JULY/AUGUST 2008

Maine medicine

IN THIS ISSUE

MMA to Hold 155th Annual Session at the Samoset Resort

MMA will conduct its 155th Annual Session Sept 4-7, 2008 at the Samoset Resort in Rockport. With a theme of, "Taking the Initiative: Steps Toward Quality and Collaboration," the session offers several hours of educational programming for which educational credits have been applied. On Thursday, Sept. 4, the program begins with a Symposium on Quality Improvement presented jointly by the Maine Hospital Association and MMA. Keynoting the session will be Elliott Fisher, M.D., MPH, Director for Health Policy Research, Dartmouth Medical School. Using data from the Dartmouth Atlas of Health Care, a compendium of national and regional information on the performance of the U.S health care system, Dr. Fisher will examine the often-held assumption that more care is better, and that more resources are needed to improve our healthcare system. The full agenda for the Thursday Symposium, as well as registration materials for the Thursday-Sunday sessions, is in the brochure inserted with this issue of *Maine Medicine*.

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. The meeting this year will also feature an open microphone session which will invite any member to present comments or concerns. The Saturday night annual banquet will feature the presentation of 50-year pins and recognition awards, as well as the transition of leadership from President William Strassberg, M.D. to President-elect Stephanie Lash, M.D. Dr. Lash practices neurology in Bangor.

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 28th 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 with MMA by completing the registration form in the brochure enclosed or by registering on-line at www.mainemed.com.

Senate Passes Medicare Fix for Physician Payments

On July 9, the United States Senate passed H.R. 6331, the "Medicare Improvements for Patients and Providers Act of 2008," by a veto-proof majority of 69-30. Eighteen Republican Senators, including Maine Senators Susan Collins and Olympia Snowe joined all the Senate Democrats to make the vote 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.

While part of the funding for the fix comes from deep cuts beginning in 2010, it is expected that a new Congress, supported by a new President will finally change the flawed Sustainable Growth Rate formula which has led to the draconian cuts.

Passage of the legislation is a tribute to the work of the medical community in this country led by the AMA, 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. 6331 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. And a special thank you as well to every MMA member who took the time in the past few months to communicate with the delegation.

110 Golfers Tee Off in Annual MMA Tournament

Dry weather and an immaculate golf course (Augusta Country Club) awaited the 110 golfers who participated in the 5th Annual MMA Benefit Golf Tournament on June 23rd. The field was the largest of any of the previous tournaments. Thanks to all who played and to the hole sponsors and many corporate affiliates who donated articles to the raffle. Net proceeds benefit the Medical Professionals Health Program.

Congratulations to the following winners, and pencil in June 22, 2009 for next year's tournament, again at the Augusta Country Club.

First Place Low Gross (59)
Premier Marketing: Mike Whitman, Chuck Calligan, David Hastings, Dale Prescott

First Place Low Net (55.2)
Tom Drottar, Dan McCormack, Phil Saraceno, Eric Jermyn

