NOVEMBER/DECEMBER 2008

Maine medicine

MAINE MEDICAL ASSOCIATION

IN THIS ISSUE

More photos from MMA's 155th Annual Session

A. Marshall Smith, MD with Lawrence Mutty, MD, and William Strassberg, MD after receiving the Mary Floyd Cushman, MD Award for Humanitarian Service

President William Strassberg, MD presented Robert Keller, MD with the President's Award for Distinguished Service

Norman Rosenbaum, MD, 50-year pin recipient

There were six recipients of 50-year pin awards, recognizing the 50th anniversary of their medical school graduation and honoring their medical careers. Two recipients, Edgar Caldwell, MD and Charles Smith, MD, were shown in the September/October issue of *Maine Medicine* receiving their 50-year pins, the other four 50-year pin recipients are shown here with Patricia Bergeron and Gordon Smith, Esq., EVP, MMA.

50 years

Noel Goodman, MD, 50-year pin recipient

Peter Webber, MD, 50-year pin recipient

Russell Briggs, MD, 50-year pin recipient

Election 2008 Recap: Democrats Make Gains in Maine & Washington - 124th Maine Legislature Takes Shape

Andrew MacLean, Esq.

Governor John Baldacci (D) prepares his last biennial budget proposal for presentation to a Maine legislature that remains in Democratic control with apparent gains in both the Senate and House. The MMA Legislative Committee, under the leadership of Samuel P. Solish, M.D. and Lisa D. Ryan, D.O., plans agenda for the new legislature.

On the day after the historic 2008 elections, the MMA is assessing the political landscape for organized medicine in Washington, D.C. and Augusta for the next two years. President-elect Barack Obama's strong win combined with Democratic gains of at least 5 seats in the U.S. Senate and 18 seats in the U.S. House mean that Democratic leaders in Washington have the opportunity to make progress on the significant issues that confront our health care system. The partisan composition of Maine's congressional delegation remains the same with incumbent Senator Susan Collins (R) and 2nd District Congressman Mike Michaud (D) easily winning their re-election efforts and former Democratic State Senator Chellie Pingree defeating Republican Charlie Summers for the 1st District seat formerly held by Tom Allen (D).

Governor John Baldacci, midway through his second term, was not on the ballot this year and undoubtedly has spent much of the fall working on his last biennial budget proposal during a turbulent time for our economy that has resulted in a potential budget gap in the current fiscal year of approximately $110 million and in the next biennium of between $500 and $800 million.

All 186 seats in the Maine legislature (151 in the House and 35 in the Senate) were on the ballot on Election Day. While election results are not final and a number of recounts are likely, it appears that the Democrats will extend their 31 vote majority by 6 in the House (96 Democrats, 54 Republicans, 1 Unenrolled) and could extend their 1-vote margin in the Maine Senate by at least 4 (20 Democrats, 13 Republicans, 2 races still undecided) and maybe more votes, depending upon the outcome of close races in Senate District 18 (Franklin County) between Representative Walter Gooley (R) and challenger former Maine Senate Democratic staffer Ann Woloson (D) and in Senate District 34 between incumbent Senator Roger Sherman (R) and challenger Representative Jacqueline Lundeen (D). Senator Lisa T. Marrache, M.D., a family physician from Waterville and one of two physicians in the last legislature, appears to have retained her seat, but first term Republican House member Robert Walker, M.D., a radiologist from Lincolnville, appears to have lost his re-election bid. Linda Sanborn, M.D., a family physician from Gorham, appears to be the winner in House District 130, a part of Gorham.

Although some legislative leadership races still are underway, Representative Hannah Pingree (D-North Haven) and Senator Libby Mitchell (D-Kennebec) have no opposition in their bids for Speaker of the House and President of the Senate respectively.

The 124th Maine Legislature will be inducted in early December and will begin its work during the week after New Year's Day.

Ballot Question 1, the "People's Veto" of the alternative funding mechanism for the Dirigo Health Program (a 1.8% "health access surcharge" and modest tax increases on beer, wine, and flavored soft drinks) appears to have passed with a margin of 64% to 36%, so the Attorney General's Office will defend the litigation challenging the constitutionality of the "savings offset payment" (SOP) while the new legislature again seeks a sustainable funding mechanism for the Program.

The MMA's Legislative Committee is scheduled to meet on Tuesday, November 18, 2008 to review the election results and to discuss the MMA's legislative agenda for the 124th Maine Legislature. In addition to the MMA's legislative agenda, the Committee expects substantial action on health care issues in the new legislature including financial pressure in the MaineCare program resulting from the state budget woes, the fiscal stability of the Dirigo Health Program, and initiatives requiring any minor on a motorcycle to wear a helmet, promoting the medical home concept, and permitting pharmacists to provide certain vaccines.

Please mark your calendar to join the MMA, the Maine Osteopathic Association, and medical specialty organizations for *Physicians' Day at the Legislature* on Thursday, May 21, 2009. Also, the MMA always is looking for volunteers to participate in the *Doctor of the Day Program* at the Maine State House. Please contact Maureen Elwell, Legislative Assistant, at melwell@mainemed.com to sign up.

