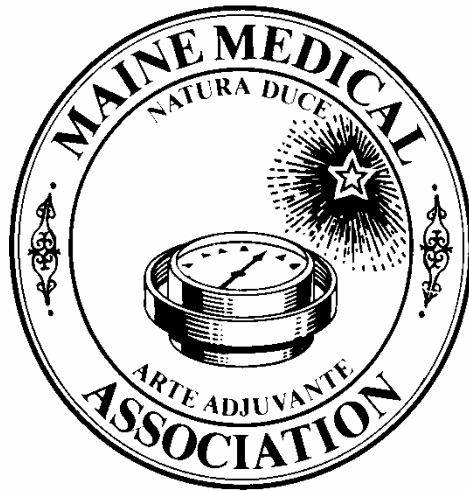


Physician's Guide to Maine Law 2012



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PHYSICIAN'S GUIDE TO MAINE LAW

As a service to members of the Maine Medical Association, this book is intended to alert Maine physicians to laws affecting aspects of their practice. It represents an attempt to highlight those laws and rules of particular interest to Maine physicians from the thirty-nine titles of Maine statutory law, the ever increasing regulations promulgated by various state agencies, applicable federal law, and the Current Opinions of the American Medical Association's Council on Ethical and Judicial Affairs. In some instances, excerpts from the statute or regulation have been quoted. In other cases, the relevant material has been paraphrased or electronic links to sources or more information have been provided.

State laws passed through June 2012 have been included and continuing updates will be made. However, since amendments to state law occur frequently, and excerpts can be misinterpreted when viewed in isolation, the full text of a relevant statute or rule should be consulted. Members are advised to consult with an MMA attorney or attorney knowledgeable in health care law for answers to specific questions.

The Association hopes that this booklet will be a ready and valuable reference for your practice.

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Physician's Guide to Maine Law
Current Through the 2nd Session of the 125th Legislature

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Notes of Importance:

- The information provided in this resource manual is subject to change without notice. Statutes and regulations change on a frequent basis. Every effort will be made to keep this Guide current, but if you need to know absolutely about a section's current status, please contact the Maine Medical Association for more information.
- The information provided is for reference purposes only and not intended to provide legal advice. If you need legal advice, please contact the MMA or a licensed attorney.
- Websites and other web-links are provided as a courtesy to our members. The links are subject to change or cancellation without notice. MMA does not take a particular position on any of these websites or their content and does not have a financial incentive to support any of the listed sites. They are provided for reference purposes only.
- The abbreviation MRSA in citations refers to the Maine Revised Statutes. The number appearing before MRSA is the title of the statute; the number after MSRA refers to the specific section. You can find the full text of the statutes at: <http://www.mainelegislature.org/legis/statutes>. The abbreviation USC refers to federal statutes, or the United States Code, found at: <http://www.gpoaccess.gov/uscode/>. CFR refers to the Code of Federal Regulations, found at: <http://www.gpoaccess.gov/cfr/>

(1) List of Maine State Agency Rules Links

All of the below listed Agency rules are adopted from the State of Maine website under [Maine State Agency Rules](#). These rules and links are subject to change without notice. The select links below are for the benefit of the users of this manual who may need to refer to a particular agency rule for further information or guidance. Please note that selecting a specific chapter will download a Word document from the agency websites.

I. Rule Chapters for the Department of Health and Human Services**1. Index**

10-144	Department of Health and Human Services - General
10-146	Office of Data Research and Vital Statistics
10-148	Community Services Programs (<i>formerly Office of Child and Family Services; see also 14-472</i>)
10-149	Office of Aging and Disability Services, part 1
14-118	Community Services Programs / Office of Substance Abuse
14-191	Mental Health and Mental Retardation - General
14-193	Office of Adult Mental Health
14-197	Office of Aging and Disability Services, part 2
14-472	Office of Child and Family Services (<i>the part that was formerly Bureau of Children with Special Needs; see also 10-148</i>)

1. 10-144 Department of Health and Human Services – General**Ch. 1 Administrative Hearings Regulations**

- [Ch. 2](#) Community Services Block Grant Program
- [Ch. 5](#) Head Start Program Rules
- [Ch. 10](#) Grievance Procedures for the Handicapped
- [Ch. 24](#) Purchase of Service Rules
- [Ch. 30](#) Maine Uniform Accounting and Auditing Practices for Community Agencies
- [Ch. 50](#) Department of Human Services Exceptions to OMB (Office of Management and Budget) Circulars
- [Ch. 51](#) Guidelines for Departmental Grants / Contracts and Appeal of Decisions
- [Ch. 52](#) Responsibilities of Physicians and Hospitals Re: Required Request for Organ Donation
- [Ch. 101](#) MaineCare Benefits Manual (*formerly Maine Medical Assistance Manual*)
- [Ch. 102](#) (*Repealed - absorbed into new 10-144 Ch. 24*)
- [Ch. 103](#) Maine Health Program Rules
- [Ch. 104](#) Maine State Services Manual
 - [Section 1:](#) Administrative Policies and Procedures
 - [Section 2:](#) Maine Drugs for the Elderly Benefit
 - [Section 3:](#) Maine Rx Plus Benefit
 - [Section 4:](#) Maine Part D Wrap Benefits
- [Ch. 105](#) Catastrophic Illness Program
- [Ch. 109](#) Quality Oversight for Commercial Health Maintenance Organizations (HMOs)
- [Ch. 110](#) Regulations Governing the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities
- [Ch. 112](#) Regulations for the Licensure of General and Specialty Hospitals in the State of Maine
- [Ch. 113](#) Regulations Governing the Licensing and Functioning of Assisted Housing Programs (*includes Assisted Living Programs, Residential Care Facilities, and Private Non-Medical Institutions*)
(*formerly 10-149 Ch. 113*)
- [Ch. 114](#) Rules Governing the Reporting of Sentinel Events (New chapter)
- [Ch. 115](#) Principles of Reimbursement for Residential Care Facilities - Room and Board Costs
- [Ch. 116](#) Filing and Review of Provider Agreement Applications for Boarding Care Facilities
- [Ch. 117](#) Regulations Governing the Licensing and Functioning of Adult Day Services Programs
- [Ch. 118](#) Regulations Governing the Licensing and Functioning of Intermediate Care Facilities for Persons with Mental Retardation
- [Ch. 119](#) Regulations Governing the Licensing and Functioning of Home Health Care Services
- [Ch. 120](#) Regulations Concerning the Licensing and Functioning of Hospice Programs
- [Ch. 121](#) Regulations Governing the Licensing and Functioning of Adult Day Services Programs (*Repealed - absorbed into 10-149 Ch. 113 as of September 1, 2003*)
- [Ch. 122](#) Regulations Governing the Maine Medical Use of Marijuana Program
- [Ch. 125](#) Regulations Governing the Licensing of Ambulatory Surgical Facilities
- [Ch. 126](#) Regulations Governing the Licensing and Functioning of End Stage Renal Disease Units/Facilities

- [Ch. 128](#) Rules Governing the Maine Registry of Certified Nursing Assistants
- [Ch. 129](#) Rules and Regulations Governing In-Home Personal Care and Support Workers
- [Ch. 150](#) Free Care Guidelines
- [Ch. 200](#) Maine Food Code (*Chapter 200 is a joint chapter with 01-001, the Department of Agriculture, Food and Rural Resources, Ch. 331*)
- [Ch. 201](#) Rules Relating to the Administration and Enforcement of Establishments Licensed by the Eating and Lodging Program
- [Ch. 202](#) Rules Relating to Public Swimming Pools and Spas
- [Ch. 203](#) Rules Relating to the Retail Sale and Delivery of Tobacco Products in Maine
- [Ch. 205](#) Rules Relating to Campgrounds
- [Ch. 206](#) Rules Relating to Lodging Establishments
- [Ch. 208](#) Rules Relating to Boys, Girls, Boys and Girls, Day Camps and Primitive and Trip Camping
- [Ch. 209](#) Rules Relating to Body Piercing
- [Ch. 210](#) Rules Relating to Tattooing
- [Ch. 211](#) Rules Relating to Micropigmentation
- [Ch. 212](#) Practice of Electrology
- [Ch. 214](#) Mass Gatherings
- [Ch. 220](#) Rules Relating to Radiation Protection
- [Ch. 221](#) Selection of Volunteer Personnel to Establish / Maintain Radiation Monitoring Program
- [Ch. 222](#) Rules Re: Public Notification of Radioactive Emissions from Nuclear Power Plant
- [Ch. 223](#) Rules Relating to Tanning Facilities
- [Ch. 224](#) Air and Water Radon Service Provider Registration Rules
- [Ch. 225](#) Licensing Suppliers of Compressed Air Used in Self-Contained Breathing Apparatus
- [Ch. 226](#) Cross Connection Rules
- [Ch. 227](#) Rules for Establishment and Operation of Crematoria
- [Ch. 230](#) Rules Relating to Drinking Water State Revolving Loan Fund
- [Ch. 231](#) Rules Relating to Drinking Water
- [Ch. 232](#) Well Drillers and Pump Installers Rules
- [Ch. 233](#) Rules Relating to Testing Private Water Systems for Hazardous Contaminants
- [Ch. 235](#) Rules Relating to Bottled Water, Bulk Water and Water Vending Machines
- [Ch. 240](#) Appointment and Administration of Local Plumbing Inspectors
- [Ch. 241](#) Maine Subsurface Wastewater Disposal Rules
- [Ch. 242](#) Rules for Conversion of Seasonal Dwelling Units into Year Round Residences in the Shoreland Zone
- [Ch. 243](#) Minimum Lot Size Rules
- [Ch. 245](#) Site Evaluators of Subsurface Wastewater Disposal Systems
- [Ch. 249](#) Rules Relating to Smoking in Public Places

- [Ch. 250](#) Rules Relating to Smoking in the Workplace
- [Ch. 251](#) Rules Governing Rabies Management
- [Ch. 252](#) Rules Governing the Implementation of Hypodermic Apparatus Exchange Programs
- [Ch. 253](#) Maine Chronic Disease Surveillance Data Quality and Follow-up Study Rules
- [Ch. 254](#) Occupational Disease Reporting Rules and Regulations
- [Ch. 255](#) Cancer Incidence Registry Regulations
- [Ch. 256](#) Maine Medical Laboratory Rules
- [Ch. 257](#) Schedule of Charges of the Diagnostic Laboratory of the Department of Health and Human Services
- [Ch. 258](#) Rules for the Control of Notifiable Diseases and Conditions
- [Ch. 259](#) Rules Establishing Blind Seroprevalence Surveys
- [Ch. 260](#) Rabies Immunization Requirements for Dog Licensure
- [Ch. 261](#) Immunization Requirements for School Children
- [Ch. 262](#) Rules and Regulations Post-secondary School Immunizations Required
- [Ch. 263](#) Maine Comprehensive and Limited Environmental Laboratory Certification Rules
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- [Ch. 265](#) Maine Drug Testing Laboratory Rules
- [Ch. 266](#) Certification Standards for Persons Conducting Chemical Analysis for Detection / Identification of Drugs
- [Ch. 267](#) Certification Standards for Persons Conducting Blood / Breath Test to determine Alcohol Level
- [Ch. 269](#) Rules Governing Self-contained Breath Alcohol Testing Equipment
- [Ch. 270](#) Rules for Sample Collection and Drug Testing in Suspected O. U. I. Cases
- [Ch. 272](#) Coordinated Care Services for Children with Special Health Needs
- [Ch. 273](#) Supplemental Security Income (SSI) Children's Program
- [Ch. 274](#) Immunization Information System (IIS) Rules
- [Ch. 276](#) Rules for Influenza Immunizing Agent Distribution Report
- [Ch. 279](#) Rules Relating to the Maine Newborn Hearing Program
- [Ch. 280](#) Rules Relating to the Maine Birth Defects Program
- [Ch. 281](#) Regulations for Spinal Screening
- [Ch. 282](#) Prenatal Care Program
- [Ch. 283](#) Rules and Regulations Relating to Testing Newborn Infants for Detection of Causes of Cognitive Disabilities and Selected Genetic Conditions
- [Ch. 286](#) WIC Program Rules
- [Ch. 287](#) Rules for Family Planning Funding
- [Ch. 288](#) Parenting Education Scholarship Program
- [Ch. 292](#) Rules for Environmental Lead Investigations
- [Ch. 293](#) Lead Poisoning Prevention Fee Rules

- [Ch. 294](#) Rule Governing the Qualifications for Local Health Officers
- [Ch. 295](#) Dental Services Development and Subsidy Programs
- [Ch. 296](#) "Fillings: The Choices You Have - Mercury Amalgam and Other Filling Materials"
- [Ch. 297](#) Dental Care Access Credit Program
- [Ch. 301](#) Food Supplement Program (*formerly Food Stamp Certification Manual*)
- [Ch. 311](#) Work Incentive Program Manual
- [Ch. 323](#) Maine General Assistance Policy Manual
- [Ch. 325](#) April 1987 Flood Recovery
- [Ch. 331](#) Public Assistance Manual (TANF)
- [Ch. 332](#) MaineCare Eligibility Manual
- [Ch. 333](#) Low Cost Drugs for Elderly and Disabled (DEL) – Eligibility
- [Ch. 334](#) MaineCare Eligibility Manual - Maine Rx Plus
- [Ch. 335](#) Health Insurance Purchase Option - Eligibility
- [Ch. 336](#) Transfer of Asset Penalty for State-funded Assistance in Residential Care
- [Ch. 351](#) Maine Child Support Enforcement Manual
- [Ch. 400](#) Fraud Investigation and Recovery Manual
- [Ch. 500](#) Hospital Cooperation Act Program Manual
- [Ch. 501](#) Maine Certificate of Need Act Limitation
- [Ch. 502](#) Community Health Program Manual
- [Ch. 503](#) Maine Certificate of Need Procedures Manual for Health Care Facilities (Other than Nursing Care Facilities)
- [Ch. 504](#) Rule to Implement 1985 Maine Medical Compact Act and Osteopathic Student Loan Program
- [Ch. 505](#) Appropriateness Review Procedures and Criteria
- [Ch. 506](#) Rules for Implementing the 1985 Amendment to Maine Medical Compact Act - Dental Care
- [Ch. 508](#) Selection Process for Identifying Sites for State Loan Repayment Program (SLRP)
- [Ch. 509](#) Rules for Designating Areas, Populations or Hospitals as Underserved by Specialty Physicians
- [Ch. 510](#) Regulations Governing the Rural Medical Access Program
- [Ch. 512](#) Community Scholarship Program
- [Ch. 607](#) ASPIRE-TANF Program Rules
- [Ch. 608](#) (*Repealed - absorbed into new 10-144 Ch. 24*)
- [Ch. 609](#) ASPIRE-JET Program Rules
- [Ch. 610](#) Maine At-Risk Child Care Program
- [Ch. 700](#) Rules Relating to the Maine Maternal and Infant Mortality Review Panel
- [Ch. 707](#) Rules Relating to the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) in Maine
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2. 10-146 Office of Data, Research and Vital Statistics

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3. 10-148 Community Service Programs (*formerly Office of Child and Family Services; see also 14-472*)

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- [Ch. 5](#) Purchase of Service Policy Manual
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- [Ch. 7](#) Rules for the Authorization of Background Checks for Prospective Adoptive Parents
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- [Ch. 11](#) Rules for Advocacy Services for Clients of the Department of Human Services
- [Ch. 12](#) Rules for Permanency Guardianship
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- [Ch. 14](#) Rules for Levels of Care for Foster Homes
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- [Ch. 17](#) Rules for Licensing of Family Foster Homes Providing Respite Care for Children
- [Ch. 18](#) Rules for the Licensure of Residential Child Care Facilities
- [Ch. 18-A](#) Rules for the Licensure of Private Non-medical Institutions-Residential Child Care Facilities
- [Ch. 19](#) Rules Providing for Licensing of Child Placing Agencies With and Without Adoption

Programs, including Addendum, Home Certification Process

- [Ch. 19-A](#) Rules for the Licensure of Private Non-medical Institutions-Child Placing Agencies With and Without Adoption Programs
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- [Ch. 32](#) Rules for the Licensing of Child Care Facilities
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- Ch. 5 Office of Elder Services Policy Manual
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Section 73: Personal Care Assistance for Severely Physically Disabled Adults
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6. 14-191 Mental Health and Mental Retardation – General

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- [Ch. 10](#) Certification Requirements for Agencies Seeking to Provide Community Based Targeted Case Management for Adults with Mental Retardation and Autism
- [Ch. 11](#) Consumer Directed Personal Assistance Services
- [Ch. 12](#) Regulations Regarding Reportable Events, Adult Protective Investigations and Substantiation Hearings Regarding Persons with Mental Retardation or Autism

9. 10-472 Office of Child and Family Services (the part that was formerly Bureau of Children with Special Needs; see also 10-148)

- [Ch. 1](#) Rights of Recipients of Mental Health Services Who are Children in Need of Treatment
- [Ch. 2](#) Homebased Family Services Program Standards
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- [Ch. 4](#) Regulations to Establish a Sliding Fee Methodology for State Grant Funded Children's Services

Attachment B (in Microsoft Excel .xls format):

[Determination of Fees for Services Provided by](#)

[DHHS Children's Services Grant Funding](#)

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- [Ch. 340](#) Mortality Tables for Determining Minimum Reserves and Nonforfeiture Benefits
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Maine Property And Automobile Insurance Cancellation Control Acts
- [Ch. 360](#) Requirements Applicable to Preferred Provider Arrangements
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- [Ch. 400](#) Requirements Relating to Authorized Insurers Terminating or
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- [Ch. 420](#) Nursing Home Care Insurance and Long-Term Care Insurance
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- [Ch. 440](#) Plan of Operation for the Worker's Compensation Residual Market Mechanism
- [Ch. 450](#) Workers' Compensation Insurance - Experience Rating
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- [Ch. 470](#) Workers' Compensation Insurance Premium Audit and Adjustment
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- [Ch. 530](#) Provisional Medical or Disability Payments to Workers' Compensation Claimants
- [Ch. 542](#) Educational Requirements for Insurance Professionals
- [Ch. 545](#) Appointment Renewal Fees - Nonresident Individual Producers and Business Entities
- [Ch. 550](#) Calculation of Premium for Interstate Workers' Compensation

Insurance Risks and Rate Filing Requirements

- [Ch. 560](#) Worker's Compensation Insurance - Employee Leasing
- [Ch. 570](#) Guaranty Association Lines of Credit
- [Ch. 580](#) Third-Party Notice of Cancellation (formerly Organic Brain Disease)
- [Ch. 585](#) Life Insurance Third-Party Notice of Cancellation; Rights of Reinstatement
for Individuals Afflicted with Organic Brain Disease
- [Ch. 590](#) Definition of Total Disability for Purposes of Extension of Benefits
- [Ch. 600](#) Screening Mammograms
- [Ch. 630](#) Rural Medical Access Program
- [Ch. 710](#) Standards for Determining Hazardous Financial Conditions for Insurance Companies
- [Ch. 730](#) Standards for Acceptance of Reinsurance of Worker's Compensation Self-Insurance
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- [Ch. 745](#) Individual Health Insurance Pilot Projects for Persons under 30 Years of Age
- [Ch. 750](#) Standardized Health Plans
- [Ch. 755](#) Health Insurance Classifications, Disclosure, and Minimum Standards
- [Ch. 760](#) Life and Health Reinsurance Agreements
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- [Ch. 825](#) Procedures and Standards for Obtaining a Hardship Exemption
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- [Ch. 850](#) Health Plan Accountability
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- [Ch. 870](#) Health Care Practitioner Self-Referrals
- [Ch. 880](#) Sale of Insurance Products by Financial Institutions and Supervised Lenders
(*Chapter 880 is a Joint Rule with 02-029 Ch.139 and 02-030 Ch.400*)
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- [Ch. 910](#) Life Insurance Illustrations
- [Ch. 915](#) Annuity Disclosure
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2. 02-297 Board of Chiropractic Licensure

- [Ch. 1](#) Definitions
- [Ch. 2](#) General Provisions
- [Ch. 3](#) Licensure Requirements for Chiropractic Doctors
- [Ch. 4](#) Requirements for Certifying Chiropractors to Practice Chiropractic Acupuncture
- [Ch. 5](#) Certification Requirements for Chiropractic Assistants and the Issuance of Temporary Certificates for Chiropractic Assistants
- [Ch. 6](#) Continuing Professional Education
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3. 02-313 Board of Dental Examiners

- [Ch. 1](#) Definitions
- [Ch. 2](#) Rules Relating to Dental Hygienists
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- [Ch. 4](#) Rules Relating to the Practice of Denturism
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- [Ch. 7](#) Licensing / Certification Late Fees
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- [Ch. 12](#) Requirements for Dental Licensure
- [Ch. 13](#) Continuing Education
- [Ch. 14](#) Rules for Use of Sedation and General Anesthesia by Dentists
- [Ch. 15](#) Mortality or Life Threatening Situations in a Dental Office
- [Ch. 16](#) Rules to Implement a 2-year Pilot Project for Independent Practice Dental Hygienists to Process Dental Radiographs in Underserved Areas of the State
- [Ch. 21](#) Use of Controlled Substances for Treatment of Pain

4. 02-343 Board of Respiratory Care Practitioners

- [Ch. 1](#) Definitions
- [Ch. 2](#) Advisory Rulings
- [Ch. 3](#) License Requirements for Respiratory Care Practitioners
- [Ch. 6](#) Code of Ethics
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5. 02-373 Board of Licensure in Medicine

- [Ch. 1](#) Rules and Regulations for Physician Licensing
- [Ch. 2](#) Physician Assistants
- [Ch. 3](#) Physician Supervision of Advanced Practice Registered Nurse under Medical Delegation
- [Ch. 4](#) Rules for the Issuance of Citations
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(Note: Chapter 10 is a joint rule with 02-383, Board of Osteopathic Licensure.)

- [Ch. 21](#) Use of Controlled Substances in Treatment of Pain

(Note: Chapter 21 is a joint rule with 02-383, Board of Osteopathic Licensure.)

6. 02-380 State Board of Nursing

- [Ch. 3](#) General Requirements Relating to Licensure
- [Ch. 4](#) Disciplinary Action and Violations of Law
- [Ch. 5](#) Regulations Relating to Training Programs and Delegation by Registered Professional Nurses of Selected Nursing Tasks to Certified Nursing Assistants
- [Ch. 6](#) Regulations Relating to Coordination and Oversight of Patient Care Services by Unlicensed Health Care Assistive Personnel
- [Ch. 7](#) Standards for Educational Programs in Nursing
- [Ch. 8](#) Regulations Relating to Advanced Practice Registered Nursing
- [Ch. 9](#) Advisory Rulings
- [Ch. 10](#) Administration of Intravenous Therapy by Licensed Nurses
- [Ch. 11](#) Regulations Relating to the Nurse Licensure Compact
- [Ch. 21](#) Use of Controlled Substances for Treatment of Pain

7. 02-382 State Board of Optometry

- [Ch. 1](#) Examination; Fees, Approved Schools; and Continuing Education
- [Ch. 2](#) Rules of Practice
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8. 02-383 Board of Osteopathic Licensure

- [Ch. 2](#) Physician Assistants
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(Note: Chapter 10 is a joint rule with 02-373, Board of Licensure in Medicine.)

- [Ch. 14](#) Continuing Medical Education
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[Ch. 22](#) Medical Liability Demonstration Project - Emergency Medicine Specialty Practice / Risk Protocol

[Ch. 24](#) Medical Liability Demonstration Project - Obstetrics and Gynecology Specialty Practice / Risk Protocol

[Ch. 26](#) Medical Liability Demonstration Project - Radiology Specialty Practice Parameters and Risk Management

9. 02-392 Maine Board of Pharmacy

[Ch. 1-34](#) *(Current rule chapters consolidated into one file.)*

10. 02-393 Board of Examiners in Physical Therapy

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[Ch. 2](#) General Provisions

[Ch. 3](#) Licensure Requirements for Physical Therapists and Physical Therapist Assistants

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11. 02-396 Board of Licensure of Podiatric Medicine

[Ch. 1](#) Licensing of Podiatrists

[Ch. 2](#) Fees

IMPORTANT: [Click here](#) to view a special notice regarding Chapter 2.

[Ch. 3](#) Continuing Education for Podiatrists

[Ch. 21](#) Use of Controlled Substances for Treatment of Pain

12. 02-415 State Board of Examiners of Psychologists

[Ch. \(All\)](#) *(All current rule chapters consolidated into one file.)*

13. 02-465 Radiologic Technology Board of Examiners

[Ch. \(All\)](#) *(All current rule chapters consolidated into one file.)*

14. 02-502 Board of Complementary Health Care Providers (formerly Acupuncture Licensing Board)

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[Ch. 3-A](#) Certification for the Formulation and Dispensing of Custom-Made Chinese Herbal Formulations

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[Ch. 5](#) Standards for Continuing Professional Education

for Acupuncturists and Naturopathic Doctors

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[Ch. 7](#) Enforcement and Disciplinary Procedures

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[Ch. 9](#) Fees

IMPORTANT: [Click here](#) to view a special notice regarding Chapter 9.

15. 02-643 Board of Speech, Audiology and Hearing

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III. Independent Agencies

1. 90-351 Workers' Compensation Board

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2. 90-590 Maine Health Data Organization

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[Ch. 241](#) Uniform Reporting System for Hospital Inpatient Data Sets and Hospital Outpatient Data Sets

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[Ch. 300](#) Uniform Reporting System for Hospital Financial Data

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Restructuring Occurrences for Maine Hospitals and Parent Entities

3. 94-457 Finance Authority of Maine (FAME)

[Ch. 604](#) Osteopathic Loan Program

[Ch. 607](#) Access to Medical Education and Health Professions Loan Program

[Ch. 616](#) Doctors for Maine's Future Scholarship Program

4. 94-630 Maine Biomedical Research Board

[Ch. 1](#) Rules for the Maine Biomedical Research Program

5. 95-629 Dirigo Health Agency

- [Ch. 2](#) Paid Claims Definition
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IV. Department of Public Safety

1. 16-163 Office of Emergency Medical Services

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2. 16-230 Maine Drug Enforcement Agency

- [Ch. 1](#) Requirements for Written Prescriptions of Schedule II Drugs

V. Department of Environmental Protection

- [Ch. 900](#) Biomedical Waste Management Rules

VI. Department of the Secretary of State, Bureau of Motor Vehicles

- [Ch. 3](#) Physical, Emotional and Mental Competence to Operate a Motor Vehicle

(2) Abandonment

See AMA Opinions (AMA Code of Medical Ethics and Policy Finder)

<http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/policy-finder-online.shtml>

<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml>

Disciplinary Sanctions

The board (of licensure in Medicine) may suspend or revoke a license pursuant to Title 5, section 10004. The following are grounds for an action to refuse to issue, modify, restrict, suspend, revoke or refuse to renew the license of an individual licensed under this chapter:

[32 MRSA §3282-A \(2\)](#)

Unprofessional conduct

A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed.

[32 MRSA §3282-A \(2\)\(F\)](#)

(3) Abortion and Miscarriage

General

Policy

It is the public policy of the State that the State not restrict a woman's exercise of her private decision to terminate a pregnancy before viability except as provided in section 1597-A. After viability an abortion may be performed only when it is necessary to preserve the life or health of the mother. It is also the public policy of the State that all abortions may be performed only by a physician.

[22 MRSA §1598 \(1\)](#)

Definitions

- A. **Abortion**: means the intentional interruption of a pregnancy by the application of external agents, whether chemical or physical or by the ingestion of chemical agents with an intention other than to produce a live birth or to remove a dead fetus.
- B. **Viability**: means the state of fetal development when the life of the fetus may be continued indefinitely outside the womb by natural or artificial life-supportive systems.

[22 MRSA §1598 \(2\)](#)

Persons who may perform abortions; penalties

- A. Only a person licensed under Title 32, chapter 36 or chapter 48, to practice medicine in Maine as a medical or osteopathic physician, may perform an abortion on another person.
- B. Any person not so licensed who knowingly performs an abortion on another person or any person who knowingly assists a nonlicensed person to perform an abortion on another person is guilty of a Class C crime.

[22 MRSA §1598 \(3\)](#)

Abortions after viability; criminal liability

- A. He knowingly disregarded the viability of the fetus; and
- B. He knew that the abortion was not necessary for the preservation of the life or health of the mother.

[22 MRSA §1598 \(4\)](#)

Immunity and employment protection

No physician, nurse or other person who refuses to perform or assist in the performance of an abortion, and no hospital or health care facility that refuses to permit the performance of an abortion upon its premises, shall be liable to any person, firm, association or corporation for damages allegedly arising from the refusal, nor shall such refusal constitute a basis for any civil liability to any physician, nurse or other person, hospital or health care facility nor a basis for any disciplinary or other recriminatory action against them or any of them by the State or any person.

No physician, nurse or other person, who refuses to perform or assist in the performance of an abortion, shall, because of that refusal, be dismissed, suspended, demoted or otherwise prejudiced or damaged by a hospital, health care facility, firm, association, professional association, corporation or educational institution with which he or she is affiliated or requests to be affiliated or by which he or she is employed, nor shall such refusal constitute grounds for loss of any privileges or immunities to which such physician, nurse or other person would otherwise be entitled nor shall submission to an abortion or the granting of consent therefore be a condition precedent to the receipt of any public benefits.

[22 MRSA §1591](#)

Discrimination for refusal

No person, hospital, health care facility, firm, association, corporation or educational institution, directly or indirectly, by himself or another, shall discriminate against any physician, nurse or other person by refusing or withholding employment from or denying admittance, when such physician, nurse or other person refuses to perform, or assist in the performance of an abortion, nor shall such refusal constitute grounds for loss of any privileges or immunities to which such physician, nurse or other person would otherwise be entitled.

[22 MRSA §1592](#)

Informed consent to abortion

- A. **Consent by the woman.** A physician may not perform an abortion unless, prior to the performance, the attending physician certifies in writing that the woman gave her informed written consent, freely and without coercion.
- B. **Informed consent.** To ensure that the consent for an abortion is truly informed consent, the attending physician shall inform the woman, in a manner that in the physician's professional judgment is not misleading and that will be understood by the patient, of at least the following:
 1. According to the physician's best judgment she is pregnant;
 2. The number of weeks elapsed from the probable time of the conception;
 3. The particular risks associated with her own pregnancy and the abortion technique to be performed; and
 4. At the woman's request, alternatives to abortion such as childbirth and adoption and information concerning public and private agencies that will provide the woman with economic and other assistance to carry the fetus to term, including, if the woman so requests, a list of these agencies and the services available from each.

[22 MRSA §1599-A](#)

Sale and use of fetuses

Whoever shall use, transfer, distribute or give away any live human fetus, whether intrauterine or extrauterine, or any product of conception considered live born for scientific experimentation or for any form of experimentation shall be punished by a fine of not more than \$5,000 and by imprisonment for not more than 5 years and any person consenting, aiding or assisting shall be liable to like punishment.

- A. **Prohibition.** A person may not use, transfer, distribute or give away a live human fetus, whether intrauterine or extrauterine, or any product of conception considered live born, for scientific experimentation or for any form of experimentation.

- B. Consenting, aiding or assisting. A person may not consent to violating subsection 1 or aid or assist another in violating subsection 1.
- C. Penalty. A person who violates this section commits a Class C crime. Violation of this section is a strict liability crime as defined in Title 17-A, section 34, subsection 4-A.

[22 MRSA §1593](#)

Failure to preserve life of live born person

Whenever an abortion procedure results in a live birth, failure to take all reasonable steps, in keeping with good medical practice, to preserve the life and health of the live born person shall subject the responsible party or parties to Maine law governing homicide, manslaughter and civil liability for wrongful death and medical malpractice.

[22 MRSA §1594](#)

Definitions:

- A. **Live Birth/Live Born:** as used in this chapter, shall mean a product of conception after complete expulsion or extraction from its mother, irrespective of the duration of pregnancy, which breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born and fully recognized as a human person under Maine law.

[22 MRSA §1594](#)

Abortion and miscarriage data

Definitions:

- A. **Abortion:** means the intentional interruption of a pregnancy by the application of external agents, whether chemical or physical, or the ingestion of chemical agents with an intention other than to produce a live birth or to remove a dead fetus, regardless of the length of gestation.
- B. **Miscarriage:** means an interruption of a pregnancy other than as provided in paragraph A of a fetus of less than 20 weeks gestation.

[22 MRSA §1596 \(1\)](#)

Abortion reports

A report of each abortion performed shall be made to the Department of Human Services on forms prescribed by the department. These report forms shall not identify the patient by name or otherwise and shall contain only the information requested on the United States Standard Report of Induced Termination of Pregnancy, published by the National Center for Health Statistics, dated January 1978, or any more recent revision of a standard report form.

The form containing that information and data shall be prepared and signed by the attending physician and transmitted to the department not later than 10 days following the end of the month in which the abortion is performed.

A physician who reports data on an abortion pursuant to this section shall be immune from any criminal liability for that abortion under section 1598.

[22 MRSA §1596 \(2\)](#)

Miscarriage reports

A report of each miscarriage shall be made by the physician in attendance at or after the occurrence of the miscarriage to the Department of Human Services on forms prescribed by the department. These report forms shall contain all of the applicable information required on the certificate of fetal death in current use.

The report form shall be prepared and signed by the attending physician and transmitted to the department not later than 10 days following the end of the month in which the miscarriage occurs.

The identity of any patient or physician reporting pursuant to this section is confidential and the department shall take the steps which are necessary to insure the confidentiality of the identity of patients or physicians reporting pursuant to this section.

[22 MRSA §1596 \(3\)](#)

Consent to a minor's decision to have an abortion

Definitions:

- A. **Abortion:** means the intentional interruption of a pregnancy by the application of external agents, whether chemical or physical, or the ingestion of chemical agents with an intention other than to produce a live birth or to remove a dead fetus.
- B. **Counselor:** means a person who is:
 - 1. A psychiatrist;
 - 2. A psychologist licensed under Title 32, chapter 56;
 - 3. A social worker licensed under Title 32, chapter 83;
 - 4. An ordained member of the clergy;
 - 5. A physician's assistant registered by the Board of Licensure in Medicine, Title 32, chapter 48;
 - 6. A nurse practitioner registered by the Board of Licensure in Medicine, Title 32, chapter 48;
 - 7. A certified guidance counselor;
 - 8. A registered professional nurse licensed under Title 32, chapter 31; or
 - 9. A practical nurse licensed under Title 32, chapter 31.
- C. **Minor:** means a person who is less than 18 years of age.

[22 MRSA §1597-A \(1\)](#)

Prohibitions; exceptions

Except as otherwise provided by law, no person may knowingly perform an abortion upon a pregnant minor unless:

- A. The attending physician has received and will make part of the medical record the informed written consent of the minor and one parent, guardian or adult family member;
- B. The attending physician has secured the informed written consent of the minor as prescribed in subsection 3 and the minor, under all the surrounding circumstances, is mentally and physically competent to give consent;
- C. The minor has received the information and counseling required under subsection 4, has secured written verification of receiving the information and counseling and the attending physician has received and will make part of the medical record the informed written consent of the minor and the written verification of receiving information and counseling required under subsection 4; or
- D. The Probate Court or District Court issues an order under subsection 6 on petition of the minor or the next friend of the minor for purposes of filing a petition for the minor, granting:
 - 1. To the minor majority rights for the sole purpose of consenting to the abortion and the attending physician has received the informed written consent of the minor; or
 - 2. To the minor consent to the abortion, when the court has given its informed written consent and the minor is having the abortion willingly, in compliance with subsection 7.

[22 MRSA §1597-A \(2\)](#)

Informed consent; disallowance of recovery

No physician may perform an abortion upon a minor unless, prior to performing the abortion, the attending physician received the informed written consent of the minor.

- A. To ensure that the consent for an abortion is informed consent, the attending physician shall:
 1. Inform the minor in a manner which, in the physician's professional judgment, is not misleading and which will be understood by the patient, of at least the following:
 - a. According to the physician's best judgment the minor is pregnant;
 - b. The number of weeks of duration of the pregnancy; and
 - c. The particular risks associated with the minor's pregnancy, the abortion technique that may be performed and the risks involved for both;
 2. Provide the information and counseling described in subsection 4 or refer the minor to a counselor who will provide the information and counseling described in subsection 4; and
 3. Determines whether the minor is, under all the surrounding circumstances, mentally and physically competent to give consent.
- B. No recovery may be allowed against any physician upon the grounds that the abortion was rendered without the informed consent of the minor when:
 1. The physician, in obtaining the minor's consent, acted in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities; or
 2. The physician has received and acted in good faith on the informed written consent to the abortion given by the minor to a counselor.

[22 MRSA §1597-A \(3\)](#)

Information and counseling for minors

The provision of information and counseling by any physician or counselor for any pregnant minor for decision making regarding pregnancy shall be in accordance with this subsection.

- A. Any physician or counselor providing pregnancy information and counseling under this subsection shall, in a manner that will be understood by the minor:
 1. Explain that the information being given to the minor is being given objectively and is not intended to coerce, persuade or induce the minor to choose either to have an abortion or to carry the pregnancy to term;
 2. Explain that the minor may withdraw a decision to have an abortion at any time before the abortion is performed or may reconsider a decision not to have an abortion at any time within the time period during which an abortion may legally be performed;
 3. Clearly and fully explore with the minor the alternative choices available for managing the pregnancy, including:
 - a. Carrying the pregnancy to term and keeping the child;
 - b. Carrying the pregnancy to term and placing the child with a relative or with another family through foster care or adoption;
 - c. The elements of prenatal and postnatal care; and
 - d. Having an abortion;
 4. Explain that public and private agencies are available to provide birth control information and that a list of these agencies and the services available from each will be provided if the minor requests;
 5. Discuss the possibility of involving the minor's parents, guardian or other adult family members in the minor's decision making concerning the pregnancy and explore whether the minor believes that involvement would be in the minor's best interests; and
 6. Provide adequate opportunity for the minor to ask any questions concerning the pregnancy, abortion, child care and adoption, and provide the information the minor seeks or, if the

person cannot provide the information, indicate where the minor can receive the information.

- B. After the person provides the information and counseling to a minor as required by this subsection, that person shall have the minor sign and date a form stating that:
1. The minor has received information on prenatal care and alternatives to abortion and that there are agencies that will provide assistance;
 2. The minor has received an explanation that the minor may withdraw an abortion decision or reconsider a decision to carry a pregnancy to term;
 3. The alternatives available for managing the pregnancy have been clearly and fully explored with the minor;
 4. The minor has received an explanation about agencies available to provide birth control information;
 5. The minor has discussed with the person providing the information and counseling the possibility of involving the minor's parents, guardian or other adult family members in the minor's decision making about the pregnancy;
 6. The reasons for not involving the minor's parents, guardian or other adult family members are put in writing on the form by the minor or the person providing the information and counseling; and
 7. The minor has been given an adequate opportunity to ask questions.

The person providing the information and counseling shall also sign and date the form, and include that person's address and telephone number. The person shall keep a copy for that person's files and shall give the form to the minor or, if the minor requests and if the person providing the information is not the attending physician, transmit the form to the minor's attending physician.

[22 MRSA §1597-A \(4\)](#)

Presumption of validity of informed written consent; rebuttal

An informed consent which is evidenced in writing containing information and statements provided in subsection 4 and which is signed by the minor shall be presumed to be a valid informed consent. This presumption may be subject to rebuttal only upon proof that the informed consent was obtained through fraud, deception or misrepresentation of material fact.

[22 MRSA §1597-A \(5\)](#)

Court order concerning consent to abortion

The court may issue an order for the purpose of consenting to the abortion by the minor under the following circumstances and procedures.

- A. The minor or next friend of the minor for the purposes of filing a petition may make an application to the Probate Court or District Court which shall assist the minor or next friend in preparing the petition. The minor or the next friend of the minor shall file a petition setting forth:
1. The initials of the minor;
 2. The age of the minor;
 3. That the minor has been fully informed of the risks and consequences of the abortion;
 4. That the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion;
 5. That, if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion;

6. That, if the minor does not have private counsel, that the court may appoint counsel.

The minor or the next friend shall sign the petition.

- B. The petition is a confidential record and the court files on the petition shall be impounded
- C. A hearing on the merits of the petition shall be held as soon as possible within 5 days of the filing of the petition. If any party is unable to afford counsel, the court shall appoint counsel at least 24 hours before the time of the hearing. At the hearing, the court shall hear evidence relating to:
 - 1. The emotional development, maturity, intellect and understanding of the minor;
 - 2. The nature, possible consequences and alternatives to the abortion; and
 - 3. Any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best interest of the minor.

The hearing on the petition shall be held as soon as possible within 5 days of the filing of the petition. The court shall conduct the hearing in private with only the minor, interested parties as determined by the court and necessary court officers or personnel present. The record of the hearing is not a public record.

- D. In the decree, the court shall for good cause:
 - 1. Grant the petition for majority rights for the sole purpose of consenting to the abortion;
 - 2. Find the abortion to be in the best interest of the minor and give judicial consent to the abortion, setting forth the grounds for the finding; or
 - 3. Deny the petition only if the court finds that the minor is not mature enough to make her own decision and that the abortion is not in her best interest.
- E. If the petition is allowed, the informed consent of the minor, pursuant to a court grant of majority rights or the judicial consent, shall bar an action by the parent or guardian of the minor on the grounds of battery of the minor by those performing the abortion. The immunity granted shall only extend to the performance of the abortion and any necessary accompanying services which are performed in a competent manner.
- F. The minor may appeal an order issued in accordance with this section to the Superior Court. The notice of appeal shall be filed within 24 hours from the date of issuance of the order. Any record on appeal shall be completed and the appeal shall be perfected within 5 days from the filing of notice to appeal. The Supreme Judicial Court shall, by court rule, provide for expedited appellate review of cases appealed under this section.

[22 MRSA §1597-A \(6\)](#)

Abortion performed against the minor's will

No abortion may be performed on any minor against her will, except that an abortion may be performed against the will of a minor pursuant to a court order described in subsection 6 that the abortion is necessary to preserve the life of the minor.

[22 MRSA §1597-A \(7\)](#)

Violations; penalties (Effective 1 July 2004)

- A. A person may not knowingly perform or aid in the performance of an abortion in violation of this section. A person who violates this paragraph commits a Class D crime.
- B. An attending physician or counselor may not knowingly fail to perform any action required by this section. A person who violates this paragraph commits a civil violation for which a fine of not more than \$1,000 may be adjudged for each violation.

[22 MRSA §1597-A \(8\)](#)

Nonseverability

In the event that any portion of this section is held invalid, it is the intent of the Legislature that this entire section shall be invalid.

[22 MRSA §1597-A \(9\)](#)

(4) Abuse

Definitions

- A. **Abuse:** means the infliction of injury, unreasonable confinement, intimidation or cruel punishment that causes or is likely to cause physical harm or pain or mental anguish; sexual abuse or sexual exploitation; or the intentional, knowing or reckless deprivation of essential needs. "Abuse" includes acts and omissions.
- B. **Adult:** means any person who has attained the age of 18 years or who is a legally emancipated minor.
- C. **Bureau:** means the Department of Health and Human Services, Bureau of Elder and Adult Services.
- D. **Caretaker:** means any individual or institution who has or assumes the responsibility for the care of an adult.
- E. **Commissioner:** means the Commissioner of Health and Human Services or a designated representative in the geographical area in which the person resides or is present.
- F. **Department:**
- G. **Dependent adult:** means an adult who has a physical or mental condition that substantially impairs the adult's ability to adequately provide for that adult's daily needs. "Dependent adult" includes, but is not limited to, any of the following:
 1. A resident of a nursing home licensed or required to be licensed under section 1817;
 2. A resident of a facility providing assisted living services licensed or required to be licensed pursuant to section 7801; or
 3. A person considered a dependent person under Title 17-A, section 555.
- H. **Emergency:** refers to a situation where:
 1. The incapacitated or dependent adult is in immediate risk of serious harm;
 2. The incapacitated or dependent adult is unable to consent to services that will diminish or eliminate the risk; and
 3. There is no person legally authorized to consent to emergency services.
- I. **Emergency services:** refers to those services necessary to avoid serious harm.
- J. **Exploitation:** means the illegal or improper use of an incapacitated or dependent adult or his resources for another's profit or advantage.
- K. **Incapacitated adult:** means any adult who is impaired by reason of mental illness, mental deficiency, physical illness or disability to the extent that that individual lacks sufficient understanding or capacity to make or communicate responsible decisions concerning that individual's person, or to the extent the adult cannot effectively manage or apply that individual's estate to necessary ends.
- L. **Neglect:** means a threat to an adult's health or welfare by physical or mental injury or impairment, deprivation of essential needs or lack of protection from these.
- M. **Protective services:** means services which will separate incapacitated or dependent adults from danger. Protective services include, but are not limited to, social, medical and psychiatric services necessary to preserve the incapacitated or dependent adult's rights and resources and to

maintain the incapacitated or dependent adult's physical and mental well-being. Protective services may include seeking guardianship or a protective order under Title 18-A, Article V.

- N. **Serious harm:** means:
1. Serious physical injury or impairment;
 2. Serious mental injury or impairment that now or in the future is likely to be evidenced by serious mental, behavioral or personality disorder, including, but not limited to, severe anxiety, depression or withdrawal, untoward aggressive behavior or similar serious dysfunctional behavior;
 3. Sexual abuse or exploitation; or
 4. Serious waste or dissipation of resources.
- O. **Serious injury** (no definition provided)
- P. **Sexual abuse or sexual exploitation:** means contact or interaction of a sexual nature involving an incapacitated or dependent adult without that adult's informed consent.

[22 MRSA §3472](#)

Spiritual treatment

Treatment not considered abuse, neglect or exploitation

An incapacitated or dependent adult shall not be considered to be abused, neglected or exploited solely because treatment is by spiritual means by an accredited practitioner of a recognized religious organization.

Treatment to be considered if requested

When medical treatment is authorized, under this chapter, treatment by spiritual means by an accredited practitioner of a recognized religious organization may also be considered if requested by the incapacitated or disabled adult or his caretaker.

[22 MRSA §3476](#)

Persons mandated to report suspected abuse, neglect or exploitation

Persons required to report

The following persons immediately shall report or cause a report to be made to the department when the person suspects that an adult has been abused, neglected or exploited and has reasonable cause to suspect that the adult is incapacitated or dependent:

- A. While acting in a professional capacity:
1. An allopathic or osteopathic physician;
 2. A medical intern;
 3. A medical examiner;
 4. A physician's assistant;
 5. A dentist;
 6. A chiropractor;
 7. A podiatrist;
 8. A registered or licensed practical nurse;
 9. A certified nursing assistant;
 10. A social worker;
 11. A psychologist;
 12. A pharmacist;
 13. A physical therapist;

14. A speech therapist;
 15. An occupational therapist;
 16. A mental health professional;
 17. A law enforcement official;
 18. A coroner;
 19. Emergency room personnel;
 20. An ambulance attendant;
 21. An emergency medical technician;
 22. Unlicensed assistive personnel;
 23. A clergy member acquiring the information as a result of clerical professional work except for information received during confidential communications;
 24. A sexual assault counselor; or
 25. A family or domestic violence victim advocate;
- B. Any person who has assumed full, intermittent or occasional responsibility for the care or custody of the adult, regardless of whether the person receives compensation; and
- C. Any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to the members of that church or religious institution, while acting in that capacity, regardless of whether the person receives compensation.

The duty to report under this subsection applies to individuals who must report directly to the department. A supervisor or administrator of a person making a report under this section may not impede or inhibit the reporting, and a person making a report may not be subject to any sanction for making a report. Internal procedures to facilitate ensure confidentiality of and apprise supervisors and administrators of reports may be established as long as those procedures are not inconsistent with this chapter.

[22 MRSA §3477 \(1\)](#)

Permitted reporters

An animal control officer, as defined in Title 7, section 3908, subsection 4, may report to the department when that person has reasonable cause to suspect that an incapacitated or dependent adult has been or is at substantial risk of abuse, neglect or exploitation.

[22 MRSA §3477 \(1-A\)](#)

Reports

Reports regarding abuse, neglect or exploitation shall be made immediately by telephone to the department and shall be followed by a written report within 48 hours if requested by the department. The reports shall contain the name and address of the involved adult; information regarding the nature and extent of the abuse, neglect or exploitation; the source of the report; the person making the report; the person's occupation; and where that person can be contacted. The report may contain any other information that the reporter believes may be helpful.

[22 MRSA §3477 \(2\)](#)

Confidentiality in case of treatment of individual suspected of causing abuse, neglect or exploitation

This section does not require any person acting in that person's professional capacity to report when all of the following requirements are met:

- A. The factual basis for knowing or suspecting abuse, neglect or exploitation of an adult covered under this subchapter derives from the professional's treatment of the individual suspected of causing the abuse, neglect or exploitation;

- B. The treatment was sought by the individual for a problem relating to the abuse, neglect or exploitation; and
- C. In the opinion of the person required to report, the abused, neglected or exploited adult's life or health is not immediately threatened.

[22 MRSA §3477 \(3\)](#)

Confidentiality in case of treatment of individual suspected of being abused, neglected, or exploited

This section does not require any person acting in that person's professional capacity to report when all of the following requirements are met:

- A. The factual basis for knowing or suspecting abuse, neglect or exploitation of an adult covered under this subchapter derives from the professional's treatment of the individual suspected of being abused, neglected or exploited.
- B. The treatment was sought by the individual for a problem relating to the abuse, neglect or exploitation, and
- C. In the opinion of the person required to report, the individual is not incapacitated and the individual's life or health is not immediately threatened.

[22 MRSA §3477 \(4\)](#)

Permissive reporting of animal cruelty, abuse or neglect

Notwithstanding any other provision of state law imposing a duty of confidentiality, a person listed in subsection 1 may report a reasonable suspicion of animal cruelty, abuse or neglect to the local animal control officer or to the animal welfare program of the Department of Agriculture, Food and Rural Resources established pursuant to Title 7, section 3902. For purposes of this subsection, the reporter shall disclose only such limited confidential information as is necessary for the local animal control officer or animal welfare program employee to identify the animal's location and status and the owner's name and address. For purposes of this subsection, "cruelty, abuse or neglect" has the same meaning as provided in Title 34-B, chapter 1, subchapter 6.

[22 MRSA §3477 \(5\)](#)

Mandatory reporting to medical examiner for post-mortem investigation

A person required to report cases of known or suspected abuse or neglect, who knows or has reasonable cause to suspect that an adult has died as a result of abuse or neglect, shall report that fact to the appropriate authority as provided in section 3026. An adult shall not be considered to be abused or neglected solely because he was provided with treatment by spiritual means by an accredited practitioner of a recognized religious organization.

[22 MRSA §3478](#)

Optional reporting

Any person may make a report if that person knows or has reasonable cause to suspect abuse, neglect or exploitation of an incapacitated or dependent adult, or has reasonable cause to suspect that an adult is incapacitated.

[22 MRSA §3479](#)

Immunity from liability

Reporting and proceedings

A person participating in good faith in reporting under this subchapter, or in a related adult protection investigation or proceeding, is immune from any civil liability that might otherwise result from these actions.

Presumption of good faith

In a proceeding regarding immunity from liability, there shall be a rebuttable presumption of good faith.

(5) Abuse, Child

Spiritual treatment

Treatment not considered abuse or neglect

Under subchapters I to VII, a child shall not be considered to be abused or neglected, in jeopardy of health or welfare or in danger of serious harm solely because treatment is by spiritual means by an accredited practitioner of a recognized religious organization.

Treatment to be considered if requested

When medical treatment is authorized under this chapter, treatment by spiritual means by an accredited practitioner of a recognized religious organization may also be considered if requested by the child or his parent.

[22 MRSA §4010](#)

Reporting of suspected child abuse or neglect

Persons required to report

The following adult persons shall immediately report or cause a report to be made to the department when the person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected:

- A. When acting in a professional capacity:
 1. An allopathic or osteopathic physician, resident or intern;
 2. An emergency medical services person;
 3. A medical examiner;
 4. A physician's assistant;
 5. A dentist;
 6. A dental hygienist;
 7. A dental assistant;
 8. A chiropractor;
 9. A podiatrist;
 10. A registered or licensed practical nurse;
 11. A teacher;
 12. A guidance counselor;
 13. A school official;
 14. A children's summer camp administrator or counselor;
 15. A social worker;
 16. A court-appointed special advocate or guardian ad litem for the child;
 17. A homemaker;
 18. A home health aide;
 19. A medical or social service worker;
 20. A psychologist;
 21. Child care personnel;
 22. A mental health professional;
 23. A law enforcement official;

24. A state or municipal fire inspector;
 25. A municipal code enforcement official;
 26. A commercial film and photographic print processor;
 27. A clergy member acquiring the information as a result of clerical professional work except for information received during confidential communications;
 28. A chair of a professional licensing board that has jurisdiction over mandated reporters;
 29. A humane agent employed by the Department of Agriculture, Food and Rural Resources;
 30. A sexual assault counselor; and
 31. A family or domestic violence victim advocate;
- B. Any person who has assumed full, intermittent or occasional responsibility for the care or custody of the child, regardless of whether the person receives compensation; and
 - C. Any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to the members of that church or religious institution, while acting in that capacity, regardless of whether the person receives compensation.

Whenever a person is required to report in a capacity as a member of the staff of a medical or public or private institution, agency or facility, that person immediately shall notify either the person in charge of the institution, agency or facility or a designated agent who then shall cause a report to be made. The staff also may make a report directly to the department.

[22 MRSA §4011-A \(1\)](#)

Required report to district attorney

When, while acting in a professional capacity, any person required to report under this section knows or has reasonable cause to suspect that a child has been abused or neglected by a person not responsible for the child, the person immediately shall report or cause a report to be made to the appropriate district attorney's office.

[22 MRSA §4011-A \(2\)](#)

Optional report

Any person may make a report if that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected.

[22 MRSA §4011-A \(3\)](#)

Mental health treatment

When a licensed mental health professional is required to report under subsection 1 and the knowledge or reasonable cause to suspect that a child has been or is likely to be abused or neglected comes from treatment of a person responsible for the abuse or neglect, the licensed mental health professional shall report to the department in accordance with subsection 1 and under the following conditions.

- A. The department shall consult with the licensed mental health professional who has made the report and shall attempt to reach agreement with the mental health professional as to how the report is to be pursued. If agreement is not reached, the licensed mental health professional may request a meeting under paragraph B.
- B. Upon the request of the licensed mental health professional who has made the report, after the department has completed its investigation of the report under section 4021 or has received a preliminary protection order under section 4034 and when the department plans to initiate or has initiated a jeopardy order under section 4035 or plans to refer or has referred the report to law enforcement officials, the department shall convene at least one meeting of the licensed mental health professional who made the report, at least one representative from the department, a licensed mental health professional with expertise in child abuse or neglect and a representative

of the district attorney's office having jurisdiction over the report, unless that office indicates that prosecution is unlikely.

- C. The persons meeting under paragraph B shall make recommendations regarding treatment and prosecution of the person responsible for the abuse or neglect. The persons making the recommendations shall take into account the nature, extent and severity of abuse or neglect, the safety of the child and the community and needs of the child and other family members for treatment of the effects of the abuse or neglect and the willingness of the person responsible for the abuse or neglect to engage in treatment. The persons making the recommendations may review or revise these recommendations at their discretion.

The intent of this subsection is to encourage offenders to seek and effectively utilize treatment and, at the same time, provide any necessary protection and treatment for the child and other family members.

[22 MRSA §4011-A \(4\)](#)

Photographs of visible trauma

Whenever a person is required to report as a staff member of a law enforcement agency or a hospital, that person shall make reasonable efforts to take, or cause to be taken, color photographs of any areas of trauma visible on a child.

- A. The taking of photographs must be done with minimal trauma to the child and in a manner consistent with professional standards. The parent's or custodian's consent to the taking of photographs is not required.
- B. Photographs must be made available to the department as soon as possible. The department shall pay the reasonable costs of the photographs from funds appropriated for child welfare services.
- C. The person shall notify the department as soon as possible if that person is unable to take, or cause to be taken, these photographs.
- D. Designated agents of the department may take photographs of any subject matter when necessary and relevant to an investigation of a report of suspected abuse or neglect or to subsequent child protection proceedings.

[22 MRSA §4011-A \(5\)](#)

Reporting procedures

Immediate report

Reports regarding abuse or neglect shall be made immediately by telephone to the department and shall be followed by a written report within 48 hours if requested by the department.

[22 MRSA §4012 \(1\)](#)

Information required

The reports shall include the following information if within the knowledge of the person reporting:

- A. The name and address of the child and the persons responsible for his care or custody;
- B. The child's age and sex;
- C. The nature and extent of abuse or neglect, including a description of injuries and any explanation given for them;
- D. A description of sexual abuse or exploitation;
- E. Family composition and evidence of prior abuse or neglect of the child or his siblings;
- F. The source of the report, the person making the report, his occupation and where he can be contacted;
- G. The actions taken by the reporting source, including a description of photographs or x rays taken; and

H. Any other information that the person making the report believes may be helpful.

[22 MRSA §4012 \(2\)](#)

Immunity from liability

Reporting and proceedings

A person, including an agent of the department, participating in good faith in reporting under this subchapter or participating in a related child protection investigation or proceeding, including, but not limited to, a multidisciplinary team, out-of-home abuse investigating team or other investigating or treatment team, is immune from any criminal or civil liability for the act of reporting or participating in the investigation or proceeding. Good faith does not include instances when a false report is made and the person knows the report is false. Nothing in this section may be construed to bar criminal or civil action regarding perjury or regarding the abuse or neglect which led to a report, investigation or proceeding.

[22 MRSA §4014 \(1\)](#)

Photographs and x rays

A person participating in good faith in taking photographs or x rays under this subchapter is immune from civil liability for invasion of privacy that might otherwise result from these actions.

[22 MRSA §4014 \(2\)](#)

Presumption of good faith

In a proceeding regarding immunity from liability, there shall be a rebuttable presumption of good faith.

[22 MRSA §4014 \(3\)](#)

Privileged or confidential communications

The husband-wife and physician and psychotherapist-patient privileges under the Maine Rules of Evidence and the confidential quality of communication under Title 16, section 53-B; Title 20-A, sections 4008 and 6001, to the extent allowed by applicable federal law; Title 24-A, section 4224; Title 32, sections 1092-A and 7005; and Title 34-B, section 1207, are abrogated in relation to required reporting, cooperating with the department or a guardian ad litem in an investigation or other child protective activity or giving evidence in a child protection proceeding. Information released to the department pursuant to this section must be kept confidential and may not be disclosed by the department except as provided in section 4008.

Statements made to a licensed mental health professional in the course of counseling, therapy or evaluation where the privilege is abrogated under this section may not be used against the client in a criminal proceeding. Nothing in this section may limit any responsibilities of the professional pursuant to this Act.

[22 MRSA §4015](#)

Discrimination

No person may be discriminated against by any employer in any way for participating in good faith in reporting under this subchapter or in a related child protection investigation or proceeding.

[22 MRSA §4017](#)

Abandoned child; safe haven provider

Definitions

- A. **Medical services provider:** means an individual certified, registered or licensed in the healing arts, including, but not limited to, a physician, nurse, podiatrist, optometrist, chiropractor, physical therapist, dentist, psychologist, physician's assistant or emergency medical services person.
- B. **Safe haven provider:** means:
 1. A law enforcement officer;

2. Staff at a medical emergency room;
3. A medical services provider; or
4. A hospital staff member at a hospital.

[22 MRSA §4018 \(1\)](#)

Request for information

A person who voluntarily delivers a child less than 31 days of age to a safe haven provider and who does not express an intent to return for the child may be requested to provide information helpful to the welfare of the child. The person who accepts a child under this section may not detain the person delivering the child to obtain information.

[22 MRSA §4018 \(2\)](#)

Action by safe haven provider; guidelines

A safe haven provider who accepts a child under this section shall promptly notify the department of the delivery of the child, transfer the child to the department at the earliest opportunity and provide to the department all information provided by the person delivering the child to the safe haven provider. The department shall establish guidelines to assist safe haven providers concerning procedures when a child is delivered to a safe haven provider under this section.

[22 MRSA §4018 \(3\)](#)

Confidentiality

All personally identifiable information provided by the person delivering the child to a safe haven provider is confidential and may not be disclosed by the safe haven provider to anyone except to the extent necessary to provide temporary custody of the child until the child is transferred to the department and except as otherwise provided by court order. All health care or other information obtained by a safe haven provider in providing temporary custody of the child may also be provided to the department upon request.

[22 MRSA §4018 \(4\)](#)

Liability

A person or entity who accepts a child under this section or provides temporary custody of a child accepted under this section is not subject to civil, criminal or administrative liability for accepting the child or providing temporary custody of the child in the good faith belief that the action is required or authorized by this section. This subsection does not affect liability for personal injury or wrongful death, including, but not limited to, injury resulting from medical malpractice.

[22 MRSA §4018 \(5\)](#)

(6) Advanced Directives (Formerly Known as Living Wills; see Power of Attorney for Healthcare)

(7) Academic Medical Centers (see Research)

(8) Advertising

AMA's Policy and Guidance on Advertising and publicity

See AMA Code of Medical Ethics and Policy Finder

<http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/policy-finder-online.shtml>

<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml>

Grounds for Discipline

The board [of licensing] may suspend or revoke a license pursuant to Title 5, section 10004. The following are grounds for an action to refuse to issue, modify, restrict, suspend, revoke or refuse to renew the license of an individual licensed under this chapter:

- A. I. Engaging in false, misleading or deceptive advertising;

[32 MRSA §3282-A \(2\)\(I\)](#)

(9) AIDS and HIV

Confidentiality of test

No person may disclose the results of an HIV test, except as follows:

- A. **Subject of test.** To the subject of the test;
- B. **Designated health care provider.** To a health care provider designated by the subject of the test in writing. When a patient has authorized disclosure of HIV test results to a person or organization providing health care, the patient's health care provider may make these results available only to other health care providers working directly with the patient and only for the purpose of providing direct medical or dental patient care. Any health care provider who discloses HIV test results in good faith pursuant to this subsection is immune from any criminal or civil liability for the act of disclosing HIV test results to other health care providers;
- C. **Authorized person.** To a person or persons to whom the test subject has authorized disclosure in writing, except that the disclosure may not be used to violate any other provisions of this chapter;
- D. **Certain health care providers.** A health care provider who procures, processes, distributes or uses a human body part donated for a purpose may, without obtaining informed consent to the testing, perform an HIV test in order to assure medical acceptability of the gift for the purpose intended. Testing pursuant to this subsection does not require pretest and post-test counseling;
- E. **Research facility.** The Department of Human Services, a laboratory certified and approved by the Department of Human Services pursuant to Title 22, chapter 411, or a health care provider, blood bank, blood center or plasma center may, for the purpose of research and without first obtaining informed consent to the testing, subject any body fluids or tissues to an HIV test if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher;
- F. **Anonymous testing sites.** To an anonymous testing site established pursuant to section 19203-B;
- G. **Other agencies.** To employees of, or other persons designated by, the Department of Corrections, the Department of Human Services and the Department of Behavioral and Developmental Services, to the extent that those employees or other persons are responsible for the treatment or care of subjects of the test. Those agencies shall adopt rules, within 90 days of August 4, 1988, pursuant to chapter 375, subchapter II, designating the persons or classes of persons to whom the test results may be disclosed. The rules of the Department of Corrections must designate those persons who may receive the results of an HIV test of a county jail inmate;
- H. **Bureau of Health.** To the Bureau of Health, which may disclose results to other persons only if that disclosure is necessary to carry out its duties as provided in Title 22, sections 3, 7 and 42 and chapters 250 and 251;

- I. **Medical records.** As part of a medical record when release or disclosure of that record is authorized pursuant to section 19203-D; or
- J. **Court ordered disclosure.**
 - 1. A person authorized by section 19203-C to receive test results following an accidental exposure; or
 - 2. A victim-witness advocate authorized by section 19203-F to receive the test results of a person convicted of a sexual crime as defined in section 19203-F, subsection 1, paragraph C, who shall disclose to a victim under section 19203-F, subsection 4.

