MAY/JUNE 2007

Maine medicine

In this issue...

MMA Committee on Legislation Examines *MaineCare & Dirigo 2.0*

This year the MMA Committee on Legislation, chaired by Katherine Pope, M.D., employed a new approach in its work, focusing its meetings on certain themes rather than working through stacks of bills impacting medicine. Two meetings have been held so far this session, focusing respectively on MaineCare and Dirigo 2.0. Photos on this page memorialize the occasions. The MaineCare discussion included new MaineCare Director Anthony Marple and MaineCare Medical Director Laureen Biczak, D.O. (Dr. Biczak has since resigned to accept a position at Goold Health System). Sen. Karl Turner, Sen. Lisa Marrache, M.D., Rep. Robert Walker and Rep. Janet Mills also attended and made brief remarks. At the Dirigo discussion, Sen. Elizabeth Mitchell,

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Rep. Robert Walker, M.D. (R, Lincolnville)

Committee Chair Katherine Pope, M.D.

Senator Libby Mitchell (D, Vassalboro)

Members of the Committee on Legislation "Dirigo Session"

MMA Becomes Administrative Home for Quality Counts!

The Maine Medical Association has been selected to become the administrative home for Quality Counts. Quality Counts is among the newest healthcare quality improvement organizations with a statewide focus in Maine. The Quality Counts mission statement is as follows:

Quality Counts is committed to working together across organizations and across communities to improve healthcare systems and outcomes with the people of Maine. Quality Counts will coordinate existing but disparate efforts across the state that support local, patient centered, and coordinated systems of care AND the resources that support them. Its goals are to promote consistent delivery of high quality care, improve access to healthcare, and contain healthcare costs.

Quality Counts traces its origins to a diverse group of stakeholders including healthcare providers, employers, payers and policymakers, who came together in the fall of 2003 to promote the need for improved systems of care for chronic illness. This group initially planned and conducted a series of Quality Counts conferences in December 2003, April 2004, and December 2005. These statewide conferences introduced attendees to the Chronic Care Model and provided specific examples of Maine providers using population-based approaches and information systems to improve care. The effort also forged collaborative relationships between

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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

Spring in Maine brings with it a sense of renewal, a new level of energy, and affords us the opportunity to see things in a new light. As we take in nature's beauty, and realize how precious life is, we begin to focus on how to care for those things around us and how to care for ourselves. Suddenly, we can find the time to exercise and have the desire to eat healthier as we yearn for our gardens to grow and provide us with an abundance of fresh fruits and vegetables. As our attention turns toward our health, one cannot help but realize that even with our best intentions, we will all someday need to access our health care system. The question is, will it still be there when we need it, and if it is, will we be able to afford it?

Maine and the nation are, once again, at a fork in the road on the journey to health system reform and universal coverage. Will we again go down the well traveled road that has resulted in many failed attempts at reform? Or can we take a new road, one that will lead us to a system of universal coverage. Imagine a state and nation where no citizen delays care because of their inability to pay for it. Imagine a day when every patient who arrives in your office has insurance coverage. While universal coverage does not necessarily equate to universal care, such coverage would go a long way toward ensuring that all Maine citizens get timely and effective medical care.

The Maine Medical Association has long advocated for solutions that would result in all Maine citizens having access to health insurance coverage, public or private. In 2003, the Association released a "White Paper" on Health System Reform which called for many reforms, including a requirement that all persons be required to purchase health insurance with public subsidies being available for those individuals who could not afford it. Now that the State of Massachusetts has enacted legislation establishing such a requirement, it has become more popular to talk about it as one of many options to expand coverage for the currently uninsured. I want to acknowledge the efforts of Maroulla Gleaton, M.D., who chaired the MMA ad hoc Committee on Health System Reform, and Jacob Gerritsen, M.D., who advanced the concept of an individual coverage mandate. They were ahead of their time!

