MARCH/APRIL 2007

Maine medicine

In this issue...

At Its Core-MMA Advocacy

Although the Maine Medical Association has continued to broaden the array of services it provides to its members (think Coding Center, Peer Review, Voluntary Practice Assessment Initiative, First Friday's CME, Physician Health Program, etc), most members still consider the Association's efforts at the State House to be at its core. This year is no exception.

With over 300 legislative proposals directly affecting healthcare, MMA's presence at the State House is constant and significant. Already this session, MMA has played a leading role in issues such as increasing the cigarette tax, continuation of Dirigo Health, allowing primary enforcement of seat belt use and increasing MaineCare rates for physicians. Please refer to Andy MacLean's legislative report inside this edition for a more complete review.

MMA provides its members with many opportunities to be involved in public policy, including the Physician of the Day program, the Physicians' Day at the Legislature and the Legislative Committee. We also publish a weekly summary of State House activities called "*Political Pulse.*" We are always looking for members who have a special interest in legislative affairs, so please let us know if you fit into that category. The Legislative Committee is chaired by Katherine Pope, M.D. of Falmouth. Sam Solish, M.D., also of Falmouth, is the Vice-Chair.

In addition to legislative efforts, the Association handles a variety of regulatory activities every week, including work before the Board of Licensure in Medicine, the Workers' Compensation Commission, the Bureau of Insurance, the Maine Health Data Organization, the Governor's MECMS Advisory Committee, and the MaineCare Advisory Committee.

Thanks to all of you who participate in any of these activities. An Association is only as good as the efforts of its volunteers. Politics is a participatory sport. There is no short cut to involvement. Call us today to participate (622-3374 and ask for Charyl).

Dora Anne Mills, M.D., M.P.H. Receives Nathan Davis Award for Outstanding Career Public Service

On Tuesday, Feb. 13, Maine CDC Director Dora Anne Mills, M.D., M.P.H. received the prestigious Nathan Davis Award for "Outstanding Career Public Servant at the State Level" from the American Medical Association. Now in its 19th year, the Dr. Nathan Davis Award honor elected officials and career public servants at the local, state and federal levels for significant achievements in the advancement of public health.

Dr. Mills graciously received the award at a dinner in Washington D.C. attended by hundreds of AMA members and guests including several representatives of the Maine Medical Association. The Master of Ceremonies was ABC News Washington correspondent George Stephanopoulos.

Dr. Mills was nominated for the award by DHHS Commissioner Brenda Harvey. In remarks made upon receiving the award, Dr. Mills encouraged the physicians in the audience to return to their hometowns later in the week and to talk with young physicians to invite their participation in the work of organized medicine. Dr. Mills noted that when she returned to her hometown (Farmington) to practice pediatrics, it was MMA Executive Committee member and urologist Michael Parker, M.D., who invited her to participate in the public health activities of MMA. She also credited Robert McAfee, M.D., former MMA and AMA President and MMA EVP Gordon Smith for their roles in her rise to prominence in public health.

In an accompanying press release from the AMA, the organization noted Dr. Mill's work in reducing the incidence of youth smoking and in preparation for the pandemic flu in distinguishing her from the nearly forty nominations received for the award.

Dr. Mills also received the MMA's Presidential Award for Distinguished Service at the 2006 Annual Meeting.

Dr. Mills is a native of Farmington and a graduate of Bowdoin College and the University of Vermont Medical School. She was appointed the Director of the Bureau of Health by former Governor Angus King during his first term as Governor. She is a board certified pediatrician and is a former Democratic National Committeewoman from Maine.

CDC Director Dora Anne Mills, M.D., M.P.H., and Terry Marchiori, Director, AMA Federation Relations.

L-R: George Stephanopoulos, Dora Anne Mills, M.D., M.P.H., and Cecil B. Wilson, M.D.

