JANUARY/FEBRUARY 2007

Maine medicine

MAINE MEDICAL ASSOCIATION

In this issue...

Dirigo Blue Ribbon Commission Issues Final Draft Report

Recommendations Include Employer and Individual Mandates

The Blue Ribbon Commission on Dirigo Health held its final scheduled meeting on December 19, 2006. At that meeting, the commission reviewed a draft final report, which is available online at http://www.dirigohealth.mainee.gov/dhsp07ja.htm. Commission members included Robert McAfee, MD, Peter Toussaint, MD, and MMA EVP Gordon Smith, Esq.

The report represents the culmination of nine meetings over a five-month period by the 20-member commission. One of the commission's primary tasks was to make recommendations for alternatives to funding the Dirigo Health program. After reviewing a variety of different options, the commission recommended that the Dirigo Health program be funded through the state's general fund and identified several potential funding sources should additional general fund revenue be needed:

- Increased taxes on tobacco products including smokeless tobacco (the cigarette tax would be increased by 50 cents per pack);
- A snack tax;
- A tax on bottled soft drinks and syrups; and,
- A tax on beer and wine.

In addition, the commission supported the continued recovery of bad debt and charity care (one of the components of the savings offset payment as it is imposed by Dirigo Health today). However, there was no support for either the continuation of the savings offset payment mechanism, nor was there support for recapturing the savings at the provider level. As a result, the commission recommended that a group of interested parties be convened to meet with the Dirigo Board and staff to determine the methodology and mechanism through which bad debt and charity care savings could be captured.

A majority of the commission members voted to endorse health insurance mandates for employers and individuals with incomes exceeding 400 percent of the federal poverty level and recommended that the governor explore how such mandates might be structured. MMA has supported compulsory health insurance since the preparation of its "White Paper" on health system reform in 2003.

The commission also recommended that individual market reform be explored, including the concepts of high risk pools, merger of Maine's individual and small group markets and reinsurance on the individual and/or merged markets.

The commission also made a number of recommendations with respect to the DirigoChoice product, including that the program be given the option to self-insure. The recommendations will be considered by the Governor and those supported by him will be submitted to the current session of the Legislature.

Dirigo Enrollment as of December 1, 2006
DirigoChoice: 13,290 enrollees

Dirigo Enrollment Distribution by Group…
27% are sole proprietors and their dependents
27% are through a small business and 46% are individuals

	04/01/06	12/01/06	Change over 8 months
Small Group	38%	27%	-11%
Sole Proprietors	30%	27%	-3%
Individual	32%	46%	+14%

Subsidy Distribution…

	04/01/06	12/01/06	Change over 8 months
Group A (100% subsidy)	1%	1%	0
Group B (80% subsidy)	44%	51%	+7%
Group C (60% subsidy)	16%	16%	0
Group D (40% subsidy)	11%	9%	-2%
Group E (20% subsidy)	6%	4%	-2%
Group F (no subsidy)	22%	19%	-3%

Subsidy Costs as a Percentage of Premium*…

	2005	2006(through June)	2007(Projected)
DHA Subsidy	49%	50%	54%
Employer/Enrollee contribution	51%	50%	46%

* = Represents the subsidy costs spread among all enrollees.

MaineCare May Abandon $56 Million MECMS

The release of the Governor's budget on January 5 provided strong evidence that the Maine Department of Health and Human Services may be preparing to abandon the flawed claims management system (MECMS) that it has struggled with for two years (Maine's 7,000 MaineCare providers have suffered greatly as well).

DHHS Commissioner Brenda Harvey appeared before a joint session of the Legislature's Committees on Health and Human Services and Appropriations and Financial Affairs on January 16 and stated that a decision would be made by the end of January. Critical to the decision is the willingness of the federal government (CMS) to participate in the cost of MECMS or of a new system or vendor.

If MECMS is abandoned, completely or partially, it is likely MaineCare would move to outsource the processing of claims, as is done in many other states, including Vermont.

MMA staff continues to monitor this situation carefully and reports to the membership weekly through *Maine Medicine Weekly Update* (available electronically). Staff also meets with MaineCare staff on a bi-weekly basis at the Governor's MECMS Provider Advisory Committee.

Even a transition from MECMS to an outsourcing arrangement (through appointment of a Fiscal Agent) would require a period of time ranging from six months to one year.

