JULY/AUGUST 04

Maine medicine

In this issue...

SAVE THE DATE

First Annual Maine Medical Association Charity Golf Tournament

Monday, August 30, 2004
Noon
Augusta Country Club

Call MMA at 622-3374 for details!

151st Annual Session to Feature Technology

Members from across the state will gather at The Colony Hotel in Kennebunkport September 10-12, 2004 for the Association's 151st Annual Session. In addition to the usual business and recreational offerings, this year's meeting features nine and one-half hours of CME. The meeting begins with a Keynote luncheon on Friday, September 10, featuring Thomas Sullivan, M.D., immediate past President of the Massachusetts Medical Society and Chairman of the AMA's Technology Advisory Committee. The remaining CME schedule for Friday and Saturday afternoon is highlighted on the right.

On Sunday morning, the meeting will conclude over breakfast with a presentation by Charles Alexander, M.D., on the Medicine and Literature Program of the Maine Humanities Council.

On Saturday morning, President Maroulla Gleaton will address members attending the General Session. Additionally, reports on professional liability, legislation and resolutions will be considered. Other items to be considered include a proposed Constitutional Amendment that would "delink" MMA and County Medical Societies, the MMA 2005 Budget and the election of officers of the MMA. The Annual Banquet will be held Saturday evening, featuring installation of Lawrence Mutty, M.D., as President.

The Tony Boffa Band will perform on Friday evening, following a traditional lobsterbake.

Childcare will be available and golf, tennis and the Edmund Hardy Road Race (7:30am Saturday) will compliment the CME and business sessions.

Registration materials are enclosed with this issue of Maine Medicine. Please register today!

Friday, September 10

2:00pm - ePrescribing - The Future is Now - *Mukesh Bhargava, MB, BS*
3:00pm - Break
3:30pm - EMR - A Pragmatic View from the Frontlines - *Douglas Jorgensen, DO*
4:30pm - Telepsychiatry - What It Is, How It Works - *Edward Pontius, MD*
What's Next? New Tech for Your Practice - AT&T

Saturday, September 11

1:30pm - How to Evaluate EMR's - *Theresa Marino*
Vendor Demonstrations
2:00pm - GE/Logician
2:30pm - Minuteman Instant Medical Record
3:00pm - Break
3:30pm - A4 Health Systems
4:00pm - Healthvision
4:30pm - Chartware
5:00pm - Wrap-up

The Colony Hotel – Kennebunkport, Maine

Political Season

On May 24th, the MMA hosted a political event for the Republican Senate Caucus with U.S. Senator Susan Collins as a guest. Other events will be held as the November 2nd election approaches, including a fundraiser for Congressman Thomas Allen on August 18th in Portland.

U.S. Senator Susan Collins with MMA President Maroulla Gleaton, M.D.

From left, State Senator Carolyn Gilman, Robert McAfee, M.D., and Doris McAfee.

From left, Richard Flowerdew, MB.BS, 1st District Congressional candidate Charles Summers, and Christopher Cary, M.D.

President's Corner

Maroulla Gleaton, M.D.,
President, MMA

Connectivity

How many times have you had a new patient encounter where the patient's verbal history is not complete enough to render the best care? You explain that you need to obtain their records from another doctor's office or a hospital. Perhaps you have to review an x-ray or CT scan reports or look at previous lab data. Next the hunt is on (after securing patient consent) to acquire and piece the puzzle together. No easy feat at times. Further, there are critical times when necessary medical information is unavailable to a provider when he or she is deciding immediate medical therapy or ordering crucial diagnostic tests.

Making patient medical information available and easily accessible to providers over a patient's lifetime is one of the most important goals and challenges of delivering healthcare today and tomorrow. Utilizing the advantages of information technology to better manage care, to increase the delivery of quality care and to reduce cost through efficiency and reduction of duplication is propitious.

> The Institute of Medicine (IOM) report in 2001 stated:
> *"Congress, the executive branch, leaders of healthcare organizations, public and private sector purchasers and health informatics associations and vendors should make a renewed national commitment to building an information infrastructure to support healthcare delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research and clinical education. This commitment should lead to the elimination of most handwritten clinical data by the end of the decade."*

Clearly, the patient electronic medical record (EMR) is a future key to improving care, increasing efficiency and fostering communication. Many medical errors are linked to a lack of information at the time and place of medical service.

Many caregivers in Maine still generate a lot of paper records with handwritten entries, which are transmitted to other providers verbally via telephone or are faxed/mailed in copied form. This often results in incomplete and difficult to read data delivered or communicated 1-2 weeks after a patient visit. More and more offices, hospitals and nursing homes are converting to EMR's, but there is little or no connectivity or sharing of the information among clinicians. Instead, these EMR's are being formed in silo fashion with significant time and money being invested.

