MMA to Hold 155th Annual Session at the Samoset Resort

On July 9, the United States Senate passed H.R. 6531, the Medicare Improvements for Patients and Providers Act of 2008, by a veto-proof majority of 60-30. Eighteen Republican Senators, including Maine Senators Susan Collins and Olympia Snowe joined all the Senate Democrats to make the veto a bipartisan success. A previous vote had failed to achieve cloture by one vote ten days earlier. Although President Bush ultimately vetoed the bill, the veto was over-riden on July 15th in both the House and Senate.

The legislation replaces the 10.6% payment cut (more in Maine) that went into effect on July 1 with a 0.5% update extension through December 31, 2008. For calendar year 2009, the update will be 1.1%. Other important provisions such as extending the GPCI floor on physician work values were also included.

Senate Passes Medicare Fix for Physician Payments

While part of the funding for the fix comes from deep cuts to the Medicare program, the legislation is a tribute to the work of the medical community in this country led by the MMA, national medical specialty societies and state medical societies which launched a strong grassroots effort to halt the payment cut, on behalf of physicians and the Medicare patients they serve.

MMA acknowledges the work of all four members of Maine’s congressional delegation in helping to pass the legislation. Senators Olympia Snowe, who co-sponsored the Senate version of H.R. 6531 with Democratic Senator Max Baucus, Susan Collins and House members Tom Allen and Mike Michaud all aggressively assisted. Given that Maine has the oldest population in the country, and as a consequence a significantly higher than average Medicare population, the legislation which brings over $50 million to Maine physicians over the next 18-months was absolutely essential.

On Saturday morning, Sept. 6, the annual “town meeting” style annual meeting of the MMA membership will handle resolutions, amendments to the Constitution and Bylaws and the report of the nominations committee.

Other significant presentations during the Friday and Saturday sessions include a keynote presentation on Friday noon entitled, “Communicating to Improve Performance” by Greg Carroll, PhD from the Institute for Health Care Communications in Connecticut, and a keynote presentation on Saturday at noon by Rev. Kate Braestrup of the Maine Warden Service. Rev. Braestrup is author of the best selling book titled, Here If You Need Me. On Sunday morning, the meeting concludes with a complementary brunch and Public Health Leadership Forum on Childhood Obesity. The Forum has been organized by the Association’s Public Health Committee.

Recreational activities during the meeting include the 26th Annual Edmund Hardy Road Race (5K) at 7:00am on Saturday morning and a 9-hole golf scramble on Saturday afternoon at 2:00pm. Ample tennis courts are also available. Room reservations are available by calling the Samoset at 1-800-341-1650. You may register by MMA by completing the registration form in the brochure enclosed or by registering online at www.mainedmed.com.
It is so easy to get caught up in the three-ring circus of the meetings and diverted by the campaigns for representation and participation. As many of you know, I am particularly interested in issues of professionalism and ethics. Several years ago, despite my concerns, our AMA adopted a resolution calling for pilot programs to study the efficacy of financial incentives to increase the availability of cadaveric organs for transplantation. This year the House of Delegates went further in asking for a change in the legislation that governs organ transplantation to allow significant financial incentives to be federal laws that govern organ transplantation to allow significant financial incentives to be.

I attended the American Medical Association in Chicago during the second week of June. This was my first direct experience with the AMA and I saw it with fresh eyes, wide open. I was in general, highly impressed by the dedication of the delegates in attendance and the topical discussions. In terms of disclosure, it should be noted that I am currently not a member of the AMA. I let my membership lapse after the Sunbeamiasco a decade or more ago, and I have not been sure about its place in my vision of medicine since that time. At the meeting, I was struck by the intensity of discussions, their vibrancy, and by the focused participation of those in attendance. Discussions included items around our practice of medicine, preservation of autonomy, legislative issues and health care reform, public health, science and new technologies, and medical education. A very controversial issue included discussion and review of physician relationships with industry. Your delegates, Drs. Evans and Simmons, and alternate delegates Gruton and Malin plowed through the experience with your truly in tow.