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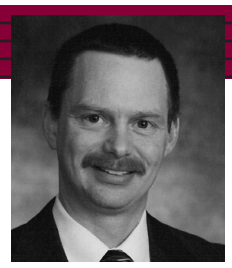
Each Monday, Maine Medicine *Weekly Update* keeps physicians and practice managers in the loop with breaking news – by fax or e-mail only. It's a free member benefit – call 622-3374 to subscribe.

President's Corner



Kevin Flanigan, M.D., President, MMA

Happy New Year to each of you. As the new year begins, we likely are all asking ourselves the same question - what does this year have in store for me? From a professional standpoint "Quality of Patient Care," is no longer something on the horizon. It is now front and center. Private insurers are using "Quality Measures" to create "Tiered Networks" or are beginning to pay bonuses to practices that meet certain "Quality Standards." Even Medicare is joining in with a program that will begin in July of this year. Under this initiative, CMS will begin to pay an additional 1.5% to practices that voluntarily report "Quality Data."

I do not believe that in the history of medicine, any physician has awakened and declared, "today I will deliver a lower standard of care than I did yesterday." In fact, it goes against every fiber of our being to even consider such a thing. Yet we are now going to have to prove that what we did today for our patients was not just as good as the care we delivered yesterday, but in fact was headed towards being better than yesterday. This applies not only to whether we have made the right diagnosis or whether we have served the patient and their caregivers well; it is instead a question of whether we can prove that once the diagnosis was made, did we adequately treat the disease and was it consistent with the current standard of care.

To an extent, this represents a shift away from claims data management as the means of judging a physician, and this is fortunate. However, management of this "quality data" now falls on us, the physicians. It will no longer be enough to simply see the patient, determine the proper diagnosis, and then institute the best treatment. We will now have to add to that list – *manage the data that shows that I am delivering to my patients the best possible care*.

This data management comes with risk. The data will have to be properly collected, analyzed and then presented. Handling any one of these steps in an improper manner could have a disastrous impact on the accuracy of the final report used to judge how satisfactory the care is that your patients receive. Of greatest concern however is not the potential for insurers to use this data to reduce our payments. It is the possibility of trial lawyers using this data against us! It is very important that the work you do in your office to monitor and improve the quality of care you provide remain in your office and not be discoverable to outside forces who may corrupt it for nefarious uses for which it was never intended.

> Yet we are now going to have to prove **that what we did today** for our patients **was not just as good** as the care we delivered yesterday, **but** in fact was headed towards being **better than yesterday.**

This is where the MMA, whose mission is to support the physicians of Maine in promoting the health of Maine's citizen and to protect the quality of medicine, stands ready to help and serve its members. An established program, currently in use by several practices, provides appropriate and customized quality review in a confidential manner.

The office-based Quality Improvement Program is a program run by our Quality Committee. Physicians whose practices use this program receive the benefit of accurate data collection because data was generated, processed and presented by them for the sole purpose of improving the quality of care they deliver. They will have access to expert guidance in the development of the program. There is no hidden agenda. The major benefit of this is the access to the expertise in developing this program. A very significant additional benefit is the extension of statutory protection from discoverability of such a certified program or its data in any legal proceedings, such as allegations of malpractice. The State of Maine only extends this statutory protection to hospitals and to practices working through the MMA's quality process. If you are in an independent practice without access to this protection from a hospital connection, our process is the only way to protect the integrity of your data and your QI process from discoverability.

This is another example of the value that the MMA provides to member physicians and Practices in Maine. If you have any questions or would like to pursue establishing a quality assurance program through the MMA, please feel free to call myself, Dr. David McDermott, Chair Quality Committee or Warene Eldridge at the MMA headquarters.

As I close, I would like to invite you to visit our website at www.mainemed.com or contact me via phone at 207-487-5875 or email at flanmansvpc@pol.net to discuss what we can do for you and what you can do for this association.

MMA Executive Committee Advances at Weekend Retreat

The Association's Executive Committee met over the three-day Martin Luther King weekend in a retreat format. For several years, the committee has chosen the memorial weekend to stop and reflect on the "big picture." Working hard to be a "knowledge-based" organization with state of the art governance, your leadership has examined the landscape upon which Maine physicians practice today and developed strategies and processes to meet the Association's mission:

The Maine Medical Association, established in 1853, is a voluntary association of physicians united to promote the health of Maine citizens, the quality of medicine in Maine, and physicians' role as advocates for their patients.

