MARCH/APRIL 2008

Maine medicine

IN THIS ISSUE

MMA Strategic Planning Process Results

For many years, beginning in the early 1990's, your MMA leadership has regularly conducted strategic planning sessions. The most recent work has resulted in the following mission statement, goal and vivid description of where the Association wants to be. Member comments on these statements are welcome and should be sent to Gordon Smith at gsmith@mainemed.com.

Mission Statement:
To support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens

Big Audacious Goal:
To be the premier healthcare organization recognized by all physicians and the public as the leader and the voice of the physician community.

Vivid Description:

1. The MMA will be an expert on healthcare systems, delivery and reform for Maine.
2. The MMA will be recognized as an expert on healthcare, healthcare delivery and potential healthcare threats to the citizens of Maine.
3 Each and every physician will feel an individual connection with the MMA.
4. The MMA will be viewed by its membership as the best advocate and voice for all Maine physicians.
5. The MMA inspires us to be the very best physician we can be; and provides assistance daily, to help us reach that goal.

MMA New Senior Section a Big Hit

Counterclockwise from top:
1. Dale Fardelmann, M.D. (L) talks with John Shaw, M.D. (R)
2. Peter McGuire, M.D. addresses attendees
3. From left: Dr. McGuire, Andrew MacLean and Buell Miller, M.D.

On January 23, 2008, twenty energetic senior members met at the MMA offices in Manchester to establish a "Senior Section" of the Association. Under the direction of Buell Miller, MD, the Section was organized for the following purposes:

1. To present to MMA's nearly five hundred retired members an opportunity to provide services as volunteers, both in free clinics in Maine and internationally.
2. To provide senior members with an opportunity to mentor residents, medical students and pre-med students.
3. To introduce senior members with opportunities to assist in MMA's advocacy agenda, both at the state house, and in the regulatory agencies.

At the inaugural meeting, Peter McGuire, MD, of Brunswick was the featured speaker. Dr. McGuire spoke on the formation of the Oasis Free Clinic in Brunswick and discussed the deep sense of satisfaction he receives through volunteering at the clinic. There are six free clinics in the state and information on each is available on the MMA website at www.mainemed.com.

The next meeting of the Section will be held in April and a speaker will discuss what it takes to be a good "mentor."

Questions about the section can be directed to Dr. Miller at bmiller@mainemed.com or at 622-3374 ext: 228. To get on the mailing list, contact Lisa Martin at lmartin@mainemed.com or call 622-3374 ext: 221.

17th Annual Practice Education Seminar

May 28, 2008 8:30 a.m. - 4:30 p.m.
Augusta Civic Center, Augusta, Maine

MMA Legislative Committee and Legislators Discuss Budget

The state's budget gap ($190 million and growing) and the Baldacci Administration's proposed solutions for it were the subject of a meeting on February 25 at MMA with MMA Legislative Committee members and six key legislators. The legislators were all serving on the Appropriations Committee or the Health and Human Services Committee and included Jeremy Fischer (D-Presque Isle), Gary Connor (D-Kennebunk), Sarah Lewin (R-Eliot), Donna Finley (R-Skowhegan), Pat Jones (D-Mt. Vernon), and Senator Kevin Raye (R-Eastport).

The February meeting, conducted as an informational forum and discussion, followed the same format as two similar meetings last year discussing MaineCare and DirigoHealth respectively.

The specific items discussed included:

- The impact of existing cuts
- Alternatives to the proposed cuts, including tax increases and use of the state's "Rainy Day" fund.
- Negative impact on physician recruitment and retention of the proposed $20 million cut in MaineCare reimbursement provider-based entities.

From left: Jackie Cawley, D.O., Rep. Jeremy Fischer and Rep. Gary Connor.

Committee members listen to legislators discuss the state's budget difficulties.

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William Strassberg, M.D., President, MMA

President's Corner

As I write this bi-monthly article, the sobering fact that my MMA Presidency is now half over is on my mind. It seems like just yesterday that Dr. Flanigan and I were standing on the podium at the Harborside Hotel with Kevin seemingly (perhaps obviously) quite relieved as the gavel was handed over. These past six months have been exhilarating and scary at times, as the MMA leadership and the 28 member Executive Committee try to both lead and respond to the many issues facing physicians and medicine in Maine in 2008. ***What have we achieved so far?***

1. We have moved forward, the MMA's substantial agenda on quality improvement. The peer review program, office-based quality assessment program and Voluntary Practice Assessment Initiative (VPAI), are all growing and providing important services to MMA members. I believe that our emphases on quality medicine and assessment will become increasingly important to membership as both outside entities and our professional organizations utilize quality reviews for measures and certification. We need to lead this in Maine.
2. We concluded 2007 with a budget in the black and the most members MMA has ever had, no small achievement given the tenor of the times. In this day and age, most medical associations are seeing a declining membership. I am happy to report that we are bucking that trend; your association is doing something right!
3. The Physician Health Program, the Coding Center and our First Friday CME programs are all achieving high levels of success.
4. We held the inaugural meeting of the MMA Senior Section which will provide an important opportunity for our retired members to participate in a host of significant projects and activities.
5. We are engaged with the Maine legislature every day with over three hundred pieces of health care legislation occupying our attention over the two-year session.

In mid-January, the MMA Executive Committee held its annual planning retreat over a long weekend. We spent a long time discussing the new Professionalism program, something I have been personally interested in for several years. The three initiatives of the program will become part of existing MMA projects within pertinent committees, including the Committee on Physician Quality and the Committee on Ethics and Discipline. This will help institutionalize the initiative and help ensure its long-term viability.

Many critical issues face Maine physicians in the coming weeks. The proposed 10.6% reduction in Medicare (July 1, 2008) and the Governor's ill-considered cut in provider-based reimbursement will both negatively impact our ability to attract and retain physicians. The workforce shortage is a huge issue which is not well understood by the public or policy makers alike. I hope you saw my op-ed piece in the *Bangor Daily News* and midcoast newspapers about this issue.

"Part of our professional responsibility as stewards of medicine in Maine is to inform our patients and the public of threats to their care. We need to do more in this area as part of our advocacy agenda."