The time is now to make certain there is a mechanism in place to coordinate the collaboration and effective communication of linkages while ensuring patient privacy at the same time. For many providers, the task of converting to EMR's alone is daunting and sometimes uncomfortable without considerable technical support and financial resources, not to mention a huge personal time investment.

Despite the difficulties to be overcome, the benefit to the patient as well as clinicians and payers cannot be denied. Maine Quality Forum Executive Director, Dennis Shubert, M.D., PhD, recently espoused the case for quality improvement through an integrated Health Information Technology (HIT) System.

- Reduction in hospitalizations
- Avoidance of unnecessary and duplicative tests
- Decrease of adverse drug events
- Reduction of redundant and overuse of medication
- Reduction of emergency department care and expense
- Improvement of confidentiality and privacy of patient information
- Reduction of risk in patient treatment

The interim one-year State Health Plan also has promoted the development of a HIT system.

One could potentially imagine other benefits to a connected HIT System across Maine such as a coordinated public health registry, bioterrorism prevention, furtherance of telemedicine for rural areas, and creation of an Emergency Medical Services network.

So given this imperative, what's happening? The Dirigo Health Maine Quality Forum has identified this connectivity as a priority. There is also significant proposed support by the Bureau of Health. The Maine Health Access Foundation is reviewing a funding proposal by the MHIC to conduct a 7-month feasibility/planning project starting in September 2004. The study will determine the feasibility of a state interconnected health care network. If feasible, it will generate an implementation plan to link the EMR of patients through a Maine Health Information Network Technology (MHINT) System.

Support can be generated from the acquisition of sophisticated technology infrastructure needed to integrate current, emerging and future healthcare information to technology systems across the state and tie it to national infrastructure as it evolves. This year, the IOM, the National Committee of Vital and Health Statistics, and the President's Information Technology Advisory Committee have recommended the development of a National Health Information Infrastructure to improve safety, reduce costs and lift the quality of healthcare exponentially.

There needs to be consensus not only about getting connected as the goal, but also unified support for the financial model of the network for overall success. The Agency for Health Care Research and Quality (AHRQ) will have funding opportunities in 2005 for states to develop and implement connectivity. Having the feasibility study and implementation plan completed will position Maine to be a more viable applicant for these funds. All other possible sources of monies need to be leveraged for sustainability as well.

Hopefully, a virtual interconnected system of healthcare information will become a reality for you and me and our patients.

To learn more about this initiative or about technology in the medical office, come to the annual Maine Medical Association Meeting at the Colony Hotel in Kennebunkport from September 10-12. You can learn more about what technology can do for you and your patients. Contact me or the MMA for further information.

Any thoughts, comments or questions can be directed to me, Maroulla Gleaton, M.D., by calling 207-622-3185, faxing 207-622-5697, or emailing gleaton@adelphia.net.

Upcoming Specialty Society Meetings

SEPTEMBER 10 - 11, 2004 *The Colony - Kennebunkport, ME*
(Being held in conjunction with MMA's Annual Session)

Maine Psychiatric Association Meeting (September 11th)
MMA Contact: Warene Eldridge 207-622-7743 or weldridge@mainemed.com

Maine Society of Anesthesiologists Meeting (September 11th)
MMA Contact: Anna Bragdon 207-622-3374 or abragdon@mainemed.com

Maine Society of Orthopedic Surgeons Meeting (September 10th & 11th)
MMA Contact: Lauren Mier 207-622-3374 or lmier@mainemed.com

Maine Urological Association Meeting (September 11th)
MMA Contact: Ann Verrill 207-622-3374 or averrill@mainemed.com

OCTOBER 1, 2004 *Bar Harbor Regency - Bar Harbor, ME*
Maine Society of Eye Physicians and Surgeons Fall Business Meeting
(To be held in conjunction with the 3rd Annual Downeast Ophthalmology Symposium)
10:30am - 12:30pm
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

OCTOBER 1-3, 2004 *Bar Harbor Regency - Bar Harbor, ME*
3rd Annual Downeast Ophthalmology Symposium
(Presented by the Maine Society of Eye Physicians and Surgeons)
MMA Contact: Chandra Leister 207-622-3374 or cleister@mainemed.com

OCTOBER 1-3, 2004 *The Colony - Kennebunkport, ME*
District I ACOG Meeting
MMA Contacts: Chandra Leister or Ann Verrill 207-622-3374 or
cleister@mainemed.com or averrill@mainemed.com

OCTOBER 8-10, 2004 *Bar Harbor Regency - Bar Harbor, ME*
Maine Chapter of the American College of Physicians Annual Scientific Meeting
MMA Contact: Warene Eldridge 207-622-3374 or weldridge@mainemed.com

