriented employee benefits administrator that partners with employers of all sizes as a trusted advisor to deliver innovative employee benefit programs, healthcare plan administration, consulting and wellness initiatives. We strive to continuously innovate and stay at the forefront of the industry, with $350 million in claims processed each year. Visit www.consociatehealth.com.

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Health Payer Consortium Seeks RN,PR Auditor and Coder

MyHealthGuide Source: Health Payer Consortium (HPC), 11/30/20

Health Payer Consortium is seeking candidates for a RN,LPN Auditor and Coder. HPC is looking for industry veterans to help manage and fulfill our expansion within the cost containment / healthcare analytics space. We are looking for independent, self-motivated, high-energy, high-quality people and as cross functional team members within their respective functional areas pertaining to cost containment.

Ideal candidates will be a RN or LPN with coding or other industry recognized certifications. The RN/LPN reports to the Executive Vice President of Claims and Specialty Networks to assist in keeping the multifunctional day to day coding and claim review processes consistent and within guidelines. The Auditor/Coder will be responsible for reviewing medical records and other supporting clinical documentation to accurately reflect the results of the medical record review.

The ideal candidate will have a deep working knowledge or expertise in the following areas:

- In and out of Network claim cost management strategy for the self-funded, regional health plan market, PPO and HMO products
- Overall claim review and claim processing operations for in and out of network claims
- Medical audit and recovery process including large bill review
- Claims editing rules and software that deal with unbundling, DRG's, and appeal processes
- Benchmarking tools such as Medicare and the various flavors of RBRVS and UCR
- Understanding of medical terminology so you can correlate information from experts such a nurses, doctors, physicians, case managers, health care attorneys, certified bill nurses and other experts

Qualifications

- Bachelor's Degree in Nursing (Associate's Degree in Nursing Diploma from accredited nursing school) and RN license in good standing. Bachelor's Degree may be substituted in lieu of a bachelor's degree and current RN license in good standing.
- Hold a AAPC or AHIMA coding certification or have the ability to obtain such certification within 9 months of employment. Hold a CPC, CPC-H, CPC-P, CPMA or CCS certification with 5+ years associated business experience within the health care industry.
- Knowledge of CMS HCC Model and Guidelines along with ICD-10 Guidelines with strong knowledge of the Medicare market, products and competition.
- Experience in managed care working with network and provider relations
- Demonstrated ability to interact with medical staff, peers and internal company staff at all levels
- Ability to solve process problems crossing multiple functional areas and business units
- Strong problem solving skills, the ability to analyze problems, draw relevant conclusions and devise and implement an appropriate plan of action
- Good business acumen, especially as it relates to Medicare and Medical clinical background
- MS Office Suite, moderate to advanced EXCEL and PowerPoint skills
- Extensive Medical chart review experience

Responsibilities

- Maintains knowledge of current regulatory and healthcare changes pertaining to Medicare/Medicaid and other Federal, State, and Local Government Healthcare programs
- Works closely with specialists and coding, providing coding corrections and guidelines when clinical and coding determinations are in conflict. Works directly with the various advisors to discuss cases that require additional evaluation and final decisions.
- Participates in both formal and informal education sessions with CDI, HIM and other clinical staff members.
- Educates on the importance of documentation, necessary verbiage and to provide a better understanding of coding, ensuring optimal auditing results, adherence to coding guidelines and complete documentation
- Works with other departments as required to address coding needs, claim issues, coding guidelines and documentation
- Performs special projects and/or other duties as assigned
- Critical thinking and problem-solving skills with strong organizational and analytical skills
- Ability to multi-task and work in a stressful and fast paced environment that has very tight timelines for work completion
- Knowledge of federal regulatory rules and regulations regarding documentation and coding
- Dependable with a demonstrated ability to effectively and independently manage own time and tasks with minimal supervision

Work Environment

- Standard work week—Monday- Friday 8-5, however additional time/effort outside of the office may occur based on the overall needs of claims volume integration and deadlines
- Laid back business environment with moderate noise levels and flexible hours
- St. Louis based employee preferred but remote workers with frequent travel to our home office in St. Louis to be strongly considered

Please send resume to jobs.schmidt@aapmail.com.