As I write this article, our legislative activities focus on the issue of proposed licensure of (lay) midwives. This issue finds midwives who are certified by a national organization requesting Maine state licensure and the ability to administer certain medications at home births. The MMA position has been to oppose licensure because of safety concerns surrounding the administration of scheduled medications by persons without sufficient training, the public confusion surrounding their anticipated title as "Licensed Certified Professional Midwives" (LCPM), and the utilization of their national organization certification as sufficient documentation for licensure in Maine. While seemingly a "no brainer", there has been an incredible amount of support for the midwives within the Joint Standing Committee on Business, Research, and Economic Development. MMA leadership was struck by the intensity of the nearly one hundred people at the hearing, as midwives attended with patients and families in tow.

Our elected officials respond to what they hear and see (and yes, you are about to hear this pitch again from me) and all too rarely hear from physicians. We are the experts and our voices can sway opinions when they are heard. While limited to a small number of midwives (twenty-two in the state), their licensure is an important issue to medicine as it potentially opens the door to other non-medical professionals who are looking for enhanced prestige or the ability to prescribe. Your MMA leadership is out there advocating for medicine and our patients, but individual member involvement is necessary too. Patients and elected representatives need to know that YOU care, and that the issue is important to you, and that you have taken a moment to demonstrate that.

I look forward to working with you as President over the remaining six months of my term. By the time you read this, the midwife issue may be water under the bridge. I hope our successes will continue and that MMA can continue to lead; Maine's physicians and their patients deserve no less. As always, I look forward to your response to these thoughts, but you will have to excuse me now as I have to call my representatives in Augusta.

Talk to me: baybones@midcoast.com.

NEW MMA COMMITTEE APPOINTMENTS

Committee on Legislation:
Baird Mallory, M.D.
Samantha Read-Smith, M.D.
Donald Wiper, M.D.

Committee on Public Health:
Daniel Oppenheim, M.D.

Committee on Physician Quality:
Kenneth A. Lombard, MD

Payor Liaison Committee:
Victoria Dalzell, M.D.

Seven Simple Steps to Deter Rx Fraud and Protect Your Good Name *by Standard Register*

With U.S. prescription fraud estimated at more than $5 billion annually, Congress mandated in 2007 that Medicaid outpatient prescriptions will be written on tamper-resistant pads. While tamper-resistant prescription pads are an essential tool in the fight against prescription fraud and drug diversion, they can't do the job alone. You and your staff play a major role in deterrence.

CMS* guidelines address counterfeiting, copying and modification. They do not offer guidance in preventing theft or falsely-issued prescriptions. As it gets harder to alter or reproduce prescription pads, criminals will get more desperate and prescription pad security will become even more important. That's where you can play a critical role. Here are the steps you can take today to safeguard the prescription pads in your care – and protect your healthcare facility or medical office's reputation.

1. Use gel pens to write prescriptions to help prevent criminals from "washing" away the original prescription. Most gel pens contain ink with color pigments that are quickly absorbed into a paper's fibers, preventing it from being washed away with chemical solvents. These pens can be found at any local office supply store and in many drug and grocery stores.

2. Choose a prescription pad solution that offers clear instructions, written on each prescription, informing pharmacists of ways to verify authenticity. This is the best way to ensure all of the security features your prescription pad offers are being utilized.

3. Advise doctors and clinical staff to keep Rx pads in their pockets; not on desks, atop counters or in exam rooms where they could be stolen. For electronic prescribing solutions, be certain to keep the drawer or chamber where the computer prescription paper sits locked at all times. Store Rx pads in a locked cabinet or drawer after hours.

4. Conduct regular and random inventory audits to instill an understanding that crimes will be detected. The best way to ensure all pads are accounted for is by using pads that feature sequential numbering similar to how banks number checks for personal and business accounts.

5. Limit access to Rx pads to only those who use them. By controlling access, you can prevent unauthorized individuals from activating the issuing system. You should also check to be sure your Rx supplier maintains strict process controls over Rx pad production, storage and delivery. Standard printing and storage processes are not sufficient for prescription pads.

6. Use teaming – Assign multiple individuals to execute tasks such as issuance and/or reconciliation to make it harder for a perpetrator to process an unauthorized activity without detection.

7. Report any prescription theft or abuse to local pharmacies, the State Board of Pharmacy, and any required regulatory agency.

* Centers for Medicare and Medicaid Services (CMS)

Upcoming at MMA

APRIL 2	8:00am – Noon	AAPC Medical Coding Certification Course
	12:30pm – 2:00pm	Aligning Forces for Quality Meeting
	2:00pm – 5:00pm	Quality Counts Board
APRIL 3	Noon – 4:30pm	Home Care & Hospice of Maine Meeting for Clinical and Hospice Forums
APRIL 4	9:00am – Noon	"First Fridays" Educational Program: Coding Update
APRIL 8	6:00pm – 9:00pm	Maine Chapter, American Academy of Pediatrics
	6:00pm – 8:00pm	Maine Radiological Society
APRIL 9	8:00am – Noon	AAPC Medical Coding Certification Course
	1:00pm – 3:00pm	Coding Audio Conference Call
APRIL 15	8:30am – 2:00pm	Physician Practice Management Forum
APRIL 16	8:00am – Noon	AAPC Medical Coding Certification Course
	1:00pm – 3:00pm	Coding Audio Conference Call
	1:00pm – 2:00pm	Operations Committee
	2:00pm – 5:00pm	Executive Committee
APRIL 17	8:00am - 3:30pm	Pathways to Excellence
	Noon – 5:00pm	Annual Meeting, Committee on Continuing Medical Education and Accreditation
APRIL 23	8:00am – Noon	AAPC Medical Coding Certification Course
	1:00pm – 3:00pm	Coding Audio Conference Call
APRIL 26	9:00am – 1:00pm	Downeast Association of Physician Assistants (DEAPA) Annual Meeting
MAY 2	9:00am – Noon	"First Fridays" Educational Program: Physicians' Guide to Maine Law
MAY 7	8:00am – Noon	AAPC Medical Coding Certification Course
	12:30pm – 2:00pm	Aligning Forces for Quality Meeting
	1:00pm – 3:00pm	Coding Audio Conference Call
	2:00pm – 5:00pm	Quality Counts Board
MAY 8	4:30pm – 6:30pm	Committee on Physician Quality
MAY 12	6:00pm – 8:30pm	Committee on Physician Health Meeting
MAY 14	8:00am – Noon	AAPC Medical Coding Certification Course
	1:00pm – 3:00pm	Coding Audio Conference Call
MAY 15	5:30pm – 7:30pm	Kennebec County Medical Society Meeting
MAY 21	8:00am – Noon	AAPC Medical Coding Certification Course
	1:00pm – 3:00pm	Coding Audio Conference Call
MAY 28	8:30am– 4:00pm	MMA's 17th Annual Practice Education Seminar @ Augusta Civic Center
	8:00am – Noon	AAPC Medical Coding Certification Course
	4:00pm – 6:00pm	Committee on Public Health
	4:00pm – 6:00pm	MMA Public Health Committee

