NOVEMBER/DECEMBER 04

Maine medicine

In this issue...

Member Communications Survey Enclosed

Please be sure to complete the enclosed Survey in order to help us better serve you!

Professional Liability Reform Campaign Launched

Access to health care services in Maine is threatened by a medical liability crisis. Increasing malpractice premiums, increasing costs of claims, verdicts and the constant threat of litigation leading to defensive medicine, all call for meaningful reform of Maine's tort laws.

On October 28, twenty Maine health care organizations announced formation of a coalition to advocate for such reform, led by the Maine Medical Association, the Maine Osteopathic Association, and the Maine Hospital Association.

At a press conference in Portland, over fifty medical students, residents, and physicians attended to hear Coalition Chair Lee Thibodeau, M.D., state:

> *In Maine, we are on the verge of a crisis. All the warning signs are present. High premiums, increasing severity of claims, difficulty in recruiting and retaining specialists – it is all here. Over the past five years, we have lost 25% of Maine's practicing neurosurgeons. I don't want my patients to have to leave Maine to get brain or spine care. I don't want Maine women to have to go to Boston to have care for their babies. With the Legislature's help, we can be ahead of the curve and avoid the situation in West Virginia, Florida, Pennsylvania and eighteen other states. But we need to act now.*

The Coalition will seek to have legislation introduced into the 122nd Legislature to enact a limit on non-economic damages and other reforms.

Other speakers at the press conference included MMA President-elect Jacob Gerritsen, M.D., MOA President-elect Thomas DeLuca, D.O., and Maine Society of Orthopedic Surgeons' President William Strassberg, M.D.

The sidebar includes current members of the coalition. Contributions for the effort can be sent to:

Coalition for Health Care Access and Liability Reform (CHCALR)
c/o Maine Medical Association
P.O. Box 190
Manchester, ME 04351

Coalition Members:

Maine Medical Association

Maine Osteopathic Association

Maine Hospital Association

Maine Neurosurgical Society

Maine Society of Anesthesiologists

Maine Academy of Family Physicians

Maine Gastroenterology Society

Maine Radiological Society

Maine Chapter, American College of Emergency Physicians

Maine Chapter, American College of Surgeons

American College of Physicians, Maine Chapter

Maine Chapter, American Academy of Pediatrics

Maine Society of Orthopedic Surgeons

Maine Society of Eye Physicians and Surgeons

Maine Section American College of OB/GYN

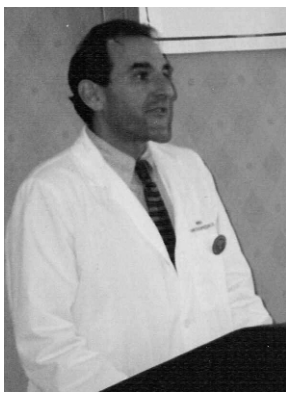
Downeast Association of Physician Assistants

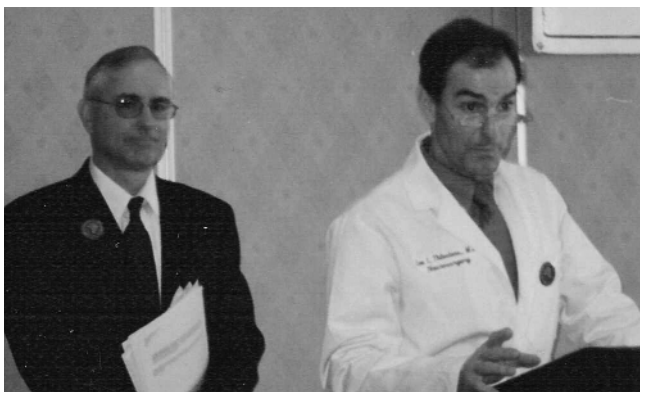
Maine Psychiatric Association

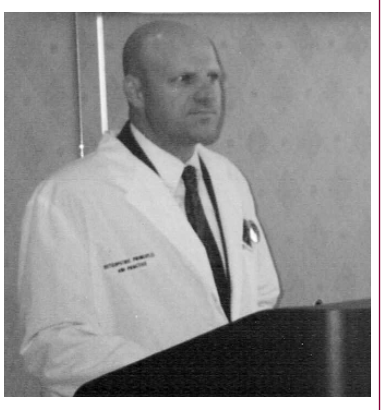
Knox County Medical Society

The Maine Chapter, American College of Osteopathic Family Physicians

The Maine Society of Otolaryngology

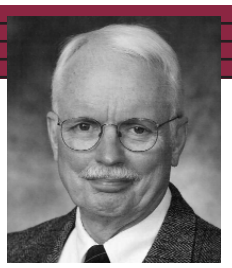






From left, William Strassberg, M.D., President, Maine Society of Orthopedic Surgeons, Jacob Gerritsen, M.D., President-elect, MMA, Lee Thibodeau, M.D., Coalition chair, Thomas DeLuca, D.O., President-elect, Maine Osteopathic Association.