Longest Drive: Men: Mark Luthe
Women: Nancy Makin

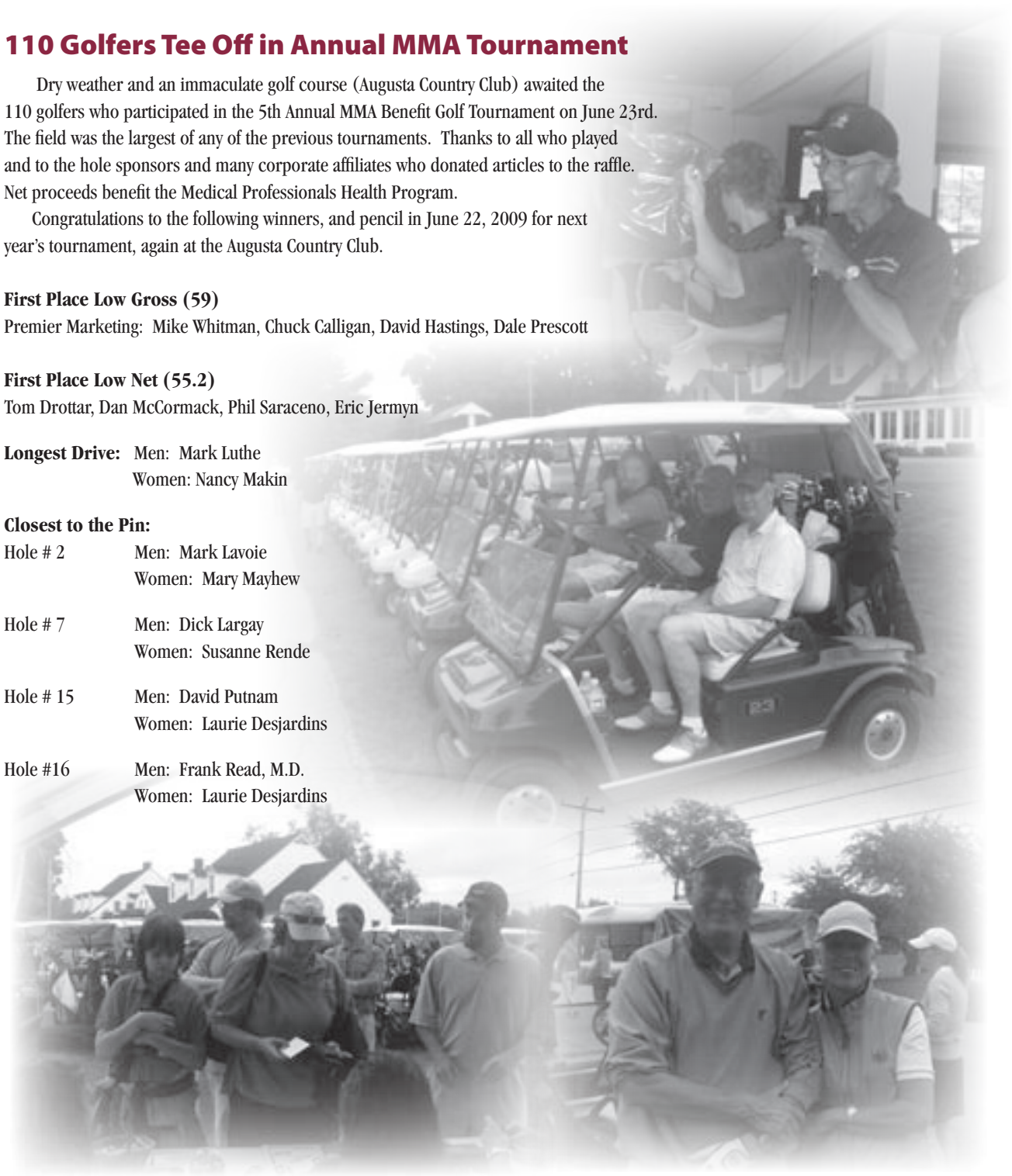
Closest to the Pin:

Hole # 2 — Men: Mark Lavoie; Women: Mary Mayhew

Hole # 7 — Men: Dick Largay; Women: Susanne Rende

Hole # 15 — Men: David Putnam; Women: Laurie Desjardins

Hole #16 — Men: Frank Read, M.D.; Women: Laurie Desjardins



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MMA Welcomes Our Newest Corporate Affiliates:

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We appreciate their support!

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William Strassberg, M.D., President, MMA

President's Corner

I attended the Annual Meeting of 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 Sunbeam fiasco a decade or more ago, and I have not been sure about it's 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 Gleaton and Makin plowed through the experience with yours 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 contrasts 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 cats 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, warts and all. It is time to rejoin.

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 and the physicians of Maine. It has been a distinct honor and privilege.

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

Alternate Delegate John Makin, M.D. and EVP Gordon Smith

Delegate's Report Annual Meeting of AMA House of Delegates 2008

By David J. Simmons, M.D.

Delegate Richard Evans, M.D. and wife Bonnie

From left, Ann Simmons, M.D., Delegate David Simmons, M.D. and Alternate Delegate Maroulla Gleaton, M.D.

It is useful to contemplate the question of, "Just what did we accomplish?" after an AMA meeting. It is so easy to get caught up in the three-ring circus of the meetings and diverted by the campaigns for election to office that it becomes difficult to focus on the work at hand. I continue to be impressed with the volume of work done in debate and policy setting and the truly democratic nature of the house of medicine.

