JANUARY / FEBRUARY / MARCH 2012

Maine medicine

MAINE MEDICAL ASSOCIATION

IN THIS ISSUE

MMA Board Members Retreat to Sunday River

Seventeen members of the Board of Directors of MMA retreated to the Jordan Grand Resort Hotel in Newry over the weekend of January 20-22 to review the strategic plan and to hear from Luis Sanchez, M.D. regarding how the Physician Health Program in Massachusetts assists professionals in that state. The Board also welcomed neighbors Scott Colby, EVP of the New Hampshire Medical Society (NHMS) and its President-elect Travis Harker, M.D. Mr. Colby and Dr. Harker shared with Board members the results of the NHMS planning retreat held last fall.

Nancy M. Cummings, M.D., President of MMA facilitated the retreat discussion and the Sunday morning presentation of Dr. Sanchez. Dr. Sanchez noted that nearly sixty percent of the work of his program involves mental health and behavioral issues, with the remaining cases involving substance abuse. Attendees were encouraged by Dr. Sanchez to adopt life-style changes that could help counter the stresses of today's medical practice.

During the strategic planning portion of the retreat, Board members reviewed twenty-one different service areas and attempted to prioritize those products and services. Ultimately, the Board decided more data needed to be gathered prior to completing the exercise.

New Hampshire Medical Society EVP Scott Colby presents data from NHMS member survey.

From Left: Buell Miller, M.D., Michael Parker, M.D., Guy Raymond, M.D., Travis Harker, M.D., Jessa Barnard, J.D., Jo Linder, M.D., and Brian Pierce, M.D.

Public Officials, Legislature, Law Enforcement Take Aim at Prescription Drug Abuse

The scourge of prescription drug abuse on Maine families and communities continues to attract attention in Augusta and indeed, across the state and nation. Several initiatives are underway aimed at assisting physicians and other prescribers in walking that fine line between adequate treatment for pain and preventing diversion and addiction. Maine continues to have the highest percentage of residents seeking treatment for opioid addiction in the nation.

On February 6, MMA hosted a CME program on this topic for physicians in Washington County. The event was held at the Regional Medical Center in Lubec and was keynoted by Attorney General William Schneider and State Senate President Kevin Raye. All of the presenters noted the impact of the problem and asked physicians to be more cautious in their prescribing habits. In return, state officials have promised to improve the tools available to prescribers including particularly the Prescription Monitoring Program (PMP).

The Governor and the Attorney General also announced recently the appointment of a 17-member working group which will follow-up on the recommendations from last fall and the work of the L.D. 1501 Working Group. MMA EVP Gordon Smith will represent MMA on the Working Group along with a number of physicians.

Chronic pain consultations are still available to practices at no cost until June 30, 2012 and can be ordered through Mr. Smith (gsmith@mainemed.com). The Association and the State Office of Substance Abuse also can make educational presentations available.

MMA members are urged to utilize the resources available and to do what they can to help address the problem.

Andrew MacLean, Esq.

Legislative Update

GOVERNOR'S SUPPLEMENTAL BUDGET PROPOSAL TARGETS MAINECARE COSTS

On the afternoon of December 6, 2011, Governor LePage and DHHS Commissioner Mary Mayhew released the Administration's proposed supplemental budget for the Department of Health & Human Services for State Fiscal Years 2012-2013. The Administration estimates the budget gap within DHHS to be $120 million in FY 2012 and $101 million in FY 2013. The Appropriations & Financial Affairs Committee held public hearings on the Governor's proposal for 3 days in mid-December and budget work is expected to be a focus of the legislature's work at least through mid-February. In addition to the supplemental budget, the 125th Maine Legislature's agenda for its Second Regular Session will include health insurance exchanges and other aspects of Affordable Care Act compliance, prescription drug diversion, and a number of bills affecting the physician-patient relationship and the public health. The 125th Legislature expects to adjourn in mid-April.

The Governor's supplemental budget proposal, L.D. 1746, proposes a major restructuring of the MaineCare program in keeping with his rhetoric since the close of the First Regular Session in June. At that time, he promised more "welfare reform" initiatives this year. The Governor and Republicans in the legislature argue that when compared with other states Maine has a disproportionate share of the population receiving health care or other social services through the Medicaid program. Democrats point out that Maine Medicaid policy during the past decade provided health insurance to more Mainers resulting in better health for those individuals and reduced bad debt and charity care for providers. This policy has made Maine one of just a handful of states with an uninsured population of less than 10%. Democrats also note the loss of federal matching funds for these necessary services and the negative financial impact on health care practitioners and institutions with resulting layoffs of health care professionals.

Although the proposal includes no direct cuts to physician reimbursement, it does cut hospital and ambulatory surgical facility reimbursement, reduces MaineCare eligibility, eliminates many important services that are "optional" under Medicaid law, and institutes arbitrary limits on services. The following is an overview of the General Fund cuts in the Governor's budget proposal:

- Sweeps half of the *Fund for a Healthy Maine* to fill the budget gap
- Eliminates all private non-medical institution ("PNMI") coverage, both behavioral health and other ($47.6+ M in FY 13)
- Eliminates targeted case management services
- Eliminates optional coverage for 19/20 year olds < 150% of FPL
- Reduces optional coverage for children "who are behaviorally challenged who are in a residential setting"
- Reduces funding for contracts for residential services in children's mental health ($1.25 M in FY 13)
- Limits mental health crisis intervention services to people with severe and persistent mental illness ($2.1 M in FY 13)
- Eliminates low-cost drugs for the elderly program ($837k in FY 12; $4.5 M in FY 13)
- Reduces coverage for brand name drugs from 4/month to 2/month ($1.2 M in FY 12; $5.8 M in FY 13)
- Reduces coverage in the Cub Care program for families >= 150% of FPL, but < 200%
- $8 M in salary savings in DHHS ($5 M in FY 12; $3 M in FY 13)
- Eliminates $1.1 M in FHM funds that went to vaccines
- Shifts more than $26 M from the FHM to Medical Care – Payments to Providers ($1 M in FY 12; $25 M in FY 13)
- Eliminates Head Start funding ($800k in FY 12; $2.5 M in FY 13)
- Eliminates MaineCare coverage for families above mandatory federal levels ($2.2 M in FY 12; $8.5 M in FY 13)
- Eliminates adult family care as optional service
- Eliminates ASC services as optional service ($17,200 in FY 12; $93,274 in FY 13)
- Eliminates dental services as optional service ($411k in FY 12; $2.2 M in FY 13)
- Eliminates OT as optional service ($79k in FY 12; $427k in FY 13)
- Eliminates vision services as optional service ($152k in FY 12; $823k in FY 13)

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SAVE THE DATES

MMA FIRST FRIDAYS EDUCATION SEMINARS

Register for these seminars at www.mainemed.com

All seminars take place at the MMA Headquarters in Manchester, Maine with Registration and Breakfast at 8:30am and the Session from 9:00am – 12:00pm.