While the mission of MMA remains intact, the existence of constant change in the delivery and financing of health care require that the Association continually examine what its members needs are, its capacity to meet those needs and the ethical imperatives associated with its actions. The weekend retreat gave committee members the opportunity to examine the current influences on the profession and the Association, the ability of the association to meet the challenges presented and the action plans required. Among the priorities identified for the coming years are assisting members in improving quality of care, improving public health and improving the environment of medical practice in Maine. Improving access to care remains an important priority as well.

One important theme highlighted was that of "Professionalism," and the need to help members and non-members return to the roots of the profession, a profession that is dedicated in service to others and to a culture of duty, honor, truth, integrity, education and compassion. In the current environment, it is too easy to forget the reason one went into medicine to begin with.

A great deal of the retreat time was spent reviewing the existing processes of the committee, including meeting agendas and the role of the smaller, seven member Steering Committee. The 28 member Executive Committee hopes to focus more on strategy, policy and high level management, while the Steering Committee is likely to become more of an "Operations" committee to oversee staff and association activities on a regular basis (without micro-managing).

A constant theme for the weekend was how to acquaint the 45% of Maine physicians who do not belong to MMA with the value that MMA provides to its members. The need to attract students, residents and young physicians also was noted.

The bottom line: The MMA will continue to grow and provide value to individual physicians and groups of physicians on a daily basis, and will be governed by a group of volunteers dedicated to governing this venerable association with knowledge, integrity and compassion, being ever cognizant of the non-profit mission stated above.

Upcoming Specialty Society Meetings

FEBRUARY 10-11, 2007 *Sugarloaf/USA*
Maine Society of Anesthesiologists
Contact: Anna Bragdon 207-441-5989 or msainfo@adelphia.net

MARCH 2-4, 2007 *Bethel Inn – Bethel, ME*
Maine Gastroenterology Society Winter Meeting
MMA Contact: Gail Begin 207-622-3374 ext: 210 or gbegin@mainemed.com

MARCH 8-10, 2007 *Sugarloaf/USA*
Maine Society of Orthopaedic Surgeons Winter Meeting
Contemporary Topics in Orthopaedics
MMA Contact: Lauren Mier 207-622-3374 ext: 223 or lmier@mainemed.com
Program Coordinator: Donna Rogers 207-947-8381 ext: 212 or drogers@downeastortho.com

MARCH 16-18, 2007 *Sugarloaf/USA*
Maine Society of Otolaryngology Winter Meeting
Contact: Leslie Rankin 207-351-3525

MARCH 23-25, 2007 *Sugarloaf/USA*
Maine Section, American College of Obstetrics and Gynecology (ACOG) Winter Meeting
Program Coordinator: Cindy Croteau 207-662-2749 or crotec@mmc.org

APRIL 29, 2007 *Harraseeket Inn – Freeport, ME*
Gastroenterology for Primary Care
MMA Contact: Gail Begin 207-622-3374 ext: 210 or gbegin@mainemed.com

MAY 4, 2007 *Harraseeket Inn – Freeport, ME*
Maine Society of Eye Physicians and Surgeons Spring Meeting
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

Thank You

to the following individuals and practices which have supported MMA this year by renewing at the sustaining membership level.

David Beebe, MD
John Bosco, MD
Maroulla Gleaton, MD
Jens Jorgensen, MD
Jo Linder, MD
Roger Renfrew, MD
David Simmons, MD
Robert Sylvester, MD
Derrick Tooth, MD
Mark Zajkowski, MD
Mayo Regional Hospital
Northeast Cardiology

And a special thank you to President Kevin Flanigan who matched the first $3,000 in sustaining memberships.

MMA Welcomes Our Newest Corporate Affiliates:

Beth Boynton & Associates
Mercer Health & Benefits
Premier Marketing Group, Inc.
Systems Engineering, Inc.
TD Banknorth Insurance
We appreciate their support!

MMA 2007 Dues

A big **Thank You** to those members who have paid their 2007 dues. The 2007 dues invoice was mailed in October. A second invoice was mailed January 16, 2007.

