JANUARY/FEBRUARY 2008

Maine medicine

MAINE MEDICAL ASSOCIATION

IN THIS ISSUE

Congress Enacts Medicare-SCHIP Package: Six-month Fix for Physician Fees

On Dec. 19, 2007, Congress passed legislation that would replace the scheduled 10.1% (actually 12 to 13% in Maine) cut in 2008 Medicare physician payments with a 0.5% increase through June 30, 2008. In the bill, signed by President Bush on December 29, 2007, Congress increased spending for Medicare physician payments by $3.1 billion. It is disappointing that Congress failed to provide a longer-term solution that is paid for and that creates a pathway for the long-term replacement of the flawed payment formula based upon the Sustainable Growth Rate (SGR). On the other hand, the 0.5% increase is better than a cut. A 10.6% reduction will occur on July 1, 2008, unless Congress acts again before that date. Details of the package are below.

Key Elements of 2007 Medicare-SCHIP Package

- Replaces 10.1 percent cut with 0.5 percent increase through June 30, 2008. If Congress fails to take action before the end of next June, physicians will face a cut of approximately 10.6 percent
- Authorizes additional 1.5 percent bonus for Medicare physician quality reporting initiative (PQRI activities) through Dec. 31, 2008
- Extends floor for work geographic adjustment and physician scarcity bonus through June 30, 2008 (very important for Maine)
- Budget offsets: removes $1.5 billion from Medicare Advantage stabilization fund; eliminates physician payment fund carried over from 2006 Medicare package and reduces payments for some Part B drugs
- Extends therapy cap exceptions, pathology billing exception and premium assistance for some low-income seniors for six months
- Extends SCHIP funding through March 31, 2009 (additional funding provided for current enrollment)

Key Elements <u>NOT</u> Included in Senate Medicare Package (Several items that were opposed by medicine were, fortunately, not included in this scaled down package.)

- Electronic prescribing requirement or reductions in payments for paper scripts
- Imaging provisions to reduce payments, mandate accreditation or establish appropriateness demonstration projects
- Change direction of Medicare's Quality Improvement Organization (QIO) program to focus on enforcement and require changes in QIO Boards
- Provisions to alter or supplant the role of the Relative Value Update Committee and provide Medicare with authority to make arbitrary payment cuts for rapidly growing services
- Create specialty specific expenditure targets

Challenge for the Future

Passing legislation by the June 30, 2008 deadline with a narrowly divided Senate will be difficult. In the next few weeks, the AMA will be working closely with state and national specialty societies to develop, coordinate and execute the 2008 campaign to provide a permanent fix to the annual challenge. MMA leadership and staff will be in Washington, D.C. April 1-3, 2008 to work with the AMA lobbying team at the annual AMA Advocacy Conference.

HANLEY AWARD DINNER

Below, Wendy Wolf, M.D., President, Maine Health Access Foundation speaks with Maria Hanley, widow of Daniel Hanley, M.D.

SAVE the DATE

5th Annual Benefit Golf Tournament
Augusta Country Club
June 23, 2008

Call 622-3374 for details!

At its Annual Dinner in November, the Daniel Hanley Center for Health Leadership presented its Annual Leadership Award to Robert Ritchie, M.D., recognizing his landmark work in establishing the Foundation for Blood Research. From left: Dr. Ritchie with Maria Hanley, Mrs. Anne Ritchie and Sean Hanley, M.D.

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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.

William Strassberg, M.D., President, MMA

President's Corner

Is Medical Professionalism Relevant to You and Your Patients?

I am fearful that the profession of medicine is turning into a second tier occupation. The medical profession is losing allure and I am concerned about future generations of physicians and how medicine will be perceived by them. The pay for most physicians is still reasonable, but our former sense of purpose and respect often feels diminished. The medical profession competes in the 2008 marketplace against many other enticing and more modern options.

Society prizes risk, outsized rewards, and rapid return of investment. How will medicine compete now and in the future with banking and e-commerce? Can you say "My Space or Google"? The landscape has changed and it is acknowledged that young people and young physicians today are appropriately concerned about quality of life, flexibility, and creativity. Our profession seems to excel in hard work and dedication to others. These are laudable traits, but without cache`, our profession will become a second choice when future generations are choosing their vocation.

The renewal of medical professionalism is important because of the direction our profession has taken. The medical industry that we are part of emphasizes productivity and the application of "accounting logic" to the practice of medicine has intruded into the autonomy of practitioners. Young physicians today might find themselves adopting a "shift work" or "production line" mentality which is after all, the nature of business.

I do not mean to demean my young colleagues, as professionalism is a value that must be taught. Instead I will ask – where are their mentors? It is the role of the experienced physician - those of us in the community, those of us teaching in residency programs, and those of us choosing to be leaders in medicine - to demonstrate best values and relationships with our patients and our profession. This component of medical teaching has fallen short in the past several decades. In retrospect, I remember questioning episodes early in my training where the attending surgeon made sure that a loose body was found, there was tissue to debride, and a meniscal tear to be treated, in each and every knee arthroscopy. Others might recall professors that enjoyed lavish travel and recreational opportunities, or accepted expensive "gifts".

The movement back to medical professionalism addresses these issues and lost values head on. Since the 1960's, society has increasingly questioned physician's commitment to public well being, and asserted that medicine was abusing its autonomy and placing self interest first. Trust, a cornerstone of professionalism, was breached and the society became increasingly aware that the trust placed in the medical profession and our privileged status was only justified by the expectation that our profession would act in an altruistic manner.

For physicians, this means using our knowledge for the benefit of both individual patients and society as a whole, and constantly placing these interests above our own. We are expected to behave in a moral and ethical fashion, and carry out our activities with integrity, both exogenously in our interactions with society, but also endogenously in terms of autonomy and self regulation.

Where does the individual physician fit into this schema, and what is the role of professional societies? Is there modern relevance in the concept of medical professionalism?

Medical educators, practitioners, and leaders in medicine all share accountability for our loss of professionalism, and diminished role in medicine. Individually, physicians wish to regain autonomy of medical decision-making, maintain the ability to provide quality care, and retain their professional values in the midst of the business of healthcare. Governmental and corporate control of medicine has imposed goals and values different from our own and we cannot alter our situation without leaving this industry of medicine behind. The healthcare industry is corporate and profit driven; measures are profits and costs, not quality of care. Return to a medical professional model will help restore physician and patient based values. This is not to say that we should be immune to cost; we must be judicious in medical decision making and be aware of expenses and the global healthcare budget.

