HEALTHcents

Eastern Michigan Chapter

December 2002

Volume 1,Issue 10

President's Message

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All right, who stole 2002? Holy time-flies-when-you're-having-fun, Batman! Just wanted to remind you that there's a Member Meeting on Wednesday, January 22, **2003** arranged by the Revenue Cycle/Patient Accounting Committee. You'll be receiving an e-mail about it before the end of the month.

And speaking of time flying, I hope you didn't forget to put the May meeting on your calendars. It's on Thursday evening, May 22 at the Fairlane Club. We're getting together for a little deja vu, for those of us around long enough to remember these meetings and for those who aren't, it's dinner and education and fellowship. It's a good thing.

During this holiday month, spend as much time with your families and friends as humanly possible. Life is short - celebrate with those you love. Peace and joy be with you.

Diane

UPCOMING MEMBER MEETING

The Next Member Meeting will be January 22, 2003 at 8AM at Providence Professional Building, 22250 Providence Dr., in Southfield. The meeting will take place on the 8th floor in room 8E. The Topics will be

- New Age Revenue Cycle Concept: Maximizing Revenue Cycle Outcomes via Clinical/Financial Integration
- Technology Without Process is Nothing More than X's and O's

Agenda

7:30 - 8:30 AM	HFMA Board Meeting 8th Floor room 8A
8:00 - 8:30	Registration /Continental Breakfast
8:30 - 9:00	Member Meeting
9:00 - 11:00	HFMA Revenue Management Committee Presentation
11:00AM	Adjournment

NEWSLETTER SUBMISSION DEADLINES

January 10, 2003 **February 3, 2003**
March 7, 2003 **April 7, 2003** **May 2, 2003**

Please note that the Newsletter will be published monthly with your cooperation. Any information for inclusion should be sent to Maryanne VanHaitsma (248)549-2703 mvanhait@dmc.org

WELCOME NEW MEMBERS

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ACCESS THE MEMBERSHIP DIRECTORY ON-LINE
www.hfma-emc.org

"Looking Ahead to 2003: The Lansing Agenda"

The Managed Care Committee sponsored an excellent presentation at the November 19th Member Meeting held at Providence Hospital. Speakers were David Finkbeiner, Senior Director of Legislative Issues with the Michigan Hospital Association and Bill Burke of Knight Consulting, who is a lobbyist for the MAHP (Michigan Association of Health Plans). They began by summarizing current issues before the Michigan Legislature, regulatory agencies and the federal government.

Enacted State Legislation in 2002:

Medical Liability Legislation – This legislation provides limited medical and dental liability for health care professionals providing care in an entity organized to deliver free care. Limited liability is also granted to professionals receiving patient follow up referrals who were initially evaluated at a free care entity.
Effective date: January 1, 2002.

Timely Payment Legislation – This legislation establishes timely payment requirements for health benefit plans and Blue Cross/Blue Shield plans.
Effective date: October 1, 2002.

Physician Self Referral – This legislation allows the referral of patients under certain conditions to facilities in which a physician has a financial interest.
Effective date: June 3, 2002.

Reciprocity of Canadian Health Care Professionals – This legislation extends reciprocity to health care professionals who are licensed, registered or certified by a province of Canada that maintains standards substantially equivalent to Michigan.
Effective date: June 3, 2002.

Nursing Scholarship Program – These two new laws provide nursing education scholarships of up to $4,000 per year for four years. Payments would be funded by the Michigan Merit Award Trust Fund. The Department of Treasury is the lead state agency to establish the program which is planned to be operational by February.
Effective dates: October 15 and 17, 2002.

Pending State Legislation:

Certificate of Need – Senate Bill 787-791 and 802 – This legislative package would repeal Michigan's certificate of need program.

Certificate of Need – Senate Bill 1436 – This bill would reform the CON program. Maintains MRI, Lithotripsy and Air Ambulance as covered services. It would replace the ad hoc review committee (5 members) with an expanded committee (9 members) including various healthcare professionals. There would also be a CON Commission.