March 2, 2012
Preventing Prescription Drug Abuse

April 6, 2012
Annual Coding Seminar - Billing and Coding, Common Coding Issues, ICD 10

May 4, 2012
Medical Ethics/Medical Rights Seminar - Physician/Patient Relationship, Minor Rights, Consent/Capacity, Living Wills/Power of Attorney

June 1, 2012
Annual HIPAA Update

September 7, 2012
Risk Management Seminar - Handling Patient Complaints (Medical Mutual Insurance Company of Maine)

October 5, 2012
Physician Compensation, Recruitment and Retention - Employment Contracts

November 2, 2012
Annual Compliance Seminar - Plans for small practices, coding, etc.

December 7, 2012
All You Wanted to Know About the Affordable Care Act and more

The programs are also available off-site/on-line through Webex. Contact the MMA office at 622-3374 for more information.

Nancy Cummings, M.D.
President, MMA

President's Corner

Today, Dr. Christopher Pezzulo, the president of the MOA and I served as the Doctors of the Day for the opening session of the state legislature. Serving as Doctor of the Day is a great experience, not only observing the Legislative process, inside and outside the chambers, but also having a voice in the decisions that are made. If you are interested in serving in this role, please contact Maureen Elwell at the MMA (melwell@mainemed.com or 622-3374 ext: 219).

This is a critical time for patients and physicians in Maine. I just read a quote today in the Connecticut State Medical Society magazine that aptly applies: There are 3 types of individuals in this world; those that determine the future, those that allow the future to happen and those that question how they got there. It is Dr. Pezzulo's and my job to represent the concerns of the physicians in Maine, and through our associations, to make sure our voices are heard and help determine the future of medical practice in Maine. This is an unprecedented time for medicine with the current system not sustainable and unproven models proposed as solutions. No matter what the future care model is, the patients have to remain the primary focus. We cannot return to the capitation of the managed care era. Our goal has to be high quality health care for all Mainers delivered in an efficient, collaborative manner. I came to Maine to practice 10 years ago to serve a need in a community and community is what I found here. When I finished training in the early 90's it was just assumed that you joined your specialty society, the state medical society and the AMA, as these were part of your entering the profession. I never questioned joining the American Academy of Orthopedic Surgeons or MMA, it was an honor. But times have changed and it is our duty as an association to change with those times. To that end, at our January Board retreat we will re-examine our relevance to our members and where MMA priorities, time and efforts should be spent. Advocacy for physicians is a top priority. We as "care givers" (I prefer this to provider) are being asked to do more and more, unrelated to direct patient care, in less and less time. The transition to the EMR has totally changed the physician patient encounter for me. Rather than eye contact with the patient, I am staring at a screen, populating fields instead of conversing with my patient. When I resort to my previous visit style, I am then staying for hours after clinic "documenting." ICD 10, which is going to cost health systems millions, is coming and an enormous burden on the person doing the coding which in many practices is the physician. This is another example of the lack of physician input into changes that impact the health care system. It is our job at the Maine Medical Association to give Maine's physicians that voice. I welcome your thoughts. You can reach me at 778-9001 or president@mainemed.com.

Gordon H. Smith, Esq.

Notes from the EVP

It is hard to believe that 2011 is a memory and that by the time you read this column, we will be well into the second month of 2012. Because of all of you, 2011 was a good year for the Maine Medical Association. Membership increased, budget goals were reached and several external and internal benchmarks were achieved. We are blessed with an experienced and committed staff, a dedicated leadership and the best members that any association today could hope for. The Association fully realizes that physicians today do not join membership associations out of a sense of obligation. Rather, they choose among various organizations they could belong to on the basis of value. And we work hard every day to provide that value.

We are fortunate to offer a number of services for which there is demand. The Medical Professional Health Program, the Office-based QI program, the External Peer Review Program, educational programs including chronic pain consultations and academic detailing on a variety of topics are just a few of these. And the ability of our three attorneys to review contracts for members has found growing popularity. In fact, I have said for years that I believe that association membership is like an insurance policy, you may hope you never need to call, but over the lifetime of a physician, there will be instances where you will want a strong state medical society to assist. Responding to complaints filed by patients at the licensing boards comes to mind. Every year, we assist dozens of members in preparing their response to one of the two medical boards.

Most members still identify advocacy for the profession as a primary reason for joining MMA. While that is gratifying, advocacy alone is not going to retain the level of membership required for MMA to be robust and to be able to offer the services that members will need in the future. As complex as the delivery and financing of health care is today, physicians will need help to be successful, whether they are employed or independently practicing. And while MMA cannot be all things to all physicians, we can focus on a few services and products that we can provide efficiently and well. We don't want to compete with Google for information. We can't compete with specialty societies in the offering of clinical education. But we can focus on those areas where we can be the best in brand.

In mid-January, MMA's 24 member board held its annual President's Retreat which focused on strategic planning and physician health. The unselfish dedication of our leadership never ceases to amaze and inspire me. Board members pay their own expenses and give up a weekend to review in-depth the work of the association and to discuss what the priorities should be for the year. Watch the upcoming issues of the *Weekly Update* and *Maine Medicine* for in-depth analysis and discussion of the issues we will be working on the remainder of 2012. And, most importantly, do not hesitate to let us know if you disagree with the priorities chosen. You are our members and our most important asset. We work for you, and I hope you will never be disappointed. As always, I welcome your feedback and can be reached at gsmith@mainemed.com or 207-622-3374 ext: 212.

