JANUARY/FEBRUARY 2005

Maine medicine

MAINE MEDICAL ASSOCIATION

In this issue...

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Each Monday, Maine Medicine *Weekly Update* keeps physicians and practice managers in the loop with breaking news – by fax or e-mail only. It's a free member benefit – call **622-3374** to subscribe.

Penobscot County Medical Society 150th Anniversary Celebration

At a gala event on September 18, 2004, the Penobscot County Medical Society celebrated its 150th Anniversary, honoring several physicians in Northern and Eastern Maine. Nearly two hundred guests joined together at the Maine Center for the Arts in Orono for what turned out to be a very special evening recognizing some very special physicians.

Lower Left: MMA Vice President and General Counsel Andrew MacLean presents Sesquicentennial Recognition Award to Robin Pritham, MD, in recognition of his grandfather "Doc" Pritham.

Lower Right: Mr. MacLean presents Sesquicentennial Recognition Award to D. Joshua Cutler, MD, in recognition of his father, Lawrence Cutler, MD.

Upper Left: Mr. MacLean presents Sesquicentennial Recognition Award to "Noni" MacBride in recognition of her late husband, Robert MacBride, MD.

Upper Right: Mr. MacLean presents Sesquicentennial Recognition Award to George Wood, III, MD, of Orono. Dr. Wood is a former MMA President and AMA Delegate.

Governor Baldacci Proposes $18 Million MaineCare Physician Fee Increase

After patiently waiting for over twenty years, Maine physicians may finally see a material increase in MaineCare reimbursement. In releasing his proposed two-year budget in January, Governor John Baldacci included three million state dollars in each year to be matched by six million federal dollars for the fee increase. The Bureau of Medical Services has also announced its intentions to convert the MaineCare fee schedule to a resource-based RVS using the values utilized by Medicare. MMA favors this approach. In the days leading up to the budget announcement, MMA and Maine Osteopathic Association representatives met with the Governor and MaineCare staff several times to advocate, in the strongest possible terms, for an increase.

In addition to MMA's advocacy efforts, concern about lack of access for the expanding MaineCare population no doubt played an important role in the Governor's decision.

Being in the proposed budget is a good start, but the budget still has to be passed by the legislature and there are certain to be many other interest groups and advocates who would prefer to see the eighteen million dollars go elsewhere. Please call your legislators today and tell them how important it is for Maine physicians taking care of MaineCare patients to receive this modest increase after flat funding for over twenty years.

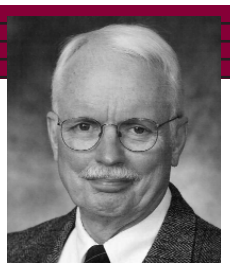
Based upon research by the Muskie School two years ago, it is estimated that the eighteen million dollar increase could bring most MaineCare fees up to at least 60% of Medicare fees.

The budget proposed $5.7 billion in spending over the two-year period beginning July 1, 2005. In order to help cover a projected $733 million gap between projected revenues and expenses without raising taxes, the budget significantly cuts state spending in some areas, including MaineCare and raises fees and fines.

Proposed cuts in MaineCare include:

- Redesigning MaineCare coverage for non-categorized adults by eliminating some services and limiting others.
- Redesigning the Community Mental Health Service Program by implementing a capitated reimbursement system for community integration services.
- Reducing medical costs by implementing primary care enforcement of seatbelt usage.
- Implementing disease management of A-typical anti-psychotic drugs.
- Establishing a multi-state purchasing pool for prescription drugs and group purchasing of generic drugs.
- Reducing estimated growth to 8% per year in each year of the biennium based on previously approved cost containment initiatives.

President's Corner



Lawrence B. Mutty, M.D.,
President, MMA

The Case for Solidarity

Emblazoned on the flag of Haiti is the motto "L'Union Fait La Force," i.e., There is Strength in Unity. Unfortunately, that Nation has been riven with disunity since it achieved independence in 1804, including 30 revolutions or coups d'etats. The historian Arnold Toynbee cited the historic axiom that, as in the case of the Greek City States, those political entities that failed to join forces in a larger coalition when circumstances required, were doomed to irrelevance and dissolution.

The medical profession, as never before, is ground between upper and nether millstones. From above by government regulation, insurance company and managed care caprice; from below by an increasing proportion of the public, unable to access nor afford care and by other helping professions who aspire to expand their scope of practice into areas formerly reserved to those with full medical training.

