

Maine medicine



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Frank O. Stred 1931 - 2003

LEESBURG, Fla. - Mr. Frank O. Stred, 72, of Leesburg, Fla., passed away Sunday, Nov. 30, 2003, in Leesburg after a brief illness.

He was born August 8, 1931, in Chambersburg, PA., the son of Frank and Helen Evans Stred.

He is survived by his wife of 48 years, Priscilla of Leesburg, daughters Susan E. Stred of Syracuse, N.Y., and Kristen H. Stred of Seattle, Wash., granddaughter Katherine K. Davis of Seattle, and sister Norma Appel of Chambersburg.

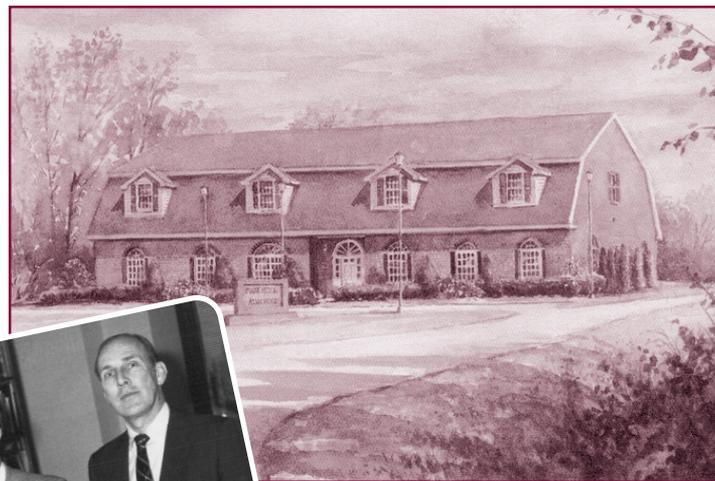
He graduated from Chambersburg High School, held a Bachelor's degree from Bates College, Lewiston, Maine, and a Master's degree from Bradley University, Peoria, Ill.

As a Highland Lakes resident he enjoyed participation in the Musicale Chorus and the Tennis Organization.

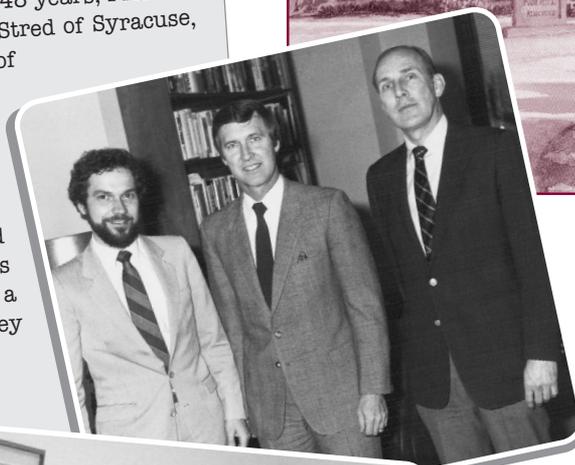
Mr. Stred retired in 1993 from the position of executive vice president of the Maine Medical Association, in Manchester, Maine, where the headquarters is named in his honor. He began his career in association management with the Alumni Association of Bates College, and had also been employed by Central Maine Power Company in Augusta, Maine and the Gorton Corporation of Gloucester, Mass.

Memorial services will be held Wednesday, Dec. 3, at 2 p.m. at Beyers Funeral Home, in Leesburg, Fla.

In lieu of flowers, remembrances can be sent to Hospice of Lake and Sumter, 12300 Lane Park Road, Tavares, FL 32778, Bates College, Lewiston, ME 04240 or the charity of your choice.



The Frank O. Stred building.



From left: Gordon Smith, EVP, Senator William S. Coben, and Frank Stred.



Frank Stred, on right, with Philip Dwyer, D.M.D. of Houlton, Maine Dental Association.

In late November, the Association learned, with great sadness, of the death of our former Executive Vice President Frank O. Stred on November 30, 2003. Frank died in Leesburg, Florida, his home since retiring from MMA in September 1993. Frank had enjoyed an active retirement of travel, tennis, music and many other activities until shortly before his death.

Frank is fondly remembered by members and staff and his legacy carries on through the Frank O. Stred Building in Manchester, MMA's office building. Highlights of Frank's fifteen year tenure included successfully moving the MMA office and staff from Brunswick to Augusta, purchasing and planning for MMA's current office park in Manchester, the establishment of a substantial reserve fund and the publication of the popular Consumers Guide to Medical Care.

To the left is the obituary prepared by Frank's family. Our condolences go out to Frank's wife of 48 years Priscilla, and his daughters Susan E. Stred, MD and Kristen H. Stred, JD.