In order to evolve (and restore medicine as a premier calling), our implicit contract with society requires renewal and renegotiation as times change. Our interests and motives have been questioned lately as they have never been questioned before. The public perception that we fail to self regulate in a way that can guarantee competence, coupled with a feeling that we have placed our own interest above that of our patients and the public, is troublesome. But, as control of healthcare has shifted from physicians to the healthcare industry, so has the blame. Patients remain attached to their physicians and want their doctor to be a partner in their health care decisions. Although tarnished, we still enjoy the trust and confidence of our patients. This differentiates us from the rest of the industry and this will be our strongest currency as we attempt to realign our position in the medical field. Of note, it is equally important for society to recognize and promulgate the concept of a professionally based value system in healthcare. This message must be transmitted by our profession and our professional societies to the public.

And what is the role of MMA and other professional societies? Medical societies represent medicine and professional values. Recently, national, regional, and academic societies have promoted the concept of medical professionalism. In the past, medical associations at times have been viewed as part of the problem as the conflicting roles of healthcare experts and physician representatives collided, but associations are extensions of individual physicians, and must espouse and exemplify professional values. The very behaviors and characteristics that the individual physician commits to – altruism, integrity, honesty, and accountability – are extended to the professional association. As aggregate leaders of medicine, medical associations must advocate for values consistent with the best medical morals and ethics. If they do not, than who will?

Medical societies and medicine's leadership are best positioned and obligated to advocate publicly for the advancement of medical professionalism and values. The higher calling of our profession is worth all the hard work. I am concerned that unless we act, unless we alter the status quo, we will lose the sense of calling, experience further loss of respect, and most importantly, lose the best and the brightest of future generations.

Talk to me: baybones@midcoast.com

Maine Medical Education Trust

The Maine Medical Education Trust is the primary vehicle for MMA philanthropy. It provides financial support and services for organizations that provide benefit to the patients of Maine and this nation. Please make your tax-deductible contribution today so that MMA can continue to give generously to worthy causes that benefit the health and well being of our communities through the MMET.

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Phone:_____ Email: _____

Mail this form with payment to: Maine Medical Association, PO Box 190, Manchester, ME 04351
If paying with credit card, you can fax to 207-622-3332.

HealthInfoNet Advances to Demonstration Phase

On Jan. 16, Maine's HealthInfoNet (HIN) Board announced that it had reached a fundraising milestone of $4 million and would proceed with development of a demonstration project that would involve as many as 2,000 physicians in the four major medical centers and fifteen additional hospitals. The project also includes the Maine Center for Disease Control and Prevention.

Maine's four largest health systems - Eastern Maine Healthcare Systems, Maine General Medical Centers, Central Maine Health Care and Maine Health all will participate in the effort to build a statewide network of electronic health records. While other states are working on similar projects, HIN would be the nation's first truly state-wide system. The network is expected to be available to participants in the demonstration project in about one year. HIN has contracted with 3M Health Information Systems, a subsidiary of 3M Co., and Orion Health to build the system and ensure its security.

If successful, patients would eventually be able to log onto the system to review their own record and to track who has been accessing it. In addition, patients of participating providers will be able to opt out of the information-sharing system.

The bulk of the funding is coming from the health systems and the Maine Health Access Foundation. MMA has supported the effort in concept since 2004 and has been represented on the Professional Advisory Committee by Paul Klainer, M.D. of Rockland.

Upcoming at MMA

FEBRUARY 6	12:30pm – 2:00pm	Aligning Forces for Quality
	2:00pm – 5:00pm	Quality Counts! Board
FEBRUARY 7	Noon – 4:30pm	Home Care and Hospice Alliance of Maine
FEBRUARY 13	8:00am - Noon	AAPC Medical Coding Certification Class
	4:00pm – 6:00pm	MMA Public Health Committee
FEBRUARY 20	8:00am - Noon	AAPC Medical Coding Certification Class
FEBRUARY 21	6:00pm – 8:30pm	Maine Association of Psychiatric Physicians
FEBRUARY 25	6:00pm	MMA Committee on Legislation
FEBRUARY 27	8:00am - Noon	AAPC Medical Coding Certification Class
FEBRUARY 28	8:00am – 3:30pm	Pathways to Excellence
MARCH 5	8:00am - Noon	AAPC Medical Coding Certification Class
	Noon – 2:00pm	MMA Operations Committee
	2:00pm – 5:00pm	MMA Executive Committee
	5:00pm – 9:00pm	Maine Chapter, American College of Emergency Physicians
MARCH 7	9:00am – Noon	"First Fridays" CME Program: HIPAA
MARCH 10	5:30pm – 8:30pm	MMA Committee on Physician Health
MARCH 12	8:00am - Noon	AAPC Medical Coding Certification Class
	12:30pm – 2:00pm	Aligning Forces for Quality
	2:00pm – 5:00pm	Quality Counts! Board
MARCH 19	8:00am - Noon	AAPC Medical Coding Certification Class
MARCH 20	4:00pm – 6:00pm	MMA Committee on Physician Quality
MARCH 26	8:00am - Noon	AAPC Medical Coding Certification Class
APRIL 2	8:00am - Noon	AAPC Medical Coding Certification Class
	12:30pm – 2:00pm	Aligning Forces for Quality
	2:00pm – 5:00pm	Quality Counts! Board
APRIL 3	Noon – 4:30pm	Home Care and Hospice Alliance of Maine
APRIL 4	9:00am – Noon	"First Fridays" CME Program: Coding Update
APRIL 8	5:00pm – 9:00pm	Maine Chapter, American Academy of Pediatrics
APRIL 9	8:00am - Noon	AAPC Medical Coding Certification Class
APRIL 16	8:00am - Noon	AAPC Medical Coding Certification Class
	Noon – 2:00pm	MMA Operations Committee
	2:00pm – 5:00pm	MMA Executive Committee
APRIL 23	8:00am - Noon	AAPC Medical Coding Certification Class

Upcoming Specialty Society Meetings

FEBRUARY 9–10, 2008 *Sugarloaf/USA*
Maine Society of Anesthesiologists Winter Meeting
Contact: Anna Bragdon 207-441-5989 or msainfo@roadrunner.com