Legislative Update continued from page 1

- Eliminates PT services as optional service ($98k in FY 12; $529k in FY 13)
- Eliminates podiatry services as optional service ($68k in FY 12; $371k in FY 13)
- Eliminates STD screening clinics as optional service ($40k in FY 12; $218k in FY 13)
- Eliminates chiropractic services as optional service ($69k in FY 12; $375k in FY 13)
- Reduces Critical Access Hospital reimbursement from 109% to 105% of cost ($291k in FY 12; $1.2 M in FY 13)
- Limits coverage to 15 outpatient hospital visits per year ($278k in FY 12; $1.5 M in FY 13)
- Limits coverage to 5 hospital admissions per member per year ($92k in FY 12; $490k in FY 13)
- Limits use of suboxone for opioid dependency treatment to 2 years ($148k in FY 12)
- Eliminates childless adult waiver program (the "non-categoricals") ($22 M in FY 13)
- Eliminates coverage of smoking cessation products ($80k in FY 12; $430k in FY 13)
- Reduces reimbursement for outpatient services at acute care hospitals by 5% effective 7/1/12 ($3.2 M in FY 13)
- Reduces reimbursement for hospital inpatient services by 10% ($768k in FY 12; $3.1 M in FY 13)

The MMA provided testimony in opposition to the entire budget proposal because of the substantial negative impact on patients and providers and you can find the MMA testimony on the web at: http://www.mainemed.com/spotlight/2011/LR2678.pdf. You can find the Appropriations Committee's budget materials on the web at: http://www.maine.gov/legis/ofpr/appropriations_committee/materials/index.htm. Finally, you can find the DHHS budget materials, including the Department's analysis of the budget gap, on the web at: http://www.maine.gov/dhhs/budget/. As of the third week in January, the Appropriations Committee had achieved consensus to reject the proposed PNMI cut, but negotiations continue on all other aspects of the budget and appear likely to continue for several more weeks.

Other action during the first several weeks of the session includes:

- Deep partisan division over mandated benefits/"essential benefits" package (L.D. 882), health insurance exchanges (L.D.s 1497 and 1498), and other aspects of ACA compliance in the Insurance & Financial Services Committee's work sessions on these "carry over" bills;
- Routine work sessions on "carry over" bills addressing concussions in student athletes/return to play (L.D. 98) and bullying or cyberbullying (L.D.s 980 and 1237) in the Education & Cultural Affairs Committee; and
- A public hearing on the proposed expansion of pharmacists' authority to provide adult vaccines (L.D. 1715).

During the legislative session, the MMA staff provides links to bills for review and comment, updates on the legislature's work, and calls-to-action through our weekly electronic newsletter, *Maine Medicine Weekly Update*. Also, the MMA Legislative Committee holds a weekly conference call to review bills and brief members on legislative action every Tuesday night at 8:00 p.m. for any interested physician or physician staff member. The conference call information is published each week in the *Maine Medicine Weekly Update*.

To find more information about the MMA's advocacy activities, visit the Legislative & Regulatory Advocacy section of the MMA web site, www.mainemed.com. 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://www.maine.gov/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.

Upcoming Specialty Society Meetings

MARCH 7, 2012 — MMA Headquarters – Manchester, ME
Maine Chapter American College of Emergency Physicians Spring Business Meeting
Contact: Maureen Elwell 622-3374 x219 or melwell@mainemed.com

APRIL 11-13, 2012 — – Bar Harbor, ME
Maine Academy of Family Physicians 20th Annual Family Medicine Update
(4/11-12 at Atlantic Oceanside, 4/13 at Jackson Labs)
Full schedule and registration information available at www.maineafp.org
Contact: Deborah Halbach 207-938-5005 or maineafp@tdstelme.net

APRIL 12, 2012 — Maine Health (110 Free Street) – Portland, ME
Pediatric Advocacy and Building Partnerships in Community Pediatrics – Catch Grant Conference
(Sponsored by Dept. of Pediatrics, MMC and Maine Chapter American Academy of Pediatrics)
Contact: Brian Youth, MD 207-662-2353 or youthb@mmc.org

APRIL 14, 2012 — Harraseeket Inn – Freeport, Maine
Maine Gastroenterology Society 2012 Update
7:30 Registration (8AM-4PM Program)
Contact: Gail Begin 207-724-2521 or gbegin@mainemed.com

APRIL 27, 2012 — Marriott at Sable Oakes – South Portland, Maine
Maine Association of Psychiatric Physicians Annual Psychiatry Update Educational Sessions
Contact: Warene Eldridge 207-215-7118 or warene54@yahoo.com

MAY 4, 2012 — Harraseeket Inn – Freeport, ME
Maine Society of Eye Physicians and Surgeons Spring Business Meeting
Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

MAY 5-6, 2012 — Harborside Hotel and Marina – Bar Harbor, ME
Maine AAP Spring Educational Conference: "Learning Together to Advance School-based Health"
Contact: Leslie Goode 207-782-0856 or ldgoode@aap.net

Upcoming at MMA

FEBRUARY 15	9:00am – 11:00am	Patient Centered Medical Home - Conveners
	11:00am – 1:00pm	Patient Centered Medical Home - Working Group
	1:00pm – 4:00pm	Aligning Forces for Quality, Patient Family Leadership Team
FEBRUARY 16	8:30am – 4:00pm	Pathways to Excellence (Maine Health Management Coalition)
FEBRUARY 29	11:30am – 2:00pm	MMA Senior Section
	5:30pm – 8:00pm	MMA Membership & Member Benefits
MARCH 2	8:30am – 2:00pm	First Fridays Seminar
MARCH 6	8:00am – 11:00am	Consumer Experience Stakeholders
MARCH 7	8:30am – 12:00pm	Maine Health Management Coalition
	2:00pm – 5:00pm	MMA Board of Directors
MARCH 8	1:00pm – 3:00pm	OSC HIT Steering Committee
MARCH 12	4:00pm – 7:00pm	Medical Professionals Health Program Committee
MARCH 15	4:00pm – 6:00pm	Peer Review Advisory Committee
MARCH 21	9:00am – 11:00am	Coalition for the Advancement of Primary Care
	11:00am – 1:00pm	Patient Centered Medical Home, Working Group
	1:00pm – 4:00pm	Aligning Forces for Quality, Patient Family Leadership Team
APRIL 4	8:30am – 12:00pm	Maine Health Management Coalition
	1:00pm – 2:00pm	Aligning Forces for Quality, Executive Leadership Team
	2:00pm – 3:00pm	Quality Counts, Executive Committee
	3:30pm – 5:00pm	Behavior Health Committee
APRIL 6	8:30am – 12:00pm	First Fridays Seminar
APRIL 12	8:30am – 4:00pm	Pathways to Excellence (Maine Health Management Coalition)
	1:00pm – 3:00pm	OSC HIT Steering Committee
APRIL 18	9:00am – 11:00am	Patient Centered Medical Home - Conveners
	11:00am – 1:00pm	Patient Centered Medical Home - Working Group
	1:00pm – 4:00pm	Aligning Forces for Quality, Patient Family Leadership Team
APRIL 24	6:00pm – 9:00pm	ME Chapter American Academy of Pediatrics
APRIL 25	2:00pm – 5:00pm	MMA Board of Directors
APRIL 28	9:00am – 12:00pm	Downeast Association of Physician Assistants Board Meeting
MAY 2	8:30am – 12:00pm	Maine Health Management Coalition
	1:00pm – 2:00pm	Aligning Forces for Quality, Executive Leadership Team
MAY 4	8:30am – 12:00pm	First Fridays Seminar
MAY 10	1:00pm – 3:00pm	OSC HIT Steering Committee
MAY 14	4:00pm – 7:00pm	Medical Professionals Health Program Committee
MAY 16	9:00am – 11:00am	Coalition for the Advancement of Primary Care
	11:00am – 1:00pm	Patient Centered Medical Home, Working Group
	1:00pm – 4:00pm	Aligning Forces for Quality, Patient Family Leadership Team
JUNE 1	8:30am – 12:00pm	First Fridays Seminar