I submit that the time is plainly at hand when, in addition, and complementary to specialty society membership, full participation in the Maine Medical Association is emergently necessary. You may be surprised, if not chagrined, to learn that, at present, only 55-60% of physicians practicing in Maine are MMA members!

We all appreciate that the great majority of the signal successes enjoyed by physicians and patients in this State have been won by the Maine Medical Association. This has been achieved by those of your colleagues in the MMA and by the full time staff, who have stoutly and faithfully bent their backs to the oars throughout many a Force 10 gale. But now, might one say, there is a Tsunami coming, and fast! Be aware that in this 122nd session of the Maine State Legislature, there are no less than 126 bills concerning health care. Everyone must turn to in order to avoid the deluge.

Please urge your colleagues to contact the office of our EVP Gordon Smith at 207-622-3374 or gsmith@mainemed.com, and request to join the MMA now. Ask them to specify their interest in a committee assignment which is the mechanism by which our agenda is set. Have them consider, for example, the Legislative, Public Health, Payor Liaison, Quality Improvement, or the Member Benefits Committee. Please also consider the MMA's Hospital Medical Staff Section, which is concerned with the tenets of medical staff self governance, the integrity of the patient-physician relationship and the development and implementation of patient care and safety standards and policies.

Every accommodation possible with respect to MMA dues payment will be made.

Any thoughts, comments or questions can be directed to me, Lawrence Mutty, M.D., by calling 207-326-4637, faxing 207-326-8352, or emailing lmutty@verizon.net.

Upcoming Specialty Society Meetings

FEBRUARY 12-13, 2005 *Sugarloaf, USA*
Maine Society of Anesthesiologists Meeting
Contact: Anna Bragdon 207-441-5989 or MSAinfo@adelphia.net

MARCH 3, 2005 *Sugarloaf, USA*
American College of Emergency Physicians, Maine Chapter
MMA Contact: Ann Verrill 207-622-3374 or averrill@mainemed.com

MARCH 4-6, 2005 *Mt. Washington Hotel – Bretton Woods, NH*
Maine and New Hampshire Radiological Society Meeting
MMA Contact: Warene Eldridge 207-622-3374 or weldridge@mainemed.com

MARCH 11-13, 2005 *Bethel Inn and Country Club - Bethel, ME*
Maine Gastroenterology Society Meeting
MMA Contact: Chandra Leister 207-622-3374 or cleister@mainemed.com

APRIL 1, 2005 *Harraseeket Inn - Freeport, ME*
Maine Society of Eye Physicians and Surgeons Spring Meeting
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

APRIL 29, 2005 *Harraseeket Inn - Freeport, ME*
Maine Gastroenterology Society Meeting *"Topics in Gastroenterology for Primary Care"*
MMA Contact: Chandra Leister 207-622-3374 or cleister@mainemed.com

MMA Names Heidi M. Lukas, CPA as Finance Director

MMA is pleased to announce the hiring of Heidi M. Lukas, CPA as MMA's Finance Director. Heidi lives in Poland, ME and comes to us from CommTel, a telecommunications company based in Winthrop where she worked in finance for five years. From 1992 to 1997 she served as Director of Finance and Administrative Operations for NorDx, an affiliate of Maine Medical Center. From 1987 to 1992 she worked for KPMG in Virginia as a Supervising Senior Accountant/Auditor.

Heidi received her undergraduate degree at the University of Maine and an M.S. in accounting at Old Dominion University. She is a licensed Certified Public Accountant and a member of the AICPA and the Maine Society of CPAs.

The position of Finance Director is a new position necessitated by MMA's growth, its relationship to the two 501 (c) 3 foundations and the increasing complexity of managing a non-profit organization and a dozen specialty societies.

Heidi will be responsible for all finance and accounting functions at MMA and will also be responsible for the financial aspects of the Maine Medical Education Trust and the Maine Medical Education Foundation. Ann Verrill, who previously handled bookkeeping, will continue with MMA in the capacity of specialty society coordinator. Ann will be responsible for the Maine Section of the American Society of Obstetrics and Gynecology, the Maine Urological Society, the Maine Chapter of the American College of Emergency Physicians, the MMA Public Health Committee and will assist with the Annual Session and special projects.

Heidi began her duties with us on Monday, January 3rd. We welcome her to MMA and look forward to having her as a strong member of our management team.