NOVEMBER 13, 2004 *Augusta Civic Center - Augusta, ME*
Maine Chapter, American Academy of Pediatrics Fall Conference
Contact: Alex Hildebrand 877-879-1509 or alexh@maine.rr.com

MMA Welcomes the Following New Members

JEAN S. BENSON, M.D., 78 Ridgewood, Bangor, ME 04401-1809. M.D. from University of Vermont College of Medicine, Burlington, VT. *Family Practice.*

TIMOTHY DEWITT CARNES, JR, M.D., 193 Main Street, Suite 1, Norway, ME 04268. M.D. from University of Rochester School of Medicine and Dentistry, Rochester, NY. *Internal Medicine.*

ROBERT CHAGRASULIS, M.D., 16 Starlight Drive, Bridgton, ME 04009. M.D. from University of South Alabama College of Medicine, Mobile, AL. *General Surgery.*

MARY ANNE CHASE, M.D., P.O. Box 114, Phippsburg, ME 04562. M.D. from Medical College of Pennsylvania, Philadelphia, PA. *Internal Medicine.*

DAVID G. FOLKS, M.D., 6 East Chestnut Street, Augusta, ME 04330. M.D. from University of Oklahoma College of Medicine, Oklahoma City, OK. *Addiction Medicine.*

JANET R. FOWLE, M.D., Miles Professional Bldg., 35 Miles Street, Damariscotta, ME 04543. M.D. from University of Minnesota Medical School, Minneapolis, MN. *Internal Medicine.*

MARK FULTON, M.D., 21 Buttonwood Lane, Portland, ME 04102. M.D. from University of Texas Medical School at Galveston, Galveston, TX. *Psychiatry.*

ALAN HARMATZ, M.D., 244 Western Avenue, South Portland, ME 04106. M.D. from New York Medical College, Valhalla, NY. *Surgery, Hand.*

KATHLEEN A. HERLIHY, M.D., 193 Main Street, Norway, ME 04268. M.D. from University of Vermont College of Medicine, Burlington, VT. *Pediatrics.*

LAURA L. JETT, M.D., 193 Main Street, Norway, ME 04268. M.D. from Ohio State University College of Medicine, Columbus, OH. *Family Practice.*

EDWARD KELMENSON, M.D., 28 Deer Hill Lane, Hampden, ME 04444. M.D. from University of Maryland School of Medicine, Baltimore, MD. *Anesthesiology.*

MAUREEN LUCAS, M.D., 5 Caldwell Road, Augusta, ME 04330. M.D. from Baylor College of Medicine, Houston, TX. *Obstetrics and Gynecology.*

LAURA POGEMILLER, M.D., 152 Dresden Avenue, Gardiner, ME 04345. M.D. from University of Minnesota Medical School, Minneapolis, MN. *Family Practice.*

CYNTHIA L. SAMMIS, M.D., 3 North Street, Machias, ME 04654. M.D. from State University of New York at Buffalo School of Medicine and Biomedical Science, Buffalo, NY. *Family Practice.*

LISA SPROAT, M.D., 45 Pearl Street, Bath, ME 04530. M.D. from University of Vermont College of Medicine, Burlington, VT. *Internal Medicine.*

JEFFREY R. STENZEL, M.D., P O Box 253, South Freeport, ME 04078. M.D. from Wright State University School of Medicine, Dayton, OH. *Psychiatry.*

NORMAN L. SYKES, M.D., 50 Union Street, Suite 2300, Ellsworth, ME 04605. M.D. from Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA. *Dermatology.*

DIRK B. VANDERSLOOT, M.D., 17 Masonic Street, Rockland, ME 04841. M.D. from University of California, Los Angeles, UCLA School of Medicine, Los Angeles, CA. *Family Practice.*

DANIEL WOOD, M.D., 1356 A Washington Street, Bath, ME 04530. M.D. from Columbia University College of Physicians & Surgeons, New York, NY. *Endocrinology.*

Important Anniversaries to be Celebrated September 18th

MMA, in conjunction with the Penobscot County Medical Society, will host an Anniversary Gala on Saturday evening, September 18th at the Maine Center for the Arts in Orono. The Penobscot County Medical Society was organized in 1854, being the first County Medical Society in Maine. The Gala will celebrate the Society's 150th Anniversary, as well as MMA's 151st Anniversary.

A commemorative video is being prepared for the event which will consist of a reception and dinner followed by the program. A silent auction will also be held. Invitations were sent in July to all MMA members in northern and eastern Maine.

Because of the unqualified success of MMA's Sesquicentennial Event last fall in Portland, a similar event in central/northern Maine was considered appropriate. There is a lot of history to be shared and celebrated with many memorable physicians and medical families, including the Prithams, the Shuberts, the Cutlers, the Woodcocks, and others. The historical presentation will feature developments in Penobscot County, but will include history in the adjacent counties including Piscataquis, Hancock, Washington, and Aroostook Counties.