President's Corner



Lawrence B. Mutty, M.D.,
President, MMA

Let The Prescriber Beware

In a previous edition of the Goodman and Gilman pharmacology text, the authors stress that, "medications are either ineffective or they are dangerous." The recent scandal involving Merck's Vioxx, described in the 21 Oct. 2004 article of the NEMJ, sounds a reverberating cautionary note regarding brand new medications. We are reminded that pharmaceutical manufacturers frequently conduct that amount of research necessary to achieve minimal compliance with FDA guidelines in order to rush to market.

This company sponsored research, has long been known to be too short term, and to frequently avoid the effects of the medication on children, the elderly, and those with co-morbid medical conditions. As well, the new drug is most often compared to placebo as opposed to head-to-head comparisons with other medications in the same class or for cost effectiveness. Now comes evidence of the suppression of negative studies.

Because of concerns that physicians might be perceived as unduly influenced by free meals, paid golf green fees, trips and other gifts from pharmaceutical manufacturers, the AMA developed a specific set of ethical guidelines. When these were promulgated, a significant source of concern was that the doctor would be inclined to recommend the more expensive latest brand name as a consequence of these favors. We all appreciate that such favors were unlikely to influence our professional concerns for the patient's well being. However, public perception of undue influence and the consequent distrust it engenders was then compounded by the worrisome and widely publicized report "To Err is Human" by the Institute of Medicine.

In the wake of studies reported in England which appeared to link an increased risk of suicide among adolescents who were prescribed several Selective Serotonin Re-uptake Inhibitors (SSRIs), the British government decided to prohibit the prescribing of those SSRI's to that age group. Following much adverse publicity, the FDA has recently required a "black box warning" be added to the package label of several SSRIs citing the dangers of increased risk of suicidal ideation and behavior when prescribed for adolescents and the need for close patient monitoring.

Now appears the ancient nemeses of tort reform, the trial attorneys. Advertisements have appeared in our daily newspapers to solicit plaintiffs who believe themselves injured by Zyprexa, and, ever on the look out for the latest targets of opportunity for zillion dollar awards, also by Vioxx. Witness *The Bangor Daily News* ad of 28 October 2004 by Goldberg and Osborne trolling for Vioxx victims.

All of these developments, lead in my opinion, to the following conclusions:

1. Physicians must exercise greater care than ever, in evaluating the evidence published in peer-reviewed journals about the efficacy and freedom from countervailing adverse effects or dangerous drug-drug interactions of any brand new medication on the particular age group and medical status of the patient to be treated.
2. Regretfully, we cannot confidently rely on the information provided by drug company detail men and women. They are our honest and hardworking neighbors, but are touting the new drug based on company studies which may fall short of reliability in one or more critical areas, as opposed to those conducted rigorously and impartially in peer reviewed journals.
3. We must work with our Congressional delegation to ensure that all proposed clinical trials are entered in a National Registry before they are conducted.
4. In order to maintain public trust, we must reassure patients that our decision to use a certain medication is based solely on what is in the patient's best interest. To achieve this, reasonable care must be exercised in order to avoid even the appearance of a conflict of interest. These issues are not always as clear cut as one might wish as there are inevitably some ambiguities. On the AMA website under "Ethical Opinions and Guidelines" answers are provided to questions about the hazards that lurk in the gray areas of support for CME, gifts from industry, travel reimbursement and the like.
5. Physicians have had long and sometimes bitter experiences prescribing a medication intended to ameliorate the pathology of one organ such as the brain, which now or later proves to have negative repercussions at distant but very sensitive sites such as the heart, kidney, liver or thyroid. The decision to prescribe requires a thorough understanding not only of pharmacology, but also an understanding of the other basic and clinical sciences as well as the experience that comes from the physical examination of many patients and the interpretation of laboratory and special studies. Physicians, (including those who practice the specialty of psychiatry), have this training and experience. Psychologists, who are seeking the right to prescribe in many States, including Maine, do not. It is for this reason that the MMA will oppose any legislation that grants prescribing privileges to individuals who do not have full education and training.

