HEALTHcents

Eastern Michigan Chapter

Leading @ the speed of light

May 2002

Volume 1,Issue 5

President's Message

Although you can't tell from the weather, the calendar indicates that we are halfway through spring and approaching the end of the chapter year. For some time now, Diane Justewicz has been very busy planning the upcoming year with her leadership team and assembling committee chairs. An important tool in this process is the results of the annual survey that members completed in February. Your input is valued and incorporated into the plan! If you did not have an opportunity to respond it is never too late to contact Diane or the incoming committee chairs to offer your suggestions, support and to volunteer your time. Diane and the leadership team will be installed at the May 21, 2002 member meeting at Providence. I encourage you all to take time from your busy schedules to show your support at the May 21 meeting and participate in an interesting education session on Hospital Ownership of Physician Practices presented by the Physician Practice Committee.

My thanks goes out to Ken Marcus for his efforts in the recent education session on the PRRB appeals process. In addition to arranging for Kathleen Scully-Hayes, Director of the Provider Reimbursement Review Board to come and address the EMC, Ken did a nice job of facilitating discussion. I'm sure those in attendance will agree that it was a unique opportunity to hear directly from the source how the PRRB works as well as receive some practical advice on how to work your appeals through the system.

I would also like to take this opportunity to thank Maryanne Van Haitsma our editor of Healthcents. This year Maryanne successfully converted Healthcents to e-mail distribution for purposes of improving timeliness of content and significantly reducing chapter administrative costs. Of course this was only a process change and the success of Healthcents continues to depend on the suggestions and contribution of articles from the members. Thank you to all of you who have submitted an article this year. In order to fully utilize the benefit of electronic communications and offer more frequent communications, more material is needed. You can help by forwarding to Maryanne your suggestions and articles on HFMA activities you have been working on, news about your organization, share some general information from some research you performed for you job, etc. Articles don't have to be lengthy or exhaustively cover a subject, and I am certain that Maryanne will be glad to help you with your submissions.

Thanks for your continued support.

Mike

Sara McGlynn

High Scorers Named, to be Honored at ANI!

HFMA's high scorers were named during the first week of May. To be eligible for this award it was necessary to test between May 1, 2001, and May 1, 2002. The following people received the award this year:

Sara J. McGlynn, CHFP, CPA was the high scorer on the Accounting and Finance Exam. Sara is the Business Coordinator at William Beaumont Hospital in Royal Oak, Michigan.

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ISSUES AFFECTING ALL PROVIDERS OF PART B LABORATORY SERVICES

In late 2001 CMS published extensive new policies and revised regulations regarding Medicare coverage of, and payment for, clinical lab tests covered by Medicare Part B. The regulations apply to all providers of Part B clinical lab services - hospital outpatient departments, physician offices, and independent labs. Most provisions of the new regulations were effective November 25, 2002, with the potential for an additional individually-approved grace period if needed to make system changes. The following are among the highlights of the regulation/policies:

NCDs. Published with the regulation are "national coverage decisions" covering more than 60 lab tests. An NCD states circumstances under which CMS deems a diagnostic test to be "reasonable and necessary." The NCDs apply nationwide, are binding on both carriers and fiscal intermediaries, and will supersede contrary local medical review policies (LMRPs). Any relevant LMRP will continue to govern coverage of the lab tests in question until the NCD becomes effective.

Coverage. Each NCD lists those ICD-9-CM diagnostic codes for which (a) there is a **presumption of medical necessity** (although subject to review for reasonableness and necessity in individual cases), (b) the test is **never covered** (generally screening tests), and (c) a test is **not generally covered**, but may in exceptional cases be covered with proper documentation.

Claims Documentation. Except as specifically noted in an NCD, the lab performing a test is not required to submit diagnostic information with its claim. However, **upon request by CMS** the lab must supply all information it received from the ordering practitioner, along with the identity and contact information for the ordering practitioner.