The benefits of MMA membership provide a good return on your dues investment, from representation at the state house and in the regulatory agencies to providing coding assistance to your staff. For questions about renewing your membership, call Lisa Martin at 622-3374 ext: 221 or email lmartin@mainemed.com.

Dirigo Health Board Votes to Assess 2007 Savings Offset Payment

Year 2 SOP to be 1.85% of paid claims

At meetings on December 28, 2006 and January 8, 2007, the Dirigo Health Board of Directors voted to assess insurers and self-insured employers a 2007 savings offset payment (SOP) in the amount of $34.3 million equal to 1.85 percent of paid claims.

According to material distributed at the January 8 meeting, the Dirigo Health Agency intends to assess a savings offset payment of 1.85 percent on plan years beginning July 1, 2007 through June 30, 2008. The agency indicated that it will notify entities subject to the SOP by April 1, 2007, that it will begin collecting the SOP beginning July 1, 2007.

Don't Wait On This One; Act Now To Get Your National Provider Identifier

Sometimes you can wait until a deadline looms before you act, like doing your taxes April 14, the night before they're due. But don't put off applying for your National Provider Identifier (NPI), the unique 10-digit code that will soon be needed for all claims.

The identifier will help ensure that medical claims are processed on time and payments are made correctly. What's more important, getting an NPI is FREE. No processing fee is required.

The NPI will take the place of any other identifying number you may use in transactions with federal and state government, as well as private payers. Administered by the Centers for Medicare & Medicaid Services (CMS), the identifier will not expire or change.

The CMS is urging doctors who file claims electronically to have their NPI long before the deadline of May 23, 2007. Why? Some payers may require it sooner, and you may be unable to complete the process quickly if large numbers wait until the last minute to apply.

Entities covered by the Health Insurance Portability and Accountability Act (HIPAA), like providers completing electronic transactions, healthcare clearinghouse and large health plans, must use only the NPI to identify covered health care providers in standard transactions after next year's May deadline.

To get your free NPI:

- Apply online at **https://NPPES.cms.hhs.gov.**
- Or call the NPI Enumerator, a contractor hired by CMS, at **(800) 465-3203** to request a paper application to mail back.
- Grant a CMS-approved electronic file interchange (EFI) organization permission to get an NPI for you. For more details about NPI and EFI, visit **www.cms.hhs.gov/NationalProvidentStand.**

UPCOMING AT MMA

February 13 8:30am – 1:00pm
Physician Practice Management Forum

March 2 9:00am – Noon
"First Fridays" Education Program: Annual HIPAA Training Update

March 6 5:30pm – 8:00pm
MMA Membership and Member Benefits Committee

March 7 2:00pm – 5:00pm
MMA Executive Committee

March 8 6:00pm – 9:30pm
Maine Association of Psychiatric Physicians Executive Committee and Committee Chairs

March 12 6:00pm – 8:30pm
MMA Committee on Physician Health

March 13 8:00am – 3:00pm
Spectrum Medical Group

March 14 1:00pm – 5:00pm
Maine Health

March 21 4:00pm – 6:00pm
MMA Public Health Committee

March 21 8:00pm
Infection Control Practitioners

March 29 All Day
Physicians' Day at the Legislature at the State House

April 3 1:00pm
Stop Stroke

April 3 5:00pm
American Academy of Pediatrics, Maine Chapter

April 4 2:00pm
Quality Counts! Board Meeting

April 5 12:30pm
Home Care Alliance

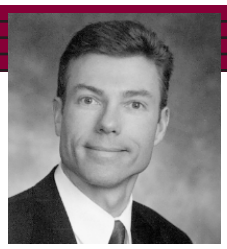
April 6 9:00am – Noon
"First Fridays" Education Program: Risk Management

April 10 8:00am – 3:00pm
Spectrum Medical Group

April 12 6:00pm – 9:30pm
Maine Association of Psychiatric Physicians Executive Committee and Committee Chairs

April 25 2:00pm – 5:00pm
MMA Executive Committee

Legislative Update



Andrew MacLean, Esq.

123rd Maine Legislature Faces Workload of More Than 2400 Bills

Maine's 186 legislators returned to Augusta on January 3, 2007 for Governor Baldacci's inauguration and budget address, and to address a record number of bills. The "First Regular Session" of the new legislature likely will conclude in mid-June. The MMA already has identified approximately 300 bills of interest to the physician community and the MMA leadership urges you to be informed about and involved in our advocacy activities!