I want to highlight just a few of the issues with which I was involved during this annual session. Other members of the delegation will share their perspectives to give you a glimpse into Maine's active 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 Federal laws that govern organ transplantation to allow significant financial incentives to be offered. The emotional pleas from those awaiting organs are compelling, but the ethics are clear that personal altruism is the best motivation for donating tissue or organs. I fear that the proof financial incentives work will not help in designing programs to educate and promote altruistic donation and may unfairly target grieving relatives of minority and financially disadvantaged populations. This is certainly a slippery slope with the latest iteration being, "transplant tourism." The lesson here is that policy can differ from ethical opinion. The other lesson is that policy, once debated and adopted, is the voice of medicine. My misgivings aside, I respect the process by which the policy was crafted.

One of the "hot button" issues of the reference committee work was the Council on Ethical and Judicial Affairs report recommending a prohibition on pharmaceutical grants for medical education. There is a long and synergistic relationship between pharmaceutical companies and clinical research. Much of this effort occurs in medical school faculties. Over time, the reliance on unrestricted grants for education has touched the full spectrum of education from medical school to residencies and postgraduate educational opportunities (CME). The Flexner report in 1911 was the first critical look at the quality and independence of medical education. I suspect its recommendations met with an equal firestorm to the recommendation from CEJA that all financial ties between medical education and pharmaceutical companies be severed. There were long lines at the microphones to give testimony on the negative impact that such an abrupt change would have on a wide range of educational initiatives. The report was not adopted and was referred back to CEJA for reconsideration. I think CEJA got the ethics right, but failed to craft a report that spoke to the aspirations of Medicine. The issue in my mind is not if we will sever ties to pharmaceutical support of education, but when, and through what process. We owe it to our independent professionalism and to the expectations of our patients to assure that medicine is an evidence-based science uninfluenced by outside corporate influence.

Finally let me celebrate a "success" in the deliberations of the annual meeting. I authored a resolution recognizing the new AMA office on Physician Health and Healthcare Disparities. It called upon the AMA to convene stakeholders to assure that issues of physician wellness be brought into the curricula of medical schools and residency programs. It also called for a closer relationship between the AMA and the Federation of State Physician Health Programs. Testimony was unanimously supportive and the resolution was adopted with only minor changes. It was gratifying to plant some seeds for the future.

Thank you for the opportunity to serve as a delegate to the AMA House of Delegates. It continues to be an honor and privilege.

Upcoming at MMA

AUGUST 13	1:00pm – 3:00pm	Coding Center Audio Conference Call
AUGUST 14	11:00am – 2:00pm	Senior Section Meeting
AUGUST 20	1:00pm – 3:00pm	Coding Center Audio Conference Call
AUGUST 27	4:00pm – 6:00pm	Committee on Public Health
SEPTEMBER 3	6:00pm – 9:00pm	Maine Chapter, American College of Emergency Physicians
SEPTEMBER 4	Noon – 4:30pm 3:00pm – 5:00pm	Home Care Alliance Quality Counts! Behavioral Integration Advisory Committee
SEPTEMBER 4-7	155th Annual Session – Samoset Resort, Rockport	
SEPTEMBER 8	5:30pm – 8:30pm	Medical Professional Health Program Committee
SEPTEMBER 10	1:00pm – 3:00pm 6:00pm – 8:30pm	Coding Center Audio Conference Call Maine Health Management Coalition Orthopedic Group
SEPTEMBER 17	1:00pm – 3:00pm 6:00pm – 9:00pm	Coding Center Audio Conference Call Maine Society of Anesthesiologists
SEPTEMBER 18	8:00am - 3:30pm	Pathways to Excellence (Maine Health Management Coalition)
SEPTEMBER 24	9:00am - 11:00am 1:00pm – 3:00pm	Patient Centered Medical Home Planning Group Coding Center Audio Conference Call
SEPTEMBER 25	4:00pm – 6:00pm	Committee on Physician Quality
SEPTEMBER 26	1:00pm – 3:00pm	Coding Center Audio Conference Call

A Few Words from MMA's President-elect

Stephanie Lash, M.D., President-elect, MMA

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 up to several 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 changing world climate to federal regulations and reimbursement issues; from social 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 multiple sclerosis, ALS or neurolathy. I cannot think of a specialty of medicine that would be without some impact from obesity. What is particularly poignant about obesity, is that it is entirely a disease of the wonderful plenty we have created for ourselves. Like tobacco and alcohol, treating it will prove very challenging. We all need to think differently about our lives, the activities we choose to do, or not do, and, of course, the very foods (and how much of them,) we eat. We also, as physicians, need to understand better what our role will be to most effectively contribute to the solutions to this challenge. I hope, as I learn more through the coming year, to share some of the data and creative potential solutions with you. And I truly hope you will share 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) 947-0558, or through my e-mail, stephanielash@roadrunner.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 Stassberg, and the preceding president, Dr. Kevin Flanigan for their incredible energy and drive in leading the Maine Medical Association.