FEBRUARY 9–10, 2008 *The Samoset Resort – Rockport, ME*
American Heart Association's 58th Annual Scientific Session - *Management of the Patient with Peripheral Arterial Disease*
Contact: Melissa Goodrich 207-523-3002 or melissa.goodrich@heart.org

FEBRUARY 14-16, 2008 *Sugarloaf/USA*
18th Annual Contemporary Topics in Orthopaedics
Contact: Lauren Mier 207-622-3374 ext: 223 or lmier@mainemed.com

FEBRUARY 29 – MARCH 2, 2008 *The Bethel Inn – Bethel, ME*
Maine Gastroenterology Society Meeting
MMA Contact: Gail Begin 207-622-3374 ext: 210 or gbegin@mainemed.com

MARCH 5, 2008 *Maine Medical Association – Manchester, ME*
Maine Chapter of the American College of Emergency Physicians Meeting
MMA Contact: Anna Bragdon 207-441-5989 or maineacep@roadrunner.com

MARCH 7 - 9, 2008 *Sugarloaf/USA*
Maine Section, ACOG Meeting
Contact: Cindy Croteau 207-662-2749

MARCH 14 - 16, 2008 *Sugarloaf/USA*
Maine Otolaryngology Society Annual Winter Meeting
Contact: Leslie Rankin 207-351-3525

APRIL 25, 2008 *Sunday River Jordan Grand Resort Hotel*
17th Annual Northern New England Rural Pediatricians Alliance (NNERPA) Meeting - *The Danger of Being Born into Rural Northern New England in 2008* - 12:15pm -9:00pm
Contact: Diana Dorsey, MD at ddorsey@dhhs.state.nh.us

APRIL 26-27, 2008 *Sunday River Jordan Grand Resort Hotel*
American Academy of Pediatrics, Maine Chapter Spring Conference - *Bright Futures and Foster Care*
Contact: Aubrie Entwood 782-0856 or agridleyentwood@aap.net

Kellie P. Miller, M.S., Joins MMA Team in January

The Maine Medical Association is pleased to announce the hiring of Kellie P. Miller, M.S., of Hallowell to serve as Director of Public Health Policy at MMA, effective Jan. 2, 2008. Kellie will also serve as Executive Director of one or more medical specialty societies or related organizations that contract with MMA for administrative services.

Kellie most recently served as Director of Emergency Preparedness for the Maine Primary Care Association in Augusta. Prior to that position, she served for 12 years as Executive Director of the Maine Osteopathic Association in Manchester. Previously, she had served in various capacities for ten years with the American Lung Association of Indiana.

At the Maine Primary Care Association, Kellie was responsible for the development and implementation of the Association's efforts regarding community planning for response to public health emergencies, with particular emphasis on Pandemic Influenza preparedness, including Community Health Centers All Hazards Preparedness.

Kellie received her Bachelor of Science Degree in Health Education at Ball State University and her Master of Science Degree from Purdue University.

Kellie currently serves as President of Medical Care Development and recently served on the Boards of the Maine Health Information Center, the Maine Health Data Processing Center and as a member of the Medicaid Advisory Committee and the Hallowell Board of Trade.

"After admiring Kellie's work for over a decade, we are now thrilled to have her join our MMA team and community," stated Gordon Smith, MMA Executive Vice President. "She knows our issues, knows many of the physicians in the state and will be an important asset on her first day and beyond. We also believe that Kellie can be an important link to establishing stronger relationships between MMA and Maine's Osteopathic community. We could not be more excited to have her working here at MMA."

Thanks to 2008 Sustaining Members

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

David Andrews, MD
Haldor Barnes, MD
John Bosco, MD
Rebecca Brackett, MD
Mark Cooper, MD
Norma Dreyfus, MD
Brian Jumper, MD
Michael Parker, MD
Reed Quinn, MD
Michael Szela, MD
Cardiovascular Consultants of ME
Central Maine Medical Center
CMMC Anesthesia
Dahl-Chase Pathology Associates
Goodall Hospital
InterMed, P.A.
Medical Rehabilitation Associates
Mount Desert Island Hospital
PrimeCare
Sunbury Primary Care

Classified Ads

Southern Maine Geriatric Position
Geriatrician needed for a nursing home practice in Maine. Competitive compensation package. Internal medicine and family practice candidates with strong interest in Geriatrics are welcome. Please Email resume to info@mainegeriatrics.com or fax to (207) 846-6789.

Part-time Physician

Be a part of the most dynamic healthcare team in the world! CHD Meridian Healthcare is seeking a Physician with occupational health, ER or orthopedic experience for a major manufacturing facility located in Bangor, Maine. This position will treat occupational injuries and illnesses, perform medical surveillance exams and provide AED program oversight. Position hours are 2 hours per week.

To apply go to www.chdmeridian.com requisition #: 07-0110. EOE

U.S. HealthWorks is an innovative leader of industrial and outpatient physical therapy centers in the nation. We are currently seeking to add highly qualified Physicians to our clinics throughout Maine.

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www.ushealthworks.com
EOE

If you would like to know how your classified ad can appear in the next issue of *Maine Medicine*, contact Shirley Goggin at 445-2260 or sgoggin@mainemed.com.

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Survey Shows Impact of Aging Physicians

There are more than 298,200 physicians between the ages of 50 and 65—36 percent of the total physician population. The national physician search and consulting firm Merritt Hawkins & Associates conducts an annual survey to determine the practice plans and career satisfaction levels of experienced physicians. Fifty-two percent of responding physicians in the recently released 2007 survey said that they have found practicing medicine less satisfying in the last five years—citing reimbursement issues, malpractice worries, long hours, and the pressure of running a business as contributing factors. Forty-nine percent of physicians responding said that they plan to make a change to their practice in the next one to three years. Some of these changes include working in non-medical fields, working on a part-time or temporary basis, and closing their practices to new patients.

The 2007 Survey of Physicians 50 to 65 Years Old notes that global physician availability will be significantly affected if physicians 50 years or older decide to see fewer patients, seek positions in non-clinical or non-medical settings, or retire permanently. This could further exacerbate anticipated physician shortages; the Council on Graduate Medical Education is predicting a shortage of 96,000 physicians by the year 2020.

For a free copy of the report, which highlights current and upcoming trends within the aging physician population, contact Jeremy Robinson at (800) 306-1330 or Jeremy.Robinson@MHAGroup.com.