Any thoughts, comments or questions can be directed to me, Lawrence Mutty, M.D., by calling 207-326-4637, faxing 207-326-8352, or emailing lmutty@verizon.net.

Upcoming Specialty Society Meetings

FEBRUARY 4-6, 2005 *Sugarloaf, USA*
Maine Urological Association & Maine Section, American College of Obstetricians and Gynecologists Combined Meeting
MMA Contact: Ann Verrill 207-622-3374 or averrill@mainemed.com

FEBRUARY 12-13, 2005 *Sugarloaf, USA*
Maine Society of Anesthesiologists Meeting
MMA Contact: Anna Bragdon 207-622-3374 or abragdon@mainemed.com

MARCH 4-6, 2005 *Mt. Washington Hotel – Bretton Woods, NH*
Maine and New Hampshire Radiological Society Meeting
MMA Contact: Warene Eldridge 207-622-3374 or weldridge@mainemed.com

MARCH 11-13, 2005 *Bethel Inn and Country Club - Bethel, ME*
Maine Gastroenterology Society Meeting
MMA Contact: Chandra Leister 207-622-3374 or cleister@mainemed.com

APRIL 1, 2005 *Harraseeket Inn - Freeport, ME*
Maine Society of Eye Physicians and Surgeons Spring Meeting
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

APRIL 29, 2005 *Harraseeket Inn - Freeport, ME*
Maine Psychiatric Association General Membership Meeting
MMA Contact: Warene Eldridge 207-622-7743 or weldridge@mainemed.com

MMA Welcomes Our Newest Corporate Affiliate:

Doc Executive

We appreciate their support!

Wanted:

Enthusiastic, talented physicians with expertise in such areas as public policy, CME, insurance reimbursement, public health, technology and organizational development, etc. to get involved in the fastest growing physician organization in Maine. A membership organization is only as effective as its volunteers. Help make MMA a more effective physician organization. Call 622-3374 today or contact Gordon Smith at gsmith@mainemed.com.

Maroulla Gleaton, M.D.
Immediate Past President, MMA

Final Words from the MMA Past President

By Maroulla Gleaton, MD, MMA Immediate Past President

Dirigo Health Initiative (Second of two parts)

So, how is the plan going to be paid for?

In the first year, the plan is being paid for by $53 million in supplemental federal assistance intended to help struggling state Medicaid programs, achieved with substantial help by Senators Collins and Snowe.

In ensuing years, DirigoChoice will be paid by something called a "Savings Offset Payment." Insurance companies and self-insured groups will be asked to contribute a portion of their premium revenue based on anticipated savings through the avoidance of charity care and bad debt in the Dirigo Health Plan. Right now an estimated $270 million of charity care is delivered by providers and hospitals each year. This actually is being paid for by the private insurance companies - little wonder premiums are going up! As DirigoChoice absorbs more and more charity care, the private insurers will be recovering more savings and need to pass that savings on to the state – thus the name Savings Offset Payment. If the SOP doesn't work, the state can assess a 4% premium tax each year. The final component of Dirigo's financing mechanism is identifying working poor in employee-sponsored plans who are eligible for MaineCare and collecting federal matching funds for their individuals.

For the past year, all stakeholders in our health care delivery and financing system have been asked to meet voluntary cost containment limits. Insurers have been asked to limit underwriting gain (after federal taxes) to 3% and individual practitioners have been asked to limit net revenue to 3%. Lastly, Maine's hospitals have been asked to limit expenses per case mix adjusted discharge to increases of 3.5% and operating margins to 3%.

Under Dirigo, electronic billing will be mandatory unless the practitioner can show extreme hardship. The last component for savings is Certificate of Need (CON), which I will discuss under the state health plan.

The Maine Quality Forum, directed by Dennis Schubert, M.D., Ph.D., is established under the auspices of the Dirigo Health Board. It has focused its initial work on several issues, including a newly launched web site. The Forum has input from a separate Advisory Council chaired by Bob McArtor, M.D. The web site will have consumer-friendly data on health care use rates and best practices. Recognizing the tremendous potential savings and quality improvement from e-prescribing and patient registries and protocols, the Forum is promoting electronic medical records and statewide connectivity. The MQF is working on a revolving loan fund to help physicians and other providers borrow money inexpensively to access and implement new information technologies. The MQF has, along with the Bureau of Health and the Maine Health Access Foundation, provided financial support to a statewide interconnected health care network feasibility/implementation plan study to be conducted by the Maine Health Information Center. The data derived from the study could then be used to garner federal moneys for a statewide health care interconnected network. This network will enable all the various EMR's throughout the state to communicate with one another to decrease duplication and increase efficiency as well as improve quality. Also, the MQF is studying the nurse staffing ratios in hospitals to determine the impact on patient safety as directed by the Legislature.