BCBSM – Legislation introduced 5/8/02 by Rep. George and Rep. Raczkowski. It would reduce their board size to 13 members (currently 35). This bill would allow BCBSM to convert to private, for-profit entity and therefore allow the state to capture proceeds of sale. **This bill appears to have been stalled and will in no way pass during the Lame Duck session. Ms. Granhom is openly opposed.

Quality Assessments:

1. Nursing Homes – approved
2. Hospitals – passed; waiting on approval from CMS. Available 1st quarter 2003.
3. HMO's – opinions have been mixed. Issue currently on "life support!"
4. Mental Health – not approved

Pending Federal Legislation:

Medicare Reform – This house passed legislation includes several provisions to improve Medicare payments to hospitals.

Inpatient update factor for inflation minus 0.25%
Sole community hospitals full inflationary update.
Reinstate periodic interim payments for critical access hospitals.
Eliminate 15% cut for home health.
IME adjustment factor reduced from 6.5 to 5.9%
MHA and AHA working to improve and include in Senate action on the bill.

2002 State Election Results:

Governor's Office – Jennifer Granholm (Dem)
Secretary of State – Terri Lynn Land (Rep)
Attorney General – Mike Cox (Rep)
US Congress – Michigan: 9 Republicans/6 Democrats – (+2 Rep)
Senate: 22 Republicans/16 Democrats – (+1 Dem)
House of Representatives: 63 Republicans/47 Democrats – (+4 Rep)
Supreme Court: Justice Elizabeth Weaver, Justice Robert Young

Mr. Finkbeiner noted that there are an unprecedented **83 new members of this legislature due to both term limits and an "early out" retirement package recently offered.
We are losing a great deal of institutional knowledge and experience in this turnover.

Proposal 4 – defeated; however this issue received a great deal of visibility and raised awareness by the public. It is believed that Governer Elect Granholm will be dedicating a portion of the tobacco settlement funds for Health Care.

Granholm's Healthcare Platform:

1. Oppose attempts to privatize BCBSM
2. Lower cost of prescriptions by leveraging state's buying power
3. Expand access through innovative public-private partnerships
4. Expand access to MiChild and Medicaid without cutting benefits
5. Strengthen and enforce Michigan's Patients' Bill of Rights
6. Overhaul public health system; appoint Michigan Surgeon General

Consensus between the two gentlemen is basically that Governor Elect Granholm will certainly have her work cut out for her in the upcoming year. She will have approximately 100 new appointments to make and is being left with a 500 million dollar deficit (which could be as high as 1.0 – 1.2 billion) in the State's budget. Also both felt as though the current administration had a way of purposely "driving wedges" between the various sectors of the healthcare industry in fear of hospitals and HMO's actually coming together and partnering up as a team in the battle for reform. However it was quite clear that Mr. Finkbeiner and Mr. Burke were truly on the same page with their concerns. The major one being that in the near future we will be faced with denying access and limiting the patient care that we provide to our Michigan population—and nobody wins in that scenario.

HAVE A SAFE AND HAPPY NEW YEAR!!!

HOSPITAL-BASED FACILITIES - BEWARE OF YOUR CURRENT OBLIGATIONS

Submitted by Maria Abrahamsen, Ms. Abrahamsen can be reached at (248) 203-0818 or mabrahamsen@dykema.com.

Application Of Provider-Based Criteria Delayed For Certain Sites

In August, CMS gave facilities that had been treated as provider-based on October 1, 2000 a reprieve. These "grandfathered" facilities will not be subject to the current provider-based criteria until the start of the first cost reporting period beginning on or after July 1, 2003.