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

President's Corner

Kevin Flanigan, M.D., President, MMA

It is hard to imagine, but it is once again that time of year. The ink is barely dry on the most recent congressional override of the SGR (Sustainable Growth Reduction) formula that mandated physician reimbursement reduction, and now we find ourselves looking at a scheduled 10% reduction for 2008. That is not a typo! Without Congressional intervention, there will be an across the board reduction of 10% for all physicians. So, what time of year is it? The time of year when organized medicine begins to lay the groundwork for this year's lobbying efforts to ensure that physicians are not left to carry the burden of medical care of America's seniors without proper reimbursement and recognition. This year's scheduled reduction would appear to be both a blessing and a curse. Conventional wisdom is that such draconian cuts will not be allowed to occur. Therefore, the approach to lobbying this year can be expanded to include reforming some of the larger issues such as insurance coverage in general.

With these goals and realities in mind, medical association leaders around the country participated in an annual pilgrimage to Washington, D.C. this past February. While there, we were apprised of this years objectives to not only lobby to fix the SGR, but also to pursue a means by which to begin the process of ensuring that all Americans have insurance coverage.

The start of this initiative is with children. This year, the SCHIP (State Children's Health Insurance Program) established in the mid 1990's is up for renewal. The current plan is to request that it not be reduced in size, but rather expanded so that all children have access to affordable insurance and thus will not have an impediment to receiving the medical care they need and deserve. In Maine, we are fortunate to have strong congressional leadership on our side. Senators Snowe and Collins both understand and support our position. Senator Collins is also sponsoring one of the bills that would not only expand the SCHIP program, but would properly fund it. On the House side, both Congressman Allen and Congressman Michaud have not only expressed support of our initiatives, but have always been strong supporters of the medical community and the patients we serve.

On the recognition side of things, our own Dora Anne Mills, MD, received the Nathan Davis award for Outstanding Government Service. She was recognized for her success and dedication to the citizens of this state as Director of the Maine CDC. In accepting the award, she served as an ambassador of organized medicine by graciously recognizing the impact of organized medicine on her and her career. She should be applauded not just for her accomplishments to date, but also for putting organized medicine front and center when it comes to what physicians can do when we work together.

As I close, I want to remind each of you that while the MMA serves to support physicians of Maine in their role as providers of quality care and as advocates for their patients, it is the support of members such as Dr. Mills and non-members such as our congressional leaders that allow us to serve you so effectively.

For comments, questions or concerns, please feel free to contact me at 487-9244 or via email at flanmansvpc@pol.net.

From left: Ann Simmons, M.D., Kevin Flanigan, M.D., Congressman Thomas Allen, Gordon Smith and David Simmons, M.D.

Check out our re-designed website: www.mainemed.com

AMA Program Allows Physicians to Opt-Out of Data Sharing

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

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

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

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

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

MMA Staff Promotions

MMA is pleased to announce two promotions within its staff of fourteen employees.

- **Diane McMahon has been named Office Manager.** Diane will also continue to provide administrative assistance to the Physician Health Program, the MMA Executive Committee, the Payor Liaison Committee and MMA EVP Gordon Smith. Diane is also responsible for the Annual Meeting.
- **Lauren Mier has been named Director of Communications.** She will remain as staff to the Maine Society of Orthopedic Surgeons and will continue to provide graphic design and IT services to all MMA staff. As MMA's first Director of Communications, Lauren will prepare the Weekly Update and prepare Op Ed pieces, press releases and letters to the editor. She will also work with MMA officers on speaking style and content.

Congratulations to Diane and Lauren.

In other staff news, **EVP Gordon Smith** was recently re-appointed by the Executive Committee as Executive Vice President for an additional six years following a performance evaluation conducted by the Association's Personnel Committee.