Now, Governor Baldacci has proposed an individual mandate as part of his Dirigo 2.0 initiative. While the details would be worked out through rule-making, the requirement would take effect on Jan. 1, 2009. A mandate for employers, with appropriate exceptions also done through rule-making would take effect on July 1, 2008. While these provisions will be aggressively opposed by some, MMA will advocate for universal coverage, as has been our position since 2003. If universal coverage were easy to achieve, it would have been accomplished in Maine and the nation long ago. But as we enjoy the Spring of 2007, winds of change are blowing, and in a favorable direction.

As always, feel free to call me at any time at 487-9244 or communicate via e-mail to flanmansvpc@pol.net

MMA Becomes Administrative Home for Quality Counts!

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providers, employers, and payers to speed broader adoption of the Planned (Chronic) Care Model in Maine and support its sustainability. In April 2006, the original Corporators endorsed the creation of Quality Counts as an independent not-for-profit corporation to be supported by membership contributions, as well as available contracts and grants.

Quality Counts has been designed to provide the following key functions:

1. Serve as statewide organizational champion and provide visible collective leadership for improving chronic illness prevention and care in Maine.
2. Promote the spread of best practices through annual statewide Quality conferences or "Best Practice Colleges."
3. Promote the spread of best practices through the creation of a statewide chronic illness prevention and care "learning network."

In June 2006, Quality Counts was established as an independent corporate entity. The organization undertook an initial campaign to solicit supporting organizational memberships, and successfully enrolled 36 Member organizations (including MMA) and/or individuals. Quality Counts organizations represent a diverse group of stakeholders and contributed $63,500 in membership dues to support the first year of Quality Counts activities.

Quality Counts also has received a grant from the Robert Wood Johnson Foundation "Aligning Forces for Quality" program. Quality Counts will receive $200,000 per year for each of three years.

As the administrative home of Quality Counts, MMA will provide a physical and administrative infrastructure for the organization. Approximately 900 square feet of office space in the Association's Frank O. Stred headquarters building will be made available to Quality Counts and Quality Counts employees will become employees of MMA for payroll and benefit purposes. The arrangement is for two years, but may be continued on a mutually acceptable basis.

As of May 11, Quality Counts Director John Barry is located in his new office and has been welcomed by MMA staff. Mr. Barry is also the Project Director for the MMA/MOA Voluntary Practice Assessment Initiative. MMA looks forward to a mutually beneficial relationship with Quality Counts. MMA EVP Gordon Smith is a member of the QC board.

Classified

New Tool from CMS Helps Physicians Adopt EHR

The Centers for Medicare and Medicaid Services (CMS) has announced the launch of an interactive Web site designed to educate solo and small- to medium-sized medical practices in the use of health information technology, including electronic health records (EHR). The Doctor's Office Quality Information Technology University (DOQ-IT U) is free and will also include lessons on culture change, vendor selection and operational redesign, along with clinical processes. For more information: http://tinyurl.com/2cls8d

Physicians can register for the DOQ-IT U Web site at: http://elearning.qualitynet.org/

Upcoming Specialty Society Meetings

JUNE 28 *Cabbage Island Clam Bake - 4:30pm*
Maine Chapter, American College of Emergency Physicians
MMA Contact: Anna Bragdon 207-441-5989 or maineacep@adelphia.net

SEPTEMBER 7-8 *Harborside Hotel & Marina - Bar Harbor, ME*
Maine Society of Orthopedic Surgeons
MMA Contact: Lauren Mier 207-622-3374 ext:223 or lmier@mainemed.com

SEPTEMBER 8 *Harborside Hotel & Marina - Bar Harbor, ME*
Maine Urological Association Annual Fall Meeting
MMA Contact: Warene Eldridge 207-622-3374 ext:227 or weldridge@mainemed.com

SEPTEMBER 26 *MMA – Manchester, ME - 6:00pm-9:00pm*
Maine Society of Anesthesiologists General Membership Business Meeting
MMA Contact: Anna Bragdon 207-441-5989 or msainfo@adelphia.net

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

SEPTEMBER 28-30 *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 Affiliate:

Cerner PowerWorks

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.

