HEALTHcents

Eastern Michigan Chapter

Leading @ the speed of light

December 2001

Volume 1,Issue 2

President's Message

A tragic and hectic fall has quickly turned to winter. I hope each of you were able to spend time with your family and friends over the holidays to enjoy and appreciate the truly important things in our lives. Hopefully 2002 will include good health and happiness for all.

I would like to take this opportunity to recognize some members for their good work this fall and bring to your attention some upcoming activities.

At our September meeting we celebrated the both the chapters 50th anniversary and national's 55th. Thanks to Connie Cape who shared with us her experiences as National Chair and reminded us of the many opportunities and benefits available through participation in local and national HFMA. Thanks to Debbie Wiley-Crossen of KPMG, for arranging both our KPMG keynote speaker Paul Hubbard, as well as KPMG's financial sponsorship of the evening.

Congratulations to Bob Dery and the other members of the Fall Conference for another outstanding conference. We are fortunate to be able to attend a local conference which provides quality education and insights from local, state and national speakers on a variety of subjects.

The EMC directories were mailed directly to members in November. Once again Linda Height has spent considerable effort putting the directory together. This year a new printing company was used and some slight format changes were made. Please let us know if you have comments or if you did not receive a directory.

Our first certification exam was conducted November 16. Contact Frank Gless for information on the many benefits of being certified, how the certification process works, study assistance and future exam dates.

Upcoming events include the January 18, 2002 Member Meeting as the Benchmarking and Decisions Support committee presents "Big Picture Financial Methods & Strategies: Lessons from Leading Health Care Organizations. Professors Smith & Wheeler from the University of Michigan Health Services and Policy Program will be leading discussions on critical components of the financial management function. Also don't forget the annual bowling night on February 13, 2002 which is always a good time. As always, various committees are busy with monthly meetings. These monthly meetings offer excellent education opportunities in an informal setting that allows for discussion of current issues facing you and your institutions.

To take advantage of these opportunities look for e-mail notices, check the calendar on the EMC website, or contact the committee chair. The EMC chapter website at www.hfma-emc.org includes a calendar of events, contact names and numbers for officers, directors and committee chairs, on-line registration for seminars and other information. Visit the National website at www.hfma.org for a wealth of information available from National.

Perhaps more important than all of the above education and professional opportunities provided by the EMC, is the opportunity for you to be involved. Involvement provides opportunities to develop new contacts, provides for personal growth and satisfaction through chapter leadership positions and can even be fun. To become involved, just contact any of the directors, committee chairs or myself, and we will be happy to put your talents to use.

Mike Tomkovich

MEDICARE COMPLIANCE TIPS FOR PHYSICIANS

Maria B. Abrahamsen

Assistant At Surgery

The Medicare carrier for Michigan has reminded physicians that a physician may bill for his or her services as an assistant at surgery only if he or she *actively* assists the primary surgeon and is involved in the actual performance of the procedure. Because of the degree to which an assistant at surgery must be engaged in the procedure, he or she may not perform or bill for another service performed during the same period he or she serves as an assistant at surgery.

Charity Begins At Home: Don't Bill Medicare For Services You Furnish To Your Family

The medical-legal literature is full of warnings to physicians against waiving fees, especially waiving co-pays and deductibles. In a different twist, the Medicare carrier for Michigan recently warned healthcare providers that they may *not* bill Medicare for goods or services furnished to a member of the provider's household or to immediate relatives. Medicare's theory is that a provider would typically furnish services free of charge to members of his or her family and household, and Medicare is obliged to pay only if the beneficiary is expected to pay for an otherwise covered service. This prohibition on billing does not, however, apply to goods furnished by an *incorporated* non-physician supplier, such as a home medical equipment company. As you might expect, Medicare's definition of "immediate relative" is extensive and includes more family members than could possibly fit around the provider's Thanksgiving dinner table.
Medicare has even addressed the effect of divorce on one's relationship with former in-laws (services to them may not be billed to Medicare even after the divorce).