The Advisory Council on Health System Development has helped to develop a 51-page interim State Health Plan that looks forward to eliciting public input via a "Tough Choices Campaign" to develop the first biennial State Health Plan next year. The goal of this roadmap on health care is to make Maine the healthiest state in the nation. If you browse through the interim State Health Plan, you can see the themes of cost, quality, and access each being addressed. Under the Cost heading, there is a substantial elucidation of the CON process which now captures Ambulatory Surgical Unit (ASU's) for the first time. The CON thresholds for initial investment are currently $2.4 million for bricks and mortar and $1.2 million for equipment before you need to apply. There is a Capital Investment Fund, which is related to the third-year operating costs of a project, established at $6.6 million for this year and there is 12.5% of the "fund" set aside each year for non-hospital projects. The section on quality discusses the geographic variation data that the Maine Quality Forum is synthesizing to put out to the public, and there is a real plug for integrating technology and implementing the chronic care model. Under the heading of Access, the expansion of MaineCare and the implementation of DirigoChoice are described.

The Commission to study Maine's Hospitals has been meeting weekly since May and plans to issue its recommendation this November. It has been studying the current comprehensive role of Maine hospitals and evaluating them in the context of the State Health Plan's priorities. It has been collecting and evaluating data on overall hospital expenditures, costs, efficiencies, and the availability of health care services. It is looking for opportunities and considering public policies to advise changes in hospital roles to encourage collaboration and improve affordability. In the Commission's final report, I expect to hear about hospital geographic regions roughly divided into three areas in the state similar to the current trauma coverage regions. This will cause quite a controversy in the public, especially if linked to a major reduction in hospital jobs.

Lastly, the veteran's study commission has been studying issues of access of concern to Maine physicians including the large amount of duplication of examinations and lab values in the management of patients by the VA system in order for the patient to receive VA drug benefits. Many practices don't even know which of their patients are seen or cared for in the VA system or receive any VA benefit. This clearly needs to be done.

So, in summary, I have tried to give you an understanding of the majority of the issues and projects that are going on under the overall Dirigo Health initiative. There certainly are many more nuances and details too numerous to mention in an article of this nature. Please feel free to email me at gleaton@adelphia.net or contact me at my office at 622-3185, if you would like to learn more.

Again, it has been a real honor to represent the physicians of Maine. I thank you for the privilege and opportunity. I look forward to continuing to serve the Association in my new position as alternate delegate to the AMA.

UPCOMING AT MMA

DECEMBER 16, 2004
10:30am
Maine Psychiatric Association,
Bed Review Committee

5:30pm
Maine Psychiatric Association,
Executive Council

DECEMBER 23, 2004
6:00pm
Maine Psychiatric Association,
Governmental and Legislative
Affairs Committee

DECEMBER 30, 2004
6:00pm
Maine Psychiatric Association,
Governmental and Legislative
Affairs Committee

JANUARY 4, 2005
1:00pm – 3:00pm
Stop Stroke!

JANUARY 10, 2005
6:00pm
Committee on Physician Health

JANUARY 11, 2005
6:00pm
Legislative Committee

JANUARY 14 – 15, 2005
All Day
Executive Committee Retreat
(in Quebec City)

JANUARY 20, 2005
5:30pm
Maine Psychiatric Association,
Executive Council

FEBRUARY 1, 2005
1:00pm – 3:00pm
Stop Stroke!

FEBRUARY 3, 2005
12:30pm – 4:30pm
Home Care Alliance

MARCH 2, 2005
2:00pm – 5:00pm
Executive Committee Meeting

Welcome to our latest Group Member:

Martin's Point Healthcare

THE CODING CENTER

Jana Purrell, CPC

The HHS Office of Inspector General (OIG) has released their annual work plan for 2005. The items on the list are areas that will be "watched" closely in the upcoming year. Some will sound familiar as they have been on the "watch" list in previous years; others are new for this year. Good news—consultations are finally off the OIG watch list this year. The list for physician services includes:

Coding of Evaluation and Management Services: To examine the pattern of physician coding of evaluation and management services and determine the service was coded accurately. Also looked at will be the controls being used to identify those physicians with incorrect coding patterns.