I was reminded of this meeting recently when the Medicare payment fix was held up in Congress through the 4th of July recess. It was the AMA that was quoted and accepted as the voice of physicians nationally, and the AMA that helped leverage additional senate votes. An interesting juxtaposition was the contrast between a vision of the AMA as a quarrelsome and frothy organization that pulled in too many directions with the focused and clear message it delivered when we needed it. It is true that the AMA must represent the interests of all physicians, and as such, positions reflect the disparate views and opinions of strong willed, difficult to herd. It is really quite a task when you think about it.

I do not appreciate the fact that the AMA remains such an internally political organization, and too often the public sees it as a self interest organization. But the AMA continues to position itself as The physician organization dedicated to promoting the health and health care of Americans. I now look much more favorably upon it, and it is time to return.

As this is my last President’s Corner, I want to extend to each and every member and reader my appreciation for this opportunity to serve the Association of Maine Physicians. It has been a distinct honor and privilege.

As always, I am available at baybones@midcoast.com.

Delegates of Maine Doctors 2008

By David J. Simmons, M.D.

As always, I am available at baybones@midcoast.com.
As physicians treating the people of Maine, we spend the bulk of our work time dealing with the “micro level” problems – one patient, one or a few symptoms, ordering one, or at most several tests, and generally only prescribing one new treatment at a time. We do this over and over in a typical day. And it is not often that we have the opportunity to step back and think actively about the “macro” issues surrounding health care. I am grateful to the Maine Medical Association for giving me the opportunity to do just this. During my tenure as a member of the Executive Committee, I have had the time to sit and work with other physicians from around the state to better understand the larger patterns of the problems we face as physicians. On a daily basis, we face a multitude of challenges on many levels; from our own personal “micro” issues at the patient level to the macro issues of poverty, cultural barriers, lack of education and domestic abuse, to tort reform, third party payer pressures, and lack of cohesion within our profession. Creating solutions to any of these problems will work toward improving the health of Maine people. My choice over the next year, as president of the Maine Medical Association, is to focus extra attention on a national public health issue that is particularly prevalent here in Maine. That is the problem of obesity. Like tobacco and alcoholism, the health impact of obesity is hard to overstate. As a neurologist, obesity produces hypertension and diabetes, two of the most significant causes of stroke. And it diminishes the function of all of my neurolologically-impaired patients whether they have stroke, PTSD, epilepsy, multiple sclerosis, or ocular disorders, just to name a few. It is of no little concern to me as many patients have diabetes, with associated complications, or are on multiple medications for blood pressure control. And it is of concern to me as obesity is a disease of the wonderful plenty we have created for ourselves. Like tobacco and alcoholism, treating it will prove very difficult, for it requires behavioral changes that are not easy to make. Some will fail, and will fall into a cycle of self-doubt and despair. But there is an important message here. The problem of obesity, like tobacco and alcoholism, is that it is entirely a disease of the wonderful plenty we have created for ourselves. Like tobacco and alcoholism, treating it will prove very difficult. But it also demonstrates the power of our professions to improve the health of the people of Maine. I can most easily be reached either on my cell phone or in my office. I highly value your thoughts with me, both on this issue and any others that are important to you, so that we as physicians, and the Maine Medical Association can do more to improve the health of the people of Maine. I can most easily be reached either at work, (207) 947-9558, or through my e-mail, stephanie.lash@mainemed.com. Lastly, I want to specifically thank Gordon Smith for his ongoing passion and marvelous stewardship of the Maine Medical Association. And I also want to thank the present MMA president, Dr. Bill Stansberg, and the preceding president, Dr. Kevin Flanigan for their incredible energy and drive in leading the Maine Medical Association.
The Joint Commission’s sentinel event database has received 4,977 reports of sentinel events. A total of 5,105 patients were affected by these events, with 3,574, or 70 percent, resulting in patient death.