An organizing Committee of Drs. George Wood, Thomas Palmer, Hadley Parrot, Warren Strout and George Bostwick are working with County Society President Richard Long, M.D. and MMA staff to put together the event. Any interested members or family of members are invited to participate by sharing stories and materials, and by joining us at the event. For more information contact Gordon Smith or Chandra Leister at MMA at 622-3374 or gsmith@mainemed.com or cleister@mainemed.com.

Needed

Physicians needed to serve on pre-litigation screening panels. A voluntary service on behalf of the profession. All specialties needed. Contact Gordon Smith, MMA Executive Vice President, at gsmith@mainemed.com or call 622-3374. Many thanks to those physicians who have already served, including the following recent panelists.

Kristin McDermott, DO
Razi Saydjari, MD
Neil Smith, MD
Robert Jones, MD
Marie Sharkey, MD
Mark Kowalski, MD
James Queenan, DO
James Dorsch, MD
Mike Mason, MD
Jacob Gerritsen, MD
Laurel Coleman, MD
William Strassberg, MD

MMA Welcomes Our Newest Corporate Affiliate:

Fleet National Bank/Bank of America

We appreciate their support!

Anthem to Offer Dirigo Product

At press time, it appeared that Anthem Blue Cross Blue Shield of Maine would offer and market the much discussed Dirigo Health product. While enrollment would begin by late Fall, the expected date of coverage is January 1, 2005.

Anthem was the only bidder in response to the Request for Proposals (RFP) issued by the Dirigo Board of Directors. The state hopes to enroll approximately 40,000 persons in the Plan during its first year.

Anthem is expected to pay providers based on the same fee schedule used in its other products.

UPCOMING AT MMA

AUGUST 19, 2004
5:30pm - 8:00pm
Membership and Member Benefits Committee

AUGUST 30, 2004
11:00am
1st Annual MMA Charitable Golf Tournament (at Augusta Country Club)

SEPTEMBER 1, 2004
4:00pm - 6:00pm
Public Health Committee

SEPTEMBER 6, 2004
Labor Day Holiday – Office Closed

SEPTEMBER 10-12, 2004
151st Annual Session,
Friday afternoon thru Sunday morning
The Colony Hotel – Kennebunkport

SEPTEMBER 13, 2004
5:30pm - 8:00pm
Committee on Physician Health

SEPTEMBER 15, 2004
10:30am - 4:00pm
Maine Governor's Council on Physical Fitness, Sports, Health & Wellness

SEPTEMBER 18, 2004
5:30pm - 9:30pm
Penobscot County Medical Society Anniversary Celebration, Maine Center for the Arts, Orono

SEPTEMBER 23, 2004
1:00pm - 5:00pm
Maine Health Access Foundation

SEPTEMBER 28, 2004
9:00am - 1:00pm
Maine Center for Public Health

OCTOBER 5, 2004
1:30pm - 3:00pm
"Stop Stroke"
6:00pm
Maine Chapter, American Academy of Pediatrics

OCTOBER 7, 2004
Noon - 4:00pm
Home Care Alliance

OCTOBER 20, 2004
2:00pm
Executive Committee (Tentative)

OCTOBER 21, 2004
9:30am - 4:30pm
Home Care Alliance
5:30pm
Maine Psychiatric Association, Executive Council

THE CODING CENTER

Jana Purrell, CPC

It's about time.....

We have all heard the phrase "Time is Money." Well, in this case it is true. When it comes to several areas of medical billing, the documentation of time can indeed make a difference in your reimbursement. You all know the rules regarding using time as the deciding factor when selecting the appropriate level of E/M service; greater than 50% of your time needs to be spent in counseling or coordination of care. And you are aware of the rules regarding the reporting of Critical Care services 99291 for the first 31-74 minutes, and 99292 for an additional 30 minutes. There is valuable information regarding the requirements for billing of Critical Care services in CPT.

But did you know that there are also other E/M codes which are based on time documentation?

Prolonged Services codes are divided into those with direct face-to-face contact with the patient (99354-99357) and those without (99358-99359). Let's talk about the face-to-face codes. (We will not discuss the non face-to-face codes here as they are not reimbursed by most payors currently). Codes 99354-99357 are used when the practitioner spends an extended amount of time face-to-face with a patient beyond the typical time associated with the E/M service; codes are further separated into inpatient and outpatient settings. These codes are "add-on" codes and should be reported in addition to the E/M service provided. Codes 99354 and 99356 report the first hour of prolonged service. Codes 99355 and 99357 report each additional 30 minutes. A few rules do apply however. You have to spend at least 30 additional minutes providing care to the patient in order to bill. It has to be face-to-face time and it does not need to be continuous.