Upcoming Specialty Society Meetings

APRIL 8, 2008 *MMA Headquarters, Manchester*
Maine Radiological Society Annual Meeting
6:00pm – 8:00pm
MMA Contact: Kellie Miller 207-622-3374 ext: 229 or kmiller@mainemed.com

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

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

MAY 2, 2008 *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 3, 2008 *Harraseeket Inn – Freeport, ME*
Maine Gastroenterology for Primary Care Conference
MMA Contact: Gail Begin 207-622-3374 ext: 210 or gbegin@mainemed.com

MAY 16, 2008 *Hilton Garden Inn – Freeport, ME (Day event)*
Maine Association of Psychiatric Physicians Annual Spring Educational Sessions
MMA Contact: Warene Eldridge 207-622-7743 or weldridge@mainemed.com

MAY 16, 2008 *Hilton Garden Inn – Freeport, ME (Evening event)*
Maine Association of Psychiatric Physicians Annual Spring General Membership Meeting
MMA Contact: Warene Eldridge 207-622-7743 or weldridge@mainemed.com

JUNE 26, 2008 *Cabbage Island*
Maine Chapter, American College of Emergency Physicians Meeting
Lobster Bake on Cabbage Island 5:00pm – 8:30pm
Contact: Anna Bragdon 207-441-5989 or maineacep@roadrunner.com

SEPTEMBER 7, 2008 *Samoset Resort – Rockport, ME*
Maine Society of Orthopedic Surgeons Annual Fall Education Sessions
MMA Contact: Warene Eldridge 207-622-3374 ext. 227 or weldridge@mainemed.com

SEPTEMBER 19, 2008 *Harborside Hotel & Marina - Bar Harbor, ME*
Maine Society of Eye Physicians and Surgeons Fall Business Meeting
(To be held in conjunction with the 7th Annual Downeast Ophthalmology Symposium)
10:30am – 12:00pm
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

SEPTEMBER 19-21, 2008 *Harborside Hotel & Marina - Bar Harbor, ME*
7th Annual Downeast Ophthalmology Symposium
(Presented by the Maine Society of Eye Physicians and Surgeons)
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

OCTOBER 17-19, 2008 *Harborside Hotel & Marina – Bar Harbor, ME*
Maine Chapter of the American College of Physicians 2008 Annual Scientific Meeting
MMA Contact: Warene Eldridge 207-622-3374 ext. 227 or weldridge@mainemed.com

Ethics and Professionalism Online Fellowship

The American Medical Association (AMA) Institute for Ethics and the Graduate Program in Bioethics at the Medical College of Wisconsin (MCW) are offering the AMA-MCW Online Fellowship in Physician Ethics and Professionalism.

The program will provide formal online training designed for physicians currently involved with an institution's ethics endeavors.

Physicians can receive graduate degree credits for each course, which may be transferable toward a master's degree in bioethics. Some courses may offer continuing medical education (CME) credit as well.

For more information, call 312-464-5260, visit www.mcw.edu/display/router.asp?docid=12286 or email ethicsfellowship@ama-assn.org.

Classified Ads

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

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

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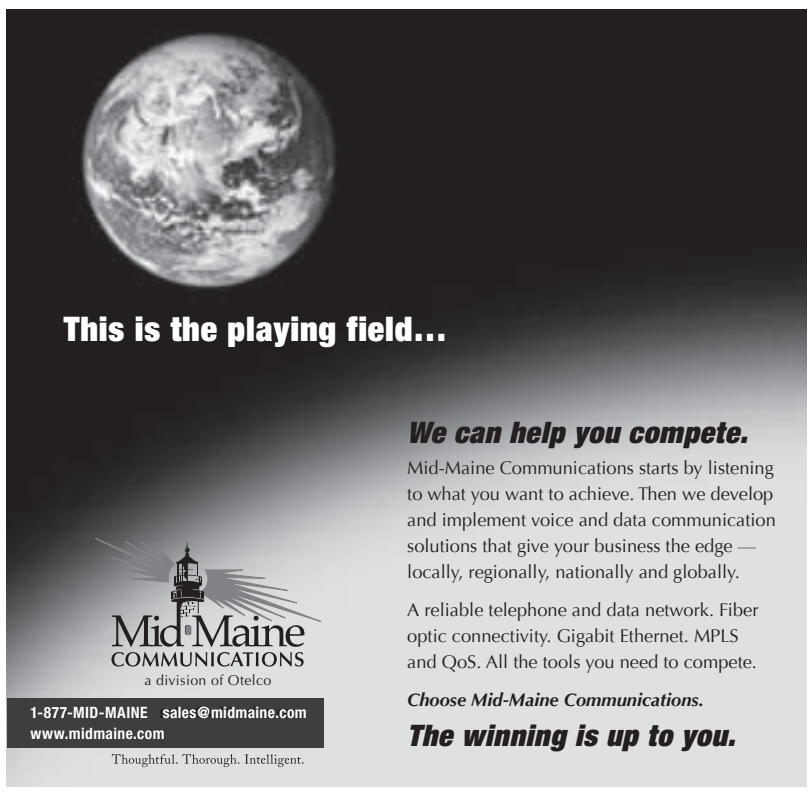

Electronic Health Records

By Kerry Weems, Acting Administrator, CMS

A new national Medicare demonstration program is aiming to show health care professionals the on-the-ground advantages of connecting to the information age.

Medicare is looking for 12 communities across the country that can bring together a broad cross-section of community leadership, leverage resources, and recruit small and medium-sized primary care physician practices willing to provide the evidence that electronic health records (EHR) can improve the quality of patient care.