This section does not prohibit limited administrative disclosure in conjunction with a mandatory testing program of a military organization subject to Title 37-B.

Nothing in this section may be construed as prohibiting the entry of an HIV test result on the patient's medical record in accordance with this chapter.

[5 MRSA §19203](#)

Informed consent required

Individual tested

Except as provided in this section and section 19203, subsections 4 and 5, an HIV test must be voluntary and undertaken only with a patient's knowledge and understanding that an HIV test is planned. A patient must be informed orally or in writing that an HIV test will be performed unless the patient declines. Oral or written information required to be given to a patient under this subsection must include an explanation of what an HIV infection involves and the meaning of positive and negative test results. A patient must be provided the opportunity to ask questions, either orally or in writing. Informed consent is not required for repeated HIV testing by health care providers to monitor the course of established infection.

[5 MRSA §19203-A \(1\)](#)

Insurers

Persons required to take an HIV test by an insurer, nonprofit hospital or medical service organization or nonprofit health care plan must provide their written informed consent on forms approved by the Superintendent of Insurance. If the test is positive, post-test counseling must be provided by the person or organization requesting the test. The Superintendent of Insurance may adopt rules to define language requirements of the form.

[5 MRSA §19203-A \(2\)](#)

Access to medical care

A health care provider may not deny any person medical treatment or care solely for refusal to give consent for an HIV test. A health care provider may not request a person's written consent to an HIV test as a precondition to the provision of health care. All written consent to testing shall be in accordance with section 19201, subsection 5-A. This section does not prohibit a health care provider from recommending an HIV test for diagnostic or treatment purposes. A physician or other health care provider is not civilly liable for failing to have an HIV test performed for diagnostic or treatment purposes if the test was recommended and refused in writing by the patient.

[5 MRSA §19203-A \(3\)](#)

Occupational exposure

Consent need not be obtained when a bona fide occupational exposure creates a significant risk of infection if a court order has been obtained under section 19203-C. The fact that an HIV test was given as a result of an occupational exposure and the results of that test may not appear in any records of the person whose blood or body fluid is the source of the exposure. If the test is positive, post-test counseling must be offered. The subject of the test may choose not to be informed about the result of the test.

[5 MRSA §19203-A \(4\)](#)**Occupational exposure in health care setting**

When a bona fide occupational exposure occurs in a health care setting, authorization to test the source patient for HIV must be obtained from that patient if the patient is present or can be contacted at the time of exposure and is capable of providing consent. At the time of exposure, if the source patient is not present and can not be contacted or is incapacitated, then any reasonably available member of the following classes of individuals, in descending order of priority, may authorize an HIV test on a blood or tissue sample from the source patient:

- A. The patient's legal guardian;
- B. An individual known to have power of attorney for health care for the patient;
- C. An adult relative, by blood, marriage or adoption;
- D. An adult with whom the patient has a meaningful social and emotional relationship; and
- E. A physician who is familiar with occupational exposures to HIV.

The individual authorizing the HIV test must be informed of the nature, reliability and significance of the HIV test and the confidential nature of the test.

If the person contacted for authorization refuses to authorize the test, the test may not be conducted unless consent is obtained from the source patient or from the court pursuant to section 19203-C.

This subsection does not authorize a person described in paragraphs A to D to receive the test result. Test results must be given to the exposed person, to a personal physician if designated by the exposed person and to either the physician who authorizes the test or the health care provider who manages the occupational exposure.

The patient may choose not to be informed about the result of the HIV test. Without express patient authorization, the results of the HIV test and the fact that an HIV test was done as a result of an occupational exposure in a health care setting may not appear in the patient's health care records. The exposed individual's occupational health care record may include documentation of the occupational exposure and, if the record does not reveal the source patient's identity, the results of the source patient's HIV test.

[5 MRSA §19203-A \(4-A\)](#)**Judicial consent to HIV test for occupational exposure**

Any person who experiences a bona fide occupational exposure may petition the District Court with jurisdiction over the facility or other place where the exposure occurred to require the person whose blood or body fluid is the source of the exposure to submit to an HIV test and to require that the results of the test be provided to the petitioner. For more information on this process, see [5 MRSA §19203-C](#).

Exposure from sexual crime

Consent need not be obtained when a court order has been issued under section 19203-F. The fact that an HIV test was given as a result of the exposure and the results of that test may not appear in a convicted offender's medical record. Counseling on risk reduction must be offered, but the convicted offender may choose not to be informed about the result of the test unless the court has ordered that the convicted offender be informed of the result.

[5 MRSA §19203-A \(5\)](#)**Preventing HIV Transmission from Pregnant Mother to Child**

Maine's HIV testing and consent law, was amended in 2011 to include a sixth subsection on the "protection of newborn infants." The amended section of the law requires health care providers caring for pregnant women to include HIV tests in the standard set of medical tests performed, subject to the consent

and procedure requirements of [5 MRSA §19203-A, sub-§ 1](#). That section requires that a patient must be informed orally or in writing that an HIV test will be performed, unless the patient declines.

Under the new law, health care providers caring for newborn infants are also required to test the infant for HIV and ensure that the results are available within 12 hours of birth if the health care provider does not know the HIV status of the mother or the health care provider believes that HIV testing is medically necessary. There is an exception if a parent objects to the test on the grounds that it conflicts with the sincere religious or conscientious beliefs and practices of the parent. The full text of the law is available by clicking [here](#).

Records

When a medical record entry is made concerning information of a person's HIV infection status, including the results of an HIV test, the following apply to the release of that information as a part of the medical record.

Authorized release

The person who is the subject of an HIV test, at or near the time the entry is made in the medical record, shall elect, in writing, whether to authorize the release of that portion of the medical record containing the HIV infection status information when that person's medical record has been requested. A new election may be made when a change in the person's HIV infection status occurs or whenever the person makes a new election. The release form must clearly state whether or not the person has authorized the release of that information. The person must be advised of the potential implications of authorizing the release of that information.

- A. When release has been authorized, the custodian of the medical record may release, upon request, the person's medical record, including any HIV infection status information contained in the medical record. Release of HIV infection status information pursuant to this paragraph is not a violation of any of the confidentiality provisions of this chapter.
- B. When release has not been authorized, the custodian of the medical record may, upon request, release that portion of the medical record that does not contain the HIV infection status information. Except as otherwise provided in this section, HIV infection status information may be released only if the person has specifically authorized a separate release of that information. A general release form is insufficient.

[5 MRSA §19203-D \(1\)](#)

Authorized disclosure

A medical record containing results of an HIV test may not be disclosed, discoverable or compelled to be produced in any civil, criminal, administrative or other proceedings without the consent of the person who is the subject of an HIV test, except in the following cases:

- A. Proceedings held pursuant to the communicable disease laws, Title 22, chapter 251;
- B. Proceedings held pursuant to the Adult Protective Services Act, Title 22, chapter 958-A;
- C. Proceedings held pursuant to the child protection laws, Title 22, chapter 1071;
- D. Proceedings held pursuant to the mental health laws, Title 34-B, chapter 3, subchapter IV, article III; and
- E. Pursuant to a court order upon a showing of good cause, provided that the court order limits the use and disclosure of records and provides sanctions for misuse of records or sets forth other methods for ensuring confidentiality.

[5 MRSA §19203-D \(2\)](#)

Utilization review; research

Nothing in this section may be interpreted to prohibit reviews of medical records for utilization review purposes by duly authorized utilization review committees or peer review organizations. Qualified personnel conducting scientific research, management audits, financial audits or program evaluation with the use of medical records may not identify, directly or indirectly, any individual patient in any report of such research, audit, evaluation or otherwise disclose the identities of persons tested in any manner.

[5 MRSA §19203-D \(3\)](#)

Access by health care providers

Nothing in this section may prohibit access to medical records by the designated health care provider of the person who is the subject of an HIV test in accordance with section 19203, subsection 2.

[5 MRSA §19203-D \(4\)](#)

Confidentiality policy (see also Health Insurance Portability and Accountability Act)

Health care providers and others with access to medical records containing HIV infection status information shall have a written policy providing for confidentiality of all patient information consistent with this chapter. That policy must require, at a minimum, action consistent with disciplinary procedures for violations of the confidentiality policy.

[5 MRSA §19203-D \(5\)](#)

HIV test after conviction for sexual assault**Request for testing**

A person who is the victim of a sexual crime, or that person's parent, guardian or authorized representative if that person is a minor or incapacitated adult, may petition the court at any time prior to sentencing or no later than 180 days after conviction to order the convicted offender to submit to HIV testing and to order that the convicted offender be informed of the test results.

[5 MRSA §19203-F \(2\)](#)

Reporting and counseling

The health care facility in which a convicted offender is tested pursuant to this section shall disclose the results of the test to the victim-witness advocate, who shall disclose the result to the petitioner. The health care facility shall, upon order of the court, disclose the results of the test to the convicted offender.

[5 MRSA §19203-F \(4\)](#)

Counseling new HIV cases

Except as otherwise provided by this chapter, persons who test positive for HIV infection must be offered post-test counseling. Persons who are authorized by section 19203-C or 19203-F to receive test results after exposure must be offered counseling regarding the nature, reliability and significance of the HIV test and the confidential nature of the test. Persons offered counseling under this section may decline the offer by signing a waiver stating that counseling has been offered and is being declined.

[5 MRSA §19204-A](#)

Post-test counseling

"Post-test counseling" must include:

- A. Personal counseling that includes, at a minimum, a discussion of:
 1. The test results and the reliability and significance of the test results. The person providing post-test counseling shall communicate the result confidentially and through personal contact;
 2. Information on good preventive practices and risk reduction plans; and
 3. Referrals for medical care and information and referrals for support services, including social, emotional support and legal services, as needed;

- B. An entry in the medical record of the person being counseled summarizing the contents of the discussion; and
- C. The offer of face-to-face counseling. If the subject of the test declines, the provider of the test may provide an alternative means of providing the information required by paragraph A.

[5 MRSA §19204-A \(2\)](#)

Written information to person being counseled

To comply with the requirements of this section regarding post-test counseling, in addition to meeting the requirements of subsection 2, the provider of an HIV test shall give to the person being counseled a written document containing information on the subjects described in subsection 2, paragraph A.

[5 MRSA §19204-A \(5\)](#)

Restrictions on requiring tests or results of tests

Employee testing

An employee or applicant for employment may not be required to submit to an HIV test or reveal whether the employee or applicant for employment has obtained an HIV test as a condition of employment or to maintain employment, except when based on a bona fide occupational qualification. The Maine Human Rights Commission shall enforce this subsection.

[5 MRSA §19204-B \(1\)](#)

Employee rights

The employment status of any employee may not be affected or changed:

- A. If the employee declines to be tested;
- B. If the employee testifies or assists in any proceeding under this chapter;
- C. If the employee asserts any other rights exercised in good faith pursuant to this chapter; or D. Because of the result of any test taken pursuant to this chapter.

[5 MRSA §19204-B \(2\)](#)

Restrictions upon revealing HIV antibody test results

An insurer, nonprofit hospital or medical services organization, nonprofit health care plan or health maintenance organization may not request any person to reveal whether the person has obtained a test for the presence of antibodies to HIV or a test to measure the virus or to reveal the results of such tests taken prior to an application for insurance coverage.

[5 MRSA §19204-C](#)

Civil liability

Any person violating this chapter is liable to the subject of the test for actual damages and costs plus a civil penalty of up to \$1,000 for a negligent violation and up to \$5,000 for an intentional violation, subject to Title 14, chapter 741.

Any person may bring an action for injunctive relief for a violation of sections 19203 and 19204 in addition to or instead of the penalties provided in this section. The applicant for injunctive relief under this section shall not be required to give security as a condition upon the issuance of the injunction.

[5 MRSA §19206](#)

Insurance (Special Restrictions in AIDS/HIV Cases)

Prohibitions

No individual or group hospital, medical or health care service contract delivered or issued for delivery in this State, other than a contract that provides benefits for specific diseases or accidental injuries only, may provide more restrictive coverage for Acquired Immune Deficiency Syndrome, or AIDS, AIDS Related Complex, or ARC, HIV-related diseases or for related services, than for any other disease or sickness, or

exclude coverage for AIDS, ARC or HIV-related diseases, except through an exclusion under which all diseases and sicknesses are treated equally.

[24 MRSA §2332-B \(2\)](#)

Test results

No nonprofit hospital or medical services organization or nonprofit health care plan may request any person to reveal whether the person has obtained a test for the presence of antibodies to HIV or a test to measure the virus or to reveal the results of such tests taken prior to an application for coverage.

[24 MRSA §2332-B \(3\)](#)

Expedited Partner Therapy (see Public Health)

(10) Ambulatory Surgical Facilities

Ambulatory surgical facility means a facility with a primary purpose of providing elective surgical care to a patient who is admitted to and discharged from the facility within the same day. In order to meet this primary purpose, a facility must at least administer anesthetic agents, maintain a sterile environment in a surgical suite and charge a facility fee separate from the professional fee. "Ambulatory surgical facility" does not include:

- A. A facility that is licensed as part of a hospital;
- B. A facility that provides services or accommodations for patients who stay overnight;
- C. A facility existing for the primary purpose of performing terminations of pregnancies; or
- D. The private office of a physician or dentist in individual or group practice, unless that facility or office is certified as a Medicare ambulatory surgical center.

[22 MRSA §1812-E \(1\)](#)

Standards

The Department of Health and Human Services rules governing Ambulatory Surgical Facilities can be found [here](#).

Annual inspection

The department shall inspect annually ambulatory surgical facilities, except that state inspections need not be performed during a year when a Medicare inspection is performed.

[22 MRSA §1812-E \(3\)](#)

Reimbursement

[2011 Public Law 657](#) ended MaineCare reimbursement for services provided by ambulatory surgical facilities.

(11) American Medical Association Code of Medical Ethics and Policy Finder

<http://www.ama-assn.org/ama/pub/about-ama/our-people/house-delegates/policy-finder-online.shtml>

<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml>

(12) Anatomical Gifts

Definitions

- A. **Agent**: means an individual:

1. Authorized to make health care decisions on the principal's behalf by a power of attorney for health care; or
 2. Expressly authorized to make an anatomical gift on the principal's behalf by any other record signed by the principal.
- B. **Anatomical gift:** means a donation of all or part of a human body to take effect after the donor's death for the purposes of transplantation, therapy, research or education.
- C. **Chief Medical Examiner:** means the Office of the Chief Medical Examiner within the Office of the Attorney General.
- D. **Decedent:** means a deceased individual whose body or part is or may be the source of an anatomical gift. "Decedent" includes a stillborn infant and, subject to restrictions imposed by law other than this chapter, a fetus.
- E. **Disinterested witness:** means a witness other than the spouse, registered domestic partner, child, parent, sibling, grandchild, grandparent or guardian of the individual who makes, amends, revokes or refuses to make an anatomical gift, or another adult who exhibited special care and concern for the individual and who is familiar with the individual's personal values. "Disinterested witness" does not include a person to which an anatomical gift could pass under section 2951.
- F. **Document of gift:** means a donor card, advance directive or other record used to make an anatomical gift. "Document of gift" also means inclusion in a donor registry.
- G. **Donor:** means an individual whose body or part is the subject of an anatomical gift.
- H. **Donor registry:** means the Maine Organ Donor Registry maintained under Title 29-A, section 1402-A as well as any other electronic database that identifies donors and complies with section 2958.
- I. **Driver's license:** means a license or permit issued by the Secretary of State to operate a vehicle whether or not conditions are attached to the license or permit.
- J. **Eye bank:** means a person that is licensed, accredited or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage or distribution of human eyes or portions of human eyes.
- K. **Guardian:** means a person appointed by a court to make decisions regarding the support, care, education, health and welfare of an individual. "Guardian" does not include a guardian ad litem.
- L. **Hospital:** means a facility licensed as a hospital under chapter 405 or the law of any state or a facility operated as a hospital by the United States, a state or a subdivision of a state.
- M. **Identification card:** means a nondriver identification card issued by the Secretary of State under Title 29-A, section 1410.
- N. **Know:** means to have actual knowledge.
- O. **Organ procurement organization:** means a person designated by the United States Secretary of Health and Human Services as an organ procurement organization.
- P. **Parent:** means a parent whose parental rights have not been terminated.
- Q. **Part:** means an organ, an eye or tissue of a human being. "Part" does not include the whole body.
- R. **Person:** means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, public corporation, government or governmental subdivision, agency or instrumentality or any other legal or commercial entity.
- S. **Physician:** means an individual authorized to practice medicine or osteopathy under the law of any state.

- T. **Procurement organization**: means an eye bank, organ procurement organization or tissue bank.
- U. **Prospective donor**: means an individual who is dead or near death and has been determined by a procurement organization to have a part that could be medically suitable for transplantation, therapy, research or education. “Prospective donor” does not include an individual who has made a refusal that is known by the procurement organization.
- V. **Reasonably available**: means able to be contacted by a procurement organization without undue effort and willing and able to act in a timely manner consistent with existing medical criteria necessary for the making of an anatomical gift.
- W. **Recipient**: means an individual into whose body a decedent’s part has been or is intended to be transplanted.
- X. **Record**: means information that is inscribed on a tangible medium or that is stored in an electronic or other medium and is retrievable in perceivable form.
- Y. **Recovery agency**: means an eye bank, organ procurement organization, tissue bank, educational institution or research organization that participates in or facilitates the execution of an anatomical gift.
- Z. **Refusal**: means a record created under section 2947 that expressly states an intent to bar other persons from making an anatomical gift of an individual’s body or part.
- AA. **Registered domestic partner**: means an individual registered as a domestic partner under section 2710, subsection 3.
- BB. **Sign**: means, with the present intent to authenticate or adopt a record:
1. To execute or adopt a tangible symbol; or
 2. To attach or logically associate with the record an electronic symbol, sound or process.
- CC. **State**: means a state of the United States, the District of Columbia, Puerto Rico, the United States Virgin Islands or any territory or insular possession subject to the jurisdiction of the United States.
- DD. **Technician**: means an individual determined to be qualified to remove or process parts by an appropriate organization that is licensed, accredited or regulated under federal or state law. “Technician” includes an enucleator.
- EE. **Tissue**: means a portion of the human body other than an organ or an eye. “Tissue” does not include blood unless the blood is donated for purposes of research or education.
- FF. **Tissue bank**: means a person that is licensed, accredited or regulated under federal or state law to engage in the recovery, screening, testing, processing, storage or distribution of tissue.
- GG. **Transplant hospital**: means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients.

[22 MRSA §2942](#)

Applicability

This chapter applies to an anatomical gift or amendment to, revocation of or refusal to make an anatomical gift, whenever made.

[22 MRSA §2943](#)

Who may make anatomic gift before donor’s death

Subject to section 2948, an anatomical gift of a donor’s body or part may be made during the life of the donor for the purpose of transplantation, therapy, research or education in the manner provided in section 2945 by:

[22 MRSA §2944](#)

Donor

The donor, if the donor is at least 18 years of age or is under 18 years of age and is:

- A. An emancipated minor; or
- B. Authorized under state law to apply for a driver's license because the donor is at least 16 years of age;

[22 MRSA §2944 \(1\)](#)

Agent of donor

An agent of the donor, unless the power of attorney for health care or other record prohibits the agent from making an anatomical gift;

[22 MRSA §2944 \(2\)](#)

Parent of the donor

A parent of the donor, if the donor is under 18 years of age and not emancipated; or

[22 MRSA §2944 \(3\)](#)

Guardian of donor

The donor's guardian.

[22 MRSA §2944 \(4\)](#)

Manner of making anatomical gift before donor's death**Donor**

A donor may make an anatomical gift:

- A. By authorizing inclusion in the donor registry;
- B. In a will; or
- C. During a terminal illness or injury of the donor, by any form of communication addressed to at least 2 other individuals who are at least 18 years of age one of whom is a disinterested witness.

[22 MRSA §2945 \(1\)](#)

Donor or other authorized person

A donor or other person authorized to make an anatomical gift under section 2944 may make a gift by a donor card, advance directive or other record signed by the donor or other person making the gift authorizing inclusion in the donor registry. If the donor or other person is physically unable to sign the record, the record may be signed by another individual at the direction of the donor or the other person must:

- A. Be witnessed by at least 2 other individuals who are at least 18 years of age, one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and
- B. State that it has been signed and witnessed as provided in paragraph A.

[22 MRSA §2945 \(2\)](#)

Anatomical gift not invalidated

Revocation, suspension, expiration or cancellation of the driver's license or identification card issued to a donor does not invalidate an anatomical gift.

[22 MRSA §2945 \(3\)](#)

Anatomical gift by will

An anatomical gift made by will takes effect upon the donor's death whether or not the will is probated. Invalidation of the will after the donor's death does not invalidate the gift.

[22 MRSA §2945 \(4\)](#)

Amending or revoking anatomical gift before donor's death

Donor or authorized person

Subject to section 2948, a donor or other person authorized to make an anatomical gift under section 2944 may amend or revoke an anatomical gift by:

- A. A record signed by:
 - 1. The donor;
 - 2. The other person; or
 - 3. Subject to subsection 2, another individual acting at the direction of the donor or the other person if the donor or other person is physically unable to sign; or
- B. A later-executed document of gift that amends or revokes a previous anatomical gift or portion of an anatomical gift either expressly or by inconsistency.

[22 MRSA §2946 \(1\)](#)

Individual acting at donor's or authorized person's direction

A record signed pursuant to subsection 1, paragraph A, subparagraph (3) must:

- A. Be witnessed by at least 2 other individuals who are at least 18 years of age, one of whom is a disinterested witness, who have signed at the request of the donor or the other person; and
- B. State that it has been signed and witnessed as provided in paragraph A.

[22 MRSA §2946 \(2\)](#)

Revocation by destruction or cancellation of document

Subject to section 2948, a donor or other person authorized to make an anatomical gift under section 2944 may revoke the gift by the destruction or cancellation of the document of gift, or a portion of the document of gift used to make the gift, with the intent to revoke the gift.

[22 MRSA §2946 \(3\)](#)

Amendment or revocation by donor during terminal illness or injury

A donor may amend or revoke an anatomical gift that was not made in a will by any form of communication during a terminal illness or injury addressed to at least 2 other individuals who are at least 18 years of age, one of whom is a disinterested witness.

[22 MRSA §2946 \(4\)](#)

Amendment or revocation of gift in will

A donor who makes an anatomical gift in a will may amend or revoke the gift in the manner provided for amendment or revocation of wills or as provided in subsection 1.

[22 MRSA §2946 \(5\)](#)

Refusal to make anatomical gift and effect of refusal

Refusal of individual

An individual may refuse to make an anatomical gift of the individual's body or part by:

- A. A record signed by:
 - 1. The individual; or
 - 2. Subject to subsection 2, another individual acting at the direction of the individual if the individual is physically unable to sign;
- B. The individual's will whether or not the will is admitted to probate or invalidated after the individual's death; or

- C. Any form of communication made by the individual during the individual's terminal illness or injury addressed to at least 2 other individuals who are at least 18 years of age, one of whom is a disinterested witness.

[22 MRSA §2947 \(1\)](#)

Individual acting at direction of individual

A record signed pursuant to subsection 1, paragraph A, subparagraph (2) must:

- A. Be witnessed by at least 2 other individuals who are at least 18 years of age, one of whom is a disinterested witness, who have signed at the request of the individual; and
- B. State that it has been signed and witnessed as provided in paragraph A.

[22 MRSA §2947 \(2\)](#)

Amendment or revocation by individual

An individual may amend or revoke a refusal:

- A. In the manner provided in subsection 1 for making a refusal;
- B. By subsequently making an anatomical gift pursuant to section 2945 that is inconsistent with the refusal; or
- C. By the destruction or cancellation of the record evidencing the refusal, or the portion of the record used to make the refusal, with the intent to revoke the refusal.

[22 MRSA §2947 \(3\)](#)

Effect of unrevoked refusal

Except as otherwise provided in section 2948, subsection 7, in the absence of an express, contrary indication by the individual set forth in the refusal, an individual's unrevoked refusal to make an anatomical gift of the individual's body or a part bars all other persons from making an anatomical gift of the individual's body or the part.

[22 MRSA §2947 \(4\)](#)

Preclusive effect of anatomical gift, amendment or revocation

Person other than donor barred

Except as otherwise provided in subsection 7, in the absence of an express, contrary indication by the donor, a person other than the donor is barred from making, amending or revoking an anatomical gift of a donor's body or a part if the donor made an anatomical gift of the donor's body or part under section 2945 or an amendment to an anatomical gift of the donor's body or the part under section 2946.

[22 MRSA §2948 \(1\)](#)

Revocation not refusal

A donor's revocation of an anatomical gift of the donor's body or a part under section 2946 is not a refusal and does not bar another person specified in section 2944 or 2949 from making an anatomical gift of the donor's body or a part under section 2945 or 2950.

[22 MRSA §2948 \(2\)](#)

Effect of gift or amendment by person other than donor

If a person other than the donor makes an unrevoked anatomical gift of the donor's body or a part under section 2945 or an amendment to an anatomical gift of the donor's body or a part under section 2946, another person may not make, amend or revoke the gift of the donor's body or part under section 2950.

[22 MRSA §2948 \(3\)](#)

Effect of revocation by person other than donor

A revocation of an anatomical gift of the donor's body or a part under section 2946 by a person other than the donor does not bar another person from making an anatomical gift of the body or a part under section 2945 or 2950.

[22 MRSA §2948 \(4\)](#)

Effect of gift of a part or for a purpose

In the absence of an express, contrary indication by the donor or other person authorized to make an anatomical gift under section 2944:

- A. An anatomical gift of a part is neither a refusal to give another part nor a limitation on the making of an anatomical gift of another part at a later time by the donor or another person under section 2945 or 2950; and
- B. An anatomical gift of a part for one or more of the purposes set forth in section 2944 is not a limitation on the making of an anatomical gift of the part for any of the other purposes by the donor or any other person under section 2945 or 2950.

[22 MRSA §2948 \(5\)](#)

Donor unemancipated minor

If a donor who is an unemancipated minor dies under 18 years of age, a parent of the donor who is reasonably available may revoke or amend an anatomical gift of the donor's body or part.

[22 MRSA §2948 \(6\)](#)

Parent's revocation of unemancipated minor's refusal

If an unemancipated minor who signed a refusal dies under 18 years of age, a parent of the individual who is reasonably available may revoke the individual's refusal.

[22 MRSA §2948 \(7\)](#)

Who may make anatomic gift of decedent's body or part**Gift by members of class; priority**

Subject to subsections 2 and 3 and unless barred by subsection 4, an anatomical gift of a decedent's body or part for purposes of transplantation, therapy, research or education may be made, in the order of priority listed, by any member of the following classes of persons who is reasonably available:

- A. An agent of the decedent at the time of death who could have made an anatomical gift under section 2944, subsection 2 immediately before the decedent's death;
- B. The spouse of the decedent;
- C. The registered domestic partner of the decedent;
- D. Adult children of the decedent;
- E. Parents of the decedent;
- F. Adult siblings of the decedent;
- G. Adult grandchildren of the decedent;
- H. Grandparents of the decedent;
- I. An adult who exhibited special care and concern for the decedent who is familiar with the decedent's personal values;
- J. The person or persons acting as the guardian of the person of the decedent at the time of death; and
- K. Any other person having the authority to dispose of the decedent's body.

[22 MRSA §2949 \(1\)](#)

Anatomical gift by member of class unless object

If there is more than one member of a class listed in subsection 1, paragraph A, D, E, F, G, H or J entitled to make an anatomical gift, an anatomical gift may be made by a member of the class unless that member or person to which the gift can pass under section 2951 knows of an objection by another member of the class. If an objection is known, the gift may be made only by a majority of the members of the class who are reasonably available.

[22 MRSA §2949 \(2\)](#)

Member of prior class reasonably available

No person may make an anatomical gift if, at the time of the decedent's death, a person in a prior class under subsection 1 is reasonably available to make or to object to the making of an anatomical gift.

[22 MRSA §2949 \(3\)](#)

Gift barred

An anatomical gift may not be made if doing so is barred by section 2947 or 2948.

[22 MRSA §2949 \(4\)](#)

Manner of making, amending or revoking anatomical gift of decedent's body or part**Authorized person: document; oral communication**

A person authorized to make an anatomical gift under section 2949 may make an anatomical gift by a document of gift signed by the person making the gift or that person's oral communication that is electronically recorded or is contemporaneously reduced to a record and signed by the individual receiving the oral communication.

[22 MRSA §2950 \(1\)](#)

Amendment or revocation by prior class member

Subject to subsection 3, an anatomical gift by a person authorized under section 2949 may be amended or revoked orally or in a record by any member of a prior class who is reasonably available. If more than one member of the prior class is reasonably available, the gift may be amended or revoked only if a majority of the reasonably available members object to the amending or revoking of the gift or they are equally divided as to whether to amend or revoke an anatomical gift.

[22 MRSA §2950 \(2\)](#)

Revocation effective if known

A revocation under subsection 2 is effective only if the procurement organization or transplant hospital or the physician or technician knows of the revocation before an incision has been made to remove a part from the donor's body or before invasive procedures have begun to prepare the recipient.

[22 MRSA §2950 \(3\)](#)

Request consent

Consent for an anatomical gift by a recovery agency under section 2949 must be documented in writing or, if secured in a telephone conversation, in a suitable recording, must disclose in plain language the specific tissue, organ or body part being donated and the purpose for which the anatomical gift will be used and must comply in all respects with rules regarding consent requirements for anatomical gifting adopted by the department pursuant to subsection 5.

[22 MRSA §2950 \(4\)](#)

Rulemaking

The department, after consultation with the Office of the Attorney General, shall adopt rules to implement this section. The rules must provide specific requirements for all recovery agencies, require federally recognized recovery agencies to demonstrate compliance with applicable federal standards governing consent to anatomical gifts and require all other recovery agencies that do not operate under federal

regulation to demonstrate adherence to the consent requirements of this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

[22 MRSA §2950 \(5\)](#)

Persons that may receive anatomical gift; purpose of anatomical gift

Named recipient

An anatomical gift of a body or part may be made to the following persons:

- A. A named hospital, accredited medical school, dental school, college, university or organ procurement organization or other appropriate person for research or education;
- B. A named individual designated by the person making the anatomical gift if the individual is the recipient of the part; or, if the part for any reason cannot be transplanted into the individual, the part passes in accordance with subsection 6 in the absence of an express, contrary indication by the person making the anatomical gift; or
- C. A named eye bank or tissue bank.

[22 MRSA §2951 \(1\)](#)

Named purpose

If an anatomical gift of one or more specific parts or of all parts is made in a document of gift that does not name a person described in subsection 1 but identifies the purpose for which an anatomical gift may be used, the following rules apply.

- A. If the part is an eye and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate eye bank.
- B. If the part is tissue and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate tissue bank.
- C. If the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ.
- D. If the part is an organ, an eye or tissue and the gift is for the purpose of research or education, the gift passes to the appropriate procurement organization.

[22 MRSA §2951 \(2\)](#)

Priority of purposes

For the purpose of subsection 2, if there is more than one purpose of an anatomical gift set forth in the document of gift but the purposes are not set forth in any priority, the gift must be used for transplantation or therapy if suitable for those purposes and, if the gift cannot be used for transplantation or therapy, the gift may be used for research or education.

[22 MRSA §2951 \(3\)](#)

No named recipient or purpose

If the anatomical gift of one or more specific parts is made in a document of gift that does not name a person described in subsection 1 and does not identify the purpose of the gift, the gift passes in accordance with subsection 6 and the decedent's parts must be used for transplantation or therapy, if suitable, and, if not suitable, the gift may be used for research or education.

[22 MRSA §2951 \(4\)](#)

General intent

If a document of gift specifies only a general intent to make an anatomical gift by words such as "donor," "organ donor" or "body donor" or by a symbol or statement of similar import, the gift passes in accordance with subsection 6 and the decedent's parts must be used for transplantation or therapy, if suitable, and, if not suitable, the gift may be used for research or education.

[22 MRSA §2951 \(5\)](#)

Rules of passing anatomical gifts

For purposes of subsection 1, paragraph B and subsections 3, 4 and 5, the following rules apply.

- A. If the part is an eye, the gift passes to the appropriate eye bank.
- B. If the part is tissue, the gift passes to the appropriate tissue bank.
- C. If the part is an organ, the gift passes to the appropriate organ procurement organization as custodian of the organ.

[22 MRSA §2951 \(6\)](#)

Passing of organ for transplantation or therapy

An anatomical gift of an organ for transplantation or therapy, other than an anatomical gift under subsection 1, paragraph B, passes to the organ procurement organization as custodian of the organ.

[22 MRSA §2951 \(7\)](#)

Custody of body or part if not passed or used

If an anatomical gift does not pass pursuant to subsections 1 to 7 or the decedent's body or part is not used for transplantation, therapy, research or education, custody of the body or part passes to the person under obligation to dispose of the body or part.

[22 MRSA §2951 \(8\)](#)

Acceptance of gift prohibited

A person may not accept an anatomical gift if the person knows that the gift was not effectively made under section 2945 or 2950 or if the person knows that the decedent made a refusal under section 2947 that was not revoked. For purposes of this subsection if a person knows that an anatomical gift was made on a document of gift, the person is deemed to know of any amendment or revocation of the gift or any refusal to make an anatomical gift on the same document of gift.

[22 MRSA §2951 \(9\)](#)

Allocation of organs for transplant or therapy

Except as otherwise provided in subsection 1, paragraph B, nothing in this chapter affects the allocation of organs for transplantation or therapy.

[22 MRSA §2951 \(10\)](#)

For more on Anatomical Gifts see [Public Law, Chapter 601](#).

(13) Antitrust**Statements of Antitrust Enforcement Policy in Health Care**

See [Federal Anti-Trust Guidelines in Health Care](#)

Health Care Practitioner Self-referral Act**Applicability**

This chapter applies to referrals for health services made on or after January 1, 1994. However, if a health care practitioner acquired an investment interest in a facility before January 1, 1993, this chapter does not apply to referrals by that health care practitioner to that facility before January 1, 1997.

[22 MRSA §2083](#)

Definitions

- A. **Bureau:** means the Bureau of Insurance.
- B. **Facility:** means any sole proprietorship, partnership, firm, corporation or other business that provides health services.

- C. **Group practice:** means a group of 2 or more health care practitioners legally organized as a partnership, professional corporation, nonprofit corporation or similar association in which:
1. Each health care practitioner who is a member, an employee or an independent contractor of the group provides substantially the full range of services that the health care practitioner routinely provides, including consultation, diagnosis or treatment, through the use of office space, facilities, equipment or personnel of the group;
 2. The services of the health care practitioners are provided through the group and payments received for health services are treated as receipts of the group; and
 3. The overhead expenses and the income from the practice are distributed by methods previously determined by the group.
- D. **Health care practitioner:** means an individual regulated under the laws of this State to provide health services. "Health care practitioners" include, without limitation, acupuncturists, chiropractors, dentists, dental hygienists, nurses, occupational therapists, optometrists, pharmacists, physical therapists, physicians including allopathic and osteopathic physicians, physician assistants, podiatrists, psychologists, clinical social workers, speech therapists and audiologists or hearing aid dealers and examiners.
- E. **Health services:** means diagnosis, treatment and rehabilitative services for an injured, disabled or sick person.
- F. **Immediate family member:** means a health care practitioner's parent, spouse, child or child's spouse.
- G. **Investment interest:** means an equity or debt security issued by a facility, including, without limitation, shares of stock in a corporation, units or other interests in a partnership, bonds, debentures, notes or other equity interests or debt instruments, except that investment interest does not include interest in a hospital licensed under state law.
- H. **Investor:** means an individual who owns, whose immediate family owns or who directly or indirectly owns a controlling interest in another facility that owns an investment interest in a facility that provides health services.
- I. **Office practice:** includes the facility or facilities at which a health care practitioner, on a regular basis, provides or supervises the provision of professional health services to individuals.
- J. **Referral:** means a referral of a patient for health services, including, without limitation:
1. The forwarding of a patient by one health care practitioner to another health care practitioner or a facility outside the health care practitioner's office practice or group practice that provides health services; or
 2. The establishment by a health care practitioner of a plan of care outside the health care practitioner's office practice or group practice that includes the provision of any health services.

[22 MRSA §2084](#)

Prohibited referrals

A health care practitioner may refer a patient to an outside facility in which that health care practitioner is an investor only when that health care practitioner directly provides health services within the facility and will be personally involved with the provision of care to the referred patient.

[22 MRSA §2085 \(1\)](#)

Exemption

Referrals by a health care practitioner are exempt from this chapter if the bureau determines that there is demonstrated need in the community for the facility and alternative financing is not available. A health care practitioner does not have to demonstrate a need for alternative financing if the practitioner has

sufficient financial resources in the provider's practice without seeking financing from outside sources other than conventional bank loans. Demonstrated need in the community for the facility exists when:

- A. There is no facility of reasonable quality that provides an appropriate service, or the bureau determines that the quality of health care services would be improved in the community, such as by providing new specialty or subspecialty services without increasing overall health care costs and utilization above levels likely to occur if such an exemption were not granted;
- B. Use of existing facilities is onerous or creates too great a hardship for patients;
- C. The facility is formed to own or lease medical equipment that replaces obsolete or otherwise inadequate equipment in or under the control of a hospital located in a federally designated health manpower shortage area; or
- D. The facility meets other standards established by rule by the bureau, including a standard allowing the bureau to determine whether the fees charged for the health services are competitive with fees charged for those services outside the community. "Community" must be defined by rule by the bureau. The following requirements must be met to be exempt under this section.
 1. Individuals who are not in a position to refer patients to a facility must be given a bona fide opportunity to invest in that facility on the same terms as those offered a referring health care practitioner.
 2. A health care practitioner who invests may not be required or encouraged to make referrals to the facility or otherwise generate business as a condition of becoming or remaining an investor.
 3. The facility shall market or furnish its services to investors who are referring health care practitioners and to other investors on equal terms.
 4. The facility may not loan funds or guarantee loans for health care practitioners who are in a position to refer patients to that facility.
 5. The income on the health care practitioner's investment must be tied to the health care practitioner's equity in the facility rather than to the volume of referrals made.
 6. An investment contract between the facility and the health care practitioner may not include a covenant or noncompetition clause that prevents a health care practitioner from investing in other facilities.
 7. When making a referral, a health care practitioner shall disclose to the patient being referred to the facility that health care practitioner's investment interest in that facility. If alternative facilities are reasonably available, the health care practitioner shall provide the patient with a list of alternative facilities. The health care practitioner shall inform the patient that the patient has the option to use an alternative facility and the patient will not be treated differently by the health care practitioner if the patient chooses to use another facility. This subparagraph applies to all investors who are health care practitioners, including those who provide direct care or services for their patients in facilities outside their office practice.
 8. If a 3rd-party payor requests information regarding a health care practitioner's investment interest, that information must be disclosed.
 9. The facility shall establish an internal utilization review program.
 10. If a health care practitioner's financial interest in a facility is incompatible with a referred patient's interest, the health care practitioner shall make alternative arrangements for that patient's care.

The bureau shall make its determination on a request for an exemption within 90 days of a completed written request.

[22 MRSA §2085 \(2\)](#)

Exception

It is not a violation of this chapter for a health care practitioner to refer a patient to a publicly traded facility in which that health care practitioner has an investment interest when:

- A. The facility is listed for trading on the New York Stock Exchange or on the American Stock Exchange or is a national market system security traded under an automated interdealer quotation system operated by the National Association of Securities Dealers;
- B. The facility, at the end of its most recent fiscal year, had total net assets of at least \$50,000,000 related to the furnishing of health services;
- C. Investment interest obtained after the effective date of this chapter is traded on the exchanges listed in paragraph A;
- D. The facility markets or furnishes its services to investors who are referring health care practitioners and to other health care practitioners on equal terms;
- E. All stock held in that facility, including stock held in the predecessor privately held facility, is of one class without preferential treatment as to status or remuneration;
- F. The facility does not loan funds or guarantee loans for health care practitioners who are in a position to make referrals to a facility;
- G. The income on the health care practitioner's investment is tied to the health care practitioner's equity in the facility rather than to the volume of referrals made; and
- H. The investment interest does not exceed 1/2 of 1% of the facility's total equity.

[22 MRSA §2085 \(3\)](#)

Compelling practitioner

A health care practitioner may not compel or coerce, or attempt to compel or coerce, any other health care practitioner to violate any provision of this chapter.

[22 MRSA §2085 \(4\)](#)

Third-party referrals

A health care practitioner may not participate in any arrangement or plan that is designed to evade the prohibitions in this chapter by using a 3rd party to redirect referrals that are prohibited under subsection 1 if the 3rd party was not involved in the referral.

[22 MRSA §2085 \(5\)](#)

Alternate facilities

If compliance with the community need and alternative financing criteria is not practical, the health care practitioner shall identify to the patient reasonably available alternative facilities. The bureau, by rule, shall designate when compliance is not practical.

[22 MRSA §2085 \(6\)](#)

Bureau opinion

Health care practitioners may request that the bureau render an advisory opinion as to whether a referral to an existing or proposed facility under specified circumstances violates the provision of this chapter. The bureau's opinion is presumptively correct as to whether the provisions of this chapter are violated.

[22 MRSA §2085 \(7\)](#)

Health organizations

Notwithstanding any provision of this chapter, a health care practitioner may refer a patient who is a member of a health maintenance organization or a preferred provider organization licensed in this State for health services to a facility outside that health care practitioner's office or group practice in which that health care practitioner is an investor when the referral is made pursuant to a contract with the organization.

[22 MRSA §2085 \(8\)](#)**Penalties**

A facility or a health care practitioner that makes or causes to be made a referral prohibited under section 2085 or presents or causes to be presented a bill or claim for service that the facility or health care practitioner knows or should know is prohibited by section 2085 is subject to a civil penalty of no more than \$2,000 for each referral, bill or claim.

A violation of this chapter by a health care practitioner or a facility constitutes grounds for disciplinary action by the applicable licensing body.

[22 MRSA §2086](#)**(14) Audits Conducted by DHHS; Guidelines and Criteria****Auditing and adjusting of health and community service provider costs**

This section governs the rules of the department and the practices of its auditors in interpreting and applying those rules with respect to payments of providers under the MaineCare program and payments by the department under grants and agreements audited pursuant to the Maine Uniform Accounting and Auditing Practices Act for Community Agencies.

Revised audit interpretations to be applied prospectively

Whenever the department's auditors revise an interpretation of a rule, agreement, circular or guideline in a manner that results in a negative adjustment of a provider's or agency's allowable costs, the revised interpretation may be applied only to provider or agency fiscal years beginning after the date of the examination report, audit report, or other written notification in which the provider or agency receives direct notice of the revised interpretation. For the fiscal year to which the report containing the revised interpretation applies, and any subsequent fiscal year ending prior to the issuance of the revised interpretation, the cost that is the subject of the revised interpretation must be considered allowable to the extent that it was allowable under the interpretation previously applied by the Office of Audit for MaineCare and Social Services, referred to in this section as "the office of audit." This subsection does not prohibit the office of audit from applying an adjustment to a fiscal year solely because that cost was not disallowed in a prior year.

[22 MRSA §41-B \(1\)](#)**Determination of "ordinary," "necessary" or "reasonable" costs**

In making findings concerning whether costs are "ordinary," "necessary" or "reasonable," the office of audit shall consider the following criteria in conjunction with applicable state and federal rules, regulations, guidelines and agreements:

- A. Whether a substantial number of providers of health care or community services in Maine incur costs of similar magnitude, frequency, quantity or price level to the costs under review.
- B. Whether the expenditure is reasonably incurred to produce, accomplish, facilitate or compensate persons for providing an item or service related to the purpose of a program or activity for which the State has contracted or for which the State otherwise provides payment.
- C. Whether the expenditure is comparable to one incurred by a department or agency of the State responsible for services or programs similar to those to which the finding applies.
- D. Whether the expenditure is consistent with meeting special needs of the population served through innovative or specialized services offered by a particular provider.

[22 MRSA §41-B \(2\)](#)

Employee compensation and benefit costs

In evaluating the reasonableness and allowability of employee wages, salaries and benefits, the department may not disallow the costs of any employee benefits, wages or salaries if the total of those costs is reasonable under the criteria set forth in subsection 2.

[22 MRSA §41-B \(3\)](#)

Special Notes

The department has made available the decisions in all MaineCare provider appeals, including the recommendations of the hearing officer and the decision of the Commissioner, at the following public website: <http://www.maine.gov/dhhs/hearings/appeals.htm>.

MaineCare program integrity recovery audit contractor agreement

As of 2012, MaineCare has been authorized to enter into an agreement with a recovery audit contractor for the purpose of ensuring MaineCare program integrity, specifically to identify and reimburse to correct underpayments and to identify and recoup overpayments under the Medicaid state plan and under any waiver of the state plan. An agreement entered into under this section must provide that payment to the contractor may be made only from amounts recovered and that payments for identifying underpayments and collecting overpayments must be made on a contingent fee basis. After payments to correct underpayments and payment of any contingent fees due to the contractor, the proceeds of collections from overpayments must be deposited into the Medical Care - Payments to Providers program, Other Special Revenue Funds account in the Department of Health and Human Services for the purpose of providing state match under the federal Medicaid program.

[22 MRSA § 13-A](#)

Credible allegations of fraud; provider payment suspensions

If the department determines that there is a credible allegation of fraud by a provider under the MaineCare program, the following procedures apply.

Suspension of payments. The department shall suspend payment in whole or in part to a MaineCare provider when a suspension is necessary to comply with Section 6402(h)(2) of the federal Patient Protection and Affordable Care Act of 2010, Public Law 111-148 and 42 Code of Federal Regulations, Part 455.

[22 MRSA § 1714-E](#)

(15) Automated External Defibrillators (AED)

Definitions

- A. **Automated external defibrillator or "AED"**: means a medical device approved by the United States Food and Drug Administration that:
1. Is capable of recognizing the presence or absence of ventricular fibrillation or rapid ventricular tachycardia;
 2. Is capable of determining, without intervention by an operator, whether defibrillation should be performed on an individual;
 3. Upon determination that defibrillation should be performed, automatically charges and requests delivery of an electrical impulse to an individual's heart; and

[22 MRSA §2150-C \(1\)](#)

Immunity

The following persons and entities are immune from civil liability for damages relating to the use, possession or purchase of an AED and arising out of acts or omissions relating to preparing for and

responding to suspected sudden cardiac arrest emergencies absent gross negligence or willful or wanton misconduct:

- A. Any person or entity that acquires an AED.
- B. Any person or entity that owns, manages or is otherwise responsible for the premises on which an AED is located;
- C. Any person who retrieves an AED in response to a perceived sudden cardiac arrest emergency;
- D. Any person who uses, attempts to use or fails to use an AED in response to a perceived sudden cardiac arrest emergency;
- E. Any physician or other authorized person who issues a prescription for the purchase of an AED;
- F. Any person or entity that is involved with the design, management or operation of an AED program; and
- G. Any person or entity that provides instruction in the use of an AED.

[22 MRSA §2150-C \(6\)](#)

(16) Autopsies

No embalming when autopsy authorized

The next of kin or legal representative of a person who has died may authorize an autopsy. If an autopsy is authorized, no person shall inject into or remove from any artery, vein, or cavity of the body of the person who has died any fluid, gas or other substance except by or with the permission of a pathologist, medical examiner or licensed physician in attendance.

On completion of the autopsy, the body shall be released for normal handling.

The provisions of this section do not apply to deaths within the jurisdiction of medical examiners or autopsies as authorized in Title 22, chapter 711.

A violation of this section is a Class E crime.

[32 MRSA §1404-A](#)

(17) Births

Registration of live births

A certificate of each live birth that occurs in this State must be filed with the clerk of the municipality in which the live birth occurred or with the state registrar within a reasonable period of time as specified by the department and must be registered if the certificate has been completed and filed in accordance with this section.

[22 MRSA §2761](#)

Certificate from hospital

When the live birth occurs in a hospital or an institution, or en route to the hospital or institution, the person in charge of the institution or the person's authorized designee shall obtain the personal data, prepare the certificate, certify by signature or by electronic process that the child was born alive at the place and time and on the date stated and file the certificate as directed in this section. The physician or other person in attendance shall provide the medical information required by the certificate in a timely fashion, in accordance with department rule.

[22 MRSA §2761 \(1\)](#)

Birth outside an institution

When a birth occurs outside an institution, the certificate must be prepared and filed by one of the following in the indicated order of priority:

- A. The physician or other person in attendance at or immediately after the birth;
- B. The father;
- C. The mother; or
- D. The person in charge of the premises where the live birth occurred.

[22 MRSA §2761 \(3\)](#)

For additional information regarding the content and processing of a birth certificate see [22 MRSA §2761](#).

Hospital-based paternity acknowledgement**Definitions**

Birthing center: As used in this section, "birthing center" means a hospital or other facility that provides childbirth services.

[22 MRSA §2761-B \(1\)](#)

Procedure

A birthing center shall provide an opportunity for all unmarried parents to complete a voluntary acknowledgement of paternity. A birthing center shall provide to each unmarried mother and alleged father, if present, written information about paternity establishment provided by the department, forms needed to voluntarily acknowledge paternity and the opportunity to speak with a person who is trained to clarify information and answer questions about paternity establishment. The birthing center shall forward all completed acknowledgement forms to the department.

[22 MRSA §2761-B \(2\)](#)

Birth certificates of foundlings; report

Whoever assumes the custody of a child of unknown parentage shall immediately report to the local town or city clerk in writing:

- A. Date and place of finding. The date and place of finding or assumption of custody;
- B. Sex, color, age. Sex; color or race; and approximate age of child;
- C. Name and address of custodian. Name and address of the person or institution with whom the child has been placed for care;
- D. Name. Name given to the child by the finder or custodian.

The place where the child was found or custody assumed shall be known as the place of birth and the date of birth shall be determined by approximation. The report shall constitute the certificate of birth. If the child is thereafter identified, the record of birth made in compliance herewith and any certificate issued thereon shall be null and void and so recorded.

[22 MRSA §2763](#)

Delayed birth registration

For information on delayed birth registration see [22 MRSA §2764](#).

Care of infants after birth

Every physician, midwife or nurse in charge shall instill or cause to be instilled into the eyes of an infant upon its birth one or 2 drops of a prophylactic solution prescribed by the department and provided without cost by the department, except an infant whose parents object to this procedure on the grounds that it conflicts with their religious tenets and practices. If one or both eyes of an infant become reddened or inflamed at any time within 4 weeks after birth, the midwife, nurse or person having charge of the infant shall report the condition of the eyes at once to a physician licensed under Title 32, chapter 36 or 48. Failure to comply with this section shall be punishable by a fine of not more than \$100 or by imprisonment for not more than 6 months.

[22 MRSA §1531](#)

Detection of serious conditions

The department shall require hospitals, birthing centers and other birthing services to test newborn infants, or to cause them to be tested, by means of blood spot screening for the presence of treatable congenital, genetic or metabolic conditions that may be expected to result in subsequent cognitive disabilities, serious illness or death...The requirement in this section that a newborn infant be tested for the presence of treatable congenital, genetic or metabolic conditions that may be expected to result in subsequent cognitive disability does not apply to a child if the parents of that child object on the grounds that the test conflicts with their religious tenets and practices.

[22 MRSA §1532](#)

Newborn Hearing Program, Program requirements

Definitions

- A. **Birth admission:** means the time after birth that the newborn remains in the hospital nursery prior to discharge.
- B. **Board:** means the Newborn Hearing Screening Advisory Board.
- C. **Hearing loss:** means a hearing loss of 30 decibels or more in the frequency region important for speech recognition and comprehension in one or both ears. The department may adopt rules to decrease the amount of decibels of hearing loss as technology allows for detection of hearing loss of 15 to 25 decibels in one or both ears.
- D. **Intervention or treatment:** means the early intervention services described in the federal Individuals with Disabilities Education Act, 20 United States Code, Chapter 33, Subchapter III, Sections 1431 to 1445, as amended. "Intervention" or "treatment" includes, but is not limited to, audiological, medical or early educational services that provide a choice of methods of communication in a variety of sensory modalities.
- E. **Parent:** means a natural parent, stepparent, adoptive parent, legal guardian or other legal custodian of a child.
- F. **Person who is culturally deaf:** means a person with permanent hearing loss who identifies as a member of the deaf community and who utilizes American Sign Language as the primary mode of communication.
- G. **Person who is hard-of-hearing or person who is deaf:** means a person with permanent hearing loss who communicates using aural or oral skills for accessing spoken language.

[22 MRSA §8822 \(1\)](#)

Information to parents of children born in hospitals

Beginning November 1, 2000, a hospital shall provide information to the parents of children born in the hospital regarding the importance of screening the hearing of newborns and of receiving follow-up care.

The information must explain the process of hearing screening, the likelihood of a child having a hearing loss, follow-up procedures and community resources and must include a description of the normal auditory, speech and language development process in children. The hospital must provide information about hearing screening that may be provided at the hospital or coordinated, scheduled or arranged for by the hospital. The program must provide this information prior to discharge from the birth admission to the hospital or within 3 months of discharge.

[22 MRSA §8822 \(2\)](#)

Information to parents of children born outside of hospitals

By November 1, 2002, when a newborn is delivered in a facility other than a hospital, the department shall provide information to the parents on the merits of having the hearing screening performed and on the availability of the hearing screening within 3 months of the date of birth.

[22 MRSA §8822 \(3\)](#)

Guidelines for services for children with hearing loss and at-risk children

The department, after consultation with the board, shall establish guidelines for the provision of follow-up services for newborn children in the State who are identified as having or being at risk of developing hearing loss. These services must include, but are not limited to, diagnostic audiologic assessment, counseling and educational services for the parents and an explanation of the potential effects of the identified hearing loss on the development of the newborn's speech, language and cognitive skills as well as the potential benefits of early identification and use of spoken or sign language.

[22 MRSA §8822 \(4\)](#)

For information on reporting, see [22 MRSA §8822](#). For information on tracking, see [22 MRSA §8824](#).

(18) Burns (Arson Reporting Immunity Act)

Reporting by health care practitioner

Reasonable cause to suspect; information disclosed

A health care practitioner, as defined by Title 24, section 2502, subsection 1-A, who, as a result of the practitioner's examination or treatment of a person for a burn injury, has reasonable cause to suspect that the burn injury was sustained in connection with an act of arson, may report to the Office of the State Fire Marshal. The health care practitioner's report may include the name and address of the person examined or treated, the basis for the practitioner's suspicion and other information which, in the judgment of the practitioner, may aid in investigation by the Office of the State Fire Marshal.

[25 MRSA §2415 \(1\)](#)

Immunity

A health care practitioner who, acting in good faith in reporting under this section or participating in a related investigation or proceeding, makes a report pursuant to subsection 1 is immune from civil or criminal liability for the act of reporting or participating in a related investigation or proceeding. Good faith does not include instances when a false report is made and the person knows the report is false. Nothing in this section may be construed to bar criminal or civil action regarding perjury.

[25 MRSA §2415 \(2\)](#)

Presumption of good faith

In a proceeding regarding immunity from liability, there shall be a rebuttable presumption that a report made under subsection 1 was made in good faith.

[25 MRSA §2415 \(3\)](#)

Privileged or confidential communications

The physician-patient privilege under the Maine Rules of Evidence is abrogated in relation to a report authorized under subsection 1.

[25 MRSA §2415 \(4\)](#)

(19) Business Arrangements and Structures

General

There are many types of arrangements and structures available to people wishing to set up a business in Maine. Each type has its own advantages and disadvantages. The basic information below will help you understand the various types of businesses available in Maine. For more information visit the following websites:

Secretary of State, Division of Corporations Website (General information)

<http://www.state.me.us/sos/cec/corp/corp.htm>

Office of Licensing and Registration

<http://janus.state.me.us/legis/statutes/13-C/title13-Cch0sec0.html>

Maine Revenue Services

<http://www.state.me.us/revenue/>

US Small Business Association (SBA)

<http://www.sba.gov/>

Maine Small Business Association (SBA)

<http://www.sba.gov/me/>

How to Organize Your Business (University of Maine Cooperative Extension Bulletin #3009)

<http://www.umext.maine.edu/onlinepubs/htmlpubs/3009.htm>

For legal advice and/or help setting up any of these types of businesses please consult with an attorney.

Sole Proprietorship

As the name indicates, this type of business is owned and operated by one person. This person is responsible for all business aspects, including all liability and any profit or loss. This structure is easy to set up and does not require any special registrations (other than trade names, trademarks, etc.).

Partnerships

A partnership is an association of two or more people to carry on a business for profit as co-owners. This type of business allows the partners to share ownership, management and assess profits/losses to each partner. This structure is easy to set up and does not require any special registrations (other than trade names, trademarks, etc.). No written agreement is needed under law to form a partnership, though one is beneficial in avoiding misunderstandings and helps clarify the business arrangements. This type of arrangement is also known as a General Partnership.

Limited Partnerships

A limited partnership is business arrangement between one or more general partners (who manage the business and are personally liable for partnership debts) and one or more limited partners (who contribute

capital, share in profits, but do not run the business and are not liable for the partnership obligations beyond contribution).

Full text of Limited Partnership Statute

<http://janus.state.me.us/legis/statutes/31/title31ch11sec0.html>

Forms and Fees

<http://www.maine.gov/sos/cec/corp/formsnew/lpforms.htm>

Limited Liability Partnership (LLP)

A LLP is a general partnership that has elected to limit personal liability for its general partners by registering this election with the Secretary of State.

Full text of Limited Liability Partnership Statute

<http://janus.state.me.us/legis/statutes/31/title31ch15sec0.html>

Forms and Fees

<http://www.maine.gov/sos/cec/corp/formsnew/llpforms.htm>

Corporation

A corporation is formed for the purpose of transacting business in the broadest sense of the word and for a profit return. This type of business requires special forms (articles of incorporations for example) to be filed with the Secretary of State.

Full text of the Maine Business Corporation Act

<http://janus.state.me.us/legis/statutes/13-C/title13-Cch0sec0.html>

Forms and Fees

<http://www.maine.gov/sos/cec/corp/formsnew/busforms.htm>

Professional Service Corporation

A professional service corporation is a type of corporation specifically for individuals licensed to provide certain services to the public, such as accounting, law, or medicine.

Full text of the Maine Professional Service Corporation Act

<http://www.mainelegislature.org/legis/statutes/13/title13ch22-Asec0.html>

Forms and fees

<http://www.maine.gov/sos/cec/corp/corp.html>

Limited Liability Company (LLC)

An LLC is a cross between a traditional corporation and a partnership. This type of organization provides a flexible business structure that has the ability to limit personal liability along with the ability to assess profits and losses to individuals.

Full text of Limited Liability Company Statute

<http://janus.state.me.us/legis/statutes/31/title31ch13sec0.html>

Forms and Fees

<http://www.maine.gov/sos/cec/corp/formsnew/llcforms.htm>

“S” Corporations

An “S” corporation is a type of business that allows a business to limit liability while also allowing the tax burden to shift directly to the shareholders. This special type of structure is typically seen in small businesses that wish the advantages of a typical corporation with the tax benefits of a partnership (i.e. no double taxation). This structure has some special incorporation requirements in order to qualify:

- A. Must be a domestic US company
- B. Can only have one type of stock
- C. Cannot have more than 35 shareholders
- D. Shareholders cannot be other business
- E. All shareholders must be individuals or estates
- F. All shareholders must be US residents

Non-Profit Corporation

A nonprofit corporation is formed for the purpose of advancing a particular objective of an organization and is not established to make a profit. Generally, this includes charitable, benevolent and educational organizations. These types of organizations receive a special tax status and benefits under the IRS Tax Code Section 501 (c)(3).

As of January 2003, all nonprofit corporations in the state of Maine are either "public benefit" or "mutual benefit" corporations.

A Public Benefit Corporation:

- A. Is designated as a public benefit corporation by statute; or
- B. Is tax exempt under section 501(c)(3) of the Internal Revenue Code; or
- C. Is organized for a public or charitable purpose and is required to distribute assets to a similar tax exempt organization upon dissolution; or
- D. Has elected to be a public benefit corporation.

Generally, if your corporation’s mission is to serve the public or community at large, it is probably a public benefit corporation. Public benefit corporations can usually be characterized as charities.

A Mutual Benefit Corporation:

- A. Is any nonprofit corporation that does not fit the description of a public benefit corporation.

Generally, if your corporation’s mission is to serve a limited number of members with common interests, it is probably a mutual benefit corporation.

As of January 2003, charity corporations have new filing and reporting requirements. For more information about these requirements, responsibilities of the Board of Directors and other necessary links, please visit:

Guide for Board Members of Charitable Corporations: <http://www.maine.gov/ag/faq.php?pods=152>

Full text for Maine Non-Profit Corporation Act

<http://janus.state.me.us/legis/statutes/13-B/title13-Bch0sec0.html>

Forms and Fees

<http://www.maine.gov/sos/cec/corp/formsnew/npcforms.htm>

Trade Names and Marks

A. Trade Name

Is a word, name, symbol, device or any combination thereof used by a person to identify his business, vocation or occupation and distinguish it from the business, vocation or occupation of others.

B. Trademark

Is any word, name, symbol or device or any combination thereof adopted and used by a person to identify goods made or sold by him and to distinguish them from goods made or sold by others.

C. Service marks

Is a mark used in the sale or advertising of services to identify the services of one person and distinguish them from the services of others.

D. Certification marks

Is a mark used upon or in connection with the products or services of one or more persons other than the owner of the mark to certify regional or other origin, material, mode of manufacture, quality, accuracy or other characteristics of such goods or services, or that the work or labor on the goods or services was performed by members of a union or other organization.

E. Collective marks

Is a trademark or service mark used by the members of a cooperative, an association or other collective group or organization, and includes marks used to indicate membership in a union, an association or other organization.