Example: Patient is an established patient who comes into the office for treatment when she is having an acute asthma attack. Physician evaluates the patient and documents a level 3 service (99213). The physician then initiates treatment of her asthma with IV drugs and an inhaler. She is monitored by the office staff and the physician periodically checks her breath sounds to evaluate the effectiveness of the treatment. Once the acute attack has resolved, she is sent home. Total time, by the physician, spent face-to-face with the patient was 60 minutes.

Physician could bill 99213, 99354. He/she would not include the time when they were not present with the patient.

Hospital Discharge Services are also time dependent codes. Again, the total time spent performing the discharge service is included; it does not have to be continuous. The codes include final exam of the patient, discussion of hospital stay, instructions for continued care, preparation of discharge record including dictation time, prescriptions, and any form completion. Code 99238 reports discharge services for less than 30 minutes and CPT code 99239 for more than 30 minutes. If no time is documented, code 99238 must be billed. (Nursing Home Discharge codes 99315 and 99316 work the same way).

Preventive Medicine Counseling codes are based on time. These codes (99401-99412) are divided into individual and group counseling. These codes are used when the counseling takes place at a separate encounter (no other services on that day) and for a patient without a medical diagnosis for the counseling (counseling is provided for promoting health and wellness or preventing illness or injury). The documentation should include time spent in counseling for things such as risk factor reduction, diet and exercise, sexual practices, dental issues, substance abuse, or injury prevention. Counseling that is given to patients with symptoms or an established illness is reported with the appropriate E/M visit code (consult, office visit, hospital visit, etc.).

In all of these situations, the documentation of the time spent with the patient is required. There needs to be clear documentation of the amount of time spent, either by using start and stop times (1300 to 1430) or the actual documentation of time (60 minutes) to support use of the corresponding codes.

These are just a few of the more commonly used time-based codes from CPT. Additional codes that are time-based include: Care Plan Oversight, Case Management, Physical Medicine Codes, Medical Nutrition, along with some of the Psychotherapy codes. Review these codes regarding the time requirements when appropriate to your practice.

Reminder: Changes to ICD9 codes are effective October 1, 2004 and there will be no grace period for Medicare claims - this means that effective with date of service 10/1/04, providers must use the current diagnosis codes - you can find the updates at: http://www.cms.hhs.gov/medlearn/icd9code.asp

By Jana Purrell, CPC, Coding/Reimbursement Specialist
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Pathways to Excellence: Update

The Pathways to Excellence Steering Committee met in Augusta on July 15 and received updates from Cigna and Anthem on the provider rewards to be associated with provider participation. The Committee also reviewed preliminary response data from the Phase III Office System Survey, looked at HEDIS based process measures and discussed using practice generated data in future initiatives. Forty nine percent of primary care physicians participated in the Phase III Office System Survey, which was an improvement of approximately 10% from the previous year. Scores were generally higher than the previous year, with the participants being surveyed on criteria related to the use of technology and other factors.

Primary care physicians received a letter in late July from the project announcing the third of three components of the PTE-Primary Care Initiative. The Committee is asking for participation in reporting clinical outcomes on diabetic patients or pediatric admissions. Practices were asked to respond by September 1, 2004. Enclosed with the letter were specifications for a set of diabetes indicators for family practice and internal medicine practices (immunizations for pediatric practices) and a data collection tool which outlined how to calculate the metrics requested and the general targets for each indicator for 2004.

The diabetes benchmarks are based on a national effort called Bridges to Excellence. Further information on the benchmarks can be obtained from: http://www.ncqa.org/dprp/dprpfaq.htm#Diabetes%20Physician%Recognition%20Program%20Measures%20for%20Adult%20Patients

Data is requested for the last 12 months. Participants will receive a blinded report of all responses and a practice code to identify the practice. Participants will also receive a report which displays the format which will be used for public reporting on the project's website. For this first phase of outcomes reporting, practices will have the opportunity to decide NOT to have their actual results publicly reported. The outcomes measurement process is expected to be reported on at least an annual basis.

Since the results of the survey will be publicly reported and will influence provider compensation, a percentage of practices will have their work process and results verified by visits from independent nurse reviewers.