Jana Purrell, CPC

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

Maine Medical Association Tel: 888-889-6597 Fax: 207-787-2377 jpurrell@thecodingcenter.org

CPT Updates for 2008

Once again, it's that most wonderful time of the year! OK, so maybe not that exciting to most of you but for some, the new CPT codes for 2008 that went into effect on January 1 maybe be just what you were hoping for. There are now 8,661 CPT codes with 244 new codes for 2008 along with 314 revisions and 50 deletions. As always, it is important to review the lists of the changes and be sure that your encounter forms, superbills, fee tickets, etc. have been updated to avoid errors in billing or more importantly, delay in payment.

The breakdown of changes is as follows:

SECTION	ADDITIONS	DELETED	REVISED
Anesthesia	2	1	1
E/M	12	3	9
Surgery	73	22	127
Radiology	8	7	24
Path/Lab	11	1	11
Medicine	21	0	119
Category II	103	5	3
Category III	13	11	13
Appendix A--Modifiers	1	0	8

Highlights this year include the re-establishment of typical times associated with the nursing home codes; new codes for smoking cessation and alcohol/substance abuse screening and intervention; medical therapy management codes added for use by pharmacists; new codes for telephone assessment and on-line assessment and management by physicians and non-physician qualified healthcare providers; many additions to the Category II codes for performance measures; and conversion of several Category III codes (temporary codes for new technology) to Category I CPT codes.

Also of note, there were changes to the terminology in several modifiers which should allow for better understanding of how these modifiers are to be used (22, 25, 58, 59, 76, and 78). Also changes were made in the criteria for the Modifier 51 exempt codes (those services that should not be listed as multiple procedures) allowing for more add-on codes which allow for different reimbursement methodologies.

In addition to the new codes, CPT 2008 continues to make revisions to the sections, subsections, and headings. Also with the addition and/or deletion of codes, it is important to look for changes in the parenthetical and cross-references to assist in coding appropriately. While we tend to focus on the new codes, revisions in the text of a code and/or the description may change the way we use the code.

As you know by now, Congress passed legislation that would replace a scheduled 10.1 percent cut in 2008 Medicare physician payments with a 0.5 percent increase through June 30, 2008. Consequently, the Medicare Participation decision period is being reopened for an additional 45 days until Feb. 15, 2008. You can find more information at http://www.ama-assn.org/ama1/pub/upload/mm/399/medicarepayment08.pdf.

You can also find the RVU table for 2008 at http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=3

The American Medical Association has details of the 2008 coding changes at their website (http://www.ama-assn.org/ama/noindex/category/18175.html) and many of the specialty societies also publish specialty-specific information on their websites.

As always, please contact The Coding Center at 888-889-6597 or checkout our newly designed website at www.thecodingcenter.org if you have questions or need assistance with your coding needs.

DHHS Announces MaineCare Claims Management Fiscal Agent Award

In a letter dated December 28, 2007, DHHS Commissioner Brenda Harvey notified Unisys Corporation that it has been conditionally awarded the contract for the *MaineCare Management Information System and Fiscal Agent Solution*, the MeCMS replacement. The company and the Department must now negotiate the details of the relationship.

Unisys was one of three vendors that responded to the Request for Proposals. ACS State Healthcare, LLC of Atlanta, Georgia and First Health Services Corporation of Glen Allen, Virginia also submitted proposals.

The Department expects contract negotiations to continue through January and the final contract is subject to review by the federal government and must be approved by the State Purchases Review Committee. Those who submitted proposals have 15 days to appeal the award.

Unisys currently provides similar fiscal agent services in West Virginia, Louisiana, and New Jersey, and recently earned the award to develop a Medicaid Management Information System in Idaho.

10 things you need to know about Medicare Advantage private fee-for-service plans

1. If you have a Medicare provider number, you may, **but do not have to**, treat any private fee-for-service (PFFS) patient.
2. There are no contracts to be signed with PFFS, but if you knowingly treat a PFFS patient and have access to the PFFS plan's terms and conditions, you are considered **"deemed."**
3. You are deemed **separately for each patient encounter**, and once deemed, Medicare does not require you to treat that patient again or any other PFFS patient in the future; however, you must remain compliant with legal and ethical patient abandonment issues.
4. As a deemed physician, you will be paid for that single patient encounter according to the **PFFS plan's terms and conditions.**
5. PFFS plans' terms and conditions are most easily found on their Web sites. Visit **www.ama-assn.org/go/ma** for a link to download most of these Web site names.
6. You must **bill the health plan**, not Medicare, for PFFS patient care.
7. There is **no Medigap** coverage in conjunction with PFFS plans.
8. Patient **copays/coinsurance** may vary both from traditional Medicare and by PFFS plan.
9. If you are a **Medicare participating physician**, you are entitled to collect the same total fees, from the PFFS plan and the patient, as you would under traditional Medicare at least through calendar year 2007.
10. If you are a **Medicare nonparticipating physician**, the PFFS plan's terms and conditions will determine that you are entitled to collect from the PFFS plan and the patient either:
    - The same total reimbursement you receive under traditional Medicare (the Medicare limiting charge including balance billing) or
    - The same total reimbursement that participating providers receive under traditional Medicare (100 percent of the Medicare fee schedule) with no balance billing allowed.