These marks are entitled to be registered with the Secretary of State.

Useful Links

[Full Text of Trade Marks and Names Statute](#)

[Forms and Fees](#)

(20) Cancer

Duty of physicians and hospitals

All hospitals and other health care facilities providing screening, diagnostic or therapeutic services with respect to cancer shall report to the Department of Human Services all persons diagnosed as having a malignant tumor or certain benign tumors as determined by rule no later than 6 months from the date of diagnosis. The report must include information on the person's usual occupation and industry of employment and other elements determined by rule to be appropriate. The Commissioner of Human Services shall adopt rules to implement this section. Rules adopted pursuant to this section are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

A physician, surgeon or other health care practitioner who diagnoses or provides treatment for cancer patients, upon notification by the Department of Human Services, shall report to the department any further information requested by the department concerning any person now or formerly under the health care practitioner's care, diagnosed as having or having had a malignant tumor. A physician, surgeon or other health care practitioner who diagnoses or provides treatment for cancer patients is required to report

any newly diagnosed cancer case to the department when that patient will not be referred to a reporting facility for diagnosis or treatment.

A facility or individual complying with the reporting requirements of this section is not liable for any civil damages as a result of such acts.

The requirements of this section do not apply to health care practitioners who provide treatment by spiritual means alone.

[22 MRSA §1402](#)

Cancer-incidence registry and regulations (see also Agency Rules Link)

The Department of Human Services shall establish, maintain and operate a statewide cancer-incidence registry.

[22 MRSA §1404](#)

(21) Certificate of Need

Maine's Certificate of Need Act provides the framework for review of proposals by or on behalf of certain health care facilities and nursing homes involving expansion of plant and equipment, the provision of new services, transfers of ownership and control and other initiatives.

For the full Maine Certificate of Need Act, including definitions, exceptions and information on the application process, see: <http://www.mainelegislature.org/legis/statutes/22/title22ch103-Asec0.html>

For more information, see the Department of Health & Human Services Certificate of Need Unit: http://www.maine.gov/dhhs/dlrs/c_o_n/

A certificate of need is generally required for:

1. Any transfer of ownership or acquisition under lease or comparable arrangement or through donation or any acquisition of control of a health care facility
2. Acquisitions of major medical equipment EXCEPT for
 - a. Major medical equipment being replaced by the owner; or
 - b. The use of major medical equipment on a temporary basis in the case of a natural disaster, major accident or major medical equipment failure.
3. Capital expenditures. The obligation by or on behalf of a health care facility of any capital expenditure of \$10,000,000 or more (EFFECTIVE 2/15/12)
4. The offering or development of any new health service.
5. New health care facility (non nursing homes). The construction, development or other establishment of a new health care facility if it requires a capital expenditure of more than \$3,000,000 or if it is a new health service. (EFFECTIVE 2/15/12).
6. An increase in the existing licensed bed complement or an increase in the licensed bed category of a health care facility, other than a nursing facility, of greater than 10%.

[22 MRSA §329](#)

(22) Chiropractic Licensure (see also Agency Rules Links)

Definitions

Chiropractic

Chiropractic means the art and science of identification and correction of subluxation and the accompanying physiological or mechanical abnormalities. The term subluxation, as utilized within the chiropractic health care system, means a structural or functional impairment of an intact articular unit. "Chiropractic" includes chiropractic acupuncture. Chiropractic recognizes the inherent recuperative capability of the human body as it relates to the spinal column, musculo-skeletal and nervous system.

Chiropractic acupuncture

Chiropractic acupuncture means the insertion of acupuncture needles through the skin at specific points. Chiropractic acupuncture is a methodology used for the correction of the soft tissue components contributing to subluxation and the accompanying physiological or mechanical abnormalities. Except as provided in section 502, chiropractic acupuncture may only be practiced by a licensee who has received a chiropractic acupuncture certification from the board.

Chiropractic doctors

Chiropractic doctors are health care providers functioning within their scope of practice as provided by this chapter.

[32 MRSA §451](#)

Licensure and Board of Chiropractic Licensure

The chiropractic practice is governed by [32 MRSA, Chapter 9](#) and [Board rules](#).

For examination and licensure requirements, see [32 MRSA § 551-554](#).

For information about the Board of Chiropractic Licensure and their processes, see [32 MRSA § 501-506](#).

(23) Closing a Medical Practice

Please contact the Maine Medical Association for resources on closing a medical practice.

(24) Communicable (Notifiable) Diseases (see also Agency Rules Links)

Rules for the Control of Notification

Who Must Report and what is required in the report

- A. Health care providers/Medical laboratories/Health care facilities/Day care facilities/Educational institutions/Correctional facilities
 1. Disease (whether a case, suspected case, carrier, or death);
 2. Date of first onset of symptoms;
 3. Patient:
 - a. Name
 - b. Birth date
 - c. Birth date
 - d. Race
 - e. Ethnicity
 - f. Sex
 - g. Occupation (if known)

- h. Residence address
 - i. Phone number
 - j. Place of work, school or child care
 - k. Parent or guardian name and address
 - l. Parent/Guardian telephone number.
4. Date of report;
 5. Health care provider name, address, and phone number;
 6. Name of hospital or other healthcare facility (if any);
 7. Name of person reporting (if not health care provider);
 8. All diagnostic laboratory findings and dates of test relevant to the notifiable condition regardless of clinical significance;
 9. Name and locating information of contacts;
 10. Other information pertinent to the case, as requested by the Department.
 11. If animal species- specify.

Department of Human Services Regulation, Bureau of Health 10-144 Chapter 258 (2) (B)

Duties of health care providers and attendants

Health care providers and persons attending a case of a notifiable disease shall arrange for such precautionary measures, consistent with the rules of the Department, including examination and isolation of the case when necessary, as are required to prevent the spread of infection to other members of the household or to the community. Proper isolation or other precautionary measures may be instituted by the Department or by the health officer after consultation with the Department. Notifiable disease cases shall receive immediate treatment according to the most recently established guidelines as promulgated by the appropriate professional organization and as are generally perceived to represent the current standard of care.

Non-compliant persons shall be reported to the Department for necessary interventions.

Department of Human Services Regulation, Bureau of Health 10-144 Chapter 258 (6)

Useful Links

[Maine DHHS Bureau of Infectious Diseases](#)

[List of Reportable Diseases in Maine](#) (pdf file)

(25) Confidentiality and Privilege

Maine Confidentiality Law

Definitions

- A. **Authorized representative of an individual:** means an individual's legal guardian; agent pursuant to Title 18-A, section 5-802; attorney-in-fact pursuant to Title 18-A, section 5-506; or other authorized representative or, after death, that person's personal representative or a person identified in subsection 3-B. For a minor who has not consented to health care treatment in accordance with the provisions of state law, Authorized representative means the minor's parent, legal guardian or guardian ad litem.
- B. **Authorization to disclose:** means authorization to disclose health care information in accordance with subsection 3, 3-A or 3-B.

- C. **Disclosure:** means the release, transfer of or provision of access to health care information in any manner obtained as a result of a professional health care relationship between the individual and the health care practitioner or facility to a person or entity other than the individual.
- D. **Health care:** means preventative, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, treatment, procedures or counseling, including appropriate assistance with disease or symptom management and maintenance, that affects an individual's physical, mental or behavioral condition, including individual cells or their components or genetic information, or the structure or function of the human body or any part of the human body. Health care includes prescribing, dispensing or furnishing to an individual drugs, biologicals, medical devices or health care equipment and supplies; providing hospice services to an individual; and the banking of blood, sperm, organs or any other tissue.
- E. **Health care facility or facility:** means a facility, institution or entity licensed pursuant to this Title that offers health care to persons in this State, including a home health care provider, hospice program and a pharmacy licensed pursuant to Title 32. For the purposes of this section, "health care facility" does not include a state mental health institute, the Elizabeth Levinson Center, the Aroostook Residential Center or Freeport Towne Square.
- F. **Health care information:** means information that directly identifies the individual and that relates to an individual's physical, mental or behavioral condition, personal or family medical history or medical treatment or the health care provided to that individual. "Health care information" does not include information that protects the anonymity of the individual by means of encryption or encoding of individual identifiers or information pertaining to or derived from federally sponsored, authorized or regulated research governed by 21 Code of Federal Regulations, Parts 50 and 56 and 45 Code of Federal Regulations, Part 46, to the extent that such information is used in a manner that protects the identification of individuals. The Board of Directors of the Maine Health Data Organization shall adopt rules to define health care information that directly identifies an individual. Rules adopted pursuant to this paragraph are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. "Health care information" does not include information that is created or received by a member of the clergy or other person using spiritual means alone for healing as provided in Title 32, sections 2103 and 3270.
- G. **Health care practitioner:** means a person licensed by this State to provide or otherwise lawfully providing health care or a partnership or corporation made up of those persons or an officer, employee, agent or contractor of that person acting in the course and scope of employment, agency or contract related to or supportive of the provision of health care to individuals, a pharmacy benefits manager as defined in section 2699, subsection 1, paragraph F or an electronic transmission intermediary.
- H. **Individual:** means a natural person who is the subject of the health care information under consideration and, in the context of disclosure of health care information, includes the individual's authorized representative.
- I. **Third party or 3rd party:** means a person other than the individual to whom the health care information relates.

[22 MRSA §1711-C \(1\)](#)

Confidentiality of health information; disclosure

An individual's health care information is confidential and may not be disclosed other than to the individual by the health care practitioner or facility except as provided in subsection 3, 3-A, 3-B, 6 or 11. Nothing in this section prohibits a health care practitioner or health care facility from adhering to applicable ethical or professional standards provided that these standards do not decrease the protection of confidentiality granted by this section.

[22 MRSA §1711-C \(2\)](#)**Written authorization to disclose**

A health care practitioner or facility may disclose health care information pursuant to a written authorization signed by an individual for the specific purpose stated in the authorization. A written authorization to disclose health care information must be retained with the individual's health care information. A written authorization to disclose is valid whether it is in an original, facsimile or electronic form. A written authorization to disclose must contain the following elements:

- A. The name and signature of the individual and the date of signature. If the authorization is in electronic form, a unique identifier of the individual and the date the individual authenticated the electronic authorization must be stated in place of the individual's signature and date of signature;
- B. The types of persons authorized to disclose health care information and the nature of the health care information to be disclosed;
- C. The identity or description of the 3rd party to whom the information is to be disclosed;
- D. The specific purpose or purposes of the disclosure and whether any subsequent disclosures may be made pursuant to the same authorization. An authorization to disclose health care information related to substance abuse treatment or care subject to the requirements of 42 United States Code, Section 290dd-2 (Supplement 1998) is governed by the provisions of that law;
- E. The duration of the authorization;
- F. A statement that the individual may refuse authorization to disclose all or some health care information but that refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences;
- G. A statement that the authorization may be revoked at any time by the individual by executing a written revocation, subject to the right of any person who acted in reliance on the authorization prior to receiving notice of revocation, instructions on how to revoke an authorization and a statement that revocation may be the basis for denial of health benefits or other insurance coverage or benefits; and
- H. A statement that the individual is entitled to a copy of the authorization form.

[22 MRSA §1711-C \(3\)](#)**Oral authorization to disclose**

When it is not practical to obtain written authorization under subsection 3 from an individual or person acting pursuant to subsection 3-B or when a person chooses to give oral authorization to disclose, a health care practitioner or facility may disclose health care information pursuant to oral authorization. A health care practitioner or facility shall record with the individual's health care information receipt of oral authorization to disclose, including the name of the authorizing person, the date, the information and purposes for which disclosure is authorized and the identity or description of the 3rd party to whom the information is to be disclosed.

[22 MRSA §1711-C \(3-A\)](#)**Authorization to disclose provided by a 3rd party**

When an individual or an authorized representative is unable to provide authorization to disclose under subsection 3 or 3-A, a health care practitioner or facility may disclose health care information pursuant to authorization to disclose that meets the requirements of subsection 3 or 3-A given by a 3rd party listed in this subsection. A health care practitioner or facility may determine not to obtain authorization from a person listed in this subsection when the practitioner or facility determines it would not be in the best interest of the individual to do so. In making this decision, the health care practitioner or facility shall respect the safety of the individual and shall consider any indicators, suspicion or substantiation of abuse. Persons who may authorize disclosure under this subsection include:

- A. The spouse of the individual;
- B. A parent of the individual
- C. An adult who is a child, grandchild or sibling of the individual;
- D. An adult who is an aunt, uncle, niece or nephew of the individual, related by blood or adoption;
- E. An adult related to the individual, by blood or adoption, who is familiar with the individual's personal values; and
- F. An adult who has exhibited special concern for the individual and who is familiar with the individual's personal values.

[22 MRSA §1711-C \(3-B\)](#)

Duration of authorization to disclose

An authorization to disclose may not extend longer than 30 months, except that the duration of an authorization for the purposes of insurance coverage under Title 24, 24-A or 39-A is governed by the provisions of Title 24, 24-A or 39-A, respectively.

[22 MRSA §1711-C \(4\)](#)

Revocation of authorization to disclose

A person who may authorize disclosure may revoke authorization to disclose at any time, subject to the rights of any person who acted in reliance on the authorization prior to receiving notice of revocation. A written revocation of authorization must be signed and dated. If the revocation is in electronic form, a unique identifier of the individual and the date the individual authenticated the electronic authorization must be stated in place of the individual's signature and date of signature. A health care practitioner or facility shall record receipt of oral revocation of authorization, including the name of the person revoking authorization and the date. A revocation of authorization must be retained with the authorization and the individual's health care information.

[22 MRSA §1711-C \(5\)](#)

Disclosure without authorization to disclose

A health care practitioner or facility may disclose, or when required by law must disclose, health care information without authorization to disclose under the circumstances stated in this subsection or as provided in subsection 11. Disclosure may be made without authorization as follows:

- A. To another health care practitioner or facility for diagnosis, treatment or care of individuals or to complete the responsibilities of a health care practitioner or facility that provided diagnosis, treatment or care of individuals, as provided in this paragraph.
 - 1. For a disclosure within the office, practice or organizational affiliate of the health care practitioner or facility, no authorization is required.
 - 2. For a disclosure outside of the office, practice or organizational affiliate of the health care practitioner or facility, authorization is not required, except that in nonemergency circumstances authorization is required for health care information derived from mental health services provided by:
 - a. A clinical nurse specialist licensed under the provisions of Title 32, chapter 31;
 - b. A psychologist licensed under the provisions of Title 32, chapter 56;
 - c. A social worker licensed under the provisions of Title 32, chapter 83;
 - d. A counseling professional licensed under the provisions of Title 32, chapter 119; or
 - e. A physician specializing in psychiatry licensed under the provisions of Title 32, chapter 36 or 48.

3. This subparagraph does not prohibit the disclosure of health care information between a licensed pharmacist and a health care practitioner or facility providing mental health services for the purpose of dispensing medication to an individual;
- B. To an agent, employee, independent contractor or successor in interest of the health care practitioner or facility or to a member of a quality assurance, utilization review or peer review team to the extent necessary to carry out the usual and customary activities relating to the delivery of health care and for the practitioner's or facility's lawful purposes in diagnosing, treating or caring for individuals, including billing and collection, risk management, quality assurance, utilization review and peer review. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales;
 - C. To a family or household member unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B;
 - D. To appropriate persons when a health care practitioner or facility that is providing or has provided diagnosis, treatment or care to the individual has determined, based on reasonable professional judgment, that the individual poses a direct threat of imminent harm to the health or safety of any individual. A disclosure pursuant to this paragraph must protect the confidentiality of the health care information consistent with sound professional judgment;
 - E. To federal, state or local governmental entities in order to protect the public health and welfare when reporting is required or authorized by law or to report a suspected crime against the health care practitioner or facility;
 - F. As directed by order of a court or as authorized or required by statute;
 - G. To a governmental entity pursuant to a lawful subpoena requesting health care information to which the governmental entity is entitled according to statute or rules of court;
 - H. To a person when necessary to conduct scientific research approved by an institutional review board or by the board of a nonprofit health research organization or when necessary for a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. A person conducting research or a clinical trial may not identify any individual patient in any report arising from the research or clinical trial. For the purposes of this paragraph, "institutional review board" means any board, committee or other group formally designated by a health care facility and authorized under federal law to review, approve or conduct periodic review of research programs. Health care information disclosed pursuant to this paragraph that identifies an individual must be returned to the health care practitioner or facility from which it was obtained or must be destroyed when it is no longer required for the research or clinical trial. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales
 - I. To a person engaged in the assessment, evaluation or investigation of the provision of or payment for health care or the practices of a health care practitioner or facility or to an agent, employee or contractor of such a person, pursuant to statutory or professional standards or requirements. Disclosure for a purpose listed in this paragraph is not a disclosure for the purpose of marketing or sales
 - J. To a person engaged in the regulation, accreditation, licensure or certification of a health care practitioner or facility or to an agent, employee or contractor of such a person, pursuant to standards or requirements for regulation, accreditation, licensure or certification;
 - K. To a person engaged in the review of the provision of health care by a health care practitioner or facility or payment for such health care under Title 24, 24-A or 39-A or under a public program for the payment of health care or professional liability insurance for a health care practitioner or facility or to an agent, employee or contractor of such a person

- L. To attorneys for the health care practitioner or facility that is disclosing the health care information or to a person as required in the context of legal proceedings or in disclosure to a court or governmental entity, as determined by the practitioner or facility to be required for the practitioner's or facility's own legal representation
- M. To a person outside the office of the health care practitioner or facility engaged in payment activities, including but not limited to submission to payors for the purposes of billing, payment, claims management, medical data processing, determination of coverage or adjudication of health benefit or subrogation claims, review of health care services with respect to coverage or justification of charges or other administrative services. Payment activities also include but are not limited to
 1. Activities necessary to determine responsibility for coverage;
 2. Activities undertaken to obtain payment for health care provided to an individual; and
 3. Quality assessment and utilization review activities, including precertification and preauthorization of services and operations or services audits relating to diagnosis, treatment or care rendered to individuals by the health care practitioner or facility and covered by a health plan or other payor;
- N. To schools, educational institutions, camps, correctional facilities, health care practitioners and facilities, providers of emergency services or a branch of federal or state military forces, information regarding immunization of an individual
- O. To a person when disclosure is needed to set or confirm the date and time of an appointment or test or to make arrangements for the individual to receive those services
- P. To a person when disclosure is needed to obtain or convey information about prescription medication or supplies or to provide medication or supplies under a prescription;
- Q. To a person representing emergency services, health care and relief agencies, corrections facilities or a branch of federal or state military forces, of brief confirmation of general health status;
- R. To a member of the clergy, of information about the presence of an individual in a health care facility, including the person's room number, place of residence and religious affiliation unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B;
- S. To a member of the media who asks a health care facility about an individual by name, of brief confirmation of general health status unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B; and
- T. To a member of the public who asks a health care facility about an individual by name, of the room number of the individual and brief confirmation of general health status unless expressly prohibited by the individual or a person acting pursuant to subsection 3-B.

[22 MRSA §1711-C \(6\)](#)

Confidentiality policies

A health care practitioner or facility shall develop and implement policies, standards and procedures to protect the confidentiality, security and integrity of health care information to ensure that information is not negligently, inappropriately or unlawfully disclosed. The policies of health care facilities must provide that an individual being admitted for inpatient care be given notice of the right of the individual to control the disclosure of health care information. The policies must provide that routine admission forms include clear written notice of the individual's ability to direct that that individual's name be removed from the directory listing of persons cared for at the facility and notice that removal may result in the inability of the facility to direct visitors and telephone calls to the individual.

[22 MRSA §1711-C \(7\)](#)

Prohibited disclosure

A health care practitioner or facility may not disclose health care information for the purpose of marketing or sales without written or oral authorization for the disclosure.

[22 MRSA §1711-C \(8\)](#)

Disclosures of corrections or clarifications to health care information

A health care practitioner or facility shall provide to a 3rd party a copy of an addition submitted by an individual to the individual's health care information if:

- A. The health care practitioner or facility provided a copy of the original health care record to the 3rd party on or after February 1, 2000;
- B. The correction or clarification was submitted by the individual pursuant to section 1711 or 1711-B and relates to diagnosis, treatment or care;
- C. The individual requests that a copy be sent to the 3rd party and provides an authorization that meets the requirements of subsection 3, 3-A or 3-B; and
- D. If requested by the health care practitioner or facility, the individual pays to the health care practitioner or facility all reasonable costs requested by that practitioner or facility.

[22 MRSA §1711-C \(9\)](#)

Requirements for disclosures

Except as otherwise provided by law, disclosures of health care information pursuant to this section are subject to the professional judgment of the health care practitioner and to the following requirements:

- A. A health care practitioner or facility that discloses health care information pursuant to subsection 3, 3-A or 3-B may not disclose information in excess of the information requested in the authorization.
- B. A health care practitioner or facility that discloses health care information pursuant to subsections 3, 3-A, 3-B or 6 may not disclose information in excess of the information reasonably required for the purpose for which it is disclosed
- C. If a health care practitioner or facility believes that release of health care information to the individual would be detrimental to the health of the individual, the health care practitioner or facility shall advise the individual and make copies of the records available to the individual's authorized representative upon receipt of a written authorization.
- D. If a health care practitioner or facility discloses partial or incomplete health care information, as compared to the request or directive to disclose under subsection 3, 3-A, 3-B or 6, the disclosure must expressly indicate that the information disclosed is partial or incomplete.

[22 MRSA §1711-C \(10\)](#)

Minors

If a minor has consented to health care in accordance with the laws of this State, authorization to disclose health care information pursuant to this section must be given by the minor unless otherwise provided by law.

[22 MRSA §1711-C \(12\)](#)

Enforcement

This section may be enforced within 2 years of the date a disclosure in violation of this section was or should reasonably have been discovered.

- A. When the Attorney General has reason to believe that a person has intentionally violated a provision of this section, the Attorney General may bring an action to enjoin unlawful disclosure of health care information.

- B. An individual who is aggrieved by conduct in violation of this section may bring a civil action against a person who has intentionally unlawfully disclosed health care information in the Superior Court in the county in which the individual resides or the disclosure occurred. The action may seek to enjoin unlawful disclosure and may seek costs and a forfeiture or penalty under paragraph C. An applicant for injunctive relief under this paragraph may not be required to give security as a condition of the issuance of the injunction.
- C. A person who intentionally violates this section is subject to a civil penalty not to exceed \$5,000, payable to the State, plus costs. If a court finds that intentional violations of this section have occurred after due notice of the violating conduct with sufficient frequency to constitute a general business practice, the person is subject to a civil penalty not to exceed \$10,000 for health care practitioners and \$50,000 for health care facilities, payable to the State. A civil penalty under this subsection is recoverable in a civil action.
- D. Nothing in this section may be construed to prohibit a person aggrieved by conduct in violation of this section from pursuing all available common law remedies, including but not limited to an action based on negligence.

[22 MRSA §1711-C \(13\)](#)

Waiver prohibited

Any agreement to waive the provisions of this section is against public policy and void.

[22 MRSA §1711-C \(14\)](#)

Immunity

A cause of action in the nature of defamation, invasion of privacy or negligence does not arise against any person for disclosing health care information in accordance with this section. This section provides no immunity for disclosing information with malice or willful intent to injure any person.

[22 MRSA §1711-C \(15\)](#)

Application

This section applies to all requests, directives and authorizations to disclose health care information executed on or after February 1, 2000. An authorization to disclose health care information executed prior to February 1, 2000 that does not meet the standards of this section is deemed to comply with the requirements of this section until the next health care encounter between the individual and the health care practitioner or facility.

[22 MRSA §1711-C \(16\)](#)

Participation in a state-designated statewide health information exchange.

The following provisions apply to participation in a state-designated statewide health information exchange.

- A. A health care practitioner may not deny a patient health care treatment and a health insurer may not deny a patient a health insurance benefit based solely on the provider's or patient's decision not to participate in a state-designated statewide health information exchange. Except when otherwise required by federal law, a payor of health care benefits may not require participation in a state-designated statewide health information exchange as a condition of participating in the payor's provider network.
- B. Recovery for professional negligence is not allowed against any health care practitioner or health care facility on the grounds of a health care practitioner's or a health care facility's nonparticipation in a state-designated statewide health information exchange arising out of or in connection with the provision of or failure to provide health care services. In any civil action for professional negligence or in any proceeding related to such a civil action or in any arbitration, proof of a health care practitioner's, a health care facility's or a patient's participation or nonparticipation in a state-designated statewide health information exchange is inadmissible as

evidence of liability or nonliability arising out of or in connection with the provision of or failure to provide health care services. This paragraph does not prohibit recovery or the admission of evidence of reliance on information in a state-designated statewide electronic health information exchange when there was participation by both the patient and the patient's health care practitioner.

- C. A state-designated statewide health information exchange to which health care information is disclosed under this section shall provide an individual protection mechanism by which an individual may opt out from participation to prohibit the state-designated statewide health information exchange from disclosing the individual's health care information to a health care practitioner or health care facility.
- D. At point of initial contact, a health care practitioner, health care facility or other entity participating in a state-designated statewide health information exchange shall provide to each patient, on a separate form, at minimum:
 1. Information about the state-designated statewide health information exchange, including a description of benefits and risks of participation in the state-designated statewide health information exchange;
 2. A description of how and where to obtain more information about or contact the state-designated statewide health information exchange;
 3. An opportunity for the patient to decline participation in the state-designated statewide health information exchange; and
 4. A declaration that a health care practitioner, health care facility or other entity may not deny a patient health care treatment based solely on the provider's or patient's decision not to participate in a state-designated statewide health information exchange.

The state-designated statewide health information exchange shall develop the form for use under this paragraph, with input from consumers and providers. The form must be approved by the office of the state coordinator for health information technology within the Governor's office of health policy and finance.

- E. A health care practitioner, health care facility or other entity participating in a state-designated statewide health information exchange shall communicate to the exchange the decision of each patient who has declined participation and shall do so within a reasonable time frame, but not more than 2 business days following the receipt of a signed form, as described in paragraph D, from the patient, or shall establish a mechanism by which the patient may decline participation in the state-designated statewide health information exchange at no cost to the patient.
- F. A state-designated statewide health information exchange shall process the request of a patient who has decided not to participate in the state-designated statewide health information exchange within 2 business days of receiving the patient's decision to decline, unless additional time is needed to verify the identity of the patient. A signed authorization from the patient is required before a patient is newly entered or reentered into the system if the patient chooses to begin participation at a later date.

Except as otherwise required by applicable law, regulation or rule or state or federal contract, or when the state-designated statewide health information exchange is acting as the agent of a health care practitioner, health care facility or other entity, the state-designated statewide health information exchange shall remove health information of individuals who have declined participation in the exchange. In no event may health information retained in the state-designated statewide health information exchange as set forth in this paragraph be made available to health care practitioners, health care facilities or other entities except as otherwise required by applicable law, regulation or rule or state or federal contract, or when the health care practitioner, health care facility or other entity is the originator of the information.

- G. A state-designated statewide health information exchange shall establish a secure website accessible to patients. This website must:
1. Permit a patient to request a report of who has accessed that patient's records and when the access occurred. This report must be delivered to the patient within 2 business days upon verification of the patient's identity by the state-designated statewide health information exchange;
 2. Provide a mechanism for a patient to decline participation in the state-designated statewide health information exchange; and
 3. Provide a mechanism for the patient to consent to participation in the state-designated statewide health information exchange if the patient had previously declined participation.
- H. A state-designated statewide health information exchange shall establish for patients an alternate procedure to that provided for in paragraph F that does not require Internet access. A health care practitioner, health care facility or other entity participating in the state-designated statewide health information exchange shall provide information about this alternate procedure to all patients. The information must be included on the form identified in paragraph D.
- I. A state-designated statewide health information exchange shall maintain records regarding all disclosures of health care information by and through the state-designated statewide health information exchange, including the requesting party and the dates and times of the requests and disclosures.
- J. A state-designated statewide health information exchange may not charge a patient or an authorized representative of a patient any fee for access or communication as provided in this subsection.
- K. Notwithstanding any provision of this subsection to the contrary, a health care practitioner, health care facility or other entity shall provide the form and communication required by paragraphs D and F to all existing patients following the effective date of this subsection.
- L. A state-designated statewide health information exchange shall meet or exceed all applicable federal laws and regulations pertaining to privacy, security and breach notification regarding personally identifiable protected health information, as defined in 45 Code of Federal Regulations, Part 160. If a breach occurs, the state-designated statewide health information exchange shall arrange with its participants for notification of each individual whose protected health information has been, or is reasonably believed by the exchange to have been, breached. For purposes of this paragraph, "breach" has the same meaning as in 45 Code of Federal Regulations, Part 164, as amended.
- M. The state-designated statewide health information exchange shall develop a quality management plan, including auditing mechanisms, in consultation with the office of the state coordinator for health information technology within the department, who shall review the plan and results.

[22 MRSA §1711-C \(18\)](#)

Physician and Psychotherapist Privilege

A communication is "confidential" if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the physician or psychotherapist, including members of the patient's family.

Maine Rules of Evidence 503 (a) (4)

General rule of privilege

A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment of the patient's physical, mental or emotional condition, including alcohol or drug addiction, among the patient, the patient's physician or psychotherapist, and persons who are participating in the diagnosis or treatment under the direction of the physician or psychotherapist, including members of the patient's family.

Maine Rules of Evidence 503 (b)

Who may claim the privilege

The privilege may be claimed by the patient, by the patient's guardian or conservator, or by the personal representative of a deceased patient. The person who was the physician or psychotherapist at the time of the communication is presumed to have authority to claim the privilege but only on behalf of the patient.

Maine Rules of Evidence 503 (d)

American Medical Association requirement

A physician shall...safeguard patient confidence within the constraints of the law

From Article IV, AMA Principles of Medical Ethics

Opinion 5.05, Confidentiality

Opinion 8.08, Informed Consent

(26) Consent to Treatment**Informed consent to health care treatment****Disallowance of recovery on grounds of lack of informed consent**

No recovery may be allowed against any physician, podiatrist, dentist or any health care provider upon the grounds that the health care treatment was rendered without the informed consent of the patient or the patient's spouse, parent, guardian, nearest relative or other person authorized to give consent for the patient when:

- A. The action of the physician, podiatrist or dentist in obtaining the consent of the patient or other person authorized to give consent for the patient was in accordance with the standards of practice among members of the same health care profession with similar training and experience situated in the same or similar communities;
- B. A reasonable person, from the information provided by the physician, podiatrist or dentist under the circumstances, would have a general understanding of the procedures or treatments and of the usual and most frequent risks and hazards inherent in the proposed procedures or treatments which are recognized and followed by other physicians, podiatrists or dentists engaged in the same field of practice in the same or similar communities; or
- C. A reasonable person, under all surrounding circumstances, would have undergone such treatment or procedure had that person been advised by the physician, podiatrist or dentist in accordance with paragraphs A and B or this paragraph.

For purposes of this subsection, the physician, podiatrist, dentist or health care provider may rely upon a reasonable representation that the person giving consent for the patient is authorized to give consent unless the physician, podiatrist, dentist or health care provider has notice to the contrary.

[24 MRSA §2905 \(1\)](#)

Presumption of validity of written consent; rebuttal

A consent which is evidenced in writing and which meets the foregoing standards, and which is signed by the patient or other authorized person shall be presumed to be a valid consent. This presumption,

however, may be subject to rebuttal only upon proof that such consent was obtained through fraud, deception or misrepresentation of material fact.

[24 MRSA §2905 \(2\)](#)

Mental and physical competency

A valid consent is one which is given by a person who, under all the surrounding circumstances, is mentally and physically competent to give consent.

[24 MRSA §2905 \(3\)](#)

Informed consent for breast cancer

Duty of physician

Notwithstanding section 2905, a physician who is administering the primary treatment for breast cancer shall inform the patient as provided in this section, orally and in writing, about alternative efficacious methods of treatment of breast cancer, including surgical, radiological or chemotherapeutic treatments or any other generally accepted medical treatment and the advantages, disadvantages and the usual and most frequent risks of each.

[24 MRSA §2905-A \(1\)](#)

Written information

The duty to inform the patient in writing may be met by giving the patient a standardized written summary or brochure as described in subsections 3 and 4.

[24 MRSA §2905-A \(2\)](#)

Standardized written summary

The standardized written summary may be developed by the Bureau of Health after consultation with the Cancer Advisory Committee.

[24 MRSA §2905-A \(3\)](#)

Brochure

The brochure must be one which is approved or made available through the National Cancer Institute, the American Cancer Society, the American College of Surgeons or any other recognized professional organization approved by the Bureau of Health.

[24 MRSA §2905-A \(4\)](#)

Signed form

A form, signed by the patient, indicating that the patient has been given the oral information required by this section and a copy of the brochure or the standardized written summary shall be included in the patient's medical record.

[24 MRSA §2905-A \(5\)](#)

Extent of duty

A physician's duty to inform a patient under this section does not require disclosure of information beyond what a reasonably well-qualified physician licensed under Title 32 would know.

[24 MRSA §2905-A \(6\)](#)

Actions barred

A patient who signs a form described in subsection 5 is barred from bringing a civil action against the physician, based on failure to obtain informed consent, but only in regard to information pertaining to alternative forms of treatment of breast cancer and the advantages, disadvantages, and risks of each method.

[24 MRSA §2905-A \(7\)](#)

Application of this section to common law rights

Nothing in this section restricts or limits the rights of a patient under common law.

[24 MRSA §2905-A \(8\)](#)

(27) Continuing Medical Education (see Agency Rules Links)

Continuing Medical Education

Each physician licensed by this Board who is actively practicing medicine and surgery shall complete during each biennial licensing period, a minimum of one hundred (100) credit hours of continuing medical education subject to the following:

- A. At least forty (40) hours must be in Category 1, as defined by the Board rules;
- B. The total one hundred (100) hours may be in Category 1;
- C. No more than sixty (60) credit hours may be in Category 2, as defined by the Board rules.

Department of Professional and Financial Regulation, Board of Licensure in Medicine, Rule Chapter 1, §8

(28) Covenants Not To Compete

In your business negotiations, you may have encountered a “non-competition agreement” or a “covenant not to compete” – a term of an employment agreement limiting a professional’s right to practice in the geographic region of the employer for a period of time. Such employment contract provisions are not uncommon in the Maine marketplace. Judicial decisions of non-competition agreements depend very much on the facts of the case. However, the Code of Medical Ethics frowns on these terms because they are likely to reduce the availability of medical care to the public. Opinion 9.02, *Restrictive Covenants and the Practice of Medicine* states the following about non-competition agreements:

Covenants-not-to-compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients’ choice of physician. (VI, VII) Issued prior to April 1977; Updated June 1994 and June 1998.

The leading Maine case on the interpretation of non-competition agreements in the health care context is *Brignull v. Albert*, a 1995 case involving two optometrists where the Maine Supreme Judicial Court enforced the non-competition agreement.

In *Brignull*, the plaintiff optometrist had offices in Ellsworth and Bar Harbor. The employment agreement between the parties provided that the defendant could not practice on Mount Desert Island or within 20 miles of Ellsworth for 4 years after leaving the practice and it provided for \$30,000 in liquidated damages for violation of the provision. Within 2 years of departing the practice, the defendant opened an office within 2 miles of the plaintiff’s Ellsworth office and in the first 6 months saw 210 of the plaintiff’s patients. The Law Court found that the non-competition agreement was reasonable and that the liquidated damages provision was enforceable. It stated that the reasonableness of such an agreement is a question of law in each case depending on the duration, geographic area, and interests to be protected by the agreement. Simply protecting the employer from business competition would not, in the Court’s view, be a legitimate interest to be protected by a non-competition agreement. The legitimate interests identified in *Brignull* were to prevent the employee from taking existing patients and to protect the good will of the business.

You may review the AMA's Code of Medical Ethics at the AMA website, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml>

General

Contractual agreements that restrict practice or competition, i.e. "covenants not to compete" are not unusual arrangements between professionals and other businesspersons. These restrictive covenants are commonly found in contracts regarding the sale or dissolution of a business or a professional practice. Although there are no state laws or regulations concerning the enforceability of such covenants, Maine courts have generally upheld the agreements where the restrictions regarding period of time and geographic area are found to be reasonable.

Examples:

- A. A covenant never again to practice in Maine would most likely be deemed unreasonable by the court.
- B. A covenant not to practice for 3 years within a 10-mile radius would probably be deemed reasonable.

Agreements Restricting the Practice of Medicine

Covenants-not-to-compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The AMA Council on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership, or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician. (VI, VII)

[AMA Code of Medical Ethics, §9.02](#)

(29) Crimes

Failure to report treatment of a gunshot wound

A person is guilty of failure to report treatment of a gunshot wound if, being a health care practitioner or emergency medical services person, that person treats a human being for a wound apparently caused by the discharge of a firearm and knowingly fails to report the same to a law enforcement agency immediately by the quickest means of communication.

[17-A MRSA §512](#)

Reports of death

Persons suspecting medical examiner case

Any person who becomes aware of a suspected medical examiner case shall immediately notify a law enforcement officer or the Office of Chief Medical Examiner. As used in this subsection, "person" means a natural person, including a public servant, and a corporation, partnership, unincorporated association or any other nonhuman legal entity, including any governmental unit.

[22 MRSA §3026 \(1\)](#)

Medical examiners suspecting medical examiner case

Any medical examiner who becomes aware of a death caused by physical injury, or in which physical injury is the suspected cause, shall immediately notify the Office of Chief Medical Examiner and the appropriate law enforcement agency. The agency shall notify the district attorney for the district in which the body is located.

[22 MRSA §3026 \(3\)](#)**Cases involving or suspected of involving physical injury attributable to criminal conduct**

Any law enforcement officer or medical examiner who becomes aware of a death involving physical injury attributable to criminal conduct, or in which physical injury attributable to criminal conduct is suspected, other than vehicular manslaughter, in addition to complying with the notification requirements in subsection 3, shall immediately notify the Attorney General.

[22 MRSA §3026 \(4\)](#)**Employment leave for victims of violence****Definition**

For purposes of this subchapter, the terms "daughter," "son," "parent" and "spouse" have the same meanings as those terms have under federal regulations adopted pursuant to 29 United States Code, Section 2654, as in effect on January 1, 2002. An employer may require an employee to provide reasonable documentation of the family relationship, which may include a statement from the employee, a birth certificate, a court document or similar documents.

[26 MRSA §850 \(1-A\)](#)**Required leave**

An employer must grant reasonable and necessary leave from work, with or without pay, for an employee to:

- A. Prepare for and attend court proceedings;
- B. Receive medical treatment or attend to medical treatment for a victim who is the employee's daughter, son, parent or spouse; or
- C. Obtain necessary services to remedy a crisis caused by domestic violence, sexual assault or stalking.

The leave must be needed because the employee or the employee's daughter, son, parent or spouse is a victim of violence, assault, sexual assaults under Title 17-A, chapter 11, stalking or any act that would support an order for protection under Title 19-A, chapter 101.

An employer may not sanction an employee or deprive an employee of pay or benefits for exercising a right granted by this section.

[26 MRSA §850 \(1\)](#)**Exceptions**

Subsection 1 is not violated if:

- A. The employer would sustain undue hardship from the employee's absence;
- B. The request for leave is not communicated to the employer within a reasonable time under the circumstances; or
- C. The requested leave is impractical, unreasonable or unnecessary based on the facts then made known to the employer.

[26 MRSA §850 \(2\)](#)**Civil penalties**

The Department of Labor may assess civil penalties of up to \$200 for each violation of this section, if notice of the violation was given to the employer and the department within 6 months of the occurrence.

[26 MRSA §850 \(3\)](#)**Endangering welfare of dependent person**

- A. A person is guilty of endangering the welfare of a dependent person if:

1. The person recklessly endangers the health, safety or mental welfare of a dependent person who is unable to perform self-care because of advanced age or physical or mental disease, disorder or defect. Violation of this paragraph is a Class D crime; or
 2. The person intentionally or knowingly endangers the health, safety or mental welfare of a dependent person who is unable to perform self-care because of advanced age or physical or mental disease, disorder or defect. Violation of this paragraph is a Class C crime.
- B. As used in this section, "endangers" includes a failure to act only when the defendant has a legal duty to protect the health, safety or mental welfare of the dependent person. For purposes of this section, a legal duty may be inferred if the defendant has assumed responsibility for the care of the dependent person.

[17-A MRSA §555](#)

(30) Deaths (Uniform Determination of Death Act)

Determination of death

An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.

[22 MRSA §2811](#)

Registration of fetal deaths

Except as authorized by the department or as required under section 1596, a certificate of each death of a fetus of 20 or more weeks of gestation that occurs in this State must be filed with the clerk of the municipality where the delivery occurred within 14 days after delivery and prior to removal of the fetus from the State.

[22 MRSA §2841](#)

Certificate filed by funeral director

The funeral director or other authorized person in charge of the disposition of the dead fetus or its removal from the State is responsible for filing the certificate. In the absence of such a person, the physician, the certified nurse midwife, the nurse practitioner or other person in attendance at or after the delivery shall be responsible for filing the certificate. The person responsible for filing the certificate shall obtain the personal data from the best qualified person or source available and shall present the certificate to the person responsible for completing the medical certification of the cause of death.

[22 MRSA §2841 \(1\)](#)

Medical certificate by physician

The medical certification must be completed and signed within 5 days after delivery by the physician in attendance at or after the delivery, except when an inquiry as to the cause of fetal death is required by law.

[22 MRSA §2841 \(2\)](#)

Medical certificate by medical examiner

When the fetal death occurs without medical attendance upon the mother at or after delivery, or when inquiry as to the cause of fetal death is required by law, the medical examiner shall complete and sign the medical certification within 5 days after delivery. A certification need not be completed before the remains are ready for release.

[22 MRSA §2841 \(3\)](#)

Registration of deaths

Definitions

- A. **Life-sustaining procedure:** means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the dying process and does not include nutrition and hydration.
- B. **Terminally ill patient:** means a patient who has been diagnosed as having an incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of the attending physician, result in death within a short time.
- C. **Health care provider:** means a physician authorized to practice in this State, nurse practitioner, or physician assistant.

[22 MRSA §2842 \(2\)](#)

Except as authorized by the department, a certificate of each death which occurs in this State shall be filed with the clerk of the municipality where death occurred within a reasonable period of time, as specified by department regulation, after the day on which death occurred and prior to the removal of the body from the State.

[22 MRSA §2842](#)

Certificate filed by funeral director

The funeral director or other authorized person in charge of the disposition of the dead human body or its removal from the State shall be responsible for filing the certificate. He shall obtain the personal data from the best qualified person or source available and he shall present the certificate to the physician or medical examiner responsible for completing the medical certification of the cause of death.

[22 MRSA §2842 \(1\)](#)

Medical certificate by physician, nurse practitioner, or physician assistant

The medical certification of the cause of death must be completed in typewritten or legibly hand-printed style and signed in a timely fashion by a physician, nurse practitioner, or physician assistant authorized to practice in the State who has knowledge of the patient's recent medical condition, in accordance with department regulations and other laws detailing who can certify and in what time frame, except when the death falls under the jurisdiction of the medical examiner as provided in section 3025. If the patient was a resident of a nursing home licensed under section 1817 at the time of death and if the health care provider in charge of the patient's care or another health care provider designated by the health care provider in charge had not examined the patient within 48 hours prior to death, or within 2 weeks prior to death in the case of a terminally ill patient, the health care provider in charge or another health care provider designated by the health care provider in charge shall examine the body prior to completing the certification of death process. Any health care provider who fails to complete the medical certification of the cause of death fully, in typewritten or legibly hand-printed style and in a timely manner, or who fails to examine the body of a nursing home resident prior to certifying cause of death as required by this section must be reported to the Board of Licensure in Medicine, the Board of Osteopathic Licensure or the State Board of Nursing, whichever is appropriate, by the State Registrar of Vital Statistics of the Department of Health and Human Services.

[22 MRSA §2842 \(2\)](#)

Medical certification

Notwithstanding subsection 2, with respect to a person who dies within the State naturally and for whom the physician, nurse practitioner, or physician assistant was the attending health care provider, the medical certification of the cause of death may be completed and signed by a physician, nurse practitioner, or physician assistant authorized to practice at the Veterans Administration Hospital at Togus or at another federal medical facility within the State or by a physician, physician assistant, or advanced practice

registered nurse licensed to practice in New Hampshire, Vermont or Massachusetts who, at the request of the Chief Medical Examiner, is willing to do so.

[22 MRSA §2842 \(2-A\)](#)

Medical certificate by medical examiner

When a death occurs under circumstances that make it a medical examiner case as defined in section 3025, or when inquiry as to the cause of death is required by law, the medical examiner shall complete in typewritten or legibly hand-printed style the medical certification of the cause of death and sign the death certificate. A certification need not be completed before the remains are ready for release.

The medical examiner is responsible for the identity of the deceased and the time, date, place, cause, manner and circumstances of death on the death certificate. Entries may be left "pending" if further study is needed; or, at the specific direction of the Attorney General relative to cases under investigation by the Attorney General's office, entries must be left "withheld" until such time as the Attorney General, in the Attorney General's sole discretion, determines that any criminal investigation and prosecution will not be harmed by public disclosure of such information. Notwithstanding section 2706, subsection 4, unless directed otherwise by the Attorney General as specified in this subsection, this information for which the medical examiner is responsible may be made available to the general public by the Office of Chief Medical Examiner.

[22 MRSA §2842 \(3\)](#)

Correction of errors on death statistic records filed under chapter 711

Certificates of death in medical examiner cases, as defined in section 3025, may be completed or amended at any time by means of forms provided by the department to the Office of Chief Medical Examiner. Either the Chief Medical Examiner or the medical examiner assigned to the case may sign the forms. The medical examiner assigned shall submit the form to the Office of the Chief Medical Examiner for filing with the State Registrar of Vital Statistics. These forms may be filed at any time after death and need not include a summary description of the evidence in support of the completion or amendment.

[22 MRSA §2842 \(4\)](#)

Electronic death registration system

Beginning July 1, 2012, a certificate of death required to be filed by any person authorized under section 2842 pursuant to this chapter may be filed using the electronic death registration system maintained by the State Registrar of Vital Statistics....The State Registrar of Vital Statistics shall adopt rules to carry out the purposes of this section.

[22 MRSA § 2847](#)

DHS Rules for the Medical Certification of the Cause of Death (see Agency Rules Links)

Maine Elder Death Analysis Review Team

The Maine Elder Death Analysis Review Team in the Attorney General's Office is expanded to 16 members from 13, and now includes a sexual assault nurse examiner, a physician and an emergency medical services professional.

[5 MRSA §200-H \(1\)](#)

For a list of the composition of the team see [Public Law, Chapter 149](#).

(31) Dentists & Dental Hygenists

For the statures governing the practice of dentists, dental hygenists, dental assistants, independent practice dental hygenists, dentuists and dental radiographers, see [Title 32, Chapter 16](#) of the Maine Revised Statutes. See also the Agency Rules Links.

Dentist Health Program

The Board of Dental Examiners may establish protocols for the operation of a professional review committee as defined in Title 24, section 2502, subsection 4-A. The protocols must include the committee reporting information the board considers appropriate regarding reports received, contracts or investigations made and the disposition of each report, provided that the committee is not required to disclose any personally identifiable information. The protocols may not prohibit an impaired dentist from seeking alternative forms of treatment.

[32 MRSA §1073\(4\)](#)

(32) Dirigo Health Program

Dirigo Health Program

The Dirigo Health Program is Governor John Baldacci's signature health care reform program enacted by the legislature in 2003 to address the "three legs" of the health care reform "stool:" access (the DirigoChoice product), quality (the Maine Quality Forum), and cost (Advisory Council on Health Systems Development, State Health Plan, and Certificate-of-Need [CON] program). You can learn more about the Dirgo Health Agency on its website: <http://www.dirigohealth.maine.gov>

You can find the original Dirigo legislation, P.L. 2003, Chapter 469, here:

<http://www.mainelegislature.org/ros/LOM/LOM121st/10Pub451-500/TableofContents.htm>

You can find the Dirigo statute, 24-A M.R.S.A., Chapter 87 here:

<http://www.mainelegislature.org/legis/statutes/24-A/title24-Ach87sec0.html>

Maine Quality Forum

The Maine Quality Forum (MQF) was established by the Governor and the legislature in September 2003. The MQF has been charged with: collecting research, promoting best practices, collecting and publishing comparative quality data, promoting electronic technology, promoting healthy lifestyles and reporting to consumers and the Legislature. The Maine Quality Forum's mission is to advocate for high quality healthcare and help each Maine citizen make informed healthcare choices. You can find more information about the quality improvement role of the Maine Quality Forum on its website:

<http://www.mainequalityforum.gov/>

(33) Disabilities

Americans with Disabilities Act (Select Sections) (F)

Definitions

- A. **Disability:** means, with respect to an individual -
1. A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
 2. A record of such an impairment; or
 3. Being regarded as having such an impairment.

[42 USC §12102](#)

- B. **Qualified individual with a disability:** The term "qualified individual with a disability" means an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires. For the purposes of this subchapter, consideration shall be given to the employer's judgment as to what functions of a job are essential, and if an employer has prepared a written description before advertising or interviewing applicants for the job, this description shall be considered evidence of the essential functions of the job.
- C. **Reasonable accommodation:** The term "reasonable accommodation" may include –
1. Making existing facilities used by employees readily accessible to and usable by individuals with disabilities; and
 2. Job restructuring, part-time or modified work schedules, reassignment to a vacant position, acquisition or modification of equipment or devices, appropriate adjustment or modifications of examinations, training materials or policies, the provision of qualified readers or interpreters, and other similar accommodations for individuals with disabilities.
- D. **Undue hardship:**
1. In general the term "undue hardship" means an action requiring significant difficulty or expense, when considered in light of the factors set forth in subparagraph (B).
 2. Factors to be considered: In determining whether an accommodation would impose an undue hardship on a covered entity, factors to be considered include:
 - a. The nature and cost of the accommodation needed under this chapter;
 - b. The overall financial resources of the facility or facilities involved in the provision of the reasonable accommodation; the number of persons employed at such facility; the effect on expenses and resources, or the impact otherwise of such accommodation upon the operation of the facility;
 - c. The overall financial resources of the covered entity; the overall size of the business of a covered entity with respect to the number of its employees; the number, type, and location of its facilities; and
 - d. The type of operation or operations of the covered entity, including the composition, structure, and functions of the workforce of such entity; the geographic separateness, administrative, or fiscal relationship of the facility or facilities in question to the covered entity.

[42 USC §12111](#)

Discrimination, General

Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

[42 USC §12132](#)

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.

[42 USC §12182 \(a\)](#)

Discrimination in employment

A. General rule

No covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures, the hiring, advancement,

or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.

B. “Discriminate” includes:

1. Limiting, segregating, or classifying a job applicant or employee in a way that adversely affects the opportunities or status of such applicant or employee because of the disability of such applicant or employee;
2. Participating in a contractual or other arrangement or relationship that has the effect of subjecting a covered entity's qualified applicant or employee with a disability to the discrimination prohibited by this subchapter (such relationship includes a relationship with an employment or referral agency, labor union, an organization providing fringe benefits to an employee of the covered entity, or an organization providing training and apprenticeship programs);
3. Utilizing standards, criteria, or methods of administration:
 - a. That have the effect of discrimination on the basis of disability; or
 - b. That perpetuate the discrimination of others who are subject to common administrative control;
4. Excluding or otherwise denying equal jobs or benefits to a qualified individual because of the known disability of an individual with whom the qualified individual is known to have a relationship or association;
5.
 - a. Not making reasonable accommodations to the known physical or mental limitations of an otherwise qualified individual with a disability who is an applicant or employee, unless such covered entity can demonstrate that the accommodation would impose an undue hardship on the operation of the business of such covered entity; or
 - b. Denying employment opportunities to a job applicant or employee who is an otherwise qualified individual with a disability, if such denial is based on the need of such covered entity to make reasonable accommodation to the physical or mental impairments of the employee or applicant;
6. Using qualification standards, employment tests or other selection criteria that screen out or tend to screen out an individual with a disability or a class of individuals with disabilities unless the standard, test or other selection criteria, as used by the covered entity, is shown to be job-related for the position in question and is consistent with business necessity; and
7. Failing to select and administer tests concerning employment in the most effective manner to ensure that, when such test is administered to a job applicant or employee who has a disability that impairs sensory, manual, or speaking skills, such test results accurately reflect the skills, aptitude, or whatever other factor of such applicant or employee that such test purports to measure, rather than reflecting the impaired sensory, manual, or speaking skills of such employee or applicant (except where such skills are the factors that the test purports to measure).

C. Medical examinations and inquiries

1. The prohibition against discrimination as referred to in subsection (a) of this section shall include medical examinations and inquiries.
2. Preemployment:

- a. Prohibited examination or inquiry- Except as provided in paragraph (3), a covered entity shall not conduct a medical examination or make inquiries of a job applicant as to whether such applicant is an individual with a disability or as to the nature or severity of such disability.
 - b. Acceptable inquiry- A covered entity may make preemployment inquiries into the ability of an applicant to perform job-related functions.
3. Employment entrance examination
4. A covered entity may require a medical examination after an offer of employment has been made to a job applicant and prior to the commencement of the employment duties of such applicant, and may condition an offer of employment on the results of such examination, if:
- a. All entering employees are subjected to such an examination regardless of disability;
 - b. Information obtained regarding the medical condition or history of the applicant is collected and maintained on separate forms and in separate medical files and is treated as a confidential medical record, except that –
 - i. supervisors and managers may be informed regarding necessary restrictions on the work or duties of the employee and necessary accommodations;
 - ii. first aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment; and
 - iii. government officials investigating compliance with this chapter shall be provided relevant information on request; and
 - c. The results of such examination are used only in accordance with this subchapter.
- D. Examination and inquiry
- 1. Prohibited examinations and inquiries
 - 2. A covered entity shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity.
 - 3. Acceptable examinations and inquiries

A covered entity may conduct voluntary medical examinations, including voluntary medical histories, which are part of an employee health program available to employees at that work site. A covered entity may make inquiries into the ability of an employee to perform job-related functions.

[42 USC §12112](#) and reflected in [5 MRSA §4553](#)

Physical Access and Barrier Removal

An entity may be in violation of the ADA when:

- A. A failure to remove architectural barriers, and communication barriers that are structural in nature, in existing facilities, and transportation barriers in existing vehicles and rail passenger cars used by an establishment for transporting individuals (not including barriers that can only be removed through the retrofitting of vehicles or rail passenger cars by the installation of a hydraulic or other lift), where such removal is readily achievable; and

[42 USC §12182 \(b\)\(2-A\)\(iv\)](#)
- B. Where an entity can demonstrate that the removal of a barrier under clause (iv) is not readily achievable, a failure to make such goods, services, facilities, privileges, advantages, or accommodations available through alternative methods if such methods are readily achievable.

[42 USC §12182 \(b\)\(2-A\)\(v\)](#)

New construction and alterations in public accommodations and commercial facilities

Application of term

Except as provided in subsection (b) of this section, as applied to public accommodations and commercial facilities, discrimination for purposes of section 12182(a) of this title includes –

- A. A failure to design and construct facilities for first occupancy later than 30 months after July 26, 1990, that are readily accessible to and usable by individuals with disabilities, except where an entity can demonstrate that it is structurally impracticable to meet the requirements of such subsection in accordance with standards set forth or incorporated by reference in regulations issued under this subchapter; and
- B. With respect to a facility or part thereof that is altered by, on behalf of, or for the use of an establishment in a manner that affects or could affect the usability of the facility or part thereof, a failure to make alterations in such a manner that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and usable by individuals with disabilities, including individuals who use wheelchairs. Where the entity is undertaking an alteration that affects or could affect usability of or access to an area of the facility containing a primary function, the entity shall also make the alterations in such a manner that, to the maximum extent feasible, the path of travel to the altered area and the bathrooms, telephones, and drinking fountains serving the altered area, are readily accessible to and usable by individuals with disabilities where such alterations to the path of travel or the bathrooms, telephones, and drinking fountains serving the altered area are not disproportionate to the overall alterations in terms of cost and scope (as determined under criteria established by the Attorney General).

Elevator

Subsection (a) of this section shall not be construed to require the installation of an elevator for facilities that are less than three stories or have less than 3,000 square feet per story unless the building is a shopping center, a shopping mall, or the professional office of a health care provider or unless the Attorney General determines that a particular category of such facilities requires the installation of elevators based on the usage of such facilities.

[42 USC §12183](#)

Access to examinations and courses

Any person that offers examinations or courses related to applications, licensing, certification, or credentialing for secondary or postsecondary education, professional, or trade purposes shall offer such examinations or courses in a place and manner accessible to persons with disabilities or offer alternative accessible arrangements for such individuals.

[42 USC §12189](#)

Maine Human Rights Act (Select sections)

Many of the anti-discrimination sections of the Maine Human Rights Act are similar to those of the provisions found in the American's with Disabilities Act. As such, only the pieces that differ from the ADA are mentioned in this section.

Unlawful employment

For any employer to fail or refuse to hire or otherwise discriminate against any applicant for employment because of race or color, sex, physical or mental disability, religion, age, ancestry or national origin, because of the applicant's previous assertion of a claim or right under former Title 39 or Title 39-A or because of previous actions taken by the applicant that are protected under Title 26, chapter 7, subchapter 5-B; or, because of those reasons, to discharge an employee or discriminate with respect to hire, tenure, promotion, transfer, compensation, terms, conditions or privileges of employment or any other matter

directly or indirectly related to employment; or, in recruiting of individuals for employment or in hiring them, to utilize any employment agency that the employer knows or has reasonable cause to know discriminates against individuals because of their race or color, sex, physical or mental disability, religion, age, ancestry or national origin, because of their previous assertion of a claim or right under former Title 39 or Title 39-A or because of previous actions that are protected under Title 26, chapter 7, subchapter 5-B;

[5 MRSA §4572 \(A\)](#)

Undue hardship; undue burden

"Undue hardship" or "undue burden" is a higher standard than "readily achievable" and requires a greater level of effort on the part of the public accommodation. In determining whether an action would result in an undue hardship, factors to be considered include:

- A. The nature and cost of the accommodation needed under this Act;
- B. The overall financial resources of the facility or facilities involved in the action, the number of persons employed at the facility, the effect on expenses and resources or the impact otherwise of the action upon the operation of the facility;
- C. The overall financial resources of the covered entity, the overall size of the business of a covered entity with respect to the number of its employees and the number, type and location of its facilities;
- D. The type of operation or operations of the covered entity, including the composition, structure and functions of the work force of the entity, the geographic separateness, administrative or fiscal relationship of the facility or facilities in question to the covered entity;
- E. All the resources available to meet the costs of the accommodation, including any government funding or other grants available for making public accommodations and places of employment accessible;
- F. The extent to which current costs of accommodations have been minimized by past efforts to provide equal access to persons with disabilities;
- G. The extent to which resources spent on improving inaccessible equipment or service could have been spent on making an accommodation so that service or equipment is accessible to individuals with disabilities, as well as to individuals without disabilities;
- H. Documented good faith efforts to explore less restrictive or less expensive alternatives
- I. The availability of equipment and technology for the accommodation;
- J. Whether an accommodation would result in a fundamental change in the nature of the public accommodation;
- K. Efforts to minimize costs by spreading costs over time; and
- L. The extent to which resources saved by failing to make an accommodation for persons who have disabilities could have been saved by cutting costs in equipment or services for the general public.

[5 MRSA §4553 \(9-B\)](#)

(34) Driving, Reporting of Impaired Drivers

Optional reporting of drivers operating under the influence of intoxicating liquor or drugs

Persons who may report

If, while acting in a professional capacity, a medical or osteopathic physician, resident, intern, emergency medical services person, medical examiner, physician's assistant, dentist, dental hygienist, dental assistant or registered or licensed practical nurse knows or has reasonable cause to believe that a person has been operating a motor vehicle, hunting or operating a snowmobile, all-terrain vehicle or watercraft while

under the influence of intoxicants and that motor vehicle, snowmobile, all-terrain vehicle or watercraft or a hunter has been involved in an accident, that person may report those facts to a law enforcement official.

[29-A MRSA §2405 \(1\)](#)

Immunity from liability

A person participating in good faith in reporting under this section, or in participating in a related proceeding, is immune from criminal or civil liability for the act of reporting or participating in the proceeding.

Nothing in this section may be construed to bar criminal or civil action regarding perjury.

In a proceeding regarding immunity from liability, there is a rebuttable presumption of good faith.

[29-A MRSA §2405 \(2\)](#)

Privileged or confidential communications

The physician-patient privileges under the Maine Rules of Evidence and the confidential quality of communication under Title 24-A, section 4224 and Title 32, section 1092-A are abrogated in relation to required reporting or other proceeding.

[29-A MRSA §2405 \(3\)](#)

Reporting of Those Unsafe to Drive Due to Age, Medical Condition

A member of the [Department of Motor Vehicles Medical Advisory] board or *other person making an examination and report of opinion*, recommendation or advice to the Secretary of State in good faith is immune from criminal or civil liability for so doing. A physician or other person who becomes aware of a physical, mental or emotional impairment that appears to present an imminent threat to driving safety and reports this information to the Secretary of State in good faith is immune from criminal or civil liability for so doing. The immunity for damages under this subsection applies only to the extent that this immunity is not in conflict with federal law or regulation.

[29-A M.R.S.A. §1258 \(6\)](#)

(35) Drugs, Prescription

Prescriber Laws & Rules (select sections)

Prescription Monitoring Program

The state legislature passed a [law](#) in 2003 that requires information about all transactions for Schedule II, III, and IV controlled substances dispensed in Maine to be reported to the state government. Pharmacies – both in and out of the state – submit data weekly. The data is then cleaned and added to a relational database. Using patients' names and birth dates, registered users of the database can log on to the web site at www.maine.gov/pmp to look up their patients online. Clinicians have immediate access to a patient's history with controlled substances freely available at their fingertips. (To register to become a requester or submitter of data, go to www.maine.gov/pmp and follow the instructions there.)

For more information about the prescription monitoring program, see <http://maine.gov/dhhs/osa/data/pmp/>.

For rules applying to the program, see: <http://maine.gov/dhhs/osa/data/pmp/rules.htm>

Participation requirements

If less than 90% of the prescribers in a class of prescribers (allopathic physicians, osteopathic physicians, dentists, physician assistants, podiatrists or advance practice registered nurses) are registered in the program on January 1, 2014, then all the members of that class of prescribers shall register in the program by March 1, 2014.

[22 MRSA § 7249\(5\)](#)

Identification of persons prescribing medicines on hospital prescription blanks

Any practitioner who writes a prescription upon a prescription blank of a hospital or clinic shall sign that practitioner's name and cause that name to be printed, stamped or typed on the blank.

This section applies to any physician's assistant or registered nurse who writes a prescription while working under the control or supervision of a physician. In case of the physician's assistant or registered nurse, the name of the physician under whom the assistant or nurse works shall be printed, stamped or typed on the blank.