As many as 1,200 physician practices nationwide could be eligible for incentive payments of up to $58,000 per physician—up to $290,000 per practice over the five-year life of the demonstration. Incentives would be based on a practice's level of EHR use, and for reporting and performance on 26 clinical quality measures.

But the rewards of joining are more than financial. An entire community can benefit from the use of EHRs, which can help avoid drug interactions, redundant lab and diagnostic tests – meaning fewer medical errors and potentially lower costs. Medicare plans to announce the winning communities in June, 2008.

Jana Purrell, CPC

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

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

Diagnosis Coding 101

We spend a significant amount of time focusing on the importance of appropriate documentation to support the services you are providing—Evaluation and Management, Diagnostic Testing, and Procedures—CPT codes. However, we have spent less time talking about the importance of diagnosis coding (ICD9 codes) and it too, has documentation requirements. We did our yearly ICD9 Updates article several months ago and I referenced ICD10. This was not to scare you but to make you aware that ICD10, the updated version of our diagnosis coding system, is coming…not sure exactly when (word on the street estimates October 2011), but it is coming. As a reminder, the ICD10 codes are more detailed (7 digits compared to 5) and will require thorough documentation by the providers for correct reporting of the codes. Now is the time to be sure you are using diagnosis codes appropriately.

In addition to reporting diagnoses codes on your claims to the insurance company, diagnosis coding is also important to support the reporting of quality measures (such as Medicare's PQRI) and supporting medical necessity.

The ICD9-CM Official Guidelines for Coding and Reporting can be found at http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines. Note there are differences between the reporting of diagnoses for outpatient versus non-outpatient services. Sections I and IV of the Guidelines pertain to outpatient coding and reporting and in particular you should review Section IV for the details of what order to report codes in and which codes are appropriate for certain services.

Some reminders when it comes to documenting and reporting diagnoses:

- Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or "working diagnosis" or other similar terms indicating uncertainty. None of these terms are found in the ICD9 book. If a definitive diagnosis is not known upon the completion of the service, the diagnosis should be listed as the symptoms, signs, abnormal test results, or other reason for the visit.
- For outpatient encounters for diagnostic tests that have been interpreted by a physician, where the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.
- A three-digit code is to be used only if it is not further subdivided. If a fourth or fifth digit is required, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code. Submitting an invalid code will cause a claim to be denied and creates more work on the back-end for the billing staff to resolve. Encounter forms and EMR systems that allow for selection of the diagnosis code should flag codes that need the fourth or fifth digit for specificity.
  - Examples: DM, HTN,↑BP, OM, MI, CHF—these abbreviations do not give enough information for the coder to select the appropriate 4th or 5th digit that is required for reporting—the extra work required to find the appropriate diagnosis causes delay in submitting the claim and receiving payment.
- Unspecified codes (NOS) Codes (usually a code with a 4th digit 9 or 5th digit 0 for diagnosis codes) are for use when the information in the medical record is insufficient to assign a more specific code. While often claims for E/M services will be paid with an unspecified code, many diagnostic tests or procedures require a detailed code or the claim will be denied.
- It is important to link the diagnosis code(s) with the services provided. When reporting diagnostic tests along with an E/M code, be sure to indicate the diagnosis that supports the service. In the example below, if the Hypertension code is linked to the glucose test, the insurance company could deny for lack of medical necessity,
  - Example: Patient is seen for an office visit and blood sugar test for Benign Hypertension and Type II Diabetes. Coding for this visit should be:
    - 99213 (OV-level 3), 401.1 (Benign HTN), 250.02 (Type II DM)
    - 82947 (glucose), 250.02 (Type II DM)
- The first code listed should be for the main reason for the visit as documented in the medical record. Any coexisting conditions that require or affect patient care treatment or management can be additionally listed. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment. The Centers for Medicare and Medicaid Services (CMS) states that "the fact that the patient has an underlying disease or co-morbidity is significant only if their presence significantly increases the complexity of the medical decision-making. Only conditions that impact the encounter are determining factors that affect the level of E/M service."
  - This is important to note with the increased use of Electronic Medical Records—just listing all of the chronic problems that a patient has in the "assessment and plan" portion of the note and indicating that they are taking medication for these conditions, does not "count" towards the level of the visit if these were not documented as being evaluated at that visit—the documentation requirements still apply and history and/or an exam still needs to be completed.
  - Additionally, if multiple diagnoses are billed to the insurance company, the documentation in the note for that visit should support that each of these diagnoses were assessed.
    - Example: Patient comes in today for evaluation of a cough. If this is the only thing that is addressed at that visit then the chronic diagnosis of GERD should not be listed on the claim for that day's visit unless it is also documented as having been evaluated.

CMS has recently published an article related to the Evaluation and Management (E/M) documentation rules which among other things, discusses the importance of medical necessity. As you all know, this is the over-arching criteria in determining the level of E/M code and is based on the presenting problem and also supported by the documentation of the medical decision making. CMS goes on to state:

- For each encounter, an assessment, clinical impression, or diagnosis should be documented. Physician medical decision-making is critical to determine the overall level of care provided during a patient encounter. Medical decision-making may vary on a visit-to-visit basis depending on the patient's condition and what the physician performed that day.
- The current status of the patient's diagnosis is also a determining factor, e.g., stable, improved, worsening, etc. Clinical impressions or diagnoses need to be written, not implied. Diagnoses count in the MDM leveling only if they impact the presenting problem. The status of diagnoses is of primary importance; if not written, the assumption is that they are improving or stable.

If you list diagnoses codes on your encounter forms (superbills, charge tickets) be sure they are specific (4th or 5th digit) and are current. If you are writing in your diagnosis code on the billing form, be sure you are giving the coder enough information to select the appropriate code. If you are using an Electronic Health Record, be sure the diagnoses files are accurate and complete.

As always, if you have questions about the information in this article or other coding questions, feel free to contact me at 888-889-6597.

CME IS CHANGING

MMA Can Help You Keep Pace

In recent years, the value of traditional continuing medical education (CME) has been questioned. The debate centered on whether traditional CME, which may enhance the knowledge base of professionals, relates to improved patient outcomes through changing physician practice behaviors.

Here's how evolution to the "new CME" occurred:

- In 2002, the American Academy of Family Physicians introduced evidence-based CME.
- In 2004, the national credit grantors (the AMA, the AAFP and the American Osteopathic Association) changed the measurement of CME from hours to credit.
- In 2005, two AMA-convened national task forces implemented two new formats: Internet point of care (PoC) and performance improvement (PI) CME.