Upcoming Specialty Society Meetings

SEPTEMBER 3, 2008 Maine Medical Association, Manchester, ME
Maine Chapter, American College of Emergency Physicians
6:00pm – 9:00pm
MMA Contact: Anna Bragdon 207-441-5989 or maineacep@roadrunner.com

SEPTEMBER 4-7, 2008 Samoset Resort, Rockport, ME
(The following Specialty Societies will be holding meetings in conjunction with MMA's Annual Session taking place at the Samoset Resort in Rockport, Maine)

Maine Society of Orthopedic Surgeons Annual Fall Education Sessions
September 5-6
MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

Maine Association of Psychiatric Physicians - Sept. 6
MMA Contact: Warene Eldridge 207-622-7743 or weldridge@mainemed.com

Maine Urological Association - Sept. 6
MMA Contact: Kellie Miller 207-622-3374 ext. 229 or kmiller@mainemed.com

SEPTEMBER 17, 2008 Maine Medical Association - Manchester, ME
Maine Society of Anesthesiologists Meeting 6:00pm – 9:00pm
MMA Contact: Anna Bragdon 207-441-5989 or msainfo@roadrunner.com

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

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

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

OCTOBER 18, 2008 Maine Medical Association – Manchester, ME
Downeast Association of Physician Assistants (DEAPA)
MMA Contact: Kellie Miller 207-622-3374 ext: 229 or kmiller@mainemed.com

NOVEMBER 14, 2008 Hilton Garden Inn – Freeport, ME
Maine Association of Psychiatric Physicians General Membership Meeting
MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

NOVEMBER 15, 2008 Eastern Maine Medical Center – Bangor, ME
American Academy of Pediatrics, Maine Chapter Fall Conference
Cutting Edge Pediatrics: Practical Hardcore Medicine for the Maine Pediatrician – 8:00am – 3:00pm
MMA Contact: Aubrie Entwood 207-782-0856 or agridleyentwood@aap.net

Classified Ads

Seeking Full-time Physician

Lake Region Primary Care (LRPC), located in Windham, Maine is currently seeking a full time physician. LRPC is a Maine Medical Partners practice with 5 physicians and a nurse practitioner providing multi-specialty primary care services in the Lakes Region area. Appropriate candidates should be board-certified in either Family Medicine, Internal Medicine or Medicine-Pediatrics.

FMI please contact Abbie Graiver (207) 761-0650 email: graiva@mmc.org or Dr. Ed Tumavicus, MD (207) 892-3233 email: tumave@mmc.org. Apply online at www.mmc.jobs.

Wanted

Physician artists to exhibit at MMA Annual meeting at the Samoset Resort in Rockport, Maine from September 4-7, 2008. Call Norm Rosenbaum, MD at 207-885-5219.

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

Notice

Pursuant to the provisions of Article X of the Association's Constitution, members are hereby advised that proposed amendments to the Constitution and Bylaws to be considered at the annual meeting on Saturday, September 6, 2008 are now available for review on the Association's website at www.mainemed.com on the home page under MMA Spotlight.

MMA Nominations Time; Volunteers Sought

MMA's Nominations process is in full swing with the Nominations Committee chaired by President-elect Stephanie Lash, M.D. Nominations and volunteers are sought for all of the Association's offices and committees. If you are interested in becoming more involved in your professional association, please contact Gordon Smith at 622-3374 ext. 212 or via e-mail to gsmith@mainemed.com. A wide variety of experiences may be awaiting you!

Third Annual Ranking of Health Care Payers is Now Available

For the third consecutive year, athenahealth, a provider of Internet-based business services for physicians, has released its ranking of health care payers. The company's 2008 PayerView℠ Rankings rates health care payers on how they interact with physicians.

This year, Aetna ranks first with Cigna in second place and Humana in third. Wellpoint (parent of Anthem BCBS of Maine) took sixth position. The rankings reflect athenahealth's 2007 claims data from more than 12,000 medical providers, representing more than 30 million medical charge lines.

You may view this year's results at www.athenapayerview.com.

Athenahealth, Inc. recently opened an operations office in Belfast and is one of MMA's newest corporate affiliates.