***All MMA Committee Meetings are now being offered through WEBEX*

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Thanks to 2012 Sustaining Members

Thank you to the following individuals and practices who have shown their support for the MMA's long-term growth by renewing at an additional sustaining membership level.

Maroulla Gleaton, MD
David Jones, MD
Garrett Martin, MD
Roger Renfrew, MD
G. Paul Savidge, MD
Michael Szela, MD
Cardiovascular Consultants of Maine
CMMC-Emergency Dept
Central Maine Orthopaedic
Coastal Women's Healthcare
Dahl-Chase Pathology Associates
Maine Rehabilitation Associates
Mid Coast Hospital
Orthopedics Associates of Portland
Pen Bay Medical Center

Medication Adherence - America's Other Drug Problem

A new campaign launched by the National Consumers League aims to get patients with chronic health problems to do what doctors can't: take their medications. Called Script Your Future, the three-year U.S. Agency for Healthcare Research and Quality-funded effort is raising awareness about the importance of taking prescribed medicines, particularly for patients with diabetes, respiratory disease, and cardiovascular disease. It's also providing tools for patients. One is a service that will send a text message reminding patients to take their medicine.

Information about the campaign is online at www.scriptyourfuture.org.

Adding Up the Cost

- One in three Americans never fill their prescriptions.
- Three out of four do not always take their meds as directed.
- More than one-third of medication-related hospital admissions are related to poor adherence.
- The cost associated with not taking medications as prescribed is $300 billion in the United States.

Source:
National Consumers League

Medical Mutual Insurance Company of Maine Risk Management Practice Tip: *Health Literacy: Delivering the Message Right Improves Patient Safety and Reduces Liability*

Patient safety cannot be assured without addressing the negative effects of low health literacy and ineffective communications on patient care. Improving health literacy is an important factor in engaging patients in preventive care, improving adherence to medication regimens and treatment plan instructions, improving the patient's ability to self-manage their healthcare and reducing the incidence of communication related errors and poor outcomes. Patients may mask their health literacy level from their care providers.

Risk Management Recommendations for Effective Patient Communications:

- Assess the literacy levels and language needs represented by the patients/community served.
- Train staff to recognize and respond appropriately to patients with literacy and language needs.
- Use well trained medical interpreters for patients with low English proficiency.
- Adopt the universal precautions approach to health literacy. Make clear communications and plain language the standard for all patient communication.
- Provide a comfortable atmosphere/environment. Do not appear hurried or distracted.
- Speak slowly and clearly, loudly if indicated. Make good eye contact.
- Assess the patient's ability to self manage their own health care. Assure the patient understands when to seek health care and recognizes the need to pursue preventive health strategies.
- Ask open-ended questions about their health history and clinical symptoms.
- Encourage the patient to ask questions.
- Provide patient discharge and other instructions in written and verbal language the patient understands. Provide the patient with a medication list, information about medications, diagnosis, results of procedures and laboratory tests and plans for follow-up care. Verify patient understanding.
- Utilize accepted methods to probe for patient understanding:
  - Visuals: Draw pictures, use three dimensional aids, media.
  - Print materials: Large print, fifth or lower grade level, key points.
  - Teach back: Ask the patient to repeat back or teach back to the clinician the clinical information or instructions discussed.
  - Show back: Ask the patient to show back to the clinician the patient care process reviewed.
  - Telephone: Have patient repeat back their understanding of telephone instructions, test results or patient follow-up appointments/ studies.
  - Ask me three questions: Ask the patient to answer three key questions from the patient encounter.
  - Note: All levels of patients have difficulty with multi-step instructions.
- Design the informed consent process to include forms written in simple sentences and in the language of the patient; use teach back during the informed consent discussion; and engage the patient in a dialogue about the nature and scope of the procedure.
- Reduce the barriers for low health literacy patients entering the health care system.
- Place patient follow-up calls.

In Summary:

The reading and arithmetic skills required to understand and successfully participate in today's healthcare systems far exceed the abilities of today's average adult. Clinical professionals and staff members can reduce untoward events and poor outcomes related to communication breakdowns due to low health literacy through a comprehensive patient assessment and adoption of the universal precautions approach to health literacy.

References may be found by accessing the complete practice tip at www.medicalmutual.com.

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.

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

MMA Members can contact the Learning Center via email; learningcenter@bnncpa.com or at 888-889-6597 with coding questions.

CORPORATE COMPLIANCE UPDATE - 2012

By Laurie Desjardins, Maggie Fortin, Janet Hodgdon, Baker Newman Noyes

Compliance remains a major focus of the Department of Health and Human Services. Through CMS, the OIG and others, oversight of Medicare and Medicaid reimbursement continues unabated and, in fact, continues to expand. This article summarizes and provides guidance on some of the recent efforts of these departments.

A REVIEW OF THE 2012 OFFICE OF INSPECTOR GENERAL WORK PLAN

This past October, as we all expected, the 2012 OIG audit list relative to possible healthcare fraud and abuse was published. The document is filled with a plethora of new topics and proposed audit activities as well as a continuation of audit activities on subjects from years past. The continuation of reviews indicates that the OIG has not satisfied their objectives for the review and should not be construed as losing interest or winding down activities.

This fiscal year's list held a few surprise categories with the OIG not providing much clarification or specifics related to the subject to be reviewed. Additionally, the Medicaid program was not spared and many new review activities are planned relating to fraud and abuse activities.

So that healthcare providers may be better prepared in scheduling their own internal monitoring and reviews, we have prepared an overview of some of the more significant 2012 OIG audit topics highlighting the issue and providing insight into the subject matter.