Internet PoC CME takes place when the physician, confronted with a question about a patient, consults an online evidence-based source and then documents a planned behavior change, based on the learned information. This is self-directed learning driven by a reflective process.

PI CME, a three-step process, begins with an assessment of each physician's current practice using identified evidence-based performance measures. Feedback compares a physician's performance to national benchmarks and to performance of peers.

The second stage involves implementation of an intervention based on the performance measures assessed in the practice. A third stage involves revaluation of performance in practice.

National groups have emerged to dominate the development and endorsement of national benchmarks for physician performance measures:

- Physician Consortium for Performance Improvement®
- National Committee for Quality Assurance
- National Quality Forum
- Ambulatory Care Quality Alliance and the Hospital Quality Alliance

Pay-for-performance and Quality

Payers of physician services are moving to a more objective assessment of both quality of care delivered and of patient outcomes. Such programs require not only nationally standardized common performance measures, but also regular reporting of performance data.

Some payers provide bonus payments to physicians who collect and report quality data. Pay-for-performance programs need to recognize the opportunity to provide incentives to physicians for participation in PI CME.

Although approved less than four years ago, PI CME is gaining acceptance as a tool that brings CME, evidence-based performance measures and the increased emphasis on quality improvement and patient safety closer together to improve the care of all patients.

More on CME Planning

Educational activities can now be designed to promote learning and change – and receive AMA PRA CME credit. Other physician professional development activities also may qualify for CME credit. See www.ama-assn.org/go/ccpd for details.

Medical Mutual Insurance Company of Maine Risk Management Practice Tip:

Drug Diversion and the Drug-Seeking Patient: Part I

In the U.S., prescription drug abuse has become an epidemic. According to a report by the National Center on Addiction and Substance Abuse at Columbia University, 15.1 million Americans, or 6 percent, admit to abusing prescription drugs – more than all other forms of drug abuse combined. The most frequently abused drugs include pain relievers such as OxyContin and Vicodin; depressants such as Valium and Xanax; and stimulants such Ritalin and Adderall.

In the Physician Office Practice:

Distinguishing a legitimate patient from a drug abuser is not easy. Physicians should be aware that drug-seeking patients often exhibit the following types of behaviors.

- Present to the office frequently
- If recently moved, refuse to give the name of a previous physician
- Pay with cash
- Are difficult to contact between office visits
- Prescription pads are unaccounted for after a certain patient's office visit
- State that only a particular drug is effective
- Refuse to see one physician
- Frequently report losing medications
- Is demanding of drugs that hold a high street value
- Regularly visit multiple physicians or uses multiple pharmacies

Most patients who take prescribed narcotic analgesics, sedative-hypnotics, or stimulants use them responsibly. However, this class of drugs generates scrutiny from the Drug Enforcement Agency (DEA) and other authorities because of their potential abuse. Physicians treating patients with chronic pain should closely adhere to pain management guidelines and document thoroughly. Consider the following principles when treating chronic pain patients:

- Perform a comprehensive evaluation and document a clear treatment plan.
- Document informed consent and agreement for treatment. If use of controlled substances is selected, obtain a pain management agreement as recommended by Board of Licensure in Medicine Guidelines.
- Consider a referral to a pain clinic.
- Perform and document a periodic review of the treatment efficacy.
- Specifically document drug treatment outcomes and the rationale for medication changes.

Do not be confrontational if a patient appears to exhibit drug seeking behaviors. Treat the patient with respect when indicating the intention to prescribe only non-narcotics or minimum quantities. If the patient protests, contact the patient's treating physician or confer with a pain specialist.

Physicians share responsibility for minimizing prescription drug abuse and drug diversion. The following procedures will help protect the physician and the practice:

- Never sign an incomplete prescription.
- Use tamper-resistant prescription pads that cannot be photocopied.
- Write the quantity and the strength of drugs in both letters and numbers as numbers alone can be easily altered.
- Be wary of patients who want a prescription immediately and are not interested in having a physical examination, are unwilling to authorize release of prior medical records or have no interest in a diagnosis or a referral.
- Be cautious if a new patient has an unusual knowledge of controlled substances or when a new patient requests a specific controlled drug and is unwilling to try another medication.
- Always perform a complete history and physical examination.
- Observe for signs of drug abuse, such as inflamed nares, skin tracks, and perforated nasal septum.
- Contact the police if you believe someone is attempting to divert prescription medications [Maine Medical Association attorneys are available to advise physicians on when and how to report (622-3374)].
- Refer to the Practitioner's Manual: An Informational Outline of the Controlled Substance Act prepared by the United States Department of Justice.

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.

Public Health Spotlight

The Maine Medical Association Public Health Committee's primary role, under the direction of Chair, Charles Danielson, MD is to support the MMA, the leadership and staff in enhancing the health of all Mainers. The committee addresses issues of healthy communities and clinical preventive services and maintains and understanding of how core public health services, such as disease control, disaster response, environmental health, vital statistics and other public health data are provided in Maine. The committee is focusing overall on three major policy initiatives in 2008:

- Childhood Immunization Supply & Vaccines
- Childhood Obesity/Management
- Toxics and Children's Health

For more information on the committee's activities, contact Kellie Miller, at kmiller@mainemed.com or 207-622-3347, ext. 229.

The Precarious US Framework for Protecting Children

Despite numerous attempts to upgrade the regulatory system, such as the CBTS, the framework to protect children from environmental toxins is precarious. Under current regulations, manufacturers of commercial chemicals (excluding pesticides) are not required to supply any toxicity data before selling their products. Nor are pesticide manufacturers obligated to supply basic premarket toxicity and exposure data necessary to ensure that children will be protected from exposure and potential harm from use of those pesticides. Indeed, the vast majority of chemicals have not been tested for DNT. The most basic toxicity tests in animals are lacking for 75% of the 3,000 highest production volume chemicals—chemicals for which annual production exceeds 1 million pounds per year. The US EPA has entered into an agreement with the American Chemistry Council, the chemical manufacturer's trade association, to provide basic toxicity screening tests for the high-production-volume chemicals by 2005 (http://www.epa.gov/chemrtk/volchall.htm), but this is voluntary.