Provider-Based *Obligations* Not Delayed

However, a fact that is often overlooked is that **all** facilities that claim hospital-based payment have been subject, since the first cost reporting period beginning on or after January 10, 2001, to the **obligations** imposed on hospital-based sites by CMS. Following are the highlights of the hospital-based obligations:

- **Location is largely irrelevant**. Unless otherwise stated, the obligations described below apply equally to hospital-based facilities that are located on or off the hospital's main campus.
- **Penalty**. The revised regulation published in August, 2002 makes it clear for the first time that loss of hospital-based status is the potential penalty for non-compliance with these hospital-based obligations.
- **EMTALA**. Hospital outpatient departments must comply with the EMTALA anti-dumping rules. (CMS will issue future clarification regarding the extent of EMTALA obligations for various categories of hospital outpatient departments).
- **Correct Physician Billing.** Physician services furnished in a hospital-based facility (other than a rural health clinic) must be billed with the correct site-of-service. In other words, the physician's bill must indicate that the service was performed in a "hospital" rather than in a "physician office" or other non-hospital site. For some services, the hospital site-of-service will result in a lower professional fee to the physician than that which would be paid in an office setting. Hospitals will want to take reasonable steps to inform the physicians who practice in hospital-based sites of the need to designate the proper site on their professional fee bills.
- **Provider Agreement**. Hospital outpatient departments must operate under the terms of the hospital's provider agreement, such as the prohibition on balance billing Medicare beneficiaries.
- **Non-Discrimination**. Physicians who practice in hospital-based areas must comply with Medicare's anti-discrimination rules, i.e. compliance with the major federal civil rights statutes.
- **Uniformity of Billing**. All Medicare patients treated in a hospital outpatient department, other than a rural health clinic ("RHC") must be billed as hospital outpatients. For example, a hospital may not bill some Medicare patients seen in that area as hospital outpatients and bill others as physician office patients.
- **72-Hour Payment Window**. Services furnished in a hospital-based site are subject to Medicare's 72-hour payment window, which bundles into the DRG all diagnostic and certain therapeutic services furnished by a hospital during the 72-hours prior to a patient's inpatient admission to that hospital.
- **Written Beneficiary Notice**. Hospital-based sites (other than RHCs) that are located **off** the hospital's main campus must furnish each Medicare beneficiary with a written notice of the beneficiary's potential personal financial liability, before services are rendered. This obligation is **separate** from any obligation to deliver an advance beneficiary notice ("ABN"). The written notice is not to be delivered to patients who are seeking services mandated by EMTALA, but must be delivered "as soon as possible" after EMTALA-mandated services are complete. The provider-based regulation contains specific (but nonetheless ambiguous) requirements for the content of this notice.
- **Health and Safety Rules**. Hospital outpatient departments must satisfy applicable health and safety rules for Medicare-participating hospitals.
- **Physician Supervision of Therapeutic Services**. Therapeutic services furnished in a hospital-based department (other than a RHC or a federally qualified health center) must be furnished under the "direct supervision" of a physician, i.e. the physician must be on-site in the facility (although not necessarily in the room where patient care is being performed) and immediately available to assist and direct. While the regulation appears literally to apply to all hospital departments, CMS' comments to the regulation indicate that the required level of physician supervision will be **presumed** to exist for departments located on the hospital's main campus.
- **Physician Supervision of Diagnostic Services**. Diagnostic services performed in a hospital-based department (other than a RHC or federally qualified health center) must be performed under the same level of physician supervision as is required when that same service is performed in a physician's office or an independent diagnostic testing facility.

As noted above, each of the requirements summarized above is currently in effect with respect to hospital-based facilities, even if the facility is not yet subject to the new provider-based criteria because of grandfathering.

PPS Capital-Related Cost Reporting Changes and Impact on Michigan Hospitals

Nature of the Changes

With the introduction of PPS Capital in 1990, hospitals were required, in most cases, to separate "old" and "new" capital-related costs, in addition to various other capital analyses. With the completion of PPS Capital transition to 100% Federal Prospective rates at September 30, 2001, Medicare has revised HCFA-2552 cost reporting instructions. Transmittal 8 introduced several changes for cost reporting periods beginning on or after October 1, 2001, reducing certain record keeping and reporting requirements.