About HPC

Health Payer Consortium (HPC) is a healthcare cost containment company with headquarters in St. Louis, MO. We are particularly adept at identifying savings that other companies may have overlooked or simply passed up. We work with third party administrators, insurance companies, stop loss carriers / MGU's, TeM Vendor groups and brokers. Visit healthpayerconsortium.com.

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ParterePlu Health Seeks Claims Analyst, Maple Grove, MN

MyHealthGuide Source: ParterePlu Health, 11/30/2020

This position will be responsible for accurate and timely adjudication of claims and payment of claims. The position will build and maintain relationships with clients and providers.

How to Apply

Please apply directly to our career site which will further request you to fill out additional information. Please do not send your resume via e-mail as this will not be acknowledged.

About ParterePlu Health

ParterePlu has been a leading accident and health reinsurance platform for over 25 years. Our products offered cover the full spectrum of health risks. We are committed to and focused exclusively on accident and health and are well-positioned to take advantage of new and unique growth opportunities.

ParterePlu is committed to being preeminent and predominant in target markets and has a reputation for innovation, technical excellence and industry knowledge that drive client-focused solutions. Our values include striving to provide the highest quality of expertise, products and services with transparency, honesty and integrity. Visit www.parterepluhealth.com.

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ParterePlu Health Seeks AVP, Contract and Policy Administration, Maple Grove, MN

MyHealthGuide Source: ParterePlu Health, 11/30/2020

This position will manage our contract and policy administration team, draft and review all Employer Stop Loss Contracts, Medical Stop Loss Contracts, Medical Excess and Quota share contracts, and build relationships with our clients and producers.

How to Apply

Please apply directly to our career site which will further request you to fill out additional information. Please do not send your resume via e-mail as this will not be acknowledged.

About ParterePlu Health

ParterePlu has been a leading accident and health reinsurance platform for over 25 years. Our products offered cover the full spectrum of health risks. We are committed to and focused exclusively on accident and health and are well-positioned to take advantage of new and unique growth opportunities.

ParterePlu is committed to being preeminent and predominant in target markets and has a reputation for innovation, technical excellence and industry knowledge that drive client-focused solutions. Our values include striving to provide the highest quality of expertise, products and services with transparency, honesty and integrity. Visit www.parterepluhealth.com.

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H.K.C. Group Seeks Health Insurance Adjusters (H.I.A.)

MyHealthGuide Source: H.K.C. Group, 11/8/2020

H.K.C. Group's Health Insurance Adjusters (H.I.A.) are licensed in Florida, New York and North Carolina. H.K.C. Group is a Utilization Review Agency and a Licensed/Certified/External Independent Review Organization and a Licensed Medical Claims Review Agency.

Our service offerings include, but are not limited to, Claim Editing, Claim Negotiations, Claim Repricing, Claim Review, Claim Settlement, Claim Audits, Claim Recovery, Medical Bill Review, Medical Bill Review Claim Scrubbing, Disease Management, DRG Validation, Medicare Claim Repricing, Pharmacy Cost Savings, Transport Retrieval, and many more services, analysis and reporting as a URAC Accredited Independent Review Organization.

Interested parties please respond to careers@hkcgroup.com

Visit us on LinkedIn at: https://www.linkedin.com/company/hkc-group/

About H.K.C. Group

H.K.C. Group provides outstanding cost containment services, Third Party Administration, Self-Insured Employee Health Plans, Health Maintenance Organizations (HMOs), ERISA and Government Health Plans, Stop Loss Carriers, Reinsurance Companies, Medical Stop Loss Carriers and Medical Excess and Quota Share Contracts. We are committed to providing our clients with the highest quality of expertise, products and services with transparency, honesty and integrity. Visit hkcgroup.com.