Upcoming Specialty Society Meetings

APRIL 28, 2007 *Harraseeket Inn – Freeport, ME*
Gastroenterology for Primary Care
MMA Contact: Gail Begin 207-622-3374 ext: 210 or gbegin@mainemed.com

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

MAY 4, 2007 *Hilton Garden Inn – Freeport, ME*
Maine Association of Psychiatric Physicians & MAPP Consultation Project
Educational Sessions (8:00am – 5:00pm)
MMA Contact: Warene Eldridge 207-622-7743 or weldridge@mainemed.com

MAY 4, 2007 *Hilton Garden Inn – Freeport, ME*
Maine Association of Psychiatric Physicians General Membership Meeting (5:30pm)
MMA Contact: Warene Eldridge 207-622-7743 or weldridge@mainemed.com

MAY 5-6, 2007 *Samoset Resort – Rockport, ME*
Spring Conference of the American Academy of Pediatrics, Maine Chapter Special Kids, Special Needs: *Topics in Children with Special Health Care Needs and Developmental Behavior Pediatrics*
Contact: Aubrie Entwood 207-685-9358 or agridleyentwood@aap.net

JUNE 1-3, 2007 *Bar Harbor Regency – Bar Harbor, ME*
Maine Chapter, American College of Surgeons Meeting
Contact: Joel LaFleur, MD 207-593-5723 or jlafleurmd@gmail.com

SEPTEMBER 28, 2007 *Harborside Hotel & Marina - Bar Harbor, ME*
Maine Society of Eye Physicians and Surgeons Fall Business Meeting
10:30am – 12:30pm *(To be held in conjunction with the 6th Annual Downeast Ophthalmology Symposium)*
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

SEPTEMBER 28-30, 2007 *Harborside Hotel & Marina - Bar Harbor, ME*
6th Annual Downeast Ophthalmology Symposium
(Presented by the Maine Society of Eye Physicians and Surgeons)
MMA Contact: Charyl Smith 207-622-3374 ext: 211 or csmith@mainemed.com

MMA Welcomes Our Newest Corporate Affiliates:

NotifyMD

The Pharmaceutical Research and Manufacturers of America (PhRMA)

Stroudwater Associates

Tap Pharmaceuticals

Tilson Technology Management

We appreciate their support!

Thank You

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.

Benjamin Cowan, MD
Joseph Flynn, MD
Charles McHugh, MD
David Phillips, Sr., MD
Bruce Sigsbee, MD
Dahl Chase Pathology Associates
Intermed
Sunbury Primary Care

UPCOMING AT MMA

APRIL 12 **11:00AM – 5:00PM**
Committee on Continuing Medical Education and Accreditation

APRIL 12 **5:30PM – 9:30PM**
Maine Association of Psychiatric Physicians

APRIL 24 **6:00PM**
MMA Committee on Legislation

APRIL 25 **7:30AM**
Corporate Affiliate Breakfast (At the Portland Country Club)

APRIL 25 **8:30AM**
Pathways to Excellence

APRIL 25 **2:00PM**
MMA Executive Committee

MAY 2 **2:00PM**
Quality Counts! Board

MAY 4 **9:00AM – NOON**
First Friday's CME Program

MAY 8 **3:30PM**
Kennebec County Medical Society

MAY 10 **4:00PM**
MMA Committee on Quality Improvement and Peer Review

MAY 14 **6:00PM**
MMA Committee on Physician Health

MAY 16 **4:00PM**
MMA Public Health Committee

MAY 17 **5:30PM**
Kennebec County Medical Society

JUNE 1 **9:00AM – NOON**
First Friday's CME Program
"Jazzing Up Your Coding Skills"

JUNE 5 **1:00PM**
Stop Stroke!

JUNE 6 **2:00PM**
MMA Executive Committee

JUNE 7 **12:30PM**
Home Care Alliance

JUNE 8 **9:00AM – NOON**
Home Care Alliance

JUNE 12 **9:00AM – 1:00PM**
Physician Practice Management Forum

Edward David, M.D., J.D. Nominated to Dirigo Health Agency Board

Former MMA President and Board of Licensure in Medicine Chairman Edward David, M.D., J.D., was nominated this past week by Governor John Baldacci to a position on the Board of the Dirigo Health Agency Board of Directors. Former MMA President Robert McAfee, M.D. chairs the Board. Dr. David's nomination must be confirmed by the Maine Senate. Dr. David lives in Holden.