The revised instructions have actually eliminated the carve out of capital-related costs from operating costs for PPS Hospitals that are paid at the fully prospective capital rate. However, if the hospital has any cost-based subproviders, you will still need to calculate capital-related costs and complete the required worksheets.

Complication for Michigan Hospitals

Although the changes are welcome, it is not as simple as it would seem for **Michigan** PPS hospitals. Even though there may not be any cost-based Medicare programs at a hospital, Michigan Medicaid continues to pay for inpatient capital-related costs based on cost as calculated by the Medicare cost report. Therefore, although the submitted Medicare cost report may not segregate capital-related costs (unless you have a cost-based subprovider), the filed report for Medicaid must still calculate program capital-related cost.

Worksheets affected by the Changes

The primary worksheets tied to the revisions are:

1. Worksheet S-2, Line 36 - Do you elect fully prospective payment for capital?
2. Worksheet A-7 Parts I – IV – Analysis and reconciliation of Capital
3. Worksheet B, Parts II and III – Allocation of Capital-Related Costs
4. Worksheet L – Calculation of Capital Payment

Worksheet S-2 should trigger the exclusion of Worksheets A-7 and B, Parts II and/or III, and should limit completion of Worksheet L to Part I, Fully Prospective Method.

No one will mourn the passing of Worksheet A-7, along with the referencing required on Worksheets A-6 and A-8. Keep in mind that if the hospital continues to use Worksheet A, Line 90, "Other Capital-Related Costs," any reclassifications will need to be made on Worksheet A-6 to the appropriate lines since Worksheet A-7 is no longer utilized.

For Worksheet B, Parts II and/or III, the elimination is really the record keeping for Column 0, Directly Assigned Capital Costs. However, for Michigan Medicaid reporting this still must be maintained on Worksheet B Part III. Medicaid never required separation of old and new.

Reporting for Medicaid for years beginning on or after October 1, 2001

Most hospitals should be able to run a second report for Medicaid submission with a "no" response to Worksheet S-2, Line 36. A likely problem is that the final settled Medicare report will not include segregated capital data. However, Medicaid historically has used the final settled Medicare report to determine Medicaid capital inpatient cost-based payment. Furthermore, the State has had growing concerns over the delays in receiving final settlements from Medicare in order to close Medicaid years. This combined with the announced Medicare capital changes has prompted Medicaid to review their policies to final settle Medicaid based on as-submitted data.



The following summarizes a presentation made at the Western Michigan Chapter of HFMA in Grand Rapids, MI made by Robert Alpiner on November 21, 2002 on "THE BENEFIT OF ADDITONAL REIMBURSEMENT FOR TELEMEDICINE SERVICES". Part 1 discusses Telemedicine and the current reimbursement issues. Part 2 will cover privacy, legal and governmental issues in a future edition of 'Health Cents"

I. What is Telemedicine?

Telemedicine is the provision of health care services, clinical information and education over a distance using telecommunication technology. Examples include Teleradiology, Teledermatology and Telepsychiatry. It is a relatively new type of patient care where the benefit is that it assists patients who might not otherwise receive proper medical care without traveling long distances and can be either rural or urban based. The type of care furnished is of similar quality to that from a hospital, but the benefit is the patient does not have to return for inpatient or outpatient facilities for follow up treatment. The Telemedicine services can be performed at a remote hospital, a nearby hospital and/or a local clinic. The services are computer/telephonically performed, yet the saving of time and distance assists patients in follow up treatments.

Several examples come to mind. Jerri Nielsen, an Indiana physician leading a group, discovered she had breast cancer at the South Pole while leading a group of explorers. Due to the end of the tourist season, no airplanes were scheduled to arrive for months once the fall season began.
Through Telemedicine services, she was able to treat herself, with assistance of her fellow travelers and contact with an Indiana hospital until she could board a plane home. The treatment included using her computer and her telephone to transmit her treatment to where she was as well as the airlifting of the needed medicine and medical supplies via parachute. This was featured on the "Dateline NBC" television show.