The 10 most frequently reported sentinel events are:
- Wrong site surgery 651
- Suicide 613
- Operative/post-operative complication 581
- Medication error 458
- Delay in Treatment 371
- Patient fall 291
- Assault, rape or homicide 186
- Patient death or injury in restraints 178
- Unintended retention of foreign body 158
- Perinatal death or loss of function 147

In addition to the areas listed above, we are seeing an increasing number of reports from payers. Certified coders can assist in addressing, responding to, and communicating to outside audit requests from Medicare—Benefit Integrity, Office of Inspector General, Comprehensive Error Rate Testing (CERT) and Recovery Audit Contractor (RAC) audits; third-party payers, and legal entities.

The Centers for Medicare and Medicaid Services (CMS) is requiring RACs to employ certified professionals. If you are not using certified coders, you may want to consider hiring some, or certifying those who have. Certified coders can talk peer-to-peer, and you want to use every advantage you can during an audit. This also supports a “good faith” effort to ensure you are coding and billing appropriately.

While it is not a requirement to have a certified coder on staff, it is important to have qualified, trained staff doing your billing and coding. In today’s insurance environment, it has become increasingly important for the physician practice to be educated in billing and documentation requirements and to ensure that billed services are medically necessary, documented appropriately, and billed accurately—particularly for compliance reasons.

It is in your best interest to provide the necessary education (initial and ongoing), resources (books, computer software programs, consultants), and support (time off and cost of workshops and training) to your billing staff. There are many options to provide this training—an on-line, self-study, preparation courses, and audioconferences. Investing now in the ongoing education of your billing staff, including supporting coding certifications can provide long-term benefits.

Additional articles: Value of a Coding Education

http://www.azap.org/gnr/200610/025ths.html

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Certified Coding Specialist

http://www.ahima.org/certification/ccs.aspx

Golding Salary Survey 2007


Please Contact The Coding Center at www.thecodingcenter.org or call 1-888-889-6597 if you would like additional information regarding the professional certification or educational opportunities.

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

Medical Coding Certification

Recently I have received several calls from physicians, asking me several questions related to certified coders. The questions include: how do we go about finding a certified coder, what is the benefit of hiring a certified coder, what should a certified coder be able to do, and what salary should we expect to pay a certified coder? I thought it might be helpful to give a brief overview of the profession to help assist you and your practices in deciding if having a certified coder on staff is right for you. There are currently two national organizations that offer a recognized coding certification for the professional coder (one which specializes in coding in physician-based settings such as physician offices, group practices, multi-specialty clinics, or specialty centers). The American Academy of Professional Coders (AAPC) offers the Certified Professional Coder (CPC) certification and the American Health Information Management Association (AHIMA) offers the Certified Coding Specialist—Physician-based (CCS-P).

A certified professional coder is an individual who has passed a coding certification examination which consists of questions regarding the correct application of CPT®, HCPCS procedure and supply codes and ICD-9-CM diagnosis codes used for billing professional medical services to insurance companies. In general, the person who has attained certification has at least two years coding experience and must maintain yearly renewal and CPE requirements to retain their certification.

The role of the certified coder varies depending on the practice and the setting. Among other things, the certified coder’s job can include:

- Determining accurate codes for diagnoses, procedures and services performed by physicians and non-physician providers in physician-based settings (these services may include evaluation and management services as well as revenue cycle services)
- Keeping current with medical compliance and reimbursement policies, such as medical necessity issues and correct coding issues
- Performing various auditing duties
- Monitoring progress resulting from periodic internal audits
- Providing training in coding and compliance issues to physicians, non-physician providers and staff
- Providing physicians and staff with up-to-date coding information from reliable, accurate sources
- Providing orientation training to include medical practice guidelines for new physicians and non-providers to the practice
- Updating encounter forms/superebills on an annual basis with respect to diagnostic, procedural and supply code changes
- Preparing and/or submitting completed CMS 1500 forms for services and procedures performed by the practice’s physicians and non-physician providers
- Reviewing explanations of benefits from payers, evaluating denied claims and filing appeals for denied claims