Dr. David until recently, practiced neurology in Bangor. He has served on the Board of Licensure in Medicine for nearly twenty years and has served as chairman for the past fifteen years. His term on the Board of Licensure ends in June and he has announced his intention to leave the Board at that time.

"Ed David is uniquely qualified to serve on the Board of Dirigo," noted Gordon H. Smith, EVP of MMA. "As a practicing physician and attorney, he certainly understands the nuances of health care politics and we look forward to working with him in this new capacity," Smith added.

In 1982, Dr. David ran unsuccessfully for the Maine House of Representatives. He also has served the state for many years as a Deputy Chief Medical Examiner.

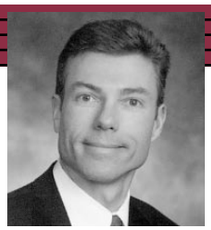
Three Large Hospital Systems Announce Cooperative Agreement

Maine Health, Eastern Maine Healthcare and Maine General Medical Center announced this past Thursday that they will collaborate and improve medical services and reduce health care spending across the state. The cooperative agreement was formalized in a *"Memorandum of Agreement."* In a nutshell, the three major areas of collaboration are as follows:

- An information technology group will work on connecting the system's respective electronic medical records so physicians at one facility can share information with another.
- A second work group will work on maximizing purchasing power for medical equipment and supplies.
- A third group will focus on improving public health, both by standardizing clinical care and through public health campaigns.

The Maine Hospital Association, Governor Baldacci, and other hospitals, all reacted favorably to the announcement. Trish Riley, Director of the Governor's Office of Health Policy and Finance, stated that she was encouraged by the announcement and she commended the administrators for supporting the goals of the state health plan.

Probably the most significant impact of the announcement for Maine physicians will be the opportunity presented to the physicians associated with three systems (which include over one-half of the physicians in the state) to work together on quality improvement activities such as the development of clinical guidelines, chronic disease registries and community health assessments.



Andrew MacLean, Esq.

$3 MILLION MAINECARE PHYSICIAN FEE INCREASE INCLUDED AS BUDGET DEBATE CONTINUES

Following organizing and orientation activities in January, the Governor's budget proposal for the State FY 2008-2009 biennium, L.D. 499, has been the focus of the first two and a half months of the First Regular Session of the 123rd Maine Legislature. The Legislature has printed and referred to committees more than 1300 bills of approximately 2400 that are expected. The First Regular Session is likely to continue until mid-June.

The Joint Standing Committee on Appropriations & Financial Affairs conducted public hearings on L.D. 499 throughout February. Among the more controversial items in the Governor's budget proposal are his school district consolidation plan, the $1 per pack increase in the cigarette excise tax, and a plan to "standardize" rates for behavioral health services to save approximately $20 million over the biennium. The MMA has been discussing the inadequacy of MaineCare reimbursement rates for physician services with the Governor and members of his administration since his election and we were pleased that he included another $3 million General Fund increase for FY 2009 in L.D. 499.

This increase would supplement the $3 million General Fund increase adopted by the 122nd Maine Legislature that brought MaineCare reimbursement rates up to approximately 53% of Medicare rates. These state General Fund appropriations are matched by federal funds such that the total rate increase in each case is somewhat more than $8 million.

The Health & Human Services Committee joined the Appropriations Committee for the hearings on the DHHS portions of the budget bill and made its recommendations to the Appropriations Committee on Monday, March 12, 2007. The HHS Committee unanimously recommended that the MaineCare physician fee increase be included in the budget. The Committee accepted only half of the projected savings through the rate standardization proposal. Unfortunately, this led to a $1 million per year cut in the Fund for a Healthy Maine, Maine's tobacco litigation settlement money that has been dedicated to tobacco cessation and prevention and other health care programs. Also, the Committee supported DHHS proceeding with a managed behavioral health care initiative effective July 1, 2007 to save $11.5 million over the biennium.