Physician Concerns and Guidance

Place of Service Errors

The OIG continues to review place of service assignment for services rendered in ambulatory surgical centers and outpatient departments of hospitals. Since physician, including non-physician practitioner (NPP), reimbursement is paid at a higher rate when services are rendered in the non-facility setting such as the office, the OIG is concerned that physician practices are not assigning the correct place of service when patients receive care in outpatient departments of a hospital or other non-office settings.

This can be a major issue if your practice has become a department of a hospital (known in Medicare parlance as a Provider Based Entity (PBE)). As a PBE, the practice becomes integrated into the facility and, as such, holds itself out as a department of the hospital. Medicare patients are considered hospital outpatients when they receive services at a PBE and, as such, their visits must be billed with an outpatient place of service code.

OIG Issue: Incident-To Services

This is a new issue for the OIG but an old concern. They want to find out if services not personally performed by a physician but billed under the physician's name (incident-to) are being reported appropriately. They state their concern as: there is no way to confirm from claims data which services billed are performed incident-to; a 2009 OIG review found 21 percent of services reviewed were performed by non-qualified personnel.

What is Incident-To?

Medicare defines incident-to as the services or supplies that are furnished as an integral although incidental part of the physician's professional services.

Incident-to requirements include: the service must be an integral part of the physician's plan of care (services may not be for a new patient or a new problem); on-going physician involvement; direct personal supervision by the physician. In addition, both the physician and NPP/auxiliary personnel must have a direct employment relationship or is a leased employee or must be employed by the same group AND the physician must be present in the office suite and immediately available if needed. Service must be provided in the office or in the home, other non-hospital or SNF setting. If these requirements are met, the service may be billed under the supervising physician's name. See the Medicare Benefit Policy Manual (pub 100-2), Chapter 15, Covered Medical and Other Health Services, Subsection 60, Service and Supplies: http://www.cms.hhs.gov/manuals/102_policy/bp102c15.pdf for more information.

Let's not forget; the person performing the service must be qualified and the services must be medically necessary. That means different things depending upon what services are performed. For example, it is within the scope of a registered nurse's license to perform the insertion of a non-indwelling bladder catheter but not in a medical assistant's scope. So, in this example, if the physician ordered the insertion of the catheter for a sterile urine specimen, the service could be considered a billable incident-to procedure if performed by a RN (if all the other incident-to requirements are met) but non billable if performed by a medical assistant.

To support billing services incident-to documentation must include: the name of the physician whose care plan is being followed, the reason for the visit, a description of the services being rendered and the name of the physician/NPP who is supervising at the time the service is being provided. NHIC, our J-14 MAC, also requires that the supervision provider co-sign the note.

What to Do:

Educate your staff on the specific requirements surrounding incident-to services and billing. Make sure documentation supports the incident-to service. You may have to revise your documentation templates and workflows to make sure you are being compliant.

Evaluation and Management Services (Multiple Issues)

Trends in Coding of Claims

The OIG continues to review E/M services for aberrant billing patterns. The goal is to confirm that the appropriate level and type of E/M service is being billed.

What to do:

We have been living with this type of scrutiny for decades. The key is to provide ongoing education and training to your practitioners and continue your chart review activities to ensure compliance.

Services Provided During Global Surgery Periods

This is a continued review of practices related to the number of follow-up E/M services provided by physicians as part of the global surgery period to determine whether the practices have changed since the global surgery fee concept was introduced.

Use of Modifiers during the Global Surgery Period (New)

This is a natural addition related to the review of global surgery periods. The only way to pull a service out of the global window for separate payment is to append a modifier (i.e. 24, 57). The OIG wants to determine if services provided during a global surgical period and billed with any of the aforementioned modifiers are being reimbursed appropriately. The concern is that the application of one of these modifiers is correctly identifying the service billed as being outside/unrelated to the global procedure.

Potential Inappropriate Payments

As electronic health records (EHRs) proliferate, the OIG says it will continue to target over documented/ "cloned" E/M services as an area for review.

Per Medicare IOM Manuals 100-04 Chapter 12 Section 30.6.1.A: "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."

The take home on this one is to make sure you review your EHR to identify how/if copying of previous visits are allowed. If information is copied forward, is it identified as historical data or treated as "brand new" for that date of service? Critically look at your templates. Are they overly prefilled? Does the practitioner's history of present illness contradict the review of systems? Does the history contradict the exam? Most importantly, does the acuity of the medical decision making support the level of service billed? In simple terms, was it medically necessary to document a comprehensive history and exam for a patient with a stubbed toe?

Expect this issue to continue to be an area of review as EHR's implementation continues. Due diligence is going to be required to assure that acuity supports the code billed.

Other Physician Issues in Brief

Compliance with Assignment Rules: The OIG will continue to review whether providers are complying with assignment rules and determine to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare.

Part B Imaging Services: Part B imaging services will continue to be reviewed to determine whether the services reflect expenses incurred and whether the utilization rates reflect industry practices.

Diagnostic Radiology Services: Medical necessity will continue to be reviewed for high dollar imaging as well as reviews of duplicate services being ordered by different specialists.

Sleep Testing: The OIG is concerned that there has been an expediential increase in the number of sleep studies billed from 2001-2009. They are reviewing to confirm the medical necessity of sleep studies billed.

Summary of the OIG Work Plan

In its spring 2011 report to Congress (covering the 6 month period ended March 31, 2011), the OIG reported expected recoveries of approximately $3.4 billion, $3.2 billion of which related to its investigations and the remainder related to audit receivables. The OIG also, for the first time, instituted a "Most Wanted Fugitives" list on its website with the 10 profiled individuals allegedly perpetrating frauds in excess of $126.6 million. Four of the fugitives have already been captured, which made room for additions to the "10 most wanted" list. While 10 are highlighted on its website, more than 170 are sought by the OIG. It is clear, based on the successes described in its semi-annual report to Congress and on its website, that the OIG will remain extremely active in its audit and review activities of all provider types.

OTHER COMPLIANCE CONSIDERATIONS, IN BRIEF

Medicaid Recovery Audit Contractors: On September 16, 2011, CMS has issued a final rule on the Medicaid recovery audit contractor program, with an effective date of January 1, 2012. This rule provides guidance to states relating to start up and operational costs, payment methodology to the Medicaid RACs and direction on adequate appeal processes, among other operational issues.