Drug Diversion and the Drug-Seeking Patient: Part II

In the Hospital Emergency Department (ED), the following is suggested when addressing a patient who is exhibiting drug seeking behavior:

1. Be assured that this is a drug seeking patient, e.g., a patient who manifested a fraudulent presentation of disease to multiple physicians in an attempt to obtain prescription drugs for resale or non-medical use. In Maine, use of the Prescription Drug Monitoring Program is helpful in identifying this type of patient.

2. It is important to differentiate the true “drug seeker” from the patient with chronic or recurring pain who has unmet healthcare needs and poorly controlled pain management. This patient may need a pain management plan developed by the primary care physician, ED provider and the patient. Education about pain management and adjunct therapy should be a part of the treatment plan. For this patient, the prescribing of narcotics may be appropriate.

3. When a patient presents to the ED with a complaint of pain, an assessment of the patient must occur and a treatment plan developed commensurate with the assessment which may be a non-narcotic prescription. It is important to document the thorough exam and the physician’s conclusion.

4. When a patient requests narcotics and the ED physician does not feel it is appropriate based on the assessment, the physician needs to explain to the patient that narcotics will not be prescribed. If the physician has information regarding multiple prescriptions obtained (in Maine, the Prescription Drug Monitoring Program), the physician may confront the patient with this.

5. The physician must be firm with his/her decision. Consistency in not prescribing the narcotics is the key to discouraging the patient from using the ED as a way to obtain drugs for non-medical or illegal use. However, the ED physician is obligated to assess the patient each time he presents in order to determine if the pain is legitimate.

6. There are several potential ramifications associated with noting “drug seeking behavior” in the medical record. These are a defamation claim, a patient claim of interference with insurance coverage, the possibility of a malpractice and the accusation of “labeling” the patient. Medical Mutual generally discourages documenting “drug seeking behavior” unless the provider’s rationale is clearly reflected. Documentation should relate to the patient’s presenting complaint of pain, the request for a specific narcotic, statements that the patient has presented to other hospitals with the same complaint, refusal by the primary care physician to refill narcotic prescription for these pain complaints, etc.

Questions frequently arise regarding what constitutes a reportable act and when law enforcement should be notified about a patient’s possible illegal activity. Information gained as part of the physician/patient relationship, including disclosure of possible criminal acts, remains confidential. However, a patient who attempts to use a physician or healthcare practitioner to obtain controlled substances, or who perpetrate illegal acts, such as illegal acquisition of drugs or substances, should be reported to the Drug Enforcement Agency (DEA) or local law enforcement agency. If this patient is insured by the Medicaid program, a report on the matter should be provided to Medicaid Surveillance.

If more questions arise regarding the appropriateness of reporting a patient’s illegal behavior, an attorney or the Maine Medical Association should be contacted.

Resources for management of pain can be found on the home page of the Maine Medical Association web site at www.mainemed.com, under “Resources for Management of Pain.”

Medical Mutual’s “Practice Tips” are offered as reference information only and are not intended to establish practice standards or serve as legal advice. MMIC recommends you obtain a legal opinion from a qualified attorney for any specific application to your practice.

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- Unintended retention of foreign body 158
- Perinatal death or loss of function 147

If added to renewable events in June 2005, data represents events reviewed since that time.

Questions regarding this information should be directed to Anita Guarnieri at aguarnieri@jointcommission.org.
Public Health Spotlight

 Acting Surgeon General, Rear Admiral Steven K. Galson, MD, MPH: Hosts Roundtable Discussion on Childhood Obesity

MMC’s Frost Street Portland office, home of the Kids Go-to and Countdown, served as the location for the Acting Surgeon General, Rear Admiral Steven K. Galson, MD, MPH to host a roundtable discussion with public health/health care/educational/early childhood leaders in Portland to focus on stemming the tide of the rise of childhood obesity in the nation as part of his nationwide tour promoting the DBHS Childhood Overweight and Obesity Prevention Initiative.