The Appropriations Committee will continue work on L.D. 499 until the end of March, at least. It is not yet clear whether the legislature is likely to achieve a 2/3 vote on a budget thereby permitting it to go into effect immediately. If they cannot, the legislature's leadership will have to plan for 90 days after passage of a majority budget and adjournment to have a budget in place by the end of the state fiscal year on June 30, 2007.

Because of the focus on the budget, relatively few bills have been scheduled for public hearing yet, particularly by the HHS Committee. In addition to our work on the budget, the MMA has testified in support of a primary enforcement seat belt law (LD. 24) and a waiting period for the purchase of firearms (LD. 361), and in opposition to a bill that would have required physicians to distribute any available fee samples prior to issuing a prescription (LD. 22).

The 123rd Maine Legislature has published lists of the bills by title filed by legislators and Executive Branch agencies by subject matter and by legislator. You can find these lists on the web at: http://janus.state.me.us/legis/lio/publications.htm. The MMA staff has summarized and categorized the bills of likely interest to the physician community and, once again, this legislature will face many important health care issues. You will find the list posted on the MMA web site, www.mainemed.com, or you may obtain it from the MMA office.

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

During the legislative session, the MMA publishes a weekly e-mail legislative update called *Political Pulse*. To subscribe, go to www.mainemed.com and visit the Legislative & Regulatory Advocacy section of the site. You will find more information about the Maine Legislature, including schedules, committee assignments, legislator contact information, audio coverage of legislative work, and newly enacted laws on the web at:
http://janus.state.me.us/legis/.

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

2007 Rural Medical Access Program

The Rural Medical Access Program is jointly administered by the Office of Rural Health and Primary Care and the Bureau of Insurance. The program promotes obstetrical and prenatal care in federally designated medically underserved areas and Health Professional Shortage Areas of Maine through assistance with insurance premiums for eligible obstetricians and family or general practice physicians. To be considered for RMAP, physicians must be practicing in Maine and have malpractice insurance for prenatal care and/or obstetrical services for at least the period of July 1, 2006 thru December 31, 2006.

Category Determination

1. Physicians whose practices are located in federally designated medically underserved areas or Health Professional Shortage Areas, who practice at least 50% of the time in underserved areas, and whose practice includes at least 10% MaineCare clients.
2. Physicians whose practices are not located in federally designated medically underserved areas or Health Professional Shortage Areas but are located in Primary Care Analysis Areas of under 20,000 population and at least 50% of the visits are patients from federally designated underserved areas and/or MaineCare.

The 2007 application for the Maine Rural Access Program can be found on the Office of Rural Health and Primary Care website at http://www.maine.gov/dhhs/boh/orhpc/. These applications must be completed and returned to the Maine Office of Rural Health and Primary Care by Friday, April 27, 2007. Late applications cannot be accepted.

If you have any questions or would like an application mailed to you, please call the Maine Office of Rural Health and Primary Care at 287-5524.

Focus on Maine's Medical Liability Laws: Evidence of Payments to a Plaintiff From a *Collateral Source*

In recent issues of *Maine Medicine*, the MMA has highlighted aspects of Maine law governing legal actions for medical malpractice, part of the common law "tort" of "negligence." These short articles have briefed you on the statute of limitations for medical malpractice actions, Maine's unique medical malpractice pre-litigation screening panels, and limits on attorney contingent fees. Black's Law Dictionary (5th Edition) defines "tort" as "a private or civil wrong or injury, other than a breach of contract, for which the court will provide a remedy in the form of an action for damages." Each action for negligence requires the existence of a legal duty from the defendant to the plaintiff, breach of that duty, and damage as a proximate result of that breach. In 24 M.R.S.A. §2906, *Collateral sources*, the Maine legislature has permitted evidence of expenses for medical care, rehabilitation services, loss of earnings, loss of earning capacity, or other economic loss paid or payable by a collateral source to be admissible after the verdict but before judgment. The statute requires the court to reduce the award accordingly, thereby mitigating the impact on the defendant(s) and the liability insurance carrier(s).