Imbesat Daudi, MD
Michael Parker, MD
Cardiovascular Consultants of ME
Coastal Women's Healthcare
MidCoast Hospital Employed Physicians
Mount Desert Island Hospital Employed Physicians

MMA Committee on Legislation Examines MaineCare and Dirigo 2.0

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Rep. Jill Conover, Rep. Wes Richardson and Sen. Peter Mills all attended, along with Trish Riley, Director of the Governor's Office on Health Policy and Finance. Lively discussion ensued at the meetings.

The Legislative Committee has now resumed conference calls which include any interested MMA member and MMA legislative staff. The calls are Thursday nights at 7:30pm. You may call MMA at 622-3374 (Charyl Smith ext. 211), if you would like to participate.

From left: Laureen Biczak, D.O., Theodore Papalimberis, M.D., Rep. Janet Mills, Brian Jumper, M.D.

The Governor's Dirigo initiative (L.D. 1890) was the subject of a lively and lengthy public hearing on May 16. It remains to be seen, as of this writing, what the Legislature will do with the proposal. Among other things, the bill includes a "shared responsibility" provision requiring employers and individuals to purchase insurance or pay a penalty. Although the details of the employer mandate would be established through rulemaking, the program's funding for State Fiscal Year 2009 assumes that the "pay or play" requirement would apply to employers with four or more full-time equivalent employees (FTE's) and that the penalty would be approximately $730 per year per FTE, generating an estimated $31-$38 million per year.

Among the other three hundred proposals impacting on medicine this session were proposals to license lay (direct-entry) midwives and to tax "elective" corrective procedures. The lay-midwifery bill has been referred to the Department of Professional and Financial Regulation for study, a result MMA had hoped for this session. As of this print deadline, the tax on cosmetic procedures is still a live issue with MMA aggressively opposing it with help from a broad coalition of health providers.

From left: David Hallbert, M.D., Senator Peter Mills, Rep. Wes Richardson, Rep. Jill Conover

MMA has also been very involved with several public health measures including bills providing for:

- Primary enforcement of the seatbelt law (successful)
- Substantial increases in the cigarette tax (result unknown at this point)
- Increased funding for the state's immunization program (defeated)

Top to bottom: David Hallbert, M.D., Rep. Wes Richardson, Sam Solish, M.D., Jo Linder, M.D., and Jack Ginty, MOA Executive Director

The Association's highest priority this session was the proposed $3 million increase in the MaineCare budget which, with the federal match, would provide over $8 million in physician fee increases. At this point, the increase is still in the budget, but with the state still facing a $200 million shortfall, constant vigilance has been required and will be needed until adjournment (June 20) to assure success.

All of the MMA testimony presented on bills may be found on the MMA website at http://www.mainemed.com/legislation/testimony/index.php.

UPCOMING AT MMA

JUNE 13 **5:30PM**
Committee on Membership and Member Benefits

JUNE 14 **2:00PM – 4:00PM**
Committee on Loan and Trust Administration

JUNE 14 **6:00PM**
Maine Association of Psychiatric Physicians, Executive Council and Committee Chairs

JUNE 21 **8:30AM**
Pathways to Excellence

JUNE 21 **4:00PM**
Committee on Quality Improvement and Peer Review

JULY 9 **6:00PM**
Committee on Physician Health

JULY 10 **6:00PM**
Maine Chapter, American Academy of Pediatrics, Executive Board

JULY 25 **2:00PM**
MMA Executive Committee
(at Dr. Flanigan's house in Pittsfield)

AUGUST 1 **2:00PM**
Quality Counts! Board Meeting

AUGUST 7 **1:00PM**
Stop Stroke

AUGUST 22 **4:00PM**
Public Health Committee

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 continues

Last time we discussed surgical modifiers—58, 78, and 79. This month we will review the correct use of modifier 59. The CPT description of modifier 59 states: **A Distinct Procedural Service:** Under certain circumstances, the physician may need to indicate a procedure or service that was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if a more descriptive modifier is not available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