In North Dakota, Cindy Gall's 3-year-old daughter, Allison, has a congenital heart defect requiring frequent visits 100 miles away in Bismark. Instead of long trips, Cindy takes her daughter to a nearby physician who relays lab work and x-rays by computer and consults via video hookup with a cardiologist in Bismark.

II. What are the Barriers in Establishing Widespread Telemedicine Implementation?

The include the following items, as Telemedicine involves using the following:

A. Costly telephone data lines.
B. Finding the computer equipment best suited for Telemedicine.
C. Establishing interstate medical license requirements.
D. Establishing fees for electronic consultations.
E. Adequate reimbursement for services.

Telemedicine services are more common in other countries, because the licensure of health care professionals and governmental involvement does not receive the same degree of scrutiny as it does in the United States.

III. What are the Reimbursement Issues?

Although Telemedicine Services can be quite beneficial to patients, it needs reimbursement so that providers can cover its costs. Previously, Telemedicine was funded by private or governmental grants. Once the grants expired, so too did the Telemedicine programs. Thus. payer systems that reimburse providers are necessary. Also, since the services are still in their infancy, the costs likely were not in any base year costs and thus were not placed in reimbursement formulas during their inception, and thus not part of reimbursement.

IV. Medicare, Medicaid and Other Payers Reimbursement.

Medicare changes from 1997 to 2001 laws include increasing population area by including more counties not in a Metropolitan Statistical Areas (MSA), removing fee splitting and including more health care professionals in reimbursement coverage.

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Formerly many areas of the country did not receive Telemedicine reimbursement unless the patient lived a large distance from an urban area and the transmitting provider for Telemedicine services was local to the patient. The changes in the Medicare laws enabled more coverage in MSA populations. Thus, the distance problem was not as prevalent. A problem still exists if a facility is not regarded as being in an MSA to receive added reimbursement. Also, formerly there was fee splitting of 75% consulting physician and 25% referring physician. This was removed to avoid possible Antikickback laws. Also, formerly nonphysicians and physician assistants did not receive reimbursement for presenting the patient to the consulting physician. Now, these health care professionals can also bill for the Telemedicine services, thus freeing up physicians. The update to Telemedicine coverage is in 42 C.F.R. 410.78.

Medicaid coverage does occur with various degrees of medical treatments in 18 states, with 2 other states having pilot projects. The amount of coverage varies depending on each state's willingness to pay for the technology.

Other Payers include coverage by some Blue Cross Plans throughout the country, such as Montana, when distance makes coverage practical. However, to date, it still is not common among most Blue Cross Plans and other third party payers.

What are some of the problems involved in a Telemedicine experience? The challenge is a health system integrating the existing patient medical information in the electronic format with the need of a Telemedicine services system providing an efficient approach to follow up care.

Telemedicine seems more acceptable to patients than to physicians as the doctors prefer to see patients face-to-face based on customary medical practice to diagnose and have a plan of treatment for the patients. One way to improve the desire for Telemedicine reimbursement is to alternate in-person and Telemedicine treatment. This enables the patient to develop trust in a physician's treatment and physician to develop confidence the patient treatment is appropriate.

Another problem is bandwidth and airspace. Bandwidth covers the strength coverage range on a transmission with larger bandwidth allowing better transmission of images from the Telemedicine service. Airspace covers the competition with cell phones and satellites to allow transmission of signals from phone lines and computer readings into the atmosphere.

Privacy is also a problem and will be covered in a future issue of "Health Cents." Health care professionals and patients are concerned about the treatments not being monitored by unintended parties.