AND LAST BUT NOT LEAST, ACCOUNTABLE CARE ORGANIZATIONS

On October 20, 2011, CMS released its final rule on accountable care organizations. Simultaneously, CMS and the OIG released an interim final rule with comment period. For ACOs, this interim final rule establishes waivers of the application of:

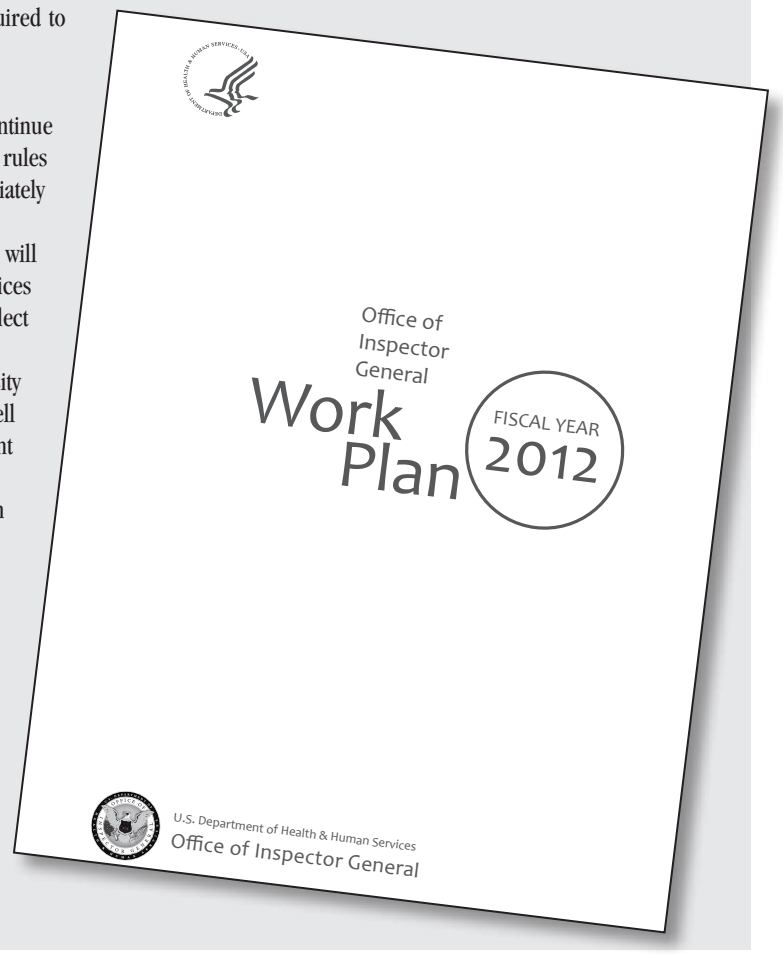
- The Physician Self-Referral Law
- The Federal anti-kickback statute, and
- Certain civil monetary penalties law provisions

These waivers will apply to specified arrangements involving ACOs, including those ACOs participating in the Advance Payment Initiative. These waivers are authorized by Section 1899(f) of the Act, as added by the Affordable Care Act, and authorized the Secretary to waive certain fraud and abuse laws as necessary to carry out the provisions of Section 1899 of the Act. The waivers will be effective on the date of publication in the Federal Register, which, as of the date of this writing, is unknown.

In addition, to coincide with CMS' release of the final ACO rule, the Federal Trade Commission (FTC) and the Department of Justice (DOJ) issued their final *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program.* The final policy is far different from the originally proposed one earlier this year. The entire statement now generally applies to all collaborations among otherwise independent providers and provider groups intending to participate in the shared savings program. The exception would be for those providers who request a voluntary expedited antitrust review. Further, since mandatory antitrust review will no longer be required, the FTC and DOJ removed language relating to that original provision.

CONCLUSION

The Department of Health and Human Services, through its agencies, is remaining ever vigilant in its oversight of Medicare and Medicaid payments to healthcare providers across the continuum of care. The future appears no different and, in fact, appears to include even more oversight than currently exists. Providers should carefully review and analyze each of the many work plans and rules that have been published in the past few months in order to determine applicability to each individual circumstance. The result should be to proactively assess the impact to the individual organization as proper planning and oversight is instrumental to a successful compliance outcome.



Online Training on Maine's Universal Childhood Immunization Program

Come away from this condensed online training with a greater understanding of the implications of this law on provider offices. In 45 minutes, the training covers:

- Basic information on the law and its benefits
- Vaccine ordering and management
- Use of ImmPact2 (Maine's immunization information system)
- Reducing private stock
- Other office procedures
- Commonly asked questions

The video can be accessed by going to the following website:

http://www.mainehealth.org/mh_body.cfm?id=7736.

The video was created by MaineHealth in partnership with the Maine Immunization Program.

Please contact Cassandra Cote Grantham at cotec1@mainehealth.org or at 207-661-7578 with any questions.

Stephen D. Sears, M.D.

From the State Epidemiologist

By Stephen D. Sears, M.D., M.P.H., State Epidemiologist, Maine Center for Disease Control and Prevention

Don't know what the fuss is- It's only pertussis

Didn't we get rid of that disease? I wish it were so, but more cases of whooping cough (Pertussis) were reported in Maine during 2011 than in any of the last five years. The northern part of the state, primarily Penobscot county, has had the largest proportion of cases. We're not alone—pertussis outbreaks have occurred in California, Chicago, New Hampshire, and elsewhere... so this message is not just for Northern Maine-it is for all of us. Pertussis is a bad disease (it is something we *should* make a fuss about).

How many pertussis cases have occurred in Maine?

In 2011, more than 200 cases of pertussis were reported to Maine CDC, compared to 53 the entire year of 2010. The majority of reported pertussis infections have occurred in Penobscot County (64%), but sporadic infections have occurred in other parts of the state. Clusters have occurred in schools, camps, sport teams and workplaces.

What is pertussis?

Pertussis is caused by the bacteria *Bordetella pertussis* and is a highly communicable, vaccine-preventable, respiratory disease that can last for many weeks. Pertussis is transmitted through direct contact with respiratory secretions of infected persons who cough or breathe on someone else. Classic pertussis symptoms include paroxysmal cough, whoop, and posttussive vomiting. Many of us have not seen whooping cough in infants but those who have remember it well. Children cough, choke, and often struggle for breath. Unfortunately, the pertussis vaccine is not given until 2 months of age. So we need to make sure that the youngest and most vulnerable are not exposed to pertussis by doing all we can to protect them.

How do we prevent pertussis?