Care Plan Oversight By Practitioners

Under traditional Medicare principles, a practitioner may bill Medicare only if the practitioner personally treats or examines the beneficiary or is able to visualize some aspect of the patients condition (i.e. interpretation of x-ray or surgical specimen) without the intervention of a third persons judgment. An exception to this general principle is Medicare coverage for a Care Plan Oversight (CPO) occurs when a physician supervises services to a beneficiary who is under the care of a home health agency or hospice and who requires complex or multi-disciplinary care involving regular physician development/revision of care plans, along with follow-up and coordination of care. There are numerous limitations on billing for CPO, such as billing no more than once per month for CPO, billing only if at least 30 minutes of CPO were furnished, and documentation requirements. CPO is billable only by the physician who signed the patients care plans.

The *Medicare Carrier Manual* states that CPO may be billed only by the physician who personally performed the CPO service, and services provided incident to a physicians service do qualify as CPO. However, the Medicare carrier for Michigan has stated recently that CPO performed by a nurse practitioner or physicians assistant within the scope of that practitioner's license is covered if the practitioner is providing ongoing care for the beneficiary in addition to oversight of home health/hospice services; presumably the services must be billed in the name of and using the PIN of the mid-level provider in order to be consistent with the *Manual*.

Ms. Abrahamsen heads the Health Care Practice Group of Dykema Gossett PLLC. She is a former member of the Board of Directors of the Eastern Michigan Chapter of HFMA and past chair of its Health Care Committee. She served as Chair of the Health Care Law Section of the State Bar of Michigan (1998-1999).
Ms. Abrahamsen may be contacted at 39577 Woodward Avenue, Suite 300, Bloomfield Hills, (248) 203-0818 or mabrahamsen@dykema.com.

NEW CMS PROVIDER AND SUPPLIER ENROLLMENT FORMS EFFECTIVE OCTOBER 1, 2001

Phyllis Donaldson-Adams

Effective October 1, 2001, new Medicare provider and supplier enrollment forms and procedures were implemented which will affect Medicare enrollment for both new providers/ suppliers and those undergoing a change of ownership ("CHOW"). The HCFA 855 form has been replaced by the HCFA-855A form (provider enrollment) and HCFA-855B form (professional/ supplier enrollment). The HCFA-855C form has been discontinued. Effective October 1, 2001, the HCFA-855A and HCFA-855B forms will be distributed only by Medicare intermediaries and carriers. HCFA State Agents (such as the Michigan Department of Consumer & Industry Services, Bureau of Health Facilities) will no longer distribute these forms as part of the initial Medicare enrollment or CHOW packets. Completed HCFA-855A and HCFA-855B forms will be returned directly to the intermediary or carrier for processing. These new forms and policy changes will have an immediate impact on providers and suppliers seeking initial enrollment with the Medicare program or approval of a CHOW, including:

- ***Notice***

It is not clear whether the provider/supplier will be required to request a HCFA-855 A or 855B form from the intermediary/carrier or whether the State Agent will furnish this notice. As a precaution, all providers/suppliers seeking initial certification or approval of a CHOW should be sure that the intermediary/carrier receives timely notice of the proposed change in certified status.

- ***Initial Enrollment and CHOW Considerations***

The new process will have a significant impact on the timing of initial Medicare certification, including CHOW situations where the purchaser of a facility is seeking new certification to avoid potential successor liability for overpayments to the prior provider. CMS has clearly stated that the State Agent may not perform a survey of a new facility until the intermediary/carrier completes review and verification of the HCFA-855A or 855B form. Given that, historically, this review and verification process has often taken 4 - 6 months to complete, new certifications will be difficult to accomplish under tight time constraints.

In conclusion, we expect that separate Medicare enrollment forms for providers and suppliers may improve the HCFA-855 review process. However, health care entities and professionals would be well served by consulting with legal counsel knowledgeable about the HCFA-855 review process and Medicare CHOW/ certification issues early in the course of the proposed certification event. Input from experienced legal counsel may reduce the time for review of the HCFA-855 forms by permitting submission of forms which are consistent with Medicare requirements, as well as intermediary/ carrier interpretations and review practices. Full and accurate completion of the HCFA-855 forms remains critical given the detailed certification section of the form and potential civil or criminal penalties for submission of false information.