Updated Sentinel Event Statistics

The Joint Commission's sentinel event statistics have been updated on the website, www.jointcommission.org. Since the sentinel event database was implemented in January 1995 through March 31, 2008, The Joint Commission 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

* = Added to reviewable events in June 2005; data represents events reviewed since that time.

Questions regarding this information should be directed to Anita Giuntoli at agiuntoli@jointcommission.org.

Jana Purrell, CPC

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

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

Medical Coding Certification

Recently I have received several calls from physician practices, 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 CEU 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 reviewing operative notes)
- 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/superbills on an annual basis with respect to diagnostic, procedural and supply code changes
- Preparing and/or submitting completed HCFA-1500 forms for services and procedures performed by the practice's physicians and non-physician providers
- Reviewing explanations of benefits from payors, evaluating denied claims and filing appeals for denied claims

In addition to the areas listed above, we are seeing an increasing number of audits from payors. 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 payors; and legal entities.

The Centers for Medicare and Medicaid Services (CMS) is requiring RACs to employ certified professional coders. If you aren't using certified coders, you may want to consider hiring some, or certifying those you have. Certified coders can talk peer-to-peer, and you'll 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—on-line, self-study, preparation courses, and audioconferences. Investing now in the ongoing education of your billing staff, including supporting coding certification can provide long-term benefits.

Additional articles:

Value of a Coding Education
http://www.aafp.org/fpm/20050300/20thev.html

Certified Professional Coder
http://www.aapc.com/certification/cpc.aspx

Certified Coding Specialist
http://www.ahima.org/certification/ccsp.asp

Coding Salary Survey 2007
http://www.aapc.com/surveys/medical-coding-salary-survey07.aspx

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.

Medical Mutual Insurance Company of Maine Risk Management Practice Tip:

Drug Diversion and the Drug-Seeking Patient: Part II

In the Hospital Emergency Department (ED), the following is suggested when addressing a person 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 reoccurring 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 offered 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 misdiagnosis 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 include 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 provider to perpetrate illegal acts, such as illegal acquisition of drugs or the selling of those drugs, 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.

Kellie Miller, Director of Public Health Policy, MMA

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 Co-op 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 DHHS' Childhood Overweight and Obesity Prevention Initiative. This initiative "targets prevention of overweight and obesity prevention, 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. Victoria Rogers and Acting US Surgeon General discuss healthy weight initiatives in the Portland area

Dr. Fanburg addressing the Acting US Surgeon General

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 Fanburg, MD, currently serving as the President of the Maine Chapter of the American Academy of Pediatrics. Dr. Fanburg 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 – kids 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 (at 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 622.3374, ext. 229.

More than 100 People Attend 17th Annual Practice Education Seminar

More than 100 physicians, practice managers, and guests attended the Association's Annual Practice Education Seminar on May 28th at the Augusta Civic Center. Featuring three topics at plenary sessions in the morning and a dozen break-out sessions in the afternoon, the day-long program presented updates on the following subjects:

- Stark II and its Phase III regulations
- Physician Profiling and Tiered Networks
- Quality Improvement initiatives in the state, including updates on Pathways to Excellence, Quality Counts, Aligning Forces for Quality, the Voluntary Practice Assessment Initiative, and the Maine Quality Forum
- Physician supply: recruitment and retention issues

U.S. Attorney for the District of Maine, Paula Silsby, presented the Keynote talk, addressing the subject of the continuing problem of prescription drug abuse in the state. Presenting with Attorney Silsby was Marcella Sorg, PhD of the Margaret Chase Smith Center at the University of Maine.

Attorney Silsby encouraged all prescribers to register to use the states Prescription Monitoring Program (PMP) which has proven to be an effective means of dealing with drug diversion. To register, log onto the PMP website at www.maine.gov/dhhs/osa/data/pmp.

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	YES	NO
Does 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 eyesight 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 pharmacists to be able to discuss any suspicious prescription form or behavior?	☐	☐
Is your practice registered to access 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:

Brown & Meyers, Inc.
CANSCAN
HRH Northern New England
Maine Bureau of Insurance
Medical Mutual Insurance Company of Maine
Mid-Maine Communications
Northeast Healthcare Quality Foundation
Office Max
Physician Billing and Consulting, LLC
Voluntary Practice Assessment Initiative

DEAPA's Transition Completed

The Downeast Association of Physician Assistants' (DEAPA) transition was finalized on July 1st, as MMA staff, Kellie Miller assumed the reigns of the thirty-one year old organization, due to the retirement of long-time administrative secretary, Linda Roberts. The office is now located at the MMA association headquarters in Manchester.