The legislature's schedule during January is devoted to committee organization and orientation, reference of bills to committees, and consideration of the Governor's SFY 2007 supplemental budget proposal. In February, committees will begin a heavy schedule of public hearings and work sessions on bills.

At a press conference on Friday, January 5, 2007, Governor Baldacci presented an overview of his SFY 2008-2009 biennial budget, the two year spending plan for the state fiscal years beginning July 1, 2007.

The MMA was very pleased to note that the Governor included in his proposal a $3 million General Fund increase in the MaineCare physician fee schedule for the second year of the biennium. With the federal match, this budget would increase MaineCare physician reimbursement by approximately $8.2 million. While it is a tremendous advantage to have this amount included in the Governor's budget, it is *not* a guarantee of success in the legislature. Please contact your own Representative and Senator and any member of the Appropriations Committee in your area to discuss the importance of increasing MaineCare reimbursement so that physicians will continue to serve MaineCare beneficiaries. The following items also are noteworthy in the Governor's budget proposal:

- A $1 per pack increase in the cigarette excise tax;
- Savings of $1.3 million in the first year and $1.4 million in the second year ($2.7 million total) as a result of an increase in the federal financial participation rate in the MaineCare program;
- Savings of $20.3 million in the first year and $27.4 million in the second year ($47.7 million total) as a result of clinical management of MaineCare members;
- Savings of $8.6 million in the first year and $11.2 million in the second year ($19.8 million total) by implementing a managed care effort for behavioral health services;
- Savings of $2 million in each year of the biennium in General Fund costs plus $17 million in each year in federal funds (approximately $20 million total) by adjusting mental health service payment rates to a standard rate per service.

You can read the Governor's budget statement and other budget documents on the web at: http://www.maine.gov/tools/whatsnew/index.php?topic=Portal+News&id=28203&v=article-2006. The Governor's biennial budget proposal has not yet been printed as a legislative document (LD). The Governor's supplemental budget proposal, L.D. 215, includes $50 million for hospital settlements and prospective interim payments. The Appropriations Committee begins hearings on L.D. 215 during the week of January 22, 2007.

The MMA has submitted the following bills for consideration by the new legislature, as recommended by the Legislative Committee late last year:

An Act to Maintain Patient Access to the MaineCare Network of Individual Health Care Practitioners, sponsored by Rep. Janet Mills (D-Wilton). This bill proposes a $3 million General Fund increase in Medicaid or MaineCare reimbursement rates for physicians & other practitioners.

An Act to Establish a Pilot Program for Return of Unused Prescription Drugs, sponsored by Rep. Anne Perry (D-Calais). This bill proposes to appropriate $300,000 to establish a mail return program as recommended by the Maine Drug Return Implementation Group.

An Act to Increase Funding for the Maine Immunization Program, sponsored by Rep. Lisa Miller (D-Somerville). This bill proposes to appropriate $6 million plus funding for 4 positions to maintain Maine's immunization program at levels recommended by the federal CDC.

An Act to Further Limit Retrospective Denials of Previously Paid Health Insurance Claims, sponsored by Sen. Lisa Marrache, M.D. (D-Kennebec). This bill would shorten the "look-back" period permitted under Maine law for retrospective audits from 18 months to 12 months.

An Act to Establish Health Care Practitioner Immunity for Consulting Physicians in Critical Specialties or Sub-specialties, sponsored by Rep. Robert Walker, M.D. (R-Lincolnville). This bill would amend the "Good Samaritan" law to provide limited immunity protection to specialty or sub-specialty physicians who provide volunteer, unpaid consultation services to treating physicians in their area of expertise.

An Act to Authorize the Board of Pharmacy to Establish a Pharmacists Health Program, sponsored by Rep. Anne Perry (D-Calais). This bill would make the statutory changes necessary to permit the Board of Pharmacy to join the MMA Physician Health Program.

An Act to Postpone the Repeal Date on Non-Hospital Expenditures in the Capital Investment Fund, sponsored by Sen. Karl Turner (R-Cumberland). This bill would extend the sunset provision on the CIF statute setting aside 12.5% of the amount of the fund each year for non-hospital projects by one year.