Robert McAfee, M.D. and Gilbert Grimes, M.D., represented the Association at the Memorial service held in Leesburg.



Maroulla Gleaton, M.D.,
President, MMA

President's Corner

The Malpractice Cloud

Whenever the subject of malpractice hits the newspaper headlines or the cover of *Newsweek*, the focus typically concerns multimillion dollar verdict awards; escalating, exorbitant premiums or lately physicians throwing in the towel in their communities to retire early, limit high risk procedures, or relocate because of the skyrocketing malpractice expense of continuing to practice medicine in their states.

A Harris poll conducted in March of 2002 involving more than 300 physicians online or over the phone were queried about the impact of the fear of litigation on their ability to practice and deliver high quality medical care. The results demonstrate that the fear of a liability suit influences all aspects of healthcare: ordering lab and radiologic tests, prescribing medication, arranging referrals, and honestly discussing adverse events with patients and colleagues.

The fear of litigation is so pervasive that an overwhelming number of physicians (83% in the Harris poll) do not feel that they can trust the current legal system to achieve a fair and reasonable result if they are sued. It is just this widespread distrust that leads many physicians to practice costly (in morbidity and dollars) defensive medicine rather than care based strictly on medical necessity.

Specific questions asked centered around three areas of medical care: "Based on your experience, have you noticed fear of malpractice liability causing physicians to (1) order more tests; (2) prescribe more medications; and (3) make more referrals than they would based on professional judgment of what is medically needed?" In the Harris poll, 94% responded affirmatively to all three questions. One could only surmise that this is excessive costly treatment which ultimately means that some people get too much care exposing them to unnecessary risk while others get too little as funds run out. What a paradox of inefficiency.

With the current MaineCare budget woes, (a lot of other States are in trouble as well) this should be an area of concern to address. One can only hope that in establishing the specifics of Dirigo Health some of these issues of costly duplicative care (i.e., defensive medicine) can be addressed and solved.

A really sad note is that despite all of these extra tests, pills and referrals to avoid malpractice exposure, claims and lawsuits continue to rise. Clearly, more treatment does not necessarily mean less liability exposure. While it is true that the vast majority of claims are disposed of without indemnity payment to a patient, it still is demoralizing and discouraging to the physician/physicians involved and the costs (in terms of both dollars and time) of defending these claims are enormous. It is clear from the literature on the subject that most malpractice lawsuits arise from dysfunctional physician-patient communication in combination with unmet patient expectations from a procedure or treatment course. Increasingly, physicians feel that lawsuits are arising from adverse events and physicians don't always have a lot of control over these events, but they get the blame.

At times, it seems as if plaintiffs have unlimited rights and the accused have none. Doctors are presumed guilty from the get go and need to prove their innocence. Truly outrageous jury awards lend credence that regardless of the facts, doctors risk losing everything they own and have worked hard for when a lawsuit is brought against them. All this has generated the "megabucks" mentality on the part of the "injured" patients spurred on by lawyers who want a huge chunk of the mother lode. Better outcomes lead to more and more unrealistic patient expectations. The incentives in the system are all wrong here. The current system is unfair and in no way helps physicians take better care of patients, which should be the primary focus.

There is a strong movement to conduct scientific and analytic review of medical errors to prevent the errors in the future. Most physicians agree (Harris poll) that open communication and analysis of incidents, adverse events and errors would help to avoid similar mistakes. However, these studies have to be done without fear or repercussion that the studies will not be used against them in court.

By studying complex and sometimes faulty medical systems carefully, there may be opportunities along the way to enhance quality, safety and reduce errors and costs. There needs to be a strong, sustained effort to educate patients and the public in general about the seriousness of the situation. Also there needs to be a shift from fault finding free for alls to systems analyses which will lead to a decrease in adverse events resulting in higher quality, safer healthcare. This is a win-win situation for us all.

Let's hope the Dirigo Quality Forum pays attention.

The results of the Harris poll, as well as other polls relating to medical liability crisis can be found on the Common Good web site at http://cgood.org/medicine/related/item?_id=30218.

Any thoughts, comments or questions can be directed to me, Maroulla Gleaton, M.D., by calling 207-622-3185, faxing 207-622-5697, or emailing gleaton@adelphia.net.