First, a little background—The National Correct Coding Initiative (NCCI) was developed to identify coding combinations that normally should not be billed by the same provider for the same patient on the same day. As part of the NCCI edits, the Centers for Medicare and Medicaid Services (CMS) acknowledged that there would be exceptions to these basic coding rules. In order to identify when a coding combination meets this exception criteria, modifiers are used. There are many modifiers that can help to identify when a provider feels these coding combinations should pay separately. For example location modifiers such as RT, LT, 25, or 57 (see HCPCs for a complete list of location modifiers).

By using a modifier it indicates to payors that the procedure or service represents a distinct procedure or service from others billed on the same date of service. It could represent a different session, different anatomical site or organ system, separate incision/excision, different lesion, or different injury or area of injury (in extensive injuries). If none of the anatomical or surgical modifiers can be used appropriately to describe the reason for the exception, then the modifier 59 can be attached.

The CCI edits always consist of pairs of HCPCS codes, and are arranged in two tables. One is the Column 1/Column 2 Correct Coding Edits table, and the other is known as the Mutually Exclusive Edits table. The NCCI file formats also include a correct coding modifier indicator for the correct coding edits table. This indicator determines whether a modifier is allowed with the code combinations. An indicator of 1 allows the procedure to bypass the edit and be considered for payment. An indicator of 0 does not allow a procedure code to bypass the edit which will cause the claim to be denied. The modifier goes on the COLUMN 2 code that meets the exception criteria.

Example: A provider performs nerve conduction studies on a patient during an office visit. The provider codes 95900 for a motor study without F-wave on the right ulnar nerve and code 95903 for a motor study with F-wave on the right medial nerve.

The NCCI edits indicate:

95903 MOTOR NERVE CONDUCTION TEST

Medicare National Correct Coding Policy Edits Apr-Jun 2007 (version 13.1)

Disclaimer

During Q2 2007, Code 95903 is considered a Column 1 Code to:

95900[1] **95920**[1]

In this example, it would be appropriate to use the 59 modifier on the nerve conduction study of the right ulnar nerve (95900) to indicate it was done on a separate nerve. The "1" indicator on the Column 2 code of 95900, indicates that this code combination will bypass the edit if appropriate and billed with the modifier. Correct coding would be: 95903, 95900-59. If these two codes are billed together without the modifier, the second service could be denied as being bundled with the primary service.

Using this modifier (59) to bypass an edit would not be appropriate if the two studies were done on the same nerve. One common error is when providers, once they receive a denial stating the service is included with another procedure, use the modifier 59 every time they bill that service. Remember that modifier 59, and the global surgery modifiers, are "exceptions" to the normal rules. By using them incorrectly, or placing them on every service, it can indicate to the payor that everything they do is an exception. This could lead to further review of a provider's billing practices.

Another note, the NCCI edits are used by CMS. Many payors also follow these edits, however some payors have created their own edits. Check the payor websites for a listing of their bundling edits.

Professionalism *(PART 2 – Continued from March/April Maine Medicine)*

The Drama of High Intensity MD on your TV

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

Traditionally, a small number of professions, acknowledged to fulfill a great and fundamental societal need, have been termed "learned professions". Medicine, law, and ministry have enjoyed this elevated status. This special claim lies both in the expertise of the profession and in a dedication to something other than their own self interest while providing services. The learned professions commit and dedicate themselves to fulfilling societies needs and obligate themselves to place the needs of society before their own.