Ms. Donaldson-Adams is the resident health care member in Dykema Gossett's Ann Arbor office. Her practice includes a focus on certificate of need and provider certification issues. Ms. Donaldson-Adams may be contacted at 315 East Eisenhower Parkway, Suite 100, Ann Arbor, (734) 214-7664, or pdadams@dykema.com.

2002 HFMA Managed Care Committee Meeting Schedule is as follows:

February 26, 2002, April 30, 2002 & June 25, 2002

Monthly meetings are held from 08:30 am until 10:30 at the Riverside Building ,25925 Telegraph Road Suite 210, Southfield, Michigan 48034
The conference room is located in the BCN building on Telegraph Road between 10 Mile and 11 Mile Roads.

The chair is Keith Carter. His number is 313-225-0896. His e-mail is KCarter@bcbsm.com.

Physician Practice Committee Meeting Schedule is as follows:

January 24, 2002, February 28, 2002, March 28, 2002, April 25, 2002, May 23, 2002, June 27, 2001
Monthly meetings are held from 9 - 10:30AM at
St. John Health System Corporate Services Building- South 28000 Dequindre Warren, MI 48092
If you are interested, please contact Jeff Ewald at 810-753-0323 or jeffrey.ewald@stjohn.org.

CMS Proposed Rule Would Codify "Incident To" Billing Requirements And Permit Independent Contractor Relationship

Kenneth R. Marcus, Esq.

Just as the "rule against perpetuities" has puzzled generations of estate planning attorneys, the Medicare "incident to" rule has challenged representatives of Medicare providers. Thus, it is significant that in a proposed rule issued August 2, 2001, the Centers for Medicare and Medicaid Services ("CMS") proposes to codify the underlying definitions and requirements for billing the services of auxiliary personnel "incident to" a physician's services and, for the first time, eliminates the requirement that the auxiliary personnel be employed by (or be under common employment with) the physician. (Medicare Physician Fee Schedule Calendar Year 2000 Proposed Rule issued August 2, 2001. (66 *Fed. Reg*. 40372 at 40382-40382, 40402-40403)).

Current Requirements

Although the "incident to" billing provision currently is codified at 42 C.F.R. § 410.26, the detailed requirements are set forth in Medicare Carrier's Manual § 2050. Thus, the Medicare Regulations at 42 C.F.R. § 410.26 provide in general as follows regarding Medicare payment for services furnished "incident to" a physician's services:

(a) Medicare Part B pays for services and supplies incident to a physician's professional services, including drugs and biologicals that cannot be self-administered, if the services or supplies are of the type that are commonly furnished in a physician's office or clinic, and are commonly furnished either without charge, or included in the physician's bill.

The incident to requirements are amplified in Section 2050 of the *Medicare Carrier's Manual*. For a service to qualify as "incident to" the services of a physician it must be:

(1) An integral, although incidental, part of the physician's professional services;
(2) Commonly rendered without charge or included in the physician's bill;
(3) Of a type that is commonly furnished in physicians' offices or clinics; and
(4) Furnished by the physician or by an individual who qualifies as an employee of the physician. (The individual may be a full or part time employee, or may be a leased employee of the physician, group practice or of the legal entity that employs the physician who provides direct personal supervision.)

Section 2050.2 of the *Medicare Carrier's Manual* provides as follows regarding the supervision requirement when a nonphysician practitioner provides services which are billed incident to a physician's services:

A nonphysician practitioner such as a physician assistant or a nurse practitioner may be licensed under State law to perform a specific medical procedure and may be able (see § 2156 or 2158, respectively) to perform the procedure without physician supervision and have the service separately covered and paid for by Medicare as a physician assistant's or nurse practitioner's service. However, in order to have that same service covered as incident to the services of a physician, *it must be performed under the direct personal supervision of the physician as an integral part of the physician's personal in-office service*. As explained in § 2050.1, this does not mean that each occasion of an incidental service performed by a nonphysician practitioner must always be the occasion of a service actually rendered by the physician. It does mean that there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the nonphysician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects his or her continuing active participation in and management of the course of treatment.