Use of Modifier –25: Are providers using modifier –25 appropriately? In general, a provider should not bill evaluation and management codes on the same day as a procedure or other service unless the evaluation and management service is separately identifiable to that procedure or service.

Use of Modifiers With National Correct Coding Initiative Edits: Claims that were paid when modifiers were used to bypass National Correct Coding Initiative edits will be examined to see if they were billed appropriately. Providers are allowed to use a modifier to bypass a code pair edit in certain circumstances.

"Long Distance" Physician Claims: Medicare B claims for face-to-face physician encounters when the practice setting and the patient's location are separated by a significant distance will be reviewed to confirm that services were provided and accurately reported.

Care Plan Oversight: Is Medicare B reimbursing appropriately for claims submitted by physicians for care plan oversight? Under the Medicare rules for home health and hospice, care plan oversight is the physician supervision of patients who need complex or multidisciplinary care requiring ongoing physician involvement.

Billing Service Companies: What is the relationship between the billing company and the physicians and any other Medicare providers who use their services and how does the arrangement impact the physicians' billing?

Medicare Payments to VA Physicians: The OIG will look at the legitimacy of Medicare paying for services billed by physicians who receive reimbursement from the Department of Veterans Affairs (VA) for the time that the physician reports as being on duty at the VA hospital. Physicians who are employed by the VA are not allowed to bill Medicare for services provided at other hospitals during the times they are "on duty" at the VA hospital.

Ordering Physicians Excluded From Medicare: Physicians that have been excluded from Federal health care programs including Medicare B are also not allowed to order services for Medicare B patients. The OIG did a recent review which showed a large number of services are still being ordered by these physicians.

Physician Services at Skilled Nursing Facilities: Several months ago we ran an article about physicians billing Medicare Part B for services rendered in their office to a patient who was residing in a nursing home. Medicare Part A and Part B will review claims with overlapping services for SNF patients to determine if duplicate payments were made. Physicians can bill Medicare B for only the professional component (-26) of the service. The technical component (-TC) is covered under the patient's Part A stay in the nursing facility and should not be billed to Medicare Part B by the physician.

Physician Pathology Services: The focus here will be on pathology services performed in the physician office. Pathology includes the examination of cells or tissue samples by a physician who then prepares a report of their findings. The OIG will be looking at the relationship between the physician who furnishes the pathology service in their office and outside pathology companies.

Cardiography and Echocardiography Services: Did the physician bill appropriately for the professional and technical components of the service? If the physician is performing the interpretation only, the modifier –26 (or interpretation only code) should be used to bill Medicare Part B.

Physical and Occupational Therapy Services: According to Medicare, physical and occupational therapies are medically prescribed treatments used for improving or restoring functions, preventing further disability, and relieving symptoms. Medicare claims for therapy services will be reviewed to determine if the services were reasonable and medically necessary, documented appropriately, and certified by physician certification statements.

Part B Mental Health Services: Payments for mental health services provided in the physicians' office setting accounted for 55% of all reimbursement for Part B mental health services in 2002. The OIG will determine if those services provided in the physicians' office setting were medically necessary and billed according to Medicare requirements.

Wound Care Services: Due to a dramatic increase in the amount Medicare allowed for certain wound care services between 1998 and 2002; claims for wound care will be reviewed for medical necessity and to see if they were billed correctly.

Provider-Based Entities: Hospital ownership of physician practices is becoming widespread. The OIG has found that many fiscal intermediaries are unaware whether these arrangements between the hospital and the practice are being treated as provider based or freestanding. It has been determined that Medicare is paying large amounts of money for services that are being billed incorrectly as provider based.

While often all the items on the OIG's work plan for the year are not completed, this list will make you aware of areas that the government is watching and can be used as a guideline to identify areas for internal audits in your own practices. The entire 2005 work plan can be viewed at www.oig.hhs.gov/publications/workplan.html

By Jana Purrell, CPC, Coding/Reimbursement Specialist
Maine Medical Association/NH Medical Society/VT Medical Society
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Notice to Physicians

A change in Chapter II, Section 15 of the MaineCare Benefits Manual, effective November 1, 2004, now requires referring physicians to supply rehabilitation potential documentation to chiropractors for MaineCare members seeking chiropractic care.