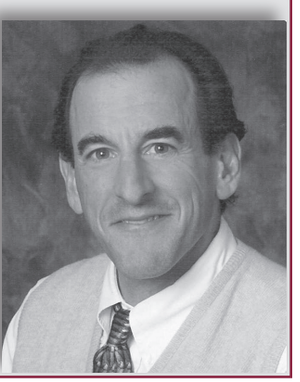
Another explanation of a profession is found in the etymological "root meaning" of the word "Profession", which literally means to "declare out loud", or "publicly proclaim". Consider your own initial declaration which was proclaimed at the completion of medical school with the recitation of the Hippocratic oath. Now you may begin to understand exactly what you meant when you stated those words a few, or perhaps so many, years ago. You committed, or professed, to this understanding and agreement with society. The understanding comprises a virtual contract between you and society and delineates both the privileges society gives to us and the commitments we make in turn.

The contract between professions and society is relatively simple. The profession is granted a monopoly over the use of a body of knowledge, as well as considerable autonomy, prestige, and financial rewards, with the understanding that members of the profession will guarantee competence, provide altruistic service, and conduct their affairs with morality and integrity. Pasted from <http://www.mja.com.au/public/issues/177_04_190802/cru10332_fm.html>

While the concept can appear convoluted, confusing, and remote or antiquated, I believe that acknowledgement, understanding, and acceptance of these parameters can provide the present day physician a distinct beacon; a pathway to follow through these challenging times as physicians are faced with financial and ethical decisions and dilemmas without prior training or clear rules, and without the guidance of precedence.

This understanding can be described by those characteristics that define our profession. They provide a rational that can be looked upon as our own "roadway to excellence". These characteristics, also defined by our "contract" with society, include:

- *Monopoly* over the use of the specialized body of knowledge
- Responsibility for teaching and *education* within the profession
- Autonomy to establish and maintain standards of practice and *self-regulation* to assure quality
- Responsibility for *integrity* and highest standards of it's knowledge base
- Service to patients and public in an *altruistic* and non self-serving fashion



Education…autonomy…self-regulation…service…altruism…are the privileges of our profession, and the expectations of the people we care for. In my next article, I will expand upon these characteristics, and demonstrate how they can help illuminate a pathway through the complexities of medicine we face today. Please feel free to communicate with me at baybones@midcoast.com. I welcome your feedback.

Medical Mutual Insurance Company of Maine: *Risk Management Practice Tip*

Appointments: Missed (No Show) & Canceled Appointments

The implementation of a missed/canceled appointment policy should assist the physician office practice in ensuring that patients return for follow-up appointments. The policy should reflect the following:

- During the patient's initial visit, the patient should be advised of the importance of keeping scheduled appointments.
- Every patient who misses (no shows) or cancels an appointment and does not reschedule should be contacted. This is done as a courtesy and to maintain continuity of patient care. Contact may be made by telephone, card or letter and should be documented in the patients' record.
- The physician should be notified or provided with a list of patients who missed or canceled an appointment. This allows him/her to direct any additional follow-up activity.
- When additional follow-up with the patient is directed by the physician, at least three contact attempts should be made.
  - The initial attempt would be the courtesy contact mentioned above.
  - The second contact attempt may be the same as used in the initial attempt, i.e., phone call, card or a letter. It is not uncommon, however, for the first attempt to be made by telephone and the second attempt made by a letter sent first class US mail.
  - The third attempt should be a letter sent certified mail request return receipt, restricted delivery.
  - For missed or canceled appointments where serious consequences could arise as a result of lack of follow-up, the letter sent in the third attempt should outline the possible medical issues that may arise from not having a medical professional evaluate their condition. Again, this should be sent certified mail request return receipt, restricted delivery.
  - If a patient refuses a certified letter:
    - Note the refusal in the patient's record.
    - Place the unaccepted letter in the envelope in the chart with the refusal receipt.
    - Make a copy of the letter.
    - Send the copy back to the patient in a plain envelope with no office practice identifiers.
- Documentation should occur in the medical record and reflect:
  - Each contact or attempt to contact the patient including telephone contact or letters sent to the patient.
  - The date of the missed or cancelled appointment and the date of the rescheduled appointment.
  - The reason why an appointment is no longer necessary (when applicable).
  - Refusal of the certified letter as discussed above.
- Referral Patients:
  - When a referred patient neglects to schedule an initial appointment or fails to keep their initial consultative appointment, a letter should be sent to the referring physician within a reasonable timeframe, e.g., 30 days, notifying them that the patient never scheduled or did not show for the initial appointment. Any patient information that had been received from the referring physician, e.g., a copy of the medical record, should be sent back to the referring physician with the letter.
  - A copy of the notification letter should be kept for the same number of years medical records are retained, i.e., 6-10 years.