[32 MRSA §13786](#)

Possession of drug samples

No person may purchase manufacturers' drug samples from any person for purposes of resale. If those samples are given gratuitously to a registered pharmacist, qualified assistant pharmacist or medical practitioner, any such sample may be given to any person, provided that any such sample is kept in containers suitably labeled to conform to the Federal Food and Drug Act and the state food and drug laws and provided that this gift shall be subject to the laws relating to the sale of drugs.

[32 MRSA §13789](#)

Reporting the Crime of Acquiring Drugs by Deception

For the purposes of this section, information communicated to a prescribing health care provider, or a person acting under the direction or supervision of a prescribing health care provider, in an effort to violate this section, including a violation by procuring the administration of a scheduled drug by deception, may not be deemed a privileged communication.

[17-A MRSA §1108 \(3\)](#)

Immunity from criminal or civil liability

A prescribing health care provider, or a person acting under the direction or supervision of a prescribing health care provider, who knows or has reasonable cause to believe that a person is committing or has committed deception may report that fact to a law enforcement officer. A person participating in good faith in reporting under this subsection, or in participating in a related proceeding, is immune from criminal or civil liability for the act of reporting or participating in the proceeding.

[17-A MRSA §1108 \(6\)](#)

Reporting Crime Against Practitioner or on Premises

A health care practitioner or facility may disclose, or when required by law must disclose, health care information without authorization to disclose under the circumstances stated in this subsection or as provided in subsection 11. Disclosure may be made without authorization as follows: (E) To federal, state or local governmental entities in order to protect the public health and welfare when reporting is required or authorized by law, to report a suspected crime against the health care practitioner or facility or to report information that the health care facility's officials or health care practitioner in good faith believes constitutes evidence of criminal conduct that occurred on the premises of the health care facility or health care practitioner.

[22 MRSA § 1711-C \(6\)](#)

Use of Controlled Substances for the Treatment of Pain (see Agency Rules Links)

For the full guidance on Use of Controlled Substances For Treatment of Pain, see the Board of Licensure in Medicine [Rule Chapter 21](#).

Principles of Proper Patient Management

The Board of Licensure in Medicine has adopted the following criteria when evaluating the clinician's treatment of pain including the use of controlled substances. Each of these principles is essential in the treatment of patients with pain.

1. **Evaluation of the Patient** — A medical history and appropriate physical examination must be obtained, evaluated and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function and history of substance abuse. It is recommended that the State's Controlled Substance Prescription Monitoring Program Database (PMP) be utilized. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.
2. **Treatment Plan** — The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the clinician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.
3. **Informed Consent and Agreement for Treatment** — The clinician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one clinician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse or substance dependence, the clinician should use a written agreement between clinician and patient outlining patient responsibilities, including:
 - a. urine/serum medication levels screening when requested;
 - b. pill count when requested;
 - c. number and frequency of all prescription refills; and
 - d. reasons for which drug therapy may be discontinued (e.g., violation of agreement).
4. **Periodic Review of Treatment Efficacy** — The clinician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the clinician's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the clinician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities. Likewise, the clinician should periodically review the course of treatment where psychoactive drugs are used for the treatment of components of chronic pain, e.g., emotional, psychological, or psychosocial stressors, and assess the appropriateness of continued use of the current treatment plan if the patient's progress is unsatisfactory.
5. **Consultation or Referral** — The clinician should consult or refer, as necessary, for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. Chronic pain often has, as a component, emotional, psychological, or

psychosocial stress. In these situations, a number of patients may benefit from psychoactive medications, as well as controlled substances for pain control. The combination of opiates with psychoactive medications, e.g., benzodiazepines, may place the patient at greater risk. The risk may be associated with drug interaction, potentiation, or abuse. In these situations, consultation with or referral to an expert in the management of such patients may be required.

6. **Medical Records** — The clinician should keep accurate and complete records to include:
- a. the medical history and appropriate physical examination;
 - b. diagnostic, therapeutic and laboratory results;
 - c. evaluations and consultations;
 - d. treatment objectives;
 - e. discussion of risks and benefits;
 - f. informed consent;
 - g. treatments;
 - h. medications (including date, type, dosage and quantity prescribed);
 - i. instructions and agreements; and
 - j. periodic reviews.

Records should remain current and be maintained in an accessible manner, readily available for review.

7. **Reportable Acts** — Generally, information gained as part of the clinician/patient relationship remains confidential. However, the clinician has an obligation to deal with persons who use the clinician to perpetrate illegal acts, such as illegal acquisition or selling of drugs; this may include reporting to law enforcement. Information suggesting inappropriate or drug-seeking behavior, should be addressed appropriately and documented. Use of the PMP is recommended.
8. **Compliance With Controlled Substances Laws and Regulations** — To prescribe, dispense or administer controlled substances, the clinician must be licensed or otherwise authorized and comply with applicable federal and state regulations. Clinicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and any relevant documents issued by the appropriate board or agency for specific rules governing controlled substances as well as applicable state regulations.

[Board of Licensure in Medicine and Board of Osteopathic Licensure Chapter 21 \(§3\)](#)

Limits on coverage of opiates and opiate replacement therapy by MaineCare

The following changes to the MaineCare Benefits Manual Section 80, Pharmacy Services became effective on January 1, 2013

If a patient has new acute pain, and opioids are allowed, prescribers will only be able to prescribe them for fifteen (15) days each year. If the patient needs more than 15 days of opioid treatment, the prescriber will need to receive Prior Authorization (PA) from MaineCare. If opioids are medically necessary and the PA request is approved, there will be a maximum allowed dose of the medication. The patient may be required to get a second medical opinion or try another treatment for pain, when appropriate.

MaineCare members will have a 24 month lifetime limit for Suboxone, Subutex and their generics. If it is medically necessary for a patient to continue use of these medications for more than 24 months, then prescribers will need to get PA from MaineCare

MaineCare members will have a 24 month lifetime limit for methadone. If it is medically necessary for a patient to continue with the medication for more than 24 months, then prescribers will need to get PA from MaineCare.

For more information visit the [Provider Section](#) of the MaineCare website.

Authorized possession by individuals

A person to whom or for whose use any scheduled drug, prescription drug or controlled substance has been prescribed, sold or dispensed for a legitimate medical purpose by a physician, dentist, podiatrist, pharmacist or other person acting in the usual course of professional practice and authorized by law or rule to do so and the owner or the person having the custody or control of any animal for which any scheduled drug, prescription drug or controlled substance has been prescribed, sold or dispensed for a legitimate veterinary medical purpose by a licensed veterinarian acting in the usual course of professional veterinary practice may lawfully possess the drug or substance, except when in use, only in the container in which it was delivered by the person selling or dispensing the drug or substance. “When in use” includes reasonable repackaging for more convenient legitimate medical use.

[22 MRSA §2383-B \(1\)](#)

Others lawfully in possession

Except as otherwise authorized or restricted, the following persons are authorized to possess, furnish and have control of scheduled or prescription drugs, controlled substances or hypodermic apparatuses:

- A. Common carriers or warehouse operators while engaged in lawfully transporting or storing prescription drugs or hypodermic apparatuses or any of their employees acting within the scope of their employment;
- B. Employees or agents of persons lawfully entitled to possession who have temporary, incidental possession while acting within the scope of their employment or agency;
- C. Persons whose possession is for the purpose of aiding public officers in performing their official duties while acting within the scope of their employment or duties;
- D. Law enforcement officers while acting within the scope of their employment and official duties
- E. Physicians, dentists, podiatrists, pharmacists or other persons authorized by law or rule to administer, dispense, prescribe or sell scheduled or prescription drugs, controlled substances or hypodermic apparatuses while acting within the course of their professional practice;
- F. With regard to the possession or furnishing of hypodermic apparatuses, persons authorized by the Bureau of Health pursuant to a hypodermic apparatus exchange program, certified under chapter 252-A while acting within the scope of their employment under such programs; and
- G. Close family members of or other persons authorized by a person lawfully in possession of the drug or controlled substance if the family member or authorized person is in possession of the drug or controlled substance for the purpose of assisting in filling a prescription, preparing the drug or substance to be administered or administering the drug or substance.

[22 MRSA §2383-B \(2\)](#)

Patient Laws & Rules (select sections)

Patient Retention of Medications

Upon discharge from a hospital licensed under chapter 405 or upon moving from a nursing facility licensed under chapter 405 or assisted living facility licensed under chapter 1663, a patient or resident retains ownership of any medications owned by the patient or resident while a patient or resident and may take those medications to the next place of treatment or residence.

[22 MRSA §1720](#)

Pharmacy/Dispenser Laws & Rules (select sections)

Generic and therapeutically equivalent substitution

A written prescription issued by a practitioner in this State may contain a box in the lower right-hand corner of the prescription form. The following words must appear to the left of this box: "Any drug which is the generic and therapeutic equivalent of the drug specified above in this prescription must be dispensed, provided that no check mark (✓) has been handwritten in the box in the lower right-hand corner."

Except with regard to a patient who is paying for a drug with the patient's own resources, any pharmacist receiving a prescription in which no handwritten check mark () is found in the box provided shall substitute a generic and therapeutically equivalent drug for the drug specified on the prescription if the substituted drug is distributed by a business entity doing business in the United States that is subject to suit and the service of legal process in the United States and the price of the substituted drug does not exceed the price of the drug specified by the practitioner; except that, when the cost of a prescription is to be reimbursed under the MaineCare program pursuant to Title 22, chapter 855, the pharmacist shall substitute a generic and therapeutically equivalent drug only when the Department of Health and Human Services has determined that the substitute drug would be a more cost-effective alternative than the drug prescribed by the practitioner. Except for prescribed drugs listed under the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code, Section 812, as amended, as Schedule II drugs, with regard to a patient who is paying for a drug with the patient's own resources, a pharmacist shall inquire about the patient's preference for either the brand-name drug or generic and therapeutically equivalent drug and dispense the drug that the patient prefers.

Except with regard to a patient who is paying for a drug with the patient's own resources, if a written prescription issued by a practitioner in this State does not contain the box described in this section, a pharmacist shall substitute a generic and therapeutically equivalent drug for the drug specified on the prescription if the substituted drug is distributed by a business entity doing business in the United States that is subject to suit and the service of legal process in the United States and the price of the substituted drug does not exceed the price of the drug specified by the practitioner, unless a practitioner has handwritten on the prescription form, along with the practitioner's signature, "dispense as written," "DAW," "brand" "brand necessary" or "brand medically necessary"; except that, when the cost of a prescription is to be reimbursed under the MaineCare program pursuant to Title 22, chapter 855, the pharmacist shall substitute a generic and therapeutically equivalent drug only when the Department of Health and Human Services has determined that the substitute drug would be a more cost-efficient alternative than the drug prescribed by the practitioner. Except for prescribed drugs listed under the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 United States Code, Section 812, as amended, as Schedule II drugs, with regard to a patient who is paying for a drug with the patient's own resources, a pharmacist shall inquire about the patient's preference for either the brand-name drug or generic and therapeutically equivalent drug and dispense the drug that the patient prefers.

Any pharmacist who substitutes a generic and therapeutically equivalent drug under this section shall inform the person to whom the drug is dispensed of the substitution. When any substitution is made under this section, the pharmacist shall cause the name of the generic and therapeutically equivalent drug, the name or abbreviation of the drug manufacturer or distributor of that substitute drug and all other information as required by section 13794 to appear on the container label of the drug dispensed.

This section does not apply to prescriptions ordered by practitioners for patients in hospitals when those prescriptions are filled by a hospital pharmacy or in any institution where a formulary system is established.

[32 MRSA §13781](#)

Patient profile record system regulation

A patient profile record system shall be maintained in all pharmacies for persons for whom prescriptions are dispensed. The patient profile record system shall be devised to enable the immediate retrieval of information necessary for the dispensing pharmacist to identify previously dispensed medication at the time a prescription is presented for dispensing. One profile record or document may be maintained for all members of a family living at the same address and possessing the same family name. The following information shall be recorded:

- A. **Name.** The family name and the first name of the person for whom the medication is intended;
- B. **Address.** The address to correspond to the name in subsection 1;
- C. **Age group.** An indication of the patient's age group, that is, infant, child or adult;
- D. **Original date of dispensing.** The original date the medication is dispensed pursuant to the receipt of a practitioner's prescription;
- E. **Prescription identification.** The number or designation identifying the prescription;
- F. **Prescriber's name.** The name of the person prescribing the drug or device;
- G. **Drug information.** The name, strength and quantity of the drug; and
- H. **Initials of pharmacist; date of refill.** The initials of the dispensing pharmacist and the date of dispensing the medication as a renewal or refill, if those initials and that date are not recorded on the back of the original prescription.

The pharmacist shall attempt to ascertain and shall record any allergies and idiosyncrasies of the patient and any chronic conditions which may relate to drug utilization as communicated to the pharmacy by the patient.

Upon receipt of a prescription, a pharmacist shall examine the patient's profile record before dispensing the medication to determine the possibility of a harmful drug interaction or reaction. Upon recognizing a potentially harmful reaction or interaction, the pharmacist shall take appropriate action to avoid or minimize the problem which may include consultation with the practitioner.

A patient profile record must be maintained for a period of not less than the amount of time required under federal Medicare laws, beginning from the date of the last entry in the profile record. As used in this section, "Medicare" means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

Under HIPAA, records are required to be maintained for a minimum period of 6 years unless another state or federal law, regulation or other legal requirement extends this period.

[32 MRSA §13785](#)

Photographic proof of identification

As a precondition to filling any prescription or dispensing any drug, a pharmacist or person acting at the direction of a pharmacist may demand, inspect and record proof of identification, including valid photographic identification, from any patient presenting a prescription or any person acting on behalf of the patient or person purchasing a targeted methamphetamine precursor. Valid photographic identification includes but is not limited to the following:

- A. A valid Maine motor vehicle operator's license;
- B. A valid Maine identification card issued under Title 29-A, section 1410;
- C. A valid United States passport;
- D. A valid passport or motor vehicle operator's license of another state, territory, possession or foreign country only if it:

1. Contains a photograph of the traveler or licensee;
 2. Is encased in tamper-resistant plastic or otherwise possesses indicia of tamper-resistance; and
 3. Identifies the traveler's or licensee's date of birth; or
- E. Other valid, tamper-resistant, photographic identification as provided in rules adopted by the board pursuant to section 13722, subsection 1, paragraph A and in accordance with Title 5, chapter 375.

[32 MRSA §13795 \(1\)](#)

Refusal to fill prescription or dispense drug

A pharmacist or person acting at the direction of a pharmacist may exercise discretion and refuse to fill any prescription or dispense any drug if unsatisfied as to the legitimacy or appropriateness of any prescription presented, the validity of any photographic identification or the identity of any patient presenting a prescription or any person acting on behalf of the patient, or the intention of the customer to use the drug targeted methamphetamine precursor according to the instructions for use. A pharmacist or person acting at the direction of a pharmacist may make a report to a law enforcement agency when that person has reasonable cause to suspect that a prescription is not legitimate or appropriate, that a person has presented photographic identification that is not valid or that a customer has the intention to use a drug or targeted methamphetamine precursor in a manner inconsistent with the instructions for use.

[32 MRSA §13795 \(2\)](#)

Security requirements

The Department of Public Safety, after consultation with the Board of Osteopathic Licensure, the Board of Licensure in Medicine and the Board of Pharmacy, shall adopt rules that establish security requirements for all written prescriptions for schedule II drugs issued by health care providers.

[32 MRSA §13786-A \(1\)](#)

Out-of-state prescription security requirements

Notwithstanding any law or rule to the contrary, a prescription for a schedule II drug written by an out-of-state practitioner on a prescription blank that does not comply with the requirements for a security prescription blank, as defined in the Department of Public Safety rule pursuant to subsection 1, may be filled by a pharmacist only if:

- A. The pharmacist receives and makes a record of oral confirmation of the validity of the prescription from the out-of-state practitioner or the practitioner's agent and the pharmacist makes a reasonable effort to determine that the oral confirmation came from the practitioner or the practitioner's agent, which may include a telephone call to the practitioner's telephone number listed in a telephone directory or other directory or other good faith efforts to confirm the identity of the person giving the oral confirmation; and
- B. The pharmacist demands, inspects and records a valid photographic identification from any person presenting a prescription or receiving a filled prescription unless:
 1. The person is the patient for whom the prescription is written;
 2. The person's identity is personally known to the pharmacist; and
 3. The pharmacist confirms by reviewing the pharmacy records that the pharmacist has previously demanded, inspected and recorded a valid photographic identification from the person.

[32 MRSA §13786-A \(2\)](#)

Partial filling of out-of-state prescriptions

The partial filling of a prescription for a schedule II drug written by an out-of-state practitioner on a prescription blank that does not comply with the requirements for a security prescription blank, as defined

in the Department of Public Safety rule pursuant to subsection 1, is permissible if the pharmacist is unable after reasonable effort to obtain the oral confirmation described in subsection 2 in the case of the practitioner's office being closed during nights, weekends or holidays. The partial filling is limited to a 72-hour supply of the controlled substance. The remaining portion of the prescription may be filled within the 72-hour period upon obtaining the oral confirmation. No further quantity may be filled beyond the 72 hours without a new prescription.

[32 MRSA §13786-A \(4\)](#)

Sale of poisonous drugs

Each licensed pharmacist who sells a poison shall affix to the package sold a label plainly marked with the name and address of the store and the word "POISON" and the name of the poison sold, and shall enter at the time of sale in a permanently bound book to be kept for that purpose the name and address of the purchaser, the date of sale, the name of the poison and the quantity sold and the person making the sale shall sign the entry. This section shall not apply to sales on prescription of practitioners, sales at wholesale to pharmacists or sales to hospitals, colleges or public institutions.

[32 MRSA §13788](#)

Using drugs not in prescription

If a pharmacist knowingly uses any drugs or ingredients in preparing or compounding a written or oral prescription of any practitioner different from those named in the prescription, that use shall constitute a civil violation for which a forfeiture of not more than \$1,000 nor less than \$50 may be adjudged.

[32 MRSA §13790](#)

Return of drugs

A drug or pharmaceutical preparation that has been dispensed on prescription may be returned to pharmacy stock after being in possession and under the control of another person and may be dispensed again if the drug is packaged in an unbroken, sealed container or if, in the case of a hospital, a licensed pharmacist determines that the drug has not been impaired.

[32 MRSA §13791](#)

Adulterating and selling drugs

Whoever fraudulently adulterates, for the purpose of sale, any drug or medicine or sells any fraudulently adulterated drug or medicine, knowing the same to be adulterated, shall be punished by a fine of not more than \$1,000 or by imprisonment for not more than 11 months. These adulterated drugs and medicines shall be forfeited and destroyed under the direction of the court.

[32 MRSA §13793](#)

Labeling of prescriptions

Every drug dispensed pursuant to prescription, whether for a legend drug or not, must carry on the label the following information:

- A. The prescription number;
- B. The date of filling;
- C. The patient's name;
- D. Directions for use;

- E. The name and strength of the drug and the amount dispensed, including either the brand name of the drug or, if a generic and therapeutically equivalent drug is dispensed it must be in accordance with section 13781;
- F. The beyond use date of the drug;
- G. The name of the practitioner prescribing the drug; and
- H. The name, address and telephone number of the pharmacy where the prescription was compounded and dispensed.

For purposes of this section, "beyond use date" means a date beyond which the contents of the prescription are not recommended to be used.

[32 MRSA §13794](#)

Unused Pharmaceutical Disposal Program

The Maine Drug Enforcement Agency shall create a system for the return of unused pharmaceuticals. The system must use prepaid mailing envelopes into which the unused pharmaceuticals are placed and returned to a single collection location. The prepaid mailing envelopes must be made available to the public at various locations, including, but not limited to, pharmacies, physicians' offices and post offices. The agency may randomly assess the toxicity of materials received under the program as long as the assessment results do not identify the patient, person who mailed the material, prescriber or pharmacy.

[22 MRSA §2700](#)

Advertising, Marketing & Costs

Advertising

It is lawful for any pharmacy, pharmacist or other licensee of the board to advertise to the public the current retail price charged for any drugs, medicines or appliances as defined in the United States Code, Title 21, Section 3211 (g) (1) which bears the legend "Caution: Federal law prohibits dispensing without prescription." The advertising may be according to either the brand name or the generic name of the drug. No media advertising of any drugs included in the United States Comprehensive Drug Abuse Prevention and Control Act of 1970, 84 Stat. 1236, is permitted.

[32 MRSA §13782](#)

Price disclosure required

A pharmacist or pharmacy technician employed by a pharmacy shall disclose upon the request of any person making an inquiry in person or by telephone the price of any brand or generic drug sold by that pharmacy.

[32 MRSA §13782-A \(1\)](#)

Sale by certain methods prohibited

It shall be unlawful for any person to sell, distribute, vend or otherwise dispose of any drug, medicine or pharmaceutical or medical preparation by means of any public exhibition, entertainment, performance, carnival or by vending machines.

[32 MRSA §13792](#)

Maine RX Plus Program

The Maine Rx Plus Program, referred to in this subchapter as the "program," is established to reduce prescription drug prices and to improve the quality of health care for residents of the State. The program

is administered by the department and must utilize manufacturer rebates and pharmacy discounts to reduce prescription drug prices.

[22 MRSA §2681 \(1\)](#)

Prescription Drug Price Reduction Act

The Legislature finds that affordability is critical in providing access to prescription drugs for Maine residents. This subchapter is enacted by the Legislature as a positive measure to make prescription drugs more affordable for qualified Maine residents, thereby increasing the overall health of Maine residents, promoting healthy communities and protecting the public health and welfare of Maine residents.

[22 MRSA §2691](#)

Emergency drug pricing

In order to achieve the public health purposes listed in section 2691, maximum retail prices for prescription drugs sold in Maine may be established pursuant to this section.

[22 MRSA §2693](#)

Profiteering in Prescription Drugs

Prescription drugs are a necessity of life. Profiteering in prescription drugs is unlawful and is subject to the provisions of this section. The provisions of this section apply to manufacturers, distributors and labelers of prescription drugs.

[22 MRSA §2697](#)

Marketing costs

Maine's law requiring manufacturers to report marketing costs for prescription drugs was repealed in 2011 in an attempt to make Maine law consistent with federal law. See [2011 Public Law, Chapter 461](#).

Confidentiality

Prescription Privacy Law

A carrier or prescription drug information intermediary may not license, use, sell, transfer or exchange for value, for any marketing purpose, prescription drug information that identifies directly or indirectly the individual who is prescribed the prescription drug.

[22 MRSA §1711-E \(2\)](#)

Maine's law requiring confidentiality of prescription drug information that identifies the prescriber was repealed in 2012 in an attempt to make Maine's law consistent with federal law. See [2011 Public Law, Chapter 494](#).

Prescription Monitoring Program Data Confidentiality

The office of Chief Medical Examiner for the purpose of conducting an investigation or inquiry into the cause, manner and circumstances of death in a medical examiner case as described in section 3025. Prescription monitoring information in the possession or under the control of the Office of Chief Medical Examiner is confidential and, notwithstanding section 3022, may not be disseminated. Information that is not prescription monitoring information and is separately acquired following access to prescription monitoring information pursuant to this paragraph remains subject to protection or dissemination in accordance with section 3022.

[22 MRSA §7250 \(4\)](#)

Prescription Drug Academic Detailing Program

Creation

By January 1, 2008, the department shall establish a prescription drug academic detailing program, referred to in this section as "the program," to enhance the health of residents of the State, to improve the quality of decisions regarding drug prescribing, to encourage better communication between the department and health care practitioners participating in publicly funded health programs and to reduce the health complications and unnecessary costs associated with inappropriate drug prescribing.

[22 MRSA §2685](#)

Program Components

Program components must include outreach and education regarding the therapeutic and cost-effective use of prescription drugs as issued in peer-reviewed scientific, medical and academic research publications and made available to prescribers and dispensers of drugs in the State, including through written information and through personal visits from program staff. To the extent possible, program components must also include information regarding clinical trials, pharmaceutical efficacy, adverse effects of drugs, evidence-based treatment options and drug marketing approaches that are intended to circumvent competition from generic and therapeutically equivalent drugs. Academic detailers shall observe standards of conduct in their educational materials and written and oral presentations as established by rules adopted by the department that are consistent with the following federal regulations regarding labeling and false and misleading advertising: the Food and Drug Administration labeling requirements of 21 Code of Federal Regulations, Part 201 (2007) and prescription drug advertising provisions of 21 Code of Federal Regulations, Part 202 (2007) and the Office of the Inspector General's Compliance Program Guidance for Pharmaceutical Manufacturers issued in April 2003, as amended. The rules must require academic detailers to disclose evidence-based information about the range and cost of appropriate drug treatment options and the health benefits and risks of all appropriate drugs.

[22 MRSA §2685 \(3\)](#)

Program Coverage

The program must provide outreach and education to prescribers and dispensers who participate in, contract with or are reimbursed by state-funded health care programs, including but not limited to the MaineCare program, the Maine Rx Plus Program, Dirigo Health insurance, the elderly low-cost drug program and the state employee health insurance program. The program may provide outreach and education to carriers, health plans, hospitals, employers and other persons interested in the program on a subscription or fee-paying basis under rules adopted by the department.

[22 MRSA §2685 \(4\)](#)

For more information, see the [Maine Medical Association website on Academic Detailing](#).

Controlled Substances Act, Select Sections (F)

General

Any person planning on using any controlled substance, as listed in the [USC Schedules of Controlled Substances](#), must register with the United States Department of Justice, Drug Enforcement Administration prior to the uses of any controlled substance.

A list of [DEA Scheduled Controlled Substances](#) along with common names and DEA numbers can be found on the [DEA Website](#)

An [Exempt List](#) of controlled substances can be found as part of the DEA's [Diversion Control Program](#)

Persons required to register

- A. Period of registration

1. Every person who manufactures or distributes any controlled substance or list I chemical, or who proposes to engage in the manufacture or distribution of any controlled substance or list I chemical, shall obtain annually a registration issued by the Attorney General in accordance with the rules and regulations promulgated by him.
2. Every person who dispenses, or who proposes to dispense, any controlled substance, shall obtain from the Attorney General a registration issued in accordance with the rules and regulations promulgated by him. The Attorney General shall, by regulation, determine the period of such registrations. In no event, however, shall such registrations be issued for less than one year nor for more than three years.

B. Authorized activities

Persons registered by the Attorney General under this subchapter to manufacture, distribute, or dispense controlled substances or list I chemicals are authorized to possess, manufacture, distribute, or dispense such substances or chemicals (including any such activity in the conduct of research) to the extent authorized by their registration and in conformity with the other provisions of this subchapter.

C. Exceptions

The following persons shall not be required to register and may lawfully possess any controlled substance or list I chemical under this subchapter:

1. An agent or employee of any registered manufacturer, distributor, or dispenser of any controlled substance or list I chemical if such agent or employee is acting in the usual course of his business or employment.
2. A common or contract carrier or warehouseman, or an employee thereof, whose possession of the controlled substance or list I chemical is in the usual course of his business or employment.
3. An ultimate user who possesses such substance for a purpose specified in section 802(25) of this title.

D. Waiver

The Attorney General may, by regulation, waive the requirement for registration of certain manufacturers, distributors, or dispensers if he finds it consistent with the public health and safety.

E. Separate registration

A separate registration shall be required at each principal place of business or professional practice where the applicant manufactures, distributes, or dispenses controlled substances or list I chemicals.

F. Inspection

The Attorney General is authorized to inspect the establishment of a registrant or applicant for registration in accordance with the rules and regulations promulgated by him.

[21 USCA §822](#)

Controlled Substances Registration Materials

[DEA Registration Procedures](#)

[DEA Registration Categories and Fees](#)

[DEA Registration Forms](#)

[DEA Change Request](#)

[Registration FAQ's](#)

Schedules of Controlled Substances, Defined

- A. Schedule I
 - 1. The drug or other substance has a high potential for abuse.
 - 2. The drug or other substance has no currently accepted medical use in treatment in the United States.
 - 3. There is a lack of accepted safety for use of the drug or other substance under medical supervision.
- B. Schedule II
 - 1. The drug or other substance has a high potential for abuse.
 - 2. The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
 - 3. Abuse of the drug or other substances may lead to severe psychological or physical dependence.
- C. Schedule III
 - 1. The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II.
 - 2. The drug or other substance has a currently accepted medical use in treatment in the United States.
 - 3. Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.
- D. Schedule IV
 - 1. The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule III.
 - 2. The drug or other substance has a currently accepted medical use in treatment in the United States.
 - 3. Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule III.
- E. Schedule V
 - 1. The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule IV.
 - 2. The drug or other substance has a currently accepted medical use in treatment in the United States.
 - 3. Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule IV.

[21 USCA §812](#)

Distributors of controlled substances in schedule I or II

The Attorney General shall register an applicant to distribute a controlled substance in schedule I or II unless he determines that the issuance of such registration is inconsistent with the public interest. In determining the public interest, the following factors shall be considered:

- A. Maintenance of effective control against diversion of particular controlled substances into other than legitimate medical, scientific, and industrial channels;
- B. Compliance with applicable State and local law;
- C. Prior conviction record of applicant under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances;

- D. Past experience in the distribution of controlled substances; and
- E. Such other factors as may be relevant to and consistent with the public health and safety.

[21 USCA §823 \(b\)](#)

NOTE: While this section normally does not apply to medical practitioners, it is important to note that Medical Marijuana (as described under the Maine Marijuana Act) is listed as a schedule I drug.

Limits of authorized activities

Registration granted under subsections ... (b) of this section shall not entitle a registrant to (1) manufacture or distribute controlled substances in schedule I or II other than those specified in the registration, or (2) manufacture any quantity of those controlled substances in excess of the quota assigned pursuant to section 826 of this title.

[21 USCA §823 \(c\)](#)

Distributors of controlled substances in schedule III, IV or V

The Attorney General shall register an applicant to distribute a controlled substance in schedule III, IV or V unless he determines that the issuance of such registration is inconsistent with the public interest. In determining the public interest, the following factors shall be considered:

- A. Maintenance of effective control against diversion of particular controlled substances into other than legitimate medical, scientific, and industrial channels;
- B. Compliance with applicable State and local law;
- C. Prior conviction record of applicant under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances;
- D. Past experience in the distribution of controlled substances,
- E. Such other factors as may be relevant to and consistent with the public health and safety.

[21 USCA §823 \(e\)](#)

Denial, revocation, or suspension of registration

A. Grounds

A registration pursuant to section 823 of this title to manufacture, distribute, or dispense a controlled substance or a list I chemical may be suspended or revoked by the Attorney General upon a finding that the registrant:

1. Has materially falsified any application filed pursuant to or required by this subchapter or subchapter II of this chapter;
2. Has been convicted of a felony under this subchapter or subchapter II of this chapter or any other law of the United States, or of any State, relating to any substance defined in this subchapter as a controlled substance or a list I chemical;
3. Has had his State license or registration suspended, revoked, or denied by competent State authority and is no longer authorized by State law to engage in the manufacturing, distribution, or dispensing of controlled substances or list I chemicals or has had the suspension, revocation, or denial of his registration recommended by competent State authority;
4. Has committed such acts as would render his registration under section 823 of this title inconsistent with the public interest as determined under such section; or
5. Has been excluded (or directed to be excluded) from participation in a program pursuant to section 1320a-7(a) of title 42. A registration pursuant to section 823(g)(1) of this title to

dispense a narcotic drug for maintenance treatment or detoxification treatment may be suspended or revoked by the Attorney General upon a finding that the registrant has failed to comply with any standard referred to in section 823(g)(1) of this title.

B. Limits of revocation or suspension

The Attorney General may limit revocation or suspension of a registration to the particular controlled substance or list I chemical with respect to which grounds for revocation or suspension exist.

C. Service of show cause order; proceedings

Before taking action pursuant to this section, or pursuant to a denial of registration under section 823 of this title, the Attorney General shall serve upon the applicant or registrant an order to show cause why registration should not be denied, revoked, or suspended. The order to show cause shall contain a statement of the basis thereof and shall call upon the applicant or registrant to appear before the Attorney General at a time and place stated in the order, but in no event less than thirty days after the date of receipt of the order. Proceedings to deny, revoke, or suspend shall be conducted pursuant to this section in accordance with subchapter II of chapter 5 of title 5. Such proceedings shall be independent of, and not in lieu of, criminal prosecutions or other proceedings under this subchapter or any other law of the United States.

D. Suspension of registration in cases of imminent danger

The Attorney General may, in his discretion, suspend any registration simultaneously with the institution of proceedings under this section, in cases where he finds that there is an imminent danger to the public health or safety. A failure to comply with a standard referred to in section 823(g)(1) of this title may be treated under this subsection as grounds for immediate suspension of a registration granted under such section. A suspension under this subsection shall continue in effect until the conclusion of such proceedings, including judicial review thereof, unless sooner withdrawn by the Attorney General or dissolved by a court of competent jurisdiction.

E. Suspension and revocation of quotas

The suspension or revocation of a registration under this section shall operate to suspend or revoke any quota applicable under section 826 of this title.

F. Disposition of controlled substances or list I chemicals

In the event the Attorney General suspends or revokes a registration granted under section 823 of this title, all controlled substances or list I chemicals owned or possessed by the registrant pursuant to such registration at the time of suspension or the effective date of the revocation order, as the case may be, may, in the discretion of the Attorney General, be placed under seal. No disposition may be made of any controlled substances or list I chemicals under seal until the time for taking an appeal has elapsed or until all appeals have been concluded except that a court, upon application therefor, may at any time order the sale of perishable controlled substances or list I chemicals. Any such order shall require the deposit of the proceeds of the sale with the court. Upon a revocation order becoming final, all such controlled substances or list I chemicals (or proceeds of sale deposited in court) shall be forfeited to the United States; and the Attorney General shall dispose of such controlled substances or list I chemicals in accordance with section 881(e) of this title. All right, title, and interest in such controlled substances or list I chemicals shall vest in the United States upon a revocation order becoming final.

G. Seizure or placement under seal of controlled substances or list I chemicals

The Attorney General may, in his discretion, seize or place under seal any controlled substances or list I chemicals owned or possessed by a registrant whose registration has expired or who has ceased to practice or do business in the manner contemplated by his registration. Such controlled substances or list I chemicals shall be held for the benefit of the registrant, or his

successor in interest. The Attorney General shall notify a registrant, or his successor in interest, who has any controlled substance or list I chemical seized or placed under seal of the procedures to be followed to secure the return of the controlled substance or list I chemical and the conditions under which it will be returned. The Attorney General may not dispose of any controlled substance or list I chemical seized or placed under seal under this subsection until the expiration of one hundred and eighty days from the date such substance or chemical was seized or placed under seal.

[21 USCA §824](#)

Labeling and packaging

A. Symbol

It shall be unlawful to distribute a controlled substance in a commercial container unless such container, when and as required by regulations of the Attorney General, bears a label (as defined in section 321(k) of this title) containing an identifying symbol for such substance in accordance with such regulations. A different symbol shall be required for each schedule of controlled substances.

B. Unlawful distribution without identifying symbol

It shall be unlawful for the manufacturer of any controlled substance to distribute such substance unless the labeling (as defined in section 321(m) of this title) of such substance contains, when and as required by regulations of the Attorney General, the identifying symbol required under subsection (a) of this section.

C. Warning on label

The Secretary shall prescribe regulations under section 353(b) of this title which shall provide that the label of a drug listed in schedule II, III, or IV shall, when dispensed to or for a patient, contain a clear, concise warning that it is a crime to transfer the drug to any person other than the patient.

D. Containers to be securely sealed

It shall be unlawful to distribute controlled substances in schedule I or II, and narcotic drugs in schedule III or IV, unless the bottle or other container, stopper, covering, or wrapper thereof is securely sealed as required by regulations of the Attorney General.

[21 USCA §825](#)

Records and reports of registrants

A. Inventory

Except as provided in subsection (c) of this section -

1. Every registrant under this subchapter shall, on May 1, 1971, or as soon thereafter as such registrant first engages in the manufacture, distribution, or dispensing of controlled substances, and every second year thereafter, make a complete and accurate record of all stocks thereof on hand, except that the regulations prescribed under this section shall permit each such biennial inventory (following the initial inventory required by this paragraph) to be prepared on such registrant's regular general physical inventory date (if any) which is nearest to and does not vary by more than six months from the biennial date that would otherwise apply;
2. On the effective date of each regulation of the Attorney General controlling a substance that immediately prior to such date was not a controlled substance, each registrant under this subchapter manufacturing, distributing, or dispensing such substance shall make a complete and accurate record of all stocks thereof on hand; and
3. On and after May 1, 1971, every registrant under this subchapter manufacturing, distributing, or dispensing a controlled substance or substances shall maintain, on a current

basis, a complete and accurate record of each such substance manufactured, received, sold, delivered, or otherwise disposed of by him, except that this paragraph shall not require the maintenance of a perpetual inventory.

B. Availability of records

Every inventory or other record required under this section shall be in accordance with, and contain such relevant information as may be required by, regulations of the Attorney General, be maintained separately from all other records of the registrant, or alternatively, in the case of nonnarcotic controlled substances, be in such form that information required by the Attorney General is readily retrievable from the ordinary business records of the registrant, and be kept and be available, for at least two years, for inspection and copying by officers or employees of the United States authorized by the Attorney General.

C. Nonapplicability

The foregoing provisions of this section shall not apply –

1. to the prescribing of controlled substances in schedule II, III, IV, or V by practitioners acting in the lawful course of their professional practice unless such substance is prescribed in the course of maintenance or detoxification treatment of an individual; or
2. to the administering of a controlled substance in schedule II, III, IV, or V unless the practitioner regularly engages in the dispensing or administering of controlled substances and charges his patients, either separately or together with charges for other professional services, for substances so dispensed or administered or unless such substance is administered in the course of maintenance treatment or detoxification treatment of an individual;
3. to the use of controlled substances, at establishments registered under this subchapter which keep records with respect to such substances, in research conducted in conformity with an exemption granted under section 355(i) or 360b(j) of this title;
4. to the use of controlled substances, at establishments registered under this subchapter which keep records with respect to such substances, in pre-clinical research or in teaching; or
5. to the extent of any exemption granted to any person, with respect to all or part of such provisions, by the Attorney General by or pursuant to regulation on the basis of a finding that the application of such provisions (or part thereof) to such person is not necessary for carrying out the purposes of this subchapter. Nothing in the Convention on Psychotropic Substances shall be construed as superseding or otherwise affecting the provisions of paragraph (1)(B), (2), or (3) of this subsection.

D. Periodic reports to Attorney General

Every manufacturer registered under section 823 of this title shall, at such time or times and in such form as the Attorney General may require, make periodic reports to the Attorney General of every sale, delivery or other disposal by him of any controlled substance, and each distributor shall make such reports with respect to narcotic controlled substances, identifying by the registration number assigned under this subchapter the person or establishment (unless exempt from registration under section 822(d) of this title) to whom such sale, delivery, or other disposal was made.

E. Reporting and record keeping requirements of drug conventions

In addition to the reporting and record keeping requirements under any other provision of this subchapter, each manufacturer registered under section 823 of this title shall, with respect to narcotic and non-narcotic controlled substances manufactured by it, make such reports to the Attorney General, and maintain such records, as the Attorney General may require to enable the United States to meet its obligations under articles 19 and 20 of the Single Convention on Narcotic Drugs and article 16 of the Convention on Psychotropic Substances. The Attorney

General shall administer the requirements of this subsection in such a manner as to avoid the unnecessary imposition of duplicative requirements under this subchapter on manufacturers subject to the requirements of this subsection.

F. Investigational uses of drugs; procedures

Regulations under sections 355(i) and 360(j) of this title, relating to investigational use of drugs, shall include such procedures as the Secretary, after consultation with the Attorney General, determines are necessary to insure the security and accountability of controlled substances used in research to which such regulations apply.

G. Change of address

Every registrant under this subchapter shall be required to report any change of professional or business address in such manner as the Attorney General shall by regulation require.

H. Reporting requirements for GHB

In the case of a drug product containing gamma hydroxybutyric acid for which an application has been approved under section 355 of this title, the Attorney General may, in addition to any other requirements that apply under this section with respect to such a drug product, establish any of the following as reporting requirements:

1. That every person who is registered as a manufacturer of bulk or dosage form, as a packager, repackager, labeler, relabeler, or distributor shall report acquisition and distribution transactions quarterly, not later than the 15th day of the month succeeding the quarter for which the report is submitted, and annually report end-of-year inventories.
2. That all annual inventory reports shall be filed no later than January 15 of the year following that for which the report is submitted and include data on the stocks of the drug product, drug substance, bulk drug, and dosage forms on hand as of the close of business December 31, indicating whether materials reported are in storage or in process of manufacturing.
3. That every person who is registered as a manufacturer of bulk or dosage form shall report all manufacturing transactions both inventory increases, including purchases, transfers, and returns, and reductions from inventory, including sales, transfers, theft, destruction, and seizure, and shall provide data on material manufactured, manufactured from other material, use in manufacturing other material, and use in manufacturing dosage forms.
4. That all reports under this section must include the registered person's registration number as well as the registration numbers, names, and other identifying information of vendors, suppliers, and customers, sufficient to allow the Attorney General to track the receipt and distribution of the drug.
5. That each dispensing practitioner shall maintain for each prescription the name of the prescribing practitioner, the prescribing practitioner's Federal and State registration numbers, with the expiration dates of these registrations, verification that the prescribing practitioner possesses the appropriate registration to prescribe this controlled substance, the patient's name and address, the name of the patient's insurance provider and documentation by a medical practitioner licensed and registered to prescribe the drug of the patient's medical need for the drug. Such information shall be available for inspection and copying by the Attorney General.
6. That section 830(b)(3) of this title (relating to mail order reporting) applies with respect to gamma hydroxybutyric acid to the same extent and in the same manner as such section applies with respect to the chemicals and drug products specified in subparagraph (A)(i) of such section.

Prescriptions

A. Schedule II substances

Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance in schedule II, which is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 301 et seq.), may be dispensed without the written prescription of a practitioner, except that in emergency situations, as prescribed by the Secretary by regulation after consultation with the Attorney General, such drug may be dispensed upon oral prescription in accordance with section 503(b) of that Act (21 U.S.C. § 353(b)).

Prescriptions shall be retained in conformity with the requirements of section 827 of this title. No prescription for a controlled substance in schedule II may be refilled.

B. Schedule III and IV substances

Except when dispensed directly by a practitioner, other than a pharmacist, to an ultimate user, no controlled substance in schedule III or IV, which is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 301 et seq.), may be dispensed without a written or oral prescription in conformity with section 503(b) of that Act (21 U.S.C. § 353(b)). Such prescriptions may not be filled or refilled more than six months after the date thereof or be refilled more than five times after the date of the prescription unless renewed by the practitioner.

C. Schedule V substances

No controlled substance in schedule V which is a drug may be distributed or dispensed other than for a medical purpose.

D. Non-prescription drugs with abuse potential

Whenever it appears to the Attorney General that a drug not considered to be a prescription drug under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. §§ 301 et seq.) should be so considered because of its abuse potential, he shall so advise the Secretary and furnish to him all available data relevant thereto.

[21 USCA §829](#)

(36) Emergency Care and Assistance

For definitions, see [32 MRSA §83](#)

Immunity from civil liability (Good Samaritan Law)

Notwithstanding any inconsistent provisions of any public or private and special law, any person who voluntarily, without the expectation of monetary or other compensation from the person aided or treated, renders first aid, emergency treatment or rescue assistance to a person who is unconscious, ill, injured or in need of rescue assistance, shall not be liable for damages for injuries alleged to have been sustained by such person nor for damages for the death of such person alleged to have occurred by reason of an act or omission in the rendering of such first aid, emergency treatment or rescue assistance, unless it is established that such injuries or such death were caused willfully, wantonly or recklessly or by gross negligence on the part of such person. This section shall apply to members or employees of nonprofit volunteer or governmental ambulance, rescue or emergency units, whether or not a user or service fee may be charged by the nonprofit unit or the governmental entity and whether or not the members or employees receive salaries or other compensation from the nonprofit unit or the governmental entity. This section shall not be construed to require a person who is ill or injured to be administered first aid or emergency treatment if such person objects thereto on religious grounds. This section shall not apply if such first aid or emergency treatment or assistance is rendered on the premises of a hospital or clinic.

[14 MRSA §164](#)

Asthma inhalers and epinephrine pens

Municipal employees and volunteers that operate or assist in any municipal recreational program or camp may receive training on how to administer asthma inhalers and epinephrine pens. Municipal employees and volunteers may possess and administer prescribed asthma inhalers and epinephrine pens in order to provide emergency aid.

[30-A MRSA §3108](#)

Immunity from civil liability for volunteer activities

Health care practitioners

Notwithstanding any inconsistent provision of any public or private and special law, an individual is not liable for an injury or death arising from medical services provided as described in this subsection unless the injury or death was caused willfully, wantonly or recklessly or by gross negligence of the individual if that individual is:

- A. A licensed health care practitioner who voluntarily, without the expectation or receipt of monetary or other compensation either directly or indirectly, provides professional services within the scope of that health care practitioner's licensure:
 1. To a nonprofit organization;
 2. To an agency of the State or any political subdivision of the State;
 3. To members or recipients of services of a nonprofit organization or state or local agency;
 4. To support the State's response to a public health threat as defined in Title 22, section 801, subsection 10;
 5. To support the State's response to an extreme public health emergency as defined in Title 22, section 801, subsection 4-A; or
 6. To support the State's response to a disaster as defined in Title 37-B, section 703, subsection 2; or
- B. An emergency medical services' person who voluntarily, without the expectation or receipt of monetary or other compensation either directly or indirectly, provides emergency medical services within the scope of that person's licensure:
 1. To support the State's response to a public health threat as defined in Title 22, section 801, subsection 10;
 2. To support the State's response to an extreme public health emergency as defined in Title 22, section 801, subsection 4-A; or
 3. To support the State's response to a disaster as defined in Title 37-B, section 703, subsection 2.

[24 MRSA §2904 \(1\)](#)

Retired physicians, podiatrists and dentists

Notwithstanding any inconsistent provision of any public or private and special law, a licensed physician, podiatrist or dentist who has retired from practice and who voluntarily, without the expectation or receipt of monetary or other compensation either directly or indirectly, provides professional services within the scope of that physician's, podiatrist's or dentist's licensure is not liable for an injury or death arising from those services unless the injury or death was caused willfully, wantonly or recklessly by the physician, podiatrist or dentist for professional services provided:

- A. To a nonprofit organization;
- B. To an agency of the State or any political subdivision of the State;
- C. To members or recipients of services of a nonprofit organization or state or local agency;

- D. To support the State's response to a public health threat as defined in Title 22, section 801, subsection 10;
- E. To support the State's response to an extreme public health emergency as defined in Title 22, section 801, subsection 4-A; or
- F. To support the State's response to a disaster as defined in Title 37-B, section 703, subsection 2.

The extended immunity under this subsection applies only if the licensed physician, podiatrist or dentist is retired from practice, possessed an unrestricted license in the relevant profession and had not been disciplined by the licensing board in the previous 5 years at the time of the act or omission causing the injury.

[24 MRSA §2904 \(2\)](#)

Hiring of Healthcare Personnel during Emergency Circumstances

Healthcare workforce

A private institution is immune from civil penalties and liability for any actions arising from allegations of inadequate investigation prior to that institution's hiring or engagement of a licensed health care worker, including but not limited to allegations of negligent hiring, credentialing or privileging, for services provided within the scope of that health care worker's licensure in response to an extreme public health emergency as defined in section 801, subsection 4-A; a health emergency declared pursuant to section 802, subsection 2; or a disaster as defined in Title 37-B, section 703, subsection 2, as long as the private institution hires or engages the services of the licensed health care worker in accordance with this subsection. When hiring or engaging the services of a health care worker:

- A. The private institution shall first make a reasonable attempt to contact the appropriate occupational or professional licensing board within or affiliated with the Department of Professional and Financial Regulation for any available information about the health care worker; and
- B. A private institution may rely on:
 1. Information available from the occupational and professional licensing boards within or affiliated with the Department of Professional and Financial Regulation regarding appropriate screening of the worker, such as background investigation, primary source verification or credentialing;
 2. The representation of a volunteer health care worker registry that is operated or certified in accordance with federal or state requirements regarding appropriate screening of the worker that is registered on that registry, such as background investigation, primary source verification or credentialing;
 3. The representation of the employing or privileging entity regarding appropriate screening of the worker that, at the time of hiring or engagement, is employed or privileged by any entity in any state, such as background investigation, primary source verification, credentialing or privileging; or
 4. The representation of a retired or unemployed worker's most recent employer or privileging entity if that employment or privileging occurred within the previous 24 months.

A private institution that complies with this subsection may hire or engage the services of a licensed health care worker and is deemed in compliance with all state licensing standards. The private institution shall initiate the standard preemployment screening process within 48 hours of the official termination of the extreme public health emergency as defined in section 801, subsection 4-A or disaster as defined in Title 37-B, section 703, subsection 2.

[22 MRSA §816 \(1-A\)](#)

See also, Employment During Extreme Public Health Emergency

Found in Public Health chapter of Guide

Treatment at the Scene

Treatment to be in accord with regional medical orders

When an ambulance service or nontransporting emergency medical service is present at an accident or other situation in which a person or persons require emergency medical treatment, the medical treatment of the patients must be carried out in accordance with any rules adopted under this chapter, any protocols as defined in section 83, subsection 19 and any verbal orders given under the system of delegation established by the regional medical director; except that:

- A. When a patient is already under the supervision of a personal physician or a physician's assistant or nurse practitioner supervised by that physician and the physician, physician's assistant or nurse practitioner assumes the care of the patient, then for as long as the physician, physician's assistant or nurse practitioner remains with the patient, the patient must be cared for as the physician, physician's assistant or nurse practitioner directs. The emergency medical services persons shall assist to the extent that their licenses and protocol allow; and
- B. A patient is not required to accept treatment to which the patient does not consent.

[32 MRSA §86](#)

Emergency medical persons

Basic and advanced skills

With advice from and in consultation with each regional council and its medical control committee and with the statewide emergency medical services' medical director, the board may provide, by rule, which skills, techniques and judgments constitute a basic emergency medical treatment.

[32 MRSA §85 \(1\)](#)

Advanced emergency medical treatment

With the advice and consultation noted in subsection 1, the board may provide, by rule, which advanced skills, techniques and judgments may be supervised by a physician by means of standing orders, by voice radio and by other means. In every case, advanced emergency medical treatment must be given in accordance with protocols adopted by the Medical Direction and Practices Board.

The board may establish by rule appropriate licensure levels for advanced emergency medical technicians and fix the qualifications for persons to hold those licenses.

[32 MRSA §85 \(2\)](#)

Ambulance services and nontransporting medical services

Ambulance services and nontransporting medical services to be licensed

Every ambulance service and nontransporting emergency medical service must be licensed, operate in accordance with the rules adopted for services under this chapter and carry the equipment called for in those rules.

[32 MRSA §86 \(1\)](#)

Care of patient

Whenever an ambulance transports a patient from the scene of an emergency, the patient must be cared for by a physician, by a flight nurse or by a person licensed under this chapter to provide emergency medical care. Whenever an ambulance transports a patient from a hospital or other health care facility to another place, the patient must be cared for by:

- A. The physician in charge of the patient's case, by a person licensed under this chapter or by a professional nurse; or

- B. A licensed practical nurse, or other person appropriately trained to care for the patient, acting under orders from the patient's physician.

The person specified in this subsection as caring for the patient shall accompany the patient in the portion of the ambulance where the patient rides.

[32 MRSA §86 \(2\)](#)

Air transportation

Any patient transported by air must be flown on a service licensed under Federal Aviation Regulations, Part 135 or Part 121. In such an instance, the flight is deemed to be an air ambulance and the patient must be cared for as provided in subsection 2.

[32 MRSA §86 \(3\)](#)

Limitation of liability for ambulance service

Except as otherwise expressly provided by statute, all governmental entities shall be immune from suit on any and all tort claims seeking recovery of damages. When immunity is removed by this chapter, any claim for damages shall be brought in accordance with the terms of this chapter.

Community Paramedicine Programs

Using the same process established by the board in rule for using pilot projects to evaluate the workability and appropriateness of incorporating a particular emergency medical treatment technique or a type of equipment into any licensure level, the board may establish up to 12 pilot projects for the purpose of developing and evaluating a community paramedicine program. A pilot project established pursuant to this subsection may not exceed 3 years in duration.

As used in this subsection, "community paramedicine" means the practice by an emergency medical services provider primarily in an out-of-hospital setting of providing episodic patient evaluation, advice and treatment directed at preventing or improving a particular medical condition, within the scope of practice of the emergency medical services provider as specifically requested or directed by a physician.

[32 MRSA § 84 \(4\)](#)

Trauma-incidence registry

Registry

The board shall maintain a statewide trauma-incidence registry that meets the requirements of the federal Trauma Care Systems Planning and Development Act of 1990, Public Law 101-590, Section 1, 104 Stat. 2915. The board shall adopt rules to define trauma.

[32 MRSA §87-B \(1\)](#)

Reporting by physicians and hospitals

Physicians and hospitals may report trauma information to the board as follows.

- A. A hospital may report to the board information regarding persons diagnosed as suffering from trauma. Trauma reports should be made no later than 30 days from the date of diagnosis or the date of discharge from the hospital, whichever is later.
- B. A physician, upon request of the board, may report to the board any further information requested by the board concerning any person now or formerly under that physician's care who was diagnosed as having suffered from trauma
- C. A physician or hospital that reports in good faith in accordance with this section is not liable for any civil damages for making the report.

[32 MRSA §87-B \(2\)](#)

Confidentiality

Any information provided to the board under this section is confidential if the information identifies or permits the identification of a trauma patient or a member of that patient's family. A person who releases information that is confidential under this section commits a civil violation for which a forfeiture not to exceed \$1,000 per violation may be adjudged.

[32 MRSA §87-B \(3\)](#)

Immunity for supervision and training**Emergency medical treatment supervision**

No physician functioning within the medical control system established by the regional medical director and practicing in a hospital to or from which patients are transported under section 86 or health care practitioner under such a physician's supervision who gives oral or written instructions to a basic emergency medical services person or an advanced emergency medical technician for the provision of emergency medical treatment outside the hospital may be civilly liable for negligence as a result of issuing the instructions, if the instructions were in accordance with the protocol for the patient's reported condition. For the purpose of aiding in establishing the use of a protocol that permits the immunity provided in this subsection, the following provisions apply:

- A. The basic emergency medical services person or advanced emergency medical technician to whom the instructions are given shall document those instructions on the state ambulance run record; and
- B. The physician or health care practitioner giving the instructions shall maintain a medical control log documenting those instructions at the time they were given and shall sign the log.

The immunity provided in this subsection extends to the hospital in which the physician described in this subsection is practicing or the health care practitioner described in this subsection is being supervised.

[32 MRSA §93-A \(1\)](#)

Emergency medical services persons' training

Except as otherwise provided in this subsection, no hospital, physician or health care practitioner providing an emergency medical services course, refresher course or continuing education course approved by Maine Emergency Medical Services may be vicariously liable for the civil liability of a person enrolled in the course to a person receiving emergency medical treatment during the course.

The immunity provided by this subsection does not apply if the person enrolled in the course is an employee of the hospital, physician or health care practitioner seeking immunity under this subsection.

[32 MRSA §93-A \(2\)](#)

Emergency Medical Treatment and Active Labor Act (EMTALA) (F)**Definitions**

- A. **Emergency medical condition**: means
 1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –
 - a. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 - b. serious impairment to bodily functions, or
 - c. serious dysfunction of any bodily organ or part; or
 2. With respect to a pregnant woman who is having contractions –

- a. that there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - b. that transfer may pose a threat to the health or safety of the woman or the unborn child.
- B. **Participating hospital:** means hospital that has entered into a provider agreement under section 1395cc of this title.
- C. **To stabilize:** means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), to deliver (including the placenta).
- D. **Stabilized:** means, with respect to an emergency medical condition described in paragraph (1)(A), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (1)(B), that the woman has delivered (including the placenta).
- E. **Transfer:** means the movement (including the discharge) of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of an individual who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.
- F. **Hospital:** includes a rural primary care hospital (as defined in section 1395x(mm)(1) of this title).

[42 USC §1395dd \(e\)](#)

- G. **Comes to the emergency department:** means, with respect to an individual who is not a patient, the individual—
1. Has presented at a hospital's dedicated emergency department, as defined in this section, and requests examination or treatment for a medical condition, or has such a request made on his or her behalf. In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;
 2. Has presented on hospital property, as defined in this section, other than the dedicated emergency department, and requests examination or treatment for what may be an emergency medical condition, or has such a request made on his or her behalf (except for certain outpatients as specified in paragraph (d)(3) of this section). In the absence of such a request by or on behalf of the individual, a request on behalf of the individual will be considered to exist if a prudent layperson observer would believe, based on the individual's appearance or behavior, that the individual needs emergency examination or treatment;
 3. Is in a ground or air ambulance owned and operated by the hospital for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department, even if the ambulance is not on hospital grounds. This provision does not apply: (1) If the ambulance is operating under communitywide EMS protocols that direct it to transport the individual to a hospital other than the hospital that owns the ambulance; for example, to the nearest hospital. In this latter case, the individual is considered to have come to the emergency department of the hospital to which the individual is transported, at the time the individual is brought onto hospital property; or (2) the ambulance is operated at the direction of a physician who is not employed or otherwise affiliated with the hospital that owns the ambulance.

4. Is in a nonhospital-owned ambulance on hospital property for presentation for examination and treatment for a medical condition at a hospital's dedicated emergency department. An individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department, even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. In the latter circumstance, the hospital may deny access if it is in "diversionary status," that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's instructions and transports the individual onto hospital property, the individual is considered to have come to the emergency department.
- H. **Dedicated emergency department:** means any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:
1. It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
 2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
 3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
- I. **Hospital property:** means the entire main hospital campus as defined in Sec. 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities.
- J. **Hospital with an emergency department:** means a hospital with a dedicated emergency department (as defined in this paragraph (b)).
- K. **Patient:** means –
1. An individual who has begun to receive outpatient services as part of an encounter, as defined in Section 410.2 of this chapter, other than an encounter that the hospital is obligated by this section to provide;
 2. An individual who has been admitted as an inpatient, as defined by this section.

[42 CFR §489.24 \(b\)](#)

Medical screening requirement

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

[42 USC §1395dd \(a\)](#)

Necessary stabilizing treatment for emergency medical conditions and labor

- A. In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either -

1. within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or
2. for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

B. Refusal to consent to treatment

A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such examination and treatment.

C. Refusal to consent to transfer

A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) of this section and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of such transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital shall take all reasonable steps to secure the individual's (or person's) written informed consent to refuse such transfer.

[42 USC §1395dd \(b\)](#)

Restricting transfers until individual stabilized

A. Rule

If an individual at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(3)(B) of this section), the hospital may not transfer the individual unless -

1.
 - a. the individual (or a legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, in writing requests transfer to another medical facility,
 - b. a physician (within the meaning of section 1395x(r)(1) of this title) has signed a certification that based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer, or
 - c. if a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification described in clause (ii) after a physician (as defined in section 1395x(r)(1) of this title), in consultation with the person, has made the determination described in such clause, and subsequently countersigns the certification; and
2. the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility. A certification described in clause (ii) or (iii) of subparagraph (A) shall include a summary of the risks and benefits upon which the certification is based.

B. Appropriate transfer

An appropriate transfer to a medical facility is a transfer -

1. in which the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual's health and, in the case of a woman in labor, the health of the unborn child;
2. in which the receiving facility -
 - a. has available space and qualified personnel for the treatment of the individual, and
 - b. has agreed to accept transfer of the individual and to provide appropriate medical treatment;
3. in which the transferring hospital sends to the receiving facility all medical records (or copies thereof), related to the emergency condition for which the individual has presented, available at the time of the transfer, including records related to the individual's emergency medical condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and the informed written consent or certification (or copy thereof) provided under paragraph (1)(A), and the name and address of any on-call physician (described in subsection (d)(1)(C) of this section) who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment;
4. in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and
5. which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of individuals transferred.

[42 USC §1395dd \(c\)](#)

Preemption

The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

[42 USC §1395dd \(f\)](#)

Nondiscrimination

A participating hospital that has specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units, or (with respect to rural areas) regional referral centers as identified by the Secretary in regulation) shall not refuse to accept an appropriate transfer of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual.

[42 USC §1395dd \(g\)](#)

No delay in examination or treatment

A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual's method of payment or insurance status.

[42 USC §1395dd \(h\)](#)

Whistleblower protections

A participating hospital may not penalize or take adverse action against a qualified medical person described in subsection (c)(1)(A)(iii) of this section or a physician because the person or physician refuses to authorize the transfer of an individual with an emergency medical condition that has not been stabilized or against any hospital employee because the employee reports a violation of a requirement of this section.

[42 USC §1395dd \(i\)](#)

Special responsibilities of Medicare hospitals in emergency cases

A. Application

In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must--

1. Provide an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) determined qualified by hospital bylaws or rules and regulations and who meet the requirements of Sec. 482.55 of this chapter concerning emergency services personnel and direction; and
2. If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends as specified by paragraph (d)(2) of this section.

[42 CFR §489.24 \(a\)](#)

B. Use of dedicated emergency department for nonemergency services

If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition.

[42 CFR §489.24 \(c\)](#)

C. Necessary stabilizing treatment for emergency medical conditions

1. General.

If any individual (whether or not eligible for Medicare benefits) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—

- a. Within the capabilities of the staff and facilities available at the hospital, for further medical examination and treatment as required to stabilize the medical condition; or
 - b. For transfer of the individual to another medical facility in accordance with paragraph (e) of this section.
2. Application to inpatients--admitted emergency patients.
 - a. When an individual has been screened under paragraph (a) of this section and found to have an emergency medical condition, and the hospital admits the patient as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital is relieved of further responsibility to the individual under this section.
 - b. A hospital has no responsibility under this section with respect to an inpatient who was admitted for elective (nonemergency) diagnosis or treatment.
 - c. A hospital is required by the conditions of participation for hospitals under part 482 of this chapter to provide care to its inpatients in accordance with those conditions of participation.

3. Refusal to consent to treatment

A hospital meets the requirements of paragraph (d)(1)(i) of this section with respect to an individual if the hospital offers the individual the further medical examination and treatment

described in that paragraph and informs the individual (or a person acting on the individual's behalf) of the risks and benefits to the individual of the examination and treatment, but the individual (or a person acting on the individual's behalf) refuses to consent to the examination and treatment. The medical record must contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of the person acting on his or her behalf). The written document should indicate that the person has been informed of the risks and benefits of the examination or treatment, or both.