Rehabilitation Potential is the documented expectation by a member's physician or PCP that the member's condition will improve significantly in a reasonable predictable period of time as a result of the prescribed treatment plan. The physician's documentation of rehabilitation potential must include the reasons used to support this expectation.

Adult members (age twenty-one and over) must have an initial evaluation by a physician that documents the member's rehabilitation potential. This requirement will not apply to members with Medicare coverage or other third party health insurance until the coverage for services by the other payor has been exhausted.

The rehabilitative potential assessment and documentation requirement is also included in new rules that will soon go into effect for Occupational, Physical, and Speech therapy services.

PUBLIC HEALTH CORNER

Save The Date:

2005 Northeast Transportation Safety Conference

(formerly the Tri-State Safety Conference)

April 21-22, 2005

Sheraton Hotel
South Portland, Maine

For more information: www.themtsc.org

visit us on the web at www.mainemed.com

See What's New!!

Physician Support Programs Provide Stability During Chaos

Physicians are not immune to the stress of practicing medicine, even though, most acknowledge the power and disablement it induces. Most physicians work hard at ignoring or detaching from the grip of stress. This reluctance to recognize that stress affects the health and performance of medical practitioners has led to a growing population of providers whose practices and personal lives are suffering. Doctors under stress do not always confine their irascibility to their patients or practice office staff, they take it out on their colleagues and their families, still unwilling to acknowledge what they are doing. Additionally, as a result of stress, doctors may experience a decline in focus and objectivity, paying less attention to details, and, possibly, making bad medical judgments.

The **Physician Support Programs** offer a forum, lead by psychiatrists who have a unique sensitivity to the issues of physicians, to establish trusting relationships among peers who can share their emotional reactions to stress and crises. The **Physician Support Programs** begin in January, 2005. Visit www.DocExecutive.com to learn more and to register.

Next Issue: *Watch for the introduction of* ***Anger Management Work Groups.***

Get PDL Updates Emailed To You

The Bureau of Medical Services is creating an email alert system to let you know of changes to the Preferred Drug List, among other things. The alert will be emailed to you as soon as a change to the PDL is approved. To sign up, go to www.ghsinc.com, click on MaineCare Pharmacy Services on the left. Scroll down to GHS Pharmacy Services Newsletter/Alert. They have also created a PDL Tracking Changes sheet which can also be found on the website.

Resolutions Enacted

At MMA's Annual Session held in September, eight Resolutions were presented of which seven were adopted. The Resolutions were on the following subjects: Reducing MaineCare Expenditures Without Reducing Reimbursement to Providers (Rejected), To Advance Medical Liability Reform in Maine, Primary Enforcement Seatbelt Law, Assault Weapons Ban, Maine Centers for Disease Control and Prevention Proposal, International Conflict and Nuclear Weapons, Motorcycle Helmets, and Water Quality in Maine Rivers.

The adopted Resolutions can be found on the MMA website (www.mainemed.com) on the home page under "What's New" or you can call the MMA office at 622-3374 to have a copy mailed to you.

Safe Prescribing Practices

By Joe McVety RPh, MBA and Jackie P. Fournier RN, CS, CHPN

The past two years a national awareness of safe medication practices has occurred. The Maine Hospital Association, the Institute for Safe Medication Practices, The Joint Commission, and hospitals throughout Maine and nationally, have established safe medication practices such as dangerous abbreviations. For the most part safe prescribing practices have expanded into the outpatient setting and Homecare & Hospice serve as an example. However new regulations within the outpatient settings require raised awareness of a need to expand our efforts in safe med practices.

In 2003 the Maine Department of Public Safety mandated that all prescriptions for controlled substances be written on a special prescription pad. The Department of Public Safety moved in this direction in an effort to reduce controlled diversion of substances. This special prescription pad contains water marks which show a "VOID" when faxed or copied. This is ideal for those times you do not want the prescription to be faxed illegally. However in home infusion & hospice settings it is legal to fax a RX for controlled substances. The issue in faxing the RX with the "VOID" is the RX can be difficult to read at times. As practitioners, you can see the need for vigilant safe prescribing practices in this new procedure.