Upcoming Specialty Society Meetings

FEBRUARY 26-28, 2004 *The Grand Summit Hotel - Sugarloaf/USA*

Contemporary Topics in Orthopedics

Contact: Donna Rogers 207-947-8381

MARCH 1-5, 2004 *Sugarloaf/USA*

Maine Medical Center's Emergency Medicine Symposium

Contact: Beverly MacLean 207-842-7046

MARCH 3, 2004 *Sugarloaf/USA*

Maine Chapter - American College of Emergency Physicians

MMA Contact: Anna Bragdon 207-622-3374 or abragdon@mainemed.com

MARCH 6-8, 2004 *The Carrabassett Inn - Sugarloaf/USA*

Maine Section - American College of Obstetricians & Gynecologists

(To be held in conjunction with the Maine Radiological Society)

MMA Contact: Ann Verrill 207-622-3374 or averrill@mainemed.com

MARCH 6-8, 2004 *The Grand Summit Hotel - Sugarloaf/USA*

Maine Radiological Society

(To be held in conjunction with the Maine Section - American College of Obstetricians & Gynecologists)

MMA Contact: Warene Chase Eldridge 207-622-3374 or weldridge@mainemed.com

MARCH 19-21, 2004 *Bethel Inn - Bethel, ME*

Maine Gastroenterology Meeting

MMA Contact: Chandra Leister 207-622-3374 or cleister@mainemed.com

MARCH 26, 2004 *Harraseeket Inn - Freeport, ME*

Topics in Gastroenterology for Primary Care

MMA Contact: Chandra Leister 207-622-3374 or cleister@mainemed.com

MARCH 26 - 28, 2004 *Sugarloaf/USA*

Maine Society of Otolaryngologists Annual Winter Meeting

Contact: Robert Dixon, MD 207-443-4511

APRIL 15-16, 2004 *The Marriott Sable Oakes - South Portland, ME*

Maine Academy of Family Physicians and Maine Psychiatric Association Joint Educational Session

Note: In addition, the Maine Psychiatric Association will hold a general membership meeting on Friday evening, 4/16.

MMA Contact: Warene Chase Eldridge 207-622-3374 or weldridge@mainemed.com

MAY 7, 2004 *The Harraseeket Inn - Freeport, ME*

Maine Society of Eye Physicians and Surgeons - The Eye MDs Spring Meeting

12:00pm - 4:30pm

MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

MAY 8-9, 2004 *Samoset Resort - Rockport, ME*

Maine Chapter, American Academy of Pediatrics Spring Conference

MMA Contact: Chandra Leister 207-622-3374 or cleister@mainemed.com

MMA Welcomes

Our Newest Corporate Affiliates:

Avasa Systems	Maine Bank & Trust
DiGiorgio Associates	Medifax/EDI
Inc./Monitor Builders Inc.	Merrill Lynch
EBSCO Reception Room	New England
Subscription Services	Compounding Center
Gross, Minsky & Mogul, P.A.	New England Health Search Inc.
Johnson and Johnson	Noyes & Chapman Insurance
Kilbride & Harris Insurance	Transco Business Technologies
Services, LLC	

We appreciate their support!

MMA wishes to thank the following donors to the Sesquicentennial Gala Silent Auction.

AFLAC of Maine	Hurley Travel Experts	The Balsams Grand Resort Hotel
A.G. Edwards & Sons	Innovative Network Solutions	The Thomas Agency
Airborne Express	LightShip Telecom	UGI Financial
Bangor Savings Bank	Maine Gold and Silver	Van Meer and Belanger, P.A.
The BC Group	Maine Bank and Trust	Verrill & Dana, L.L.P.
BCR - Business Communications Resources	Marriott- Sable Oakes- South Portland	Wyoming Medical Society
Boise Office Solutions	McCandless Epstein & O'Donovan, L.L.P.	The Fairmont Algonquin
Cunningham Security Systems	McDonald, Page, Schatz, Fletcher & Co.	The Coding Center
Curtis, Thaxter, Stevens, Broder & Micoleau, LLC	MedBill Resources	Portland Saab
DiGiorgio Associates, Inc./Monitor Builders, Inc.	MMIC Media	Portland Volvo
The Flower Spot	Orthopedic Associates	Performance Motors
General Linen	PayChex, Inc.	Standard Register
Hannaford Brothers	Plastic & Hand Surgical Associates	
Healthcare Management Associates	Portland Headlight Audio/Visual	
Health Care Marketing	Portland Professional Pharmacy	
Holiday Inn by the Bay	Robinhood Free Meetinghouse	
	Swiss Time Watch and Clock Repair	
	Tess Gerritsen, M.D.	