Results from the Office Systems Survey, Process Measures based on HEDIS, and Clinical Outcomes as reported to the Maine Health Management Coalition this year will form the basis of eligibility for a 2004 quality bonus from CIGNA. The bonus will be distributed by the MHMC in December, 2004 for Cigna Healthcare patients. Current plans are to base one-third of the reward amount based on performance results in each section (Office Systems results, Process measure results, Outcomes participation and results). Anthem Blue Cross and Blue Shield is also working with the Coalition and is likely to have a bonus compensation program in place soon, if only on an interim basis. Anthem had hoped to have a provider incentive program in Maine by July 1, 2004. Part of the reason for the delay involved developing an appropriate methodology for attributing patients to a physician and the necessity of Anthem of Maine working with colleagues in New Hampshire and Connecticut in order to have an Anthem East incentive program that is consistent among the three state Anthem Plans. The amounts of bonus payments by Anthem have not been established. CIGNA has put $400,000 into its bonus pool which will be distributed through existing PHO contracts.

Technical or procedural questions may be addressed to Ted Rooney, Project Leader at 729-4929 or trooney@mhmc.info or Jan Wnek, M.D., Clinical Advisory at janicewnek@mhmc.info.

While the Maine Medical Association neither endorses nor opposes the MHMC PTE program, we do believe it is important for members to know of the project and its implications.

Charging Interest/Late Fees for Unpaid Bills

Editors Note: *The issue of charging interest/late fees for overdue bills is something of interest to medical practices. Recently the Maine Dental Association asked for clarification from Will Lund, Director of the Consumer Credit Protection division and we are reprinting his response. While these recommendations reference dentists, the same rules apply to medical practices.*

Prompted by a recent call from a Maine Dental Association member, the MDA Central Office contacted the Maine Office of Consumer Credit Protection to determine the rules governing whether or not a dentist can charge a fee on unpaid bills. The following is a summary of recommendations from Will Lund, Director of the Consumer Credit Protection division.

1. If you are a true "creditor" (i.e., if you regularly extend (and encourage extension of) consumer credit as a part of your business), then you must make written disclosures of the amount financed, the finance charge and the APR (annual percentage rate), consistent with the rules of Truth-in-Lending.
2. However, according to Mr. Lund, most dentists are not true creditors. Rather, they are what he calls "involuntary creditors." In other words, the contract for services, and the signs on the wall, tell patients that payment is due at the time services are provided. However, because of the size of the bills and the financial circumstances of some patients, payment plans or installments are occasionally permitted as an accommodation to patients.
3. If a dentist decides that charges should be added, Mr. Lund recommends that those charges be termed "late fees" rather than "interest." Interest comes about as a result of a planned extension of credit, but that is not the case in most "involuntary credit" medical charges.
4. In order to successfully assess late fees on patients, a dentist relies on creation of a contract (i.e., "If I provide this service and if you don't pay, then you agree to pay me late fees"). To strengthen his or her argument that a contract was created, the dentist must make certain that such fees were disclosed to the patient prior to the delivery of services. Mr. Lund recommends that a contract or agreement for services be entered into between the dentist and the patient, in which it is made clear that treatment costs are due upon completion of services (or after insurance pays whatever it is going to), and that failure to pay such costs of treatment will result in a monthly late fee. Mr. Lund suggests that such fees not exceed 18% per year, or 1-1/2% per month, not because that limit is part of current law, but because most consumers think that limit is part of the law, and most consumers consider it reasonable.
5. In addition to being disclosed to the consumer prior to services rendered, the charges should also be listed at every other available opportunity; e.g., on brochures, on invoices, in any payment reminder letters, and on signs posted on the wall or on the countertop.
6. It is not legally sufficient to notify a patient that fees will be charged, if that notification comes only after the patient becomes delinquent in his or her payments.
7. Mr. Lund recommends that a paragraph similar to the following become part of the original agreement for services and all other communications: "Charges for services are due and payable when the services are provided. Invoices unpaid after X days will be subject to a late fee of 18% per year, or 1 - 1/2 percent per month, on the unpaid balance."

For more information, Mr. Lund recommends that dentists speak with their own legal counsel. With that attorney's help, he recommends that dentists draft and utilize paperwork and notices that will reduce or eliminate any "unfair surprise" complaints from patients that they didn't know bills were payable upon presentment, or that they didn't know that a late fee would be assessed if those prompt payment requirements were not met.

Thank you to the Maine Dental Association for permission to reprint this article from its newsletter.

QUALITY COUNTS! Report of Strategic Planning Session

Nearly forty individuals, including thirteen physicians, spent July 13th discussing the future of the "Quality Counts" initiative. This project, led initially by an Advisory Group put together by MaineHealth and Anthem, began in the fall of 2003 to communicate the business case for changing systems of healthcare and to expand on successful efforts to date to improve care across the state.

The strategic planning session, convened by Lisa LeTourneau, M.D., and facilitated by Jim Kupel and Amy Weinschenk of Crescendo Consulting Group, was designed to determine the future of the project and to seek agreement on its mission and function. The session objectives included:

- Agree upon the mission and function of Quality Counts in the future
- Suggest the organizational structure, capacity and financial model to fulfill the mission
- Identify existing organizations and individuals who could be approached in developing structure, capacity and finances
- Develop a short action plan to achieve the first few key objectives

As a result of the day's discussions, a favorable and productive outcome was realized and the Project is likely to continue under a new organizational structure.