The European Commission proposed a new regulatory framework for chemicals, REACH (Registration, Evaluation, and Authorization of Chemicals). Under REACH, chemical manufacturers would have to assume a much greater burden for showing the lack of harm from use of their products. Specifically, REACH would require both European and non-European manufacturers doing business in Europe to submit more extensive toxicity data for about 30,000 chemicals on the market, including reproductive and DNT data for those chemicals produced in highest quantity. Chemicals found to be hazardous would be subject to an authorization procedure to show that they can be used safely or that there are no safer alternatives. This registration process would not guarantee that chemicals are safe, but it is a step in the right direction.

The American Chemistry Council has objections to REACH, stating that "the proposed regulation is burdensome, costly, and impractical" (http://www.accnewsmedia.com/site/page.asp?TRACKID=&VID=1&CID=359&DID=1256). The pharmaceutical industry used similar objections to ward off regulations before the thalidomide epidemic ushered in requirements for pharmaceutical agents to undergo extensive premarket testing in clinical trials.

Citation: Lanphear BP, Vorhees CV, Bellinger DC (2005) Protecting Children from Environmental Toxins. PLoS Med 2(3): e61 doi:10.1371/journal.pmed.0020061

The Power of Women: American Heart Association's National Movement to make women aware of their risk of heart disease, the No. 1 cause of death among women

An 11 minute DVD, hosted by Kim Block, entitled "Wisdom Gained from the Heart" is available through the American Heart Association at no charge. This DVD features discussions by experts about CVD including signs and symptoms of heart attack and stroke and major risk factors for CVD in women, including diabetes and smoking. Dr. Dervilla McCann, the Chief of Cardiology Services at St. Mary's Regional Medical Center and chair of the Maine Health Cardiovascular Workgroup is highlighted in the DVD, along with Past President of the Senate, Elizabeth Mitchell whose message of raising awareness and ensuring that women truly understand that heart disease is something to pay attention to. Currently, only 21% of women view heart disease as a health threat. To receive a free copy of the DVD, contact Elizabeth Foley, Chair, Maine Women and Heart Health Committee at 207-622-7566, ext 297 or email efoley@mcd.org.

MMA Receives Board of Licensure Support to Provide Consultations in Pain Management

The Maine Medical Association, through a contract with the Board of Licensure in Medicine, is now offering a consultation service to medical practices on the subject of pain management. At no cost to the practice, Noel Genova PA-C will visit any practice which requests the assistance and conduct an audit on existing narcotics prescribing. The audit will review items such as:

- Use of the Prescription Monitoring Program
- Use of a modern narcotics contract, and compliance with its terms
- Use of a registry of narcotics users
- Compliance with BOLM Guidelines for Prescribing for Pain (1999)
- Review of the chart to review appropriate consultations, periodic office examinations and use of evidence-based guidelines

The consultations will be strictly confidential with the results being provided only to the practice. These consultations are available to both members and non-members, private practices and employed physicians, FQHC's and Rural Health Centers.

To schedule a consultation, call Noel at 671-9076 or MMA at 622-3374 ext. 212 (Gordon Smith, Esq.).

Maine Tobacco HelpLine Has Been Proven to Work for Thousands of People Across the State

This year, Mainers will join the millions of Americans who attempt one of the hardest challenges – quitting smoking.

Besides the promise of better health, experts are predicting a large spike in people motivated to quit due to financial reasons; it's never been more expensive to smoke in Maine. The average smoker in the state pays almost $1,500 per year for cigarettes.

But the unfortunate fact is that most people won't be successful if they do not seek help and support. For every smoker who successfully quits each year, many more make attempts but do not succeed.

Fortunately, the Maine Tobacco HelpLine has been proven to work for thousands of people across the state. Whether someone has been using tobacco for decades or just a few years, the chances for success go up dramatically with assistance from the HelpLine.

The HelpLine offers free and confidential resources for people who are thinking about quitting or who are ready to quit smoking. Personal coaching through the HelpLine has been proven to be three times more effective than an attempt to quit without support.

In addition to coaching, the HelpLine provides a variety of services to help people quit, including nicotine replacement medication for qualifying individuals. The majority of callers, about 92 percent, are tobacco users. However, advice and coaching are also available for people who want to help a friend or family member quit.

Dr. Dora Mills, Maine's Chief Health Officer and Director of the Maine CDC in the Department of Health and Human Services, said, "The HelpLine's services are important for anyone who wants to quit smoking. If an individual has tried to quit before without success, we are encouraging them to try again, with our help, in 2008."

The HelpLine's toll-free number is 1-800-207-1230

Andrew MacLean, Esq.

Legislative Update

Legislature Struggles with Budget Gap of $200 Million Plus Prior to April Adjournment

Through the first two months of the 123rd Maine Legislature's Second Regular Session, the focus of attention has been the State's worsening fiscal situation. In early January, Governor Baldacci submitted his FY 2008-2009 supplemental budget (L.D. 2173) to address a $95 million shortfall. During the first week of March, the Governor released a "change package" to the budget that requires more than $200 million in savings to balance without new revenue. As usual, the budget proposals achieve significant savings through cuts in health care and social service programs. The Appropriations Committee and legislative leaders are working hard to resolve this budget challenge before a scheduled April 16, 2008 adjournment date.

Maine's 186 legislators undoubtedly are anxious to complete their work and to join the 2008 election campaign featuring an exciting Presidential race, but they must resolve not only the difficult supplemental budget, but also refinements to the school consolidation law, a new legislative initiative to bring stability to the funding of the Dirigo Health Program and modest reform to the health insurance market, and hundreds of other bills still in committee work before adjournment.

The FY 2008-2009 supplemental budget, as amended by the Governor's "change package," represents a 5.06% increase in General Fund spending in FY 2008 and a 7.35% decrease in General Fund spending in FY 2009 for programs under the jurisdiction of the Joint Standing Committee on Health & Human Services. This portion of the budget includes most, if not all, of the State's health care and social service spending.

While the MMA is concerned about all of the health care cuts, we are particularly troubled by a provision that would cut more than $20 million in reimbursement for hospital-based physicians. This reduction affects those institutions being reimbursed on the basis of their costs under a federal program known as "provider-based" reimbursement.