4. Delay in examination or treatment

- a. A participating hospital may not delay providing an appropriate medical screening examination required under paragraph (a) of this section or further medical examination and treatment required under paragraph (d)(1) of this section in order to inquire about the individual's method of payment or insurance status.
- b. A participating hospital may not seek, or direct a patient to seek, authorization from the individual's insurance company for screening or stabilization services to an individual until after the hospital has provided the appropriate medical screening examination required under paragraph (a) of this section, and initiated any further medical examination and treatment that may be required to stabilize the emergency medical condition under paragraph (d)(1) of this section.
- c. An emergency physician is not precluded from contacting the patient's physician at any time to seek advice regarding the patient's medical history and needs that may be relevant to the medical treatment and screening of the patient, as long as this consultation does not inappropriately delay services required under paragraph (a) or paragraph (d)(1) of this section.

5. Refusal to consent to transfer

A hospital meets the requirements of paragraph (d)(1)(ii) of this section with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with paragraph (e) of this section and informs the individual (or a person acting on his or her behalf) of the risks and benefits to the individual of the transfer, but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer. The hospital must take all reasonable steps to secure the individual's written informed refusal (or that of a person acting on his or her behalf). The written document must indicate the person has been informed of the risks and benefits of the transfer and state the reasons for the individual's refusal. The medical record must contain a description of the proposed transfer that was refused by or on behalf of the individual.

[42 CFR §489.24 \(d\)](#)

D. Availability of on-call physicians

Each hospital must maintain an on-call list of physicians on its medical staff in a manner that best meets the needs of the hospital's patients. Physicians, including specialists and subspecialists, are not required to be on call at all times. The hospital must have written policies and procedures in place to respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control.

[42 CFR §489.24 \(j\)](#)

(37) Ethics, Code of Medical Ethics of the American Medical Association

See: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.shtml>

(38) Fees and Charges**See AMA Opinions**

[AMA Code of Medical Ethics](#) Chapter 6.00, Opinions on Fees and Charges

[AMA Policy Finder](#)

(39) Genetic Information and Use of**See AMA Opinions**

[AMA Code of Medical Ethics](#), Chapter 2.0, Opinions on Social Policy Issues

[AMA Policy Finder](#)

Maine Laws**Definitions**

- A. **Genetic characteristic:** means any inherited gene or chromosome, or alteration of a gene or chromosome that is scientifically or medically believed to predispose an individual to a disease, disorder or syndrome or to be associated with a statistically significant increased risk of development of a disease, disorder or syndrome.
- B. **Genetic information:** means the information concerning genes, gene products or inherited characteristics that may be obtained from an individual or family member.
- C. **Genetic test:** means a test for determining the presence or absence of an inherited genetic characteristic in an individual, including tests of nucleic acids such as deoxyribonucleic acid, or DNA, ribonucleic acid, or RNA, or mitochondrial DNA, and tests of chromosomes or proteins in order to identify a predisposing genetic characteristic.

[5 MRSA §19301](#)

Employment discrimination prohibited

An employer may not fail or refuse to hire, discharge or otherwise discriminate against an employee or applicant for employment with respect to the compensation, terms or conditions of employment on the basis of genetic information concerning that individual or because of the individual's refusal to submit to a genetic test or make available the results of a genetic test or on the basis that the individual received a genetic test or genetic counseling, except when based on a bona fide occupational qualification.

[5 MRSA §19302](#)

Discrimination in health, hospital and dental insurance

An insurer, nonprofit hospital and medical service organization or health maintenance organization that issues individual or group hospital, health or dental insurance may not discriminate against an individual or eligible dependent on the basis of genetic information or the refusal to submit to a genetic test or make available the results of a genetic test or on the basis that the individual or eligible dependent received a genetic test or genetic counseling in the issuance, withholding, extension or renewal of any hospital confinement or other health insurance, as defined by the superintendent, by rule, or in the fixing of the rates, terms or conditions for insurance, or in the issuance or acceptance of any application for insurance. This subsection does not apply to accidental injury, specified disease, hospital indemnity, disability, long-term care and other limited benefit health insurance policies and contracts.

[24-A MRSA §2159-C](#)

Confidentiality

All of the state and federal, statutes, rules and regulations governing confidentiality, use of medical information, disclosures, authorizations and mandatory reports apply to the use of genetic information.

Please see the sections on Confidentiality, Consent to Treatment, HIPAA, Medical Records, and Mandatory Reports for more information.

(40) Good Samaritan Law (see Emergency Care and Assistance)

(41) Health Insurance Portability and Accountability Act of 1996 (HIPAA)(F)

Purpose of HIPAA

“...[T]o improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.”

In plain English, HIPAA allows people to maintain their health insurance coverage (the continuity part) while allowing them the ability to change jobs or health plans (the portability part). In addition, HIPAA provides certain protections around a person’s protected health information and limits who has access to that information and how it can be transmitted, mailed, e-mailed etc.

Administrative Simplification

Main sections

Of all of the sections of HIPAA it is the Administrative Simplification section that affects most of the healthcare industry. This section is composed of four main parts plus and an enforcement component. These provisions are:

- A. Electronic Health Transactions Standards (Code Sets)
- B. Unique identifiers for providers, employers, and health plans
- C. Security of health information and electronic signature standards (the Security Rule)
- D. Privacy and confidentiality standards (the Privacy Rule)
- E. Enforcement Provisions

Purpose of Administrative Simplification

The purpose of Administrative Simplification is to:

- A. Standardize, simplify and improve the efficiency of electronically transmitted health care information,
- B. Provide a greater level of protection for confidential patient health information,
- C. Increase health data security and
- D. Decrease administrative costs

[View the Combined Regulation Text](#) of HIPAA, Unofficial Version

HITECH Amendments

Congress passed the Health Information Technology for Economic and Clinical Health (HITECH) Act in 2009 as part of the American Recovery and Reinvestment Act. HITECH amends and adds to HIPAA. New civil money penalty amounts apply to HIPAA Privacy and Security Rule violations occurring after February 17, 2009. Covered entities and business associates must comply now with breach notification obligations for breaches that are discovered on or after September 23, 2009. OCR announced previously

that it would use its enforcement discretion not to impose fiscal sanctions with regard to breaches discovered before February 22, 2010. Since that date has passed, OCR will enforce the Breach Notification Interim Final Rule, including with the possible imposition of sanctions, as it does with the HIPAA Privacy and Security Rule requirements. For more information about the HITECH Amendments, visit the [Office of Civil Rights HITECH Act page](#).

Enforcement

The Office of Civil Rights will handle enforcement of HIPAA violations. Penalties for HIPAA violations range from monetary fines to imprisonment, based on the nature and severity of the violation.

For more information on the HIPAA enforcement provisions, please go to the [Office of Civil Rights Enforcement Page](#).

Useful Resources

[DHHS Office of Civil Rights](#)

[HIPAA Frequently Asked Questions](#)

[How to File a Complaint](#)

[AMA HIPAA Compliance Resources](#)

For more information about complying with HIPAA, including sample forms and trainings, contact the Maine Medical Association at 622-3374.

(42) Hospital Financial Disclosures

Itemized bills

Each hospital licensed by the State under chapter 405 shall inform all patients, or their legal guardians, in writing, at the time of the patient's discharge, that it will provide an itemized bill upon their request.

The request may be made by the patient or his legal guardian at discharge or at any time within 7 years after discharge.

The hospital shall provide an itemized bill to the person making the request within 30 days of the request.

Notwithstanding this section, effective July 1, 1985, each hospital shall itemize on the hospital bill of each patient the cost of nursing services provided to that patient.

[22 MRSA §1712](#)

Prohibition on payment for health care facility mistakes or preventable adverse events

Definitions

- A. **Health Care Facility**: means a hospital or ambulatory surgical center licensed under chapter 405.
- B. **Mistake or preventable adverse event**: see [22 MRSA §1721](#) for full list of events within the health care facility's control to avoid.

[22 MRSA §1721 \(1\)](#)

Prohibition

A health care facility is prohibited from knowingly charging a patient or the patient's insurer or the patient's employer as defined in Title 39-A, section 102, subsection 12 for health care services it provided as a result of or to correct a mistake or preventable adverse event caused by that health care facility.

[22 MRSA §1721 \(2\)](#)

Patient education

A health care facility is required to inform patients of the prohibition on payment for health care facility mistakes or preventable adverse events.

[22 MRSA §1721 \(3\)](#)

Financial disclosure

Each hospital licensed under this chapter must annually publicly disclose:

- A. IRS Form 990. The federal Internal Revenue Service Form 990, including all related disclosable schedules, for the hospital and for each tax-exempt entity related to the hospital that is required by federal law to file that form with the Internal Revenue Service; and
- B. IRS Form 1120. The federal Internal Revenue Service Form 1120 for each for-profit entity in which the hospital has a controlling interest.

Information required to be disclosed under this section must be submitted by the hospital to the department within 5 months after the end of the hospital's fiscal year or within 5 months after the date on which the entity files the applicable form with the Internal Revenue Service. The department shall make available for public inspection and photocopying copies of all documents required by this section and shall post those documents on the department's publicly accessible website.

[22 MRSA §1819-A](#)

(43) Hospital and Health Care Provider Cooperation Act**Legislative findings and intent**

The Legislature finds that it is necessary and appropriate to encourage hospitals and other health care providers to cooperate and enter into agreements that will facilitate cost containment, improve quality of care and increase access to health care services. This Act provides processes for state review of overall public benefit, for approval through certificates of public advantage and for continuing supervision. It is the intent of the Legislature that a certificate of public advantage approved under this chapter provide state action immunity under applicable federal antitrust laws.

[22 MRSA §1842](#)

For the full Hospital and Health Care Provider Cooperation Act, see [Title 22, Chapter 405-A](#).

For more information on filing and maintaining certificates of public advantage, see [22 MRSA §1844](#).

For more information on the continuing supervision of holders of certificates of public advantage and revocation of a certificates, see [22 MRSA §1845](#).

(44) Hypodermic Apparatus, Sale of**Authorized seller**

A hypodermic apparatus, as defined in Title 17-A, section 1101, subsection 2, may be sold only by a manufacturer or dealer of embalming supplies, manufacturer or dealer of medical or dental supplies, wholesale druggist, manufacturing pharmacist, pharmacist, veterinarian, agricultural supply store or manufacturer of surgical instruments.

[32 MRSA §13787-A \(1\)](#)

Purchaser

Any person who is 18 years of age or older may purchase a hypodermic apparatus from a seller described in subsection 1.

[32 MRSA §13787-A \(2\)](#)

Criminal immunity

Immunity from criminal prosecution is governed by the following:

- A. A seller described in subsection 1 is "expressly authorized" within the meaning of Title 17-A, section 1110, subsection 1, paragraph A.
- B. A seller described in subsection 1 or a purchaser described in subsection 2 is "expressly authorized" within the meaning of Title 17-A, section 1111, subsection 1, paragraph A.

[32 MRSA §13787-A \(3\)](#)

Immunity limited

This section does not limit prosecution for violation of any law prohibiting or regulating the use, possession, dispensing, distribution or promotion of controlled substances, scheduled drugs or drug paraphernalia.

[32 MRSA §13787-A \(4\)](#)

Medicaid not affected

This section does not diminish, expand or otherwise affect Medicaid reimbursement for hypodermic apparatuses.

[32 MRSA §13787-A \(5\)](#)

(45) Hysterectomy (F)

According to federal regulations:

Additional condition for Federal Financial Participation (FFP)

- A. FFP is not available in expenditures for any sterilization or hysterectomy unless the Medicaid agency, before making payment, obtained documentation showing that the requirements of this subpart were met. This documentation must include a consent from, an acknowledgement of receipt of hysterectomy information or a physician's certification under Sec. 441.255(d)(2), as applicable.

[42 CFR §441.256](#)

(46) Immunization

Immunization Requirements

For immunization requirements for health care employees, providers and facilities, as well as day care, school, college and campground entry, see the [Maine Immunization Program website](#).

Universal Childhood Immunization Program

The Universal Childhood Immunization Program was established by [2009 Public Law 595](#) to provide all children from birth until 19 years of age in the State with access to a uniform set of vaccines as determined and periodically updated by the Maine Vaccine Board. Vaccine purchase is funded by an assessment on health insurance carriers and 3rd-party administrators registered under Title 24-A of the Maine Revised Statutes. For information about the Maine Universal Immunization program see the [Maine Vaccine Board Website](#). See also [22 MRSA §1066](#), establishing the program.

Pharmacist Administration (see Pharmacist Health Program and Scope of Practice)

(47) Impaired Physician, Reporting of

Committee reports

Any professional competence committee within this State and any physician licensed to practice or otherwise lawfully practicing within this State shall, and any other person may, report the relevant facts to the appropriate board relating to the acts of any physician in this State if, in the opinion of the committee, physician or other person, the committee or individual has reasonable knowledge of acts of the physician amounting to gross or repeated medical malpractice, habitual drunkenness, addiction to the use of drugs, professional incompetence, unprofessional conduct or sexual misconduct identified by board rule. The failure of any such professional competence committee or any such physician to report as required is a civil violation for which a fine of not more than \$1,000 may be adjudged.

Except for specific protocols developed by a board pursuant to Title 32, section 1073, 2596-A or 3298, a physician, dentist or committee is not responsible for reporting misuse of alcohol or drugs or professional incompetence or malpractice as a result of physical or mental infirmity or by the misuse of alcohol or drugs discovered by the physician, dentist or committee as a result of participation or membership in a professional review committee or with respect to any information acquired concerning misuse of alcohol or drugs or professional incompetence or malpractice as a result of physical or mental infirmity or by the misuse of alcohol or drugs, as long as that information is reported to the professional review committee. Nothing in this section may prohibit an impaired physician or dentist from seeking alternative forms of treatment.

[24 MRSA §2505](#)

Provider, entity and carrier reports

A health care provider or health care entity shall, within 60 days, report in writing to the disciplined practitioner's board or authority the name of any licensed, certified or registered employee or person privileged by the provider or entity whose employment or privileges have been revoked, suspended, limited or terminated or who resigned while under investigation or to avoid investigation for reasons related to clinical competence or unprofessional conduct, together with pertinent information relating to that action. Pertinent information includes a description of the adverse action, the name of the practitioner involved, the date, the location and a description of the event or events giving rise to the adverse action, identification of the complainant and the medical records involved. Upon request, the following information must be released to the board or authority within 20 days of receipt of the request: medical records relating to the event or events; written statements signed or prepared by any witness or complainant to the event; and related correspondence between the practitioner and the provider or entity. The report must include situations in which employment or privileges have been revoked, suspended, limited or otherwise adversely affected by action of the health care practitioner while the health care practitioner was the subject of disciplinary proceedings, and it also must include situations where employment or privileges have been revoked, suspended, limited or otherwise adversely affected by act of the health care practitioner in return for the health care provider or health care entity terminating such proceeding. Any reversal, modification or change of action reported pursuant to this section must be reported immediately to the practitioner's board or authority, together with a brief statement of the reasons for that reversal, modification or change. The failure of any health care provider or health care entity to report as required is a civil violation for which a fine of not more than \$5,000 may be adjudged.

Carriers providing managed care plans are subject to the reporting requirements of this section when they take adverse actions against a practitioner's credentials or employment for reasons related to clinical competence or unprofessional conduct that may adversely affect the health or welfare of the patient.

[24 MRSA §2506](#)

Society reports

Any professional society within this State which takes formal disciplinary action against a member relating to professional ethics, professional incompetence, moral turpitude, or drug or alcohol abuse shall, within 60 days of the action, report in writing to the appropriate board the name of the member, together with pertinent information relating to the action. The report shall include situations in which membership or privileges have been revoked, suspended, limited or otherwise adversely affected by action of the health care practitioner while the health care practitioner was under investigation or the subject of proceedings and it shall also include situations where membership or privileges have been revoked, suspended, limited or otherwise adversely affected by an act of the health care practitioner in return for the professional society's not conducting or for its ceasing such investigation proceeding. The report shall include situations under which an individual under societal investigation resigns during that pending investigation. The failure of any such society to report as required is a civil violation for which a fine of not more than \$1,000 may be adjudged.

[24 MRSA §2507](#)

Effect of filing

The filing of a report with the board pursuant to this chapter, investigation by the board or any disposition by the board may not, in and of itself, preclude any action by a hospital or other health care facility or health care entity or professional society comprised primarily of physicians to suspend, restrict or revoke the privileges or membership of the physician.

[24 MRSA §2508](#)

Board records**Record of physicians**

Each board shall create and maintain a permanent record of the names of all physicians licensed by it or otherwise lawfully practicing in this State and subject to the board's jurisdiction along with an individual historical record for each physician relating to reports or other information furnished the board under this chapter or otherwise pursuant to law. The record may include, in accordance with rules established by the board, additional items relating to a physician's record of medical practice as will facilitate proper periodic review of the physician's professional competency.

[24 MRSA §2509 \(1\)](#)

Reports dismissed without disciplinary action; removal and destruction

If the board dismisses any report submitted to it without imposing disciplinary action, the report must be removed from the physician's individual historical record and destroyed, unless the report has been placed on file for a specified amount of time pursuant to Title 10, section 8003, subsection 5, paragraph E. Reports placed on file pursuant to Title 10, section 8003, subsection 5, paragraph E may only be removed and destroyed upon the expiration of the specified amount of filing time.

[24 MRSA §2509 \(2\)](#)

Forms; acceptance of other forms

The board shall provide forms for filing reports pursuant to this chapter. Reports submitted in other forms shall be accepted by the board.

[24 MRSA §2509 \(3\)](#)

Disclosure to physician

A physician shall be provided with a written notice of the substance of any information received pursuant to this chapter and placed in his individual historical record.

[24 MRSA §2509 \(4\)](#)

Examination of records by physician; response to information

A physician or his authorized representative shall have the right, upon request, to examine the physician's individual historical record which the board maintains pursuant to this chapter, and to place into the record a statement of reasonable length of the physician's view of the correctness or relevance of any information existing in the record. The statement shall at all times accompany that part of the record in contention. This subsection shall not apply to material submitted to the board in confidence prior to licensure by the board.

[24 MRSA §2509 \(5\)](#)

Court action for amendment or destruction

With the exception of orders of the board relating to disciplinary action, and reports placed on file for a specified amount of time pursuant to Title 10, section 8003, subsection 5, paragraph E, a physician has the right to seek through court action pursuant to the Maine Rules of Civil Procedure the amendment or destruction of any part of that physician's historical record in the possession of the board. When a physician initiates court action under this subsection, the board shall notify the persons who have filed complaints of the physician's request to amend these complaints or expunge them from the record. Notice to complainants must be sent to the last known address of the complainants. The notice must contain the name and address of the court to which a complainant may respond, the specific change in the complaint that the physician is seeking or the complaint that the physician seeks to expunge, and the length of time that the complainant has to respond to the court. The board shall provide complainants with at least 60 days' notice from the date the notice is sent in which to respond.

[24 MRSA §2509 \(6\)](#)

Confidentiality of information

Confidentiality; exceptions

Any reports, information or records received and maintained by the board pursuant to this chapter, including any material received or developed by the board during an investigation shall be confidential, except for information and data that is developed or maintained by the board from reports or records received and maintained pursuant to this chapter or by the board during an investigation and that does not identify or permit identification of any patient or physician; provided that the board may disclose any confidential information only:

- A. In a disciplinary hearing before the board or in any subsequent trial or appeal of a board action or order relating to such disciplinary hearing;
- B. To governmental licensing or disciplinary authorities of any jurisdiction or to any health care providers or health care entities located within or outside this State that are concerned with granting, limiting or denying a physician's privileges, but only if the board includes along with the transfer an indication as to whether or not the information has been substantiated by the board;
- C. As required by section 2509, subsection 5;
- D. Pursuant to an order of a court of competent jurisdiction; or
- E. To qualified personnel for bona fide research or educational purposes, if personally identifiable information relating to any patient or physician is first deleted.

[24 MRSA §2510 \(1\)](#)

Confidentiality of orders in disciplinary proceedings

Orders of the board relating to disciplinary action against a physician, including orders or other actions of the board referring or scheduling matters for hearing, shall not be confidential.

[24 MRSA §2510 \(2\)](#)

Confidentiality of letters of guidance or concern

Letters of guidance or concern issued by the board pursuant to Title 10, section 8003, subsection 5, paragraph E, are not confidential.

[24 MRSA §2510 \(2-A\)](#)

Availability of confidential information

In no event may confidential information received, maintained or developed by the board, or disclosed by the board to others, pursuant to this chapter, or information, data, incident reports or recommendations gathered or made by or on behalf of a health care provider pursuant to this chapter, be available for discovery, court subpoena or introduced into evidence in any medical malpractice suit or other action for damages arising out of the provision or failure to provide health care services. This confidential information includes reports to and information gathered by a professional review committee.

[24 MRSA §2510 \(3\)](#)

Penalty

Any person who unlawfully discloses such confidential information possessed by the board shall be guilty of a Class E crime.

[24 MRSA §2510 \(4\)](#)

Physician-patient privilege; proceedings by board

The physician-patient privilege shall, as a matter of law, be deemed to have been waived by the patient and shall not prevail in any investigation or proceeding by the board acting within the scope of its authority, provided that the disclosure of any information pursuant to this subsection shall not be deemed a waiver of such privilege in any other proceeding.

[24 MRSA §2510 \(5\)](#)

Confidentiality of professional competence review records

Except as otherwise provided by this chapter, all professional competence review records are privileged and confidential and are not subject to discovery, subpoena or other means of legal compulsion for their release to any person or entity and are not admissible as evidence in any civil, judicial or administrative proceeding. Information contained in professional competence review records is not admissible at trial or deposition in the form of testimony by an individual who participated in the written professional competence review process. Nothing in this section may be read to abrogate the obligations to report and provide information under section 2506, nor the application of Title 32, sections 2599 and 3296.

[24 MRSA §2510-A](#)

Protection; waiver

This chapter's protection may be invoked by a professional competence committee or by the subject of professional competence review activity in any civil, judicial or administrative proceeding. This section's protection may be waived only by a written waiver executed by an authorized representative of the professional competence committee.

[24 MRSA §2510-A \(1\)](#)

Adverse professional competence review action

Subsection 1 does not apply in a proceeding in which a physician contests an adverse professional competence review action against that physician, but the discovery, use and introduction of professional competence review records in such a proceeding does not constitute a waiver of subsection 1 in any other or subsequent proceedings seeking damages for alleged professional negligence against the physician who is the subject of such professional competence review records.

[24 MRSA §2510-A \(2\)](#)

Defense of professional competence committee

Subsection 1 does not apply in a proceeding in which a professional competence committee uses professional competence review records in its own defense, but the discovery, use and introduction of professional competence review records in such a proceeding does not constitute a waiver of subsection 1 in the same or other proceeding seeking damages for alleged professional negligence against the physician who is the subject of such professional competence review records.

[24 MRSA §2510-A \(3\)](#)

Waiver regarding individual

Waiver of subsection 1 in a proceeding regarding one physician does not constitute a waiver of subsection 1 as to other physicians.

[24 MRSA §2510-A \(4\)](#)

Release to other review bodies, agencies, accrediting bodies

A professional competence committee may furnish professional competence review records or information to other professional review bodies, state or federal government agencies and national accrediting bodies without waiving any privilege against disclosure under section 2510-A.

[24 MRSA §2510-B \(1\)](#)

Release to physician

A professional competence committee may furnish professional competence review records to the physician who is the subject of the professional competence review activity and the physician's attorneys, agents and representatives without waiving any privilege against disclosure under section 2510-A.

[24 MRSA §2510-B \(2\)](#)

Release of directory information

A professional competence committee may furnish directory information showing membership, clinical privileges, provider panel or other practice status of a physician with the health care entity to anyone without waiving the privilege against disclosure under section 2510-A.

[24 MRSA §2510-B \(3\)](#)

Immunity

Any person acting without malice, any physician, podiatrist, health care provider, health care entity or professional society, any member of a professional competence committee or professional review committee, any board or appropriate authority and any entity required to report under this chapter are immune from civil liability:

- A. **Reporting:** For making any report or other information available to any board, appropriate authority, professional competence committee or professional review committee pursuant to law;

[24 MRSA §2511 \(1\)](#)
- B. **Assisting in preparation:** For assisting in the origination, investigation or preparation of the report or information described in subsection 1; or

[24 MRSA §2511 \(2\)](#)
- C. **Assisting in duties:** For assisting the board, authority or committee in carrying out any of its duties or functions provided by law.

[24 MRSA §2511 \(3\)](#)

MMA's Medical Professional Health Program

A Medical Professional Health Program is conducted by the Maine Medical Association under protocols developed with the Board of Licensure in Medicine, the Board of Osteopathic Licensure, the Board of Dental Examiners, the Board of Pharmacy and the Board of Nursing.

If you, or a colleague, have a potential impairment, please contact:

The Medical Professional Health Program at (207) 623-9266

(48) Insurance Regulations (Select Sections)

Health Care Bill of Rights

Part A requires carriers to provide a toll-free telephone number that certificate holders can call to determine if a policy has been cancelled or reinstated after payment of the premium. It requires carriers to provide notice to plan enrollees regarding any exclusions or limits of coverage for childhood immunizations. Part A also requires carriers to post at least 5 individual and 5 small group health plans on its publicly accessible website for comparison purposes and sets minimum standards for explanation of benefits documents used by carriers.

Part B establishes standards for provider profiling programs used by carriers.

Part C requires carriers and health maintenance organizations to include certain information about product offerings in the annual report supplement to the Department of Professional and Financial Regulation, Bureau of Insurance.

Part D extends the notice period for all carriers to notify policyholders of proposed rate increases. It also permits the Attorney general to request a rate hearing regarding proposed rate increases for individual health plans.

Part E requires health maintenance organizations to disclose loss information upon request from contract holders in the same manner as insurance companies. Part E also authorizes the Superintendent of Insurance to adopt rules requiring small group health carriers to offer standardized small group health plans. Part E also requires the Superintendent of Insurance to undertake market conduct exams of health insurance companies no less frequently than once every 3 years, beginning in 2010.

Part F requires a carrier replacing a previous carrier to honor any prior authorizations for prescription drugs for an enrollee undergoing a course of treatment for a period of 6 months.

For the full text see [Public Laws, Chapter 439](#). The law is found in various sections of [Title 24-A](#), the Maine Insurance Code.

Protection of Consumers and Small Business Owners from Rising Health Care Costs

Part B directs the Superintendent of Insurance to adopt rules for physician performance measurement, reporting, and tiering programs. The Superintendent may consult with the advisory council. Part C requires that the Department of Health and Human Services post on its publicly accessible website the federal Internal Revenue Service Form 990 and forms already filed by hospitals with the department within 30 days of the effective date of the bill, as amended.

[24-A MRSA §2694-A](#)

[22 MRSA §1819-A](#)

For more on Consumer and Small Business Owner Protection see [Public Law, Chapter 350](#).

Plan requirements

A carrier offering or renewing a health plan in this State must meet a number of requirements regarding:

1. Demonstration of adequate access to providers
2. Credentialling

3. Provider's right to advocate for medically appropriate care
4. Termination of participating providers Prohibition on financial incentives
5. Grievance procedure for enrollees
6. Identification of services provided by certified nurse practitioners and certified nurse midwives
7. Standing referrals to specialists
8. Continuity of care
9. Continuity of prescriptions
10. Maximum allowable charges
11. Protection from balance billing by participating providers
12. Notice of amendments to provider agreements
13. Limits on retrospective denials
14. Uniform explanation of coverage documents and standardized definitions
15. Language and culture
16. Prohibition on "most favored nation" clauses.

See [24-A MRSA§ 4303](#)

For more requirements of health insurance carriers, including issues of utilization review, enrollee choice of primary care and other providers, access to clinical trials, and external reviews, see also [24-A MRSA, Chapter 56-A](#), the Health Plan Improvement Act.

Mandated Benefits

Maine law contains a number of mandated benefits, requiring health insurance plans to cover certain services, providers or individuals. Examples of mandated benefits as of 2011 include maternity and routine newborn care, medically-necessary infant formula, contraceptives, mental health services, home health services, diabetes supplies and services, mammograms, acupuncture services, breast cancer treatment, prostate cancer screening, colorectal cancer screening, chiropractic services, treatment for HIV/AIDS, children's early intervention services and coverage for autism spectrum disorders.

A health policy that provides coverage for the mandate as required may contain provisions for maximum benefits and coinsurance and limitations, deductibles and exclusions to the same extent that these provisions are applicable to all coverage and are not inconsistent with the requirements of the particular mandate.

For a summary of all mandated benefits in Maine and which plans they apply to, see the Bureau of Insurance chart, http://www.maine.gov/pfr/insurance/consumer/mandated_benefits.htm

For the full list of requirements that apply to nonprofit hospital service plans, nonprofit medical service plans or nonprofit health care plans, see [Title 24, Chapter 19](#).

For the full list of requirements that apply to individual plans, see [Title 24-A, Chapter 33](#).

For the full list of requirements that apply to group health plans, see [Title 24-A, Chapter 35](#).

For the full list of requirements that apply to HMOs, see [Title 24-A, Chapter 56](#).

For requirements that apply to all plans, see [Title 24-A, Chapter 56-A](#), the Health Plan Improvement Act.

Telemedicine Service Coverage

Telemedicine; definition

For the purposes of this section, "telemedicine," as it pertains to the delivery of health care services, means the use of interactive audio, video or other electronic media for the purpose of diagnosis,

consultation or treatment. “Telemedicine” does not include the use of audio-only telephone, facsimile machine or e-mail.

[24-A MRSA §4316 \(1\)](#)

Coverage

A carrier offering a health plan in this State may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health care provider. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health care services provided through in-person consultation. A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

[24-A MRSA §4316 \(2\)](#)

Mandatory offer to extend coverage for dependent children up to 25 years of age

Dependent child; definition

As used in this section, “dependent child” means the child of a person covered under an individual health insurance policy when that child:

- A. Is unmarried;
- B. Has no dependent of the child’s own; and
- C. Is a resident of this State or is enrolled as a full-time student at an accredited public or private institution of higher education.

Offer to extend coverage

Notwithstanding section 2703, subsection 3, a . . . health insurance policy that offers coverage for a dependent child must offer such coverage, at the option of the policyholder, until the dependent child is 25 years of age. An insurer may require, as a condition of eligibility for coverage in accordance with this section, that a person seeking coverage for a dependent child provide written documentation on an annual basis that the dependent child meets the requirements in subsection 1.

[24-A MRSA §2742-B \(Individual Policies\)](#)

[24-A MRSA §2833-B \(Group Plans\)](#)

[24-A MRSA §4233-B \(HMOs\)](#)

Extension of Dependent Coverage

A carrier offering a health plan subject to the requirements of the federal Affordable Care Act that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age, consistent with the federal Affordable Care Act

[24-A MRSA §4320-B](#)

(49) Interns and Residents

Licensing of Interns and Residents

Residents

An applicant who is qualified under section 3271, subsection 1, may receive a temporary educational certificate from the board to act as a hospital resident. A certificate to a hospital resident may be renewed annually at the discretion of the board for not more than 7 years.

[32 MRSA §3279 \(2\)](#)

Joint-program resident

An applicant who is enrolled in a program of medical and graduate medical training conducted jointly by a medical school accredited by the Liaison Committee on Medical Education and a graduate medical education program approved by the Accreditation Council on Graduate Medical Education may receive a temporary educational certificate from the board to act as a hospital resident as part of that graduate medical education program if the applicant is concurrently enrolled in the final year of medical training and the initial year of graduate medical education. The board may not issue a certificate pursuant to this subsection for a period longer than that required to obtain the M.D. degree. The period during which the certificate is in force may not be considered in determining satisfaction of the requirement for postgraduate medical education under section 3271, subsection 2.

[32 MRSA §3279 \(2-A\)](#)

Conditions of certification

An applicant for a temporary educational certificate may not be certified unless the board finds that the applicant is qualified and that there exists no cause, as set forth in section 3282-A, that would be considered grounds for disciplinary action against a licensed physician or surgeon. The board, in its discretion, may require an examination for applicants for temporary educational certificates. Recipients of these certificates are entitled to all the rights granted to physicians who are licensed to practice medicine and surgery, except that their practice is limited to the training programs in which they are enrolled. A temporary educational certificate may be suspended or revoked, or the board may refuse to renew the certificate, for the reasons stated in section 3282-A, or if the intern or hospital resident has violated the limitations placed upon the intern's temporary educational certificate.

[32 MRSA §3279 \(3\)](#)

Visiting instructors

A physician who has an unrestricted license to practice medicine or surgery in another state may practice medicine or surgery in this State when the physician is performing medical procedures as part of a course of instruction in graduate medical education in a hospital located in this State. The right of a visiting medical instructor to practice medicine in this State may be suspended or revoked for the reasons stated in section 3282-A, or if the visiting medical instructor has performed medical procedures that are not a part of a course of instruction.

[32 MRSA §3279 \(4\)](#)

Contract students

An applicant who is qualified under section 3271, subsection 1, who received a medical education as a contract student as provided in Title 20-A, chapter 421, and who agrees to practice in a primary care or other specialized area as defined in Title 20-A, section 11803, subsection 2, or an underserved area as defined in Title 20-A, section 11802, is considered to have completed the postgraduate training requirements of section 3271, subsection 2, upon satisfactory completion of at least 12 months in a graduate educational program approved as specified in section 3271. The board may make the relicensure of an individual for 4 years after the individual's licensure under this subsection contingent on the individual's continuing to practice in an underserved area. This subsection applies only to individuals entering into a contract under Title 20-A, chapter 421, on or before December 31, 1984.

[32 MRSA §3279 \(5\)](#)

Fees

The board shall set fees for physicians and students licensed pursuant to this section. The amounts set for licenses issued under this section may not be more than \$300.

[32 MRSA §3279 \(6\)](#)

(50) Lead Poisoning Prevention

Screening by health care providers

All health care providers shall advise parents of the availability and advisability of screening their children for lead poisoning. A health care program that receives funds from the State and has a child health component shall provide screening of children for lead poisoning in accordance with rules adopted by the department.

[22 MRSA §1317-C](#)

For more information:

Maine Lead Poisoning Control Act, [32 MRSA, Chapter 252](#).

[Maine CDC Screening, Testing and Follow Up Guidelines](#)

[Maine Lead Poisoning Prevention Program](#)

[CDC Childhood Lead Poisoning Prevention Program](#)

Maine Lead Poisoning Prevention Fund

Fund established

The Lead Poisoning Prevention Fund, referred to in this section as "the fund," is established within the department as a nonlapsing fund for the purposes specified in this section.

[22 MRSA §1322-E \(1\)](#)

Sources of fund

The fund is funded from all fees collected under section 1322-F and from other funds accepted by the commissioner or allocated or appropriated by the Legislature

[22 MRSA §1322-E \(2\)](#)

Prevention purposes

Allocations from the fund must be made for the following purposes:

- A. Grants for funding community and worker educational outreach programs to enable the public to identify lead hazards and take precautionary actions to prevent exposure to lead. At least 50% of the fund must be allocated for grants for the purposes of this paragraph;
- B. An ongoing major media campaign to fulfill the purposes of the educational and publicity program required by section 1317-B;
- C. Measures to prevent children's exposure to lead, including targeted educational mailings to families with children that occupy dwellings built prior to 1978 with culturally appropriate information on the health hazards of lead, the identification of lead sources, actions to take to prevent lead exposure and the importance of screening children for lead poisoning;
- D. Measures to prevent occupational exposures to lead for private and public employees, including improvements in the effectiveness of the occupational disease reporting system required in chapter 259-A in identifying and educating health care providers, employers and lead-exposed adults about occupational lead poisoning prevention strategies; and
- E. Funding an assessment of current uses of lead and the availability, effectiveness and affordability of lead-free alternatives.
- F. Funding for educational programs and information for owners of rental property used for residential purposes.

[22 MRSA §1322-E \(3\)](#)

Administration

The Bureau of Health shall administer the fund allocations with the review and advice of an advisory board established by the department pursuant to section 1323. Preference must be given to programs that reach high-risk or underserved populations. The bureau may contract for professional services to carry out the purposes of this section.

[22 MRSA §1322-E \(4\)](#)

(51) Licensure in Medicine, General Medical (see also Agency Rules Links)

Licensure required

Unless licensed by the board, an individual may not practice medicine or surgery or a branch of medicine or surgery or claim to be legally licensed to practice medicine or surgery or a branch of medicine or surgery within the State by diagnosing, relieving in any degree or curing, or professing or attempting to diagnose, relieve or cure a human disease, ailment, defect or complaint, whether physical or mental, or of physical and mental origin, by attendance or by advice, or by prescribing or furnishing a drug, medicine, appliance, manipulation, method or a therapeutic agent whatsoever or in any other manner unless otherwise provided by statutes of this State. An individual licensed under chapter 36 may prefix the title "Doctor" or the letters "Dr." to that individual's name, as provided in section 2581, or a chiropractor licensed by this State may prefix the title "Doctor" or the letters "Dr." to that individual's name when accompanied by the word "Chiropractor," or a dentist duly licensed by this State may prefix the title "Doctor" or the letters "Dr." to that individual's name or a naturopathic doctor licensed by this State may prefix the title "Doctor" or the letters "Dr." to that individual's name when accompanied by the word "Naturopathy" or the words "Naturopathic Medicine" or an optometrist duly licensed under the laws of this State may prefix the title "Doctor" or the letters "Dr." to that individual's name when accompanied by the word "Optometrist" or a podiatrist licensed under the laws of this State may prefix the title "Doctor" or the letters "Dr." to that individual's name when accompanied by the word "Podiatrist" or "Chiropodist."

Whoever, not being duly licensed by the board, practices medicine or surgery or a branch of medicine or surgery, or purports to practice medicine or surgery or a branch of medicine or surgery in a way cited in this section, or who uses the title "Doctor" or the letters "Dr." or the letters "M.D." in connection with that individual's name, contrary to this section, commits a Class E crime. The prefixing of the title "Doctor" or the letters "Dr." or the appending of the letters "M.D." by an individual to that individual's name or the use of the title of doctor or physician in any way by an individual not licensed as described is prima facie evidence that that individual is purporting to practice medicine or surgery contrary to this section, except that nothing contained in this section prevents an individual who has received the doctor's degree from a reputable college or university, other than the degree of "Doctor of Medicine" from prefixing the letters "Dr." to that individual's name, if that individual is not engaged, and does not engage, in the practice of medicine or surgery or the treatment of a disease or human ailment. Nothing in this chapter may be construed as to affect or prevent the practice of the religious tenets of a church in the ministration to the sick or suffering by mental or spiritual means.

All fees set in this chapter are nonrefundable application fees or administrative processing fees payable to the board at the time of application or at the time board action is requested. Unless otherwise specified, the board shall set the fees.

[32 MRSA §3270](#)

Qualifications for medical licensure

Except where otherwise specified by this chapter, all applicants for licensure as a physician or surgeon in the State must satisfy the following requirements:

Medical education

Each applicant must:

- A. Graduate from a medical school designated as accredited by the Liaison Committee on Medical Education;
- B. Graduate from an unaccredited medical school, be evaluated by the Educational Commission for Foreign Medical Graduates and receive a permanent certificate from the Educational Commission for Foreign Graduates; or
- C. Graduate from an unaccredited medical school and achieve a passing score on the Visa Qualifying Examination or another comprehensive examination determined by the board to be substantially equivalent to the Visa Qualifying Examination.

[32 MRSA §3271 \(1\)](#)

Postgraduate training

Each applicant who has graduated from an accredited medical school on or after January 1, 1970 but before July 1, 2004 must have satisfactorily completed at least 24 months in a graduate educational program accredited by the Accreditation Council on Graduate Medical Education, the Canadian Medical Association or the Royal College of Physicians and Surgeons of Canada. Notwithstanding other requirements of postgraduate training, an applicant is eligible for licensure when the candidate has satisfactorily graduated from a combined postgraduate training program in which each of the contributing programs is accredited by the Accreditation Council on Graduate Medical Education and the applicant is eligible for accreditation by the American Board of Medical Specialties in both specialties. Each applicant who has graduated from an accredited medical school prior to January 1, 1970 must have satisfactorily completed at least 12 months in a graduate educational program accredited by the Accreditation Council on Graduate Medical Education, the Canadian Medical Association or the Royal College of Physicians and Surgeons of Canada. Each applicant who has graduated from an accredited medical school on or after July 1, 2004 or an unaccredited medical school must have satisfactorily completed at least 36 months in a graduate educational program accredited by the Accreditation Council on Graduate Medical Education, the Canadian Medical Association, the Royal College of Physicians and Surgeons of Canada or the Royal Colleges of England, Ireland or Scotland. An applicant who has completed 24 months of postgraduate training and has received an unrestricted endorsement from the director of an accredited graduate education program in the State is considered to have satisfied the postgraduate training requirements of this subsection if the applicant continues in that program and completes 36 months of postgraduate training. Notwithstanding this subsection, an applicant who is board certified by the American Board of Medical Specialties is deemed to meet the postgraduate training requirements of this subsection.

[32 MRSA §3271 \(2\)](#)

Examination

Each applicant must achieve a passing score on each component of the uniform examination of the Federation of State Medical Boards or other examinations designated by the board as the qualifying examination or examinations for licensure. Each applicant must additionally achieve a passing score on a State of Maine examination administered by the board.

[32 MRSA §3271 \(3\)](#)

Fees

Each applicant shall pay a fee up to \$600 plus the cost of the qualifying examination or examinations.

[32 MRSA §3271 \(4\)](#)

Board action

An applicant may not be licensed unless the board finds that the applicant is qualified and no cause exists, as set forth in section 3282-A, that may be considered grounds for disciplinary action against a licensed physician or surgeon.

[32 MRSA §3271 \(5\)](#)

Prior criminal convictions as an element of fitness to practice; ten year limit

For applicants to and licensees and registrants of the Board of Licensure in Medicine, the Board of Osteopathic Licensure, the Board of Dental Examiners, the State Board of Examiners of Psychologists, the State Board of Social Worker Licensure, the State Board of Nursing, the Board of Chiropractic Licensure, the Board of Trustees of the Maine Criminal Justice Academy, the State Board of Examiners in Physical Therapy, the State Board of Alcohol and Drug Counselors, the Board of Respiratory Care Practitioners, the Board of Counseling Professionals Licensure, the Board of Occupational Therapy Practice, the Board of Examiners on Speech-language Pathology and Audiology, the Board of Hearing Aid Dealers and Fitters, the Radiologic Technology Board of Examiners, the Nursing Home Administrators Licensing Board, the Board of Licensure of Podiatric Medicine, the Board of Complementary Health Care Providers, the Maine Board of Pharmacy, and the Emergency Medical Services' Board and applicants for massage therapy licensure or licensed massage therapists, the following apply:

- A. The procedures outlined in sections 5301 and 5302 for the consideration of prior criminal conviction as an element of fitness to practice a licensed profession, trade or occupation apply within 10 years of the applicant's or licensee's final discharge, if any, from the correctional system.
- B. Beyond the 10-year period, ex-offender applicants or licensees with no additional convictions must be considered in the same manner as applicants or licensees possessing no prior criminal record for the purposes of licensing decisions.
- C. There is no time limitation for consideration of a registrant's, an applicant's or licensee's conduct that gave rise to the criminal conviction if that conduct is otherwise a ground for disciplinary action.

[5 MRSA §5303 \(2\)](#)

Confidentiality of personal information of applicant or licensee

An applicant or licensee shall provide the board with a current professional address and telephone number, which will be their public contact address, and a personal residence address and telephone number. An applicant's or licensee's personal residence address and telephone number is confidential information and may not be disclosed except as permitted by this section or as required by law, unless the personal residence address and telephone number have been provided as the public contact address. Personal health information submitted as part of any application is confidential information and may not be disclosed except as permitted by this section or as required

by law. The personal health information and personal residence address and telephone number may be provided to other governmental licensing or disciplinary authorities or to any health care providers located within or outside this State that are concerned with granting, limiting or denying a physician's employment or privileges.

[32 MRSA §2600-A](#)

Waiver for exceptional circumstances

The board may waive the requirements of subsection 2 for a physician who does not meet the postgraduate training requirements but who meets the requirements of this subsection.

- A. To be considered for a waiver under this subsection, the physician must:
 1. Be a graduate of a foreign medical school, not including a medical school in Canada or Great Britain;
 2. Be licensed in another state; and
 3. Have at least 3 years of clinical experience in the area of expertise.

- B. If the physician meets the requirements of paragraph A, the board shall use the following qualifications of the physician to determine whether to grant a waiver:
 - 1. Completion of a 3-year clinical fellowship in the United States in the area of expertise. The burden of proof as to the quality and content of the fellowship is placed on the applicant;
 - 2. Appointment to a clinical academic position at a licensed medical school in the United States;
 - 3. Publication in peer-reviewed clinical medical journals recognized by the board;
 - 4. The number of years in clinical practice; and
 - 5. Other criteria demonstrating expertise, such as awards or other recognition.
- C. The costs associated with the board's determination of licensing eligibility in regard to paragraph B must be paid by the applicant upon completion of the determination under paragraph B
- D. The application cost must reflect and not exceed the actual cost of the final determination.

[32 MRSA §3271 \(6\)](#)

Special License Categories

The board may issue a license limited to the practice of administrative medicine as defined by routine technical rule of the board adopted pursuant to Title 5, chapter 375, subchapter 2-A.

[32 MRSA §3271 \(7\)](#)

Licenses

Each physician licensed under this chapter is entitled to receive a license under the seal of the board and signed by the chair and the secretary, which must be publicly displayed at the individual's principal place of practice, as long as this individual continues the practice of medicine.

[32 MRSA §3274](#)

Licensure by reciprocity

Licensure without examination

The board may, at its discretion, grant licensure without written examination to a physician in good standing who otherwise meets the requirements of section 3271 and who has been:

- A. Examined and certified by the National Board of Medical Examiners;
- B. Examined and licensed by a board of another state, if the examination passed by the applicant is determined by the board to be equivalent to its own examination; or
- C. Graduated from a nationally accredited medical school located in the United States, Canada or the British Isles and:
 - 1. Has been examined and certified by the Medical Council of Canada; or
 - 2. Has been examined and certified by the board of a Canadian province or a country in the British Isles, if the examination passed by the applicant is determined by the board to be equivalent in all essentials to its own examination.

An applicant may not be licensed pursuant to this section, unless the board finds that no cause exists, as set forth in section 3282-A, that would be considered grounds for disciplinary action against a licensed physician or surgeon.

[32 MRSA §3275 \(1\)](#)

Fees

A physician who applies for a license pursuant to subsection 1 shall pay a fee of not more than \$600.

[32 MRSA §3275 \(2\)](#)

Temporary licensure

A physician who is qualified under section 3275 may, without examination, be granted a temporary license for a period not to exceed one year, when the board determines that this action is necessary in order to provide relief for local or national emergencies or for situations in which the number of physicians is insufficient to supply adequate medical services. The fee for this temporary license may not be more than \$400.

[32 MRSA §3276](#)

Camp physicians

A physician who is qualified under section 3275 may, at the discretion of the board, be temporarily licensed as a camp physician so that the physician may care for the campers in that particular camp for which the physician was hired and retained as a camp physician. That physician is entitled to practice only on patients in the camp. The temporary license must be obtained each year. Application for this temporary license must be made in the same form and manner as for regular licensure. An examination may not be exacted from applicants for these temporary licenses. The fee for temporary licensure may not be more than \$400 annually.

[32 MRSA §3277](#)

Emergency 100-day License (formerly called Locum tenens)

A physician who presents a current active unconditioned license from another United States licensing jurisdiction and who can provide reasonable proof of meeting qualifications for licensure in this State must be issued a license to serve temporarily for declared emergencies in the State or for other appropriate reasons as determined by the board. The license is effective for not more than 100 days. The fee for this license may be not more than \$400.

[32 MRSA §3278](#)

Biennial renewal of licenses; qualification; fees; reinstatement after lapse

Renewal of licenses

A physician licensed pursuant to section 3271 or 3275 shall apply to the board for relicensure using application forms and submitting supporting documents required by the board. Except as provided in paragraph A for initial proration of expiration dates, the board shall provide to every physician whose application is approved and accepted a proof of license renewal that is valid for no longer than 2 years.

- A. Beginning with licenses expiring after July 1, 1994, regardless of the date of initial licensure or last license renewal, the license of every physician born in an odd-numbered year expires at midnight in 1995 on the last day of the month of the physician's birth. The license of every physician born in an even-numbered year expires at midnight in 1996 on the last day of the month of the physician's birth. Upon expiration, a physician must renew the license issued pursuant to this section and this license must be renewed every 2 years by the last day of the month of birth of the physician seeking license renewal by means of application to the board, on forms prescribed and supplied by the board.
- B. At least 60 days prior to expiration of a current license, the board shall mail to each licensee at the licensee's last known address a notice of the requirement to renew the license with appropriate application forms for the renewal. Whenever a licensee fails, prior to the expiration of the licensee's current license, to return to the board a completed application either to renew the license or to withdraw from licensure, the board shall notify the licensee as soon as possible at the licensee's last known address that the license renewal is past due. Thirty days after the notice has been sent, if the application has neither been submitted by the licensee nor returned by the United States Postal Service as undeliverable, the board shall notify the licensee by certified mail, return receipt requested, that the licensee's license has been administratively suspended for 30 days. If an administratively complete relicensure application, pursuant to subsection 3,

paragraph B, has not been submitted within the 30-day period of administrative suspension, the license immediately and automatically lapses. The board may not restore the license prior to completion of the reinstatement proceedings pursuant to subsection 4.

[32 MRSA §3280-A \(1\)](#)

Criteria for license renewal

- A. The board may pose any question to the licensee or other sources that the board determines appropriate related to qualification for relicensure. These matters may include, but are not limited to, confirmation of health status, professional standing and conduct, professional liability claims history and license status in other jurisdictions. The board shall, after affording the licensee due process, deny license renewal if the board finds cause that may be considered grounds for refusal to renew the license pursuant to section 3282-A, including but not limited to, a determination that an outstanding financial obligation to the Board exists; and
- B. Every licensee seeking renewal of a license with the intent of conducting active medical practice in this State shall submit evidence, satisfactory to the board, of successful completion of a course of continuing medical education within the preceding 24 months, as prescribed by rule. A physician licensed pursuant to section 3271 or 3275 may not engage in the practice of medicine in this State in any degree, including advising or prescribing medication for self, friends or family with or without charge, unless the board has found the licensee qualified by continuing medical education and has marked the current license with the designation "active."

[32 MRSA §3280-A \(2\)](#)

Fees

- A. The board may charge a license renewal application fee of not more than \$500 to all applicants for license renewal.
- B. In addition to the application processing fee, the board may require payment of a late application fee of not more than \$100 from all licensees, regardless of age, from whom the board has not received an administratively complete license renewal application prior to the license expiration date. An application is not administratively complete if it is not signed and dated by the licensee or does not provide full information and responses of sufficient detail to permit board review, evaluation and decision on renewal qualification. An application received without the required license renewal application fee is considered incomplete and the applicant is subject to a late fee.
- C. The board may prorate the fee for biennial relicensure for physicians who have been initially licensed within the past 12 months. The manner of proration, if done, must be explained in the board's published schedule of fees. The board may waive all or a portion of the established license renewal application fee upon receipt of a request for waiver based on hardship or other special circumstance. Any waiver request granted and the basis for the waiver must be recorded in the minutes of the board's proceedings.
- D. Unless received and deposited to the board's account in error and in violation of this section or the board's rules, a license renewal application fee or late fee paid to the board is not refundable if the board or the board's staff has commenced processing the application, regardless of the board's action on the application.

[32 MRSA §3280-A \(3\)](#)

Reinstatement after lapse

A physician may be reinstated after the lapse of a license under the following conditions:

- A. A license that has lapsed pursuant to subsection 1, paragraph B may be reinstated upon application by the physician on forms provided by the board. A physician whose license has lapsed for more than 5 years shall apply for a new license in order to practice medicine in the State.

- B. When applying for reinstatement, the licensee must state the reason why the license lapsed and pay all fees in arrears at the time of lapse plus the current license renewal application fee and a nonrefundable reinstatement application processing fee of \$100.
- C. The board may not reinstate a lapsed license if the board finds any cause that may be considered a ground for discipline pursuant to section 3282-A if the license had been in force. Prior to concluding that no cause exists, the board shall conduct the inquiries required by subsection 2, paragraph A for applications for renewal. In addition, the board may not reinstate the license of any physician who has not provided evidence satisfactory to the board of having actively engaged in the practice of medicine continuously for at least the past 12 months under the license of another jurisdiction of the United States or Canada unless the applicant has first satisfied the board of the applicant's current competency by passage of written examinations or practical demonstrations as the board may from time to time prescribe for this purpose through rulemaking.

[32 MRSA §3280-A \(4\)](#)

Withdrawal of license

The holder of a license or temporary license who notifies the board in writing of the withdrawal of the holder's license is not required to pay licensure fees or penalties beyond those due at the time of the holder's withdrawal, but after a holder gives this notice, the holder's license to practice is not valid until reinstated by the board.

An applicant for reinstatement is entitled to be reinstated upon paying a reinstatement fee of \$50 and satisfying the board that the applicant has paid all fees and penalties due at the time of the applicant's withdrawal, and no cause exists for revoking or suspending the applicant's license, and the applicant has applied within 5 years after the applicant's withdrawal, and was in active practice outside this State within one year prior to the filing of application for reinstatement.

[32 MRSA §3281](#)

Disciplinary sanctions

Disciplinary proceedings and sanctions

The board shall investigate a complaint, on its own motion or upon receipt of a written complaint filed with the board, regarding noncompliance with or violation of this chapter or any rules adopted by the board.

The board shall notify the licensee of the content of a complaint filed against the licensee as soon as possible, but not later than 60 days after receipt of this information. The licensee shall respond within 30 days. The board shall share the licensee's response with the complainant, unless the board determines that it would be detrimental to the health of the complainant to obtain the response. If the licensee's response to the complaint satisfies the board that the complaint does not merit further investigation or action, the matter may be dismissed, with notice of the dismissal to the complainant, if any.

If, in the opinion of the board, the factual basis of the complaint is or may be true and the complaint is of sufficient gravity to warrant further action, the board or a subcommittee of the board may request and conduct an informal conference with the licensee. The board shall provide the licensee with adequate notice of the conference and the issues to be discussed. The complainant may attend and may be accompanied by up to 2 individuals, including legal counsel. The conference must be conducted in executive session of the board or a subcommittee of the board, pursuant to Title 1, section 405, unless otherwise requested by the licensee. Before the board decides what action to take at the conference or as a result of the conference, the board or a subcommittee of the board shall give the complainant a reasonable opportunity to speak. Statements made at the conference may not be introduced at a subsequent formal hearing unless all parties consent. The complainant, the licensee or either of their representatives shall maintain the confidentiality of the conference.

When a complaint has been filed against a licensee and the licensee moves or has moved to another state, the board may report to the appropriate licensing board in that state the complaint that has been filed, other complaints in the physician's record on which action was taken and disciplinary actions of the board with respect to that physician.

When an individual applies for a license under this chapter, the board may investigate the professional record of that individual, including professional records that the individual may have as a licensee in other states. The board may deny a license or authorize a restricted license based on the record of the applicant in other states.

If the board finds that the factual basis of the complaint is true and is of sufficient gravity to warrant further action, it may take any of the following actions it determines appropriate.

- A. With the consent of the licensee, the board may enter into a consent agreement that fixes the period and terms of probation best adapted to protect the public health and safety and rehabilitate or educate the licensee. A consent agreement may be used to terminate a complaint investigation, if entered into by the board, the licensee and the Attorney General's office.
- B. In consideration for acceptance of a voluntary surrender of the license, the board may negotiate stipulations, including terms and conditions for reinstatement, that ensure protection of the public health and safety and serve to rehabilitate or educate the licensee. These stipulations may be set forth only in a consent agreement signed by the board, the licensee and the Attorney General's office.
- C. If the board concludes that modification or nonrenewal of the license is in order, the board shall hold an adjudicatory hearing in accordance with Title 5, chapter 375, subchapter IV.
- D. If the board concludes that suspension or revocation of the license is in order, the board shall file a complaint in the District Court in accordance with Title 4, chapter 5.

The board shall require a licensee to notify all patients of the licensee of a probation or stipulation under which the licensee is practicing as a result of board disciplinary action. This requirement does not apply to a physician participating in an alcohol or drug treatment program pursuant to Title 24, section 2505, a physician who retires following charges made or complaints investigated by the board or a physician under the care of a professional and whose medical practices and services are not reduced, restricted or prohibited by the disciplinary action.

[32 MRSA §3282-A \(1\)](#)

Grounds for discipline

The board may suspend or revoke a license pursuant to Title 5, section 10004. The following are grounds for an action to refuse to issue, modify, restrict, suspend, revoke or refuse to renew the license of an individual licensed under this chapter:

- A. The practice of fraud or deceit in obtaining a license under this chapter or in connection with service rendered within the scope of the license issued;
- B. Habitual substance abuse that has resulted or is foreseeably likely to result in the licensee performing services in a manner that endangers the health or safety of patients;
- C. A professional diagnosis of a mental or physical condition that has resulted or may result in the licensee performing services in a manner that endangers the health or safety of patients;
- D. Aiding or abetting the practice of medicine by an individual who is not licensed under this chapter and who claims to be legally licensed;
- E. Incompetence in the practice for which the licensee is licensed. A licensee is considered incompetent in the practice if the licensee has:
 1. Engaged in conduct that evidences a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public; or

2. Engaged in conduct that evidences a lack of knowledge or inability to apply principles or skills to carry out the practice for which the licensee is licensed;
- F. Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior, including engaging in disruptive behavior, that has been established in the practice for which the licensee is licensed. For purposes of this paragraph, “disruptive behavior” means aberrant behavior that interferes with or is likely to interfere with the delivery of care;
- G. Subject to the limitations of Title 5, chapter 341, conviction of a crime that involves dishonesty or false statement or relates directly to the practice for which the licensee is licensed, or conviction of a crime for which incarceration for one year or more may be imposed;
- H. A violation of this chapter or a rule adopted by the board;
- I. Engaging in false, misleading or deceptive advertising;
- J. Prescribing narcotic or hypnotic or other drugs listed as controlled substances by the Drug Enforcement Administration for other than accepted therapeutic purposes;
- K. Failure to report to the secretary of the board a physician licensed under this chapter for addiction to alcohol or drugs or for mental illness in accordance with Title 24, section 2505, except when the impaired physician is or has been a patient of the licensee;
- L. Failure to comply with the requirements of Title 24, section 2905-A; or
- M. Revocation, suspension or restriction of a license to practice medicine or other disciplinary action; denial of an application for a license; or surrender of a license to practice medicine following the institution of disciplinary action by another state or a territory of the United States or a foreign country if the conduct resulting in the disciplinary or other action involving the license would, if committed in this State, constitute grounds for discipline under the laws or rules of this State.

[32 MRSA §3282-A \(2\)](#)

Emergency action

Upon its own motion or upon complaint, the board, in the interests of public health, safety and welfare, shall treat as an emergency a complaint or allegation that an individual licensed under this chapter is or may be unable to practice medicine with reasonable skill and safety to patients by reason of mental illness, alcohol intemperance, excessive use of drugs, narcotics or as a result of a mental or physical condition interfering with the competent practice of medicine. In enforcing this paragraph, the board may compel a physician to submit to a mental or physical examination by physicians designated by it. Failure of a physician to submit to this examination when directed constitutes an admission of the allegations against the physician, unless the failure was due to circumstances beyond the physician's control, upon which a final order of disciplinary action may be entered without the taking of testimony or presentation of evidence. A physician affected under this paragraph must, at reasonable intervals, be afforded an opportunity to demonstrate that the physician can resume the competent practice of medicine with reasonable skill and safety to patients.

For the purpose of this chapter, by practicing or by making and filing a biennial license to practice medicine in this State, every physician licensed under this chapter who accepts the privilege to practice medicine in this State is deemed to have given consent to a mental or physical examination when directed in writing by the board and to have waived all objections to the admissibility of the examining physicians' testimony or examination reports on the grounds that the testimony or reports constitute a privileged communication.

Injunctions must issue immediately to enjoin the practice of medicine by an individual licensed to practice under this chapter when that individual's continued practice will or may cause irreparable damage to the public health or safety prior to the time proceedings under this chapter could be instituted and completed. In a petition for injunction pursuant to this section, there must be set forth with particularity

the facts that make it appear that irreparable damage to the public health or safety will or may occur prior to the time proceedings under this chapter could be instituted and completed. The petition must be filed in the name of the board on behalf of the State.

[32 MRSA §3286](#)

Peer Review

Review committee member immunity

A physician licensed under this chapter who is a member of a utilization review committee, medical review committee, surgical review committee, peer review committee or disciplinary committee that is a requirement of accreditation by the Joint Commission on Accreditation of Hospitals or is established and operated under the auspices of the physician's respective state or county professional society or the Board of Licensure in Medicine is immune from civil liability for undertaking or failing to undertake an act within the scope of the function of the committee.

[32 MRSA §3293](#)

Records of proceedings of medical staff review committees confidential

All proceedings and records of proceedings concerning medical staff reviews, hospital reviews and other reviews of medical care conducted by committees of physicians and other health care personnel on behalf of hospitals located within the State or on behalf of individual physicians, when the reviews are required by state or federal law, rule or as a condition of accreditation by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association Committee on Hospital Accreditation or are conducted under the auspices of the state or county professional society to which the physician belongs, are confidential and are exempt from discovery.

Provision of information protected by this section to the board pursuant to Title 24, section 2506 does not waive or otherwise affect the confidentiality of the records or the exemption from discovery provided by this section for any other purpose.

[32 MRSA §3296](#)

(52) Limited English Proficiency (LEP)

As part of the federal government's effort to promote effective communication between health and social service providers and people with limited English proficiency, the Office of Civil Rights has issued revised guidance to help practitioners and organizations meet the federal requirements for LEP. Below are some of the key excerpts from the OCR guidance.

Who Is Covered

Department of Health and Human Services regulations, 45 CFR §80.3(b)(2), require all recipients of federal financial assistance from HHS to provide meaningful access to LEP persons. Federal financial assistance includes grants, training, use of equipment, donations of surplus property, and other assistance.

Recipients of HHS assistance may include:

- A. Hospitals, nursing homes, home health agencies, and managed care organizations
- B. Universities and other entities with health or social service research programs
- C. State, county, and local health agencies
- D. State Medicaid agencies
- E. State, county and local welfare agencies
- F. Programs for families, youth, and children
- G. Head Start programs

- H. Public and private contractors, subcontractors and vendors
- I. Physicians and other providers who receive Federal financial assistance from HHS

Recipients of HHS assistance do not include, for example, providers who only receive Medicare Part B payments. However, MaineCare does require MaineCare “providers [to] ensure that MaineCare members are able to communicate effectively with them regarding their medical needs.” MaineCare will reimburse providers for interpreters required for limited and non-English speaking members and/or deaf/hard of hearing members, when these services are necessary to communicate effectively with members regarding health needs. Interpreter services can only be covered in conjunction with another covered MaineCare service. For more guidance on MaineCare’s policy on paying for interpretation services, see: http://www.maine.gov/dhhs/oma/MulticulturalResource/appendix_g.html. The bottom line is that virtually all physician offices will be required to provide language access services.