V. Reasons for an increase in reimbursement for Telemedicine services.
Why should there be an increase in Telemedicine services? The technology exists so that patients do not have to go back to hospitals for follow up treatment. Patients are more knowledgeable about using the technology through Videocassette Recorders (VCRs) and Personal Digital Assistants (PDAs). Also, manufacturers of products market Telemedicine equipment to health care providers using this improved technology.

Additionally, Medicare (and other payers') inpatient and outpatient treatments are very expensive. For example, the Medicare inpatient average treatment cost was approximately $4,000 in 2001 per CMS determination. These treatments become very expensive unless there is a means to prevent hospitalization. The utilization can be increased for Telemedicine, however, this service is still very expensive. For example, at the 2002 American Health Lawyers Association presentation by Ms. Mary Marta, Esq. indicated $1,191 per hub and $476 per spoke for each Telemedicine encounter.

VI. There can be a saving of money to third party payers and hospitals by less inpatient encounters.
Efficient treatment of patients using Telemedicine services saves money to third party payers. That is a reason why they should consider more coverage for this service. See the example in Exhibit A.

It will take significant utilization of services for hospitals to cover their costs from this Exhibit.

In Part 2 of this article, we cover the privacy, legal and government issues that need consideration.

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Exhibit A An Example Showing How Both Third Party Payers and Hospitals Benefit from Having Telemedicine Reimbursement

The following example demonstrates a positive outcome for parties with Telemedicine service.

Patient A comes into the hospital with a diagnosis and received Telemedicine follow up services
Patient B comes into the hospital with a more severe diagnosis without having Telemedicine services
Regular Payment for a Diagnosis Related Grouping (DRG) with a $6,000 Payment
This Patient Has Its DRG Changed Due to Ability to Receive Telemedicine Services and Hospital Receives a $4,000 DRG Payment
Assume 5 Telemedicine Sessions at $200 per Session Paid

a. Saving of Money to Third Party Payers

1) Saving of $1,000 to Payer on Patient A

$6,000 DRG That Would Have Been Paid Without Telemedicine for Patient A
-4,000 DRG That Was Paid With Telemedicine for Patient A
$2,000 Difference
- 1,000 for 5 Telemedicine Sessions Paid @$200 per session
$1,000 Saved by Third Party Payer on Patient A

2) There is No Saving to Third Party Payer on Patient B

$6,000 DRG Needed for Patient B
-6,000 Paid on Patient B
$ 0 Difference

3) Total Savings to Third Party Payer on 1) and 2) is $1,000

b. Hospital Has Potential for Covering Cost of Service from the Telemedicine Program

$ 4,000 from DRG for Patient A
1,000 from Telemedicine Sessions for Patient A
6,000 from DRG for Patient B
$11,000
4,000 Less DRG from Patient A
6,000 Less DRG from Patient B
$ 1,000 Net Amount Before Telemedicine Expenses (See Below for $1,390 expense)

This model demonstrates a $390 loss for one Medicare patient to the hospital ($1,000 profit before expense less $1,390 expenses below). However, this is a start-up situation that over time and with community acceptance faces later reversal into profits.

This example has the following information:
a. 1.0 Full Time Equivalent (FTE) Employees at $25 per hour covering from 8 a.m. to 6 p.m. Estimated
b. Consulting Physician at $50 a session for 8 sessions a day (Contracted) Estimated
c. Employee Benefits Cost is 20% of Employee Compensation Based on Hospital Studies
d. Equipment (Non-Leased) Costs $1,000,000 and Has a 10 Year Life Based on American Hospital Association Useful Life Guidelines
e. Other Departmental Operating Cost (Including Purchasing Computer Terminals and Servers and The Leased Telemedicine Equipment) is $40,000 Estimate
f. Administrative and General Cost is 15% of Total Costs Based on Hospital Studies; This cost includes the allocation of Malpractice Insurance, Hospital Executive Responsibilities, Payroll, Accounting and Information Technologies Servicing the Telemedicine Services Department
g. The Total Square Feet of the Telemedicine Department is 5,000
h. Operation of Plant and Housekeeping Cost is $10.00 a Square Foot Based on Hospital Studies
i. Depreciation Building is $20.00 a Square Foot Based on Hospital Studies
j. Medical Records Cost of $30,000 for Servicing Outpatient Clinics Based on Hospital Studies (Used for Telemedicine in This Study)