This initiative “targets prevention of overweight and obesity, and the promotion of healthy lifestyles, for young people. Dr. Galson declared.

The “Healthy Youth for a Healthy Future” initiative focuses on recognizing and showcasing communities throughout the nation that are addressing childhood overweight and obesity prevention by helping kids stay active, encouraging healthy eating habits, and promoting healthy choices.”

Dr. Galson appreciated the 2 hour opportunity in Maine to meet with key community stakeholders to discuss childhood obesity prevention and learn about existing prevention programs. He was able to meet and discuss the “Let’s Go” initiative in the Portland area with Dr. Victoria Rogers and also with MMA member, Jonathan Faushburg, MD, currently serving as the President of the Maine Chapter of the American Academy of Pediatrics. Dr. Faushburg noted that physicians are willing to jump on board and are searching for practical tools to assist them in their practices.

The Surgeon General stated, “There evidently is tension between academic performance vs physical activity time allowance in the schools. There is no reason to separate the two – who are less stressed are more focused and their academic performance increases.”

The MMA Public Health Committee is answering that call to ensure that our member physicians have access to the necessary clinical tools for their patients. Fall 2008 marks the date for the newly developed public health web page (www.mainemed.com) to be unveiled to provide that needed one-stop search for the most up to date tools to deal with childhood obesity in the clinical setting. For more information, contact Kellie Miller, Director of Public Health Policy at kmiller@mainemed.com or 622-5374, ext. 229.

Public Health Policy, MMA

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ARE YOU PRACTICING SAFE PRESCRIBING?

By Rx Security

According to the National Institute of Drug Abuse, an estimated 9 million people over the age of 12 used prescription drugs for non-medical reasons in a single year.

With prescription drug abuse on the rise in America, is your medical facility doing everything it can to practice safe prescribing? Take the following self-test to see how well your medical practice is doing in the war against prescription drug abuse.

Safe Prescribing Evaluation

Do your facility use personalized, counterfeit resistant, copy-proof prescription pads?

Do you use counterfeit-resistant prescription paper when printing prescriptions on your office printer?

Is the prescription pad inventory stored in a locked cabinet with limited access?

In the examination room, are prescription pads kept in a locked drawer, out of sight and easy patient access?

Have you evaluated your practice’s risk of internal fraud and implemented steps to minimize it?

When pads are stolen or misplaced do you contact your local pharmacies with the unique pad identifier number?

Do you have good communication with your local pharmacies to be able to discuss any suspicious prescription form or behavior?

Is your practice registered to accept patient data in the prescription monitoring program (pmp)?

Prescription drug abuse often begins, with a forged, stolen, altered or copied prescription form. 20 years ago, before the introduction of secure prescription pads, physicians happily used white pads. Since then, prescription pads evolved from using colour paper to using counterfeit-resistant paper with multiple security features. Tens of thousands of American physicians have been diligently using secure prescription pads, for drugs that are not covered by the triplicate and duplicate programs.

With the introduction of electronic medical records (EMR), it is important that physicians don’t take a step backward in the evolution of prescription forms by going back to white paper. Counterfeit resistant prescription forms, to be used hand in hand with your software, are readily available for standard office printers.

Using secure prescription forms is only one part of the equation to resolving prescription drug abuse. It is, however, a very easy and inexpensive safe prescribing step for all medical professionals to take.

Rx Security, an MMA Corporate Affiliate and a leading supplier of counterfeit-resistant prescription forms, first introduced this technology in 1989.

Today, tens of thousands of physicians use their product as a weapon in the fight against prescription drug abuse. Rx Security hears firsthand stories of prescription drug abuse regularly, from physicians across the United States. They may be reached through their website www.rxsecurity.com.