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.

2007 Physician Quality Reporting Initiative Announced

The Centers for Medicare and Medicaid Service have announced a Physician Quality Reporting Initiative (PQRI) starting July 1 and ending on December 31, 2007, which potentially will pay a bonus up to 1.5% on Part B services delivered by your office during that time period. The CSMS Quality of Care Committee continues to closely monitor the federal roll-out and will update you regarding the various measures and reporting requirements through the www.csms.org website and future newsletters.

In the meantime, the following are specifics regarding the program:

You may use any of the 74 PQRI quality measures (which have been recognized by the AMA and others). If there are no more than three measures used, each measure must be reported for at least 80% of cases in which a measure was reportable. If four or more measures are used, again at least three measures must be reported for at least 80% of applicable cases. Reporting is claims based reporting and can be submitted either electronically or via paper-based CMS 1500 claims. Any bonus earned during the second half of 2007 will be paid in 2008.

Participation is voluntary but requires an NPI number on submitted claims. If you are interested in this project, you can obtain further information at: www.cms.hhs.gov/pqri.

CMS Extends Transition to NPI

The Centers for Medicare & Medicaid Services announced on April 2 that it is implementing a contingency plan to extend the compliance date for the National Provider Identifier (NPI) from May 23, 2007 to May 23, 2008.

Physician practices covered under the Health Insurance Portability and Accountability Act, are required to get NPIs for the organization and their providers, and submit those numbers on all HIPAA electronic standard transactions, including claims. Medicare is requiring use of the NPI on the revised paper 1500 claim form.

CMS announced its contingency plan after it became apparent that many covered entities would not be able to fully comply with the NPI standard by May 23. This guidance would protect covered entities from enforcement action if they continue to act in good faith to come into compliance, and they develop and implement contingency plans to enable them and their trading partners to continue to move toward compliance. CMS notes that transactions often require the participation of two covered entities and that non-compliance by one may put the second in a difficult position.

The enforcement process is complaint-driven. If a complaint is filed against a covered entity, CMS will evaluate the entity's "good faith efforts" to comply with the standards and would not impose penalties on covered entities that have deployed contingencies to ensure that the smooth flow of payment continues.

CMS encourages health care providers that have not yet obtained NPIs to do so immediately, and to use their NPIs in HIPAA transactions as soon as possible. Applying for an NPI is fast, easy and free. Visit the National Plan/Provider Enumeration System (NPPES) website at https://nppes.cms.hhs.gov/.

NPI Tip

When applying for your NPI, CMS urges you to include your legacy identifiers, not only for Medicare but for all payors. If reporting a Medicaid number, include the associated state name. This information is critical in the development of "crosswalks" to help in the transition to the NPI.

Patient Safety: Updated Sentinel Event Statistics

As of December 31, 2006, The Joint Commission's sentinel event statistics have been updated and are available on The Joint Commission website, www.jointcommission.org. Since the sentinel event database was implemented in January 1995, The Joint Commission has received 4,074 reports of sentinel events. A total of 4,202 patients were affected by these events, with 3,021, or 72 percent, resulting in patient death. The 10 most frequently reported sentinel events are:

Wrong-site surgery	532
Patient suicide	522
Operative/post-operative complication	494
Medication error	387
Delay in treatment	303
Patient fall	224
Patient death or injury in restraints	153
Assault, rape or homicide	141
Perinatal death/loss of function	125
Transfusion error	100

Any questions can be addressed to Coleen Smith as: csmith@jointcommission.org.

Maine medicine

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