Calculation of the Cost of the Telemedicine Department is $557,250 as follows:

$ 62,500 = $25 Per Hour x 1.0 FTEs x 10 hours per day x 250 days
12,500 = 20% Employee Benefits ($182,500 x .2)
100,000 = Consulting Physician $50 per patient x 8 patients per day x 250 days
100,000 = Depreciation Building of 5,000 Square Feet x $20
40,000 = Other Departmental Operating Costs
100,000 = Depreciation Equipment ($1,000,000 / 10 Years)
415,000 = Subtotal
62,250 = Administrative and General Percent of 15%

50,000 = Operation of Plant and Housekeeping of 5,000 Square Feet x $10
30,000 = Medical Records of $1,000,000 from Department x 3% Time on Telemedicine
$557,250 = Total Cost
2,000 Divided by 2,000 Patient Visits Expected Each Year
$ 278 Total Cost Per Patient Per Visit
x 5 Treatments
$ 1,390 Cost for the 5 Treatments

Calendar of Events– HFMA

JANUARY 2003

1-10 Healthcents Submission deadline

1-16 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

1-22 Member Meeting - New Age Revenue Cycle Concept: Maximizing Revenue Cycle Outcomes via Clinical/Financial Integration and Technology With out Process is Nothing More than X's and O's (Providence Medical Bldg. 8th floor; 8:30AM)

1-23 Financial Analysis/Decision Support (BCN Building; 8:30AM)

1-28 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

FEBRUARY 2003

2-3 Healthcents Submission deadline

2-12 HFMA Annual Bowling Night (Langan's Norwest Lanes (14 Mile & Northwestern; 6:30PM))

2-20 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

2-25 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

2-27 Financial Analysis/Decision Support (BCN Building; 8:30AM)

MARCH 2003

3-7 Healthcents Submission Deadline

3-20 Member Meeting - Annual Ins. & Reimb. Update (DoubleTree, Novi; 8:30AM)

3-20 Membership Committee Meeting (following I & R Update- Double Tree)

3-25 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

3-26 Managed Care Committee Meeting (CSB, Warren Rm S-101; 8:30AM)

3-27 Financial Analysis/Decision Support (BCN Building; 8:30AM)

APRIL 2003

4-7 Healthcents Newsletter Submission

4-17 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

4-22 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

4-24 Financial Analysis/Decision Support (BCN Building; 8:30AM)

MAY 2003

5-2 Healthcents Newsletter Submission

5-15 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

5-15 Managed Care Committee Meeting (CSB, Warren Rm S-101; 8:30AM)

5-22 Financial Analysis/Decision Support (BCN Building; 8:30AM)

5-22 Membership Committee Meeting (prior to Member Meeting at Fairlane Club)

5-22 Member Meeting - (The Fairlane Club, Dearborn; 5PM)

5-27 Physician Practice Meeting (CSB, Warren Rm S-101; 9AM)

JUNE 2003

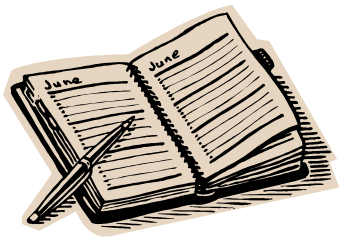
6-12 Annual Golf Outing – Shenandoah Country Club

6-19 Insurance & Reimb. Committee Meeting (BCN Building; 8:30AM)

6-24 Physician Practice Committee Meeting (CSB, Warren Rm S-101;9AM)

6-26 Financial Analysis/Decision Support Committee (BCN Building; 8:30AM)

Dates subject to change if necessary.



HFMA-Eastern Michigan Chapter

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FY 2002-2003

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