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Voya Seeks Stop-loss Product Manager

MyHealthGuide Source: Voya, 11/2/2020

Profile Summary

Voya Financial in Windsor, CT or Downtown Minneapolis, MN is looking to hire someone into the Senior Product Manager role for our Stop Loss insurance business. In this role the incumbent will be asked to work closely with the Voya sales team to assist with securing distribution channels, product development, and ongoing marketing strategies. The individual hired for this role will be working across all value streams.

Application and link to job posting online

Profile Description

- Contribute to sales through the timely development of products which are responsive to customer and distribution partner needs and meet strategic objectives.
- Recommend timely changes to product features, benefits, rates, compensation and sales support materials through market research and ongoing analysis of sales results in light of changing market conditions.
- Develop effective technologies for assigned product lines. Initiate ideas for new products and services, and lead the technology for-use and use of product including profitability and competitive analysis, recommend products and improvement on the basis of analysis.
- Execute marketing strategies including promotional campaigns, sales support and presentation and non-employee populations, and preparing sales kits and promotional materials.
- Monitor and report on competitors to evaluate company position in the marketplace. Lead competitive analysis and product benchmarking efforts. Monitor and report on competitor products against the competition, exercising customer and distribution segments served by the product line. Recommend product enhancements and modifications to maintain competitive position for and customer use. Ensure sales management decisions regarding product changes are made with full knowledge of the competitive environment, and identify potential threats and new ideas.
- Communicate with sales support and distribution channels on issues involving product development, sales, and marketing. Ensure appropriate for use with the product, and related sales situations that the product was designed for.
- Participate in projects impacting assigned product lines such as sales illustration formats, annual report formats, underwriting programs and procedures.
- May develop financial models, including top-line financial projections. Exhibit discretion in preparing financial and administering market program budget. Coordinate pricing and licensing decisions
- Other duties as assigned

Knowledge & Skills

- Prior experience with Stop Loss insurance or healthcare market place experience is a requirement.
- Bachelors degree or equivalent experience
- 8 + years experience in the insurance industry
- Excellent oral and written communication skills, project management skills, and negotiation skills
- Thorough knowledge of assigned products
- Excellent problem solving and decision making skills
- Ability to effectively present information in group settings
- Strong social skills
- Proven project management and analytical skills
- Organizational, prioritizing and time management skills
- PC skills including a working knowledge of word processing, project management, graphics, and spreadsheet software

Critical Skills

At Voya, we have identified the following critical skills which are key to success in our culture:

- *Customer Focused: Passionate drive to delight our customers and offer unique solutions that deliver on their expectations*
- *Critical Thinking: Thoughtful process of analyzing data and problem solving data to reach a well-reasoned solution*
- *Team Mentality: Partnering effectively to drive our culture and execute on our common goals*
- *Business Acumen: Appreciation and understanding of the financial services industry in order to make sound business decisions*
- *Learning Agility: Openness to new ways of thinking and acquiring new skills to retain a competitive advantage*

About Voya

Voya Financial, Inc. (NYSE: VOYA), helps Americans plan, invest and protect their savings – to get ready for a secure retirement. We are a Fortune 500 company that has been serving our customers and national customers in the United States. Voya is a Fortune 500 company that had $13 billion in revenue in 2018. The company had $695 billion in total assets under management and administration as of June 30, 2019. Voya's business is focused on helping our customers, participants, and clients. We have been an institution at a time – Voya's vision is to be America's Retirement Company. Certified as a "Great Place to Work" by the Great Place to Work® Institute, Voya is equally committed to conducting business in a way that is good for our employees, our communities and our environment. Voya was also recognized as a 2020 World's Most Admired Company by Fortune magazine, one of the 2020 World's Most Ethical Companies® by the Ethisphere Institute, as a member of the Bloomberg Gender Equality Index (GEI) for 2019, and is "Work for Disability Inclusion" on the Disability Equality Index by Disability IN. Visit voya.com.