Section 2050.1C of the *Medicare Carrier's Manual* provides as follows regarding the employment requirement:

C. Employment.—To be considered an employee for purposes of this section, the nonphysician performing an incident to service may be a part-time, full-time, or leased employee of the supervising physician, physician group practice, or of the legal entity that employs the physician (hereafter referred to collectively as the physician or other entity) who provides direct personal supervision (as described below). A leased employee is a nonphysician working under a written employee leasing agreement which provides that:

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The nonphysician, although employed by the leasing company, provides services as the leased employee of the physician or other entity; and The physician or other entity exercises control over all actions taken by the leased employee with regard to the rendering of medical services to the same extent as the physician or other entity would exercise such control if the leased employee were directly employed by the physician or other entity.

In order to satisfy the employment requirement, the nonphysician (either leased or directly employed) must be considered an employee of the supervising physician or other entity under the common law test of an employer/ employee relationship specified in §210(j)(2) of the Act, 20 CFR404.1007, and §RS 2101.020 of the Retirement and Survivors Insurance part of the Social Security Program Operations Manual System.

Services provided by auxiliary personnel not in the employ of the physician, physician group practice, or other legal entity, even if provided on the physician's order or included in the physician's bill are not covered as incident to a physician's service since the law requires that the services be of kinds commonly furnished in physicians' offices and commonly either rendered without charge or included in physicians' bills. As with the physicians' personal professional service, the patient's financial liability for the incidental services is to the physician, physician group practice, or other legal entity. Therefore, the incidental service must represent an expense incurred by the physician, physician group practice, or other legal entity responsible for providing the professional service.

The Proposed Rule

CMS proposes to amend 42 C.F.R. 410.26 include the operative definitions and billing requirements, which generally conform to the provisions of the Medicare Carrier's Manual. The most significant aspect of the proposed regulation, however, is that it would eliminate the requirement, as set forth in Section 2050.1C of the *Medicare Carrier's Manual*, that services furnished by auxiliary personnel must be employed by the physician, physician group practice, or other legal entity, to qualify as "incident to" even if all of the other requirements for physician supervision are satisfied. CMS proposes to eliminate the employment requirement, and to permit an independent contractor relationship. Thus, the proposed regulation at 42 C.F.R.§ 410.26(a)(1) would define "auxiliary personnel" as follows:

> (1) Auxiliary personnel means any individual who is acting under the supervision of a physician**,** regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner).

CMS discusses the rationale for this proposed change in the preamble to the proposed regulation:

Currently, our manual requires that the physician be either the employer of the auxiliary personnel or be an employee of the same entity that employs the auxiliary personnel. We note that, under our manual, auxiliary personnel may be either employees, leased employees, or independent contractors. An independent contractor relationship appears to be common current practice because it affords the auxiliary personnel the flexibility to work with various physicians or practitioners on a part-time basis. *We do not believe that the nature of the employment relationship is critical for purposes of payment for services incident to the services of physicians and practitioners, so long as the auxiliary personnel reports to a physician or practitioner under the required level of supervision. We see no clinical reason to exclude independent contractor physicians and practitioners from the class of practitioners who can receive Medicare payment for services incident to their own services based solely on their status as independent contractors. Accordingly, we propose to allow auxiliary personnel to provide services incident to the services of physicians or practitioners who supervise them, regardless of the employment relationship.* Thus, auxiliary personnel may be employees, leased employees, or independent contractors, and may provide services incident to the services of physicians and practitioners who employ or contract with them or who are employees or independent contractors of the same entity, provided that the other requirements for payment for "incident to" services are met. *We note, however, that the employment relationship remains relevant under our rules prohibiting reassignment of Medicare benefits.*
66 *Fed. Reg*. 40372 at 40382 (Emphasis added)

Conclusion

It is always in the best interests of the Medicare program and participating providers for substantive rules to be promulgated in compliance with the notice and comment provisions of the Administrative Procedure Act (5 U.S.C. § 553), rather then merely being published in non-binding policy manuals such as the *Medicare Carrier's Manual,* particularly regarding a provision such as the "incident to" rule, which implicates substantive payment as well as compliance issues.

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CMS has acknowledged that carriers and intermediaries have provided inconsistent advice regarding the interpretation of Medicare payment policy that is not set forth in the formal regulations. Thus, CMS at long last has recognized that the "incident to" rule is of sufficient importance to justify codifying the underlying definitions and the operative requirements.