Thanks for making it such a success



UPCOMING AT MMA

FEBRUARY 10, 2004

9:00am

Physician Practice Management Forum

1:30pm - 3:00pm
"Stop Stroke"

6:00pm
Legislative Committee

FEBRUARY 18, 2004

6:00pm

Payor Liaison Committee

FEBRUARY 19, 2004

8:30am - 4:30pm

Home Care Alliance

6:00pm
Maine Psychiatric Association

FEBRUARY 23, 2004

5:30pm

Hospice Planning Meeting

FEBRUARY 24, 2004

1:00pm

Hospice Planning Meeting

FEBRUARY 25, 2004

4:00pm

Public Health Committee

FEBRUARY 26, 2004

9:00am

Home Care Alliance

MARCH 8, 2004

5:30pm

Committee on Physician Health

MARCH 9, 2004

6:00pm

Legislative Committee

MARCH 16, 2004

8:00am

Infection Control Officers

MARCH 17, 2004

2:00pm

Executive Committee

MARCH 18, 2004

8:30am

Home Care Alliance

APRIL 6, 2004

6:00pm

American Academy of Pediatrics,
Maine Chapter

APRIL 7, 2004

4:00pm

Public Health Committee

MMA WELCOMES THE FOLLOWING NEW MEMBERS

MARESSA ALEJANDRO, M.D., 189 Academy Street, Apt 3, Fort Fairfield, ME 04742. M.D. from Ponce School of Medicine, Ponce, Puerto Rico. *Internal Medicine.*

SALLY D. HALEY, M.D., 93 Church Road, Brunswick, ME 04011-7306. M.D. from Uniformed Services University of the Health Sciences, Bethesda, MD. *General Practice.*

MICHAEL A. JOHNSON, M.D., 885 Union Street, Suite 120, Bangor, ME 04401. M.D. from University of Virginia School of Medicine, Charlottesville, VA. *Ophthalmology.*

STANLEY J. RUSSIN, JR., M.D., 22 Bramhall Street, Portland, ME 04102. M.D. from Hahnemann University School of Medicine, Philadelphia, PA. *Internal Medicine.*

MAHENDRA R. SHETH, M.D., 140 Academy Street, Suite 5, Presque Isle, ME 04769. M.D. from Medical College MS University of Baroda, Baroda, India. *General Surgery.*

SUSAN A. SPECKHART, M.D., 100 Campus Drive, Unit 107, Scarborough, ME 04074. M.D. from University of Tennessee, Memphis, College of Medicine, Memphis. *Hematology.*

Resident Members:

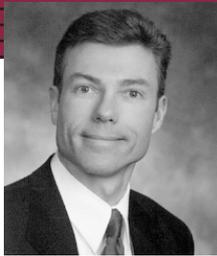
JEFFREY HUGH DONALDSON, M.D., 22 Bramhall Street, Portland, ME 04102. M.D. from Ohio State University College of Medicine, Columbus, OH. He is a resident at Maine Medical Center.

ROBINSON M. FERRE, M.D., 22 Bramhall Street, Portland, ME 04106. M.D. from Medical College of Wisconsin, Milwaukee, WI. He is a resident at Maine Medical Center.

MICHELLE R. SICARD, M.D., 18 West Street Unit #1, Freeport, ME 04032. M.D. from Tufts University School of Medicine, Boston, MA. She is a resident at Maine Medical Center.

TAMARA N. TODD, M.D., 22 Bramhall Street, Portland, ME 04102. M.D. from Louisiana State University School of Medicine in New Orleans, New Orleans, LA. She is a resident at Maine Medical Center.

LEGISLATIVE UPDATE



Andrew MacLean, Esq.

Legislators Confront Yet Another Mainecare Budget Deficit as the Second Regular Session Begins

The Baldacci Administration proposes a series of revenue transfers and cuts in DBDS/DHS spending in FY 04 through emergency administrative rules and a budget bill, L.D. 1828, to address a budget deficit of more than

\$100 million – physician and patient advocacy leads to withdrawal of proposals to limit patient visits to hospitals, federally-qualified health centers, and rural health clinics, to eliminate coverage for some elective surgeries such as gastric bypass procedures, and to reduce reimbursement for children's EPSDT visits.

The 121st Legislature's second session opened on January 7, 2004 and the pace of legislative activity has been brisk during the first month as members look forward to adjournment in late March or early April. Many of the new bills approved for introduction to the second session were printed and referred to committees on the first or second day of legislative activity. The committees have deadlines to finish work on bills carried over from the first session in January and to complete work on second session bills by March 12, 2004.

The Appropriations and Health & Human Services Committees devoted the week of January 12th to public hearings on the painful cuts proposed in health care, mental health and mental retardation, and other social service programs. Appropriations work sessions began during the week of January 19th and ground to a halt during the last week of January because of a dispute over a proposed \$8.5 million (approximately \$25 million with federal match) cut to Maine hospitals and the \$53 million in seed money for the Dirigo Health Plan. Reacting to legislative objections to the proposed hospital cut, the Governor proposed an alternative "tax and match" scheme designed to raise \$14-16 million and to reduce the hospital cut to approximately \$2.5 million. Democrats in the Legislature appear to be willing to accept this proposal. On the other hand, Republicans object to both the hospital proposals and have expressed concern about the sustainability of Maine's recent expansions of the MaineCare program, including the Dirigo Health Plan. They have suggested that the Governor put the Dirigo Health Plan on hold and use the seed money to address the budget deficit.