You can find 24 M.R.S.A. §2906 on the web at: http://janus.state.me.us/legis/statutes/24/title24sec2906.html.

CMS Physician Quality Reporting Initiative (PQRI)

The CMS Physician Quality Reporting Initiative (PQRI) replaced PVRP as a result of the Tax Relief and Health Care Act of 2006, passed last December. PQRI will begin July 1, 2007. Go to www.cms.hhs.gov/pqri/ to learn more. To receive e-mail updates on physician issues, including PQRI, sign up for the Physician Open Door listserve at: www.cms.hhs.gov/apps/mailinglists/default.asp?audience=4. The PQRI establishes a financial incentive for eligible professionals to participate.

MMA will dedicate one of its First Friday education programs to this topic. On Friday morning, May 4th, CMS officials and MMA staff will instruct MMA members and staff on the details of this "pay for performance" program that gives physicians an opportunity to earn 1½% additional Medicare reimbursement on an annual basis.

Jana Purrell, CPC

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

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

Modifier Maze

I know we have talked about the use of modifiers in this column before, but I often get questions on how to use modifiers. It seems that they are often being misused. Therefore, I thought this topic was worth a refresher. In general, billing or coding staff is responsible for ensuring that the appropriate modifiers be placed on the code for payment, however, it is important for providers to be aware of the modifiers and to document appropriately to support the use of the modifiers. While there are several types of modifiers, I will briefly review some of the surgery modifiers in this article. In future articles, I will review other modifier issues. In addition, CMS has recently identified some of the problem areas and clarified the use of modifiers 58, 78, and 79. For the complete article, go to http://www.medicarenhic.com/providers/articles/surgerymod_0207.htm

Modifier 58—Staged or Related Procedure or Service by the Same Provider During the Postoperative Period

This modifier is used on the second surgery performed during the postoperative period of another surgery. The second procedure can be:

- planned at the time of the original surgery (staged) (repeated debridements)
- more extensive than the original procedure (mastectomy following lumpectomy)
- for therapy following a diagnostic surgical procedure (radical perineal prostatectomy with bilateral pelvic lymphadenectomy following prostate biopsy)
- reapplication of a cast during the 90 day global period

Coding Tips:

- not used to report the return to the operating room for treatment of a problem from the first procedure (this is reported using modifier 78)
- not to be used on procedure codes that describe multiple sessions or services (i.e. 67101 Repair of retinal detachment, one or more sessions…)
- a new postoperative time period begins when the second procedure is billed

Modifier 78—Return to the Operating Room for a Related Procedure During the Postoperative Period

Use this modifier for a return trip to the Operating Room (defined as a place where the sole purpose is for performing surgical procedures—cardiac catherization suite, laser suite, endoscopy suite. Does not include the patient's room, minor treatment room, recovery room) for a related surgical procedure during the postoperative period of a previous major surgery.

Coding Tips:

- used only on a surgical code requiring a return to the OR for a related reason
- generally used for a complication from the first surgery
- it should not be used if the complication from the initial surgery does not require a return to the OR
- not used if the identical procedure is repeated by the same physician (use modifier 76)
- a new postoperative period does not begin with the use of modifier 78

Example: A single vessel coronary artery graft is performed on March 10. The following day, the patient starts hemorrhaging as a complication from the surgery. The patient is returned to the operating room to locate and control the bleeding. Correct coding for the return procedure on March 11 is code 35820-78, exploration for postoperative hemorrhage, thrombosis or infection; chest.