The following mission for the Project was adapted from the second Quality Counts Conference Consensus Statement.

"Quality Counts" is committed to working together across organizations and across communities, to improve healthcare systems and outcomes with the people of Maine and with Dirigo Health to coordinate existing but disparate efforts across the state that support local, patient-centered, and coordinated systems of care AND the resources that support them in order to: Promote consistent delivery of high quality care, improve access to healthcare and strive to contain healthcare costs.

An organizational objective is comprehensive adoption and assessment of the Chronic Care Model across Maine.

Primary Organizational functions will include:

- Provide Leadership and Serve as a Change Agent
- Influence State Health Policy
- Advocate and Promote
- Coordination and Inventory of Existing Efforts
- Goal Setting and Prioritization
- Improve Communications Between and Among Health Care Resources
- Resource Identification and Gap Analysis
- Facilitate Technical Assistant, e.g. Training and Education

The group agreed that Quality Counts did not need to be a separate 501 (c) 3 organization to achieve its mission, but did agree it should mirror how several entities are shaped in Maine today. A broad group of corporators/partners would serve as founding members and a subset of this group would serve as an Executive Board. The project will need to be housed at an existing 501 (c) 3 organization and several potential "homes" were nominated at the strategic planning session. MMA's Maine Medical Education Trust is one possibility, although there are several other possibilities.

MMA will continue to inform members of the development of the "Quality Counts" Project through Maine Medicine and Maine Medicine Weekly Update.

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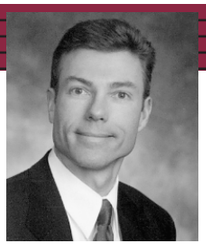
LEGISLATIVE UPDATE



Andrew MacLean, Esq.

MMA Publishes Comprehensive Summary of Health Care Legislation from the 121st Maine Legislature

The MMA's biennial summary of health care legislation passed by the current legislature is a valuable member benefit and a resource to ensure that your practice is in compliance with Maine law. Copies of the summary will be available at the MMA's Annual Session at The Colony in Kennebunkport in September, during MMA presentations at medical staff and specialty society meetings, and upon request from the MMA office. While legislators are campaigning in their districts and the State House is quiet, implementation of the Dirigo Health Plan keeps the MMA staff busy.

The 121st Maine Legislature has adjourned, but health care policy continues to develop in Augusta this summer as the five boards or commissions established in the Dirigo Health Plan legislation (P.L. 2003, Chapter 469) and numerous subcommittees continue their work to carry out Governor Baldacci's health care access, quality improvement, and cost containment initiatives. The Dirigo Health Board of Directors hopes to finalize its negotiations with Anthem Blue Cross Blue Shield of Maine by the end of July. The MMA and other observers await the release of a revised State Health Plan by the Governor's Office of Health Policy & Finance (GOHPF). Also, the GOHPF is finalizing a rule setting out a methodology for determining the Capital Investment Fund, the annual budget for the Certificate-of-Need (CON) program. The Maine Quality Forum Advisory Council has focused its work on technology and data issues. The Commission to Study Maine's Community Hospitals is framing the issues and seeking consensus on recommendations following a period of gathering data. The MMA staff has been involved in several meetings ranging from two hours to day-long each week as the development of the Dirigo Health Plan proceeds. You can track the implementation of the Dirigo Health Plan on the web at: http://www.maine.gov/governor/baldacci/healthpolicy/index.html.

The 2004 campaign season now is in full swing. You no doubt have seen candidates in 4th of July parades and municipal celebrations in your communities. The MMA and the MMA's political action committee, the *Maine Physicians Action Fund,* encourage you to introduce yourself to the candidates for the 122nd Maine Legislature and to offer yourself as a resource on health care issues. You can find candidate information on the 2004 elections at the Secretary of State's web site: http://www.maine.gov/sos/cec/elec/2004elec.htm.

The MMA Legislative Committee and staff are preparing for the 122nd Maine Legislature by meeting the candidates and developing a legislative agenda. If you have issues you would like the MMA to consider addressing through legislation, please let us know.

During the legislative session, the MMA publishes by e-mail, a weekly legislative update called "Political Pulse." To subscribe, go to www.mainemed.com and visit the Legislative and Regulatory Advocacy section of the site. You will find more information about the 121st Maine Legislature on the web at http://janus.state.me.us/legis. You can view the text of adopted legislation through the Public Law (P.L.) citation by going to "Constitution, Statutes & Laws" then "Session Laws of the State of Maine" and finally "Laws of Maine as Enacted by the 121st Legislature."