Information From Ordering Practitioner. Practitioners are not **required** to provide any specific diagnostic information with their order for a lab test, unless specifically mandated by an NCD or LMRP. However, a lab may **request** additional relevant information from the ordering practitioner to support the medical necessity of the test ordered. CMS "encourage [s] physician voluntarily to provide diagnostic information . . . with the order." Furthermore, if CMS makes a preliminary decision that a test was not reasonable and necessary, CMS may request from the ordering practitioner those parts of the medical record relevant to the claim under review. If the practitioner does not provide adequate evidence of medical necessity, the lab is denied payment, subject to the lab's right to request additional medical necessity information from the ordering practitioner.

What Constitutes an "Order"? Non-hospital diagnostic lab tests must be ordered by the beneficiary's treating physician (or appropriate non-physician practitioner). However, CMS' comments to the lab regulations state that the practitioner's signature on a lab requisition form is not the only acceptable evidence of an order. Documentation of the test order written in the patient's medical record is an acceptable alternative. CMS will issue clarifying instructions on this point to its contractors.

Date of Service. CMS states its intent to develop a national coverage policy, which will define the "date of service" for lab tests to be the date the specimen was collected. (The date of service must be reported on the Medicare claim form.)

Coding of Screening Tests. CMS declined to establish a rule regarding the proper coding of tests ordered for screening purposes that reveal abnormal findings. CMS will request that the American Hospital Association's Coding Clinic resolve this issue.

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MEMBER MEETING ANNOUNCEMENT-May 21, 2002

The Physician Practice Committee of HFMA-Eastern Michigan Chapter would like to invite you to the next member meeting at Providence Hospital in the Hospital Auditorium on Tuesday, May 21, 2002. Topic - Hospital Ownership of Physician Practices - Improving Financial Performance. The speakers David and Marianne Speicher, draw on their consulting experiences with physician group practices nationally to address specific problems and solutions in claims and receivables management.
A Continental Breakfast will be served. Please feel free to bring a colleague and introduce them to HFMA. It promises to be a wonderful morning of networking and education. Attached is a file of the member meeting announcement with more detailed informtion. Please pass it to other colleagues who might be interested.
You may register TODAY on the chapter web site at http://www.hfma-emc.org
The cost is $30 for HFMA members and $40 for guests if you sign up on or before May 14, 2002.

The Agenda is as follows:

7:30 - 8:30	HFMA Board Meeting
8:00 - 8:30	Registration/Continental Breakfast
8:30 - 9:00	Member Meeting-Awards/Installation of Officers
9:00 - 10:30	Workshop Part I
10:30 - 10:45	Break
10:45 - 12:00	Workshop Part II
12:00 PM	Adjournment

HFMA Insurance and Reimbursement Committee Meeting

Thursday, May 23, 2002
08:30 am to 10:30 am
Riverside Building
25925 Telegraph Road
Suite 210
Southfield, MI 48034

Chris Rossman of Honigman, Miller, Swartz and Cohn LLP will be presenting "The Four W's of Self-Disclosure of Overpayments - When, Where, Why and to Whom to Self-Disclose" The sessions will address Medicare Part and Part B, Medicaid and Blue Cross Blue Shield of Michigan self-disclosure requirements. Practical examples will be presented to highlight the considerations involved. This presentation will equal one (1) CPE hour.
Hope to see you there!

BENCHMARKING DECISION SUPPORT COMMITTEE

The next meeting of the Benchmarking Decision Support Committee will be on Friday, May 24 @9AM at the Riverside Building at 25925 Telegraph between 10 and 11 Mile Roads. The meeting will be held in Providence Patient Accounting Conference Room on the second floor.

Certification News and Other Stuff…

The next Chapter sponsored Core and Specialty Certification Exams are scheduled for Friday, June 28, 2002. National is also presenting a coaching course and exam at ANI on June 16 and 17, 2002. If you are thinking of taking the exam, it is time to be registering so that your proctor may be assigned and all matters in readiness for a smooth exam experience. The test is administered on-line so you will know your scores immediately. The charge for the Core exam is $100; the specialty exams are $70. For more specifics, please contact bclark@hfma.org or pzenger@hfma.org.