PUBLIC HEALTH CORNER

Save The Date:

152nd Annual Session

Educational Theme: *"Emerging Infectious Disease"*

Volunteers and suggestions for the program are welcome.
Course Director: Jo Linder, M.D.

September 9-11, 2005

The Harborside Hotel and Marina – Bar Harbor, ME
For more information contact: Gordon Smith at gsmith@mainemed.com

Your Opinion Matters!

If you haven't done so already, please take 60 seconds out of your day and complete MMA's Communications Survey which was included in the November/December issue of Maine Medicine.

Can't find your survey? Fill it out on-line at www.mainemed.com or call the MMA office at 622-3374 for a new copy.

JUNE 6, 2005

MAINE MEDICAL ASSOCIATION SECOND ANNUAL CHARITABLE GOLF TOURNAMENT

The Dan Hanley Memorial Trust

2004 Health Care Leadership Forum

Report on Proceedings

The Dan Hanley Memorial Trust, founded in 2003 in honor of the work of Dan Hanley, M.D. past Executive Director of the Maine Medical Association, has recently released a report on Proceedings of the 2004 Hanley Health Care Leadership Forum.

The Hanley Forum provides a high-level but neutral arena in which top health leaders are encouraged and supported to forge substantive agreements about policy, collaboration, and resources. The 2004 Forum focused on developing a Maine collaborative model for adopting and implementing screening and risk factor reduction guidelines as they are released nationally for implementation. Fifty statewide participants represented payers, hospitals, practitioners, health care delivery systems, public health groups and community-based coalitions, state agencies, employers, health educators, and quality assurance coordinators.

Using the Obesity Guideline recently released by the U.S. Preventive Services Task Force as a test guideline, the Forum explored how collaborative leadership by Maine's health care providers, health organizations, state agencies, and communities can be leveraged to improve the link between favorable research findings and better health outcomes for Maine people. Participants recognized that effective leadership and many excellent organizational efforts are already promoting best practices. However, participants also recognized that breaking down barriers to systemic change requires statewide leadership. The Forum also identified where and how such leadership might be applied to leverage existing efforts in order to increase the speed and reach of best practices.

The input from the Forum has been used to develop the following *Vision,* eight recommended *Success Indicators* and eight *Strategies for Action* that will build on and reinforce the leadership and comprehensive work underway across Maine organizations and practices. The Trust will work closely with identified leaders to move the work along, will continue to act as a convener to promote statewide action, and will report progress toward the vision of success throughout the year and at the 2005 Hanley Forum.

Vision

A comprehensive statewide Healthy Weight Initiative improves health and quality of life for Maine people.

Success Indicators

- Standardized protocols and tools are in place for implementation of the Obesity Guideline including the use of BMI as a vital sign.
- Providers implement the Obesity Guideline.
- A statewide Healthy Weight coalition and broad-based community initiatives are in place.
- A statewide tracking system is in place and used over time to improve practice.
- The evidence base regarding successful interventions is strengthened.
- Public policy supports a focus on healthy weight and effective implementation of the Obesity Guideline.
- There is improved nutrition and exercise.
- There is a decrease in obesity and in negative effects.

Strategies for Action

- Develop a statewide Healthy Weight Coalition.
- Develop and gain endorsement of standardized protocols and tools for implementation of the Obesity Guideline.
- Address healthy weight in health plan benefits packages.
- Put a statewide tracking system in place with baselines.
- Implement the Obesity Guideline and healthy weight initiatives across health care, employer, and community-based settings.
- Develop and implement public education plans.
- Address healthy weight at the policy level and through the Dirigo Process.
- Develop and implement pilot projects and initiatives.

The executive summary and full report on the proceedings of the 2004 Hanley Forum are available on the Dan Hanley Memorial Trust website, www.hanleytrust.org.

MMA Executive Committee Holds Strategic Planning Retreat

Feeling too warm for comfort, the MMA Executive Committee journeyed north to Quebec City January 14-16, to conduct a strategic planning session and to hear from a leading physician in the Provincial Ministry of Health. Dr. Michel A. Bureau, Director General of Health Services and Academic Medicine lead off the meeting with an excellent presentation on the current status of the provincial health system.