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Apostrophe Announces Stop Loss Manager Opening

MyHealthGuide Source: Apostrophe, 11/20/20

Apostrophe is building the health plan that can fix America.

The largest, most innovative self-insured employers have figured out how to cut their healthcare costs by 20%-40% while delivering better benefits to their employees. Apostrophe's Intelligent Health Benefits platform "self-fund" products plug-and-play for the other 80% of US employers who self-insure their health benefits.

We are backed by top tier investors including Blue Cross Blue Shield and Norwest Venture Partners. Our revenue is growing at 250% year-over-year and we are on track for profitability in the next 24 months. This is a rare opportunity to join a fast growing Series A company but have the impact of an early founder.

Who You Are

You are detail-oriented, results-oriented and enjoy delivering high quality, on-time solutions for your customers. You are a self-starter who can work effectively in a fast-paced environment. You are a team-oriented, fun-loving person who will be successful in this role are motivated to understand complex Stop Loss arrangements and possess the requisite industry knowledge to resolve all Stop Loss challenges.

What You'll Do

- Review Stop Loss contracts and provide detailed business requirements to configuration team
- Examine plan documents to ensure that claims are processed in accordance with employer and Stop Loss expectations
- Ensure proper cost containment techniques have been employed in support of loss ratio targets
- Coordinate all Stop Loss services along with large dollar claims to achieve ongoing employer satisfaction
- Build and maintain all necessary Stop Loss reporting including notification reports, funding requests, and monthly aggregate reporting
- Develop implementation plans and manage the implementation of new or changed Stop Loss processes
- Follow relevant Stop Loss and self-funded insurance regulatory developments and determine how these developments impact or workflows need to be modified
- Ensure operational processes are analyzed for continuous process improvement
- Define performance metrics as necessary to measure the impacts (positive or negative) of current and new business processes
- Establish and maintain positive working relationships with internal and external stakeholders

Preferred Experience

- Minimum of 5 years of experience supporting self-funded employer administration along with experience managing Stop Loss teams
- Broad knowledge of self-funded health insurance payer practices
- Knowledge of regulations that apply to self-funded clients
- Knowledge of all industry Stop Loss processes and procedures
- Experience communicating and influencing effectively at all levels and with vendors
- Solid mathematical aptitude with ability to quantify impact and ROI of initiatives
- Strong technical skills, business intelligence, and a full understanding of the needs of customers

Interested candidates should send resume to **Bianca Palmer**, HR Business Partner, at bianca.palmer@apostrophehealth.com.

Who We Are

Apostrophe's Intelligent Health Benefits replace the health plan administration and legacy provider network to deliver better benefits for less money to self-insured employers. We are driven by simplicity, transparency and love to provide healthcare purchasing stewardship and market-leading member care that puts employees back in control of cost and experience.

We are a certified B Corporation and Techstars Boulder 2017 company building a fast-growing, mission-driven company in a fast-growing market.

We are committed to Denver/Boulder talent with plenty of parking, transit options and snacks. We offer a competitive benefit package including 401k, medical, dental, vision, life insurance, short and long term disability, return and family benefits for employees and their families. If you don't currently live in Colorado but are willing to relocate, we can help!

Apostrophe does not discriminate based on race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations. We are committed to providing an inclusive and welcoming environment for all members of our staff, volunteers, subcontractors, vendors, and clients. Visit www.apostrophe.health.

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Virtue Health Opens Two Positions: Vice President Of Business Development and Benefits Marketing Coordinator

MyHealthGuide Source: Virtue Health, 11/20/2020

Benefits Marketing Coordinator
Location Madison, New Jersey, United States
Application and Posting Link

Vice President Of Business Development
Location Madison, New Jersey, United States
Application and Posting Link

About Virtue Health

We work with employers and their health advisors to deliver proven and tested self-funded solutions with ease. Visit virtuehealthcare.com.

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Editorial Notes, Disclaimers & Disclosures

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- Articles are selected based on relevance and diversity.
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  - Provide another email address.
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