The MMA's advocacy on the budget has been complicated by this provision because blended into it is a $3 million General Fund fee increase for physicians reimbursed according to the MaineCare fee schedule enacted as part of the biennial budget in 2007 (L.D. 499). The Department estimates that this provision would result in a 12% increase in the fee schedule. Still, it would result in a cut in physician reimbursement at a time when recruitment and retention of physicians in Maine, even in hospital-owned practices, is very difficult. Not only do the hospital-based practices take all MaineCare patients and, therefore, are the safety net in many parts of the state, they are expected to assume greater responsibility for quality improvement and patient safety initiatives in return for the enhanced reimbursement. The MMA has been working closely with the Maine Hospital Association on this issue.

While the budget situation has dominated the health care debate at the State House this year, the MMA has been involved in a number of other health care initiatives.

The MMA worked closely with the Maine Hospital Association to obtain an acceptable outcome on L.D. 2044, *An Act to Prohibit Payment to Health Care Facilities for Treatment to Correct Mistakes or Preventable Adverse Events*, sponsored by Rep. Patsy Crockett (D-Augusta). Prompted by CMS action and voluntary policies adopted by hospitals in Maine and other states against charging for so-called "never" events, the bill will prohibit hospitals and ambulatory surgical facilities from billing for a list of 27 events based upon a model established by the National Quality Forum. L.D. 2044 received an 11-2 "ought to pass as amended" report from the Health & Human Services Committee with the legislature's two physicians, Senator Lisa Marrache, M.D. (D-Kennebec) and Representative Bob Walker, M.D. (R-Lincolnville), voting against the bill because they preferred moving more slowly with a narrower list of events.

The MMA also has been engaged in a 2-year effort to negotiate a bill to license direct-entry midwives, many of whom are known as "certified professional midwives." The MMA along with the Maine Section of the American College of Obstetricians & Gynecologists, the Maine Chapter of the American Academy of Pediatrics, and the Maine Academy of Family Physicians have opposed licensure through L.D. 1827, *An Act to License Certified Professional Midwives to Promote Greater Patient Safety and Access*. Proponents of the bill claim that these midwives, not trained in the medical model like certified nurse midwives, need licensure to achieve legitimacy and to obtain certain medications. Opponents have argued that licensure would put the State's imprimatur on the practice of home births, thereby encouraging a practice that does not meet current safety and quality standards, and would confuse the public about the education, training, and experience of "licensed certified professional midwives" compared to "certified nurse midwives." As required by statute, the Department of Professional & Financial Regulation produced a *Sunrise Review Regarding the Practice of Licensed Midwifery* report that recommends against licensure. This issue remains hotly debated in a closely divided Business, Research & Economic Development Committee with a majority supporting licensure and a minority rejecting licensure but wanting to provide legal access to some medications.

Once again, the Dirigo Health Program has been at the center of the health care reform debate. House Majority Leader Hannah Pingree (D-North Haven) is the prime sponsor of the recently printed L.D. 2247, *An Act to Continue Maine's Leadership in Covering the Uninsured*. The bill seeks a stable source of funding for the Program and proposes an increase in the cigarette tax from $2.00 to $2.50 per pack plus an increase in other tobacco taxes and an alternative to the "savings offset payment" (SOP). The SOP would be replaced with a "health access surcharge" of 1.8% on paid health insurance claims. It would establish a reinsurance association for the individual health insurance market in lieu of a high risk pool and makes modest amendments to Maine's community rating law. It would permit health insurance companies to test new products designed for individuals under age 30, subject to approval by the Superintendent of Insurance. Lastly, the bill would make permanent the temporary voluntary cost containment targets on hospital consolidated operating margins and cost increases included in the original Dirigo legislation in 2003. Recently, the legislature has split along party lines on most issues relating to the Dirigo Health Program and the modest insurance market reforms in this bill may not be enough to generate much support from Republican legislators. A recent example of the continuing partisan divide in the health care reform debate in Maine is the party line vote both in the Insurance & Financial Services Committee and in the Senate on the confirmation of Mila Kofman, J.D. for Superintendent of Insurance.

Another Dirigo initiative has been a revived state health planning process. Recently, the Governor's Office of Health Policy & Finance and the Advisory Council on Health Systems Development have published the 2008/2009 State Health Plan. You can find the new State Health Plan and related documents on the web at: http://www.maine.gov/governor/baldacci/cabinet/health_policy.html.

In addition to these initiatives, the MMA has been involved in the development of legislation to improve screening for lead poisoning (L.D. 2172) and autism (L.D. 1977), on insurance coverage for colorectal screening (L.D. 2109), to protect children in vehicles from second hand smoke (L.D. 2012), and to protect children from toxic chemicals (L.D. 2048) and lead (L.D. 2053) in toys and other children's products, among many other bills.

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

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

To find more information about the MMA's advocacy activities, go to www.mainemed.com and visit the Legislative & Regulatory Advocacy section of the site. You will find more information about the Maine Legislature, including schedules, committee assignments, legislator contact information, audio coverage of legislative work, and newly enacted laws on the web at: http://janus.state.me.us/legis/.

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

Did your Retirement Plan Get an Invitation to the Estate Plan?

By Gail Conley,CFP®, Senior Vice President and Ed Morrow, J.D., LL.M., Key Private Bank

Qualified retirement plans and IRAs have grown to be a very significant part of many estates. These plans are tremendous vehicles for retirement accumulation. But estate planning for these accounts can be complex.

Estate Planning and Tax Advantages for IRAs

While the income tax deferral advantages for IRAs and qualified retirement plans are similar during an owner's lifetime, this is not true for subsequent generations. The vast majority of qualified retirement plans force a non-spousal beneficiary to take assets within five years or, often, much sooner. By contrast, an IRA would typically allow a 6-year-old grandchild as beneficiary **76 years** of tax deferral!

The Myth of the Stretch IRA

Many a tax advisor has touted the benefit of tax deferred compounding with "stretch" IRA planning. A "stretch" IRA gives a beneficiary the option to defer withdrawals over the maximum amount of time permitted under IRS tables. The problem is that beneficiaries frequently waste this opportunity and withdraw more than this after the IRA owner's death -- often the entire account. Thus, the "stretch-out" fizzles and the long-term rosy projections from the tax advisor are more ***myth*** than reality.