Currently serving as President of DEAPA is William Bisbee, PA-C, of Dover-Foxcroft, the Past President is Gregg Christensen, PA-C of Greenville, Treasurer is Samuel Umbriaco, PA-C of Brunswick and Secretary is Noel Genova, PA-C of Portland. The Downeast Association of Physician Assistants was incorporated on April 1, 1977, as a nonprofit organization and is representative 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 policies and upholds the principles, purposes, and philosophy for which the AAPA was founded.

The Founding Father of the Physician Assistant Profession was Eugene A. Stead, Jr., MD (1908-2005). He received his undergraduate and medical education at Emory University and interned at the Peter Bent Brigham Hospital in Boston and served as a Professor of Medicine and Chairman of the Department of Medicine at Duke University. Based upon his and colleagues growing use of ex-military corpsmen in the early 1960s to help run specialty units at Duke, Dr. Stead began to formulate his two-year curriculum to expand the prior education and experience of these corpsmen to become competent physician assistants. With the support of the Duke faculty and administration, he launched the first formal educational program for physician assistants at Duke University in 1965.

Any member wishing to contact DEAPA, can do so by calling DEAPA's office at 207.620.7577 or email kmiller@deapa.com or go to www.deapa.com. The mailing address is 30 Association Drive, PO Box 190, Manchester, Maine 04351 and fax number is 207.622.3332.

Legislative Update

Andrew MacLean, Esq.

DIRIGO PEOPLE'S VETO CAMPAIGN HEADLINES SUMMER ADVOCACY ACTIVITIES

The 123rd Maine Legislature has adjourned and candidates for the 124th Maine Legislature are campaigning in their districts, but the health policy debate continues in Augusta. It also is playing out around the state in the campaign to mount a "People's Veto" of L.D. 2247, An Act to Continue Maine's Leadership in Covering the Uninsured, a bill intended to provide a sustainable and stable source of funding for the Dirigo Health Program and to make some modest changes to the regulation of health insurance in Maine. Based upon its historic support for Governor Baldacci's Dirigo health care reform effort, the MMA has joined the campaign against the People's Veto effort.

The People's Veto initiative concerning L.D. 2247 is the most significant health policy debate in Maine this summer. The People's Veto campaign, known as *Fed Up With Taxes* (FUWT), is an initiative of business interest groups including the Maine Beverage Association, the Maine Grocers Association, the Maine Restaurant Association, the Maine State Chamber of Commerce, and others. Employing Article IV, Part Third, Section 17 of the Maine Constitution, FUWT seeks to invalidate new funding for Dirigo that replaces the controversial "savings offset payment" (SOP) with a 1.8% "health access surcharge," a combination of alcohol and soft drink taxes, and some money from the Fund for a Healthy Maine.

In order to put the matter on the November ballot, FUWT must obtain petition signatures from a number of voters not less than 10% of the total votes cast for Governor during the last gubernatorial election preceding the filing of the petition (55,000) within in 90 days following adjournment of the legislature (July 17, 2008). If the Secretary of State certifies sufficient signatures by August 17, 2008, the matter will be placed on the November 2008 general election ballot.

Since enactment in 2003, the MMA has supported the Dirigo health care reform initiative as part of a "pluralistic approach" to health care reform articulated by the MMA general membership in a resolution adopted at the 2001 Annual Session. MMA EVP Gordon Smith and former MMA and AMA President Robert McAfee, MD were members of the 2006 Blue Ribbon Commission on the Dirigo Health Program that included these tax increases among its recommendations as funding alternatives for the Dirigo Health Program. The MMA urged the Insurance & Financial Services Committee to adopt the new taxes because of standing public health policy in favor of taxing products that contribute to higher health care costs resulting from obesity and smoking and using the revenue to increase the availability of health care services for the uninsured.

The MMA is participating in a campaign against the People's Veto, known as *Health Coverage for Maine* (HCFM), composed of health care and consumer groups including the American Cancer Society, the American Heart Association, AARP, the Maine State Employees Association, the Maine Education Association, the Maine Primary Care Association, Consumers for Affordable Health Care, the Maine People's Alliance, Maine Equal Justice, and Physicians for Social Responsibility.