The MMA welcomes your participation in our legislative advocacy activities. For more information, contact Andrew MacLean, General Counsel & Director of Governmental Affairs at amaclean@mainemed.com.

American College of Surgeons Statement on the Physician Acting as an Expert Witness

The "Statement on the physician expert witness" was originally published in June 2000. This revised statement incorporates revisions recommended by the College's Patient Safety and Professional Liability Committee and was approved by the Board of Regents at its February 2004 meeting.

Physicians understand that they have an obligation to testify in court as expert witnesses on behalf of the plaintiff or defendant as appropriate. The physician who acts as an expert witness is one of the most important figures in malpractice litigation. In response to the need to define the recommended qualifications for the physician expert witness and the guidelines for his or her behavior, the Patient Safety and Professional Liability Committee of the American College of Surgeons has issued the following statement. The statement is an adaptation of guidelines developed by the Council of Medical Specialty Societies and several other medical groups.

Recommended qualifications for the physician who acts as an expert witness:

- The physician expert witness must have a current, valid, and unrestricted license to practice medicine in the state in which he or she practices.
- The physician expert witness should be a diplomate of or have status with a specialty board recognized by the American Board of Medical Specialties, as well as be qualified by experience or demonstrated competence in the subject of the case.
- The specialty of the physician expert witness should be appropriate to the subject matter in the case.
- The physician expert witness who provides testimony for a plaintiff or a defendant in a case involving a specific surgical procedure (or procedures) should hold current privileges to perform those same procedures in a hospital that is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA).
- The physician expert witness should be familiar with the standard of care provided at the time of the alleged occurrence and should be actively involved in the clinical practice of the specialty or the subject matter of the case during the time the testimony or opinion is provided.
- The physician expert witness should be able to demonstrate evidence of continuing medical education relevant to the specialty or the subject matter of the case.
- The physician expert witness should be prepared to document the percentage of time that is involved in serving as an expert witness. In addition, the physician expert witness should be willing to disclose the amount of fees or compensation obtained for such activities and the total number of times he or she has testified for the plaintiff or defendant.

Recommended guidelines for behavior of the physician acting as an expert witness:

- Physicians have an obligation to testify in court as expert witnesses when appropriate. Physician expert witnesses are expected to be impartial and should not adopt a position as an advocate or partisan in the legal proceedings.
- The physician expert witness should review all the relevant medical information in the case and testify to its content fairly, honestly, and in a balanced manner. In addition, the physician expert witness may be called upon to draw an inference or an opinion based on the facts of the case. In doing so, the physician expert witness should apply the same standards of fairness and honesty.
- The physician expert witness should be prepared to distinguish between actual negligence (substandard medical care that results in harm) and an unfortunate medical outcome (recognized complications occurring as a result of medical uncertainty).
- The physician expert witness should review the standards of practice prevailing at the time and under the circumstances of the alleged occurrence.
- The physician expert witness should be prepared to state the basis of his or her testimony or opinion and whether it is based on personal experience, specific clinical references, evidence-based guidelines, or a generally accepted opinion in the specialty. The physician expert witness should be prepared to discuss important alternate methods and views.
- Compensation of the physician expert witness should be reasonable and commensurate with the time and effort given to preparing for deposition and court appearance. It is unethical for a physician expert witness to link compensation to the outcome of a case.
- The physician expert witness is ethically and legally obligated to tell the truth. Transcripts of depositions and courtroom testimony are public records, and subject to independent peer reviews. Moreover, the physician expert witness should willingly provide transcripts and other documents pertaining to the expert testimony to independent peer review if requested by his or her professional organization. The physician expert witness should be aware that failure to provide truthful testimony exposes the physician expert witness to criminal prosecution for perjury, civil suits for negligence, and revocation or suspension of his or her professional license.

Ethics Note: Disruptive Behavior

All medical staff bylaws have provisions for addressing "disruptive behavior" by physicians. The challenge in drafting such bylaw terms is to provide for intervention when such behavior may affect patient care, but to avoid "gag orders." Physicians should be allowed to provide criticism designed to improve patient care. The California Medical Association Model Medical Staff Bylaws [section 2.2-1(b)(2)] suggests that physicians must "be able to work cooperatively with others so as not to adversely affect patient care." In Opinion 9.045, *Physicians with Disruptive Behavior*, the AMA Code of Medical Ethics defines "disruptive behavior," states that each medical staff must have policies to address disruptive behavior, and provides a checklist of elements to be considered in developing such policies. You can view the ethics opinions on the AMA web site at http://www.ama-assn.org/apps/pf_online/pf_online. Go to "Ethical Opinions" and then "E-9.00, Opinions on Professional Rights and Responsibilities."

Maine medicine

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