Twenty-two members of the Committee met and in a self-facilitated session reviewed the strengths, weaknesses, opportunities and threats to MMA. Members also were asked to indicate the three most critical issues they believed faced MMA. Among the top issues internally were membership, the changing face of membership and medicine and the role of employment. Externally the issues of reimbursement, particularly from public payors, and professional liability were most frequently noted. Many other issues, both internally and externally were noted as well. Lack of adequate financial resources was continually noted as a challenge. The issue of improving the quality of care and responding to the various quality initiatives was also noted as critical, as was the need to embrace technology including the use of electronic medical records. The importance of working with Maine's hospital community was highlighted, as well.

Despite the considerable challenges, members seemed to believe that MMA had many strengths, including a long history of success and professionalism and that the organization was well-positioned to assist Maine's physicians with the considerable challenges faced. Continuity of staff and strong elected/volunteer leadership were also cited as advantages.

The Committee will continue to develop a strategic plan through a planning process and a portion of the next few Committee meetings will be dedicated to this effort. The Committee would welcome the input of any member regarding the issues facing MMA and the needs of members in the current environment and into the future. Your thoughts can be provided to any Committee member or to staff through e-mail to Gordon Smith, EVP at gsmith@mainemed.com.

UPCOMING AT MMA

FEBRUARY 15, 2005
6:30pm – 9:00pm
Legislative Committee

FEBRUARY 16, 2005
4:00pm
Maine Psychiatric Association, Executive Council

FEBRUARY 17, 2005
9:30am – 4:30pm
Home Care Alliance

FEBRUARY 23, 2005
6:15pm
Payor Liaison Committee

MARCH 1, 2005
1:00pm – 3:00pm
Stop Stroke!

MARCH 2, 2005
1:00pm
Personnel Committee

2:00pm
Executive Committee

MARCH 8, 2005
6:00pm – 9:00pm
Legislative Committee

MARCH 9, 2005
4:00pm – 6:00pm
Public Health Committee

MARCH 14, 2005
6:00pm – 8:30pm
Committee on Physician Health

MARCH 15, 2005
8:00am – 3:30pm
Infectious Control Practitioners

MARCH 17, 2005
2:00pm – 4:00pm
Governor's Council on Physical Fitness

MARCH 31, 3005
10:30am
Riverview Psychiatric Facility, Bed Review Committee

5:30pm
Maine Psychiatric Association

APRIL 5, 2005
1:30pm – 3:00pm
Stop Stroke!

APRIL 7, 2005
12:30pm – 4:30pm
Home Care Alliance

APRIL 12, 2005
6:30pm – 9:00pm
Legislative Committee

APRIL 13, 2005
2:00pm
Executive Committee

THE CODING CENTER

Laurie Desjardins, CPC

Understanding Medicare's Coverage of an Initial Preventive Physical Exam

Starting January 15, 2005 Medicare will cover an initial preventive physical exam (IPPE) for beneficiaries during the first 6 months of Part B coverage. To be eligible their enrollment benefit must begin on or after 1/1/05.

THINGS TO KNOW:

The patient does not have to be new to your practice, but does have to be new to Medicare, within their first 6 months of coverage.

WHAT NEEDS TO BE INCLUDED IN THE IPPE?

- Comprehensive medical and social history
- Review of risk factors for depression
- Review of patient's level of safety and functional ability
- Exam including measurement of height, weight, BP, visual acuity
- An EKG (Required)
  - If the primary care physician or qualified non-physician practitioner refers the beneficiary to an outside physician or entity for the EKG service, the primary care physician or qualified non-physician practitioner will incorporate the results of the EKG into the beneficiary's medical record to complete the IPPE
  - Both components of the IPPE, the examination portion and the EKG, must be performed for either of the components to be paid
  - Education, counseling, appropriate referral, based on above
  - A brief, written plan (such as a checklist) given to patient for obtaining screening and other preventive services that are paid for separately under Medicare B benefits IPPE

If not sure of eligibility status—have patient sign an ABN indicating that Medicare may not cover the visit.

WHO MAY PERFORM THE IPPE?

Section 611 of the Medicare Modernization Act amended the statute to provide that in addition to physicians certain NPP's, that is, PAs, NPs, and CNS will be able to furnish the new preventive physical examination to eligible beneficiaries.

Congress did not specifically authorize certified nurse midwives (CNMs) to perform the IPPE. Unless CNMs are able to qualify as one of these other types of NPPs designated by the statute for purposes of the new IPPE benefit, they will not be eligible to provide this service to beneficiaries for Medicare Part B coverage purposes.