While the MMA is concerned about the likely impact of this budget, we are relieved that the Baldacci Administration spared physicians from an across-the-board reduction in reimbursement and avoided further diversions from the *Fund for a Healthy Maine*. The Governor will propose and the Legislature will have to wrestle with a second supplemental budget - for State FY 05 - later this session. Balancing the 2005 budget will be even more difficult and may force policymakers to consider some new revenue sources, such as an increase in the cigarette excise tax.

In legislative action on substantive bills, the Business, Research & Economic Development Committee is poised to recommend passage of bills expanding the scope of

practice of acupuncturists (L.D. 263) and authorizing pharmacists to dispense emergency contraception (L.D. 1152). In early January, an infertility treatment mandate bill (L.D. 213) was defeated 113-25 in the House and 19-13 in the Senate. Two more mandated health insurance benefit bills will be considered this session – a very difficult environment for health insurance mandates.

The most significant new bill submitted in the second session is Senator Michael Brennan's (D-Cumberland) L.D. 1713, *Resolve, to Establish the Commission to Study Access to Prescription Medication for Persons with Mental Illness*, a bill that asks whether prescribing authority should be extended beyond physicians to other mental health providers. This bill is scheduled for a public hearing before the Health & Human Services Committee on Tuesday, February 10, 2004. The Maine Medical Association strongly opposes granting prescriptive authority to non-physicians.

Following the recommendations of a gubernatorial task force appointed last year, Governor Baldacci is expected to submit a bill later this session to combine the Department of Behavioral & Developmental Services (DBDS) and the Department of Human Services (DHS). If this proposal is accepted by the Legislature, the MMA will work with other health care and public health organizations to ensure that the role of the State Health Officer, the Director of the Bureau of Health, is not too far removed from the Commissioner and the Governor in the hierarchy to have appropriate influence on the State's health care and public health policy.

Three major initiatives are highlights in the regulatory arena. The Dirigo Health Board of Directors and the four other boards or commissions established in the Dirigo Health Plan legislation (L.D. 1611) have been pursuing their missions since late last year. The Dirigo Health Board expects to issue its request for proposals (RFP) for participating health plans in mid-February. Also, the MMA continues to work with the Maine Osteopathic Association and DHS officials to work out the issues of concern to physicians with the MaineCare preferred drug list (PDL). Some time during the first quarter of this year, MMA expects DHS to announce criteria for exempting physicians from the prior authorization requirement. Finally, in a rulemaking proceeding before the Workers' Compensation Board that began last year, a representative of Hannaford Brothers has urged the Board to cut the conversion factor used in the fee schedule since 1995 from \$60 to \$49.10. The management members of the Board have expressed support for this initiative while the labor members have opposed it because they are concerned about the impact on access. This will remain an issue before the Board for the foreseeable future.

During the legislative session, the MMA publishes, by e-mail, a weekly legislative update called "Political Pulse." To subscribe, go to www.mainemed.com and visit the Legislative and Regulatory Advocacy section of the site.

You will find more information about the 121st Maine Legislature on the web at <http://janus.state.me.us/legis>. You can review bill or amendment text and check the status of any bill at this site by going to "Session Information" and "Bill Status Search." To review the complete list of legislative committee assignments, go to <http://janus.state.me.us/house/commlist.doc>.

The MMA welcomes your participation in our legislative advocacy activities. For more information, contact Andrew MacLean, General Counsel & Director of Governmental Affairs at amaclean@mainemed.com.

MMA and AMA Partner to Support Physicians in the Courtroom

The Maine Medical Association has participated in a joint venture between the American Medical Association and several state medical societies known as the "Litigation Center" since its establishment in the early 1990s. Participating medical societies formed the Litigation Center to complement organized medicine's advocacy in the legislative and regulatory arenas with support for the interests of physicians and patients in our civil justice system.

AMA President Donald J. Palmisano, M.D., J.D., a Litigation Center Executive Committee member, says, "It is crucial that organized medicine apply its resources to advocate for the best interests of patients and physicians in every arena. The Litigation Center's work in the courts is on the cutting edge of this important mission."

The Litigation Center has assisted physicians and their patients in 62 cases across the country in both trial and appellate courts during the past two and one-half years. These cases have involved physician and patient rights with respect to health plan practices and "medical necessity" determinations, managed care coverage restrictions, professional liability and clinical trials, peer review, Medicaid funding, medical staff integrity, and medical society advocacy. The Litigation Center assists in these cases through *amicus* briefs, participation as a party in the lawsuit, and financial or technical support.