The 123rd Maine Legislature has published lists of the bills by title filed by legislators and Executive Branch agencies by subject matter and by legislator. You can find these lists on the web at: http://janus.state.me.us/legis/lio/publications.htm. The MMA staff now has summarized and categorized the bills of likely interest to the physician community and, once again, this legislature will face many important health care issues. The MMA's bill list includes the following:

- 5 bills on childhood obesity and physical activity
- 2 bills on thimerosal in vaccines
- 5 bills on pharmaceutical prescribing data
- 16 bills on health care reform, including those on the Dirigo Health Program, single-payer health care, and a state-sponsored health insurer
- health insurance mandates on infertility treatment, hearing aids, and cancer screening
- 47 bills on insurance practices, including the regulation of insurance
- 16 bills on medical liability, including bills on the timeliness of the screening panels, to shorten the statute of limitations in some instances, to study the medical malpractice situation, and to consider the health court concept
- 27 bills on mental health and substance abuse issues
- 14 bills on prescription drug issues
- 27 bills on public health & safety issues
- 23 bills on the regulation of health care facilities
- 29 bills on scope of practice, licensing, and disciplinary issues for individual health care practitioners, including a bill to license lay midwives
- 14 bills on tobacco issues, including several bills on "fire-safe" cigarettes
- 12 bills on workers' compensation issues

You will find the list posted on the MMA web site, www.mainemed.com, or you may obtain it from the MMA office.

You can find joint standing committee assignments on the web at: http://janus.state.me.us/house/jtcomlst.htm.

You can find your Senator and Representative on the web at: http://janus.state.me.us/house/townlist.htm.

During the legislative session, the MMA publishes a weekly e-mail 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 Maine Legislature, including schedules, committee assignments, legislator contact information, audio coverage of legislative work, and newly enacted laws on the web at: http://janus.state.me.us/legis/.

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

Medical Mutual Insurance Company of Maine: Risk Management Practice Tip

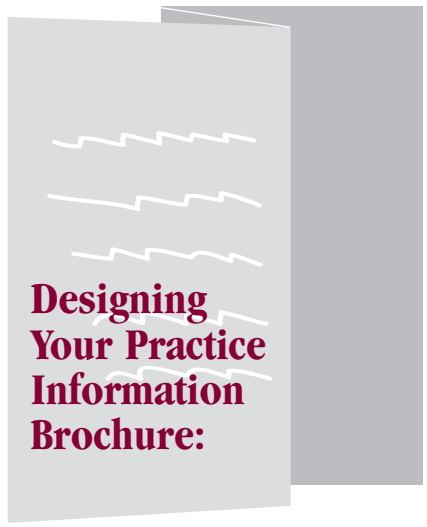
Brochure/Practice Information Handout

An effective means of communicating the practice's office policies and expectations is in a written hand out such as a brochure or information sheet. Educating your new and established patient population enhances patient relations and satisfaction. It is an inexpensive way to convey each party's responsibilities in the physician-patient relationship.

Preparing a Patient Information Brochure:

Consider including the following information in your patient information brochure:

- A welcome statement which outlines your practice philosophy and goals.
  - Professional information about each physician including the physician's undergraduate and medical schools, residencies, special training, board certifications and the length of time the physician has been in practice in the area.
- Specialty, type and scope of practice.
- Office hours, appointment policies, and the days the office is closed. Address missed (no-shows) and canceled appointments. Touch upon after-hours care as well as weekend and holiday practice coverage.
- List all phone numbers prominently.
  - Clarify telephone procedures.
    - Explain how you handle prescription refill requests.
    - Indicate special telephone hours, if applicable.
    - Note when patients can expect a return call.
    - List a billing number if it is a separate telephone line.
    - Cite your policy regarding weekend calls for non-emergencies.
    - Address your automated answering system if utilized.
- Describe your fee schedule, financial policy, billing policies and the use of collection agencies. Include your policy regarding when payment for service is expected, and the arrangement of payment plans.
- Describe insurance agreements and policies. Explain whether or not your staff will assist in preparing and processing insurance claims.
- Provide a map with clear, simple directions to the practice.
- Explain your method of obtaining or reporting test results.
- Include an invitation asking patients to actively participate in their own care.



You are in the best position to determine what form, style and topics are most appropriate for your practice information document.