NEW CODES FOR IPPE

G0344 – Initial Preventive Physical Exam; face-to-face services limited to new beneficiaries during the first 6 months of enrollment
G0366 – Electrocardiogram; routine EKG with at least 12 leads with interpretation and report, performed as a component of the initial preventive physical exam
G0367 – tracing only; without interpretation and report, performed as a component of the initial IPPE
G0368 – interp and report only; performed as a component of the initial IPPE

PAYMENT FOR IPPE

G0344 crosswalk from 99203
G0366 crosswalk from 93000
G0367 crosswalk from 93005
G0368 crosswalk from 93010

G0366 and G0367 are not payable in a facility setting.

These services are subject to the Medicare deductible ($110) and coinsurance.

If a separately identifiable medical service is provided during the same visit as the IPPE, use CPT codes 99201-99215 and append modifier 25 to the problem visit.

NOTE: make sure you document a separately identifiable evaluation and management service. *See Reporting a Preventive Service With A Problem Oriented Visit* at our website in the Articles folder (http://www.thecodingcenter.org/paper/documents/Preventiveservices.pdf) for a review on the requirements for supporting these two services.

WHAT ELSE IS NOTE WORTHY IN 2005?

Screening lab tests will be covered for:

- Specific Cardiovascular Screening Blood Tests – covered for screening purposes every 5 years.
- 80061 Lipid Panel
- 82465 Cholesterol, serum, or whole blood, total
- 83718 Lipoprotein, direct measurement; high-density cholesterol
- 84478 Triglycerides

With diagnosis codes:

- V 81.0 Special Screening for ischemic heart disease
- V81.1 Special Screening for hypertension
- V81.2 Special Screening for other and unspecified cardiovascular conditions

Diabetes Screening Tests – for patients with identified risk factors

Per the MedLearn article that describes coverage: "Coverage will be provided for two screening tests per calendar year for individuals diagnosed with pre-diabetes, and one screening test per year for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested. This coverage does not apply to individuals previously diagnosed as diabetic." The criteria for coverage is discussed in a MedLearn article MMA-Diabetic Screening Tests at (http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3637.pdf)

For more information from the source go to MedLearn Matters, Preventive Services Educational Resource Web Guide at http://www.cms.hhs.gov/medlearn/preventiveservices.asp

One last note: G0001 – the HCPCS code for Medicare venipuncture has been deleted in 2005; to report venipuncture to Medicare use 36415.

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Maine Psychiatric Association: The Consultation Project

By David A. Moltz, M.D.

Maine is a predominantly rural state, with a population of 1.2 million. Most of the 300 psychiatrists are geographically concentrated in the lower quarter of the state, leaving family practitioners and other primary care providers throughout the state without access to psychiatric consultation. The Maine Psychiatric Association is attempting to address this problem with an innovative program called *The Consultation Project.*

Developed in collaboration with the Maine Academy of Family Physicians, the program links volunteer psychiatrists with rural primary care practices. An ongoing consultative relationship is developed, in which the rural practitioner calls on the psychiatrist as needed for advice and guidance. The contacts are by telephone or email, and are in the nature of "informal consultations" rather than treatment or supervision. The primary care provider (PCP) is an independent practitioner with prescribing privileges. The consultant makes suggestions, but the final decision is the consultee's. Cases which cannot be handled by informal contacts, are referred to a statewide telepsychiatry initiative, which provides a "face-to-face" consultation that is reported back to the practitioner and the consultant.

The liability involved in this project is minimal. The project has been advised by Professional Risk Management Services, associated with the American Psychiatric Association, that liability is quite low as long as the relationship is clearly understood to be consultative.

What is novel about the Consultation Project is the ongoing relationship between consultant and consultee, which allows them to develop a shared body of experience, as well as the opportunity to consult on cases over time, allowing for longitudinal consultation. The project is just being implemented, and already 19 psychiatrists have volunteered to participate.

This has been a very positive demonstration to primary care providers that the psychiatric community is able to respond to their needs. We anticipate that more volunteers will join as the project proceeds, and that many consultants will cover multiple practices, allowing a substantial impact on the ability of primary care practitioners to provide quality psychiatric treatment across the state.

For more information, please contact Dr. David A. Moltz at dmoltz@sweetser.org.