Notable safe prescribing practices are:

1. Concentrated morphine solution should be written in milligrams and not by volume. Some practitioners write "morphine liquid, 5-10ml every 3-4 hrs prn". Since morphine liquid comes in various concentrations there could be a ten fold dosing error with this order, which could be fatal to a patient.
2. Avoid abbreviations which could be misinterpreted; examples:
   - A. ug for microgram and being read as mg
   - B. AD, AS, AU for eye being read as OD, OS, OU for ear
   - C. u for unit being read as a 0, such as 10u insulin and 100 units being administered.
   - D. cc for cubic centimeters being read as u for units. Use ml instead.
3. Do Not Use a trailing zero after a decimal point (1.0mg), being read as 10 mg. Write 1 mg.
4. Leading decimal zero before a decimal dose (0.5mg) to avoid interception of 5mg. Write 0.5mg.
5. Always write out the whole drug name.
   - A. ARA A for vidarabine being interpreted as cytarabine (ARA C)
   - B. AZT for zidovudine (Retrovir) mistaken as azathioprine or aztreonam
   - C. DTO for paregoric being interpreted as opium
   - D. MgSO4 for magnesium sulfate read as morphine sulfate
   - E. T3 for Tylenol #3 being read as liothyronine
   - F. Writing IV Vanc for IV Vancomycin being read as Invanz

These are just a few of the safe prescribing practices, which will ensure our patients remain medication error free. Kennebec Professional Pharmacy and HealthReach have avoided any significant medication errors, hence safe med administration for the patients we serve. With your assistance we will continue to do so. Thank you for your continued assistance in making safe med practices a gold standard in patient care.

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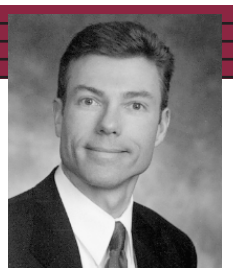
LEGISLATIVE UPDATE



Andrew MacLean, Esq.

MMA and Allies Will Seek to Improve Medical Liability Climate in Maine in 122nd Maine Legislature

Happy Holidays! The 2004 campaign season ended on November 2, 2004 and the 122nd Maine Legislature is organizing for its First Regular Session that will begin just after the New Year. At its meeting on November 9, 2004, the MMA Legislative Committee finalized its agenda for the next two years – the agenda will focus on two key initiatives: improving the medical liability climate in Maine by enacting a cap on non-economic damages in medical malpractice actions and raising MaineCare (Medicaid) rates to the level of Medicare reimbursement for physicians.

All 186 of Maine's legislative seats (151 House and 35 Senate) are contested every two years so all were up for grabs on November 2, 2004. While several recounts must be finished, the Democratic Party appears to have maintained control of both the State House and Senate following the election. As in the 121st Legislature, the Democrats will have a slim 18-17 edge in the State Senate. Four incumbent Democratic Senators and two incumbent Republican Senators lost their re-election bids.

The composition of the House likely will be 76 Democrats, 73 Republicans, 1 Unenrolled, and 1 Green. Eight incumbent Democrats lost their seats and three incumbent Republicans lost their seats. The Democrats control of the House has narrowed from the 121st Legislature by 6 seats. Physicians Thomas Shields (R-Auburn) and Lisa Marrache (D-Waterville) both retained their seats.

You can view the list of apparent Senate winners at: http://www.state.me.us/legis/senate/. You can view the list of apparent House winners at: http://janus.state.me.us/house/122_cand.htm.

House Democrats have nominated John Richardson (D-Brunswick) as their candidate for Speaker of the House. Assuming the Democrats maintain control, Representative Richardson will become Speaker. Representative Richardson is serving his fourth and final consecutive term in the House. He is a lawyer and is married to an obstetrician-gynecologist. House Democrats also have selected Glenn Cummings (D-Portland) to be Majority Leader and Robert Duplessie (D-Westbrook) to be Majority Whip. The three other caucuses are expected to pick their leaders during the week of November 15th.

At the MMA Legislative Committee meeting on November 9, 2004, approximately 30 physicians from the Committee, *the Coalition for Health Care Access & Liability Reform,* and state specialty societies discussed the election results and the range of issues likely to face physicians and others in the medical community in the 122nd Legislature. Anticipating a 2006-2007 biennial budget "structural gap" of approximately $733 million and further Dirigo health care reform initiatives, the Committee has elected to submit three pieces of legislation for consideration in the next two years:

- *Medical liability reform.* The core of the bill will be a $250,000 cap on non-economic damages in medical malpractice actions, but it may include other elements as well such as strengthening the pre-litigation screening panels.
- *MaineCare reimbursement rates.* The bill will seek to increase Maine's Medicaid reimbursement rates for physicians to match Medicare rates.
- *Capital Investment Fund.* The bill will propose an extension of the July 1, 2007 sunset clause in the provision of the Dirigo Health legislation that sets aside 12.5% of the Capital Investment Fund, the annual limit on spending in the certificate-of-need program, for non-hospital projects.