The MMA would like to thank the following companies for exhibiting at the May 28th Physician Education Practice Seminar:

Broun & Meyers, Inc.
CAINSAN
HRH Northern New Hampshire
Maine Bureau of Insurance
Medical Mutual Insurance Company of Maine
Mid Maine Communications
Northeast Healthcare Quality Foundation
Office Max
Physician Billings and Consulting, LLC
Voluntary Practice Assessment Initiative

Maine Medicine page 5
Stead, Jr., MD (1908-2005). He received corpsmen in the early 1960s to help run the general public. The Downeast Association of Physician Assistants was incorporated on April 1, 1977, as a nonprofit organization and was comprised of the physician assistants employed within the State of Maine. Its primary objective is to enhance quality medical care to the people of Maine through a process of continuing medical education to the membership, other health care workers, and the general public. As a constituent organization of the American Academy of Physician Assistants, DEAPA meets all provisions of the AAPA's bylaws and guidelines. DEAPA's Transition...
Notes from the E VP

I appreciate the opportunity to communicate in this second E VP column. I hope you are all experiencing a summer and further hope that you will consider attending all or a portion of the Association’s Annual Meeting bring held this year at the Samoset Resort in Rockport from Sept. 4-7, 2008. Details are included in the brochure which is enclosed with this issue of Maine Medicine.

By the time you read this, the dust will hopefully have settled on a temporary fix to the Medicare physician payment problem which resulted in a reduction in fees on July 1 of 10.6% but only 11% in Maine and other rural states. As I write this article, Congress is returning to Washington from the Fourth of July recess and is expected to fix the problem and apply the fix retroactively to claims for services rendered to Medicare patients on or after July 1. It will be a serious blow to Medicare, Medicare recipients and Medicare providers if the cut is not restored. The reduction represents over $55 million in Maine alone. It certainly is frustrating to see policy hamstrung by partisanship, both within Washington and Augusta. Little wonder that people are cynical and that the popularity of Congress falls below that of the President in recent national polling. On a more positive note, the Association is experiencing a good year so far with membership up and revenues as expected and even exceeded in some areas. Expenses are on track, although it is constantly a challenge to offer a type of services members have come to expect from MMA and yet live by projections of anticipated revenue. We have to do our best. I think for a small, independent medical society, we offer a surprisingly diverse group of products and services, including the Physician Health Program, the Coding Center, the Voluntary Practice Assessment Initiative, CME programs, the Physicians Guide to Maine Law, the legal hotline and other offerings. These are all in addition to the advocacy we do everyday at the state house and in the regulatory agencies. We are pleased to have our new “Senior Section” operating so that even our retired members have more meaningful relationships with MMA. One thing we haven’t done very well is to listen to what you, the members, want and need. While our 28 Executive Committee members do what they can to bring back your thoughts from their regions, medicine and practice is changing so fast that we may not be keeping up. In order to be better listeners, we are preparing a survey to be sent to a scientifically selected random group of members. We will be asking about 25 to 25 questions that will focus on your needs and MMA’s effectiveness in meeting them. If you are one of the members selected to participate, we hope you will do so. The survey will be sent out both electronically and on paper, and you will have multiple opportunities to complete it in a way that is most convenient for you. The survey will also ask four questions relating to the pharmaceutical industry. These questions will be approved in advance by MMA. The survey is being paid for through an unrestricted grant from the Pharmaceutical Research and Manufacturers Association.

We appreciate your membership and I hope you will not hesitate to give me a call (222-3373 ext. 212) or drop me an e-mail at gsmith@mainemed.com, if you or anyone else at MMA may ever be of assistance.

MMA Participants in HealthInfoNet Stakeholder Process

The HealthInfoNet Stakeholder Process, being conducted as the result of a Resolve enacted by the Legislature in the past legislative session, continued this past week with a June 24th meeting at the Dirigo Health Agency in Augusta.