Our Chapter wishes to support our membership in seeking certification. The Chapter has scheduled certification exams once each quarter during 2002. The exam dates for the remainder of calendar year 2002 are September 27 and December 20. It may be possible to schedule an individual test date and time with a proctor if needed. In addition, the Chapter has purchased a copy of the Core Exam Study Guide and will soon purchase specialty materials. These study materials will be made available on a first come first served basis to members. Plans are underway for a ½ day Core Exam Coaching Course for interested candidates. The date for the Coaching Course is tentatively set for June 14 or 21, 2002 depending upon interest and availability of potential candidates. If you would like more information regarding certification or to schedule a special test date, Frank Gless, Certification Chairman (313) 396-5947 or via the Internet at fgless@deloitte.com respectively.

Watch for more on certification in future newsletters. We plan to discuss the advantages and the process by which an HFMA member may become certified and publish (anonymously) questions and answers that may be of interest to our members.

High Scorers Named, to be Honored at ANI!

HFMA's high scorers were named during the first week of May. To be eligible for this award it was necessary to test between May 1, 2001, and May 1, 2002. The following people received the award this year:

Sara J. McGlynn, CHFP, CPA was the high scorer on the Accounting and Finance Exam. Sara is the Business Coordinator at William Beaumont Hospital in Royal Oak, Michigan.

Sonya M. Wyatt was the high scorer on the Core Exam. Sonya is the Management Accountant at CareAlliance Health Services in Charleston, South Carolina.

Diane McClellan was the high scorer on the Financial Management of Physician Practices Exam. Diane is the Controller for Hampden County Physician Practices in Springfield, Massachusetts.

Scott W. Goodin, CHFP was the high scorer on the Managed Care Exam. Scott is the Director of Business Development and Contracting for Saint Mary's Health Network in Reno, Nevada.

David J. O'Neal, Sr., CMA was the high scorer on the Patient Financial Services Exam. David is the General Accounting Manager at Carilon Health System in Roanoke, Virginia.

Certified Members who encourage other members to become certified are eligible to win the Certified Member get a Certified Member award each year. Those members who become certified during the year are given a form to complete; it asks them to name the certified member who was most instrumental in causing them to become certified. The member who is named most often wins this award. This year the winner is Stephen M. Stewart, CHFP. Stephen is the Chief Operating Officer for the CBE Group in Waterloo, Iowa. Stephen is a proctor for the Iowa chapter and has used his laptop computer to make testing very available to members not only of the Iowa chapter, but also to members of surrounding chapters.

Winners of these awards receive:

- Air transportation to the ANI in Seattle,
- Ground transportation,
- One-night's lodging at the ANI, and
- They will be honored at the Certified Luncheon, and
- They will receive a plaque acknowledging their achievement.

Every certified member is eligible to win the award for encouraging other members to become certified and every member who tests between May 1, 2002 and May 1, 2003 is eligible to win the high scorer award for next year. Now is the time to begin planning to win next year's award!

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Denial Based on Frequency. CMS has not specified national frequency limitations for most tests covered by an NCD. CMS will defer to local carriers and intermediaries to make these decisions based "on local practice." Contractors (i.e. carriers and intermediaries) will not be permitted, effective February 21, 2002, to deny a claim based on frequency unless (a) a frequency limit is specified in an NCD or LMRP, or the service is specifically excluded from Medicare coverage, or (b) the contractor first considers any documentation submitted by the lab as evidence of medical necessity in a specific case.

Use of Frequency Screens. Effective February 21, 2002, a Medicare contractor may not use a frequency screen that could result in a frequency-based denial of a lab claim, unless information about the appropriate frequency has been published by the contractor or by CMS.

ABNs. CMS states in comments to the regulations that a lab may not bill a beneficiary for a test that is not covered because it has been performed too frequently, unless the lab obtained a properly executed ABN.