Further, if the final regulation is promulgated in the form of the proposed rule, providers will enjoy a significantly greater degree of flexibility in light of the inclusion of independent contractors within the definition of auxiliary personnel. For example, the past decade has witnessed numerous affiliation transactions among hospitals and hospital systems, with the result that "incident to" arrangements had to be carefully reviewed, and in certain cases restructured, to assure continued compliance with the employment requirement. Under the proposed expanded definition of auxiliary personnel, providers can focus their attention on patient care and physician supervision considerations rather than on the niceties of employment law.

Mr. Marcus serves as Chair of the Payment and Reimbursement Interest Group of the Health Law Section of the American Bar Association. He is a member of the Advisory Board of *BNA's Medicare Report*. This article is not intended to furnish legal advice. Readers desiring such advice should seek the services of a competent professional. Readers wishing to discuss or comment regarding this article may contact the author at Kenneth R. Marcus, P.C., 6960 Orchard Lake, Suite 315, West Bloomfield, MI 48322; 248-865-9955; Krmarcus@aol.com.

HFMA Bowling Night

Date: Wednesday, February 13, 2002
Time: 7PM - ??? (Eat beginning at 6:30)
Place: Langan's Norwest Lanes (14 Mile and Northwestern Hwy.)
Cost: $25 per person (includes 3 games, shoe rental, pizza, beer & soft drinks, prizes)
Cash Bar Available
To reserve your spot, please e-mail Pete Stewart at stewapet@selectcare.com ASAP then send a check payable to HFMA by February 1, 2002 to:
Pete Stewart, SelectCare Inc., Auditing Services
2401 West Big Beaver, Troy, MI 48084
Phone# (248) 637-5374
Eight lanes are reserved and we can accept 40 bowlers.

HIPAA Auditing 101 Training

February 26, 2002

The HIPAA Auditing 101 course will provide a structured analysis of how to perform a HIPAA audit.

The instructor for the course will be Keith Young. Mr. Young is the Managing Partner of Integrity Solution, LLC. He has a decade of experience in the risk management field. His area of expertise is in working with companies in the media, health care, financial services, government and manufacturing industries to design, develop and deploy enterprise-wide risk management strategies.

e-mail **Pete Stewart, Internal Audit - Chair** if your interested, there are 8 slots currently available for this all-day seminar. Cost: $150.00
E-mail Pete as follows: stewapet@selectcare.com

UPCOMING MEMBER MEETING

The Benchmarking and Decision Support Committee of HFMA and Beaumont Hospitals Presents

Big Picture Financial Methods & Strategies: Lessons from Leading Health Care Organizations

Friday, January 18, 2002

Providence Hospital And Medical Center in the Hospital Auditorium 16001 W. Nine Mile Rd. Southfield, MI 48037 (248) 424-3000

Eastern Michigan Chapter – Current Year Events

MEMBER MEETING

The Chapter year was kicked off on September 20 at the Ukrainian Cultural Center. We were honored to have 8 past presidents join us for the cocktail and hors d' oeuvres reception graciously sponsored by KPMG. Thank you, KPMG, for your support.

Debbie Wiley-Crossen spoke of her experiences as a participant in the 21st USA/UK International Exchange in Oxford, England in July of this year to start off the meeting. Connie Cape gave us a taste of what it was like to be the National HFMA Chair for the 2000-2001 Chapter year in her presentation. Paul Hubbard of KPMG then informed us of what we may have to anticipate "looking through the crystal ball" at the future of healthcare. All in all, it was a fascinating evening.

We would like to again express our heartfelt gratitude to KPMG for sponsoring the meeting.

FALL CONFERENCE

The 48th Annual HFMA Fall Conference, Surviving Healthcare in the New Millennium, was held October 18-19, 2001. Over 300 members, guests, speakers, students and vendors from the Eastern, Western and Great Lakes Chapters attended.

Attendees had the opportunity to hear Michigan Attorney General, Jennifer Granholm's presentation of current initiatives and investigations being spearheaded by her office including activities to protect Michigan citizens from bio-terrorism and other terrorist actions. Phyllis Cowling, National HFMA Chairman - Elect from Amarillo, Texas joined the conference on Thursday and offered greetings from National through her interpretive Texas "drawl". Participants then had the opportunity to choose from 13 breakout sessions.