After welcoming participants, which included MMA EVP Gordon Smith, Esq. co-convenors Josh Cutler, M.D. and Dev Culver went through a number of house-keeping and scheduling matters. After considering the minutes of the May 30 meeting, the results of a June 20 conference call regarding valuation and return on investment models was presented.

Next on the agenda was a presentation on approaches in other states made by co-convenors Josh Cutler, M.D. and Dev Culver went through a number of housekeeping and scheduling matters. After considering the minutes of the May 30 meeting, the results of a June 20 conference call regarding valuation and return on investment models was presented.

The primary purpose of the Stakeholder Group is to help identify potential revenue sources to support the on-going HealthInfoNet project. Based upon discussion thus far, and considering what other states have done, potential sources include one or more of the following:

- State general fund appropriation
- Revenue Bonds, issued by the state
- Assessment on health insurance premiums
- Tax on providers (MMA would vigorously oppose this option)
- User fees

The HIIN Board is currently working to develop a sustainable business model, but some amount of public financing is likely to be required.

Currently the HealthInfoNet project is preparing its demonstration project involving several of the larger health systems in the state. To date, the project has received substantial funding from the Maine Health Access Foundation, the Maine Quality Forum and the Maine CED. Several hospital systems have also generously contributed. The state has also provided some general fund appropriations.

Based upon the Legislative Resolve, the stakeholder process must include at least the following:

1. Identification of broad-based, stable, ongoing revenue sources;
2. Development of a technology investment account to help ensure the establishment of the HIIN and provide financial assistance in the future to health care providers with limited resources with the costs of electronic medical records and e-prescribing;
3. Estimating return on investment from shared electronic clinical information;
4. Establishing eligibility criteria for funding assistance.
5. Developing a methodology for measuring the quality and cost impact of HIIN and shared electronic clinical information.

Medicare Revises Advance Beneficiary Notice (ABN) Form

The Advance Beneficiary Notice (ABN) is a notice given to Medicare beneficiaries indicating that Medicare is unlikely to provide coverage for a specific service or procedure. By completing the ABN, the physician and other providers inform the patient that the patient may bear financial responsibility for the service. The patient then is able to consider options and make an informed decision.

CMS released its revised ABN in March 2008. All providers (including independent laboratories), physicians, practitioners, and suppliers may use this revised ABN for all situations where Medicare payment is expected to be denied. CMS will allow a 6-month transition period from the date of implementation for use of the revised form and instructions. All providers and suppliers must begin using the revised ABN (CMS-1500) no later than September 1, 2008.

Some Key Features Of The New ABN Are That It:

- Has a new official title, the “Advance Beneficiary Notice of Noncoverage (ABN),” in order to more clearly convey the purpose of the notice;
- Replaces both the existing ABN-G and ABN-L;
- May also be used for voluntary notifications, in place of the Notice of Exclusion from Medicare Benefits (NEMB);
- Has a mandatory field for cost estimates of the items/services at issue; and
- Includes a new beneficiary option, under which an individual may choose to receive an item/service, and pay for it out of-pocket, rather than have a claim submitted to Medicare.

Instructions for using the new ABN as well as English and Spanish versions of the notice may be downloaded from the CMS website by going to http://www.cms.hhs.gov/BRN02_ABNG_ABNL.asp. Physicians also have an option of downloading a form that can be customized if they choose to include the ABN into other business practices. As in previous ABNs, physicians must indicate why they believe Medicare may not pay for the service along with an estimated cost of the service. Acceptable reasons include:

- Medicare does not pay for post tests for your condition.
- Medicare does not pay for these tests as often as this (denied as too frequent).
- Medicare does not pay for experimental or research use tests.

If a service or procedure is not a covered benefit, it is not necessary to complete an ABN. However, notifying a patient that the service is not a Medicare benefit and that the patient bears financial responsibility for the service no doubt decreases misunderstandings with patients.
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