Who Is a Limited English Proficient Individual

Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be limited English proficient, or "LEP," and may be eligible to receive language assistance with respect to a particular type of service, benefit, or encounter.

How Does a Recipient Determine the Extent of Its Obligation To Provide LEP Services

Recipients are required to take reasonable steps to ensure meaningful access to their programs and activities by LEP persons. While designed to be a flexible and fact-dependent standard, the starting point is an individualized assessment that balances the following four factors:

Four Factor Test:

- A. The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee;
- B. The frequency with which LEP individuals come in contact with the program;
- C. The nature and importance of the program, activity, or service provided by the program to people's lives; and
- D. The resources available to the grantee/recipient and costs. As indicated above, the intent of this guidance is to suggest a balance that ensures meaningful access by LEP persons to critical services while not imposing undue burdens on small business, small local governments, or small nonprofits.

After applying the above four-factor analysis, a recipient may conclude that different language assistance measures are sufficient for the different types of programs or activities in which it engages, or, in fact, that, in certain circumstances, recipient-provided language services are not necessary. (As discussed below, recipients may want to consider documenting their application of the four-factor test to the services they provide.) For instance, some of a recipient's activities will be more important than others and/or have greater impact on or contact with LEP persons, and thus may require more in the way of language assistance.

Recipients have two main ways to provide language services: **Oral interpretation** either in person or via telephone interpretation service (hereinafter "interpretation") and **written translation** (hereinafter "translation"). Oral interpretation can range from on-site interpreters for critical services provided to a high volume of LEP persons, to access through commercially-available telephonic interpretation services. Written translation, likewise, can range from translation of an entire document to translation of a short description of the document.

For example, if two physicians in the same field, one with a Spanish-speaking assistant and one with a Vietnamese-speaking assistant, practice in the same geographic area and have a custom/ practice of referring patients between each other, it may be appropriate for the first doctor to refer LEP Vietnamese

patients to the second doctor and for the second doctor to refer LEP Spanish patients to the first doctor. In certain circumstances, a referral would not be appropriate: for example, a Korean speaking LEP woman comes to a battered women's shelter requesting assistance. Although the shelter has space, it has no arrangement to provide language assistance for LEP persons. Instead, as with all LEP persons, the staff only offer her a prepared list of three shelters in the neighborhood that generally provide language assistance. The staff does not check to assure that any of the three alternative shelters can actually provide the Korean language assistance she needs, or that any have space available for her.

The correct mix should be based on what is both necessary and reasonable in light of the four-factor analysis.

Oral Language Services (Interpretation)

Interpretation is the act of listening to something in one language (source language) and orally translating it into another language (target language). Where interpretation is needed and is reasonable, recipients should consider some or all of the following options for providing competent interpreters in a timely manner:

- A. Hiring Bilingual Staff
- B. Hiring Staff Interpreters
- C. Contracting for Interpreters
- D. Using Telephone Interpreter Lines
- E. Using Community Volunteers
- F. Use of Family Members or Friends as Interpreters

Written Language Services (Translation)

What Documents Should be Translated

Vital written materials could include, for example:

- A. Consent and complaint forms.
- B. Intake forms with the potential for important consequences
- C. Written notices of eligibility criteria, rights, denial, loss, or decreases in benefits or services, actions affecting parental custody or child support, and other hearings
- D. Notices advising LEP persons of free language assistance
- E. Written tests that do not assess English language competency, but test competency for a particular license, job, or skill for which knowing English is not required
- F. Applications to participate in a recipient's program or activity or to receive recipient benefits or services

Nonvital written materials could include:

- A. Hospital menus
- B. Third party documents, forms, or pamphlets distributed by a recipient as a public service
- C. For a non-governmental recipient, government documents and forms
- D. Large documents such as enrollment handbooks (although vital information contained in large documents may need to be translated)
- E. General information about the program intended for informational purposes only

Elements of Effective Plan on Language Assistance for LEP Persons

If, after completing the four-factor analysis, a recipient determines that it should provide language assistance services, a recipient may develop an implementation plan to address the identified needs of the LEP populations it serves. Such recipients have considerable flexibility in developing this plan.

Excepts from: Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons
(<http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html>)

See also the AMA document, Office Guidance for Communicating with Limited English Proficient Patients: http://www.ama-assn.org/ama1/pub/upload/mm/433/lep_booklet.pdf

(53) MaineCare (see also Agency Rules Links)

MaineCare is the state's medical assistance program and is administered by the Bureau of Medical Service, Department of Human Services. In 2009, the Legislature adopted a compromise on proposed cuts in reimbursement to hospital-based physicians that increased the MaineCare physician fee schedule from approximately 57% to approximately 70% of Medicare rates effective February 1, 2010.

Useful Links

[Office of MaineCare Services \(formerly Bureau of Medical Services\) Home Page](#)

[Office of MaineCare Services Provider Page](#)

[MaineCare Benefits Manual](#), Department of Health and Human Services Rule Chapter 101

(54) Maine Health Data Organization (see also Agency Rules Links)

Purposes

The objective of the organization is to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Maine citizens and to issue reports, as provided in section 8712. This database must be publicly accessible while protecting patient confidentiality and respecting providers of care. The organization shall collect, process, analyze and report clinical, financial, quality and restructuring data. The organization shall promote public transparency of the quality and cost of health care in the State in conjunction with the Maine Quality Forum. It is also required by statute to create an interactive website displaying prices paid for specific procedures performed at all Maine hospitals and impacted surgical, diagnostic or other nonhospital facilities.

[22 MRSA § 8703](#)

[22 MRSA § 8712](#)

The organization is governed by [Title 22 MRSA, Chapter 1683](#) and [rules](#). For more information, view visit the [MHDO Website](#).

In 2009, the Legislature extended the operation of the Maine Health Data Processing Center to September 1, 2015. The center shall collect and process health care claims data in coordination with existing state, regional and local agencies. Such efforts must include, but are not limited to: establishing, maintaining and making available to the Maine Health Data Organization an all-payor and all-setting health care database system based on claims data in addition to the existing databases of the Maine Health Data Organization; to collect, process and maintain health care data extracted from claims data; collecting and processing data from 3rd-party payors, 3rd-party administrators and governmental agencies; and

promoting high-quality and accurate data to support easy and flexible access to the health care database by multiple users under terms and conditions specified by the Maine Health Data Organization.

[10 MRSA § 682](#)

The Maine Health Data Processing Center is governed by [Title 10, MRSA Chapter 102-A](#).

Clinical data

Information required

Pursuant to rules adopted by the board for form, medium, content and time for filing, each health care facility shall file with the organization the following information:

- A. A completed uniform hospital discharge data set, or comparable information, for each patient discharged from the facility after June 30, 1983 and for each hospital outpatient service occurring after June 30, 1996; and
- B. In addition to any other requirements applicable to specific categories of health care facilities, the organization may require the filing of data as set forth in this chapter or in rules adopted pursuant to this chapter.

[22 MRSA §8708 \(1\)](#)

Additional information on ambulatory services and surgery

Pursuant to rules adopted by the board for form, medium, content and time for filing, each provider shall file with the organization a completed data set, comparable to data filed by health care facilities under subsection 1, paragraph B. This subsection may not be construed to require duplication of information required to be filed under subsection 1.

[22 MRSA §8708 \(2\)](#)

More than one licensed health care facility or location

When more than one licensed health care facility is operated by the reporting organization, the information required by this chapter must be reported for each health care facility separately. When a provider of health care operates in more than one location, the organization may require that information be reported separately for each location.

[22 MRSA §8708 \(3\)](#)

Medical record abstract data

In addition to the information required to be filed under subsections 1 and 2 and pursuant to rules adopted by the organization for form, medium, content and time of filing, each health care facility shall file with the organization such medical record abstract data as the organization may require.

[22 MRSA §8708 \(5\)](#)

Merged data

The board may require the discharge data submitted pursuant to subsection 1 and any medical record abstract data required pursuant to subsection 5 to be merged with associated billing data.

[22 MRSA §8708 \(6\)](#)

Additional data

Subject to the limitations of section 8704, subsection 1, the board may adopt rules requiring the filing of additional clinical data from other providers and payors as long as the submission of data to the organization is consistent with federal law. Data filed by payors must be provided in a format that does not directly identify the patient.

[22 MRSA §8708 \(6-A\)](#)

Authority to obtain information

Nothing in this section may be construed to limit the board's authority to obtain information that it considers necessary to carry out its duties.

[22 MRSA §8708 \(7\)](#)

Financial data; scope of service data

Financial data and scope of service data must be filed, stored and managed as follows.

A. Financial data

Each health care facility shall file with the organization, in a form specified by rule pursuant to section 8704, financial information including costs of operation, revenues, assets, liabilities, fund balances, other income, rates, charges and units of services, except to the extent that the board specifies by rule that portions of this information are unnecessary.

B. Hospitals; standardized accounting template

When filing the financial information required under subsection 1, a hospital also shall file information using the standardized accounting template published in the report of the Commission to Study Maine's Community Hospitals in February 2005. The hospital shall file this information using an electronic version of the template provided to the hospital by the organization. If in succeeding years the template needs to be modified, the board shall adopt rules specifying the filing requirements. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.

C. Certification required

The board may require certification of such financial reports and attestation from responsible officials of the health care facility that such reports have to the best of their knowledge and belief been prepared in accordance with the requirements of the board.

D. Scope of service data

Each health care facility shall file with the organization scope of service information, including bed capacity by service provided, special services, ancillary services, physician profiles in the aggregate by clinical specialties, nursing services and such other scope of service information as the organization determines necessary for the performance of its duties.

[22 MRSA §8709](#)

Other health care information**Development of health care information systems**

In addition to its authority to obtain information to carry out the specific provisions of this chapter, the organization may require providers and payors to furnish information with respect to the nature and quantity of services or coverage provided to the extent necessary to develop proposals for the modification, refinement or expansion of the systems of information disclosure established under this chapter. The organization's authority under this subsection includes the design and implementation of pilot information reporting systems affecting selected categories or representative samples of providers and payors.

Information on mandated services

The organization is authorized and directed to require providers of mammography services to furnish information with respect to those services for the purpose of assisting in the evaluation of the social and financial impact and the efficacy of the mandated benefit for screening mammograms under Title 24, section 2320-A and Title 24-A, sections 2745-A and 2837-A.

The information that may be collected includes the location of mammography units, the purchase of new mammography units, the number of screening and diagnostic mammograms performed, the charge per

mammogram and the method and amount of payment, and the number of cancers detected by screening mammograms.

[22 MRSA §8711](#)

Reports

The organization shall produce clearly labeled and easy-to-understand reports as follows. Unless otherwise specified, the organization shall distribute the reports on a publicly accessible site on the Internet or via mail or e-mail, through the creation of a list of interested parties. The organization shall publish a notice of the availability of these reports at least once per year in the 3 daily newspapers of the greatest general circulation published in the State. The organization shall make reports available to members of the public upon request.

Quality

At a minimum, the organization, in conjunction with the Maine Quality Forum, established in Title 24-A, section 6951, shall develop and produce annual quality reports.

Average Payments

At a minimum, the organization, with advice from the Maine Health Data Processing Center as authorized in Title 10, section 681, shall develop and produce annual reports on average private-payer payments for services provided by health care facilities and health care practitioners, excluding emergency services. For health care facilities, the reports must include, but are not limited to, the average private-payer payments per service per facility and total number of services per facility.

Comparison report

At a minimum, the organization shall develop and produce an annual report that compares the 15 most common diagnosis-related groups and the 15 most common outpatient procedures for all hospitals in the State and the 15 most common procedures for nonhospital health care facilities in the State to similar data for medical care rendered in other states, when such data are available.

Physician services

The organization shall provide an annual report of the 10 services and procedures most often provided by osteopathic and allopathic physicians in the private office setting in this State. The organization shall distribute this report to all physician practices in the State. The first report must be produced by July 1, 2004.

[22 MRSA §8712](#)

(55) Managed Care Organizations, Select Statutes

Health Plan Improvement Act (Patient Bill of Rights)

Definitions

- A. **Adverse health care treatment decision:** means a health care treatment decision made by or on behalf of a carrier offering a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an enrollee.
- B. **Authorized representative:** means:
 1. A person to whom an enrollee has given express written consent to represent the enrollee in an external review;
 2. A person authorized by law to provide consent to request an external review for an enrollee; or
 3. A family member of an enrollee or an enrollee's treating health care provider when the enrollee is unable to provide consent to request an external review.
- C. **Carrier:** means:

1. An insurance company licensed in accordance with this Title to provide health insurance;
 2. A health maintenance organization licensed pursuant to chapter 56;
 3. A preferred provider arrangement administrator registered pursuant to chapter 32;
 4. A fraternal benefit society, as defined by section 4101;
 5. A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 24;
 6. A multiple-employer welfare arrangement licensed pursuant to chapter 81; or
 7. A self-insured employer subject to state regulation as described in section 2848-A.
 8. *An employer exempted from the applicability of this chapter under the federal Employee Retirement Income Security Act of 1974, 29 United States Code, Sections 1001 to 1461 (1988) is not considered a carrier.
- D. **Clinical peer:** means a physician or other licensed health care practitioner who holds a nonrestricted license in a state of the United States in the same or similar specialty as typically manages the medical condition, procedure or treatment under review, or other physician or health care practitioner with demonstrable expertise necessary to review a case.
- E. **Enrollee:** means an individual who is enrolled in a health plan or a managed care plan.
- F. **Health care treatment decision:** means a decision regarding diagnosis, care or treatment when medical services are provided by a health plan, or a benefits decision involving determinations regarding medically necessary health care, preexisting condition determinations and determinations regarding experimental or investigational services.
- G. **Health plan:** means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan, other than a plan that provides only accidental injury, specified disease, hospital indemnity, Medicare supplement, disability income, long-term care or other limited benefit coverage.
- H. **Independent review organization:** means an entity that conducts independent external reviews of adverse health care treatment decisions.
- I. **Managed care plan:** means a plan offered or administered by a carrier that provides for the financing or delivery of health care services to persons enrolled in the plan through:
1. Arrangements with selected providers to furnish health care services; and
 2. Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan.
 3. * A return to work program developed for the management of workers' compensation claims may not be considered a managed care plan.
- J. **Medically necessary health care:** means health care services or products provided to an enrollee for the purpose of preventing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:
1. Consistent with generally accepted standards of medical practice;
 2. Clinically appropriate in terms of type, frequency, extent, site and duration;
 3. Demonstrated through scientific evidence to be effective in improving health outcomes;
 4. Representative of "best practices" in the medical profession; and
 5. Not primarily for the convenience of the enrollee or physician or other health care practitioner.
- K. **Ordinary care:** means, in the case of a carrier, the degree of care that a carrier of ordinary prudence would use under the same or similar circumstances. For a person who is an agent of a

carrier, "ordinary care" means the degree of care that a person of ordinary prudence would use under the same or similar circumstances.

- L. **Participating provider:** means a licensed or certified provider of health care services, including mental health services, or health care supplies that has entered into an agreement with a carrier to provide those services or supplies to an individual enrolled in a managed care plan
- M. **Peer-reviewed medical literature:** means scientific studies published in at least 2 articles from major peer-reviewed medical journals that present supporting data that the proposed use of a drug or device is safe and effective.
- N. **Plan sponsor:** means an employer, association, public agency or any other entity providing a health plan.
- O. **Provider:** means a practitioner or facility licensed, accredited or certified to perform specified health care services consistent with state law.
- P. **Religious nonmedical provider:** means a provider who provides only religious nonmedical treatment or religious nonmedical nursing care.
- Q. **Special condition:** means a condition or disease that is life-threatening, degenerative or disabling and requires specialized medical care over a prolonged period of time.
- R. **Specialist:** means an appropriately licensed and credentialed health care provider with specialized training and clinical expertise.
- S. **Standard reference compendia:** means:
 1. The United States Pharmacopeia Drug Information or information published by its successor organization; or
 2. The American Hospital Formulary Service Drug Information or information published by its successor organization.

[24-A MRSA §4301-A](#)

HMO's and the Practice of Medicine

Any health maintenance organization authorized under this chapter is not deemed to be practicing medicine and is exempt from provisions of law relating to the practice of medicine, except that this subsection may not be asserted by a health maintenance organization as a defense to any action brought by an enrollee pursuant to section 4313.

[24-A MRSA §4222 \(3\)](#)

Confidentiality; liability; access to records

A. Confidentiality

Any data or information pertaining to the diagnosis, treatment or health of an enrollee or applicant obtained from that enrollee or applicant or a provider by a health maintenance organization must be held in confidence and may not be disclosed to any person except: to the extent that it may be necessary to carry out the purposes of this chapter; upon the express consent of the enrollee or applicant; pursuant to statute or court order for the production of evidence or the discovery of evidence; or in the event of claim or litigation between that enrollee or applicant and the health maintenance organization when such data or information is pertinent. A health maintenance organization is entitled to claim any statutory privileges against such disclosure that the provider who furnished such information to the health maintenance organization is entitled to claim.

B. Liability

A person who, in good faith and without malice, as a member, agent or employee of a quality assurance committee, assists in the origination, investigation or preparation of a report or information related to treatment previously rendered, submits that report or information to a

health maintenance organization or appropriate state licensing board, or assists the committee in carrying out any of its duties under this chapter is not subject to civil liability for damages as a consequence of those actions, nor is the health maintenance organization that established that committee or the officers, directors, employees or agents of that health maintenance organization liable for the activities of that person. This section may not be construed to relieve any person of liability arising from treatment of a patient.

1. The information considered by a quality assurance committee and the records of its actions and proceedings are confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency or in an appeal, if permitted, from the findings or recommendations of the committee. A member of a quality assurance committee or an officer, director, staff person or other member of a health maintenance organization engaged in assisting the committee or any person assisting or furnishing information to the committee may not be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on these activities.
 2. Information considered by a quality assurance committee and the records and proceedings of that committee used pursuant to paragraph A by a state licensing or certifying agency or in an appeal must be kept confidential and are subject to the same provisions concerning discovery and use in legal actions as are the original information and records in the possession and control of the health care review committee.
- C. Access to records: To fulfill the obligations of a health maintenance organization under section 4204, subsection 2-A, paragraph B, a health maintenance organization must have access to treatment records and other information pertaining to the diagnosis, treatment and health status of any enrollee.

[24-A MRSA §4224](#)

Enrollee choice of primary care provider

A carrier offering a managed care plan shall allow enrollees to choose their own primary care providers, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A carrier shall allow physicians, and certified nurse practitioners who have been approved by the State Board of Nursing to practice advanced practice registered nursing without the supervision of a physician pursuant to Title 32, section 2102, subsection 2-A, to serve as primary care providers for managed care plans. A carrier is not required to contract with certified nurse practitioners or physicians as primary care providers in any manner that exceeds the access and provider network standards required in this chapter or chapter 56, or any rules adopted pursuant to those chapters. A carrier must allow enrollees in a managed care plan to change primary care providers without good cause at least once annually and to change with good cause as necessary. When an enrollee fails to choose a primary care provider, the carrier may assign the enrollee a primary care provider located in the same geographic area in which the enrollee resides.

[24-A MRSA §4306](#)

Indemnification

A contract between a carrier offering a health plan and a provider for the provision of services to enrollees may not require the provider to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges incurred in connection with any claim or action brought against the health plan based on the carrier's own fault. Nothing in this section may be construed to remove responsibility of a carrier or provider for expenses or liabilities caused by the carrier's or provider's own negligent acts or omissions or intentional misconduct.

[24-A MRSA §4308](#)

Limit on retrospective denials of previously paid health insurance claims

The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months. The retrospective denial of a previously paid claim may be permitted beyond 12 months from the date of payment only for the following reasons:

- A. The claim was submitted fraudulently;
- B. The claim payment was incorrect because the provider or the insured was already paid for the health care services identified in the claim;
- C. The health care services identified in the claim were not delivered by the provider;
- D. The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;
- E. The claim payment is the subject of adjustment with another insurer, administrator or payor; or
- F. The claim payment is the subject of legal action.

[24-A MRSA §4303 \(10-B\)](#)

Other Statutory References of Interest:

Reporting Requirement:	<u>24-A MRSA §4302</u>
Plan Requirements:	<u>24-A MRSA §4302</u> ; <u>24-A MRSA §4303</u>
Utilizations Review:	<u>24-A MRSA §4304</u>
Quality of Care:	<u>24-A MRSA §4305</u>
Access to Clinical Trials:	<u>24-A MRSA §4310</u>
Access to prescription drugs:	<u>24-A MRSA §4311</u>
Independent external review:	<u>24-A MRSA §4312</u>
Carrier liability; cause of action:	<u>24-A MRSA §4313</u>

(56) Mandatory Reports

Maine law requires the mandatory reporting of many diseases, conditions, situations, etc. Many of these are covered in the sections of the same title. For purposes of efficiency, a list of major title mandatory reports is listed below.

List of Mandatory Reports

- A. Abortions and Miscarriages
- B. Abuse (Adult, Child and Elder)
- C. AIDS and HIV
- D. Births
- E. Burns
- F. Cancer
- G. Communicable Diseases (Public Health)
- H. Crime, Failure to report
- I. Deaths
- J. Gunshot Wounds

A person is guilty of failure to report treatment of a gunshot wound if, being a health care practitioner or emergency medical services person, that person treats a human being for a wound apparently caused by the discharge of a firearm and knowingly fails to report the same to a law enforcement agency immediately by the quickest means of communication.

[17-A MRSA §512 \(1\)](#)

- K. Head Injury
- L. Impaired Physician
- M. Lead Poisonings
- N. Occupational Diseases (Public Health)
- O. Sentinel Events
- P. New Born Hearing Evaluations

(57) Medical Education Program**Doctors for Maine’s Future Scholarship Program**

There is established the Doctors for Maine’s Future Scholarship Program, referred to in this section as “the scholarship program,” to provide a tuition subsidy of 50% of the cost of attendance annually, up to a maximum of \$25,000 per student annually, for eligible students who enter qualifying Maine-based medical school programs for the purpose of increasing the number of physicians in this State who practice in primary care, underserved specialties or underserved areas of the State. For the purposes of this section, “cost of attendance” means the tuition and fees applicable to an eligible student, together with estimated other expenses reasonably related to cost of attendance at a qualifying Maine-based medical school program.

[20-A MRSA §12103-A](#)**Qualifying Maine-based medical school program**

“Qualifying Maine-based medical school program” means an allopathic or osteopathic medical school program affiliated with a medical school accredited by the Liaison Committee on Medical Education or its successor or the American Osteopathic Association or its successor in which:

- A. An educational or health care institution located in this State participates in curriculum development and the selection of students for admission;
- B. No fewer than 10 students per class year are enrolled and in which these students are required to complete not less than one academic year of the medical school curriculum at facilities located in this State;
- C. Funds are raised through philanthropic resources and the private sector to match 100% of those funds appropriated or allocated by the State for scholarships under section 12103; and
- D. The program curriculum includes required clerkship experiences in and training and course completion in rural health care and primary care.

[20-A MRSA §12101 \(8-A\)](#)

For more on Doctors for Maine’s Future Scholarship Program and Eligibility see [Public Law, Chapter 410](#) or [20-A MRSA § 12103-A](#).

(58) Medical Examiner Act

The Medical Examiner Act consists of many sections related to the Office of the Medical Examiner. Below are several select sections as they relate to medical examiners and and/or medical examiner cases.

Certain information confidential

The following records in the possession or custody of a medical examiner or the Office of the Chief Medical Examiner are not public records within the meaning of Title 1, section 402, subsection 3 and are confidential:

- A. Medical records relating to a medical examiner case;
- B. Law enforcement agency reports or records relating to a medical examiner case;
- C. Communications with the Department of the Attorney General relating to a medical examiner case;
- D. Communications with the office of a district attorney relating to a medical examiner case;
- E. Death certificates and amendments made to the certificates, except for the information for which the medical examiner is responsible, as listed in section 2842, subsection 3, and not ordered withheld by the Attorney General relating to a medical examiner case or missing person;
- F. Photographs and transparencies, histological slides, videotapes and other like items relating to a medical examiner case; and
- G. Written or otherwise recorded communications that express or are evidence of suicidal intent obtained under section 3028, subsections 4 and 5.

[22 MRSA §3022 \(8\)](#)

Cooperation with research requests

The Office of Chief Medical Examiner shall cooperate with research requests by supplying abstracted data to interested persons consistent with the available resources of the office.

[22 MRSA §3022 \(9\)](#)

Access to or dissemination of confidential records

Access to or dissemination of records made confidential under subsection 8 is limited to:

- A. A criminal justice agency for the purpose of the administration of criminal or juvenile justice;
- B. A person for whom the Chief Medical Examiner determines access is necessary or desirable to carry out a duty under this Act;
- C. A person for whom the Chief Medical Examiner determines access is necessary or desirable to allow for the harvesting of a decedent's organs and other tissues;
- D. A person when authorized or required under any state or federal law, rule or regulation; and
- E. A person pursuant to a court order.

Access to or dissemination of records as provided under paragraphs A to C can be done as a matter of course by the Chief Medical Examiner unless the Attorney General directs otherwise.

[22 MRSA §3022 \(12\)](#)

Access to certain information by certain persons

Unless a medical examiner case is under investigation by the Department of the Attorney General or the office of a district attorney and the Attorney General or the district attorney determines that there is a reasonable possibility that release or inspection interferes with a criminal investigation or prosecution by the disclosure:

- A. Items identified in subsection 8, paragraphs F and G may be inspected and copies obtained, upon payment of any required fee under section 3035, by:
 1. A next of kin of the deceased, as defined under section 2843-A. The Chief Medical Examiner may provide the original of the items described in subsection 8, paragraph G to the next of kin or other person to whom that item is addressed or directed;
 2. An insurer that may be responsible for payment of benefits as a result of a death if relevant to the payment obligation;
 3. An attorney representing the estate of the decedent or the decedent's property if relevant to the representation; and

4. An attorney representing a person or a person's estate and exploring a possible civil action against the estate of the decedent if relevant to the representation; and
- B. A person may inspect and obtain a copy of communications identified in subsection 8, paragraphs C and D, except work product as defined in Rule 16(b)(3) of the Maine Rules of Criminal Procedure, as long as the communications would otherwise be open to inspection and release if in the possession or custody of the Department of the Attorney General or the office of a district attorney.

[22 MRSA §3022 \(13\)](#)

Testing for HIV

Notwithstanding Title 5, chapter 501, the Chief Medical Examiner in a medical examiner case may test for the human immunodeficiency virus and may disclose the test result as authorized under subsection 12. As used in subsections 10, 12, 13 and 14, "person" means a natural person, including a public servant, or a corporation, partnership, unincorporated association or other legal entity, including a governmental unit.

[22 MRSA §3022 \(15\)](#)

Medical examiner case

Circumstances of death that must be reported

A medical examiner case may exist and must be reported as provided in section 3026 when remains are found that may be human and raise suspicion that death has occurred under any of the following circumstances:

- A. Death is suspected of having been caused by any type of physical injury, including poisoning, regardless of whether the suspected manner of death is homicide, suicide or accident. This circumstance must be reported irrespective of whether the deceased had been attended by a physician, was a patient in a hospital, survived for a considerable time following the physical injury or died from terminal natural causes consequent to and following the physical injury;
- B. Suddenly when the person is in apparent good health and has no specific natural disease sufficient to explain death
- C. During diagnostic or therapeutic procedures under circumstances indicating gross negligence or when clearly due to trauma or poisoning unrelated to the ordinary risks of those procedures;
- D. Death when the person is in custody pursuant to an arrest, confined in a state correctional facility, county institution, facility or local lockup, unless clearly certifiable by an attending physician as due to specific natural causes;
- E. Death while the person is a patient or resident of a facility of the Department of Behavioral and Developmental Services or residential care facility maintained or licensed by the Department of Human Services, unless clearly certifiable by an attending physician as due to specific natural causes;
- F. Death suspected of being due to a threat to the public health when the authority of the medical examiner is needed to adequately study the case for the protection of the public health;
- G. Death suspected of not having been certified, including, but not limited to, bodies brought into the State and any buried remains uncovered other than by legal exhumation;
- H. Deaths suspected of being medical examiner cases which may have been improperly certified or inadequately examined, including, but not limited to, bodies brought into the State under those circumstances;
- I. Sudden infant death syndrome deaths and all other deaths of children under the age of 18 unless clearly certifiable by an attending physician as due to specific natural causes unrelated to abuse or neglect;

- J. Whenever human or possibly human remains are discovered not properly interred or disposed of, for which the responsibility to do so cannot be readily determined; or
- K. Any cause when there is no attending physician capable of certifying the death as due to natural causes. When a person dies who is under the care of a religious practitioner who uses prayer and spiritual means of healing, the fact that the deceased has been under such religious care does not warrant suspicion of foul play or investigation beyond that warranted by the other facts of the case.

*In any case in which the necessity of a report is questionable, a report must be made.

[22 MRSA §3025 \(1\)](#)

Medical examiner case determination

Notwithstanding that a case must be reported under subsection 1, the acceptance of any reported death as a medical examiner case is to be determined by the Chief Medical Examiner unless acceptance is specifically ordered by the Attorney General or district attorney having jurisdiction.

The following deaths that must be reported need not be accepted by the Chief Medical Examiner as a medical examiner case:

- A. Deaths due to the consequences of long-term alcohol use, long-term exposure to environmental or occupational toxins or long-term exposure to carcinogens;
- B. Deaths in the elderly who have sustained limb or axial fractures, excluding the head, for which they are or have been hospitalized; or
- C. Sudden natural deaths in the elderly who have not had previous specific symptoms or who were not under treatment by a physician for the specific natural cause that is considered to be the cause of death

These reportable deaths may be referred back to the attending physician by the Chief Medical Examiner for certification of the death, even though the attending physician has not treated the patient for the specific natural disease that the attending physician will enter as the physician's diagnosis.

[22 MRSA §3025 \(1-A\)](#)

Transplant operations

No operation for the transplant of an organ or a portion of any organ may take place, when the donor's death occurs under circumstances indicating a medical examiner case, without approval of the medical examiner. Any doctor performing a transplant operation when the donor has died under these circumstances shall note the condition of the vital organs in the region of surgery and shall include this notation in a written report of the operation and manner in which death was pronounced, with the report to be given to the medical examiner upon his request. The medical examiner may choose to be present during the removal of the donated organ.

[22 MRSA §3025 \(3\)](#)

Delayed reports

When a death has occurred that falls under this law as a medical examiner case and the body has already been released for final disposition, the case may be accepted and the body ordered held for examination by a medical examiner, but no exhumation may take place when the body has been finally interred, except pursuant to section 3029.

[22 MRSA §3025 \(5\)](#)

Reports of death

Persons suspecting medical examiner case

Any person who becomes aware of a suspected medical examiner case shall immediately notify a law enforcement officer or the Office of Chief Medical Examiner. As used in this subsection, "person" means

a natural person, including a public servant, and a corporation, partnership, unincorporated association or any other nonhuman legal entity, including any governmental unit.

[22 MRSA §3026 \(1\)](#)

Law enforcement officers suspecting medical examiner case

Any law enforcement officer who becomes aware of a suspected medical examiner case shall immediately notify the Office of Chief Medical Examiner.

[22 MRSA §3026 \(2\)](#)

Medical examiners suspecting medical examiner case

Any medical examiner who becomes aware of a death caused by physical injury, or in which physical injury is the suspected cause, shall immediately notify the Office of Chief Medical Examiner and the appropriate law enforcement agency. The agency shall notify the district attorney for the district in which the body is located.

[22 MRSA §3026 \(3\)](#)

Cases involving or suspected of involving physical injury attributable to criminal conduct

Any law enforcement officer or medical examiner who becomes aware of a death involving physical injury attributable to criminal conduct, or in which physical injury attributable to criminal conduct is suspected, other than vehicular manslaughter, in addition to complying with the notification requirements in subsection 3, shall immediately notify the Attorney General.

[22 MRSA §3026 \(4\)](#)

Procedure at scene of death

Movement or alteration of body prohibited

Except as otherwise provided in this section:

- A. In any medical examiner case a person may not move or alter the body or any objects at the scene of death prior to the arrival, or without the express authorization, of the medical examiner or Office of Chief Medical Examiner;
- B. In any medical examiner case in which physical injury attributable to noncriminal conduct is suspected or in which any physical injury by motor vehicle, including vehicular manslaughter, is suspected, a person may not move or alter the body or any objects at the scene of death prior to the arrival, or without the express authorization, of the district attorney for the district in which the body is located or the district attorney's authorized representative; and
- C. In any medical examiner case in which physical injury attributable to criminal conduct other than vehicular manslaughter is suspected, a person may not move or alter the body or any objects at the scene of death prior to the arrival, or without the express authorization, of the Attorney General or the Attorney General's authorized representative.

[22 MRSA §3027 \(1\)](#)

Preservation or removal of body

In any medical examiner case in which the body is in danger of being destroyed or lost or the location of the body renders it a serious threat to the safety or health of others, a person may take whatever steps are reasonably necessary for the retention or preservation of the body prior to the arrival or authorization of the medical examiner or the Office of Chief Medical Examiner. The person shall first, if practicable, exactly mark the location and position of the body.

In any medical examiner case in which physical injury attributable to criminal conduct other than vehicular manslaughter is not suspected and the presence of the body is likely to cause hardship or outrage, and a medical examiner or the Office of Chief Medical Examiner can not be reached in a reasonable period of time, the district attorney for the district in which the body is located or the district attorney's authorized representative may authorize removal of the body by the law enforcement officer in

charge of the scene. The officer shall first, if practicable, exactly mark the location and position of the body.

- A. When death occurs in a medical facility such as a hospital or an ambulance, the body may be removed to a mortuary under the following conditions:
 1. The incident causing the death did not occur in the medical facility;
 2. The body is transported to a secure place in the same condition as when death occurred; and
 3. The only alterations are the disconnecting of fixed medical equipment.

[22 MRSA §3027 \(2\)](#)

Procedures

- A. Before removal of the body as provided in subsection 2, the law enforcement officer shall whenever possible arrange for photographs, measurements and a record of the location and position of the body.
- B. When the death is suspected of involving physical injury attributable to criminal conduct other than vehicular manslaughter, the procedure in this subsection must be undertaken with the supervision of an authorized representative of the Attorney General.
- C. In all medical examiner cases in which physical injury attributable to criminal conduct other than vehicular manslaughter is suspected, the procedure in this subsection may be waived concurrently by the Chief Medical Examiner and the Attorney General or the Attorney General's authorized representative.
- D. In all other medical examiner cases the procedure in this subsection may be waived concurrently by the medical examiner and the district attorney for the district in which the body is located or the district attorney's authorized representative.

[22 MRSA §3027 \(3\)](#)

Investigation; autopsy

Authority to conduct investigation

The medical examiner or the person expressly authorized by the Chief Medical Examiner has authority to conduct an investigation and inquiry into the cause, manner and circumstances of death in a medical examiner case. The medical examiner or authorized person shall, if it is determined necessary, immediately proceed to the scene and, subject to the authority of the Attorney General, assume custody of the body for the purposes of the investigation, and shall retain custody until the investigation has been completed or until the Chief Medical Examiner has assumed charge of the case.

[22 MRSA §3028 \(1\)](#)

Investigation by law enforcement officer

When death is not suspected to be the result of physical injury attributable to criminal conduct, the medical examiner may elect not to proceed to the scene, or the Chief Medical Examiner may elect not to dispatch a medical examiner or the person expressly authorized by the Chief Medical Examiner under subsection 1 to the scene. If the medical examiner elects not to proceed to the scene, or the Chief Medical Examiner elects not to dispatch a medical examiner or authorized person to the scene, the law enforcement officer in charge of the scene shall:

- A. Investigate, take photographs and take possession of useful objects as directed by the medical examiner, authorized person or the Office of Chief Medical Examiner pursuant to subsection 4;
- B. Remove the body in accordance with the instructions of the medical examiner, authorized person or the Office of Chief Medical Examiner; and
- C. Make a report of the investigation available to the medical examiner, authorized person or the Office of Chief Medical Examiner.

[22 MRSA §3028 \(2\)](#)

Assistance of law enforcement agency

The medical examiner, the person expressly authorized by the Chief Medical Examiner or the pathologist as described in subsection 8, may request the assistance and use of the facilities of the law enforcement agency having jurisdiction over the case for the purposes of photographing, fingerprinting or otherwise identifying the body. That agency shall provide the medical examiner, authorized person or pathologist with a written report of the steps taken in providing the assistance.

[22 MRSA §3028 \(3\)](#)

Possession of useful objects

Except as otherwise directed by the Attorney General, the Attorney General's deputies or assistants, the medical examiner, the person expressly authorized by the Chief Medical Examiner or the Office of Chief Medical Examiner may direct that a law enforcement officer at the scene make measurements, take photographs and take possession of all objects that in the opinion of the medical examiner, authorized person or the Office of Chief Medical Examiner may be useful in establishing the cause, manner and circumstances of death. For these same purposes, the medical examiner, authorized person or the Office of Chief Medical Examiner may direct that a law enforcement officer take possession of any objects or specimens that have been removed from the victim at the scene or elsewhere while under medical care.

[22 MRSA §3028 \(4\)](#)

Requests for objects

Any person having possession of any object or objects, as described in subsection 4, shall at the request of the medical examiner or the person expressly authorized by the Chief Medical Examiner give that object or objects to a law enforcement officer, to the medical examiner, to the authorized person or to the Office of Chief Medical Examiner. Medical personnel and institutions turning over any objects or specimens that have been removed from the victim while under medical care are immune from civil or criminal liability when complying with this subsection. Original written or recorded material that might express suicidal intent must be sent to the Office of the Chief Medical Examiner. The Chief Medical Examiner may elect to accept copies in place of originals.

[22 MRSA §3028 \(5\)](#)

Examination of body

In all cases except those requiring a report on a body already disposed of and not to be exhumed for examination, the medical examiner or the person expressly authorized by the Chief Medical Examiner shall conduct a thorough examination of the body.

[22 MRSA §3028 \(6\)](#)

Written report

Upon completing an investigation, the medical examiner shall submit a written report of findings to the Chief Medical Examiner on forms provided for that purpose. The medical examiner shall retain one copy of the report.

If a medical examiner reports suspected abuse, neglect or exploitation to the Chief Medical Examiner, the Chief Medical Examiner, by reporting that information to the department on behalf of the medical examiner, fulfills the medical examiner's mandatory reporting requirement under section 3477 or 4011-A.

[22 MRSA §3028 \(7\)](#)

Autopsy

If, in any medical examiner case, in the opinion of the medical examiner, the Chief Medical Examiner, the district attorney for the district in which the death has occurred or the Attorney General, it is advisable and in the public interest that an autopsy be made, the autopsy must be conducted by the Chief Medical Examiner or by a physician that the medical examiner, with the approval of the Chief Medical Examiner, may designate. The medical examiner, with the approval of the Chief Medical Examiner, may elect to perform the autopsy. The person who performs the autopsy shall make a complete report of the findings

of the autopsy and shall transmit the report to the medical examiner and the Office of Chief Medical Examiner, retaining one copy of the report.

[22 MRSA §3028 \(8\)](#)

Autopsy of child

In the case of a child under the age of 3 years, when death occurs without medical attendance or, if attended, without a specific natural cause, the medical examiner shall order an autopsy. The autopsy may be waived by the Chief Medical Examiner, as long as the Chief Medical Examiner includes the reason for the waiver in the record.

[22 MRSA §3028 \(9\)](#)

Chief Medical Examiner; jurisdiction

The Chief Medical Examiner may assume jurisdiction over a medical examiner case and may recertify the death when the Chief Medical Examiner finds that it is in the public interest to do so. The Chief Medical Examiner shall include the reasons for so doing in the record.

[22 MRSA §3028 \(10\)](#)

Final release of body

In any medical examiner case the body shall not be finally released for embalming or burial except by order of the medical examiner in charge of the case, or by the Chief Medical Examiner. No medical examiner may release a body without first ensuring that the case has been reported to the Office of Chief Medical Examiner.

[22 MRSA §3028 \(11\)](#)

Report to domestic abuse panel

If the Chief Medical Examiner determines that a death resulted from criminal conduct and that the victim was pregnant at the time of death, the Chief Medical Examiner shall send a copy of any report prepared under this section to the Domestic Abuse Homicide Review Panel created pursuant to Title 19-A, section 4013.

[22 MRSA §3028 \(12\)](#)

(59) Medical-Legal Cooperation Code

CODE OF COOPERATION
AMONG
MAINE STATE BAR ASSOCIATION,
MAINE MEDICAL ASSOCIATION,
AND
MAINE OSTEOPATHIC ASSOCIATION

W I T N E S S E T H:

WHEREAS, members of the Maine State Bar Association (MSBA), the Maine Medical Association, (MMA), and the Maine Osteopathic Association (MOA) recognize problems of co-operation between the medical and legal professions and the duties of both professions to the public and to the administration of justice, and further recognize that medical-legal co-operation is necessary in order to maintain the proper attitudes of mutual respect of each of these learned professions for the other;

WHEREAS, the MSBA, MMA, and MOA have appointed their respective members study these problems;

WHEREAS, as a result of hearings and discussions among the associations, it is agreed that it is in the best interest of the parties and persons involved that the professions work together cooperatively;

WHEREAS, the MSBA, MMA, and MOA recognize that the basis of all cooperation is in the best interest of the client/patient and the protection of his or her privacy and the confidentiality of the patient's privacy in the form of his or her medical records; and

WHEREAS, the parties acknowledge that the actions of the respective members hereunder shall be governed by their respective codes of professional ethics and state law, this agreement notwithstanding.

NOW THEREFORE, IT IS HEREBY AGREED AMONG THE PARTIES AS FOLLOWS:

ARTICLE I

SCOPE OF CODE OF COOPERATION

1. The code applies only in civil proceedings.

ARTICLE II

MEDICAL REPORTS AND RECORDS

1. Physician's Duties.
 - A. To limit the information provided to any party to only that which is released by the patient pursuant to Maine law or specifically required by law.
 - B. To provide adequate information to the attorney requesting the same concerning the patient, including results of examination, diagnosis, tests, prognosis, and up-to-date bill for services rendered pursuant to the patient's authorization or as specifically required by law.
 - C. To supply such a report or record within a reasonable time after the same is requested.
 - D. When requested by the attorney, to provide supplemental reports or records when any significant change occurs in the patient's condition after a reasonable length of time has expired following a prior report or as specifically required by law.
 - E. To treat the attorney with courtesy, civility, and respect.
2. Attorney's Duties.
 - A. To compensate promptly the physician for the report or copies of the record if said compensation is requested and to provide such compensation in advance if the physician so requests. Payment should not be dependent upon the success of the law suit. For the purposes of the Code, prompt compensation or prompt payment shall be construed to mean payment within 30 days of receipt of a bill, unless otherwise agreed to in advance.

- B. To provide the physician with an authorization as may be required by Maine law permitting the physician to divulge the information to the attorney.
- C. To disclose to the physician the fact of the lawyer's representation and the identity of their client.
- D. To treat the physician with courtesy, civility, and respect.

ARTICLE III

CONFERENCES BETWEEN THE ATTORNEY AND THE PHYSICIAN

1. It is agreed that it is mutually advantageous for the physician and attorney to confer in reference to the particular case prior to time of trial. It is understood that the attorney shall pay the physician for the time involved in the conference, including the time involved preparing for the conference. The fee to be charged by the physician or the basis of the fee (i.e. hourly rate, etc.) shall be agreed upon prior to the conference and shall be commensurate with the value of the physician's time and overhead in his or her medical practice. This bill shall be paid promptly by the attorney and shall not be contingent upon the success of the law suit.
2. To the extent practical, the conference shall take place at the physician's office unless other arrangements are mutually acceptable. Arrangements for such conferences should be made a sufficient time in advance of the trial so that the conference can be fitted in the schedule of the attorney and the physician.
3. Prior to any conference, the attorney must provide the physician with an authorization as may be required by Maine law permitting the physician to divulge information to the attorney.

ARTICLE IV

COURT TESTIMONY

1. Both parties recognize that there is a necessity for the dissemination of information to both professions concerning the time problems involved in court testimony. The MMA and MOA recognize that the legal profession faces calendar problems, which include the uncertainty of dates in a fluid trial calendar. The MSBA likewise recognizes that the physician's appointments are made in advance and that physicians are, in addition, faced with pressing medical problems which cannot be deferred.
2. Attorney's Duties.
 - A. The attorney shall notify the physician of the proposed trial date as soon as practical after being informed of the date by the court and ascertain whether the physician will be available at that time.
 - B. The attorney shall keep the physician's office advised of the status of the calendar and notify the physician as soon as possible prior to trial of the probable trial date.
 - C. The attorney should give the physician as much notice as possible of the time when the physician's attendance in court is desired. Physicians should not be asked to appear until the attorney is reasonably certain that they will not have to remain at the court house more than a short period of time before being allowed to testify. The attorney shall endeavor to obtain the

physician's testimony as soon as possible after his arrival in the courtroom subject to orderly and proper presentation of the case.

- D. In the event of settlement, the physician should be immediately notified of the fact that the case is settled so that his schedule is not interfered with to an excessive extent.
 - E. The attorney should not use a subpoena to secure the attendance of a physician in court unless the physician refuses to abide by the terms of this Agreement.
 - F. The attorney and the physician shall agree upon the fee to be charged for the physician's participation in the trial as a witness. The fee shall be commensurate with the value of the physician's time and overhead in his or her medical practice. If the physician has a sub-specialty in forensic medicine, the fee may be consistent with customary fees for that sub-specialty. The physician should be compensated promptly for his appearance as a witness.
3. Physician's Duties.
- A. The physician has an obligation to give testimony regarding his patient in court. If the physician undertakes the care of a patient and litigation ensues, the physician is duty bound to testify as to medical condition of that patient.
 - B. When given reasonable notice of the time at which the physician will be called upon to testify, the physician should make a reasonable effort to be available at that time or shall notify the attorney promptly of any conflicts.

ARTICLE V

DEPOSITIONS OF THE PHYSICIAN

- 1. The principles set forth in Article IV regarding court testimony shall be applicable with respect to obtaining the testimony of a physician by means of an oral deposition.
- 2. In the event that the oral deposition of the physician becomes necessary, mutual agreements shall be made between the attorney and the physician as to time, place thereof, fees to be charged and any policies regarding cancellation.
- 3. Unless otherwise agreed to in advance: if an attorney cancels a scheduled deposition within 24 hours in advance of the scheduled date for a bona fide emergency, then the physician may not charge the attorney for the physician's lost time; if a physician cancels the deposition within 24 hours in advance of the scheduled date for a bona fide emergency then the attorney shall pay the physician the agreed upon fee at the time the deposition is rescheduled. Unless otherwise agreed to in advance: if the attorney cancels within 24 hours for reason other than a bona fide emergency, then the attorney shall pay the physician for his or her time lost due to the late cancellation; if the physician cancels within 24 hours for reason other than a bona fide emergency, then the physician shall not charge the attorney for the deposition when it is rescheduled.
- 4. The attorney shall compensate the physician for the time spent in preparing for, attending, and reviewing the transcript of the deposition. The physician's fee shall be agreed upon by the attorney and physician in accordance with the guidelines outlined in Article IV(F).

ARTICLE VI

PHYSICIAN'S BILL FOR MEDICAL

SERVICES RENDERED TO PATIENTS

1. If medical insurance is available and has not been paid, or assigned, to the physician, the attorney should use the attorney's best efforts to see that the proceeds of the insurance when received are applied to payment of medical and hospital bills.
2. Every attorney shall attempt to obtain in writing authority from the client-patient to pay all medical bills in full in the event of a recovery following trial or upon settlement. If such authority is obtained, and if the attorney and physician reach a written agreement to protect the client-patient from billing for medical services rendered during the pendency of the legal action, it will be the duty of the attorney to pay the medical bills from the net proceeds of the case after deducting attorney's fees and costs. If the client-patient refuses to provide written authorization to pay all medical bills from the recovery, the attorney shall use best efforts, consistent with Maine Bar Rules, to notify the primary or treating physician of that refusal.
3. Consistent with Maine Bar Rules, it shall be the duty of the attorney to notify the physician when the trial concludes or when the case is settled and the amount of any recovery or settlement.
4. Nothing in this section prohibits a physician from billing the patient for the balance of any medical bill not paid in full.

ARTICLE VII

MEDIATION

1. A Medical-Legal Co-operation Committee (the "Committee") shall be formed and composed of a member of the MSBA, MMA, and MOA.
2. The purpose of the Committee shall be to mediate grievances between members of the medical profession and the legal profession.
3. If a dispute cannot be mediated in a manner satisfactory to all parties, the Committee may issue an opinion passing upon the conduct to the appropriate regulatory body of the professional.

ARTICLE VIII

SOCIAL RELATIONS

1. The parties agree that they will explore further areas of co-operation between them, such as joint educational seminars and lectures, or joint social gatherings to foster and improve relations between the two professions.

(60) Medical Malpractice (see Professional Liability)

(61) Medical Marijuana

Maine Medical Marijuana Act

Maine first enacted a medical marijuana law at referendum in 1999. This law was repealed and replaced by a citizen referendum in 2009 and legislation enacted by the 124th Legislature in 2010. The 125th Legislature amended the law in 2011.

You can find the Maine Medical Marijuana Act at [Title 22, Chapter 558-C](#).

The Department of Health & Human Services has information about the implementation of the Maine Medical Marijuana Act on the web at: <http://www.maine.gov/dhhs/dlrs/mmm/index.shtml>.

The [rules](#) governing the program have been updated effective December 31, 2012. They include more information about qualifying conditions, physicians' written certifications and other details of the program.

Qualifying medical conditions

The "debilitating medical conditions" now covered by the Act include:

- A. Cancer, glaucoma, HIV/AIDS, hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn's disease, agitation of Alzheimer's disease, nail-patella syndrome or the treatment of these conditions;
- B. A chronic or debilitating disease or medical condition or its treatment that produces intractable pain, which is pain that has not responded to ordinary medical or surgical measures for more than 6 months;
- C. A chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: cachexia or wasting syndrome; severe nausea; seizures, including but not limited to those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis; or
- D. Any other medical condition or its treatment approved by DHHS by administrative rule (none as of July 2010).

[22 MSRA § 2422\(2\)](#)

As of 2011, DHHS is required to adopt rules regarding the consideration of petitions from the public to add medical conditions or treatments to the list of debilitating medical conditions.

[22 MSRA § 2424\(2\)](#)

Authorized conduct by a physician

A physician may provide a written certification for the medical use of marijuana under this chapter and, after having done so, may otherwise state that in the physician's professional opinion a qualifying patient is likely to receive therapeutic benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition.

[22 MSRA § 2423-B](#)

Adult qualifying patient

Prior to providing written certification for the medical use of marijuana under this section, a physician shall inform an adult qualifying patient of the risks and benefits of the medical use of marijuana and that the patient may benefit from the medical use of marijuana.

[22 MSRA § 2423-B\(1\)](#)

Minor qualifying patient

Prior to providing written certification for the medical use of marijuana by a minor qualifying patient under this section, a physician, referred to in this subsection as "the treating physician," shall inform the minor qualifying patient and the parent or legal guardian of the patient of the risks and benefits of the medical use of marijuana and that the patient may benefit from the medical use of marijuana. Except with regard to a minor qualifying patient who is eligible for hospice care, prior to providing a written certification under this section, the treating physician shall consult with a qualified physician, referred to

in this paragraph as "the consulting physician," from a list of physicians who may be willing to act as consulting physicians maintained by the department that is compiled by the department after consultation with statewide associations representing licensed medical professionals. The consultation between the treating physician and the consulting physician may consist of examination of the patient or review of the patient's medical file. The consulting physician shall provide an advisory opinion to the treating physician and the parent or legal guardian of the minor qualifying patient concerning whether the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition. If the department or the consulting physician does not respond to a request by a treating physician within 10 days of receipt of the request, the treating physician may provide written certification for treatment without consultation with another physician.

[22 MSRA § 2423-B\(2\)](#)

Expiration

A written certification form for the medical use of marijuana under this section expires one year after issuance by the qualifying patient's physician.

[22 MSRA § 2423-B\(3\)](#)

Form; content

A written certification under this section must be in the form required by rule adopted by the department and may not require a qualifying patient's physician to state the patient's specific medical condition.

[22 MSRA § 2423-B\(4\)](#)

Possible sanctions

Nothing in this chapter prevents a professional licensing board from sanctioning a physician for failing to properly evaluate or treat a patient's medical condition or otherwise violating the applicable standard of care for evaluating or treating medical conditions.

[22 MSRA § 2423-B\(5\)](#)

Written certification

"Written certification" means a document on tamper-resistant paper signed by a physician, that expires in one year and that states that in the physician's professional opinion a patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition. A written certification may be made only in the course of a bona fide physician-patient relationship after the physician has completed a full assessment of the qualifying patient's medical history.

[22 MSRA § 2422\(16\)](#)

Some risks remain for physicians in treating medical marijuana patients, even in the 14 states that have enacted medical marijuana legislation:

- A. **The uncertain status of marijuana under federal law.** Use of marijuana remains illegal under federal law. During the Bush Administration, it was never clear how aggressive federal authorities would be towards so-called "medical marijuana," although their focus seemed to be on dispensaries in California that were perceived by some to be pushing the limits of the law. Recently, Attorney General Eric Holder issued a statement indicating that the Obama Administration had no desire to pursue those involved in legitimate use of medical marijuana under state law.
- B. **Drug regulatory concerns.** The standard for prescribing drugs by practitioners is FDA approval. Because marijuana, even for medical purposes, is not approved by the FDA, the MMA staff recommends that you not use the term "prescribe" with respect to medical marijuana and that you not use a prescription blank with such patients. Should you decide to work with medical marijuana patients, it is better framed as a matter of patient choice - that the physician is

willing to work with the medical marijuana patient as he or she uses marijuana for medical purposes.

- C. **Liability concerns.** While the degree of risk may be debatable, physicians who work with medical marijuana patients cannot eliminate all risk because they are treating a patient who is using an unregulated drug, a drug that does not meet the standard in this country of FDA approval and that may include unknown amounts of active ingredient and impurities. Again, the MMA staff recommends that you include in your documentation of the relationship with the medical marijuana patient that he or she is aware of and assumes responsibility for these risks.

(62) Medical Records

In the last several years, in addition to issues of privacy and confidentiality of medical information, access to medical records has been a huge topic on both the state and federal levels. On the federal side there are compliance requirements under the Health Insurance and Portability and Accounting Act (HIPAA). There are also requirements under state law. Federal and state laws are not mutually exclusive and in many ways the two overlap and complement each other. This section only covers the medical record access requirements under Maine law.

Patient access to hospital medical records

If a patient of an institution licensed as a hospital by the State, after discharge from such institution, makes written request for copies of the patient's medical records, the copies must, if available, be made available to the patient within a reasonable time unless, in the opinion of the hospital, it would be detrimental to the health of the patient to obtain the records. If the hospital is of the opinion that release of the records to the patient would be detrimental to the health of the patient, the hospital shall advise the patient that copies of the records will be made available to the patient's authorized representative upon presentation of a proper authorization signed by the patient. The hospital may exclude from the copies of medical records released any information related to a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration.

If an authorized representative for a patient requests, in writing, that a hospital provide the authorized representative with a copy of the patient's medical records and presents a proper authorization from the patient for the release of the information, copies must be provided to the authorized representative within a reasonable time.

A written request or authorization for release of medical records under this section satisfies the requirements of section 1711-C, subsection 3.

A patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem may submit to a hospital health care information that corrects or clarifies the patient's treatment record, which must be retained with the medical record by the hospital. If the hospital adds to the medical record a statement in response to the submitted correction or clarification, the hospital shall provide a copy to the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem.

Reasonable costs incurred by the hospital in making and providing copies of medical records and additions to medical records must be borne by the requesting person and the hospital may require payment prior to responding to the request. The charge for copies of records may not exceed \$10 for the first page and 35¢ for each additional page.

Release of a patient's medical records to a person other than the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem is governed by section 1711-C.

[22 MRSA §1711](#)**Fees charged for records**

Whenever a health care practitioner defined in section 1711-B furnishes requested copies of a patient's treatment record or a medical report or an addition to a treatment record or medical report to the patient or the patient's authorized representative, the charge for the copies or the report may not exceed the reasonable costs incurred by the health care practitioner in making and providing the copies or the report. The charge for copies of records may not exceed \$10 for the first page and 35¢ for each additional page.

[22 MRSA §1711-A](#)**Patient access to treatment records; health care practitioners****Access**

Upon written authorization executed in accordance with section 1711-C, subsection 3, a health care practitioner shall release copies of all treatment records of a patient or a narrative containing all relevant information in the treatment records to the patient. The health care practitioner may exclude from the copies of treatment records released any personal notes that are not directly related to the patient's past or future treatment and any information related to a clinical trial sponsored, authorized or regulated by the federal Food and Drug Administration. The copies or narrative must be released to the designated person within a reasonable time.

If the practitioner believes that release of the records to the patient is detrimental to the health of the patient, the practitioner shall advise the patient that copies of the treatment records or a narrative containing all relevant information in the treatment records will be made available to the patient's authorized representative upon presentation of a written authorization signed by the patient. The copies or narrative must be released to the authorized representative within a reasonable time.

Except as provided in subsection 3, release of a patient's treatment records to a person other than the patient is governed by section 1711-C.

[22 MRSA §1711-B \(2\)](#)**Person receiving the records**

Except as otherwise provided in this section, the copies or narrative specified in subsection 2 must be released to:

- A. The person who is the subject of the treatment record, if that person is 18 years of age or older and mentally competent;
- B. The parent, guardian ad litem or legal guardian of the person who is the subject of the record if the person is a minor, or the legal guardian if the person who is the subject of the record is mentally incompetent;
- C. The designee of a durable health care power of attorney executed by the person who is the subject of the record, at such time as the power of attorney is in effect; or
- D. The agent, guardian or surrogate pursuant to the Uniform Health-care Decisions Act.

[22 MRSA §1711-B \(3\)](#)**Corrections and clarifications of treatment records**

A patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem may submit to a health care practitioner health care information that corrects or clarifies the patient's treatment record, which must be retained with the treatment record by the health care practitioner. If the health care practitioner adds to the treatment record a statement in response to the submitted correction or clarification, the health care practitioner shall provide a copy to the patient or, if the patient is a minor who has not consented to health care treatment in accordance with the laws of this State, the minor's parent, legal guardian or guardian ad litem.

[22 MRSA §1711-B \(3-A\)](#)**Minors**

This section does not affect the right of minors to have their treatment records treated confidentially pursuant to the provisions of, chapter 260.

[22 MRSA §1711-B \(4\)](#)**HIV test**

Release of information regarding the HIV infection status of a patient is governed by Title 5, section 19203-D.

[22 MRSA §1711-B \(5\)](#)**Retention of records**

This section does not alter the existing law or ethical obligations of a health care practitioner with respect to retaining treatment records.

[22 MRSA §1711-B \(5\)](#)**Record Retention**

Although the Maine Legislature periodically considers imposing a minimum retention period, Maine statutes do not have any required retention period for physician practices. Accordingly, the principal guidance is the AMA's ethics opinions and Maine's statute of limitations for bringing lawsuits. The MMA recommends that physicians use *6 years, the longest civil period of limitations as the minimum period of retention of records*. [AMA Ethics Opinion 7.05, Retention of Medical Records](#) gives physicians the following guidance:

Physicians have an obligation to retain patient records which may reasonably be of value to a patient. The following guidelines are offered to assist physicians in meeting their ethical and legal obligations:

- A. Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be a part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.
- B. If a particular record no longer needs to be kept for medical reasons, the physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.
- C. In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information.
- D. Whatever the statute of limitations, a physician should measure time from the last professional contact with the patient.
- E. If a patient is a minor, the statute of limitations for medical malpractice claims may not apply until the patient reaches the age of majority (Maine's provision for minors is different. A minor has 6 years after the cause of action accrues or 3 years from the age of majority, whichever occurs first).
- F. Immunization records must always be kept.
- G. The records of any patient covered by Medicare or Medicaid must be kept at least 5 years.
- H. In order to preserve confidentiality when discarding old records, all documents should be destroyed.

- I. Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.

Maine's hospital licensing regulations require adult records to be maintained for 7 years and the records of minors to be retained for 6 years beyond the age of majority. See [DHS Rule Chapter 112, Regulations for Licensure of General & Specialty Hospitals](#), §3.5.5. A hospital licensed pursuant to chapter 405 or a health care practitioner as defined in section 1711-C, subsection 1, paragraph F may not destroy an image of a patient recorded using x rays, magnetic resonance imaging or computerized tomography without the consent of the patient. [22 MRSA §1721](#)

Record Disposal

As the owner of the medical record, the physician has the obligation to properly store or dispose of the record. The physician has an ethical obligation to notify patients of the move or closure so that they may obtain a copy of their medical records or have them transferred to another practice. Ideally, the physician will notify each patient by letter to the last known address. Often, a written notice is supplemented by publishing a notice in the newspaper on three or more occasions giving patients a reasonable period of time to request records or a transfer of records. This will, hopefully, reach patients for whom the physician does not have an accurate address. See [AMA Ethics Opinion 7.03, Records of Physicians Upon Retirement or Departure From a Group](#).

(63) Medical Staff

Hospital duties

The governing body of every licensed hospital shall assure that:

- A. Organization of medical staff. Its medical staff is organized pursuant to written bylaws that have been approved by the governing body
- B. Provider privileges. Provider privileges extended or subsequently renewed to any physician are in accordance with those recommended by the medical staff as being consistent with that physician's training, experience and professional competence;
- C. Program for identification and prevention of medical injury. It has a program for the identification and prevention of medical injury which shall include at least the following:
 1. One or more professional competence committees with responsibility effectively to review the professional services rendered in the facility for the purpose of insuring quality of medical care of patients therein. Such responsibility shall include a review of the quality and necessity of medical care provided and the preventability of medical complications and deaths;
 2. A grievance or complaint mechanism designed to process and resolve as promptly and effectively as possible grievances by patients or their representatives related to incidents, billing, inadequacies in treatment and other factors known to influence malpractice claims and suits;
 3. A system for the continuous collection of data with respect to the provider's experience with negative health care outcomes and incidents injurious to patients, whether or not they give rise to claims, patient grievances, claims, suits, professional liability premiums, settlements, awards, allocated and administrative costs of claims handling, costs of patient injury prevention and safety engineering activities, and other relevant statistics and information; and
 4. Education programs for the provider's staff personnel engaged in patient care activities dealing with patient safety, medical injury prevention, the legal aspects of patient care,

problems of communication and rapport with patients and other relevant factors known to influence malpractice claims and suits; and

- D. External professional competence committee. Where the nature, size or location of the health care provider makes it advisable, the provider may, upon recommendation of its medical staff, utilize the services of an external professional competence committee or one formed jointly by 2 or more providers.