The most effective way to prevent pertussis is through vaccination. DTaP is given to children younger than 7 years of age, and Tdap is given to older children and adults. According to data from the 2010 National Immunization Survey, 86.6% of Maine children aged 19-35 months have received 4 or more doses of DTaP vaccine, and 63.2% of adolescents aged 13-17 years have received one or more doses of Tdap vaccine. Although these coverage levels are comparable to national statistics, additional efforts are needed to ensure that all Maine children are protected. Check the vaccine status of your patients to make sure they are up to date for their age.

Infants aged <2 months have the largest burden of pertussis-related hospitalizations and deaths, yet they are too young to be vaccinated. Since 2005, the Advisory Committee on Immunization Practices (ACIP) has recommended Tdap booster vaccines to unvaccinated postpartum mothers and other family members of newborns to protect them from pertussis... this "cocooning" strategy has proven to be difficult to implement. As a result, ACIP now recommends Tdap vaccination for pregnant women who previously have not received Tdap, preferably during the third or late second trimester (after 20 weeks' gestation). If not administered during pregnancy, Tdap should be administered immediately postpartum.

So what else can we do in addition to vaccination?

Be on the alert for pertussis. If you see someone who is coughing, especially if it is paroxysmal or associated with vomiting—THINK PERTUSSIS. It is also important to note that pertussis can cause milder illness in immunized persons. Be aware that outbreaks are occurring in Maine and test for pertussis by sending a nasopharyngeal swab for PCR (polymerase chain reaction) testing on anyone with cough for 2 weeks or more or any symptomatic person who has been exposed to someone with pertussis. If symptoms are highly suggestive of pertussis, it is best to start treatment before the PCR result returns. Patients with confirmed or highly suspected pertussis should be isolated at home until they have completed 5 days of antibiotics.

And what about you?—yes you the clinician.

A single dose of Tdap is recommended for all health care workers, regardless of age. If you have not been vaccinated yet, now is the time. Make it your New Year's resolution.

Lastly, a few final words.

Pertussis is serious, very contagious, and can last a long time. In fact, untreated patients are considered infectious for 3 weeks after cough onset. Treatment can be initiated any time during the first 3 weeks of illness. Although it may not modify the symptoms if given later in the course of illness, it will decrease the infectious period.

So let's all make a fuss and stamp out pertussis. If you suspect pertussis, diagnose pertussis or have any questions, call Maine CDC 24/7 at 1-800-821-5821. Together we can make a healthier, safer Maine.

Public Health Spotlight

Membership Approves Policies Regarding Patient Counseling, Clean Air Act, Climate Change

Jessa Barnard, J.D., Director of Public Health Policy, MMA

The Maine Medical Association Public Health Committee regularly raises policy issues critical to the health of Mainers with the MMA membership. In the last *Maine Medicine*, this column highlighted the resolution submitted by the Public Health Committee at Annual Session regarding influenza vaccination of health care workers, urging all members and member practices to require influenza vaccination for staff. Three other resolutions proposed by the Committee were also approved by the membership this past September.

1. Prompted by the passage in Florida of legislation that prohibits health care providers from freely asking their patients questions related to gun safety or from recording such information in their medical record, the Committee proposed a resolution regarding patient counseling. The adopted policy calls on the MMA to vigorously and actively defend the physician-patient-family relationship and actively oppose state efforts to interfere in the content of communication in clinical care delivery between clinicians and patients. The policy is not limited to the area of gun control and condemns any interference by government or other third parties that compromise a physician's ability to communicate his or her medical opinion as to the information or suggested management options that are in the best interest of their patients.

   This resolution was cosponsored by the Maine Academy of Family Physicians, Maine Chapter of the American Academy of Pediatrics and Maine Chapter of the American College of Physicians. The Committee has shared this resolution with the Florida Medical Association and specialty groups in Florida and offered support in their efforts to oppose the law in Florida. MMA staff will also be able to use this policy in support of our testimony at the statehouse on issues such as reproductive health and medical confidentiality.

2. Last summer, the Maine Medical Association joined the Healthy Air Coalition, a group of statewide and local health care and public health organizations concerned about Maine's air quality and attacks on the Clean Air Act in Congress. We also were invited to several meetings, organized by the American Lung Association, with Senators Snowe and Collins' staff to discuss the Clean Air Act and the health impacts on health of exposure to air pollution. These activities culminated with the passage in September of a policy supporting the Clean Air Act. The policy reads that the Maine Medical Association strongly supports the Clean Air Act and emphatically opposes all attempts to weaken, dismantle, overrule, or otherwise impede the Environmental Protection Agency from enforcing or implementing it.

3. The third resolution deals with the MMA's position on global climate change. The policy arose because effective action has yet to be taken to substantially reduce dependence on fossil fuels and also because the MMA's 2009 resolution on wind power has been misconstrued as taking sides on the wind power debate. The new policy reaffirms the MMA's position on the health threats posed by global climate change and the need to develop alternative energy sources as one way of reducing climate change, as adopted in its 2009 policy "Global Climate Change" and in turn rescinds the MMA's 2009 policy "Wind Energy and Public Health."

The Committee continues to work to implement all three of these policies. The group is also active in a number of other policy arenas. To highlight just a few, in the past months the Committee has spoken at press conferences regarding the Kid Safe Product Act and removing the hormone-disrupting chemical BPA from children's products, has submitted comments regarding the Department of Environmental Protection's product stewardship program and testified at budget hearings in December on the public heath implications of diverting the Fund for Healthy Maine and cutting MaineCare coverage for preventive services proposed in Governor LePage's supplemental DHHS budget. The Committee will be most active this winter on the budget and other legislative proposals related to public health.

The Committee is seeking additional members who are interested in joining this active and engaged group. If you are interested, please contact Jessa Barnard at jbarnard@mainemed.com. In 2012, the Committee will meet via phone and in person at the MMA offices from 4-6 pm on the following dates: February 8th, April 11th, June 13th, August 8th, October 10th and December 12th.

Lisa M. Letourneau, M.D., MPH

Quality Counts

By Lisa M. Letourneau, M.D., MPH, Executive Director, Quality Counts

Quality Counts 2012 Annual Conference Slated for April 4th

"Partnering with Patients: Finding the Bright Spots to Transform Care"

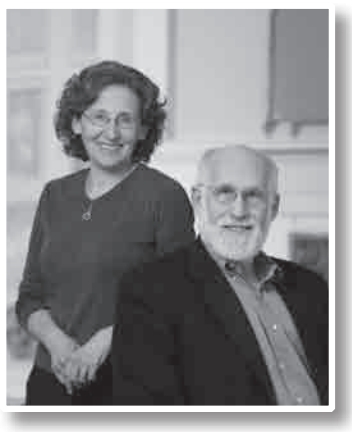
Each year, Maine Quality Counts (QC) hosts a statewide conference intended to serve as a "*best practice college"* highlighting efforts to improve health care quality, and offering attendees specific models and tools for working collaboratively to improve health and health care. This year's conference will be held on April 4, 2012 at the Augusta Civic Center, titled "Partnering with Patients: Finding the Bright Spots to Transform Care" and will focus on the theme of engaging patients to improve care.