The Litigation Center has had success in two recent U.S. Supreme Court rulings. In these two important managed care cases, the Court adopted the position advocated by the Litigation Center. In *Rush Prudential HMO, Inc. v. Moran*, the Court upheld the Illinois independent review process for determinations of medical necessity. In *Kentucky Association of Health Plans, Inc. v. Miller*, the Court determined that Kentucky's "any willing provider" law was not pre-empted by existing federal law. The Employee Retirement Income Security Act of 1974 (ERISA) pre-empts state laws that relate to any employee benefit plan. However, the Court found that the Kentucky law was "saved" from pre-emption because it regulates insurance. These two cases are key victories in the states' efforts to regulate managed care.

The Litigation Center has been involved in important cases in northern New England as well. The Center participated in the highly-publicized battle by the Exeter, New Hampshire hospital medical staff to establish its independence from the hospital administration. Also, the Center has assisted in a Maine case seeking to define the scope of the peer review privilege in our state. MMA EVP Gordon Smith was a founding member of the Executive Committee of the Litigation Center and served as its Vice-Chairman for two years and its Chairman for two years. All fifty state medical societies currently join with the AMA to fund the Litigation Center.

Biotechnology in Maine - a mixed reception

By Douglas R. Johnson, Ph.D., Executive Director, Maine Biotechnology Information Bureau

To physicians, biotechnology is a familiar word. The first pharmaceutical product from biotechnology - human insulin - was introduced in 1982. More than 155 biotechnology-derived drugs and vaccines are now on the market. Biotech products are well accepted by both physicians and patients.

Now, biotechnology is transforming agriculture. The first biotech crop, a tomato with improved shelf life, was introduced in 1992. Since then, 56 biotech crops have been introduced in the U.S.

But unlike in medicine, biotech in agriculture has opponents. Though small in number, they are well organized and use the media to frighten consumers. For example, activists warned that StarLink corn, a biotech animal feed that mistakenly entered the food supply, was allergenic. It wasn't. The result is a confused public.

In the event your patients may voice concerns, here is a primer on biotech in agriculture.

The ability to precisely relocate genes has allowed researchers to bypass selective breeding and give plants new agronomic traits directly. Corn and cotton varieties that resist insects have been developed as have soybeans and corn that resist herbicide damage. Last year, 80 percent of the soybeans, three-fourths of the cotton and more than one-third of the corn planted in the U.S. were biotech varieties.

In the pipeline are crops with enhanced nutritional qualities, like Golden Rice with extra vitamin A to help prevent blindness in developing countries. A virus-resistant sweet potato for Africa is also undergoing field tests. Down the road are foods that deliver vaccines, more healthful oils and field crops engineered to produce large quantities of pharmaceutical products, inexpensively.

In the early 1980s, U.S. regulators established a "coordinated framework" to regulate biotech crops. As a result, biotech crops receive an unprecedented level of scrutiny from the Environmental Protection Agency, the Department of Agriculture and the Food and Drug Administration. Not one single adverse reaction to biotech foods has ever been reported. Scientific and medical groups, including the American Medical Association, have given biotech foods a clean bill of health.

Yet in Maine, opposition has been intense. Maine was the first (and to this day only) state to deny approval to a biotech crop - insect resistant corn. An experimental crop of biotech corn being grown at the University of Maine was destroyed. In the legislature, proponents and opponents of biotech regularly battle over laws to limit the technology. One law would have banned biotech crops in Maine altogether. The result is that Maine farmers are being denied technology that last year boosted farm income by \$2.5 billion and cut pesticide use by 163 million pounds.

Three years ago, the debate over crop biotech in Maine had gotten so polarized and information reaching the public through the press so inaccurate that we incorporated the Maine Biotechnology Information Bureau as an educational nonprofit. Since then we've been busy talking with reporters, appearing on television and radio and speaking before civic groups.

Maine's natural resource-based industries - forestry, farming and aquaculture - stand to benefit greatly from biotechnology. Maine's cold climate and short growing season can be offset by biotech enhanced crops. But for that to happen, Mainers will have to coalesce to support crop biotech just as it has medical biotech.

If you would like more information about the Maine Biotechnology Information Bureau or would like to receive our free biweekly e-mail newsletter, which covers Maine's biotech sector, send an e-mail to info@mainebioinfo.org.

Public Health Corner

Do you know of a stroke survivor support group in your community? If so, please email abragdon@mainemed.com or call Anna at 622-3374. We are helping the Stop Stroke Coalition develop a master list.