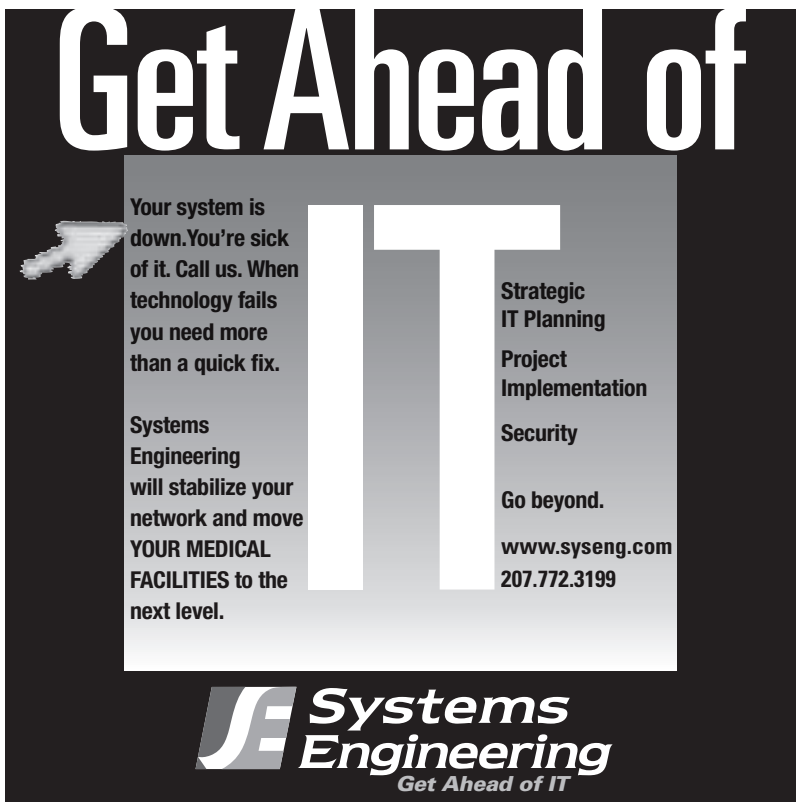
If you know of a PFFS plan that is not in compliance with the points on this list, please contact the American Medical Association Private Sector Advocacy unit at (312) 464-4367.

SAVE THE DATE

2008 Annual Practice Education Seminar

Wednesday May 28, 2008

Augusta Civic Center



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*

New Federal Rules May Help You Transition to Electronic Health Records

The federal Stark and anti-kickback laws strictly govern relationships and exchanges between health care entities. However, two Department of Health and Human Services (HHS) rules, effective October 10, 2006, created new exceptions and safe harbors under those laws to support physicians' adoption of technology.

One of the rules sets up two new safe harbors under the anti-kickback statute for electronic prescribing and electronic health records (EHRs).

ELECTRONIC PRESCRIBING The electronic prescribing safe harbor protects unlimited donation of electronic prescribing technology (hardware, software, information technology, training and support) by:

- A hospital to its medical staff
- A medical group practice to its members
- A prescription drug plan sponsor or Medicare Advantage organization to prescribing health care professionals, pharmacies and pharmacists in the plan

Prescribing applies broadly to all items and services that normally require a prescription, including drugs and durable medical equipment. Those who already possess similar technology are not eligible.

RULES FOR EHRs The EHR safe harbor protects donation of interoperable software or information technology and training (not hardware) that is necessary and used predominantly – but not exclusively – to create maintain, transmit or receive EHRs. An electronic prescribing component must be included.

Covered donors may include individuals and entities that provide covered services and submit claims or requests for payment to any federal health care program and health plans. Covered recipients include individuals and entities engaged in the delivery of health care.

Recipients must pay at least 15 percent of the donor's cost, and the donor cannot provide or finance the recipient's payment. The safe harbor ends on December 31, 2013.

Neither an electronic prescribing nor electronic health records system can be donated based on volume or value of referrals from a recipient.

MORE RULES The other rule creates two new exceptions under the Stark law essentially identical to the anti-kickback safe harbors. The 2003 Medicare Prescription Drug Improvement and Modernization Act mandated these rules to encourage physicians to adopt electronic prescribing and EHRs. Although Medicare mandates electronic prescribing for some entities, it is currently optional for physicians.

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Medical Mutual Insurance Company of Maine Risk Management Practice Tip:

Faxing Faxing Faxing Faxing Faxing Faxing Faxing Faxing Faxing Faxing Patient Information

Maintaining the confidentiality of patient information is the responsibility of all healthcare entities. Communication of patient information occurs through many different mediums including traditional paper and electronic faxing. When faxing is used, a policy should be in place to assure that the confidentiality of the information is protected.

Policy

The following elements should be considered for inclusion in a policy.

I. Location
- Assure the fax machine or computer (if faxing electronically) is located in a secure area, not accessible to unauthorized persons.

II. Faxing Documents
- Cover sheet should display:
  - Date and time of transmission
  - Sender facility name, address and sender's name if relevant
  - Patient's name
  - Receiving facility's name, telephone number, fax number
  - Authorized receiver's name
  - Number of pages transmitted
  - Statement addressing redisclosure of information
  - Instructions to verify receipt of documents
- Verify availability of receiver before beginning transmittal.
- Request authorized receiver to acknowledge the receipt of the documents.
- Document the receiver's acknowledgment in the patient's medical record.

III. Receiving Fax
- Paper method
  - Identify one individual to monitor the fax machine.
  - Remove the documents from the tray immediately upon completion of the transaction.
  - Count the number of pages to assure the correct number was received.
- Read cover letter and follow the instructions for acknowledgement of the transmission.
- Deliver or send the documents electronically to the intended receiver.

IV. Misdirected Fax
- If a fax transmission fails to reach recipient, check internal logging system of the fax machine (for paper faxes) to obtain recipients fax number or retrieve through the software program, the fax number to which an electronic fax was sent.
- Fax a request to the recipient, using the incorrect fax number, explaining the misdirection and asking that all received documents be immediately returned via mail. Note that electronic faxes may be able to be rerouted to the sender.
- Notify the sending physician of the error and the corrective action taken.
- Keep a log of misdirected faxes, identify causes/trends and implement procedural changes to prevent a reoccurrence.

V. Faxes should not be used:
- As the sole notification method of abnormal test results
- To communicate urgent requests

VI. Faxing Prescriptions
- Laws and regulations for faxing prescriptions must be followed and may vary by state. For Schedule II Controlled Substances and III-V Substances please refer to the Drug Enforcement Administration (DEA) website or access the latest version of the Drug Enforcement Administration Practitioner's Manual also found on-line.

Summary

Implementation of the above recommendations will assist in minimizing the risk of unauthorized access and the breach of patient confidentiality. While utilizing either method to fax patient information is acceptable, electronic faxing may offer greater security. Faxing directly from a software program allows faxes to be directed from the privacy of the user's computer. Incoming faxes can be password protected and can be directed only to specified individuals, thereby, assuring tighter security. The electronic option prevents access by unauthorized individuals and the potential misplacement or loss of a paper document.

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.

How to Make Sure PQRI Reporting "Counts"

Medicare Physician Quality Reporting Initiative (PQRI) participants must use their *National Provider Identification* (NPIs) correctly for quality data submissions to count toward successful reporting. However, CMS has advised that some billing houses are stripping NPIs out of claims before sending them for processing and payment.