[24 MRSA §2503](#)

Provider, entity and carrier reports

A health care provider or health care entity shall, within 60 days, report in writing to the disciplined practitioner's board or authority the name of any licensed, certified or registered employee or person privileged by the provider or entity whose employment or privileges have been revoked, suspended, limited or terminated or who resigned while under investigation or to avoid investigation for reasons related to clinical competence or unprofessional conduct, together with pertinent information relating to that action. Pertinent information includes a description of the adverse action, the date, the location and a description of the event or events giving rise to the adverse action. Upon request, the following information must be released to the board or authority: medical records relating to the event or events; written statements signed or prepared by any witness or complainant to the event; and related correspondence between the practitioner and the provider or entity. The report must include situations in which employment or privileges have been revoked, suspended, limited or otherwise adversely affected by action of the health care practitioner while the health care practitioner was the subject of disciplinary proceedings, and it also must include situations where employment or privileges have been revoked, suspended, limited or otherwise adversely affected by act of the health care practitioner in return for the health care provider or health care entity terminating such proceeding. Any reversal, modification or change of action reported pursuant to this section must be reported immediately to the practitioner's board or authority, together with a brief statement of the reasons for that reversal, modification or change. The failure of any health care provider or health care entity to report as required is a civil violation for which a fine of not more than \$5,000 may be adjudged.

Carriers providing managed care plans are subject to the reporting requirements of this section when they take adverse actions against a practitioner's credentials or employment for reasons related to clinical competence or unprofessional conduct that may adversely affect the health or welfare of the patient.

[24 MRSA §2506](#)

Effect of filing

The filing of a report with the board pursuant to this chapter, investigation by the board or any disposition by the board may not, in and of itself, preclude any action by a hospital or other health care facility or health care entity or professional society comprised primarily of physicians to suspend, restrict or revoke the privileges or membership of the physician.

[24 MRSA §2508](#)

Review committee member immunity

A physician licensed under this chapter who is a member of a utilization review committee, medical review committee, surgical review committee, peer review committee or disciplinary committee that is a requirement of accreditation by the Joint Commission on Accreditation of Hospitals or is established and operated under the auspices of the physician's respective state or county professional society or the Board of Licensure in Medicine is immune from civil liability for undertaking or failing to undertake an act within the scope of the function of the committee.

[32 MRSA §3293](#)

Records of proceedings of medical staff review committees confidential

All proceedings and records of proceedings concerning medical staff reviews, hospital reviews and other reviews of medical care conducted by committees of physicians and other health care personnel on behalf of hospitals located within the State or on behalf of individual physicians, when the reviews are required by state or federal law, rule or as a condition of accreditation by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association Committee on Hospital Accreditation or are conducted under the auspices of the state or county professional society to which the physician belongs, are confidential and are exempt from discovery.

Provision of information protected by this section to the board pursuant to Title 24, section 2506 does not waive or otherwise affect the confidentiality of the records or the exemption from discovery provided by this section for any other purpose.

[32 MRSA §3296](#)

(64) Medicare Assignment, Posting Acceptance of

An allopathic physician licensed pursuant to chapter 48, an osteopathic physician licensed pursuant to chapter 36, a chiropractor licensed pursuant to chapter 9 and a podiatrist licensed pursuant to chapter 51 who treats Medicare-eligible individuals shall post in a conspicuous place that professional's policy regarding the acceptance of Medicare assignment.

This posting must state the policy on accepting assignment and name the individual with whom the patient should communicate regarding the policy.

The Board of Licensure in Medicine, the Board of Osteopathic Licensure, the Board of Licensure of Podiatric Medicine and the Board of Chiropractic Licensure shall enforce the provisions of this section and inform each licensee of the licensee's obligation under this law. Each board may discipline a licensee under its jurisdiction for failing to comply with this section and impose a monetary penalty of not less than \$100 and not more than \$1,000 for each violation.

[32 MRSA §3297](#)

(65) Mental Health and Mental Retardation (see also Agency Rules Links)

Definitions

- A. **Designated nonstate mental health institution:** means a nonstate mental health institution that is under contract with the department for receipt by the hospital of involuntary patients.
- B. **Least restrictive form of transportation:** means the vehicle used for transportation and any restraining devices that may be used during transportation that impose the least amount of restriction, taking into consideration the stigmatizing impact upon the individual being transported.
- C. **Licensed physician:** means a person licensed under the laws of the State to practice medicine or osteopathy or a medical officer of the Federal Government while in this State in the performance of his official duties.
- D. **Licensed clinical psychologist:** means a person licensed under the laws of the State as a psychologist and who practices clinical psychology.
- E. **Likelihood of serious harm:** means:
 1. A substantial risk of physical harm to the person as manifested by recent threats of, or attempts at, suicide or serious self-inflicted harm;

2. A substantial risk of physical harm to other persons as manifested by recent homicidal or violent behavior or by recent conduct placing others in reasonable fear of serious physical harm;
 3. A reasonable certainty that the person will suffer severe physical or mental harm as manifested by recent behavior demonstrating an inability to avoid risk or to protect the person adequately from impairment or injury; or
 4. For the purposes of section 3873-A, in view of the person's treatment history, current behavior and inability to make an informed decision, a reasonable likelihood that the person's mental health will deteriorate and that the person will in the foreseeable future pose a likelihood of serious harm as defined in paragraphs A, B or C
- F. **Mentally ill person:** means a person having a psychiatric or other disease which substantially impairs his mental health, including persons suffering from the effects of the use of drugs, narcotics, hallucinogens or intoxicants, including alcohol, but not including mentally retarded or sociopathic persons. A person with developmental disabilities or a person diagnosed as a sociopath is not for those reasons alone a mentally ill person.
- G. **Nonstate mental health institution:** means a public institution, a private institution or a mental health center, which is administered by an entity other than the State and which is equipped to provide inpatient care and treatment for the mentally ill.
- H. **Patient:** means a person under observation, care or treatment in a psychiatric hospital or residential care facility pursuant to this subchapter, a person receiving services from an assertive community treatment team, a person receiving intensive mental health management services from the department or a person being evaluated for emergency admission under section 3863 in a hospital emergency department.
- I. **Progressive treatment program** means a program of court-ordered services provided to participants under section 3873-A.
- J. **Psychiatric hospital** means:
1. A state mental health institute;
 2. A nonstate mental health institution; or
 3. A designated nonstate mental health institution.
- K. **Residential care facility:** means a licensed or approved boarding care, nursing care or foster care facility which supplies supportive residential care to individuals due to their mental illness.
- L. **Severe and persistent mental illness** means a diagnosis of one or more qualifying mental illnesses or disorders plus a listed disability or functional impairment that has persisted continuously or intermittently or is expected to persist for at least one year as a result of that disease or disorder. The qualifying mental illnesses or disorders are schizophrenia, schizoaffective disorder or other psychotic disorder, major depressive disorder, bipolar disorder or a combination of mental disorders sufficiently disabling to meet the criteria of functional disability. The listed disabilities or functional impairments, which must result from a diagnosed qualifying mental illness or disorder, include inability to adequately manage one's own finances, inability to perform activities of daily living and inability to behave in ways that do not bring the attention of law enforcement for dangerous acts or for acts that manifest the person's inability to protect the person from harm.
- M. **State mental health institute:** means the Riverview Psychiatric Center or the Dorothea Dix Psychiatric Center.
- N. **Inability to make an informed decision** means being unable to make a responsible decision whether to accept or refuse a recommended treatment as a result of lack of mental capacity to

understand sufficiently the benefits and risks of the treatment after a thorough and informative explanation has been given by a qualified mental health professional.

- O. **Assertive community treatment** or "ACT" means a self-contained service with a fixed point of responsibility for providing treatment, rehabilitation and support services to persons with mental illness for whom other community-based treatment approaches have been unsuccessful. Assertive community treatment uses clinical and rehabilitative staff to address symptom stability; relapse prevention; maintenance of safe, affordable housing in normative settings that promote well-being; establishment of natural support networks to combat isolation and withdrawal; the minimizing of involvement with the criminal justice system; individual recovery education; and services to enable the person to function at a work site. Assertive community treatment is provided by multidisciplinary teams who are on duty 24 hours per day, 7 days per week; teams must include a psychiatrist, registered nurse, certified rehabilitation counselor or certified employment specialist, a peer recovery specialist and a substance abuse counselor and may include an occupational therapist, community-based mental health rehabilitation technician, psychologist, licensed clinical social worker or licensed clinical professional counselor. An ACT team member who is a state employee is, while in good faith performing a function as a member of an ACT team, performing a discretionary function within the meaning of Title 14, section 8104-B, subsection 3.

[34-B MRSA §3801](#)

Confidentiality of information

Generally

All orders of commitment, medical and administrative records, applications and reports, and facts contained in them, pertaining to any client shall be kept confidential and may not be disclosed by any person. For exceptions, see: [34-B MRSA §1207](#).

Violation

Disclosure of client information in violation of this section is an offense under the licensing standards of the mental health professional committing the violation and must be promptly reported to the licensing board with jurisdiction for review, hearing and disciplinary action.

[34-B MRSA §1207 \(4-A\)](#)

Disclosure to family, caretakers

Under the following circumstances, a licensed mental health professional providing care to an adult client may disclose to a family member, to another relative, to a close personal friend or caretaker of a client or to anyone identified by the client, the client's health information that is directly relevant to the person's involvement with the client's care.

- A. If a client with capacity to make health care decisions is either present or available prior to disclosure, the professional may disclose the information:
1. When the client gives oral or written consent;
 2. When the client does not object in circumstances in which the client has the opportunity to object; or
 3. When the professional may reasonably infer from the circumstances that the client does not object.
- B. The professional may disclose the information if in the professional's judgment it is in the client's best interests to make the disclosure and the professional determines either that the client lacks the capacity to make health care decisions or an emergency precludes the client from participating in the disclosure.

[34-B MRSA §1207 \(5-A\)](#)

Disclosure of danger

A licensed mental health professional may disclose protected health information that the professional believes is necessary to avert a serious and imminent threat to health or safety when the disclosure is made in good faith to any person, including a target of the threat, who is reasonably able to prevent or minimize the threat.

[34-B MRSA §1207 \(6-A\)](#)

Client Rights

Any resident of a state institution has a right to nutritious food in adequate quantities, adequate professional medical care, an acceptable level of sanitation, ventilation and light, a reasonable amount of space per person in any sleeping area, a reasonable opportunity for physical exercise and recreational activities, protection against any physical or psychological abuse and a reasonably secure area for the maintenance of permitted personal effects.

[34-B MRSA §1430](#)

Patient's Rights

A patient in a hospital or residential care facility under this subchapter has the following rights.

Civil rights

Every patient is entitled to exercise all civil rights, including, but not limited to, the right to civil service status, the right to vote, rights relating to the granting, renewal, forfeiture or denial of a license, permit, privilege or benefit pursuant to any law, the right to enter into contractual relationships and the right to manage his property, unless:

- A. The chief administrative officer of the hospital or residential care facility determines that it is necessary for the medical welfare of the patient to impose restrictions on the exercise of these rights and, if restrictions are imposed, the restrictions and the reasons for them shall be made a part of the clinical record of the patient;
- B. A patient has been adjudicated incompetent and has not been restored to legal capacity; or
- C. The exercise of these rights is specifically restricted by other statute or rule, but not solely because of the fact of admission to a hospital or residential care facility.

[34-B MRSA §3803 \(1\)](#)

Humane care and treatment

Every patient is entitled to humane care and treatment and, to the extent that facilities, equipment and personnel are available, to medical care and treatment in accordance with the highest standards accepted in medical practice.

[34-B MRSA §3803 \(2\)](#)

Restraints and seclusion

Restraint, including any mechanical means of restricting movement, and seclusion, including isolation by means of doors which cannot be opened by the patient, may not be used on a patient, unless the chief administrative officer of the hospital or residential care facility or his designee determines that either is required by the medical needs of the patient.

- A. The chief administrative officer of the hospital or facility shall record and make available for inspection every use of mechanical restraint or seclusion and the reasons for its use.
- B. The limitation of the use of seclusion in this section does not apply to maximum security installations.

[34-B MRSA §3803 \(3\)](#)

Communication

Patient communication rights are as follows.

- A. Every patient is entitled to communicate by sealed envelopes with the department, a member of the clergy of his choice, his attorney and the court which ordered his hospitalization, if any.
- B. Every patient is entitled to communicate by mail in accordance with the rules of the hospital.

[34-B MRSA §3803 \(4\)](#)

Visitors

Every patient is entitled to receive visitors unless definitely contraindicated by his medical condition, except that he may be visited by a member of the clergy of his choice or his attorney at any reasonable time.

[34-B MRSA §3803 \(5\)](#)

Sterilization

A patient may not be sterilized except in accordance with chapter 7.

[34-B MRSA §3803 \(6\)](#)

Habeas corpus

Any person detained pursuant to this subchapter is entitled to the writ of habeas corpus, upon proper petition by himself or by a friend to any justice generally empowered to issue the writ of habeas corpus in the county in which the person is detained.

[34-B MRSA §3804](#)

Prohibited acts; penalty

A. Unwarranted hospitalization

A person is guilty of causing unwarranted hospitalization, if he willfully causes the unwarranted hospitalization of any person under this subchapter.

B. Denial of rights

A person is guilty of causing a denial of rights if he willfully causes the denial to any person of any of the rights accorded to him by this subchapter.

C. Penalty

Causing unwarranted hospitalization or causing a denial of rights is a Class C crime.

[34-B MRSA §3805](#)

Voluntary Admissions

A hospital for the mentally ill may admit on an informal voluntary basis for care and treatment of a mental illness any person desiring admission or the adult ward of a legally appointed guardian, subject to the following conditions.

A. Availability of accommodations

Except in cases of medical emergency, voluntary admission is subject to the availability of suitable accommodations.

[34-B MRSA §3831 \(1\)](#)

B. Standard hospital information

Standard hospital information may be elicited from the person if, after examination, the chief administrative officer of the hospital deems the person suitable for admission, care and treatment.

[34-B MRSA §3831 \(2\)](#)

C. Persons under 18 years of age

Any person under 18 years of age must have the consent of his parent or guardian.

[34-B MRSA §3831 \(3\)](#)

D. State mental health institute

Any person under 18 years of age must have the consent of the commissioner for admission to a state mental health institute.

[34-B MRSA §3831 \(4\)](#)

E. Adults under guardianship

An adult ward may be admitted on an informal voluntary basis only if his legally appointed guardian consents to the admission and the ward makes no objection to the admission.

[34-B MRSA §3831 \(5\)](#)

F. Adults with advance health care directives

An adult with an advance health care directive authorizing mental health hospital treatment may be admitted on an informal voluntary basis if the conditions specified in the advance health care directive for the directive to be effective are met in accordance with the method stated in the advance health care directive or, if no such method is stated, as determined by a physician or a psychologist. If no conditions are specified in the advance health care directive as to how the directive becomes effective, the person may be admitted on an informal voluntary basis if the person has been determined to be incapacitated pursuant to Title 18-A, Article 5, Part 8. A person may be admitted only if the person does not at the time object to the admission or, if the person does object, if the person has directed in the advance health care directive that admission to the hospital may occur despite that person's objections. The duration of the stay in the hospital of a person under this subsection may not exceed 5 working days. If at the end of that time the chief administrative officer of the hospital recommends further hospitalization of the person, the chief administrative officer shall proceed in accordance with section 3863, subsection 5.

This subsection does not create an affirmative obligation of a hospital to admit a person consistent with the person's advance health care directive. This subsection does not create an affirmative obligation on the part of the hospital or treatment provider to provide the treatment consented to in the person's advance health care directive if the physician or psychologist evaluating or treating the person or the chief administrative officer of the hospital determines that the treatment is not in the best interest of the person.

[34-B MRSA §3831 \(6\)](#)

Freedom to leave**A. Patient's right**

A patient admitted under section 3831 is free to leave the hospital at any time after admission without undue delay following examination by a licensed physician or a licensed clinical psychologist, except that admission of the person under section 3863 is not precluded, if at any time such an admission is considered necessary in the interest of the person and of the community.

B. Notice

The chief administrative officer of the hospital shall cause every patient admitted under section 3831 to be informed, at the time of admission, of:

1. His status as an informally admitted patient; and
2. His freedom to leave the hospital under this section.

[34-B MRSA §3832](#)

Involuntary Admission**Nonstate mental health institution**

The chief administrative officer of a nonstate mental health institution may receive for observation, diagnosis, care and treatment in the institution any person whose admission is applied for under any of the

procedures in this subchapter. An admission may be made under the provisions of section 3863 only if the certifying examination conducted pursuant to section 3863, subsection 2 was completed no more than 2 days before the date of admission.

- A. The institution, any person contracting with the institution and any of its employees when admitting, treating or discharging a patient under the provisions of sections 3863 and 3864 under a contract with the department, for purposes of civil liability, must be deemed to be a governmental entity or an employee of a governmental entity under the Maine Tort Claims Act, Title 14, chapter 741.
- B. Patients with a diagnosis of mental illness or psychiatric disorder in nonstate mental health institutions that contract with the department under this subsection are entitled to the same rights and remedies as patients in state mental health institutes as conferred by the constitution, laws, regulations and rules of this State and of the United States.
- C. Before contracting with and approving the admission of involuntary patients to a nonstate mental health institution, the department shall require the institution to:
 1. Comply with all applicable regulations;
 2. Demonstrate the ability of the institution to comply with judicial decrees as those decrees relate to services already being provided by the institution; and
 3. Coordinate and integrate care with other community-based services.
- D. Beginning July 31, 1990, the capital, licensing, remodeling, training and recruitment costs associated with the start-up of beds designated for involuntary patients under this section must be reimbursed, within existing resources, of the Department of Behavioral and Developmental Services.

[34-B MRSA §3861 \(1\)](#)

State mental health institute

The chief administrative officer of a state mental health institute:

- A. May receive for observation, diagnosis, care and treatment in the hospital any person whose admission is applied for under section 3831 or 3863 if the certifying examination conducted pursuant to section 3863, subsection 2 was completed no more than 2 days before the date of admission; and
- B. May receive for observation, diagnosis, care and treatment in the hospital any person whose admission is applied for under section 3864 or is ordered by a court.

Any business entity contracting with the department for psychiatric physician services or any person contracting with a state mental health institute or the department to provide services pertaining to the admission, treatment or discharge of patients under sections 3863 and 3864 within a state institute or any person contracting with a business entity to provide those services within a state institute is deemed to be a governmental entity or an employee of a governmental entity for purposes of civil liability under the Maine Tort Claims Act, Title 14, chapter 741, with respect to the admission, treatment or discharge of patients within a state institute under sections 3863 and 3864.

[34-B MRSA §3861 \(2\)](#)

Involuntary treatment

Except for involuntary treatment ordered pursuant to the provisions of section 3864, subsection 7-A, involuntary treatment of a patient at a designated nonstate mental health institution or a state mental health institute who is an involuntarily committed patient under the provisions of this subchapter may be ordered and administered only in conformance with the provisions of [34-B MRSA § 3861\(3\)](#).

Emergency procedure

A person may be admitted to a mental hospital on an emergency basis according to the procedures of [34-B MRSA § 3863](#).

In 2012 the law was clarified to state that admission to a psychiatric hospital on an emergency basis under the provisions of this section is not commitment to a psychiatric hospital. See of [34-B MRSA § 3863 \(9\)](#).

Progressive treatment program – Application

The superintendent or chief administrative officer of a psychiatric hospital, the commissioner or the director of an ACT team, except as limited by subsection 10, may obtain an order from the District Court to admit a patient to a progressive treatment program according to the procedures of [34-B MRSA § 3873-A](#).

Judicial procedure and commitment

An application to the District Court to admit a person to a mental hospital is governed by [34-B MRSA §3864](#).

Convalescent status

Authority

Convalescent status, discharge from convalescent status and rehospitalization are governed by the provisions of [34-B MRSA § 3870](#).

Discharge

Examination

The chief administrative officer of a hospital shall, as often as practicable, but no less often than every 30 days, examine or cause to be examined every patient to determine that patient's mental status and need for continuing hospitalization.

[34-B MRSA §3871 \(1\)](#)

Conditions for discharge, discharge against medical advice and notice requirements are found at [34-B MRSA §3871](#).

Mental Disability and Retardation

Olmstead and the “Least Restrictive” Policy

Olmstead was a landmark US Supreme Court case that established the commonly known principle of the “least restrictive treatment environment.” In deciding this case the Supreme Court made two very firm conclusions about the nature of mental disabilities:

- A. The first, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumption that persons so isolated are incapable or unworthy of participating in community life.
- B. The second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement and cultural enrichment.

After having made these determinations, the Court held that “states are required to provide community based treatment for persons with mental disabilities when the state’s treatment professions determine that

such placement is appropriate, affected persons do not oppose such treatment and placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others with mental disabilities.” Further, undue institutionalization of persons with mental disabilities qualifies as discrimination by reason of disability under the Americans with Disabilities Act.

Olmstead v. L.C., 527 U.S. 581 (1999)

Maine policy concerning least restrictive treatment environments

It is the policy of the State to provide education, training and habilitative services to mentally retarded persons who need those services, except that nothing in this chapter may replace or limit the right of any mentally retarded person to treatment by spiritual means alone, through prayer, if that treatment is requested by the person or by his next of kin or guardian.

It is the policy of the State that the setting for the services described in subsection 1 must, consistent with adequate care and treatment:

- A. Impose the fewest possible restrictions on the liberty of persons with intellectual disabilities or autism; and
Be as close as possible to the patterns and norms of the mainstream of society.

[34-B MRSA §5002](#)

Rights and basic protections of a person with mental retardation or autism

A person with mental retardation or autism is entitled to rights and basic protections in areas including humane treatment, communications, work, voting, access to medical care, and to be generally free from restraints.

[34-B MRSA §5005](#)

Reporting Violations

Any alleged violation of the rights of a person receiving services must be reported immediately to the Office of Advocacy of the department and to the Attorney General's office.

[34-B MRSA §5604-A](#)

(66) Midwifery

Certified Midwives Access to Certain Medications

Drug administration by certified midwives under certain conditions

A midwife who can verify to a licensed pharmacist by certification card that the midwife has met the certification standards of an international certification agency whose mission is to establish and administer certification for the credential of certified professional midwife or other certifying body recognized by the board may:

Possess, in the course of the practice of midwifery, only the noncontrolled prescription drugs and substances set out in this subsection:

- A. Oxygen;
- B. Oxytocin, excluding the oxytocic drug methergine, for the sole purpose of postpartum control of maternal hemorrhage;
- C. Vitamin K;
- D. Eye prophylaxis; and
- E. Local anesthetics or numbing agents for repair of lacerations; and

[32 MRSA §13811 \(1\)](#)

Administer, in the course of the practice of midwifery, those drugs that are listed in subsection 1. When administering oxytocin, a certified midwife may not administer more than 20 units of oxytocin to a single patient. Oxytocin may be administered only for postpartum purposes in order to treat hemorrhaging and

specifically may not be used to induce labor. When a certified midwife administers oxytocin in accordance with this subsection, the certified midwife shall report that use to the maternal and child health division of the Department of Health and Human Services, the Maine Center for Disease Control and Prevention within 7 days of the use of oxytocin.

[32 MRSA §13811 \(2\)](#)

Dispensing of medication by pharmacist

A pharmacist, who in good faith relies upon a certification card presented by a midwife identifying that the midwife has met the certification standards described under section 13811, may sell and dispense to the midwife the noncontrolled prescription drugs and substances identified in section 13811.

[32 MRSA §13812 \(1\)](#)

(67) Minors, Treatment and Consent of

Minor's Rights to Health Care Treatment

Usually, a physician must obtain consent to treatment of a minor from a parent or guardian, although the minor generally is involved in the process. Most of the time, the minor and both parents are involved in a family discussion about the treatment, but situations involving divorced parents can present challenges to the physician that are more practical than legal. In most cases of divorce, the parents have “shared parental rights and responsibilities,” meaning that both parents have the right to be involved in the major decisions of the child’s life, including decisions about health care treatment. [19-A MRSA §1501 \(5\)](#). If a parent is claiming exclusive rights to make decisions about a minor’s medical treatment, the physician should ask for documentation such as a divorce judgment awarding “sole parental rights and responsibilities” to one parent, an order terminating the parental rights of one parent, or other court order limiting a parent’s rights to participate in the medical decision-making process.

While the general rule is that physicians must obtain informed consent to treatment for minors from their parents, there are exceptions to the rule. *Some* minors may provide consent to *all* types of health care treatment and *all* minors may provide consent to *some* types of health care treatment. A minor may give consent to all types of health care treatment if the minor:

- A. Has been living separately from parents or legal guardians for at least 60 days and is independent of parental support;
- B. Is or was legally married;
- C. Is or was a member of the Armed Forces of the United States;
- D. Has been emancipated by the court pursuant to Title 15, section 3506-A. ([22 MRSA §1503](#))

All minors may give consent to certain sensitive types of treatment where an obligation of parental consent may be an obstacle to treatment and, therefore, may not be in the best interest of the minor. These types of treatment include:

- A. Family planning services, including contraception, pregnancy testing, and emergency contraception ([22 MRSA §1908](#));
- B. Treatment of venereal disease or drug alcohol abuse in the hospital setting, but parental consent is required if the hospitalization continues for more than 16 hours ([22 MRSA §1823](#));
- C. Collection of sexual assault evidence through a sexual assault forensic examination ([22 MRSA §1507](#));
- D. Treatment of venereal disease or drug or alcohol abuse by a physician ([32 MRSA §§2595](#) and [3293](#));
- E. Treatment of drug or alcohol abuse or for emotional or psychological problems ([22 MRSA §1502](#));

- F. Consent to give blood by a 17 year old ([22 MRSA §1502-A](#));
- G. Certain services provided by alcohol and drug counselors, social workers, or psychologists ([32 MRSA §§6221, 7004, 3817](#)).

A minor may consent to an abortion if she accomplishes one of the following:

- A. Provides the physician performing the abortion with her informed written consent and the written consent of a parent or another adult family member such as an aunt or grandmother;
- B. Provides the physician performing the abortion with her informed written consent and receives abortion counseling. The counseling may be provided by a physician or from an approved counselor, who may be a psychiatrist, a psychologist, a social worker, an ordained clergy member, a physician's assistant, a nurse practitioner, a guidance counselor, a registered nurse, or a licensed practical nurse; or
- C. Provides the physician performing the abortion with her informed written consent and a court order. ([22 MRSA §1597-A](#)).

The physician retains discretion to notify the parents if he or she believes that failure to do so would "seriously jeopardize the health of the minor or would seriously limit the practitioner's or provider's ability to provide treatment." [22 MRSA §1505 \(2\)](#). In general, a minor who consents to health care treatment is entitled to the same confidentiality rights as adults and is financially responsible to the physician for that treatment. [22 MRSA §§1505\(1\)](#) and [1506](#). A physician who takes reasonable steps to determine that a minor is entitled to consent to health care treatment is immune from liability for a parent's claim that the physician provided care without parental consent. [22 MRSA §1504](#).

Definition

Minor: means a person under 18 years of age.

[22 MRSA §1501 \(3\)](#)

Consent, General

In addition to the ability to consent to treatment for health services as provided in sections 1823 and 1908 and Title 32, sections 2595, 3292, 3817, 6221 and 7004, a minor may consent to treatment for abuse of alcohol or drugs or for emotional or psychological problems.

[22 MRSA §1502](#)

Consent to give blood

A minor may consent to give blood if the minor is at least 17 years of age, notwithstanding any other provision of law.

[22 MRSA §1502-A](#)

Authority (to Consent)

A minor may give consent to all medical, mental, dental and other health counseling and services if the minor:

- A. **Living separately; independent of parental support-** Has been living separately from parents or legal guardians for at least 60 days and is independent of parental support;
- B. **Married-** Is or was legally married;
- C. **Armed Forces-** Is or was a member of the Armed Forces of the United States; or
- D. **Emancipated-** Has been emancipated by the court pursuant to Title 15, section 3506-A.

[22 MRSA §1503 \(3\)](#)

Good faith reliance on consent

A health care practitioner or health care provider who takes reasonable steps to ascertain that a minor is authorized to consent to health treatment as authorized in section 1503 and who subsequently renders treatment in reliance on that consent is not liable for failing to have secured consent of the minor's parent or guardian prior to providing health care services to the minor.

[22 MRSA §1504](#)

Confidentiality; notification

- A. **Confidentiality**- Except as otherwise provided by law, a minor who may consent to health care services, as provided in this chapter or by other provision of law, is entitled to the same confidentiality afforded to adults.
- B. **Parental notification**- A health care practitioner or health care provider may notify the parent or guardian of a minor who has sought health care under this chapter if, in the judgment of the practitioner or provider, failure to inform the parent or guardian would seriously jeopardize the health of the minor or would seriously limit the practitioner's or provider's ability to provide treatment.

[22 MRSA §1505](#)

Financial responsibility

Unless the parent or guardian expressly agrees to assume full or partial responsibility, a minor who consents to health care services as provided in this chapter is responsible for the costs of those services. A minor may not be denied benefits or services to which the minor is entitled from a health care practitioner, health care provider, insurer or public agency because the minor has given the consent for those services as provided in this chapter.

[22 MRSA §1506](#)

Consent for sexual assault forensic examination

Notwithstanding the limitations set forth in section 1503, a minor may consent to health services associated with a sexual assault forensic examination to collect evidence after an alleged sexual assault.

[22 MRSA §1507](#)

Consent to a minor's decision to have an abortion

Except as otherwise provided by law, no person may knowingly perform an abortion upon a pregnant minor unless:

- A. The attending physician has received and will make part of the medical record the informed written consent of the minor and one parent, guardian or adult family member;
- B. The attending physician has secured the informed written consent of the minor as prescribed in subsection 3 and the minor, under all the surrounding circumstances, is mentally and physically competent to give consent;
- C. The minor has received the information and counseling required under subsection 4, has secured written verification of receiving the information and counseling and the attending physician has received and will make part of the medical record the informed written consent of the minor and the written verification of receiving information and counseling required under subsection 4; or
- D. The Probate Court or District Court issues an order under subsection 6 on petition of the minor or the next friend of the minor for purposes of filing a petition for the minor, granting:
 - 1. To the minor majority rights for the sole purpose of consenting to the abortion and the attending physician has received the informed written consent of the minor; or
 - 2. To the minor consent to the abortion, when the court has given its informed written consent and the minor is having the abortion willingly, in compliance with subsection 7.

[22 MRSA §1597-A \(2\)](#)**Treatment of minors, Consent****Hospitals**

Any hospital licensed under this chapter or alcohol or drug treatment facility licensed pursuant to section 7801 that provides facilities to a minor in connection with the treatment of that minor for:

- A. venereal disease;
- B. abuse of drugs or alcohol; or
- C. for the collection of sexual assault evidence through a sexual assault forensic examination

is under no obligation to obtain the consent of that minor's parent or guardian or to inform that parent or guardian of the provision of such facilities so long as such facilities have been provided at the direction of the person or persons referred to in Title 32, sections 2595 (repealed), 3292, 3817, 6221 or 7004 (social workers).

The 16-Hour Rule and Parental Consent

The hospital shall notify and obtain the consent of that minor's parent or guardian if that hospitalization continues for more than 16 hours.

[22 MRSA §1823](#)**Medical Providers (Physicians)**

An individual licensed under this chapter who renders medical care to a minor for:

- A. treatment of venereal disease;
- B. abuse of drugs or alcohol; or
- C. for the collection of sexual assault evidence through a sexual assault forensic examination

is under no obligation to obtain the consent of the minor's parent or guardian or to inform the parent or guardian of the treatment. This section may not be construed to prohibit the licensed individual rendering the treatment from informing the parent or guardian. For purposes of this section, "abuse of drugs" means the use of drugs solely for their stimulant, depressant or hallucinogenic effect upon the higher functions of the central nervous system and not as a therapeutic agent recommended by a practitioner in the course of medical treatment.

[32 MRSA §3292](#)**Psychological Services**

Any person licensed under this chapter who renders psychological services to a minor for problems associated with the abuse of drugs or alcohol is under no obligation to obtain the consent of said minor's parent or guardian or to inform such parent or guardian of such services. Nothing in this section shall be construed so as to prohibit the licensed person rendering such services from informing such parent or guardian. For purposes of this section "abuse of drugs" means the use of drugs solely for their stimulant, depressant or hallucinogenic effect upon the higher functions of the central nervous system and not as a therapeutic agent recommended by a practitioner in the course of medical treatment.

[32 MRSA §3817](#)**Counseling Services**

Any person licensed under this chapter who renders counseling services to a minor for the treatment of problems associated with the abuse of drugs or alcohol is under no obligation to obtain the consent of that minor's parent or guardian or to inform that parent or guardian of that treatment. Nothing in this section may be construed so as to prohibit the licensed person rendering that treatment from informing that parent or guardian. For the purposes of this section "abuse of drugs" means the use of drugs solely for their stimulant, depressant or hallucinogenic effect upon the higher functions of the central nervous system and not as a therapeutic agent recommended by a practitioner in the course of medical treatment.

[32 MRSA §6221](#)**Medical treatment order****Who may Petition**

The department (of Human Services), a physician or a chief medical administrator of a hospital may petition for a medical treatment order.

[22 MRSA §4071 \(1\)](#)**Contents of petition**

A petition shall be sworn and shall include at least the following:

- A. Name, date of birth and municipal residence, if known, of the child;
- B. The name and address of the petitioner and his professional position;
- C. Name and municipal residence, if known, of each parent and custodian;
- D. A summary of the medical diagnosis and treatment alternatives;
- E. A request for the court to order specific treatment; and
- F. A statement that attempts to notify and secure consent from the custodians have been unsuccessful, either because they cannot be located or they have refused consent.

[22 MRSA §4071 \(2\)](#)**Notice to parents and custodians**

The petitioner shall, by any reasonable means, attempt to notify the parents and custodians of his intent to request the order and of the time and place he will make the request, unless the petitioner believes that the child would suffer increased serious injury during the time needed to notify them.

[22 MRSA §4071 \(3\)](#)**Order**

On the basis of the petition or other evidence, the court may order medical treatment for the child if the custodians are unable or unwilling to consent to it, and the treatment is necessary to treat or prevent an immediate risk of serious injury. The order shall include a notice to the parents and custodians of their right to counsel, as required under section 4032, subsection 2, paragraph G, and notice of the date and time of the hearing.

[22 MRSA §4071 \(4\)](#)**Service of order**

If a hearing has not been held prior to issuing the order, a copy of the order and petition shall be served on the parents and custodians by:

- A. In-hand delivery by the judge or court clerk to any parent, custodian or their counsel who is present when the order is issued;
- B. Service in accordance with the District Court Civil Rules. Notwithstanding the civil rules, service by publication of an order and petition shall be complete 5 days after a single publication; or
- C. Another manner ordered by the court.

[22 MRSA §4071 \(5\)](#)**Hearing**

If a hearing has not been held prior to issuing the order, then it shall be held within 10 days of its issuance, unless all parties agree to a later date. If, after the hearing, the court finds, by a preponderance of the evidence, that the medical treatment ordered is necessary to treat or prevent the immediate risk of serious injury to the child, then it may continue the order.

[22 MRSA §4071 \(6\)](#)

Authorization for Certain Campers To Self-administer Emergency Medication

A recreational camp for boys or girls must have a written policy authorizing campers to self-administer emergency medication, including, but not limited to, an asthma inhaler or an epinephrine pen.

[22 MRSA §2496 \(2\)](#)

(68) Nursing (see also Agency Rules Links)

For Maine statutes governing the practice of nursing, see [Title 32, Chapter 31](#) of the Maine Revised Statutes. This Chapter also applies to advanced practice registered nurses, including certified nurse practitioners, certified nurse midwives, certified clinical nurse specialists and certified nurse anesthetists. For information regarding certified nursing assistants and unlicensed assistive persons in facilities, see also Title 22, [Sections 1812-G](#) and [1812-J](#).

Nurse health program

The board may establish protocols for the operation of a professional review committee as defined in Title 24, section 2502, subsection 4-A. The protocols must include the committee's reporting information the board considers appropriate regarding reports received, contracts or investigations made and the disposition of each report, as long as the committee is not required to disclose any personally identifiable information. The protocols may not prohibit an impaired nurse from seeking alternative forms of treatment.

The board may contract with other agencies, individuals, firms or associations for the conduct and operation of a nurse health program operated by a professional review committee as that term is defined in Title 24, section 2502, subsection 4-A.

[32 MRSA 2105-A\(5\)](#)

(69) Optometry (see also Agency Rules Links)

Scope of Practice

An optometrist may not administer therapeutic drugs by injection, other than for emergency treatment of anaphylaxis. They may, however, dispense or sell contact lenses that contain and deliver pharmaceutical agents that are authorized under the Maine Revised Statutes, [Title 32, chapter 34-A](#).

An optometrist who graduated from optometric college in the year 1996 or thereafter and who is an advanced therapeutic licensee is authorized to independently treat glaucoma. In order to be authorized to independently treat glaucoma, an advanced therapeutic licensee who graduated from optometric college prior to 1996 must provide evidence to the board of no more than 30 glaucoma-related consultations with a physician.

[32 MRSA §2430-B](#)

Licensure Requirements

The following are the requirements applicants must meet before licensure:

- A. Be at least 18 years of age;
- B. Be a graduate of a recognized school of optometry; and
- C. Have succeeded in an examination as described in section 2422.

[32 MRSA §2417 \(1\)](#)

For more on Optometrists' Scope of Practice see [Title 32, chapter 34-A](#) and Agency Rules links.

(70) Osteopathic Physicians (see also Agency Rules Links)

Licensure

Qualifications and fees

An individual, before engaging in the practice of osteopathic medicine in this State, shall make application for a license to the board, on a form prescribed by the board. The application must be filed with the board at least 60 days before the date of examination together with a fee of not more than \$525. The applicant shall present a diploma granted by a school or college of osteopathic medicine approved by the American Osteopathic Association. That applicant shall present evidence of having completed an internship of at least 12 months in a hospital conforming to the minimal standards for accreditation by the American Osteopathic Association, or the equivalency, as determined by the board. All applicants shall provide reasonable and proper facts as the board in its application may require. The board at its discretion may permit an applicant, who is otherwise qualified to be examined during internship, a license to be withheld until successful completion of internship.

All fees set in this chapter are nonrefundable application fees or administrative processing fees payable to the board at the time of application or at the time board action is requested. Unless otherwise specified, the board shall set the fees.

An applicant may not be licensed unless the board finds that the applicant is qualified and that no cause exists, as set forth in section 2591-A, that would be considered grounds for disciplinary action against a licensed physician.

[32 MRSA §2571](#)

Examination and reexamination

Applicants must be examined in whole or in part in writing and must be thorough in subjects the board determines necessary, including osteopathic theories and methods, to determine the competency of the candidate to practice osteopathic medicine in the State. If the examination is passed in a manner satisfactory to the board, the board shall issue to the applicant a license granting the applicant the right to practice osteopathic medicine in this State. If the applicant fails to pass the examination, the applicant is entitled to one reexamination within one year after failure upon payment of a fee set by the board.

Osteopathic physicians who have been certified by the National Board of Osteopathic Examiners or have been strictly examined and licensed to practice osteopathic medicine in another state, which has equivalent licensing requirements to this State, may be licensed to practice osteopathic medicine in this State upon the payment of not more than \$300 and the substantiation to the board that the applicant is a graduate of a school or college of osteopathic medicine approved by the American Osteopathic Association and that the license was obtained in the other state. The board may at its discretion require an examination of any such applicant.

[32 MRSA §2572](#)

Temporary licensure

An osteopathic physician in good repute who is a graduate of a school or college of osteopathic medicine approved by the American Osteopathic Association, serving as a fellow, intern or resident physician in a hospital in this State, shall register with the board and must be issued a temporary license by the board evidencing the right to practice only under hospital control. Such a license may not be issued for a period in excess of one year but may be renewed from time to time, not to exceed an aggregate of 5 years. The license must be in a form prescribed by the board and may be revoked or suspended by the board with the suspension or revocation effective immediately when written notification from the board is received by the hospital. An examination may not be required for applicants for this temporary license. The fee for such a license may not be more than \$450.

[32 MRSA §2573](#)

Locum tenens

An osteopathic physician who is a graduate of a school or college of osteopathic medicine approved by the American Osteopathic Association and who is of good repute may, at the discretion of the board, be given a temporary license to be effective for not more than 6 months after issuance, for the purpose of permitting the physician to serve as "locum tenens" for another osteopathic physician who is unable, because of illness or some other substantiated reason, to maintain the practice, thus fulfilling a need in that area for providing health services. The fee for such a license may be not more than \$600.

[32 MRSA §2574](#)

Biennial relicensure, fees and reinstatement

Upon satisfactorily qualifying for licensure, the applicant may be issued a license by the board, which is dated and signed by its members and upon which the official seal of the board is affixed. The license must designate the holder as a physician licensed to practice osteopathic medicine in the State of Maine. The license must be publicly displayed at the individual's principal place of practice.

Every osteopathic physician legally licensed to practice in this State, shall, on or before the expiration date of the osteopathic physician's license, pay to the board a fee set by the board not to exceed \$600 for the renewal of the osteopathic physician's license to practice. An osteopathic physician's license is issued for a period of 2 years and must be renewed in accordance with a schedule adopted by the board by rule. Rules adopted pursuant to this section are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A. In addition to the payment of the renewal fee, each licensee applying for the renewal of the osteopathic physician's license shall furnish to the board satisfactory evidence that the osteopathic physician has attended in the 2 preceding years at least 100 hours of educational programs devoted to continuing medical education approved by the board. The required education must be obtained from formalized programs of continuing medical education sponsored by recognized associations, colleges or universities, hospitals, institutes or groups approved by the board. A copy of the current approved list must be available in the office of the secretary-treasurer of the board. At least 40% of these credit hours must be osteopathic medical education approved in the rules established by the board. The board may adjudicate continuing medical education performance in situations of illness, hardship or military service upon written petition by the applicant. The secretary-treasurer of the board shall send a written notice of the foregoing requirements to each osteopathic physician, at least 60 days prior to each osteopathic physician's license expiration date, directed to the last known address of the licensee and enclosing with the notice proper blank forms for application for renewal. If a licensee fails to furnish the board evidence of attendance at continuing medical educational programs, as approved by the board, fails to pay the renewal fee or fails to submit a completed application for renewal, the osteopathic physician automatically forfeits the right to practice osteopathic medicine in this State. After the expiration of a license, the board shall send notice by first class mail to each licensee who has failed to meet the requirements for renewal. If the failure is not corrected within 30 days, then the osteopathic physician's license may be considered lapsed by the board. The secretary-treasurer of the board may reinstate the osteopathic physician upon the presentation of satisfactory evidence of continuing medical education as outlined and approved by the board and upon payment of the renewal fee.

Relicensure fees provided for under this section are not required of an osteopathic physician who is 70 years of age or older on the first day of January of the year in which the relicensure is made, although the requirements for continuing medical education apply without regard to age.

The license entitles an individual to whom it is granted the privilege to practice osteopathic medicine in any county in this State, in all its branches as taught in a school or college of osteopathic medicine approved by the American Osteopathic Association with the right to use drugs that are necessary in the practice of osteopathic medicine.

An individual to whom a license is granted under this section shall designate that individual's status as an osteopathic physician either by the letters D.O. following the licensee's name or by the words

"osteopathic physician" following or accompanying the licensee's name when the prefix Doctor or Dr. is used.

An applicant not complying with relicensure requirements is entitled to be reinstated upon paying the relicensure fee for the given year and satisfying the board that the applicant has paid all relicensure fees due at the time of the applicant's withdrawal, and that a cause does not exist for revoking or suspending the applicant's license. The board shall determine the skill and competence of an osteopathic physician applying for a reinstatement who has not been engaged in the active practice of osteopathic medicine in this or some other state for a period in excess of one year from the date of the physician's most recent relicensure in Maine.

[32 MRSA §2581](#)

Camp physicians

An osteopathic physician who is a graduate of a school or college of osteopathic medicine approved by the American Osteopathic Association and who is of good repute may, at the discretion of the board, make application for a temporary license to practice as a camp physician at a specified camp. Such an osteopathic physician is entitled to practice only on the patients at the camp. The license must be obtained each year. Applications for such a temporary license must be made in the same manner as for regular licenses. An examination may not be exacted from applicants for temporary licenses. The fee may not be more than \$600.

[32 MRSA §2575](#)

Disciplinary actions

Disciplinary proceedings and sanctions

The board shall investigate a complaint, on its own motion or upon receipt of a written complaint filed with the board, regarding noncompliance with or violation of this chapter or of rules adopted by the board.

The board shall notify the licensee of the content of a complaint filed against the licensee as soon as possible, but, absent unusual circumstances justifying delay, not later than 60 days from receipt of this information. The licensee shall respond within 30 days. The board shall share the licensee's response with the complainant, unless the board determines that it would be detrimental to the health of the complainant to obtain the response. If the licensee's response to the complaint satisfies the board that the complaint does not merit further investigation or action, the matter may be dismissed, with notice of the dismissal to the complainant, if any.

If, in the opinion of the board, the factual basis of the complaint is or may be true, and the complaint is of sufficient gravity to warrant further action, the board may request an informal conference with the licensee. The board shall provide the licensee with adequate notice of the conference and of the issues to be discussed. The complainant may attend and may be accompanied by up to 2 individuals, including legal counsel. The conference must be conducted in executive session of the board, pursuant to Title 1, section 405, unless otherwise requested by the licensee. Before the board decides what action to take at the conference or as a result of the conference, the board shall give the complainant a reasonable opportunity to speak. Statements made at the conference may not be introduced at a subsequent formal hearing unless all parties consent.

When a complaint has been filed against a licensee and the licensee moves or has moved to another state, the board may report to the appropriate licensing board in that state the complaint that has been filed, other complaints in the licensee's record on which action was taken and disciplinary actions of the board with respect to that licensee.

When an individual applies for a license under this chapter, the board may investigate the professional record of that individual, including professional records that the individual may have as a licensee in other states. The board may deny a license or authorize a restricted license based on the record of the applicant in other states.

If the board finds that the factual basis of the complaint is true and is of sufficient gravity to warrant further action, it may take any of the following actions it considers appropriate:

- A. With the consent of the licensee, enter into a consent agreement that fixes the period and terms of probation best adapted to protect the public health and safety and to rehabilitate or educate the licensee. A consent agreement may be used to terminate a complaint investigation, if entered into by the board, the licensee and the Attorney General's office;
- B. In consideration for acceptance of a voluntary surrender of the license, negotiate stipulations, including terms and conditions for reinstatement, that ensure protection of the public health and safety and that serve to rehabilitate or educate the licensee. These stipulations may be set forth only in a consent agreement signed by the board, the licensee and the Attorney General's office;
- C. If the board concludes that modification or nonrenewal of the license is in order, the board shall hold an adjudicatory hearing in accordance with the provisions of Title 5, chapter 375, subchapter IV; or
- D. If the board concludes that suspension or revocation of the license is in order, the board shall file a complaint in the District Court in accordance with Title 4, chapter 5.

[32 MRSA §2591-A \(1\)](#)

Grounds for discipline

The board may suspend or revoke a license pursuant to Title 5, section 10004. The following are grounds for an action to refuse to issue, modify, restrict, suspend, revoke or refuse to renew the license of an individual licensed under this chapter:

- A. The practice of fraud or deceit in obtaining a license under this chapter or in connection with service rendered within the scope of the license issued;
- B. Habitual substance abuse that has resulted or is foreseeably likely to result in the licensee performing services in a manner that endangers the health or safety of the licensee's patients;
- C. A professional diagnosis of a mental or physical condition that has resulted or may result in the licensee performing the licensee's duties in a manner that endangers the health or safety of the licensee's patients;
- D. Aiding or abetting the practice of osteopathic medicine by an individual not duly licensed under this chapter and who claims to be legally licensed;
- E. Incompetence in the practice for which the licensee is licensed. A licensee is considered incompetent in the practice if the licensee has:
 - 1. Engaged in conduct that evidences a lack of ability or fitness to discharge the duty owed by the licensee to a client or patient or the general public; or
 - 2. Engaged in conduct that evidences a lack of knowledge, or inability to apply principles or skills to carry out the practice for which the licensee is licensed;
- F. Unprofessional conduct. A licensee is considered to have engaged in unprofessional conduct if the licensee violates a standard of professional behavior that has been established in the practice for which the licensee is licensed;
- G. Subject to the limitations of Title 5, chapter 341, conviction of a crime that involves dishonesty or false statement or that relates directly to the practice for which the licensee is licensed, or conviction of a crime for which incarceration for one year or more may be imposed;
- H. A violation of this chapter or a rule adopted by the board;
- I. Engaging in false, misleading or deceptive advertising;
- J. Advertising, practicing or attempting to practice under a name other than one's own;
- K. Division of professional fees not based on actual services rendered;
- L. Failure to comply with the requirements of Title 24, section 2905-A; or

- M. Revocation, suspension or restriction of a license to practice medicine or other disciplinary action; denial of an application for a license; or surrender of a license to practice medicine following the institution of disciplinary action by another state or a territory of the United States or a foreign country if the conduct resulting in the disciplinary or other action involving the license would, if committed in this State, constitute grounds for discipline under the laws or rules of this State.

[32 MRSA §2591-A \(2\)](#)

Penalty

An individual who attempts to practice osteopathic medicine without proper license or who induces the belief that that individual is legally engaged in the practice of osteopathic medicine without having fully complied with all requirements of law commits a Class E crime; except that nothing in this chapter may be construed to prohibit a lawfully qualified osteopathic physician in another state meeting a licensed osteopathic physician in this State for consultation.

[32 MRSA §2598](#)

Assistants

Nothing contained in this chapter may be construed to prohibit an individual from rendering medical services, if these services are rendered under the supervision and control of a physician, if the individual has satisfactorily completed a training program approved by the Board of Osteopathic Licensure. Supervision and control may not be construed as requiring the personal presence of the supervising and controlling physician at the place where these services are rendered, unless a physical presence is necessary to provide patient care of the same quality as provided by the physician. Nothing in this chapter may be construed as prohibiting a physician from delegating to the physician's employees certain activities relating to medical care and treatment carried out by custom and usage when these activities are under the direct control of and in the personal presence of the physician. The physician delegating these activities to employees, to program graduates or to participants in an approved training program is legally liable for the activities of those individuals, and any individual in this relationship is considered the physician's agent. Nothing contained in this section may be construed to apply to registered nurses acting pursuant to chapter 31.

When the delegated activities are part of the practice of optometry as defined in chapter 34-A, then the individual to whom these activities are delegated must possess a valid license to practice optometry in Maine or otherwise may perform only as a technician within the established office of a physician and may act solely on the order of and under the responsibility of a physician skilled in the treatment of eyes as designated by the proper professional board and without assuming evaluation or interpretation of examination findings by prescribing corrective procedures to preserve, restore or improve vision.

[32 MRSA §2594-A](#)

(71) Pharmacy Practice

Scope of Practice – Vaccine administration

Pharmacists' scope of practice is expanded to allow them to administer all vaccines licensed by the United States Food and Drug Administration that are recommended by the United States Centers for Disease Control and Prevention Advisory Committee on Immunization Practices, or successor organization, for administration to adults to a person 18 years of age or older according to a valid prescription when the person has an existing primary care physician or other existing relationship with a nurse practitioner or an authorized practitioner in this State. When the person does not have an existing relationship with a primary care physician, nurse practitioner or other practitioner in this State, the pharmacist may proceed to administer according to a treatment protocol established by an authorized

practitioner or a written standing order. Licensed pharmacists can administer all forms of influenza vaccines to a person 9 years of age or older without a prescription.

[32 MRSA §13702-A \(28\)](#)

[32 MRSA §13831](#)

For more on Pharmacists' Scope of Practice see the Maine Pharmacy Act, [32 MRSA Chapter 117](#).

Pharmacist Health Program

The Maine Board of Pharmacy may establish protocols for the operation of a professional review committee as defined in Title 24, section 2502, subsection 4-A. The protocols must include the committee's reporting information the board considers appropriate regarding reports received, contracts or investigations made and the disposition of each report, as long as the committee is not required to disclose any personally identifiable information. The protocols may not prohibit an impaired pharmacist or pharmacy technician from seeking alternative forms of treatment.

The board has the power to contract with other agencies, individuals, firms or associations for the conduct and operation of a pharmacist health program operated by a professional review committee as that terms is defined in Title 24, section 2502, subsection 4-A.

[32 MRSA §13721 \(3\)](#)

Professional review committee defined

"Professional review committee" means a committee of physicians, dentists, pharmacists, nurses or a combination of members of all 3 professions formed by a professional society for the purpose of identifying and working with physicians, dentists and other licensees of the Board of Dental Examiners, physician assistants, pharmacists and pharmacy technicians and nurses who are disabled or impaired by virtue of physical or mental infirmity or by the misuse of alcohol or drugs, as long as the committee operates pursuant to protocols approved by the Board of Licensure in Medicine, the Board of Dental Examiners, the Board of Osteopathic Licensure, the Maine Board of Pharmacy, and the State Board of Nursing

[24 MRSA §2502 \(4-A\)](#)

Patient information regulation

Explanation by pharmacist

With each new prescription dispensed, the pharmacist, in addition to labeling the prescription in accordance with the requirements of the State, must orally explain to the patient or the patient's agent the directions for use and any additional information, in writing if necessary, to assure the proper utilization of the medication or device prescribed. For those prescriptions delivered outside the confines of the pharmacy, the explanation shall be by telephone or in writing. This section does not apply to those prescriptions for patients in hospitals or institutions where the medication is to be administered by a nurse or other individual licensed to administer medications or to those prescriptions for patients who are to be discharged from a hospital or institution.

[32 MRSA §13784 \(1\)](#)

Maintenance of current reference material

To ensure that proper information is available to each pharmacist, each pharmacy or pharmacist shall maintain current reference material on drug interactions.

[32 MRSA §13784 \(2\)](#)

Retail price

With each prescription dispensed, the pharmacist shall disclose to the patient in writing the usual and customary price of the prescription and the cost of any payment toward the price required of the patient.

(72) Physician Assistants

Physician Assistants in Maine must receive a license from either the Board of Licensure in Medicine or the Board of Osteopathic Licensure, depending on the supervising physician. The relevant laws and rules can be found here:

Board of Licensure in Medicine laws: [32 MRSA § 3270-A to §3270-C](#)

[Board of Licensure in Medicine rules](#) (downloads Word document)

Board of Osteopathic Licensure laws: [32 MRSA § 2594-A to § 2594-D](#)

[Board of Osteopathic Licensure rules](#) (downloads Word document)

Podiatric assistants

For the law governing podiatric assistants, see [32 MRSA §3552-A](#).

(73) Physician/Psychotherapist-Patient Privilege**Definitions:**

- A. **Patient:** A person who consults or is examined or interviewed by a physician or psychotherapist.
- B. **Physician:** A person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be.
- C. **Psychotherapist:** is
 1. A person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition, including alcohol or drug addiction, or,
 2. A person licensed or certified as a psychologist or psychological examiner under the laws of any state or nation, while similarly engaged.

[Maine Rules of Evidence, Rule 503 \(a\)](#)

Confidential Communication

A communication is "confidential" if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the physician or psychotherapist, including members of the patient's family.

Maine Rules of Evidence, Rule 503 (a) (4)

General rule of privilege

A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment of the patient's physical, mental or emotional condition, including alcohol or drug addiction, among the patient, the patient's physician or psychotherapist, and persons who are participating in the diagnosis or treatment under the direction of the physician or psychotherapist, including members of the patient's family.

Maine Rules of Evidence, Rule 503 (b)

Privilege of accused

When an examination of the mental condition of an accused in a criminal proceeding is ordered by the court for the purpose of determining criminal responsibility, the accused has a privilege to refuse to

disclose and to prevent any other person from disclosing any communication concerning the offense charged, made in the course of the examination.

Maine Rules of Evidence, Rule 503 (c)

Who may claim the privilege

The privilege may be claimed by the patient, by the patient's guardian or conservator, or by the personal representative of a deceased patient. The person who was the physician or psychotherapist at the time of the communication is presumed to have authority to claim the privilege but only on behalf of the patient.

Maine Rules of Evidence, Rule 503 (d)

Exceptions

A. Proceedings for hospitalization

There is no privilege under this rule for communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization.

B. Examination by order of court

Except as otherwise provided in subdivision (c), if the court orders an examination of the physical, mental or emotional condition of a patient, whether a party or a witness, communications made in the course thereof are not privileged under this rule with respect to the particular purpose for which the examination is ordered unless the court orders otherwise.

C. Condition an element of claim or defense

There is no privilege under this rule as to communications relevant to an issue of the physical, mental or emotional condition of the patient in any proceeding in which the condition of the patient is an element of the claim or defense of the patient, or of any party claiming, through or under the patient or because of the patient's condition, or claiming as a beneficiary of the patient, through a contract to which the patient is or was a party, or after the patient's death, in any proceeding in which any party puts the condition in issue.

D. Exception for information communicated to acquire drugs by deception.

Maine Rules of Evidence, Rule 503 (e)

(74) Power of Attorney for Healthcare (see also Advanced Healthcare Directives)

Under Maine law, the term “advance directive” means any spoken or written instructions someone gives about the health care someone wants if a time comes when they are too ill to decide. A health care power of attorney is an example of an advance directive that must be in writing. A written power of attorney allows patients to appoint agents to make health care decisions, choose treatments they want or do not want, name a primary care provider, state wishes about donating their body or body parts and state wishes about funeral and burial arrangements.

Anyone 18 or older may execute a Maine Health Care Advance Directive in whole or in part. Those younger than 18 may also be able to use an advance directive under certain limited circumstances.

For Maine’s sample Advanced Healthcare Directive form, see <http://www.maine.gov/dhhs/oes/resource/adf.pdf>

For frequently asked questions about Advanced Healthcare Directives in Maine, see:

<http://www.maine.gov/dhhs/oes/resource/rit2chew.htm#facts>

For Maine's law on Advanced Healthcare Directives, including obligations of health care providers, see the Uniform Health-Care Decisions Act, [Title 18-A, Part 8](#).

Health care providers must comply with an individual instruction of the patient and with a reasonable interpretation of that instruction made by a person then authorized to make health-care decisions for the patient.

[18-A MRSA §5-807\(d\)](#)

In absence of an agent named in an Advanced Healthcare Directive (or court-appointed guardian), physicians may turn to other surrogates to make health care decisions for patients who lack capacity, in this order:

1. Spouse (unless legally separated);
1. Someone with whom the patient share an emotional, physical and financial bond similar to a spouse;
2. Adult children;
3. Parents;
4. Adult brothers and sisters;
5. Adult grandchildren;
6. Adult nieces and nephews; and
7. Adult aunts and uncles.

[18-A MRSA §5-805](#).

Maine law also allows for financial power of attorneys, see [18-A MRSA Part 9](#).

(75) Professional Liability

Medical Malpractice

Medical malpractice is an aspect of the common law “tort” of “negligence.” Black’s Law Dictionary (5th Edition) defines “tort” as “a private or civil wrong or injury, other than a breach of contract, for which the court will provide a remedy in the form of an action for damages.” Each action for negligence requires the existence of a legal duty from the defendant to the plaintiff, breach of that duty, and damage as a proximate result of that breach.

The following are types of damages that may be awarded in actions for professional negligence:

- A. **Compensatory damages:** means damages to compensate an injured party. There are two types of compensatory damages:
 1. Economic damages, which consist of:
 - a. Current and future medical expenses, including the cost of medical care, medicines and medical supplies; and
 - b. Employment-related damages, including lost wages, lost or diminished earning capacity and lost earning opportunity; and
 2. Noneconomic damages, which are damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium, hedonic damages, injury to reputation and all other nonpecuniary losses of any kind or nature.

- B. **Punitive damages:** means damages intended to punish willful, malicious or fraudulent behavior and to discourage similar behavior by others.

Notice of claim before suit

No action for professional negligence may be commenced until the plaintiff has:

- A. Served and filed written notice of claim in accordance with section 2853;
- B. Complied with the provisions of subchapter IV-A; and
- C. Determined that the time periods provided in section 2859 have expired.

[24 MRSA §2903 \(1\)](#)

Tort Reforms

Maine has seven provisions of law that may be referred to as Maine's "tort reforms." These provisions have contributed to a medical malpractice insurance market that offers some of the lowest liability premium rates in the country and the second lowest to Vermont in New England according to a 2005 study on the subject by the Maine Bureau of Insurance. These provisions include:

- A. Mandatory pre-litigation screening and mediation panels;
- B. A favorable statute of limitations;
- C. A provision addressing evidence of payments to a plaintiff from a collateral source;
- D. A provision regarding the apportioning of fault among a claimant and one or more defendants;
- E. Limits on attorney contingent fees;
- F. A provision providing for periodic payment of damage awards; and
- G. A provision protecting statements of benevolence or sympathy ("I'm sorry" law).

Mandatory Pre-Litigation Screening & Mediation Panels

Maine's *Mandatory prelitigation screening and mediation panels*, [24 M.R.S.A. §§2851-2859](#), were adopted in the mid-1980s to identify and encourage the early resolution of meritorious malpractice claims and to encourage the early withdrawal or dismissal of claims that lack merit. The 3-member panel is composed of a chairperson who is a retired judge or someone with "judicial experience," an attorney, and a health care practitioner (preferably the same type of practitioner in the same specialty as the practitioner alleged to have committed malpractice). The panel conducts a hearing, generally lasting no more than a day, within an administrative structure that is less formal than a judicial hearing. The panel applies the same standard of proof that a court would apply in a civil matter. The plaintiff must prove negligence and proximate causation by a *preponderance of the evidence* and the defendant must prove comparative negligence by the same standard. The panel makes its findings in writing within 30 days of the close of the hearing. The findings must address the following questions about negligence and causation:

- A. Whether the acts or omissions complained of constitute a deviation from the applicable standard of care by the health care practitioner or provider charged with that care;
- B. Whether the acts or omissions complained of proximately caused the injury complained of; and
- C. If negligence on the part of the health care practitioner or provider is found, whether any negligence on the part of the patient was equal to or greater than the negligence on the part of the practitioner or provider.

The proceedings before the panel, including deliberations, testimony, and findings, are confidential, but the panel findings are admissible in later court action according to guidelines set forth in the statute and in a series of decisions by the Maine Supreme Judicial Court. These Law Court decisions have provided

some procedural and evidentiary guidelines for the panel process, but they have upheld the constitutionality of the panel's role in resolving medical malpractice cases in Maine.