Both modifiers 58 and 78 are used when "related" procedures are performed. The differences include:

Modifier 58 should be used when…

- a surgery is planned prospectively at the time of the original procedure
- a surgical procedure is required that is more extensive than the original procedure
- therapy is required following a diagnostic surgical procedure
- new postoperative period with second procedure

Modifier 78 should be used when…

- during the postoperative period, a second procedure most commonly due to a complication of the original surgery that requires a return to the operating room or is directly associated with the original procedure performed
- no new postoperative period with second procedure

Modifier 79—Unrelated Procedure or Service by the Same Provider During the Postoperative Period

This modifier is used to indicate that an unrelated procedure was performed by the same provider (or provider of the same specialty in the same group) during the postoperative period or another procedure.

Coding tips:

- can be used on major and minor procedures
- a different diagnosis should be reported to indicate the unrelated procedure
- a new postoperative period will begin when the unrelated procedure is billed

Example: A total knee replacement (27447) is performed. Thirty days after the procedure for the knee replacement, the patient falls and breaks her arm. The patient undergoes repair of an ulnar shaft fracture (25545). Procedure code 25545-79 should be submitted for the second procedure.

It is important that the provider be aware of these modifiers so that he/she can alert the billing staff of the particular circumstances to ensure these procedures are coded correctly. The insurance companies specifically state that separate payment will not be made for an additional procedure performed during the global postoperative period of a prior procedure if billed without one of these modifiers.

MaineCare DUR Committee

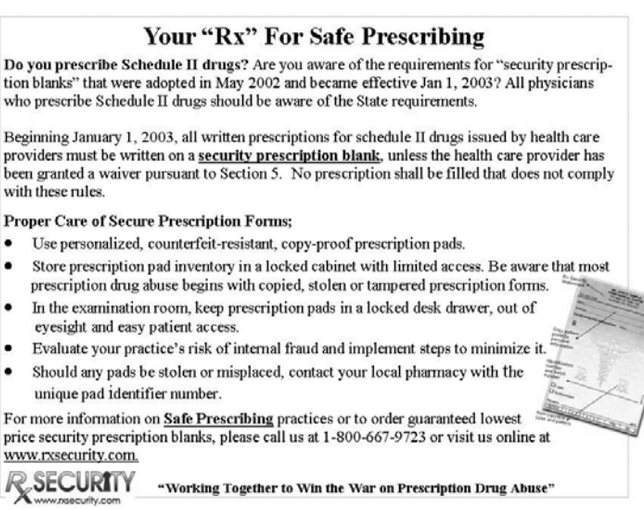
The MaineCare Drug Utilization Review (DUR) Committee generally meets the first Tuesday of each month at 6:00pm at the MaineCare offices in Augusta. The list of Committee members are below. (GHS indicates a relationship with Goold Health System, the contractor for the drug program. OMS indicates the Office of MaineCare Services.)

VOTING MEMBERS

Reggie Gracie, R.Ph., PIN Rx William Alto, MD, Dartmouth Family Practice Jessica Oesterheld, MD, Psychiatrist, Spurwink and GHS James Demosthenes, R.Ph., Cigna Laurie Roscoe, R.Ph., Anthem, *Co-Chair* Robert Weiss, MD, Cardiologist, Independent Practitioner, *Co-chair* Timothy Clifford, MD, Family Practice, GHS Jabbar Fazeli, MD, MMC Mike Ouellette, R.Ph., GHS Julie Pease, MD, Psychiatrist, Sweetzer Syd Sewall, MD, Pediatrician Andrew Cook, MD, Psychiatrist (DBDS) Courtney Oland, R.Ph., Waltz Pharmacies Laureen Biczak, DO, Infectious Disease, formerly OMS, now GHS.

NON-VOTING MEMBERS

Bruce McClenahan, OMS Jude Walsh, Governor's Office Brenda McCormick, OMS Lori Bond, GHS Intern, University of Rhode Island School of Pharmacy



Your "Rx" For Safe Prescribing

Do you prescribe Schedule II drugs? Are you aware of the requirements for "security prescription blanks" that were adopted in May 2002 and became effective Jan 1, 2003? All physicians who prescribe Schedule II drugs should be aware of the State requirements.