Ms. Abrahamsen may be contacted at 39577 Woodward Avenue, Suite 300, Bloomfield Hills, (248) 203-0818, or emailto:mabrahamsen@dykema.com.

BLUE CROSS BLUE SHIELD OF MICHIGAN PRACTITIONER BILLING CHANGES

Blue Cross Blue Shield of Michigan (BCBSM) has recently announced a number of changes relating to practitioner billing and payment.

Concurrent Care

BCBSM has stated that concurrent care of the same patient by more than one physician is payable only if:

- The physicians do not furnish duplicative services.
- The attending physician requests another physician to assume responsibility for a separately identifiable medical condition.
- The condition in question requires "diverse specialized medical services"; as a result, the physician providing concurrent care will usually be in a different specialty or sub-specialty than the attending.
- The attending physician does not possess the skills and knowledge to treat the separately identifiable condition.
- The attending physician documents "the nature, complexity and severity" of the separate medical condition that warrants concurrent care.

Differs from Medicare. BCBSM's policy on coverage of concurrent care differs somewhat from Medicare's policy, including:

- Medicare does not require the attending physician to document the nature of the condition that triggers concurrent care. The more general Medicare standard requires the existence of documentation of "the role each physician played in the patient's care (i.e. the condition or conditions for which the physician treated the patient)."

- The applicable Medicare Manual provisions acknowledge the relevance of "the patient's condition and the inherent reasonableness and necessity of the services, as determined by the carrier's medical staff in accordance with locality norms."

Physicians who furnish concurrent care to BCBSM patients will be subject to recoupment if the conditions outlined above (including documentation by the attending physician) are not satisfied.

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Lower Payments for Services in Facilities

For many years the Medicare program has identified services that are commonly furnished in a *physician office* and has paid physicians a lower professional fee when those same services are furnished in a *health care facility*. The rationale for this differential is to avoid making duplicative payments to the facility and the physician for practice overhead, and to avoid compensating the physician for practice overhead expenses he or she did not in fact incur.

Effective for dates of service beginning July 1, 2002, BCBSM will adopt the 2001 version of Medicare's RBRVS, which includes differentials in payment rate for a number of services based on where the physician's services are performed.

The new system will distinguish between "non-facility settings" (such as a physician's office, independent laboratory, and patient's home for certain services) and "facility settings" (e.g. inpatient and outpatient hospital facilities, long-term care facilities, and ambulatory surgical facilities).

Some hospital-sponsored clinics and hybrid practice sites (such as hospital-operated time-share suites) may raise billing ambiguities. Key factors in determining how to bill physician services performed in these sites will include: whether the physician bears the expense of overhead and whether the hospital bills a facility fee for use of the site.

Billing Inpatient Visits

BCBSM has announced that *each day* of physician services to a hospital inpatient is to be reported on a *separate* line of the physician claim form (HCFA or CMS-1500) which specifies the date of service.

Ms. Abrahamsen may be contacted at 39577 Woodward Avenue, Suite 300, Bloomfield Hills, (248) 203-0818, or mabrahamsen@dykema.com.

HELPING PHYSICIANS MINIMIZE RISKS OF EMTALA ACTIONS

By J. Kay Felt, J.D.

review of alleged violations of the Emergency Medical Treatment and Active Labor Act (known as EMTALA or the Anti-dumping Act) suggests that many allegations could be avoided with careful attention to detail, particularly on the part of physicians or other persons who are supervised or directed by physicians. Hospital controlled physician practices are particularly vulnerable to these allegations, and represent a disproportionate amount of EMTALA actions.

The Act requires a hospital to provide a medical screening examination to any patient who "comes" with an emergency medical condition and to any woman having contractions. Within its capabilities, the hospital also must stabilize or treat the patient before a transfer. The capabilities of the hospital include its on-call physicians and the ancillary services routinely available. Past practices of a hospital in handling similar cases is evidence of its capability. The term "transfer" includes discharge, but does not include death or the departure of a patient without permission of facility personnel. There may be no delay in providing services for the purpose of inquiring about third party payment status or other sources for payment.