Blood Donors Needed; Reminder of Criteria

Many times potential blood donors ask their physicians if they are eligible to give blood. Recently, the Blood Services Division of the New England Region of the American Red Cross asked MMA to remind members of the current criteria for eligibility.

To be eligible, donors must:

- be 17 years of age or older
- weigh 110 pounds or more
- be in general good health and not have a history of hepatitis or other potentially infectious disease.

There is no upper age limit and most medications do not preclude a person from donating. Should you have a question regarding patients' eligibility to donate, you may call Richard Benjamin, MBChB, PhD, Chief Medical Officer of the New England Region of the American Red Cross at 1-800-462-9400 ext. 2222 or e-mail him at Benjaminr@usa.redcross.org.

This year alone, Maine patients will require 50,000 units of red cells. Members of the public are encouraged to call 1-800-GIVE-LIFE to obtain further information about donating blood, or to schedule an appointment to donate blood.

As of January 28, 2004, all people who come to donate blood at an American Red Cross location will be required to present positive identification before they can donate. Volunteer donors can use a government-issued picture identification, like a driver's license, or an American Red Cross donor card to positively identify themselves. If the donor does not have either one of those identifications, then he/she must present two other means of acceptable identification.

Ethics Note: Peer Review

Review of a physician's or other health care professional's patient care by a group of his or her professional peers long has been an accepted means of ensuring that the public receives the best medical care possible. Under Maine law, the process of peer review is known as a "professional competence review activity," defined at 24 M.R.S.A. §2502(4-B). You can view this definition online at <http://janus.state.me.us/legis/statutes/24/title24sec2502.html>. You can view the confidentiality provisions applicable to peer review activities in Maine at <http://janus.state.me.us/legis/statutes/24/title24sec2510-A.html>. The AMA Code of Medical Ethics provides brief comments on peer review in Opinion 9.10, Peer Review. You can view the ethics opinions on the AMA web site at http://www.ama-assn.org/apps/pf_online/pf_online. Go to "Ethical Opinions" and then "E-9.00, Opinions on Professional Rights and Responsibilities."

MAINE MEDICAL ASSOCIATION

30 Association Drive
P.O. Box 190
Manchester, ME 04351
207-622-3374
1-800-772-0815
Fax: 207-622-3332
info@mainemed.com
www.mainemed.com

NEWSLETTER EDITOR

Richard A. Evans, M.D.
207-564-0715
Fax: 207-564-0717
raevans95@earthlink.net

PRESIDENT

Maroulla S. Gleaton, M.D.
207-622-3185
Fax: 207-622-5697
gleaton@adelphia.net

PRESIDENT-ELECT

Lawrence B. Muttty, M.D.
207-326-4637
Fax: 207-326-8352
muttys@hypernet.com

EXECUTIVE VICE PRESIDENT

Gordon H. Smith, Esq.
207-622-3374
Fax: 207-622-3332
gsmith@mainemed.com

Information in this newsletter is intended to provide information and guidance, not legal advice.

Since exact language and definitions of key terms are critical to understanding the requirements of legislation, rules or laws, we encourage you to read each carefully. Articles submitted to Maine Medicine represent the views of the author only and do not necessarily represent MMA policy.



Jana Purrell, CPC

When can we use the 99211 Level I evaluation and management code?

This is one of our most frequently asked questions. This service is often referred to as a "nurse visit". There are times when you can bill for a visit in addition to a diagnostic test or an injection performed in your office by a non-physician. There are also times when you can bill for a service provided by auxiliary staff. We refer to this as an "incident to" service meaning that it is being provided incident to the physician's service.

You can find the "incident to" rules at: http://www.cms.hhs.gov/manuals/14_car/3b2049.asp#_2050_1

Let's define a few things:

Auxiliary personnel — Any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician. This can include technician, nurse, medical assistant, or aide.

Direct supervision — Direct supervision in the office setting does not mean that the physician must be present in the same room. However, the physician must be present in the office suite and immediately available throughout the time the service is being performed.

When we talk about "physician" in this context we include physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, and clinical psychologist. Direct supervision may be provided by any of these providers.

To use the "99211" code there needs to be documentation to support the use of a visit code and there needs to be clear medical necessity for the visit. There should be a chief complaint, a brief element of history, exam, and/or decision making to indicate that "evaluation and management" took place. If the patient is coming in solely for the test or injection and that is the only service rendered, do not bill for a separate visit. However, if it is necessary to review the patient's history, take vital signs, and comment on the care plan, bill 99211 with the -25 modifier in addition to the supply, injection or diagnostic test.