- Design options include a pamphlet, booklet, brochure or information sheet format.
- Solicit staff suggestions to identify problem areas requiring clarification in the booklet. When relating your policies, approach your explanation from the patient's perspective, thereby expressing your concern for the patient.
- Set a personal tone in the document by using the "you" form in the text rather than "our patients."
- Consider the size and type of font. Select a clearly legible type style.
- Write the brochure at approximately the fifth-grade reading level; avoid clinical information.
- Determine the number of documents to be printed. A six-month supply allows you the option of making revisions.
- Distribute your practice information document to both new and established patients.

An informational document is an inexpensive vehicle to educate patients. It can save your staff valuable time by eliminating the need to frequently explain policies and procedures. Most importantly, it promotes goodwill among your patients.

Medical Mutual's "Practice Tips" are offered as reference information only and are not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.

Assessment Reduced to Fund Maine's Rural Medical Access Program

The Maine Bureau of Insurance has reduced the assessment on medical professional liability insurance premiums needed to fund the state's Rural Medical Access Program (RMAP) from 1.25% to .75% on policies commencing on and after July 1, 2006. The statute allows for the rate to increase/decrease in future policy years, if necessary, depending on the total program balance. The new .75% rate will remain in effect until the Superintendent notifies insurers of a necessary change per the statute.

The new .75% rate will remain in effect until the Superintendent notifies insurers of a necessary change per the statute.

The program, which has been in effect since July 1, 1990, helps offset the cost of medical professional liability insurance premiums for physicians who provide prenatal care and delivery services in the state's underserved communities.

The Bureau of Health and Human Services determines the eligibility requirements a physician must meet in order to receive premium assistance and which communities are designated as underserved. Contact Charles Dwyer at the Maine Office of Rural Health and Primary Care at 287-5503 for more information. Applications for the subsidy are available online at www.maine.gov/dhhs/BOH/orhpc/.

For further information about the program, please contact Lauri Cooper at the Maine Bureau of Insurance, 34 State House Station, Augusta, ME 04333 or by email at laurelyn.s.cooper@maine.gov.

New Poll Reveals Americans' VIEWS About Physicians & MEDICAL CARE

A new study has found most Americans are satisfied with the quality of health care they receive from their physicians but hold drug and insurance companies responsible for its high costs.

ABC News, the Kaiser Family Foundation and *USA Today* surveyed 1,201 adults nationwide in September. Those polled were asked about their views and experiences related to health care costs and quality, as well as their attitudes towards possible policy solutions.

Here are some highlights of that study:

Nearly 90 percent of the public is satisfied with the medical care and communication received from their doctors and with their own health insurance coverage.

Half of those surveyed said excessive profits of drug and insurance companies are to blame for rising health care costs. More than a third blamed medical malpractice suits, and fraud and waste in the health care system.

Nearly 80 percent do not agree that doctors who charge higher prices provide better medical care.

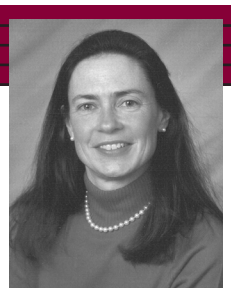
More than 50 percent think that the quality of their family's health care would stay the same under a universal health insurance system and would support a government-run universal coverage program.

Nearly 80 percent think the most effective way to control health care costs would be to allow individuals to shop around for the best prices for health care and health insurance.

The telephone survey has a sampling error of plus or minus 3 percentage points for results based on total respondents.

Read the full report at www.kff.org/kaiserpolls/pomr101606pkg.cfm

The Coding Center by Jana Purrell, CPC, Coding/Reimbursement Specialist



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Updates for 2007

I'm sure you all know that the CPT codes for 2007 went into effect on January 1 (meaning dates of service of January 1) with no grace period, so hopefully you have all updated your encounter forms, superbills, fee tickets, etc.

For the most part the changes this year were rather unexciting (I know some of you may be saying "they are always unexciting!). The big challenge this year lies in the rearranging of several sections of codes. The AMA put a lot of effort into "cleaning up the junk drawers" of CPT. There have been new subsections added, new parenthetical and instructional notes included, with a concerted attempt to make finding and using the codes more user-friendly.

On the positive side—no new modifiers, minor changes to E/M visits (other than the addition of anticoagulation management codes), and most of the new codes and descriptions happening in the Category II and Category III codes (Performance Measures and Temporary Codes for Emerging Technology).