Physicians and providers who use billing houses should check that NPIs are not being stripped out of claims because CMS applies the bonuses to the individual NPI. Quality data submissions will not count toward potential PQRI reporting bonuses if the NPI is not reported.

Signs of "Dropped" NPIs

Since mid-October, Medicare has been sending "warning codes" to some PQRI participants, indicating that claims did not show an NPI in the required primary provider fields.

PQRI participants who receive any one of these codes – M389, M390, M391, and M392 – should verify that their NPIs are properly included with all claims. If the physician continues to receive warning codes, it's possible that a billing agent or clearinghouse is stripping the NPI out of claims before sending them to Medicare.

In addition, CMS has advised that clearinghouses or billing services may be stripping the NPI from the claim but adding it back on the remittance advice.

Physicians and providers who suspect this may be happening should call NHIC, Corp (Medicare Part B Carrier) in Biddeford, Maine at 207-294-4300 to determine if submitted claims are being received without NPIs.

PQRI participants have until February 29, 2008, to submit claims and quality data information pertaining to the 2007 program ending December 31.

Did Your EHR Get a Stamp of Approval?

The Certification Commission for Healthcare Information Technology has certified more than 50 office-based health information technology products. Certification is a stamp of approval that physicians can consider when choosing an electronic health record system.

All certified products are listed on www.cchit.org.

Volunteers Sought to Serve as Physician of the Day at State House

The 123rd Maine Legislature re-convened for its Second Regular Session on January 2, 2008. As has been the custom for several years, the Maine Medical Association and the Maine Osteopathic Association will provide a physician each day to provide emergency medical assistance should the need arise. Physicians are needed in all specialties. If you are able to give a few hours, usually in the morning, please contact Andrew MacLean at 622-3374, ext. 214 or via e-mail to amaclean@mainemed.com.

"Being the Doctor of the Day at the Legislature is not only enjoyable; it is a great opportunity to meet our lawmakers. It is not unusual for a lawmaker, even one who is not in your district, to seek out the doctor and ask an opinion about a particular bill. The physician has great visibility and can have an impact on measures that are important to the profession."

Adele Carroll, D.O., York County

Andrew MacLean, Esq.

Legislative Update

123rd Maine Legislature Convenes for Second Regular Session

The 123rd Maine Legislature returned to Augusta January 2, 2008 to begin its Second Regular Session. The session is expected to last about four months and to focus on the state budget deficit, school consolidation, and other administrative and fiscal issues. Without new leadership emerging to work on health care reform, it is unlikely that meaningful reform can take place when efforts such as the Blue Ribbon Commission recommendations for Dirigo failed last year, with this same group of legislators.

With the deadline for "carry-over" bills approaching, on Thursday, December 6, 2007, the 123rd Maine Legislature's Judiciary Committee held a public hearing on 6 medical liability bills carried over from the First Regular Session earlier in 2007. The Committee considered the following bills:

L.D. 367, *An Act to Protect Emergency Room Personnel from Civil Liability* (for denying drugs to potential drug seekers)

L.D. 469, *An Act to Disseminate "Lessons Learned" from Medical Injury Claims* (based upon liability claims data analyzed by the Board of Licensure in Medicine)

L.D. 608, *An Act to Extend the Statute of Limitations for Certain Medical Malpractice Cases* (proposed a "discovery rule" for the statute of limitations)

L.D. 684, *An Act to Permit Medical Providers an Opportunity to Express Regret for a Medical Error* (duplicative of legislation enacted in the 122nd Maine Legislature)

L.D. 857, *Resolve, to Create a Medical Malpractice Study Group* (Bureau of Insurance conducted a study of the Maine market in 2005 as required by the Dirigo Health legislation)

L.D. 1271, *An Act to Establish Health Care Practitioner Immunity for Consulting Physicians in Critical Specialties or Subspecialties* (proposed "Good Samaritan" protection for "curbside consults"

The Judiciary Committee leadership had advised interested parties that it did not intend to move forward with legislation in favor of either side in the tort reform debate, but to maintain the *status quo*. Accordingly, the MMA, the Maine Hospital Association, Medical Mutual Insurance Company of Maine, and the Maine Trial Lawyers Association agreed to recommend that the Committee kill all 6 of the bills. At the same time, each organization gave Committee members its perspective on the issues as well as the history of the tort reform in Maine.

Two members of the public spoke in favor of L.D. 608, the most damaging of the bills for the tort reform coalition, and they were the only members of the public to speak on any of them. Richard Flowerdew, M.D. spoke on several bills on behalf of Spectrum Medical Group.

While the MMA was disappointed not to move forward with L.D. 1271, submitted on behalf of the MMA, the relatively stable liability insurance market, the political environment, and the downside risk of action on L.D. 608 and several other of the 6 bills caused the MMA, along with other members of the coalition, to pursue this course of action.

Maine Medical Association staff Andrew MacLean, Gordon Smith, and Kellie Miller will direct the Association's advocacy efforts this year, and with staff from the Maine Osteopathic Association, will provide assistance to the "Doctor of the Day" program. Physicians interested in serving as the "Doctor of the Day" should communicate with Andrew MacLean at amaclean@mainemed.com.

Among the health care issues to be resolved are the following:

- Efforts by the "direct entry" midwives to be licensed (opposed by MMA, the Maine Chapter of ACOG, the Maine Chapter of the American Academy of Pediatrics, and the Maine Academy of Family Physicians).
- Seven health insurance bills carried over from the previous session, all pending before the Joint Standing Committee on Insurance and Financial Affairs. The proposals cover a wide variety of issues, including market reform, rate regulation, single payor, mandated benefits, and Dirigo Health.
- A proposal to mandate that employers with more than 25 employees provide up to five sick days per year to their full and part-time employees.

MMA's Legislative Committee, under the leadership of Katherine Pope, M.D., Chair and Samuel Solish, M.D., Vice Chair, will meet on a regular basis to review pending proposals and to determine the MMA position on each.

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.

To find more information about the MMA's advocacy activities, 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.

Maine Medical Association Physician Health Program

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Thank You

Thank you to the following individuals who served on a pre-litigation screening panel during the last seven months of 2007.