Following a cheerful hospitality hour sponsored by Blue Cross, the attendees were entertained by Michael Skupin, Survivor II television participant, who brought video clips and "behind the scene" commentary on surviving the outback and the injuries he incurred for which he is fully recovered. He actually said he would do it again!

Friday sessions included, by popular demand, Jeanne Scott, Director of Government Relations, NDC Health, Healthcare Policy and Problems in the 107th Congress. Attendees concluded the Conference by attending additional breakout sessions.

The 49th Conference is already scheduled to be held October 17-18, 2002. If you are interested in participating on the

HFMA-EMC OFFICERS AND BOARD OF DIRECTORS FY 2001-2002

2001-2002 Officers		
Michael A. Tomkovich, CPA - President	(248) 489-6058	tomkovim@trinity-health.org
Diane S. Justewicz, FHFMA - President-Elect	(810) 753-0307	diane.justewicz@stjohn.org
Sue S. Carter - Secretary/Treasurer	(248) 849-2738	scarter1@providence-hospital.org
David G. Zilli, CPA - Immediate Past President	(313) 343-1503	david_zilli@bshsi.com
Board of Directors		
James J. Birchler, CPA (2003)	(734) 769-7139	jbirchler@rc.net
Jeff B. Ewald, CPA (2002)	(810) 753-0323	jeffrey.ewald@stjohn.org
David L. Kulek, FHFMA (2003)	(313) 253-9606	kulekd@oakwood.org
Kenneth B. Lipan, FHFMA (2003)	(313) 874-4527	klipan@hfhs.org
Cynthia L. Long, FHFMA (2003)	(248) 652-5634	cllong@crittenton.com
Sara J. McGlynn, CPA (2003)	(248) 551-9376	smcglynn@beaumont.edu
Darlene M. Mitchell, CPA (2003)	(313) 874-9526	dmitche1@hfhs.org
Lynn M. Torossian, CHFP, CPA (2002)	(313) 791-5234	torossil@oakwood.org
Maryanne Van Haitsma, FHFMA (2002)	(248) 549-2703	dmvanh@home.com
Mary A. Whitbread, CPA (2003)	(313) 874-9533	mwhitbr1@hfhs.org

PRODUCT BASE REPORTING
FOR CLINICAL SERVICES

1. INTRODUCTION

One of the most intriguing problems facing healthcare institutions today is that of rationally planning for the delivery of clinical services. As we move more and more into a network environment, it is extremely crucial to be able to rationally plan for clinical services in terms of market coverage, capital investment, and operational expense.

The solution to this problem lies in the integration of information systems across the network of providers to provide data to identify where services are being provided, what services are being provided, and why those services are being provided at that particular site. The great planning and management issue to be answered is simply, "What services should be provided, and where."

In order to maximize the value of services provided, it is essential to identify services to a particular product. For the purposes of this discussion, a "Product" is defined to be a discrete service (a procedure or set of procedures, or a course or regimen of care) that the providing entity has the ability to offer or not offer as part of its compendium of services. For example, gall bladder surgery would not be a product different from appendectomies, since both involve the same set of skills and resources, and it would not make sense to offer one but not do the other. Both would fall under the "product" of general surgery. However, heart transplants are a service that an institution can choose to offer or not offer, and therefore heart transplants can be viewed as a separate and distinct product.

2. IMPORTANCE OF "PRODUCTS"

It is important that the delivering institution have a clear view of its products, as defined by the institution. The goal in product definition is to identify all clinical services to the particular product that caused those services to be delivered. If the institution can reasonably identify services to the institutional definition of product, a number of benefits can accrue:

- The source of demand for all ancillary services can be identified to the particular product, and the product mix.
- A matrix can be constructed that shows the demand for all services by product, by delivery site.
- Through linkage to the patient zip code or other location identifier, a matrix can be built that shows the demand for services by product by market area.
- Clinical service costs can be built by product by site, and aggregated across the entire network of providers.
- The delivery system can build a P&L by product by site, and aggregate by product, to determine the appropriateness of existing and proposed product mixes and delivery sites.
- Market demand for "products" can be assessed, and used to rationalize the investment of new capital and operating resources among sites and among products.