Separate Trusts: Often a Poor Solution

Naming a separate trust as beneficiary can prevent the beneficiary from squandering the stretch opportunity. Unfortunately, many long-term trusts do not qualify for the longest "stretch" income tax deferral under stringent IRS rules. A trust that is ideal for ordinary estate planning can be a disaster for estate plans with large retirement plans. This can force distributions out of retirement plan or IRA accounts in as little as one to five years.

Problems with Young Beneficiaries

The reality that the deferral is *optional* hits home when you consider this question: How many 18 year olds inheriting a million dollar IRA voluntarily spend only 1/65 or $13,485 in the first year? Excessive spending or inadvertent withdrawals may also be an issue for older family members, who might be under the influence of a spendthrift spouse.

Solution

A trusteed IRA combines the tax benefits of an IRA with the estate planning benefits of a trust. A trusteed IRA owner, working with his or her estate planning attorney, may customize the beneficiary designation form. This flexibility allows the owner to encourage continued tax deferral by limiting a beneficiary to the minimum required distributions, but with discretion to go beyond this for reasons listed by the *owner*. This ensures the stretch out happens in a manner appropriate to a beneficiary's needs.

Keeping Your Hard Earned Legacy in the Family

A trusteed IRA also allows the owner to control who the beneficiary may appoint as their beneficiary, allowing a hard earned legacy to be kept in the family bloodline. This can be ideal for second marriage and blended family situations. Restricting unlimited withdrawals can also ensure that inherited funds don't inadvertently cause a child's legacy to become marital property divisible in a divorce or subject to lawsuit. Unlike an ordinary custodial IRA, a carefully crafted trusteed IRA becomes a third party created spendthrift trust after the owner's death. Such trusts are generally granted comprehensive spendthrift protection from creditors, which may be especially important for beneficiaries who live in states like Maine that limit creditor protection for IRAs.

Trusteed IRAs are ideal for those with rollover-eligible profit sharing, 401(k), 403(b) or Keogh plans or any IRAs (including SEP, SIMPLE, and Roth) over $500,000 who want to ensure optimal tax deferral and enhanced asset protection for their beneficiaries. For additional information, please contact Gail Conley, CFP®, Senior Vice President Key Private Bank at 207-623-5604.

Eating Disorders Learning Collaborative Teams In Place

Eleven Maine communities now have in place teams trained to provide coordinated health care treatment for those with eating disorders. Teams consisting of at least one medical practitioner, therapist, and registered dietitian are in Augusta, Belfast, Blue Hill, Calais, Camden, Farmington, Lewiston, South Portland, and Waterville, and at Bowdoin College in Brunswick, and the Long Creek Youth Development Center in South Portland.

Prior to the establishment of these teams, people with eating disorders have sometimes found it very difficult to identify providers who will work together to address this complex problem. These coordinated teams will establish a model of care that heretofore has not existed in many areas of Maine, especially in rural areas.

The teams are part of the Eating Disorders Learning Collaborative which provides initial training and ongoing performance improvement and support related to best practices for treating anorexia, bulimia, binge eating, and eating disorders not otherwise specified. The teams provide services to children, teens, young adults, and others with eating disorders.

The initial two-day training program was in October, and Learning Sessions on issues teams have identified will be offered by expert consultants six times a year via web conferencing. Team members also have access to ongoing consultation through the Peer Supervision group offered at New England Eating Disorders Program at Mercy Hospital.

The three-year project will add at least ten teams per year resulting in the formation of more than 30 interdisciplinary teams to provide services throughout Maine. This network of care providers will result in earlier and more effective treatment and help prevent more serious and more expensive complications.

In addition to establishing and training treatment teams, the Eating Disorders Learning Collaborative will also raise awareness of the problem of eating disorders in Maine and develop training for Gatekeepers who might identify and refer people at risk.

This project is a joint effort of Medical Care Development, Inc., a not for profit organization formed in 1966 to improve health systems in Maine, and Mainely Girls, a not for profit organization founded in 1996 to work with rural communities to assist them to focus on girls' needs in a preventive and proactive manner and to work on the state level to bring about positive change for girls.

Support for this project has come from The Betterment Fund, The Davis Family Foundation, The Hilda and Preston Davis Foundation, and The Maine Center for Disease Control and Prevention, Department of Health and Human Services.

For specific information about a team, to join an existing team, or to establish a new team in your area, please contact Mary Orear at megirls@midcoast.com or (207) 230-0170.

MedPAC Supports 1.1 Percent Pay Increase

On January 10, the Medicare Payment Advisory Commission (Med-PAC) recommended a 1.1 percent increase in Medicare physician payments for 2009. MedPAC arrived at this figure by subtracting the expected growth in productivity (1.5%) from the expected acceleration in price inputs (2.6%). The recommendation also calls for Congress to pass legislation allowing Medicare to confidentially report back to physicians about their resource use. For more information, go to http://www.medpac.gov.

At this point, because of the stopgap measure that Congress passed late last year, Medicare physician payments are 0.5 percent higher in 2008 than in 2007. However, without further congressional action, Medicare payments to physicians will be reduced by approximately 10.6 percent beginning July 1, 2008.

Lay Mid-Wives Seek Increased Recognition Through Licensure

For over a year, twenty-two certified midwives (non-nurse) have sought increased recognition through state licensure. MMA, the Maine Chapter of ACOG, the Maine Academy of Family Physicians, the Maine Chapter of the American Academy of Pediatricians and the March of Dimes all oppose the proposal, which has been the subject of intense grassroots lobbying efforts by both proponents and opponents.

The original bill (L.D. 1827) would grant limited prescribing rights to the mid-wives and delegate issues regarding education and training to a national midwife certifying organization.

As of this writing, the Committee handling the bill, The Business Regulation and Economic Development Committee appears split with a slim majority favoring licensing and the remaining members of the Committee favoring a more limited proposal allowing access to a small number of drugs, such as pitocin and oxygen.

Last session, the proposal was subject to a "Sunrise Review" analysis by the Department of Professional and Financial Regulation. The report of the Department recommended that licensing should not be granted, but a majority of Committee members voted to set aside the report and proceed to licensing. At this point, the ultimate resolution of the matter is unknown. MMA remains concerned about the expansion of scope of practice of non-medical personnel. At a time when the state demands more of physicians in terms of quality improvement and patient safety, many legislators are willing to apply a different standard to non-physicians.

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