Some EMTALA cases involve alleged non-compliance with the law (42 USC Section 1395dd) and regulations (42 CFR, Part 489, Sections 489.20 and 489.24). Even more cases involve incomplete or inappropriate documentation. The penalties are severe. Physicians are responsible for monetary penalties of up to $50,000 per violation, and may be terminated from the Medicare and Medicaid programs for repeated or flagrant violations. Monetary penalties and terminations may be imposed even when the involved patients are not Medicare or Medicaid beneficiaries. In addition, any patient who sustains an injury may bring an action for damages. The statute of limitations is two years.

Hospitals also face severe penalties, often based on the degree to which emergency physicians and on-call medical specialists comply with EMTALA. A hospital can be subject to a monetary penalty of up to $50,000 ($25,000 for smaller hospitals), and lawsuits seeking damages. More importantly, a hospital is subject to two levels of unannounced surveys by the designated state agency, and the need to prepare a credible correction plan or credible allegation of compliance. This can result in significant loss of staff time and consulting fees, even before the monetary penalty phase begins.

Physicians can minimize allegations of non-compliance for themselves and the hospitals they serve by understanding and fulfilling their responsibilities:

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- **On-call physicians should review their responsibilities to patients with emergency medical conditions**. Many physicians who are on call still do not fully understand that one of the obligations of being on call is to respond within a reasonable time to a request of an emergency physician to assess and stabilize a patient with an emergency medical condition. It is not an excuse that a physician has a busy office full of patients. The physician must be prepared to interrupt the schedule, respond to call, and return later to see scheduled patients. It is not an excuse that a physician is performing procedures elsewhere. Call should not be scheduled concurrently with other scheduled responsibilities that would potentially prohibit response. Call is not optional. If an on-call physician fails or refuses to respond, the emergency physician is required to put the name and address of the on-call physician's who fails to appear on the transfer form that accompanies the patient to another institution. The only exception is for physicians who are treating other emergency patients at the same facility when a new patient comes.

  An emergency medical condition is defined as a condition in which the patient has acute symptoms (which include pain, psychiatric conditions and substance abuse) of sufficient severity to put the patient's health in serious jeopardy or to result in serious impairment of bodily functions or serious dysfunction of a body organ or part. Stabilization results when the patient has received such treatment that, within medical probability, no material deterioration will be likely from a transfer. A pregnant woman with contractions is stabilized only by delivery, or physician certification that there is time for a transfer to another facility, and that the transfer is in the best interests of the woman or her unborn child, or that the contractions are false labor.

- **Emergency physicians should make it clear and document whether or not immediate attention of an on-call physician is required to assess and stabilize a patient.** Sometimes there is confusion about whether the immediate presence of the on-call physician is required. If the immediate presence of the on-call physician is required, the physician must come. If the emergency physician is able to conduct the medical screening examination and stabilize the patient, the on-call physician may not be required to come immediately, but may come later to determine whether the patient should be admitted or released. The emergency physician should make it clear, however, whether the patient is or is not stable, and should document those issues in the medical records. If the emergency physician decides in the meantime to transfer a stable patient to another facility, there may be a violation of hospital procedure or an impairment of good relations between the physicians, but there would not be an EMTALA violation.

- **Physicians should understand their responsibilities to pregnant women.** Generally, a woman having contractions is deemed to be stabilized only upon delivery. A woman having contractions should not be transferred unless a physician can certify that the woman and her unborn child can safely be transferred and that the benefits of transfer outweigh the risks, or that the contractions are false labor.

- **Physicians should make contact with receiving facilities to arrange for transfers and should document their contacts carefully.** It sometimes happens that a physician may decide that a patient should be transferred to another facility because the other facility has superior resources, and the benefits of transfer outweigh the risks. Nonetheless, there is a violation of EMTALA if the physician fails to obtain the other facility's agreement. The first step is to contact the other facility, determine if it has the capacity and willing physicians to undertake the patient's care and obtain the facility's consent.