In short, through the identification of all patient care services to a particular discrete product, the institution can, in essence, zero-base budget by product. New and proposed products can be assessed along with existing products, to determine the best use of delivery system resources to maximize the value of services provided. Demand for ancillary services can be projected based on the institution plan for the delivery of the products identified. Delivery site location, capital investments, and operating resources can all be pinpointed based on institutional objectives relative to product, product mix, and market demand for services.

3. INFORMATION REQUIREMENTS FOR PRODUCT-BASED BUDGETING

In order to implement product-based budgeting and planning, the institution must first come up with a list of discrete products that the institution believes it has the managerial discretion to offer, or not offer, as a healthcare delivery organization. It is then essential to identify patient encounters (both inpatient and outpatient) to a particular product. Ideally, this would be done based on the primary reason for the particular encounter. For example, a patient may be referred into the system for an evaluation for a heart transplant. This particular referral or encounter occurred because the institution had a heart transplant program as a product, and the patient encounter should be identified to that program, regardless of whether or not the patient ever actually has a heart transplant.

It should be noted here than any mapping of historical medical records data would not always identify the correct program, a patient admitted for heart transplant evaluation would be identified as a cardiovascular patient, but would not necessarily show up as a heart transplant patient.

4. USE AND AGGREGATION OF DATA

Once the primary cause of the patient encounter is identified to a particular program, is it relatively easy to identify the resources used, and aggregate those resources by program, and by delivery site. Given these data, one can:

- Identify the demand for products, and identify the proper placement of delivery sites.
- Rationalize the placement of ancillary services, based on programmatic decisions as to the placement and sizing of product delivery sites.
- Rationally determine the placement of high-tech and referral sites to optimally support the delivery of healthcare services.
- Determine the impact system-wide by product of decisions as to the investment of resources by product and by site.
- Look at trade-offs by product to determine the most efficacious mix of services to maximize value to the customer.

Prepared by
Stephen W. Loree
Strategic Financial Planning
The Detroit Medical Center
December 14, 2001

HFMA Eastern Michigan Chapter Committees
FY 2001-2002

Committee	Chairperson (s)	Phone#	E-Mail Addresses
Awards/Founders Merit	Bill Lubaway	(248) 347-1416	bill_lubaway@voyager.net
Awards/Founders Merit	Barbara Kootsillas	(248) 489-6706	KootsilB@trinity-health.org
Benchmarking/Decision Support	Sara McGlynn	(248) 551-9376	smcglynn@smtpgw.beaumont.edu
Certification/Financial Mgt. Course	Frank Gless	(313) 396-5847	Fgless@deloitte.com
Compliance/HealthLaw	Dave Franklin	(810) 498-4950	david_franklin@bshsi.com
Chapter Audit	David Nathan, E&Y	(313) 596-7100	david.nathan@ey.com
Education Council	Susan Stokes	(586) 786-9532	susan-stokes@hfma-emc.org
Elections	David Zilli	(313) 343-1503	david_zilli@bshsi.com
Fall Conference	Robert Dery	(248) 223-3223	deryb@plante-moran.com
Historian/Retired members			
Davis Mgt. System/Information Systems	Susan Stokes	(586) 786-9532	susan-stokes@hfma-emc.org
Insurance & Reimbursement	Sue Carter	(248) 849-2738	scarter1@providence-hospital.org
Insurance & Reimbursement	Marge Korczyk	(313) 396-3559	Mkorczyk@dttus.com
Internal Audit	Pete Stewart	(248) 637-5374	stewapet@selectcare.com
MACPA/HFMA	Jeff Ewald	(810) 753-0323	jeffrey.ewald@stjohn.org
Managed Care	Keith Carter	(313) 225-0896	kcarter@bcbsm.com
Member Meetings	Sheila Pierson	(248) 849-5824	spierson@providence-hospital.org
Membership/Member Involvement	Tony Gaglio	(313) 882-7100	gags500@yahoo.com
New Member Orientation	Marina Houghton	(313) 882-7100	mariahoughton@wolinski.com
Membership Service Plan	Linda Height	(313) 640-2408	linda_height@bshsi.com
Membership Survey	Diane Justewicz	(810) 753-0307	diane.justewicz@stjohn.org
Newsletter	Maryanne Van Haitsma	(248) 549-2703	dmvanh@home.com
Nominations	David Zilli	(313) 343-1503	david_zilli@bshsi.com
Patient Accounting	Cathy Brunkey	(586) 466-9812	brunkeyc@trinity-health.org
Physician Practice	Jeff Ewald	(810) 753-0323	jeffrey.ewald@stjohn.org
Placement/Professional Development	Bob Lauer	(248) 858-6156	lauerr@trinity-health.org
ProAction	Mary Ann Bayer	(248) 661-2460	
Social Activities	Tammy Chinavare	(248) 305-7857	chinavat@trinity-health.org
Social Activities	James J. Kopp	(248) 641-1440	ocs4pymt@aol.com