Karen Bruck, MD
Philip Crichton, MD
Robert Day, MD
Dorothy Kurtz, DPM
William Rogers, MD
Marie Sharkey, MD
Paul Smith, MD
John Southall, MD
Amy Tan, MD

We apologize to anyone who served and whose name may have been inadvertently omitted.

Dirigo Health Update

(As reported by the Dirigo Health Agency for August 2007 and October 2007)

Because of funding constraints, the Dirigo Health Agency capped individual enrollment in DirigoChoice on August 1, 2007 and small group enrollment on September 1, 2007. This chart compares the current enrollment in DirigoChoice to the enrollment at its highest level, immediately preceding the implementation of the caps.

Enrollment:	**Aug. 1, 2007**	**Oct. 1, 2007**	**Change over 2 months**
Number enrolled	15,113	14,536	-577

Enrollment Distribution by Group:	**Aug. 1, 2007 (1)**	**Oct. 1, 2007 (2)**	**Change over 2 months**
Small Group	3,505 (23%)	3,409 (23%)	-96 (0%)
Sole Proprietors	4,249 (28%)	4,080 (28%)	-169 (0%)
Individual	7,400 (49%)	7,215 (49%)	-185 (0%)

(1) These numbers total 15,154, rather than 15,113; however, they are the numbers reported by the Dirigo Health Agency
(2) These numbers total 14,704, rather than 14,536; however, they are the numbers reported by the Dirigo Health Agency

Subsidy Distribution:	**Aug. 1, 2007 (1)**	**Oct. 1, 2007 (2)**	**Change over 2 months**
Group A (100% subsidy)	81 (1%)	76 (1%)	-5 (0%)
Group B (80% subsidy)	7,978 (52%)	7,645 (52%)	-333 (0%)
Group C (60% subsidy)	2,340 (15%)	2,199 (15%)	-141 (0%)
Group D (40% subsidy)	1,496 (10%)	1,453 (10%)	-43 (0%)
Group E (20% subsidy)	701 (5%)	651 (4%)	-50 (-1%)
Group F (no subsidy)	2,558 (17%)	2,560 (18%)	+2 (+1%)

(1) These numbers total 15,154, rather than 15,113; however, they are the numbers reported by the Dirigo Health Agency
(2) These numbers total 14,704, rather than 14,536; however, they are the numbers reported by the Dirigo Health Agency

Subsidy Costs as a Percentage of Premium*:	**2005**	**2006**	**2007 (to date)**
DHA Subsidy	49%	53%	54%
Employer/Enrollee Contribution	51%	47%	46%

** Represents the subsidy costs spread across all enrollees*

Costs of Coverage (Year to Date):	
Dirigo Subsidies	$32,569,205.98
Employer/Enrollee Contribution	$27,463,935.99
Total	$60,033,141.97

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Stark Law Changes Are Looming

The Stark Law states that if a physician (or immediate family member) has a financial relationship with an entity, the physician may not refer to the entity for "designated health services" (DHS) payable by Medicare. Also, the entity may not present a claim or bill for payment unless an exception applies.

Penalties for violation of Stark can include $15,000 and exclusion from Medicare and Medicaid. The Centers for Medicare & Medicaid Services (CMS) has been changing the Stark Law. Here's a brief review:

Stark III Final Rules CMS published Phase III of Stark Law regulations September 5, 2007. The rules were effective December 4, 2007.

Indirect compensation arrangements: Physicians will now "stand in the shoes" of their group practice to determine direct and indirect compensation arrangements. This closes a "loophole" so compensation arrangements between physician organizations and DHS entities will be treated as arrangements between the entity furnishing DHS and the group's referring physician directly.

Fair market value safe harbor: The safe harbor that strictly required one of two specific methodologies for calculating fair market value of physician services has been eliminated. Parties may now choose their own valuation methodologies.

Physician recruitment: This now includes rural health clinics. A recruited physician must relocate from "outside" the hospital's "geographic area" (further clarified), plus either a minimum number of miles or minimum percentage of new patient revenue. When a hospital makes recruitment payments through a physician group practice, a signed, written agreement is required and must be enforced. In certain circumstances, a practice may allocate costs on a per capita basis rather than as an actual additional incremental cost. A group may impose on a recruited physician reasonable "practice restrictions," such as restrictive covenants.

Group practice issues: Independent contractors must provide services under a direct contractual arrangement with the group practices; leased employees are prohibited. Includes new rules related to profit sharing and productivity bonuses.

In-office ancillary services exception: The exception is clarified, discussing telemedicine, shared space and per-use/per-click fees.

Office space and equipment rental: A clarification indicates lessee must exclusively control the facility and staffing when a patient is provided a DHS. Per-use fee arrangements are unlikely to comply.

Non-monetary compensation/medical staff incidental benefits: Repayment of any exceeded non-monetary compensation caps to avoid violation is limited. Hospitals may host an annual medical staff appreciation event. Pagers must be dedicated for hospital communication.

Other changes address charitable donations, compliance training, retention payments and intra-family referrals.

Find the Stark changes at www.access.gpo.gov/su_docs/fedreg/a070905c.html; scroll to CMS.

Aversion to the Patent Process is Easily Remedied in Maine

By Brian J. Libby, Ph.D., Associate, Verrill Dana, LLP

Maine inventors were named on almost 200 U.S. patents that issued in 2007. Several of these patents protect medically-related inventions, including, for example, an apparatus for measuring intravascular blood flow, a device for diagnosing stress and injury in anatomical soft tissue, a system for connecting an electrode to skin, a fibrin sealant bandage for treating wounds and a surgical scalpel.

Given the success that Maine inventors have enjoyed in obtaining patent protection for their inventions, it is unfortunate that some clever inventions will never be made available to the public. This is particularly troubling where the invention is medically-related because medically-related inventions improve human health and, in some cases, save lives.

One reason why some inventions never reach the public is that some inventors are intimidated by, and/or do not have time to partake in, the process of seeking patent protection. These inventors may be surprised to know, however, that not only is the process of obtaining a patent a straightforward one, but that there are great resources in Maine that are available to prospective patentees and entrepreneurs.

The process for seeking a patent essentially includes the steps of preparing a patent application that thoroughly describes the invention for which protection is sought, filing the application with the US Patent and Trademark Office ("USPTO"), and communicating with the USPTO as needed regarding the patentability of the invention until a patent is allowed (or until the inventor decides to abandon the application).