The Maine Bureau of Insurance has commissioned the only independent third party review of the panel process and that review is favorable. In its 1997 report entitled, *Analysis of the Effectiveness of the Medical Professional Liability Prescreening Panels*, AMI Risk Consultants, Inc. found that the panels have been successful in promoting quicker recovery for those who receive awards and promoting earlier dismissal of claims that conclude with no award while not reducing the overall average size of awards.

While several other states have a screening panel system in their medical liability laws, none seem to have a system that is as effective as Maine's. Maine's system *is the national standard* against which other states' systems are judged. The majority of medical malpractice claims in Maine are resolved at or before the panel stage in the case. Each year, only a few medical malpractice cases in Maine are tried to a jury. Accordingly, Maine's screening panels probably are the most important "reform" of our medical liability laws.

[24 MRSA §§2851-2859](#)

Statute of Limitations

The *Statute of limitations for health care providers and health care practitioners*, 24 M.R.S.A. §2902, provides that actions for medical negligence must be brought within 3 years from occurrence for adults. For minors, the action must be brought within 6 years from occurrence or 3 years from the age of majority whichever is shorter. The limitation of actions involving a foreign object is measured from discovery of the object. Compared to other states, the Maine statute of limitations for medical malpractice is quite favorable to the health care practitioner because the general civil statute of limitations is 6 years from occurrence and because of the absence of a "discovery rule." Most other states' statute of limitations for medical malpractice permit the period of litigation exposure to be expanded by measuring the period from the time the negligent act or omission is or should have been discovered, rather than from the occurrence of the negligent act or omission.

[24 MRSA §2902](#)

Evidence of Payments to a Plaintiff from a Collateral Source

In 24 M.R.S.A. §2906, *Collateral sources*, the Maine legislature has permitted evidence of expenses for medical care, rehabilitation services, loss of earnings, loss of earning capacity, or other economic loss paid or payable by a collateral source to be admissible after the verdict but before judgment. The statute requires the court to reduce the award accordingly, thereby mitigating the impact on the defendant(s) and the liability insurance carrier(s).

[24 MRSA §2906](#)

Comparative Negligence: Apportioning Fault

This section describes how Maine law addresses situations in which multiple defendants and the claimant may have been negligent. In 14 M.R.S.A. §156, *Comparative negligence*, the Maine legislature has blended the concepts of joint and several liability, modified comparative negligence, and contributory negligence. It provides that a plaintiff's recovery may be reduced to the extent the jury determines is "just and equitable" having regard to the claimant's share of responsibility for the damage. Recovery is barred if the claimant is found to be equally or more at fault. Finally, the statute states that each defendant is jointly and severally liable to the claimant for the full amount of the damages, but any defendant has the right to request that the jury determine the percentage of fault contributed by each defendant.

[14 MRSA §156](#)

Limits on Attorney Contingent Fees

In 24 M.R.S.A. §2961, *Contingent Fees*, the Maine legislature has limited the contingency fees that plaintiffs' attorneys may charge in order to mitigate the incentive to inflate fee recovery by pushing for higher damages. The limits, excluding litigation expenses, are:

- A. 33 1/3% of the first \$100,000 in damages;
- B. 25% of the next \$100,000 in damages; and
- C. 20% of any amount over \$200,000.

A plaintiff's attorney may, however, petition the court for a higher award and based upon anecdotal reports, it is common practice for attorneys to make such requests of the court. According to AMA data, approximately 16 states have limits on attorney contingent fees.

[24 MRSA §2961](#)

Periodic Payment of Damage Awards

Maine's tort laws recognize that requiring a health care practitioner to pay a large damage award in a lump sum could pose a significant financial hardship that could threaten the viability of his or her practice. Maine law permits a court to order periodic payment rather than lump-sum payment if future damages equal or exceed \$250,000. See 24 M.R.S.A. §2951, *Provision for structured awards*.

[24 MRSA §2951](#)

Communications of Sympathy or Benevolence (“I’m Sorry” Provision)

Maine's tort laws recognize that patients who have experienced an unanticipated outcome during an encounter with the health care system are less likely to take legal action if the health care practitioner(s) show empathy in the circumstances and communicate directly with them about the unanticipated outcome. The so-called “I’m sorry” provision prevents any statement or gesture of apology, sympathy, or condolence to a patient, or to his or her relative or representative, from being used in an action for professional negligence. See 24 M.R.S.A. §2907, *Communications of sympathy or benevolence*.

[24 MRSA §2907](#)

(76) Public Health (see also Agency Rules Links)

Maine's Public Health laws can be found in [Title 22](#) of the Maine Revised Statutes.

Public Health Infrastructure

Part 2 of [Title 22](#) establishes the State's public health infrastructure including district and local health officers.

Statewide Coordination in Public Health Activities and the Universal Wellness Initiative

In 2009, the Legislature enacted a bill that coordinates and streamlines the public health system in this State. It prepares the state public health system for national federally recognized public health accreditation and ensures the effective, efficient, and evidence-based delivery of essential public health services. It recognizes and formally establishes Healthy Maine Partnerships, district coordinating councils for public health, and the Statewide Coordinating Council for Public Health. It also establishes a universal wellness initiative using the existing resources of the public health infrastructure. The initiative requires the development and distribution of a resource toolkit for the uninsured and a health risk assessment for all people of the State with a focus on the uninsured and those facing health disparities. It also requires the Department of Health and Human Services, Maine Center for Disease Control and Prevention to issue an annual report card on health for each public health district in the State and for the state health plan to publish the report cards.

For more on the Public Health Infrastructure see [Title 22, MRSA, Chapter 152](#).

Fund for a Healthy Maine

The Fund for a Healthy Maine (FHM) was created by the Maine Legislature in 1999 to receive and disburse Maine's share of payments from a settlement of major lawsuits involving tobacco companies. Maine participated in the national tobacco settlement because many Maine people have suffered disease and death as a result of tobacco use. The Fund remains Maine's primary investment in public health and preventative healthcare. For more information about the fund and approved uses of the funds, see [22 MRSA §1511](#).

Control of Notifiable Diseases and Conditions

Maine's statutes on responding to notifiable diseases and conditions is contained in [Title 22 MRSA, Chapter 250](#).

Health emergency

In the event of an actual or threatened epidemic or public health threat, the department may declare that a health emergency exists and may adopt emergency rules for the protection of the public health relating to:

- A. Procedures for the isolation and placement of infected persons for purposes of care and treatment or infection control;
- B. Procedures for the disinfection, seizure or destruction of contaminated property; and
- C. The establishment of temporary facilities for the care and treatment of infected or exposed persons, which are subject to the supervision and regulations of the department and to the limitations set forth in section 807.

[22 MRSA §802 \(2\)](#)

Inspection

If the department has reasonable grounds to believe that there exists a public health threat, either on public or private property, a duly authorized agent of the department may enter any place, building, vessel, aircraft or common carrier with the permission of the owner, agent or occupant where the public health threat is reasonably believed to exist and may inspect and examine the same. If entry is refused, that agent shall apply for an inspection warrant from the District Court pursuant to Title 4, section 179, prior to conducting the inspection.

[22 MRSA §803](#)

Control of communicable diseases

The department may establish procedures for agents of the department to use in the detection, contacting, education, counseling and treatment of individuals having or reasonably believed to have a communicable disease. The procedures shall be adopted in accordance with the requirements of this chapter and with the rules adopted under section 802.

For purposes of carrying out this chapter, the department may designate facilities and private homes for the confinement and treatment of infected persons posing a public health threat. The department may designate any such facility in any hospital or other public or private institution, other than a jail or correctional facility. Designated institutions must have necessary clinic, hospital or confinement facilities as may be required by the department. The department may enter into arrangements for the conduct of these facilities with public officials or persons, associations or corporations in charge of or maintaining and operating these institutions.

[22 MRSA §807](#)

For more on investigating, examining and responding to individuals believed to have a communicable disease, see [22 MRSA §§807-814](#)

Privileged or confidential communications in public health situations

Privileges abrogated: Subject to the limitations imposed by United States Code, Title 42, Sections 290dd-3 and 290ee-3, the physician-patient and psychotherapist-patient privileges under the Maine Rules of Evidence and those confidential communications described under Title 5, section 19203, Title 24-A, section 4224, Title 32, section 7005 and Title 34-B, section 1207, are abrogated to the extent necessary to permit reporting to the Bureau of Health any incidents of notifiable disease or condition; cooperating with the Bureau of Health or an intervention team appointed by the Bureau of Health in investigating a case of a notifiable disease or condition or suspected epidemic, or taking preventive action in such a case; or giving evidence in a proceeding pursuant to this chapter. Information released to the bureau pursuant to this section must be kept confidential and may not be disclosed by the bureau except as provided in section 824 and Title 5, section 19203, subsection 8.

[22 MRSA §815 \(1\)](#)

Limitation: Statements made to a licensed mental health or medical professional in the course of counseling, diagnosis, therapy, treatment or evaluation when the privilege is abrogated under this section may not be used against the client in a criminal proceeding.

[22 MRSA §815 \(2\)](#)**Immunity****For private institutions**

Any private institution, its employees or agents are immune from civil liability to the extent provided in Title 14, chapter 741, as if that institution were a state agency and its employees and agents were state employees, for any acts taken to provide for the confinement or restraint of a person committed pursuant to this chapter or for participating in reporting under this chapter, or for engaging in any prescribed care within the meaning of this chapter in support of the State's response to a declared extreme public health emergency in accordance with the provisions of this chapter and Title 37-B, chapter 13, subchapter 2.

Reporting and proceedings

Any person participating in reporting under this chapter or participating in a related communicable disease investigation or proceeding, including, but not limited to, any person serving on or assisting a multidisciplinary intervention team or other investigating or treatment team, is immune from civil liability for the act of reporting or participating in the investigation or proceeding in good faith. Good faith does not include instances when a false report is made and the reporting person knows or should know the report is false.

[22 MRSA §816](#)**Reporting communicable diseases****General**

Whenever any physician knows or has reason to believe that any person whom the physician examines or cares for has or is afflicted with any disease or condition designated as notifiable, that physician shall notify the department and make such a report as may be required by the rules of the department. Reports must be in the form and content prescribed by the department and the department shall provide forms for making required reports.

[22 MRSA §822](#)

Time requirements

The reporting of a notifiable disease or condition must be made by telephone to the department immediately upon determination that a person has that disease and must be followed by a written report mailed to the department within 48 hours.

[22 MRSA §823](#)

Confidentiality

Any person who receives information pursuant to this chapter shall treat as confidential the names of individuals having or suspected of having a notifiable disease or condition, as well as any other information that may identify those individuals. This information may be released to the department for adult or child protection purposes in accordance with chapters 958-A and 1071, or to other public health officials, agents or agencies or to officials of a school where a child is enrolled, for public health purposes, but that release of information must be made in accordance with Title 5, chapter 501, where applicable. In the event of an actual or threatened epidemic or outbreak or public health threat or emergency, as declared by the Director of the Bureau of Health, the information may also be released to private health care providers and health and human services agencies for the purpose of carrying out public health functions as authorized by this chapter. Information not reasonably required for the purposes of this section may not be released. All information submitted pursuant to this chapter that does not name or otherwise identify individuals having or suspected of having a notifiable disease or condition may be made available to the public at the sole discretion of the department.

[22 MRSA §824](#)

Penalties

Any person who knowingly and willfully fails to comply with reporting requirements for notifiable diseases or conditions commits a civil violation for which a fine of not more than \$250 may be adjudged. A person who knowingly or recklessly makes a false report under section 822 or who knowingly violates section 824, is civilly liable for actual damages suffered by a person reported upon and for punitive damages and commits a civil violation for which a fine of not more than \$500 may be adjudged.

[22 MRSA §825](#)

Mandatory blood-borne pathogen test

Definitions

- A. **Bona fide occupational exposure:** means skin, eye, mucous membrane or parenteral contact of a person with the potentially infectious blood or other body fluids of another person that results from the performance of duties by the exposed person in the course of employment.
- B. **Employer; employer of the person exposed:** includes a self-employed person who is exposed to the potentially infectious blood or other body fluids of another person.
- C. **Informed consent:** means consent that is:
 1. Based on an actual understanding by the person to be tested:
 - a. That the test is being performed;
 - b. Of the nature of the test;
 - c. Of the persons to whom the results of that test may be disclosed;
 - d. Of the purpose for which the test results may be used; and
 - e. Of any reasonably foreseeable risks and benefits resulting from the test; and
 2. Wholly voluntary and free from express or implied coercion.

[22 MRSA §831](#)

Judicial consent to blood-borne pathogen test

- A. Petition

Any person who experiences a bona fide occupational exposure may petition the District Court with jurisdiction over the facility or other place where the exposure occurred to require the person whose blood or body fluid is the source of the exposure to submit to a blood-borne pathogen test and to require that the results of the test be provided to the petitioner as long as the following conditions have been met:

1. The exposure to blood or body fluids creates a significant risk of infection with a blood-borne pathogen, as defined by the Bureau of Health through the adoption of rules;
2. The authorized representative of the employer of the person exposed has informed the person whose blood or body fluid is the source of the occupational exposure and has sought to obtain written informed consent from the person whose blood or body fluid is the source of the exposure; and
3. Written informed consent was not given by the person whose blood or body fluid is the source of the exposure and that person has refused to be tested.

B. Pre-hearing duties of the court (omitted)

C. Hearings (omitted)

D. Determination

The court shall require the person whose blood or body fluid is the source of the exposure to obtain a blood-borne pathogen test and shall require that the results of the test be provided to the petitioner only if the petitioner proves by a preponderance of the evidence that:

1. The exposure to blood or body fluids of the person created a significant risk of infection with a blood-borne pathogen as defined by the Bureau of Health through the adoption of rules;
2. An authorized representative of the employer of the person exposed has informed the patient of the occupational exposure and has sought to obtain written informed consent from the person whose blood or body fluid is the source of the exposure; and
3. Written informed consent was not given by the person whose blood or body fluid is the source of the exposure and that person has refused to be tested.

E. Consent

The court may not order a person whose blood or body fluid is the source of the exposure to obtain a blood-borne pathogen test unless the employee exposed to the blood or body fluids of that person has consented to and obtained a blood-borne pathogen test immediately following that documented exposure.

F. Costs

The employer of the person exposed is responsible for the petitioner's reasonable costs related to obtaining the results of a blood-borne pathogen test pursuant to this section, including the payment of the petitioner's attorney's fees.

[22 MRSA §832](#)

Occupational Diseases (see also Agency Rules Links)

Duties of physicians and hospitals

All physicians or hospitals shall report to the Department of Human Services all persons diagnosed as having an occupational disease no later than 30 days from the date of diagnosis or from discharge from a hospital. The report shall include any factor known to the physician which is suspected of being a contributing factor to the disease, including, but not limited to, whether or not the person smokes and, if so, the frequency of smoking.

A physician, upon notification by the Department of Human Services, shall report to the department any further information requested by the department concerning any person now or formerly under his care, diagnosed as having or having had an occupational disease.

No physician or hospital complying with the reporting requirements of this section may be liable for any civil damages as a result of those acts.

[22 MRSA §1493](#)

Confidentiality

The names and related information which may identify individuals having an occupational disease shall be confidential and may be released only to other public health officials, agents or agencies, or by court order or by written authorization of the individual being reported on. All other information submitted pursuant to this chapter may be made available to the public.

[22 MRSA §1494](#)

Employment During Extreme Public Health Emergency

Required leave

An employer shall grant reasonable and necessary leave from work, with or without pay, for an employee for the following reasons related to an extreme public health emergency:

- A. The employee is unable to work because the employee is under individual public health investigation, supervision or treatment related to an extreme public health emergency;
- B. The employee is unable to work because the employee is acting in accordance with an extreme public health emergency order;
- C. The employee is unable to work because the employee is in quarantine or isolation or is subject to a control measure in accordance with extreme public health emergency information or directions issued to the public, a part of the public or one or more individuals;
- D. The employee is unable to work because of a direction given by the employee's employer in response to a concern of the employer that the employee may expose other individuals in the workplace to the extreme public health emergency threat; or
- E. The employee is unable to work because the employee is needed to provide care or assistance to one or more of the following individuals: the employee's spouse or domestic partner as defined under Title 18-A, section 1-201, subsection (10-A); the employee's parent; or the employee's child or child for whom the employee is the legal guardian.

For purposes of this subsection, "extreme public health emergency" has the same meaning as in Title 22, section 801, subsection 4-A.

[26 MRSA §875 \(1\)](#)

Exceptions

An employer who fails to grant a leave under subsection 1 is not in violation of subsection 1 if:

- A. The employer would sustain undue hardship from the employee's absence, including the need to downsize for legitimate reasons related to the impact of the extreme public health emergency on the operation of the business;
- B. The request for leave is not communicated to the employer within a reasonable time under the circumstances; or
- C. The employee to be granted leave under subsection 1, paragraph E is a state, county or municipal employee whose responsibilities are related to services necessary for protecting the public's health and safety in an extreme public health emergency if the employer requires the employee to work, unless there are no other options or persons able to provide care or assist one or more of the individuals listed under subsection 1, paragraph E.

[26 MRSA §875 \(2\)](#)

Duration of leave

Leave granted under subsection 1 must be for the duration of an extreme public health emergency and for a reasonable and necessary time period following the termination of the extreme public health emergency for diseases or conditions that are contracted or exposures that occurred during the extreme public health emergency.

[26 MRSA §875 \(3\)](#)

Documentation.

Upon the employee's return to work, the employer has the right to request and receive written documentation from a physician or public health official supporting the employee's leave.

[26 MRSA §875 \(4\)](#)

Benefits retained

The taking of leave under this subchapter may not result in the loss of any employee benefits accrued before the date on which the leave commenced and does not affect the employee's right to health insurance benefits on the same terms and conditions as applicable to similarly situated employees. For any leave that extends beyond the time described in subsection 3, the employer shall allow an employee to continue the employee's benefits at the employee's expense. The employer and employee may negotiate for the employer to maintain benefits at the employer's expense for the duration or any portion of this extended leave.

[26 MRSA §875 \(5\)](#)

Civil penalties

The Department of Labor may assess civil penalties of up to \$200 for each violation of this section if notice of the violation is given to the employer and the department within 6 months of the occurrence.

[26 MRSA §875 \(6\)](#)

Application

This subchapter applies to all public and private employers, including the State and its political subdivisions.

[26 MRSA §875 \(7\)](#)

Expedited Partner Therapy

For the full statute regarding expedited partner therapy, see Title 22, [Sections 1241](#) and [1242](#) of the Maine Revised Statutes.

General

Notwithstanding any other provision of law, a health care professional who makes a clinical diagnosis of a sexually transmitted disease may provide expedited partner therapy for the treatment of the sexually transmitted disease if in the judgment of the health care professional the sexual partner is unlikely or unable to present for comprehensive health care, including evaluation, testing and treatment for sexually transmitted diseases. Expedited partner therapy is limited to a sexual partner who may have been exposed to a sexually transmitted disease within the previous 60 days and who is able to be contacted by the patient.

[22 MRSA §1242](#)

"Expedited partner therapy" means prescribing, dispensing, furnishing or otherwise providing prescription antibiotic drugs to the sexual partner or partners of a person clinically diagnosed as infected with a sexually transmitted disease without physical examination of the partner or partners.

[22 MRSA §1241\(2\)](#)

Counseling

A health care professional who provides expedited partner therapy shall provide counseling for the patient, including advice that all women and symptomatic persons, and in particular women with symptoms suggestive of pelvic inflammatory disease, are encouraged to seek medical attention. The health care professional shall also provide written materials provided by the department to be given by the patient to the sexual partner

[22 MRSA §1242\(1\)](#)

Immunity for health care professional

A health care professional who provides expedited partner therapy in good faith without fee or compensation under this section and provides counseling and written materials as required in subsection 1 is not subject to civil or professional liability in connection with the provision of the therapy, counseling and materials, except in the case of willful and wanton misconduct. A health care professional is not subject to civil or professional liability for choosing not to provide expedited partner therapy.

[22 MRSA §1242\(3\)](#)

Motorcycle helmet requirement for persons under 18 years of age**Requirement**

The following persons must wear protective headgear:

- A. If under 18 years of age, a passenger on a motorcycle or in an attached side car;
- B. If under 18 years of age, an operator of a motorcycle.

[29-A MRSA §2083 \(1\)](#)

Compliance

An operator of a motorcycle, parent or guardian may not allow a passenger under the age of 18 years to ride in violation of this section.

[29-A MRSA §2083 \(2\)](#)

School health**School physician**

Each school board shall appoint one or more school physicians.

Duties

The school physician shall advise the administrative unit on school health issues, policies and practices and may also perform any other health-related functions assigned by the board.

[20-A MRSA §6402-A](#)

Other functions

A school physician may perform other medical and health-related duties assigned by the school board which may include all or some of the following:

- A. Examine and diagnose students referred by teachers and other school employees to protect against the outbreak of contagious diseases in the schools;
- B. Examine students for participation in physical education and athletic activities;
- C. Advise and serve as medical consultant to the school nurse; or
- D. Examine school employees and property if the physician believes it is necessary to protect the health of students.

[20-A MRSA §6402-A \(2\)](#)

Prohibition

A school physician may not treat any student examined under this subchapter unless the physician is also the student's personal physician.

[20-A MRSA §6402-A \(3\)](#)

Appointment

Appointment shall be on a yearly basis.

[20-A MRSA §6402-A \(4\)](#)

Tracking Prevalence of Childhood Obesity

A school nurse or trained screener shall collect body mass index data from students in the school administrative unit in accordance with rules of the Department of Health and Human Services. Data may not be collected from a student whose parent or guardian objects on religious or philosophical grounds.

A school nurse shall report the data collected to the Department of Health and Human Services, Maine Center for Disease Control and Prevention. Data reported pursuant to this subsection may be reported in the aggregate only and may not identify an individual student.

[20-A MRSA §6455](#)

School Physical Education

The Commissioner of Education shall conduct a statewide assessment, using a survey or sampling methodology, of the current physical education capacities of elementary schools in the State.

The Obesity and Chronic Disease Fund is established as an interest-bearing account administered by the Department of Education. Balances in the fund may be used to pay for new equipment, new staff training, new personnel, new administrative costs and other expenses not related to an existing physical education program and for the implementation of a new physical education program for elementary schools.

[20-A MRSA 6631](#)

For more information on school health, including immunization, screening and nutrition requirements, and bullying prevention see [Title 20-A, Chapter 223](#) of the Maine Statues.

For information on bullying and head injury policies, see also [20-A MRSA § 254](#).

The requirement for scoliosis screening of students in schools has been repealed.

[20-A MRSA §6452](#) REPEALED

Menu Labeling

A chain restaurant with locations in the State of Maine shall state on a food display tag, menu or menu board the total amount of calories per serving of each food and beverage item listed for sale on the food display tag, menu or menu board. A menu or menu board or written nutrition information provided to a customer by a chain restaurant must contain the following statement in a clear and conspicuous manner and in a prominent location: "To maintain a healthy weight, a typical adult should consume approximately 2,000 calories per day; however, individual calorie needs may vary.

"Chain restaurant" means an eating establishment that does business under the same trade name in 20 or more locations, at least one of which is located in the State, that offers predominantly the same type of

meals, food, beverages or menus, regardless of the type of ownership of an individual location. "Chain restaurant" does not include a grocery store.

[22 MRSA §2500-A](#)

For more information, see [Public Laws 2009, Chapter 359](#).

(77) Research, Maine Biomedical Research Program

The Maine Biomedical Research Program is established to promote economic development and jobs in the State primarily by making state investments in organizations with successful results in attracting biomedical research funds from specified grant sources. As a secondary purpose, the Maine Biomedical Research Program is intended to provide incentives for small eligible institutions to grow. The program shall disburse program funds from the Maine Biomedical Research Fund to eligible institutions.

For more information regarding eligibility and the application process. See [5 MRSA §13103](#).

(78) Research, Human Subjects (Select Sections)

“The Common Rule”

All human subjects research that is either funded or support by the federal government falls under the jurisdiction of Title 45 of the Code of Federal Regulation, Section 46, The Protections of Human Subjects (“The Common Rule”). As stated in 45 CFR § 46:

“...this policy applies to all research involving human subjects conducted, supported or otherwise subject to regulation by any federal department or agency which takes appropriate administrative action to make the policy applicable to such research. This includes research conducted by federal civilian employees or military personnel, except that each department or agency head may adopt such procedural modifications as may be appropriate from an administrative standpoint. It also includes research conducted, supported, or otherwise subject to regulation by the federal government outside the United States.”

[45 CFR §46.101](#)

The Common Rule, enforcement and regulatory oversight for HHS funded research is administrated by the Office of Human Research Protections (OHRP). For more information, please click on any of the links below:

[Full Text of the Common Rule](#)

[NIH Required Training for Human Participant Protections](#)

[The Belmont Report](#)

[IRB Registration Information](#)

[OHRP Guidance by Topic](#)

[FDA Compliance Website](#)

[CDC Research Website](#)

[NIH Research Resources](#)

It should be noted that all of the following federal agencies have adopted similar version of the Common Rule governing research support by them:

Department of Agriculture

[7 CFR §1c](#)

Department of Energy

[10 CFR §745](#)

National Aeronautics and Space Administration	14 CFR §1230
Department of Commerce	15 CFR §27
Consumer Product Safety Commission	16 CFR §1028
Agency for International Development	22 CFR §225
Department of Housing and Urban Development	24 CFR §60
Department of Justice	28 CFR §46
Department of Defense	32 CFR §219
Department of Education	34 CFR §97
Department of Veterans Affairs	38 CFR §16
Environmental Protection Agency	40 CFR §26
National Science Foundation	45 CFR §690
Department of Transportation	49 CFR §11
Central Intelligence Agency	By Executive Order 12333
Department of Agriculture	By Statute

Select Definitions

- A. **Research:** "...a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes."
- B. **Research subject to regulation:** and similar terms are intended to encompass those research activities for which a federal department or agency has specific responsibility for regulating as a research activity, (for example, Investigational New Drug requirements administered by the Food and Drug Administration). It does not include research activities which are incidentally regulated by a federal department or agency solely as part of the department's or agency's broader responsibility to regulate certain types of activities whether research or non-research in nature (for example, Wage and Hour requirements administered by the Department of Labor).
- C. **Human subject:** means a living individual about whom an investigator (whether professional or student) conducting research obtains:
1. Data through intervention or interaction with the individual, or
 2. Identifiable private information.
- D. **Intervention:** includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes. Interaction includes communication or interpersonal contact between investigator and subject. Private information includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Private information must be individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects.
- E. **Institutional Review Board (IRB):** means an institutional review board established in accord with and for the purposes expressed in this policy.

[45 CFR §46.102](#)

(79) Rural Medical Access Program (see also Agency Rules Links)

Definitions

- A. **Insurer:** means any insurer authorized to transact insurance in this State and any insurer authorized as a surplus lines insurer pursuant to chapter 19.
- B. **Physician's employer:** means any hospital, health care facility, clinic or other entity that employs a physician and pays for or otherwise provides professional liability insurance for the physician.
- C. **Program:** means the Rural Medical Access Program.
- D. **Self-insured:** means any physician, hospital or physician's employer insured against the physician's professional negligence or the hospital's professional liability through any entity other than an insurer as defined in subsection 1. For purposes of this chapter, a physician, hospital or physician's employer that does not purchase insurance is considered self-insured.

[24-A MRSA §6303](#)

Assessments authorized

To provide funds for the Rural Medical Access Program, insurers may collect pursuant to this chapter assessments from physicians licensed and practicing medicine in this State and hospitals and physician's employers located in the State.

[24-A MRSA §6304](#)

Assessment from policyholders and self-insureds

With respect to professional liability insurance policies for physicians and hospitals issued on or after July 1, 1990, each insurer shall collect an assessment from each policyholder. With respect to professional liability insurance for self-insureds issued on or after July 1, 1990, each self-insured shall pay an assessment as directed by the superintendent. The superintendent shall determine the amount of the assessment in accordance with this chapter. Notwithstanding any provision of law, assessments made and collected pursuant to this chapter do not constitute premium, as defined in section 2403, for purposes of any laws of this State relating to taxation, filing of insurance rates or assessment purposes other than as expressly provided under this chapter. The assessments are considered as premium only for purposes of any laws of this State relating to cancellation or nonrenewal of insurance coverage and the determination of hospital financial requirements under Title 22, chapter 107.

[24-A MRSA §6304 \(1\)](#)

Required support

Every insured and self-insured physician, hospital, and physician's employer shall support the Rural Medical Access Program as provided in this chapter. Any physician, hospital or physician's employer that fails to pay the assessment required by this chapter is subject to a civil penalty not to exceed \$2,000, payable to the bureau, to be recovered in a civil action.

[24-A MRSA §6304 \(2\)](#)

Assistance from boards and Department of Human Services; insure through other means

The Board of Licensure in Medicine and the Board of Osteopathic Licensure shall assist the superintendent in identifying those physicians who insure against professional negligence by means other than through insurers defined in section 6303. The Department of Human Services shall assist the superintendent in determining the insuring entity for any licensed hospital or physician's employer, in identifying those hospitals and physician's employers that insure against professional negligence by means other than through insurers defined in section 6303 and in identifying the individual or entity who makes the insurance payment for each physician.

[24-A MRSA §6304 \(3\)](#)

Determination of assessments paid

After review of the records provided by the Board of Licensure in Medicine, the Board of Osteopathic Licensure and the Department of Health and Human Services, Division of Licensure and Certification, and the assessment receipts of the malpractice insurers, the superintendent shall determine those physicians, hospitals and physician's employers that have paid the required assessments.

[24-A MRSA §6304 \(4\)](#)

Assessment rates; program fund balance

For assessment years prior to July 1, 2006, the assessment is 1.25% of premium. For assessment years commencing July 1, 2006 and after, the assessment is .75% of premium unless adjusted pursuant to this subsection. The assessment rate is intended to result in collections no greater than \$500,000 per assessment year. When the program fund balance is \$50,000 or less, the assessment rate must increase to 1% of premium. When the program fund balance is more than \$50,000, the assessment rate must decrease to .75% of premium. The superintendent shall notify affected parties of any assessment rate adjustment and the effective date of that adjustment.

The program fund balance may be used to pay assistance to qualified eligible physicians in prior years for which there were insufficient funds. If all prior years' eligible qualified physicians have received assistance, any excess funds must be carried forward to subsequent plan years as part of the program fund balance. Excess funds must be applied first to the assessment year commencing July 1, 1998 and then to each successive assessment year.

For the purposes of this section, "program fund balance" means the total funds collected in excess of assistance paid for all years.

[24-A MRSA §6305 \(3\)](#)

Funds held by insurers

Insurers shall invest assessments collected subject to chapter 13. Interest earned on investments must be credited to the Rural Medical Access Program.

[24-A MRSA §6306](#)

Qualifications for premium assistance**Eligibility qualifications**

A physician is a qualified physician eligible to participate in the program if that physician:

- A. Is licensed to practice medicine in the State;
- B. Accepts and serves Medicaid patients;
- C. Provides complete obstetrical care for patients, including prenatal care and delivery, provided that physicians in an underserved area without a facility for obstetrical delivery are still eligible if they provide only prenatal care and have referral agreements for delivery with a physician meeting the requirements of paragraphs A and B; and
- D. Practices at least 50% of the time in areas of the State that are underserved areas for obstetrical and prenatal medical services as determined by the Department of Human Services.

The Commissioner of Human Services shall determine those physicians who meet the requirements of this subsection. The commissioner shall adopt rules, pursuant to the Maine Administrative Procedure Act, determining underserved areas with respect to obstetrical and prenatal care. "Underserved areas" includes medically underserved areas, health manpower shortage areas and other priority areas determined by the commissioner. The commissioner may adopt rules pursuant to the Maine Administrative Procedure Act defining the scope of services that must be provided to meet the requirements of paragraphs B and C and the method of prioritizing underserved areas for purposes of distribution of the funds authorized by section 6308.

[24-A MRSA §6307 \(1\)](#)

Ineligible if premium owed

Any physician or physician's employer who owes premiums to any insurer for any policy year prior to the year that participation in the program is sought is not eligible to participate.

[24-A MRSA §6307 \(2\)](#)

Funding of the program

The amount of funds available for the program is determined as follows.

A. Available funds

The amount available for the program for policy years beginning on or after July 1, 1990, but before July 1, 1991, is 1/2 of the amount of the assessment determined under section 6305 for that year. For policy years beginning on or after July 1, 1991, the Bureau of Insurance shall determine the amount available, except that the amount may be no less than the assessment determined for that year.

B. Determination of participants in the program

The superintendent shall apply the standards of prioritization adopted by the Commissioner of Health and Human Services to determine the physicians who are eligible for the program. The funding available for each qualified physician is the amount equal to the difference between the physician's medical malpractice insurance premiums with obstetrical care coverage and the physician's premiums without obstetrical care coverage; however, the funding must be at least \$5,000 but may not be more than \$15,000 as determined by the superintendent. Program payments must be made to the individual or entity paying the medical malpractice premium for the qualified physician.

[24-A MRSA §6308](#)

Intercorporate transfers

The superintendent may order intercorporate transfers of funds to balance assessments and program payments on an equitable basis among insurers and to provide for payments to eligible self-insureds.

[24-A MRSA §6309](#)

Appeals

A. Assessments

Physicians, hospitals and physicians' employers aggrieved by an insurer's application of the assessment provided for in this chapter may request a hearing before the superintendent. The hearing must be held in accordance with chapter 3, the Maine Administrative Procedure Act and procedural rules of the bureau.

B. Eligibility

Physicians aggrieved by an eligibility determination by the Department of Health and Human Services under section 6307 may request a hearing under the Maine Administrative Procedure Act.

[24-A MRSA §6310](#)

(80) Sentinel Events, Reporting of**Definitions**

A. **Division:** means the Department of Health and Human Services, Division of Licensing and Regulatory Services.

B. **Health care facility:** means a state institution as defined under Title 34-B, chapter 1 or a health care facility licensed by the division, except that it does not include a facility licensed as a

nursing facility or licensed under chapter 1664. “Health care facility” includes a general and specialty hospital, an ambulatory surgical facility, an end-stage renal disease facility and an intermediate care facility for persons with mental retardation or developmental disabilities.

- C. **Immediate jeopardy:** means a situation in which the provider’s noncompliance with one or more conditions of participation in the federal Medicare program has caused, or is likely to cause, serious injury, harm or impairment to or death of a patient.
- D. **Major permanent loss of function:** means sensory, motor, physiological or intellectual impairment that was not present at the time of admission and requires continued treatment or imposes persistent major restrictions in activities of daily living.
- E. **Near miss:** means an event or situation that did not produce patient injury, but only because of chance, which may include, but is not limited to, robustness of the patient or a fortuitous, timely intervention.
- F. **Root cause analysis:** means a structured process for identifying the causal or contributing factors underlying adverse events. The root cause analysis follows a predefined protocol for identifying these specific factors in causal categories.
- G. **Sentinel event:** means:
1. An unanticipated death, or patient transfer to another health care facility, unrelated to the natural course of the patient’s illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility;
 2. A major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility that is present at the time of the discharge of the patient. If within 2 weeks of discharge from the facility, evidence is discovered that the major loss of function was not permanent, the health care facility is not required to submit a report pursuant to section 8753, subsection 2;
 3. An unanticipated perinatal death or major permanent loss of function in an infant with a birth weight over 2,500 grams that is unrelated to the natural course of the infant’s mother’s illness or underlying condition or proper treatment of that illness or underlying condition in a health care facility; and
 4. Other serious and preventable events as identified by a nationally recognized quality forum and determined in rules adopted by the department pursuant to section 8756.

[22 MRSA §8752](#)

Mandatory reporting of sentinel events

A health care facility shall notify the division whenever a sentinel event has occurred, as provided in this chapter.

Notification

A health care facility shall notify the division of a sentinel event by the next business day after the event occurred or the next business day after the facility discovers that the event occurred. The notification must include the date and time of notification, the name of the health care facility and the type of sentinel event pursuant to section 8752, subsection 4-A.

[22 MRSA §8753 \(1\)](#)

Reporting

The health care facility shall file a written report no later than 45 days following the notification of the occurrence of a sentinel event pursuant to subsection 1. The written report must be signed by the chief executive officer of the facility and must contain the following information:

- A. Facility name and address;
- B. Name, title and phone number of the contact person for the facility;
- C. The date and time of the sentinel event;
- D. The type of sentinel event and a brief description of the sentinel event; and
- E. A thorough and credible root cause analysis. A root cause analysis is thorough and credible only in accordance with the following.
 1. A thorough root cause analysis must include: a determination of the human and other factors most directly associated with the sentinel event and the processes and systems related to its occurrence; an analysis of the underlying systems and processes to determine where redesign might reduce risk; an inquiry into all areas appropriate to the specific type of event; an identification of risk points and their potential contributions to the event; a determination of potential improvement in processes or systems that would tend to decrease the likelihood of such an event in the future or a determination, after analysis, that no such improvement opportunities exist; an action plan that identifies changes that can be implemented to reduce risks or formulates a rationale for not undertaking such changes; and, where improvement actions are planned, an identification of who is responsible for implementation, when the action will be implemented and how the effectiveness of the action will be evaluated.
 2. A credible root cause analysis must include participation by the leadership of the health care facility and by the individuals most closely involved in the processes and systems under review, is internally consistent without contradictions or unanswered questions, provides an explanation for all findings, including those identified as “not applicable” or “no problem,” and includes the consideration of any relevant literature.
 3. The root cause analysis submitted to the division may exclude protected professional competence review information pursuant to the Maine Health Security Act.

[22 MRSA §8753 \(2\)](#)

Cooperation

A health care facility that has filed a notification or a report of the occurrence of a sentinel event under this section shall cooperate with the division as necessary for the division to fulfill its duties under section 8754.

[22 MRSA §8753 \(3\)](#)

Immunity

A person who in good faith reports a near miss, a suspected sentinel event or a sentinel event or provides a root cause analysis pursuant to this chapter is immune from any civil or criminal liability for the act of reporting or participating in the review by the division. "Good faith" does not include instances when a false report is made and the person reporting knows the report is false. This subsection may not be construed to bar civil or criminal action regarding perjury or regarding the sentinel event that led to the report.

[22 MRSA §8753 \(4\)](#)

Near miss notification

A health care facility may notify the division of the occurrence of a near miss. Should a facility report a near miss, the notification must include the date and time of notification, the name of the health care

facility and the type of event or situation pursuant to section 8752, subsection 4-A that is related to the near miss.

[22 MRSA §8753 \(5\)](#)

Compliance

Oversight

The division shall place primary emphasis on ensuring effective corrective action by the facility.

[22 MRSA §8755 \(1\)](#)

Penalties

When the division determines that a health care facility failed to report a sentinel event pursuant to this chapter, the health care facility is subject to a penalty imposed in conformance with Title 5, chapter 375, subchapter 4 and payable to the State of not more than \$10,000 per violation. If the facility in good faith notified the division of a suspected sentinel event and the division later determines it is a sentinel event, the facility is not subject to a penalty for that event. Funds collected pursuant to this section must be deposited in a dedicated special revenue account to be used to support sentinel event reporting and education.

[22 MRSA §8755 \(2\)](#)

Administrative hearing and appeal

To contest the imposition of a penalty under this section, a health care facility must submit to the division a written request for an administrative hearing within 10 days of notice of imposition of a penalty pursuant to this section. Judicial appeal must be in accordance with Title 5, chapter 375, subchapter 7.

[22 MRSA §8755 \(3\)](#)

Injunction

Notwithstanding any other remedies provided by law, the Office of the Attorney General may seek an injunction to require compliance with the provisions of this chapter.

[22 MRSA §8755 \(4\)](#)

Enforcement

The Office of the Attorney General may file a complaint with the District Court seeking injunctive relief for violations of this chapter.

[22 MRSA §8755 \(5\)](#)

Targeted surveillance for methicillin-resistant Staphylococcus aureus

All hospitals licensed under chapter 405 shall perform targeted surveillance for methicillin-resistant Staphylococcus aureus in high-risk populations, as defined by the Maine Quality Forum established pursuant to Title 24-A, section 6951, consistent with the federal Centers for Disease Control and Prevention guidelines.

(81) Staffing & Supervision

Criminal background checks

Beginning October 1, 2010, a facility or health care provider subject to the licensing or certification processes of chapter 405, 412 or 419 shall obtain, prior to hiring an individual who will work in direct contact with a consumer, criminal history record information on that individual, including, at a minimum, criminal history record information from the Department of Public Safety, State Bureau of Identification. The facility or health care provider shall pay for the criminal background check required by this section.

[22 MRSA §1724](#)

Delegation

For the Maine law on physician delegation to physician assistants and other employees, see [32 MRSA §3270-A](#).

For the law on physician immunity from civil and criminal liability when supervising a physician assistant on active state service in the performance of the physician assistant's duty, see [37-B MRSA §185](#).

(82) Sexual Misconduct

Sexual Misconduct by Physicians and Physician Assistants (see also Agency Rules Links)

Definition

Physician/physician assistant sexual misconduct is behavior that exploits the physician/physician assistant-patient relationship in a sexual way. This behavior is nondiagnostic and/or nontherapeutic, may be verbal or physical, and may include expressions or gestures that have a sexual connotation or that a reasonable person would construe as such. Sexual misconduct is considered incompetence and unprofessional conduct as defined by 32 M.R.S.A 2591-A (2) and 32 M.R.S.A. 3282 -A (2).

Levels of Misconduct

Under Maine Law there are two levels of sexual misconduct. Behavior listed in both levels may be the basis for disciplinary action.

A. Sexual violation

Any conduct by a physician/physician assistant with a patient that is sexual or may be reasonably interpreted as sexual, even when initiated by or consented to by a patient, including but not limited to:

1. Sexual intercourse, genital to genital contact;
2. Oral to genital contact;
3. Oral to anal contact or genital to anal contact;
4. Kissing in a sexual manner (e.g. - French kissing);
5. Any touching of a body part for any purpose other than appropriate examination, treatment, or comfort, or where the patient has refused or has withdrawn consent;
6. Encouraging the patient to masturbate in the presence of the physician/physician assistant or masturbation by the physician/physician assistant while the patient is present; and,
7. Offering to provide practice-related services, such as drugs, in exchange for sexual favors.

B. Sexual impropriety

Behavior, gestures, or expressions by the physician/physician assistant that are seductive, sexually suggestive, or sexually demeaning to a patient, including but not limited to:

1. Kissing;
2. Disrobing, draping practices or touching of the patient's clothing that reflect a lack of respect for the patient's privacy; deliberately watching a patient dress or undress, instead of providing privacy for disrobing;
3. Subjecting a patient to an examination in the presence of another when the physician/physician assistant has not obtained the verbal or written consent of the patient or when consent has been withdrawn;
4. Examination or touching of genitals without the use of gloves;

5. Inappropriate comments about or to the patient, including but not limited to making sexual comments about a patient's body or underclothing; making sexualized or sexually demeaning comments to a patient, criticizing the patient's sexual orientation (homosexual, heterosexual, or bisexual); making comments about potential sexual performance during an examination or consultation (except when the examination or consultation is pertinent to the issue of sexual function or dysfunction); requesting details of sexual history or sexual likes or dislikes when not clinically indicated;
6. Using the physician/physician assistant-patient relationship to solicit a date or initiate romantic relationship;
7. Initiation by the physician/physician assistant of conversation regarding the sexual problems, preferences, or fantasies of the physician/physician assistant; and,
8. Examining the patient without verbal or written consent.

Sanctions

A. Sexual violation

Findings of sexual violations are egregious enough to warrant revocation of a physician/physician assistant's medical license. Boards may, at times, find that mitigating circumstances do exist and, may impose a lesser sanction.

B. Sexual impropriety

Findings of sexual impropriety will result in harsh sanction, which may include revocation. Special consideration should be given to at least the following when determining an appropriate sanction:

1. Patient harm;
2. Severity of impropriety;
3. Culpability of licensee;
4. Psychotherapeutic relationship;
5. Inappropriate termination of physician/physician assistant-patient relationship;
6. Age of patient;
7. Physical /mental capacity of patient;
8. Number of times behavior occurred;
9. Number of patients involved;
10. Period of time relationship existed; and,
11. Evaluation/assessment results.

Department of Professional and Financial Regulation, Board of Licensure in Medicine/Board of Osteopathic Licensure, [Rule Chapter 10](#)

Sexual activity with recipient of services prohibited

A person who owns, operates or is an employee of an organization, program or residence that is operated, administered, licensed or funded by the Department of Behavioral and Developmental Services or the Department of Human Services may not engage in a sexual act, as defined in Title 17-A, section 251, subsection 1, paragraph C, with another person or subject another person to sexual contact, as defined in Title 17-A, section 251, subsection 1, paragraph D, if the other person, not the actor's spouse, is a person with mental illness who receives therapeutic, residential or habilitative services from the organization, program or residence.

[34-B MRSA §3008](#)

Transportation and storage of forensic examination kits

If an alleged victim of gross sexual assault has a forensic examination and has not reported the alleged offense to a law enforcement agency when the examination is complete, the licensed hospital or licensed health care practitioner that completed the forensic examination shall notify the nearest law enforcement agency. That law enforcement agency shall transport the completed kit, identified only by a tracking number assigned by the hospital or health care practitioner, to its evidence storage facility. The law enforcement agency shall store the kit for at least 90 days from the time of receipt. If during that 90-day period the alleged victim reports the offense to a law enforcement agency, the investigating agency shall take possession of the kit.

In the case of a forensic examination performed under Title 24, section 2986, subsection 5, the law enforcement agency must immediately notify the district attorney for the district in which the hospital or health care practitioner is located that such a forensic examination has been performed and a forensic examination kit has been completed under Title 24, section 2986, subsection 5.

[25 MRSA §3821](#)

Sexual Assault Support Information

To access hotline advocates for free and confidential support, or to receive more information on sexual assault and available services, please call the toll-free statewide hotline. You will automatically be connected to the sexual assault crisis and support center nearest you.

Statewide Sexual Assault Support Hotline **1-800-871-7741 Or TTY: 1-888-458-5599**

For more information, visit the [Maine Coalition Against Sexual Assault](#) (MECASA) and see [the links to centers](#) that serve each Maine county.

(83) Sterilization

Informed consent required

Except as provided in this chapter, prior to initiating sterilization procedures on any individual, a physician shall obtain and record the informed consent of that individual.

[34-B MRSA §7004 \(1\)](#)

- A. Hearing required to determine ability to give informed consent for sterilization
 1. A hearing to determine ability to give informed consent for sterilization is required when sterilization is sought for:
 2. Persons under age 18 years and not married or otherwise emancipated;
 3. Persons presently under public or private guardianship or conservatorship;
 4. Persons residing in a state institution providing care, treatment or security, or otherwise in state custody; or
 5. Persons from whom a physician could not obtain informed consent.

[34-B MRSA §7004 \(2\)](#)

(84) Suicide

See AMA Positions on Physician Assisted Suicide

[E-2.211 Physician-Assisted Suicide](#)

[H-140.952 Physician Assisted Suicide](#)

Maine Law

Currently, Maine does not have a specific law covering the issue of physician-assisted suicides. Maine does, however, have a law that makes it a crime for any person to aid or solicit another to commit suicide.

- A. A person is guilty of aiding or soliciting suicide if he intentionally aids or solicits another to commit suicide, and the other commits or attempts suicide.
- B. Aiding or soliciting suicide is a Class D crime.

[17-A MRSA §204](#)

(85) Utilization Review (see also Agency Rules Links)**Review entities**

A. Licensure

A person, partnership or corporation, other than an insurer, nonprofit service organization, health maintenance organization, preferred provider organization or employee of those exempt organizations, that performs medical utilization review services on behalf of commercial insurers, nonprofit service organizations, 3rd-party administrators, health maintenance organizations, preferred provider organizations or employers shall apply for licensure by the Bureau of Insurance and pay an application fee of not more than \$400 and an annual license fee of not more than \$100; except that programs of review of medical services for occupational claims compensated under Title 39-A are subject only to the certification requirements of that title and are not subject to licensure under this section. A person, partnership or corporation, other than an insurer or nonprofit service organization, health maintenance organization, preferred provider organization or the employees of exempt organizations, may not perform utilization review services or medical utilization review services unless the person, partnership or corporation has received a license to perform those activities.

B. Listing

The Bureau of Insurance shall compile and maintain a current listing of persons, partnerships or corporations licensed pursuant to this section.

C. Information required

1. Each person, partnership or corporation licensed pursuant to this section shall, at the time of initial licensure and on or before April 1st of each succeeding year, provide the Bureau of Insurance with the following information:
 - a. The process by which the entity carries out its utilization review services. The information provided to the bureau must include the categories of health care personnel that perform any activities coming under the definition of utilization review and whether or not these individuals are licensed in the State. The information provided to the bureau also must include copies of any licensure agreements the utilization review entity has in effect with any entity that sells or furnishes the utilization review entity with medical utilization review criteria and the expiration date of any such agreements. If the utilization review entity develops its own medical utilization review criteria, the utilization review entity shall include copies of any policies and procedures or both for the use of the criteria;
 - b. The process used by the entity for addressing beneficiary or provider complaints;
 - c. The types of utilization review programs offered by the entity, such as:
 - i. Second opinion programs;
 - ii. Prehospital admission certification;

- iii. Preinpatient service eligibility determination; or
 - iv. Concurrent hospital review to determine appropriate length of stay; and
 - d. The process chosen by the entity to preserve beneficiary confidentiality of medical information.
 - e. As part of its initial application, the entity shall submit copies of all materials to be used to inform beneficiaries and providers of the requirements of its utilization review plans and their rights and responsibilities under the plan.
2. Transition for existing entities. Notwithstanding subsection 1, persons, partnerships or corporations performing utilization review services on the effective date of this section shall have 90 days from its effective date to submit an application to the superintendent. The superintendent shall act upon those applications within 6 months of the date of receipt of the application, during which time the review entities may continue to perform medical utilization review services.

[24-A MRSA §2771](#)

Minimum standards

A utilization review program of the applicant must meet the following minimum standards:

A. Notification of adverse decisions

Notification of an adverse decision by the utilization review agent must be provided to the insured or other party designated by the insured within a time period to be determined by the superintendent through rulemaking and must include the name of the utilization review agent who made the decision.

B. Reconsideration of determinations

All licensees shall maintain a procedure by which insureds, patients or providers may seek reconsideration of determinations of the licensee.

C. Accessibility of representatives

A representative of the licensee must be accessible by telephone to insureds, patients or providers and the superintendent may adopt standards of accessibility by rule.

D. Medical utilization review criteria

The licensee must have written medical utilization review criteria to be employed in the review process. The criteria must be available for review as a part of any review conducted pursuant to section 2774, subsection 1 and a copy of the criteria must be provided to the bureau upon request.

E. Information materials; confidentiality.

A copy of the materials designed to inform applicable patients of the requirements of the utilization plan and the responsibilities and rights of patients under the plan and an acknowledgment that all applicable state and federal laws to protect the confidentiality of individual medical records are followed must be filed with the bureau.

F. Penalty for noncompliance with utilization review programs

A medical utilization review program may not recommend or implement a penalty of more than \$500 for failure to provide notification. This subsection does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary.

G. Prohibited activities

A medical utilization review entity shall ensure that an employee does not perform medical utilization review services involving a health care provider or facility in which that employee has a financial interest.

[24-A MRSA §2772](#)**Utilization review services**

As used in this chapter, unless the context indicates otherwise, "utilization review services" or "medical utilization review services" means a program or process by which a person, partnership or corporation, on behalf of an insurer, nonprofit service organization, 3rd-party administrator, health maintenance organization, preferred provider organization or employer that is a payor for or that arranges for payment of medical services, seeks to review the utilization, appropriateness or quality of medical services provided to a person whose medical services are paid for, partially or entirely, by that insurer, nonprofit service organization, 3rd-party administrator, health maintenance organization, preferred provider organization or employer. The terms include these programs or processes whether they apply prospectively or retrospectively to medical services. Utilization review services include, but are not limited to, the following:

- A. Second opinion programs;
- B. Prehospital admission certification;
- C. Preinpatient service eligibility certification;
- D. Concurrent hospital review.

[24-A MRSA §2773](#)**Enforcement**

The following provisions govern enforcement of this chapter.

A. Periodic reviews

The superintendent may conduct periodic reviews of the operations of the entities licensed pursuant to this chapter to ensure that they continue to meet the minimum standards set forth in section 2772 and any applicable rules adopted by the superintendent. The superintendent may perform periodic telephone audits of licensees to determine if representatives of the licensee are reasonably accessible, as required by section 2772.

B. Action against licensee

The superintendent is authorized to take appropriate action against a licensee which fails to meet the standards of this chapter or any rules adopted by the superintendent, or who fails to respond in a timely manner to corrective actions ordered by the superintendent. The superintendent may impose a civil penalty not to exceed \$1,000 for each violation, as permitted by section 12-A, or may deny, suspend or revoke the license.

C. Opportunity to provide information and request hearing

Before taking the actions authorized by this section to deny, suspend or revoke the license, the superintendent shall provide the licensee with reasonable time to supply additional information demonstrating compliance with the requirements of this chapter and the opportunity to request a hearing to be held consistent with the provisions of the Maine Administrative Procedure Act, Title 5, chapter 375.

D. Authority to adopt rules

The superintendent may adopt rules necessary to implement the provisions of this chapter

E. Rulings on appropriateness of medical judgments not authorized

Nothing in this chapter requires or authorizes the superintendent to rule on the appropriateness of medical decisions or judgments rendered by review entities and their agents.

[24-A MRSA §2774](#)**Utilization Review Data**

A. Report required

On or before April 1st of each year, any insurer or 3rd-party administrator which issues or administers a program or contract in this State providing coverage for hospital care that contains a provision whereby in nonemergency cases the insured is required to be prospectively evaluated through a prehospital admission certification, preinpatient service eligibility program or any similar preutilization review or screening eligibility program or any similar preutilization review or screening procedure prior to the delivery of contemplated hospitalization, inpatient or outpatient health care or medical services which are prescribed or ordered by a duly licensed physician shall file a report on the results of that evaluation for the preceding year with the superintendent which shall contain the following:

1. The number and type of evaluations performed. For the purposes of this section, the term "type of evaluations" means the following preutilization review categories: presurgical inpatient days; setting of medical service, such as inpatient or outpatient services; and the number of days of service;
2. The result of the evaluation, such as whether the medical necessity of the level of service contemplated by the patient's physician was agreed to or whether benefits paid for the service were reduced by the insurer;
3. The number and result of any appeals by the patients or their physicians as a result of initial review decisions to reduce benefits for services as determined through prospective evaluations; and
4. Any complaints filed in a court of competent jurisdiction and served upon an insurer filing under this section stating a cause of action against that insurer on the basis of damages to patients alleged to have been approximately caused by a delay, reduction or denial of medical benefits by the insurer, as determined through prospective evaluations, and the determination of liability or other disposition of the complaint.

B. Residents

This section is applicable to evaluations, appeals and complaints relating to residents of this State only.

C. Confidentiality

Any information provided pursuant to this section shall not identify the patients.

[24-A MRSA §2847](#)

Penalty for failure to notify of hospitalization

An insurance policy may not include a provision permitting the insurer to impose a penalty for the failure of any person to notify the insurer of an insured person's hospitalization for emergency treatment. For purposes of this section, "emergency treatment" has the same meaning as defined in Title 22, section 1829.

This section applies to policies and certificates executed, delivered, issued for delivery, continued or renewed in this State after the effective date of this section. For purposes of this section, all policies are deemed to be renewed no later than the next yearly anniversary of the contract date.

[24-A MRSA §2847-A](#)

Notification prior to cancellation

The superintendent shall, by January 1, 1991, adopt rules to provide for notification of the insured person and another person, if designated by the insured, prior to cancellation of a health insurance certificate for nonpayment of premiums, and to provide restrictions on cancellation when an insured person suffers from organic brain disease.

The rules may include, but are not limited to, definitions, minimum disclosure requirements, notice provisions and cancellation restrictions.

The requirements of this section apply to all policies and certificates executed, delivered, issued for delivery, continued or renewed in this State.

[24-A MRSA §-C](#)

Penalty for noncompliance with utilization review programs

A policy or certificate issued or renewed after April 8, 1994 may not contain a provision that permits, upon retroactive review and confirmation of medical necessity, the imposition of a penalty of more than \$500 for failure to provide notification under a utilization review program. This section does not limit the right of insurers to deny a claim when appropriate prospective or retroactive review concludes that services or treatment rendered were not medically necessary.

[24-A MRSA §2847-D](#)

(86) Workers' Compensation

Workers' Compensation in Maine is governed by [Title 39-A](#) of the Maine Revised Statutes. You can also download the [rules](#) applicable to Workers' Compensation from the Maine Workers' Compensation Board.

Entitlement to compensation and services generally

[Title 39-A MRSA, Chapter 5](#) includes the general rules of employee eligibility for Workers' Compensation as well as the role of physicians in providing medical examinations, handling medical information and the medical fee schedule. Chapter 5 of the Workers' Compensation [rules](#) includes more information on medical fee reimbursement levels and physician reporting requirements.

Entitlement

If an employee who has not given notice of a claim of common law or statutory rights of action, or who has given the notice and has waived the claim or rights, as provided in section 301, receives a personal injury arising out of and in the course of employment or is disabled by occupational disease, the employee must be paid compensation and furnished medical and other services by the employer who has assented to become subject to this Act.

Selection of Independent Medical Examiners in Workers' Compensation Cases

Examiner system

The board shall develop and implement an independent medical examiner system consistent with the requirements of this section. As part of this system, the board shall, in the exercise of its discretion, create, maintain and periodically validate a list of not more than 50 health care providers that it finds to be the most qualified and to be highly experienced and competent in their specific fields of expertise and in the treatment of work-related injuries to serve as independent medical examiners from each of the health care specialties that the board finds most commonly used by injured employees. An independent medical examiner must be certified in the field of practice that treats the type of injury complained of by the employee. Certification must be by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or their successor organizations. The board shall establish a fee schedule for services rendered by independent medical examiners and adopt any rules considered necessary to effectuate the purposes of this section.

Duties

An independent medical examiner shall render medical findings on the medical condition of an employee and related issues as specified under this section. The independent medical examiner in a case may not be the employee's treating health care provider and may not have treated the employee with respect to the injury for which the claim is being made or the benefits are being paid. Nothing in this subsection precludes the selection of a provider authorized to receive reimbursement under section 206 to serve in the capacity of an independent medical examiner. Unless agreed upon by the parties, a physician who has examined an employee at the request of an insurance company, employer or employee in accordance with section 207 during the previous 52 weeks is not eligible to serve as an independent medical examiner.

[39-A MRSA §312](#)

See also, Chapter 4, Maine Workers' Compensation Board [Rules](#)

Useful Links and Websites

[Maine's Workers' Compensation Board Web Site](#)

[Workers' Compensation FAQ's](#)

[Facts About Maine's Workers' Compensation Laws](#)

Workers' Compensation and HIPAA

Many physicians and physician practices face this issue on a regular basis. In general, unless restricted by law, a covered entity must disclose protected health information about a patient being examined for a workers' compensation claim without needing an authorization to:

- A. An insurer,
- B. State Workers' Compensation Administrators or
- C. Other persons involved in the workers' compensation system.

Provided that:

- A. The covered entity complies with all relevant federal and state laws; and
- B. The minimum necessary standard is maintained between the covered entity and the receiving party(s).

[45 CFR §164.512 \(L\) and OCR Guidance](#)

(87) Wrongful birth; wrongful life

It is the intent of the Legislature that the birth of a normal, healthy child does not constitute a legally recognizable injury and that it is contrary to public policy to award damages for the birth or rearing of a healthy child.

- A. Birth of healthy child; claim for damages prohibited.

No person may maintain a claim for relief or receive an award for damages based on the claim that the birth and rearing of a healthy child resulted in damages to him. A person may maintain a claim for relief based on a failed sterilization procedure resulting in the birth of a healthy child and receive an award of damages for the hospital and medical expenses incurred for the sterilization procedures and pregnancy, the pain and suffering connected with the pregnancy and the loss of earnings by the mother during pregnancy.

- B. Birth of unhealthy child; damages limited.

Damages for the birth of an unhealthy child born as the result of professional negligence shall be limited to damages associated with the disease, defect or handicap suffered by the child.

- C. Other causes of action.

This section shall not preclude causes of action based on claims that, but for a wrongful act or omission, maternal death or injury would not have occurred or handicap, disease, defect or deficiency of an individual prior to birth would have been prevented, cured or ameliorated in a manner that preserved the health and life of the affected individual.

[24 MRSA §2931](#)

(88) Wrongful Death

Maine law recognizes a cause of action for wrongful death. Damages for the loss of comfort, society and companionship is limited to \$250,000, increased from \$75,000. The cap for non-economic damages has been increased from \$400,000 to \$500,000.

- A. Whenever the death of a person shall be caused by a wrongful act, neglect or default, and the act, neglect or default is such as would, if death had not ensued, have entitled the party injured to maintain an action and recover damages in respect thereof, then the person or the corporation that would have been liable if death had not ensued shall be liable for damages as provided in this section, notwithstanding the death of the person injured and although the death shall have been caused under such circumstances as shall amount to a felony.
- B. Every wrongful death action must be brought by and in the name of the personal representative of the deceased person. The amount recovered in every wrongful death action, except as otherwise provided, is for the exclusive benefit of the surviving spouse if no minor children of the children if no surviving spouse, one-half for the exclusive benefit of the surviving spouse and one-half for the exclusive benefit of the minor children to be divided equally among them if there are both surviving spouse and minor children, and to the deceased's heirs to be distributed as provided in section 2-106 if there is neither surviving spouse nor minor children. The jury may give damages as it determines a fair and just compensation with reference to the pecuniary injuries resulting from the and in addition shall give such damages that will compensate the estate of the deceased person for reasonable expenses of medical, surgical and hospital care and treatment and for reasonable funeral expenses.. In addition, the jury may give damages not exceeding \$500,000 for the loss of comfort, society and companionship of the deceased, including any damages for emotional distress arising from the same facts as those constituting the underlying claim, to the persons for whose benefit the action is brought. The jury may also give punitive damages not exceeding \$250,000. An action under this section must be commenced within 2 years after the decedent's death. If a claim under this section is settled without an action having been commenced, the amount paid in settlement must be distributed as provided in this subsection. A settlement on behalf of minor children is not valid unless approved by the court, as provided in Title 14, section 1605.
- C. Whenever death ensues following a period of conscious suffering, as a result of personal injuries due to the wrongful act, neglect or default of any person, the person who caused the personal injuries resulting in such conscious suffering and death shall, in addition to the action at common law and damages recoverable therein, be liable in damages in a separate count in the same action for such death, brought, commenced and determined and subject to the same limitation as to the amount recoverable for such death and exclusively for the beneficiaries in the manner set forth in subsection (b), separately found, but in such cases there shall be only one recovery for the same injury.
- D. Any action under this section brought against a governmental entity under Title 14, sections 8101 to 8118, shall be limited as provided in those sections.

[18-A MRSA §2-804](#)

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