The FUWT campaign will be emphasizing the tax increases in L.D. 2247 and will try to capitalize on the general public's concern about current economic conditions, while the HCFM campaign will emphasize continuing efforts to provide quality, affordable health care coverage for all Mainers.

During the summer and fall, the MMA also will participate in a stakeholder group convened by the Department of Professional & Financial Regulation to implement L.D. 2253, *An Act to License Certified Professional Midwives* that allows so-called "lay midwives" to possess and use a limited number medications for home births.

Campaigns for all 186 seats in the Maine Legislature are underway now and will become more intense after Labor Day. The MMA encourages physicians to meet the candidates for your House and Senate seats and to offer to be a resource on health policy issues. You can find candidate information on the Secretary of State's web site, http://www.state.me.us/sos/cec/elec/upcoming.html. If you would like help identifying the candidates in your House and Senate districts, or if you would like the MMA's analysis of a particular race, please contact me. The Democrats' 31-vote margin in the House of Representatives will be difficult for the Republicans to overcome, but the 1-vote margin (18-17) in favor of the Democrats in the Senate means that the fall Senate campaigns will be hotly contested and very interesting to watch!

The MMA's summary of all legislation tracked during the 123rd Maine Legislature will be available prior to the Annual Session in September.

The MMA Legislative Committee will organize and develop its agenda for the 124th Maine Legislature this fall with a meeting likely to be scheduled in October. Chair Katherine S. Pope, M.D., an anesthesiologist from Cumberland Foreside, will be retiring from the position after 5 years of exemplary service and Samuel Solish, M.D., an ophthalmologist from Falmouth, currently the Vice Chair, will assume the Chair's role. If you have an issue you would like the Legislative Committee to consider addressing in its legislative agenda, please contact me as I will collect ideas from now through late fall.

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

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

Thank You

A special thank you to the following physicians who served as volunteers on prelitigation screening panels from January thru June 2008. Physicians willing to volunteer may contact the MMA EVP Gordon Smith at 622-3374 ext: 212 or via email at gsmith@mainemed.com.

Robert Clough, MD Molly Collins, MD (aka Mary Collins) **John Gay, MD** Jeff Graham, MD **Sandra Harris, MD**
John Klemperer, MD **Joseph Lopes, MD** Doug MacGillvray, MD **Guy Nuki, MD** Kevin Olehnik, MD
Burton Pearl, MD Ed Salmon, MD **Carrie Thackeray, MD**

Board of Pharmacy and DPFR Work Group Meet on Midwifery Law

An ad hoc Advisory Committee requested by the Governor and established by the Department of Professional and Financial Regulation met on June 24th to review draft proposed rules that would allow access by direct-entry midwives to a limited category of medication to have available at home births. Medical interests were represented on the Committee by Jay Naliboff, M.D., District Chair for Maine for the American College of Obstetrics and Gynecology. Dr. Naliboff practices in Farmington. MMA representatives also attended the meeting.

Other members of the Advisory Committee include Dr. Dora Anne Mills, Director of the Maine CDC; Jill Breen deBethune, Certified Professional Midwife; and Dana Hunter, Pharmacist, Member, Board of Pharmacy.

The Committee is Chaired by Anne Head, acting Commissioner of the Department and is staffed by Geraldine Betts, Administrator, Board of Pharmacy and Jeff Frankel, staff attorney.

Following introductions, the members reviewed a draft set of rules that would implement Chapter 669, effective July 18th which allows access to the medications, which the Legislature granted while at the same time defeating the midwives attempt to be licensed by the state.

The draft rules, which still must go to public hearing and ultimately be approved by the Board of Pharmacy, include details on what credentials the midwife must show to the pharmacist to obtain the medication, and also requires the midwife to report use of the drugs to the Maine CDC.

Anne Head reminded Committee members of the letter she had received from the Governor, which requested comprehensive oversight of the use of the medication in order to protect the safety of mothers and their infants.

In a letter dated April 22, 2008, the day he signed the controversial legislation, the Governor wrote to Acting Commissioner Head, and made the following requests:

I direct you, as the Acting Commissioner of the Department of Professional and Financial Regulation, to take whatever steps are deemed necessary, in conjunction with the Board of Pharmacy's rulemaking process, to incorporate, among other provisions, recordkeeping and reporting requirements regarding: the verification of midwife credentials by licensed pharmacists, access to specified medications by certified midwives, and the administration of any of the specified medications by midwives to their patients.