Newsletter Submission Dates :
February 2002 Newsletter - Friday, January 25, 2002
March/April 2002 Newsletter - Friday, March 22, 2002

Maryanne VanHaitsma, Editor:
Phone: (248) 549-2703
E-Mail: dmvanh@home.com

Calendar of Events – HFMA

JANUARY

1-18-2002	Member Meeting – Presented by Benchmarking/Decision Support Committee (Providence Hospital; 9AM)
1-24-02	Insurance & Reimb. Committee Meeting (Riverside Building, 8:30AM)
1-24-02	Physician Practice Committee Meeting (St. John, 28000 Dequindre; 9AM)
1-25-02	Healthcents material submission deadline

FEBRUARY

2-13-02	HFMA Bowling Night (Langan's Norwest Lanes, 6:30PM)
2-22-02	Benchmarking/Decision Support Meeting (Riverside Building; 9AM)
2-26-02	Managed Care Committee Meeting (Riverside Build ing; 8:30AM)
2-28-02	Insurance & Reimb. Committee Meeting (Riverside Building; 8:30AM)
2-28-02	Physician Practice Committee Meeting (St. John, 28000 Dequindre; 9AM)

MARCH

3-20-02	Member Meeting - Insurance and Reimbursement Annual Update (DoubleTree, Novi; 9AM)
3-22-02	HealthCents material submission deadline
3-22-02	Benchmarking/Decision Support Meeting (Riverside Building; 9AM)
3-28-02	Physician Practice Committee Meeting (St. John, 28000 Dequindre; 9AM)

APRIL

4-19-02	Benchmarking/Decision Support Meeting (Riverside Building; 9AM)
4-25-02	Physician Practice Committee Meeting (St. John, 28000 Dequindre; 9AM)
4-25-02	Insurance & Reimb. Committee Meeting (Riverside Building; 8:30AM)
4-30-02	Managed Care Committee Meeting (Riverside Building; 8:30AM)

MAY

5-23-02	Physician Practice Committee Meeting (St. John, 28000 Dequindre; 9AM)
5-23-02	Insurance & Reimb. Committee Meeting (Riverside Building; 8:30AM)
5-24-02	Benchmarking/Decision Support Meeting (Riverside Building; 9AM)

JUNE

6-13-02	Annual Golf Outing (Shenandoah County Club in West Bloomfield)
6-21-02	Benchmarking/Decision Support Meeting (Riverside Building; 9AM)
6-25-02	Managed Care Committee Meeting (Riverside Building; 8:30AM)
6-27-02	Physician Practice Committee Meeting (St. John, 28000 Dequindre; 9AM)
6-27-02	Insurance & Reimb. Committee Meeting (Riverside Building; 8:30AM)

Dates subject to change if necessary. Compliance and Patient Accounting Committee dates will be forthcoming.

HFMA Insurance and Reimbursement Committee Meeting Schedule is as follows:

January 24, 2002, February 28, 2002, April 25, 2002, May 23, 2002 , and June 27, 2002
The Annual Reimbursement Update will be held in March 20, 2002.

Monthly meetings are held from 08:30 am until 10:30 am
at the Riverside Building, 25925 Telegraph Road ,Suite 210 , Southfield, Michigan 48034
The conference room is located in the BCN building on Telegraph Road between 10 Mile and 11 Mile Roads.