Wireless Options for Healthcare: Reaching the Right Decision

By Mireille Gotsis, Senior Offer Manager for Healthcare Solutions, AT&T Wireless, now part of Cingular Wireless

WHY GO WIRELESS?

Today's physicians, nurses, and medical staff are challenged to do more with less. Decreasing reimbursements are driving increased patient loads, which in turn require that medical decisions be made more quickly and efficiently than ever before. Prescription reimbursements are tightly controlled by drug formularies. Reaching the right decision and prescribing the correct medication depends upon having the right information available at the point of care. Today's healthcare practitioners, however, often find they don't have all the information they need at hand (for example, when a request for a prescription request comes in after hours, or when needing to check a patient's lab results outside of the hospital or clinical setting).

Increasingly, physicians are using hand-held devices to access medical records. Real-time wireless access to patient information allows physicians to make the right decisions, get reimbursed more quickly, and have the freedom to practice "on the go."

CHOOSING YOUR BEST WIRELESS OPTION: FACTORS TO CONSIDER

Which type of wireless network? Not all wireless is equal, and it is important to consider where wireless access is required. Physicians, nurses, and medical staff who work in multiple facilities will require wireless wide area network (WWAN) connectivity, which gives them the ability to make phone calls, check email, and access patient and other medical data wirelessly wherever they are located. The most popular WWAN network used by more than 70% of the world's mobile workers today is based on the global GSM standard. Some medical providers are also installing wireless local area networks (WLAN) on the Wi-Fi spectrum. This allows wireless access within a limited range – typically, inside a hospital, or within a short distance of a WLAN access point.

What types of wireless devices? This is an individual decision; however, physicians typically find PDA's (handheld devices with either keyboard or a stylus – often coupled with phone capability) to be the most convenient. These devices fit conveniently inside a lab coat, and are light and easy to carry. When purchasing such a device, it's important to consider the following factors:

- Do you need to access patient records and email outside a clinic or hospital setting? If so, consider a PDA with WWAN capability.
- Do you frequently roam between a hospital, which has a Wi-Fi network, and other facilities, which don't? If so, consider using a WWAN-enabled PDA with a slot that will allow you to insert a Wi-Fi card for local network access. Conversely, some Wi-Fi-enabled PDAs come equipped with a slot for a WWAN card. Alternatively, think about linking your cell phone to a PDA using special software built with Bluetooth technology that gives you a cordless connection between the two devices. Use the phone as a modem for the PDA; on the weekends, free yourself from the PDA altogether, and use your phone for personal business. You may also be able to receive SMS messages on your phone eliminating the need for a pager.

WHAT ABOUT SECURITY?

Wireless networks are increasingly used in healthcare today – whether by emergency medical technicians sending patient information directly from the ambulance to the emergency room, physicians routing prescriptions wirelessly to a local pharmacy, or home healthcare workers sending billing information in real-time. Your wireless carrier can explain your security options for safeguarding the confidentiality of patient data; in addition, wireless consultants can advise you in making the right selection.

Mireille Gotsis is a Senior Offer Manager for Healthcare Solutions at Cingular Wireless. Cingular Wireless serves the real-time wireless needs of HMOs, IDNs and academic medical centers nationwide. Critical real-time medical applications are deployed on the Cingular Wireless GPRS/EDGE network today, the fastest national wireless data network.

Medicine by Media? A Personal Observation

By Ronald Blum, M.D.

How do you deal with your patient's responding to pharmaceutical advertising?

Is such advertising an enhancement or interference in your practice of medicine?

While encouraging communication is admirable, do we really need pharmaceutical marketers creating unfounded expectations in our patients? Optimum clinical management and the patient's best interests already are our goal. There is no need for a related industry to interfere, except for their own gain. We have no calling to be party to their sales objectives. Physicians should avoid complicity.

A recent study by the Henry J. Kaiser Family Foundation reports that just under one-third of all adults reported speaking to their doctor about a drug they saw advertised, and 44% of them were given a prescription for that drug by that doctor. This translates to 13% of American adults receiving a specific prescription because they saw a drug advertisement!

Is this an incentive to the pharmaceutical industry? You bet! Dollar sales of the 50 most advertised drugs increased 32% from 1999 to 2000, while sales for all other drugs only rose 14%. This corresponds to a whopping increase of 25% in the number of prescriptions of the 50 most advertised drugs compared to a 4% increase in all others.