Further, I direct ...a report to my office by Nov. 15, 2009 including information on the activity of certified midwives, their access and use of any of the specified medications, and any recommendations that would enhance the safety of Maine citizens who may receive services from certified midwives.

During the meeting, the committee members made a number of suggestions regarding the proposed rule. An amended draft will be distributed to the members prior to the Board of Pharmacy proceeding to consider the proposal and sending it to public hearing. Until the rule is considered and adopted, it is unlikely that any pharmacy would be comfortable in dispensing the medications, although the law is effective July 18, 2008.

Gordon Smith, MMA EVP

Notes from the E VP

I appreciate the opportunity to communicate in this second EVP column. I hope you are all enjoying the summer and further hope that you will consider attending all or a portion of the Association's Annual Meeting being 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% nationally but over 11% in Maine and in 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 in Washington and Augusta. Little wonder that people are cynical and that the popularity of Congress falls below even 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 the types of services members have come to expect from MMA and yet live by projections of anticipated revenue. But we do our best. I think for a small state 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 20 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 three or four questions relating to the pharmaceutical industry. These questions will be approved in advance by MMA. The survey is being paid for through an unrestrictive grant from the Pharmaceutical Research and Manufacturers Association.

We appreciate your membership and I hope you will not hesitate to give me a call (622-3374 ext: 212) or drop me an e-mail at gsmith@mainemed.com, if I or anyone else at MMA may ever be of assistance.

MMA Participates 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 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.

Next on the agenda was a presentation on approaches in other states made by Shaun T. Alfreds, MBA, CPHIT of the Center for Health Policy and Research at the University of Massachusetts Medical School. Mr. Alfreds presented a number of slides on the sustainability and approaches of similar projects in other states.

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 each prescription filled
- Assessment on health insurance premiums
- Tax on providers (MMA would vigorously oppose this option)
- User fees

The HIN 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 CDC. 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 HIN 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 HIN 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, physicians 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 the 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-R-131) 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/BNI/02_ABNG-ABNL.asp. Physicians also have an option of downloading a form that can be customized if they choose to integrate 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 these 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.

Invite a Physician to Join MMA

Encourage your colleagues to become an MMA member and take advantage of the benefits of membership.

Contact Lisa in the MMA Membership Department at 622-3374 ext: 221 or email lmartin@mainemed.com.

Highlights of Cancer Facts & Figures 2008

(From the American Cancer Society, New England Division)

- In 2008, an estimated 1,437,180 new cancer cases and 565,650 deaths from cancer are expected in the U.S. In Maine, new cancer cases are estimated at 8,140 (down from 8,340 in 2007) and cancer deaths at 3,270 (up from 3,190 in the previous year) for 2008.
- Lung cancer remains the number one cause of cancer death in the U.S. with an estimated 215,020 new cases (up from 213,380 in 2007) and 161,840 deaths (up from 160,390 the previous year) expected in 2008. Since 1987, more women have died each year from lung cancer than from breast cancer. In Maine, 1,330 new cases of lung cancer and 980 deaths are estimated for 2008.
- Colorectal cancer is the third most common cause of cancer in both men and women in the U.S. In 2008, the Society estimates that 108,070 Americans will be diagnosed with colorectal cancer, and 49,960 will die of the disease. In Maine, approximately 860 new cases of colorectal cancer will be diagnosed and 260 deaths are estimated for 2008.
- Breast cancer remains the most common incident cancer among women in the U.S., excluding skin cancer. An estimated 184,450 new cases (up from 178,480 in 2007) and 40,930 deaths are expected among U.S. women in 2008. Mortality rates from breast cancer have steadily decreased in women as a result of earlier detection and improved treatment as well as reduced hormone replacement therapy following the publication of results from the Women's Health initiative in 2002. Maine is estimated to have approximately 990 new cases of breast cancer and approximately 190 deaths in 2008.
- Prostate cancer is the most common cancer diagnosed among men in the U.S., excluding skin cancer. An estimated 186,320 new cases (down from 218,890 in 2007) and 28,660 deaths (up from 27,050 the previous year) are expected in 2008. African American men continue to experience significantly higher incidence rates than white men. In Maine, 1,110 men will be diagnosed with prostate cancer in 2008; and 180 will die from the disease.

The full report can be viewed at www.cancer.org/statistics

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