Example #1: CC: Patient here for weekly blood pressure check
Patient feels well. No complaints of headache or dizziness.
BP: Left arm-140/80 Right arm-144/84
Continue diet and exercise program. Check BP next week. Keep appt with Dr. Jones on 3/4/04.
Bill 99211

Example #2: CC: Patient here for protime check
Patient complains of frequent headaches and has noticed increase fatigue.
BP: Left arm-134/90 Right arm-130/84
Discussed with PA. Protime drawn this morning. Continue meds as prescribed. Dr. Smith will call patient this afternoon with results
Bill 99211 and 85610

Caution here: It is important to ask yourself if doing the "extra work" necessary to bill for the visit is being done for medical necessity and not just to bill for the nurse time.

There needs to be documentation from the physician outlining the orders for the service and the supervising physician should sign off on the note. Remember the ordering physician is not always the supervising physician. It is important for the services to be billed under the supervising physician.

And primarily, there has to be direct supervision. This means that the supervising physician has to be in the building—not on his/her way to the office, not in the hospital, not at home.

A reminder that "incident to" rules apply to Medicare. Be aware that 3rd party payors may have different requirements for the reporting of services for non-physician providers that are not credentialed with them. Be sure to check with payors before billing for the services of auxiliary staff.



By Jana Purrell, CPC, Coding/Reimbursement Specialist
Maine Medical Association/NH Medical Society/VT Medical Society
Tel: 888-889-6597, jpurrell@thecodingcenter.org
ldesjardins@thecodingcenter.org

When Your Patients Have Problems With Their Health Insurance

The Maine Bureau of Insurance, Consumer Health Care Division (CHCD) is available to help consumers with health insurance information and complaints. In 2002, CHCD assisted over 7,250 callers by answering their questions and informing them of their rights. These rights include the right to: apply for a standing referral from the primary care practitioner when a condition warrants ongoing care from a specialist, appeal decisions made by the health insurance carrier when the company denies a requested benefit, to know the name, title and qualifications of persons making medical decisions about them at the insurance company, to have assistance from the Bureau of Insurance when they disagree with the insurance company.

Bureau of Insurance regulations for fully funded insurance plans provide for two appeal levels with the insurance carrier and a third appeal level called "external review" for medical necessity denials. Either the healthcare provider or the consumer can request a first level appeal following an adverse determination (denial for coverage) by a carrier. Only the consumer or their representative can request a second level appeal or an external review. The second level appeal differs from the first in that the issues are reviewed by a different medical peer and there is opportunity for the consumer to attend a hearing if they so choose. The external review is conducted independent of the insurance company and consumers can also request a hearing which is conducted by telephone. The three levels of appeal provide the consumer multiple opportunities to present their case and to be heard by three different review groups or entities.

We encourage consumers to utilize the appeals process if they disagree with the insurance company's decision and we encourage them to submit a complaint form to the Bureau of Insurance so that we can assist them in knowing their rights.

Any questions or complaints regarding health insurance can be called in or mailed to:

Consumer Health Care Division
Maine Bureau of Insurance
State House Station 34, Augusta, Maine 04333
Tel. 1-800-300-5000

Check out the website at: www.maineinsurancereg.org
for helpful information on all types of insurance

MMA wants to hear from you!

Issues or concerns you would like to see addressed by the MMA:

Please provide your name and telephone number or e-mail address so that we may contact you if clarification or further information is needed.

Name: _____

Telephone: _____

E-mail: _____

Return to MMA via fax at 207-622-3332. Thank you!



Consumer Information Statute

Governor John E. Baldacci recently wrote to Maine physicians reminding them of the requirements of 24 MRSA Section 2987 which requires all health care practitioners to notify patients in writing of their charges for health care services commonly offered. This provision was included in the Dirigo Health legislation and applies to all licensed health professionals, not just physicians. Hospitals have a similar statute found elsewhere in the Dirigo Health law.

The provision does not state how many different services have to be listed, nor does it state how the patients are to be notified. You may, for instance, choose to post the charges in your waiting area. The provision was effective last Sept., when the rest of the Dirigo law became effective. The provision is one of several in the statute intended to inform patients of the costs of medical care. The theory behind these provisions is that with third party payments being so prevalent, consumers have lost touch with the true cost, and value, of the care they receive. There are also some legislators who believe that consumers will actually compare prices when they seek care.

MMA attorneys Andrew MacLean and Gordon Smith are able to help members determine how they would like to comply with the provision. The exact language of the provision follows:

§2987. Consumer Information

A health care practitioner shall notify patients in writing of the health care practitioner's charges for health care services commonly offered by the practitioner. Upon request of a patient, a health care practitioner shall assist the patient in determining the actual payment from a 3rd party payor for a health care service commonly offered by the practitioner. A patient may file a complaint with the appropriate licensing board regarding a health care practitioner who fails to provide the consumer information required by this section.

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