According to a recent Anthem Blue Cross & Blue Shield publication, pharmaceutical industry expenditures for direct-to-consumer advertising have increased from $800 million in 1996 to $2 billion, 200 million in 2001. Any wonder why? The industry estimates that every direct-to-consumer advertising dollar yields an additional $4.20 in sales.

"If you're not part of the solution, you're part of the problem" was a poignant slogan in the '70's. If you see direct-to-consumer advertising as a problem, an interference in our practice of medicine, and a factor in the price of medications we prescribe, then you have a choice to be part of the solution. You can personally relate your opinion to the pharmaceutical representatives you may meet, and to the companies they represent by letter or email. But a greater impact would be to educate our patients, so we are not indiscriminately contributing to the statistics above.

Our inaction will only further enable the pharmaceutical industry, while a collective, definitive stance may stem the tide of this advertising trend.

Ronald Blum M.D. is a Family and Occupational Physician practicing in Island Falls, Maine. He was the 2003 Maine Family Physician of the Year.

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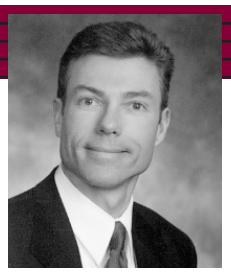
LEGISLATIVE UPDATE



Andrew MacLean, Esq.

122nd Maine Legislature Gets to Work on Property Tax Reform; Governor's 2006-2007 Budget Proposal Includes $3 Million Annual Increase in Mainecare Physician Payment Rates

Maine's 186 legislators began their First Regular Session on Tuesday, January 4, 2005 and they are expected to complete their business by mid-June. In addition to our own initiatives on medical liability reform and MaineCare reimbursement rates, the MMA will be engaged in advocacy on physicians' behalf in the continuing implementation of the Dirigo Health Plan, the Governor's 2006-2007 biennial budget, and a host of new bills addressing issues in our health care system.

As a result of nearly 5 years of advocacy by the MMA and allies, Governor Baldacci and his health care staff have recognized the dire need for an increase in reimbursement rates for Maine physicians and have included $3 million for this purpose in the 2006-2007 biennial budget proposal. With the federal Medicaid match, this will infuse nearly $10 million in the MaineCare physician fee schedule.

You can read information about the Governor's budget and find a link to the budget document on the web at: http://www.maine.gov/governor/baldacci/issues/budget/index06-07.html.

While inclusion in the Governor's budget is a tremendous advantage, it by no means assures passage of the fee increase by the legislature. Please contact your own legislators and any member of the Appropriations Committee who may be near your home or practice to advise them how important this fee increase is to your ability to continue seeing MaineCare patients!

Work in the first several weeks of the legislative session has focused on committee orientation and the property tax reform initiative, but public hearings likely will begin in earnest in early February. The MMA usually tracks about 350 bills of interest to Maine physicians during the two-year legislative session. You can view the list of all bill titles filed by legislators prior to the December 17, 2004 cloture deadline on the web at: http://janus.state.me.us/legis/lio/LR122r1/.

The MMA has submitted 4 bills for consideration by the 122nd Maine Legislature:

- *An Act to Preserve the Medical Liability Climate in Maine* (Sen. Karl Turner, R-Cumberland)
- *An Act to Maintain Patient Access to the MaineCare Network of Individual Health Care Practitioners* (Rep. Edward Dugay, D-Cherryfield)
- *An Act to Extend the Sunset Provision on Non-hospital Expenditures in the Capital Investment Fund* (Sen. Karl Turner, R-Cumberland)
- *An Act to Ensure Coverage for Medically Necessary Breast Reduction & Symptomatic Varicose Vein Surgery* (Rep. Anne Perry, D-Calais)

The new legislature has the closest partisan split in both houses in a number of years. The Maine Senate is composed of 19 Democrats & 16 Republicans. The Maine House is composed of 76 Democrats, 73 Republicans, 1 Green Independent, & 1 Unenrolled member. The leaders of the 122nd Maine Legislature are:

SENATE LEADERSHIP

Senate President:
Betheda Edmonds (D-Cumberland)

Senate Majority Leader:
Michael Brennan (D-Cumberland)

Assistant Senate Majority Leader:
Kenneth Gagnon (D-Kennebec)

Senate Minority Leader:
Paul Davis (R-Piscataquis)

Assistant Senate Minority Leader:
Carol Weston (R-Waldo)