Beginning January 1, 2003, all written prescriptions for schedule II drugs issued by health care providers must be written on a **security prescription blank**, unless the health care provider has been granted a waiver pursuant to Section 5. No prescription shall be filled that does not comply with these rules.

Proper Care of Secure Prescription Forms;

- Use personalized, counterfeit-resistant, copy-proof prescription pads.
- Store prescription pad inventory in a locked cabinet with limited access. Be aware that most prescription drug abuse begins with copied, stolen or tampered prescription forms.
- In the examination room, keep prescription pads in a locked desk drawer, out of eyesight and easy patient access.
- Evaluate your practice's risk of internal fraud and implement steps to minimize it.
- Should any pads be stolen or misplaced, contact your local pharmacy with the unique pad identifier number.

For more information on **Safe Prescribing** practices or to order guaranteed lowest price security prescription blanks, please call us at 1-800-667-9723 or visit us online at www.rxsecurity.com.

RX SECURITY www.rxsecurity.com "Working Together to Win the War on Prescription Drug Abuse"

Professionalism

The Drama of High Intensity MD on your TV

By William Strassberg, MD, President-elect, Maine Medical Association

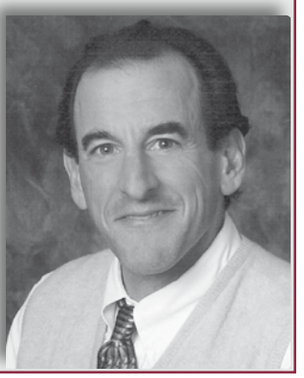
What might happen if they developed a new TV drama called Medicine: The Profession. The series could star an experienced medical professional working within turbulent and challenging economic and professional landscapes. The protagonists are constantly adapting to new and ever more complex arrays of obstacles and oversight, and are encumbered with over-reaching and ever more sinister regulations. These exogenous forces seem determined to crush their spirit. Overworked and over stressed, they feel they could not give more of themselves. Sounds hot? Maybe not, but it sounds like our life!

So then…why are we here? Why do we struggle to do what we do so very well? What is medicine, really? Why is it so special? And what is this entity we call our profession? What does it mean to us and what does it mean to the people whose lives we touch every day?

I guess I am a slow learner but it took me nearly 15 years before I began to have a sense of what it meant to me to be a physician. Probably just like you, I received my diploma in medical school, recited my oath, and jumped on that internship → residency → medical practice treadmill. I always worked hard, and I feel I did reasonably well. During this process however, the business of medicine changed yearly. I contended with evolving state and federal regulations, rising patient expectations, endogenous and exogenous competition, declining reimbursement, personnel shortages, and I tried to balance the pull of medicine with family and personal needs.

This life as outlined becomes a stressful road towards exhaustion, and it seems I rarely provided myself the time to sit and enjoy the big picture - what I meant to my patients and, in return, what they meant to me. The good news is that no matter how busy, overworked, and stressed we are, this reality is always there. It will always boil down to you, a patient, trust, and the physician-patient relationship. No matter how hard these rules and regulations may seem to make our lives, they cannot take the patient and our relationships away from us. It is a source of our strength and energy, and will always be there. It is our "force," and it is always with us!

So exactly how can this "force field" be useful to us? How can we tap that energy? As physicians, we have long and taxing careers and at times our energy will wane. I have found that going back to these roots, going back to me, the patient, and the "professionalism" that privileges us, serves as a renewable source of my energy and passion for medicine.



What is "professionalism"? And what does "profession" mean? A Profession can be defined as a group of people who:

- Possess a specialized body of knowledge
- Practice within an ethical framework
- Fulfill a broad societal need
- Enjoy a societal mandate to practice, educate, and regulate their profession

In the May/June issue of *Maine Medicine*, I will continue this discussion and explore more deeply the essence of a "profession."

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