QC 2012 is a partnership effort of Maine Quality Counts (QC), the Maine Primary Care Association and the Maine Public Health Association, and is held in collaboration with the Maine Medical Association, Maine Osteopathic Association, Maine Association of Area Agencies on Aging, University of New England (UNE) and the Maine Network of Healthy Communities. ***QC 2012 will offer a unique opportunity for stakeholders from across the state to convene and identify steps for transforming care, with a major focus on engaging patients in transforming care.***

There is growing awareness of the need to effectively engage patients as key partners in transforming care. QC 2012 will provide a range of opportunities to learn from national and local experts about best practices to partner with and how to engage patients to achieve high value, patient-centered care, including specific examples of ways to work collaboratively with patients in Maine.

QC 2012 will feature both national speakers and a wide range of local breakout sessions highlighting success stories in Maine. Keynote speakers include Jerome Groopman, M.D., MPH and Pamela Hartzband, M.D. speaking on their recent book, "*Your Medical Mind"*. Dr. Groopman is an oncologist at Beth Israel Deaconess and Chair of Medicine at Harvard Medical School. Dr. Hartzband is an endocrinologist at Beth Israel Deaconess and Faculty Member at Harvard Medical School. Their book sheds light on how the human mind approaches medicine to help reveal the array of forces that can aid or impede the medical decision making process.

We recognize that providers can often wrestle with best ways to engage patients and families in their efforts to improve the quality of health care. On behalf of Maine Quality Counts, we invite you to join us for QC 2012 to find the "bright spots", build understanding, and join a discussion about the drivers behind the patient decision-making process.



Jerome Groopman, M.D., MPH and Pamela Hartzband, M.D.

QC 2012 Registration begins on Monday, February 20th online at: www.mainequalitycounts.org

More information about Maine Quality Counts and our quality initiatives can be found at: www.mainequalitycounts.org. If you need additional information contact our Maine Quality Counts staff at: 207.622.3374, x218, or go to www.mainequalitycounts.org.

Maine Quality Counts mission *is transforming health and health care in Maine by leading, collaborating, and aligning improvement efforts.* ***Our vision is:*** *Through the active engagement and alignment of people, communities, and health care partners, every person in Maine will enjoy the best of health and have access to patient-centered care that is uniformly high quality, equitable, and efficient.*

Maine PCMH Pilot

Notice of Plan for Phase 2 Expansion - Summary

Conveners of the multi-payer Maine Patient Centered Medical Home (PCMH), the Dirigo Health Agency's Maine Quality Forum, Maine Quality Counts, and the Maine Health Management Coalition, announce plans to **expand the Pilot to include an additional 20 adult practices in January 2013**. *An application process will be announced and made available online on or before February 1, 2012*. This information is being made available as an introduction to the expectations for application and selection.

Interested practice sites are advised to read the full "Notice of Plan for Phase 2 Expansion" posted on the Maine Quality Counts website (www.mainequalitycounts.org/major-programs/patient-centered-medical-home.html), and should register their intent to apply by completing the "Phase 2 Intent to Apply" form online at http://www.surveymonkey.com/s/ME_PCMH_Pilot_Phase2_Intent_to_Apply.

Timeline for Pilot Practices

- January 12, 2012 – Pilot Conveners communicate plans for Phase 2 expansion broadly within state
- January 2012 – Interested practices are asked to submit online Intent to Apply.
- February 1, 2012 –Maine PCMH Pilot Phase 2 practice application posted online
- March 31, 2012 - Deadline for practices to submit online application
- April – May, 2012 – Review of applications by Pilot staff, PCMH Pilot Selection Committee
- May 1, 2012 – Phase 2 Community Care Team (CCT) application posted online
- May 31, 2012 - Phase 2 practices selected
- July 15, 2012 – Deadline for CCTs to submit online application
- August 1, 2012 – Phase 2 CCTs selected
- January 1, 2013 – Phase 2 practices and CCTs begin participation in Maine PCMH Pilot

Questions

For questions about this information or plans for Pilot expansion, please access information on the Maine PCMH Pilot on the Quality Counts website: http://www.mainequalitycounts.org/major-programs/patient-centered-medical-home.html

You may also contact the following:

- For questions on the Maine PCMH Pilot, contact Nancy Grenier at tel. 240-8767 or ngrenier@mainequalitycounts.org
- For questions on the Maine PCMH Pilot Community Care Teams (CCTs), contact Helena Peterson at tel. 266-7211, or hpeterson@mainequalitycounts.org
- For general questions or clinical concerns, contact Dr. Lisa Letourneau at tel. 415.4043 or lletourneau@mainequalitycounts.org
- For questions about the MaineCare Health Homes program, contact Michelle Probert at tel. 287.2641, or michelle.probert@maine.gov.

Stable COPD: The Latest AMA Therapeutic Insights Online Topic

The American Medical Association announces the release of **Management of Stable COPD**, the latest AMA Therapeutic Insights newsletter.

Maine physicians can access their personal prescribing profile showing their individual prescribing patterns for Stable COPD alongside state, national and specialty prescribing patterns. Just select the Maine newsletter and click Personal Prescribing Profile.

AMA Therapeutic Insights

- is free and online
- highlights one disease condition per issue
- features individual, state, national prescribing data* and evidence-based treatment guidelines
- is written by top disease experts in collaboration with the AMA
- offers *AMA PRA Category 1 Credit™*

While most treatment-oriented CME programs focus solely on disease management, AMA Therapeutic Insights takes it one step further. This program delivers the actual prescribing patterns for the disease.

Visit **http://www.ama-assn.org/ama/pub/education-careers/continuing-medical-education/cme-credit-offerings/therapeutic-insights.page** to read this issue, as well as previous newsletters on dyslipidemia, tobacco dependence, migraine, Alzheimer's Disease and more.

**The prescribing data in AMA Therapeutic Insights are provided by IMS Health. The AMA does not collect or have access to physician prescribing data in any form. The AMA is accredited by the ACCME to provide continuing medical education for physicians.*

Maine medicine
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