The big changes this year are in the Integumentary section and in the Radiology section. In the Integumentary system the major changes include new descriptions for the destruction codes to specify destruction services for premalignant or benign lesions and new Moh's microsurgery codes were added to describe anatomic site. In Radiology, most of the changes entail the deletion and renumbering of many codes along with new subheadings (magnetic resonance, ultrasound, fluoroscopic guidance) to allow for more logical location of codes. It is important to understand that in most cases the description of the code has not changed, just the code number. Be sure to reference the new Appendix M for an easy crosswalk. Which brings up another point—several companies have the rights to publish the CPT book—some of the editions published by some companies do not contain all of the Appendices (A thru M this year) (i.e. the Expert Edition). All publications from the AMA do contain all sections.

In total, there were 258 codes added, 79 codes revised, 308 codes deleted, and 91 changes to guidelines, introductory notes, headings and cross references. Additionally, the work RVU values were revised for several sections of codes (in particular E/M services). While the conversion factor was frozen from last year at 37.89, the change in RVU's may make the reimbursement for some of your services go up or down. You can view the 2007 RVU table at http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF

By now, most of you have probably been updated on the particulars for your specialties. Below are several websites that may have information you may find useful as we start using CPT 2007:

- Medicare has published two recent important MLN Matters Articles regarding 2007 Physician Fee Schedule Payment Policies. These can be found at:
  http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5443.pdf
  http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5459.pdf

Items of interest here include:

- A new G code (G0377) has been created for the administration of Part D vaccines and payment for G0377 will be cross walked to CPT code 90471 for one year
- Addition of a one-time preventive ultrasound screening for abdominal aortic aneurysms (AAA), for at risk beneficiaries, **only available** as part of the Initial Preventive Physical Examination (also referred to as the Welcome to Medicare physical)
- CMS has established separate payment for sodium hyaluronate products that have come on the market since October 2003. Four interim Q codes are in effect for these products as of January 1, 2007, i.e., Q4083 (Hyalgan/supartz inj per dose), Q4084 (Synvisc inj per dose), Q4085 (Euflexxa inj per does), and Q4086 (Orthovisc inj per dose).

- The AMA has published a corrections document that goes along with CPT 2007 that identifies some errors in the publication. This can be found at:
  http://www.ama-assn.org/ama1/pub/upload/mm/362/2007cptcorrections.pdf

One last thing—reminder, time is running out on taking advantage of Aetna's settlement agreement. Physicians and their staff are encouraged to scrutinize claim payments to make sure Aetna adheres to the terms of its settlement agreements. In many cases, it will be up to physicians to hold Aetna accountable.

In 2006, Aetna reached an agreement with state medical societies to pay resubmitted claims for Evaluation and Management visits billed with a Modifier-57-indicating that the decision for surgery was made during the visit-when billed with major (global 90-day) procedures. Aetna changed its policy effective Feb. 12, 2006, and began paying these claims that it had previously denied.

To be properly compensated, physicians must take action early in the new year. For 120 days starting Jan. 1, 2007, physicians can resubmit previously denied claims for service that took place between Jan. 1, 2005 and Feb. 11, 2006.

As always, please contact The Coding Center at 888-889-6597 if you have questions or need assistance with your coding.

AMA Program Allows Physicians to Opt-Out of Data Sharing

MMA members who are concerned about their prescribing data being used for pharmaceutical marketing may want to participate in the American Medical Association's Prescribing Data Restriction Program. This option may be preferable to the potential passage of L.D. 4 by the legislature which would prohibit the use of such information in marketing, regardless of the physician's desires.

The AMA does not collect or distribute physician prescription data. But the AMA does license its physician databases to other organizations, and those organizations can append prescribing data from other sources to the AMA's data. The combined information is then packaged and licensed to the pharmaceutical industry.

The AMA's Prescribing Data Restriction Program allows physicians to specify how they wish their data to be used. According to the AMA, physicians can decide whether to deny pharmaceutical sales representatives access to their prescribing habits.

If a pharmaceutical company or sales representative uses data inappropriately, the AMA program allows physicians to register complaints.

For more information, go to http://www.ama-assn.org/ama/pub/category/12054.html

THANK YOU to the following individuals who served on a pre-litigation screening panel during the last six months of 2006.

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We apologize to others who may have served whom we are not aware of.

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