This process may also include, at the discretion of the inventor, the step of conducting a search of prior references for the purpose of assessing the patentability of the invention. If elected, it is a good idea to perform this search prior to the preparation of the application as the results of the search will help the inventor to decide whether to even pursue patent protection and, if the decision to do so is in fact made, the preparer of the patent application to describe the invention in a light that is most favorable to the inventor.

A disadvantage of having a patentability search performed can be the fee charged by the professional who carries out the search. The Maine inventor, however, can avoid this cost by engaging the services of the Maine Patent Program, which is administered by the Center for Law and Innovation of the University of Maine School of Law and has offices in Portland and in Orono. The Maine Patent Program, which is state-funded, conducts patentability searches (and a variety of other services) at no charge for Maine-based inventors. (Further information regarding the Maine Patent Program, including information for contacting the Program, is available at *http://www.mainepatent.org.*)

Although the Maine Patent Program offers a variety of services, it does not, however, prepare patent applications for examination of patentability by the USPTO. The inventor therefore should seek the help of a qualified patent professional, that is, an attorney or agent who is registered with the USPTO, in having the patent application prepared. Not only will the patent professional help prepare the application, but that individual also will help file the application with the USPTO and communicate with the USPTO as needed as the USPTO decides whether to issue a patent from the application. Further, if desired, the patent professional also can help the inventor with the patentability search, including providing to the inventor an opinion regarding the results of the search. (For a list of registered patent professionals who are located in this state, please visit the USPTO web site at *http://www.uspto.gov* or contact the Maine Patent Program.)

Resources available to the Maine inventor are not limited only to those that assist inventors with the patent process. For example, the Maine Technology Institute (MTI), which like the Maine Patent Program is state-funded, offers early-stage, capital and commercialization assistance for the research and development of innovative technology. Under its Seed Grant Program, MTI awards up to $12,500 per project, as many as six times per year, to support very early activities for product development and/or commercialization. Further, under its Development Award program, MTI invests up to $500,000 per project, as many as three times per year, to support research and development of new products. (Further information regarding MTI, including its contact information, is available at *http://www.mainetechnology.org.*)

These are only some of the resources that are available to the Maine inventor/ entrepreneur. The information provided herein therefore is not meant to be an exhaustive list of those resources, nor is it meant to provide a complete description of the patenting process and its important considerations. For a more detailed description of available resources and/or the patent process, please contact a registered patent professional or the Maine Patent Program.

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U.S. District Court Judge Woodcock Issues Preliminary Injunction in Maine Prescriber Data Law Challenge

On Friday, December 21, 2007, U.S. District Court Judge John A. Woodcock, Jr. issued an order granting the plaintiffs' (3 prescription drug information intermediaries or "data mining" companies) motion for a preliminary injunction against enforcement of L.D. 4, *An Act to Amend the Prescription Privacy Law,* enacted by the 123rd Maine Legislature earlier this year and scheduled to become effective on January 1, 2008. While some portions of the new law will take effect, they are largely restatements of current law on patient information privacy.

Judge Woodcock decided that the ability to "opt out" of pharmaceutical companies' use of prescriber data for marketing purposes, the principal distinction between Maine's law and the New Hampshire law struck down on First Amendment grounds in the U.S. District Court for the District of New Hampshire earlier this year and on appeal before the U.S. Court of Appeals for the First Circuit [*IMS Health, Inc. v. Ayotte,* 490 F. Supp. 2d 163 (D.N.H. 2007)], made no difference in the First Amendment analysis. Acknowledging that the "opt out" provision made the question "closer," Judge Woodcock concluded, "[n]evertheless, at its heart, the Law operates by making illegal the transfer of truthful commercial information for particular uses and disclosures and, as such, the Law must withstand intermediate scrutiny" (a constitutional standard of review). "Tracking the prescribed intermediate scrutiny analysis, the Court concludes that the provisions of the Maine Law that seek to restrict the use and disclosure of commercial information violate the free speech guarantee of the First Amendment."

It is likely that no further action will take place in the Maine litigation on these issues until the First Circuit Court of Appeals issues a decision in the New Hampshire case.

The Court recognized the patient's interest in the privacy of his or her prescription data, but concluded that L.D. 4 does little to further that legitimate state interest. However, observers in organized medicine have been particularly interested in a recognition of the prescriber's interest in the privacy of their own data and, like the New Hampshire District Court, Judge Woodcock was very skeptical of any such privacy right. He found that the Maine law provides Maine prescribers with a "limited right of confidentiality" and that "insurance companies, governmental agencies, quality assurance committees, utilization reviewers, and others have the right and responsibility to assess their prescribing patterns." He found that "the Law only marginally advances the governmental interest in prescriber privacy."

Responding to one of L.D. 4's stated purposes of decreasing the influence of drug representatives, the Court stated, "[b]y far the most effective tool that the prescriber possesses to reduce the influence of detailers is to refuse to see them."

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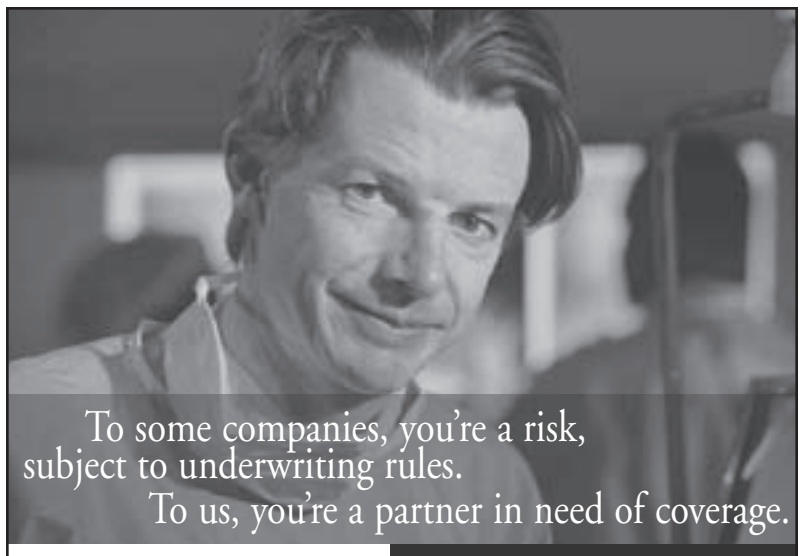

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