During the legislative session, the MMA publishes, by e-mail, a weekly legislative update called "Political Pulse." To subscribe, go to www.mainemed.com and visit the Legislative & Regulatory Advocacy section of the site. You will find more information about the 122nd Maine Legislature on the web at: http://janus.state.me.us/legis.

The MMA welcomes your participation in our legislative advocacy activities, including participating in our weekly conference calls during the legislative session. For more information, contact Andrew MacLean, Vice President & General Counsel, at amaclean@mainemed.com.

Dirigo Health Update: *DirigoChoice*

The health insurance product being offered through Anthem was the subject of a four week marketing campaign in November. As of October 29, over 4,000 quotes had been sent out by Anthem and over 1,000 individuals had enrolled for coverage beginning January 1, 2005. Most of the enrolled are from the ranks of the self-employed, but 27 small businesses have covered their employees and 21 additional small businesses (defined as less than 50 employees) are known to be preparing applications. Dirigo Health staff hopes to have 10,000 persons enrolled by January 1.

Open enrollment for individuals will begin in February 2005, with coverage for benefits being available in April 2005.

Commission to Study Maine's Hospitals

The Commission's reporting date has been extended to January and public hearings will be held on a draft report to be issued in early December. Watch for information in Maine Medicine *Weekly Update* for information on the draft and the hearings.

Issues likely to be included in the report are administrative streamlining, standardized reporting, mandatory regionalization, certificate of need, insurance rule chapter 850, antitrust and collaboration/consolidation.

D. Joshua Cutler, M.D., a Portland cardiologist and Lewis Hanson, D.O., a family physician practicing in Portland are the two physicians on the nine-member Commission which was appointed by Governor Baldacci.

Maine Quality Forum (MQF)

The Forum's Director Dennis Shubert, M.D., has aggressively pursued a goal of providing more and better data to Maine's consumers. Toward that end, the Forum's website (www.mainequalityforum.org) is now available to the public and has been the subject of much discussion. MMA members are encouraged to access the site and review the 32 charts of information. While individual physicians are not identified, it is not particularly difficult to indirectly identify physicians in some of the geographic areas.

MMA and MHA have policy statements on the data which are linked to the web-site. A subcommittee of the MQF Advisory Committee, chaired by Jan Wnek, M.D., is preparing a list of performance indicators that may eventually be an important tool for Maine's physicians.

Health Systems Development Advisory Council

This Council is charged with preparing a new State Health Plan by July 1, 2005. A "tough choices" campaign is being developed to receive input from various segments of the public. "Town meetings" in Portland, Lewiston and Brewer are being scheduled in March to evaluate the public's priorities regarding health care. As of this writing, controversy has arisen regarding the intended use of an "invitation only" approach to the sessions.

MMA uses the vehicle of Maine Medicine *Weekly Update* as the primary communication to members about Dirigo Health and its various elements. If you are not currently receiving this communication, send your email address or fax number to Lisa Martin at lmartin@mainemed.com or call her at 622-3374.

Ethics Note: *Sexual Misconduct*

Recently, the local news media covered a story about a Maine health care practitioner who allegedly became involved in a sexual relationship with one patient, or perhaps even more than one. While the dangers of such conduct are evident to most practitioners, it is useful to review and remember the current ethical and legal guidelines on this subject. The AMA Code of Medical Ethics defines sexual misconduct as sexual contact that occurs *concurrent with* the physician-patient relationship in Opinion 8.14, *Sexual Misconduct in the Practice of Medicine.* The Code expands on this guidance by discussing sexual or romantic relations with key third parties such as spouses or partners, parents or guardians, or proxies in Opinion 8.145, *Sexual or Romantic Relations between Physicians and Key Third Parties.* The two physician licensing boards have adopted an administrative rule on sexual misconduct, called Board of Licensure in Medicine/Board of Osteopathic Licensure Rule Chapter 10, *Sexual Misconduct.* You can read this rule online at: ftp://ftp.state.me.us/pub/sos/cec/rcn/apa/02/373/373c010.doc. You can view the ethics opinions on the AMA web site at http://www.ama-assn.org/apps/pf_online/pf_online. Go to "Ethical Opinions" and then "E-8.00, Opinions on Practice Matters."

Maine medicine

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