HOUSE LEADERSHIP

Speaker of the House:
John Richardson (D-Brunswick)

House Majority Leader:
Glenn Cummings (D-Portland)

Assistant House Majority Leader:
Robert Duplessie (D-Westbrook)

House Minority Leader:
David Bowles (R-Sanford)

Assistant House Minority Leader:
Joshua Tardy (R-Newport)

The legislative leaders have made assignments to the joint standing committees of the legislature that do the bulk of work on the bills. You can view the list of committee assignments on the web at: http://janus.state.me.us/house/jtcomlst.htm. The primary committees having jurisdiction over health care matters are the Joint Standing Committees on Health & Human Services, Insurance & Financial Services, Business, Research & Economic Development, and Judiciary.

You can find your House member on the web at: http://janus.state.me.us/house/townlist.htm. You can find your Senator on the web at: http://www.state.me.us/legis/senate/senators/index.htm. Please take the time to introduce yourself to your two legislators.

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 & Regulatory Advocacy section of the site. You will find more information about the 122nd Maine Legislature on the web at: http://janus.state.me.us/legis.

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

Ethics Note: *Discrimination on the Basis of Sexual Orientation*

Prominent in the public debate today is the role of marriage in our society and civil rights for gays and lesbians. Maine has tried several times, through the legislative and initiative processes, to ensure the most basic civil rights for gays and lesbians by prohibiting discrimination on the basis of sexual orientation in the Maine Human Rights Act. The 122nd Maine Legislature will consider several bills on marriage and civil unions in the next two years. The AMA Code of Medical Ethics has prohibited such discrimination in the practice of medicine and in the activities of organized medicine for more than 30 years. See Opinion 9.03, *Civil Rights and Professional Responsibility.* 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."

AMA Advises: *You Can Still File for Reimbursement Under the CIGNA Settlement Claims Distribution Fund*

A February 2004 settlement between CIGNA HealthCare and U.S. physicians set a claims period that ends February 18, 2005. That means there's still time to file for additional reimbursement from the settlement fund of $540 million.

Any physician or physician group that provided covered services to CIGNA enrollees between August 4, 1990 and September 5, 2003, has a variety of options in recovering claims. You need not be a contracted provider with CIGNA to submit a claim form.

You can participate in one of two funds. Category A funds allow you to receive a portion of $30 million to be divided in accordance with a payment formula set forth in the settlement agreement.

Or you can file to receive funds in one of three categories or the Claim Distribution Fund. This fund is available for denials or reductions in payments as a result of specific coding and bundling edits or medical necessity decisions. CIGNA must pay a minimum of $40 million from this fund, with no ceiling on the amount the insurer must pay for appropriate claims.

The Managed Care Advisory Group (MCAG), a physician practice claims recovery company, offers AMA members a discount on recovery fees. MCAG will pull information from your files and submit a claim for you. Contact MCAG at http://64.2.241.220/mcag/main/ or call 800-355-0466.

You may also go to www.hmosettlements.com and complete the process on your own.

All Physicians Gain

Whether filing a claim or not, all physicians may stand to benefit from the CIGNA settlement because it may improve physician-related business practices as well as cash payments. MMA has CD-ROMS available for members on the Cigna settlement. Call Charyl Smith at 622-3374 or via email at csmith@mainemed.com for a free copy.

Maine Medical Association Directory of Free Clinics and Overseas Medical Volunteer Programs

MMA wishes to maintain a directory of domestic and overseas voluntary medical service by Maine Physicians. The purpose is to afford recognition of such commendable activity but it may also assist with physician recruitment or providing addresses for donations of money or medical supplies.

If you are currently offering or know of a Maine physician who is serving at a Free Clinic in Maine or a medical mission overseas, please contact MMA President Lawrence Mutty, M.D. at the following address:

L.B. Mutty, M.D., P.O. Box 573, 88 Water Street, Castine, ME 04421
Email: lmutty@verizon.net

Thank You to Pre-litigation Screening Panel Volunteers

MMA would like to acknowledge and thank the following physicians who recently have given of their time to serve on a pre-litigation screening panel. The voluntary effort of such physicians is essential to the operation of the panel system.

Patricia Small, MD	William Phillips, MD	Kent Clark, MD
Peter Huang, MD	Phil Peverada, MD	Brian Pierce, MD
Roy Ulin, MD	John Makin, MD	William Strassberg, MD

Maine medicine

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