- **Physicians should obtain patient or patient surrogate informed consent to a transfer or refusal to transfer, after disclosing the risks and benefits.** The informed consent process should be documented both on the EMTALA mandated transfer form and in the patient's medical record. Transfer should be offered only when the benefits of transfer outweigh the attendant risks. A pregnant woman with contractions may be transferred only if there is physician certification that the patient may be safely transferred to the receiving institution. If the patient or surrogate refuses transfer, after disclosure of all benefits and risks, the refusal should be documented in writing on a refusal form and in the medical records. If a patient or surrogate requests transfer, the informed written request should be in the medical record.

- **Physicians should fulfill all documentation responsibilities:**

1. Complete a transfer form that contains all EMTALA required information.
2. Document that the patient is stable before transfer (or discharge).
3. Take personal responsibility for all documentation. Many EMTALA violations affect physicians who delegate documentation responsibilities to residents or nursing personnel. The physician should personally review and sign off on all documentation.
4. Send all available medical records with the patient, including history and physical, nature of emergency condition, observations; test results and treatment provided. Do not wait for incomplete information that can be faxed as soon as available to the receiving facility, often before the patient arrives.
5. Document the type of equipment and support staff necessary for a transfer (e.g., are ACLS certified paramedics sufficient or is physician presence required).

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- **Physicians should avoid unnecessary controversy on the face of the medical record.**
- Minimize use of the term "refuse" in the medical record or in conversations with ambulance companies or receiving facilities. Use of this term will almost invariably result in a report of alleged violation; a notice of termination of the hospital's provider agreement; a CMS directed survey; the need to prepare a credible allegation of compliance or correction, as applicable ; a CMS directed resurvey to verify correction; and proceedings to determine monetary penalties. The term "refuse" should be reserved only for situations in which an on-call physician fails or refuses to come when requested by an emergency physician specifically to assess, stabilize or treat a patient with an emergency medical condition.
- Use incident reports or other administrative reports, to document disputes among facility staff or with receiving or transferring facilities.

- **Physicians should understanding the responsibilities of hospital-owned or operated off-campus sites.** EMTALA applies to any facility that has an emergency department, which is defined to include emergency rooms and trauma centers as well. It also may include urgent care centers, depending on the level of service provided.

  Once EMTALA applies, it applies to all parts of the facility, including sidewalks, parking lots and driveways. It also applies to any off-campus site that is operated as a hospital department, such as OB clinics, physical therapy centers and physician offices operated as an out-patient site. Off-site facilities must be prepared to receive patients with emergency conditions and pregnant women having contractions. They must have designated personnel to initiate the medical screening examination, protocols and procedures, established contacts with the main campus, procedures for transfer of patients to the main campus or dispatch of main campus personnel to the site. They also must have arrangements with other nearby facilities for transfer of patients who cannot be transferred safely to the main campus for treatment of possible emergency treatment needs. They should also have protocols for dealing with patients who leave without a complete screening examination. They should have a medical record and complete documentation of the circumstances for every patient who leaves without a complete screening examination, including all examination and treatment offered and any refusal of the patient to accept stabilization or treatment.

Hospital providers can minimize allegations of non-compliance by:

- Posting signs required by EMTALA in hospital emergency and obstetrical areas.
- Keeping a log of all persons who seek emergency care, and documenting on the log all significant events including: whether the patient refused treatment; was refused treatment; was transferred; was admitted and treated; was stabilized and transferred; or was stabilized and discharged.
- Documenting patient refusals of a medical screening examination, stabilization or treatment, including whether a written informed refusal is obtained.
- Maintaining a list of on-call medical staff specialists.
- Determining the capacity of the hospital to provide on-call physicians in specialties that are not fully staffed.
- Preparing off-campus facilities, including provider-based clinics and physician offices, to receive and properly transfer pregnant women having contractions and other persons with possible emergencies.
- Preparing off-campus facilities to assess when patients must be transported to the main hospital or another more appropriate hospital.
- Identifying what areas outside a hospital's buildings, in addition to driveways, sidewalks and parking lots are subject to EMTALA.

Physicians, clinical staff, health care administrators and other facility personnel should realize that the first review of an alleged EMTALA violation must be performed very rapidly by CMS or delegated quality improvement organization (QIO, formerly professional review organizations or PRO) or state agency staff. They have only a few days under applicable law to investigate. The record must speak for itself. Any medical record or other documentation deficiencies that raise doubts about hospital or physician compliance will almost invariably trigger a notice of termination, surveys, resurveys and the potential for monetary penalties.
Physicians are often surprised when months or even years after an incident, they are notified that civil monetary penalties are under consideration. This step occurs after all other processes are completed relating to the hospital's continued participation in the Medicare and Medicaid programs. If CMS believes there was a violation, whether or not it has since been corrected, it will notify the QIO to perform a sixty-day fact-finding review. Physicians and hospitals at risk of monetary penalties will be offered an opportunity to meet with the QIO. The purpose of the meeting is for them to provide any information they think may be helpful to CMS and the Office of Inspector General in determining whether to institute formal proceedings to impose monetary penalties. The QIO responsibility is purely fact-finding; it does not make any determination of whether there was a violation. Increasing numbers of alleged violations are being reported. The time to stop these allegations is before they start.

For more information about compliance with EMTALA and required policies and procedures, call Kay Felt at (313) 568-6700 or contact her at kfelt@dykema.com.

HFMA Eastern Michigan Chapter Committees
FY 2001-2002

HFMA Officerrs FY 2001-2002

Michael Tomkovich, President	**(248)489-6058**	**tomkovim@trinity-health.org**
Diane Justewicz – Vice-President	**(810)753-0307**	**Diane.Justewicz@stjohn.org**
Sue Carter – Treasurer	**(248)849-2738**	**scarter1@providence-hospital.org**
David Zilli – Past President	**(313)343-1503**	**david_zilli@bshsi.com**

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Newsletter Submission Dates :

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Calendar of Events – HFMA

MAY

5-21-02	Member Meeting (Providence Hospital; 8:30AM)
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 Committee Meeting (Riverside Building; 9AM)

JUNE

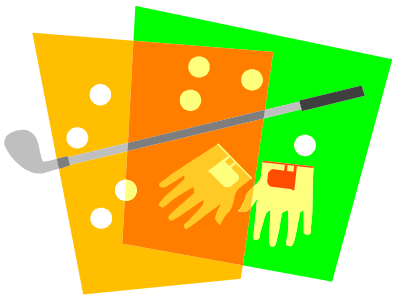
6-13-02	Annual Golf Outing (Shenandoah County Club in West Bloomfield)
6-21-02	Benchmarking/Decision Support Committee Meeting (Riverside Building; 9AM)
6-25-02	Managed Care Committee Meeting (Riverside Building; 8:30AM)
6-27-02	Physician Practice Committee Meeting (St. John, 28000 Dequindre; 9AM)
6-27-02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

Dates subject to change if necessary.

2002 HFMA Insurance and Reimbursement Committee Meeting Schedule is as follows:

May 23, 2002 , and June 27, 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.



HFMA GOLF OUTING

Date: June 13, 2002 - 18 holes with cart
Place: Shenandoah County Club in West Bloomfield

Agenda

9:00 AM Continental Breakfast
9:30 Shotgun Start
10:00 AM - 7PM Open Bar
Lunch at the turn
5:00 PM New York Strip or Whitefish Dinner
Entertainment (Comedian) after Dinner

Hole-in-one and other contests.

Complete Package $145 per person. So get your foursome together today! Send check payable to HFMA with foursome names and dinner preference to : Tammy Chinavare, Trinity Continuing Care, 34605 Twelve Mile Rd., P.O. Box 9185, Farmington Hills, MI 48333-9185