During the legislative session, the MMA staff provides links to bills for review and comment, updates on the legislature's work, and calls-to-action through our weekly electronic newsletter, *Maine Medicine Weekly Update*. To find more information about the MMA's advocacy activities, visit the Legislative & Regulatory Advocacy section of the MMA web site, www.mainemed.com. 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.

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Welcome

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Stephanie Lash, M.D., President, MMA

President's Corner

At our annual meeting in Rockland this year, the Maine Medical Association voted nearly unanimously to work to overturn referendum Question One concerning the alternative financing for Dirigo, and other health care reforms, which were in part supported by taxes on beverages of choice, most notably a new tax on sugared beverages. In making this decision, we knew we were going up against big business and deep pockets. And as it turned out, our campaign has been outspent by millions of dollars supplied by Pepsi Cola, Coca Cola, Anheuser-Busch and other well-known names in the beverage industry. Pepsi and Coca Cola interests alone contributed over $2 million! In addition to being heavily out spent, as Gordon predicted, the MMA has had to do the majority of the real work to get the word out. Numerous physicians in southern and central Maine have generously given their time to make TV spots, write articles, speak with editorial boards, staff press conferences, and answer question on both TV and radio. In this effort, other interested parties including the AMA, the AARP, members of citizens advocacy groups, some members of the legislature and the public have assisted us. But, while our coalition is large, more than thirty organizations in total, the leadership on this issue has been provided by Gordon and Edith Smith. Their work has been extraordinary. If you want to see how to speak truth to power and to use resources efficiently, you have to look no further than our own home grown Maine advocates. Win or lose, a very heartfelt thanks to Edith and Gordon for all you have done on this campaign to defend the interests of the people of Maine and to have worked so tirelessly to ensure healthcare coverage for all Mainers. Win or lose the MMA can hold its head high. And win or lose I give credit to the Governor, the legislature and the many who have worked so hard to develop Dirigo and the other reforms. These are sincere efforts, which have helped to improve health care coverage for all in Maine. Win or lose, we, the MMA, must continue this work.

Information For Your Patients on Heating/Energy Assistance This Winter

During the most recent MMA Annual Session at The Samoset Resort in September, the MMA General Membership passed Resolution #3, *Addressing Cost Burdens to Patients*. In this Resolution, the MMA committed to provide information to physicians regarding assistance for their patients regarding energy costs as we approach the winter of 2009 in an economic slump.

The principal federal heating assistance program is known as LIHEAP, the *Low Income Home Energy Assistance Program*. As a result of the work of Maine's congressional delegation and others, Maine will get nearly $80 million of the $5 billion being distributed nationwide, a 72% increase over the $46 million Maine received in 2007. Maine has increased eligibility for the program from 170% of the federal poverty level (FPL) to 200% ($20,800 for an individual), or in some cases for the very young or very old to 230%. The average LIHEAP benefit will be $940 this year up from $757 last year. Your local community action program (CAP) processes the applications for the benefit. You can find a list of the CAP agencies in the state on the Maine State Housing Authority web site, www.mainehousing.org.

The MMA has been participating in a regional group in the capital area organized by the United Way of Kennebec Valley as a forum for assessment of needs in the community and for a determination of resources available. The following are some key points from the work of this group. While some of this information is specific to southern Kennebec County, you may have similar agencies or resources in your area.

- The Kennebec Valley CAP agency may be reached at 800-542-8227.
- The statewide human services hotline, 211, will have a special track for heating assistance.
- Citizens Energy or 1-800-JOEFOROIL will be available again beginning in January 2009. LIHEAP eligibility makes one automatically eligible for this program that makes 100 gallons of heating oil available.
- The "Keep ME Warm" fund accepts donations from businesses and may be accessed through 211.
- The United Carpenters Union in the Kennebec Valley is making volunteer labor available for winterization; call Wanda at KVCAP.
- The Kennebec County Sheriff's Department is making firewood available for the needy.
- The "Energy Crisis Intervention Program" (ECIP) is a DHHS program that makes a maximum of $400 in heating assistance available for those who have exhausted their LIHEAP benefit.
- Central Maine Powers' (CMP) "Electric Lifeline" low income assistance program is based upon LIHEAP eligibility and has a maximum annual benefit of $600. The number for this program is 800-750-4000. As most physicians probably know, a physician's documentation of a "medical emergency" can delay disconnection for 30 days and this may be renewed 2 times.
- The Salvation Army in Augusta (623-3752) has heat, rent, and electric assistance available for those in eligible communities on a first come, first served basis and the heating assistance typically is 100 gallons at a time.
- Good Will Industries in Augusta (contact Dan, 626-0170) expects to have resources available in January. Good Will will be the agency processing requests for assistance from the United Way of Kennebec Valley Emergency Fund. This fund is intended to be the fund of last resort in the capital area. The "Heat Helpers" cannister campaign in the Augusta area will support this fund and anyone who wishes to make a tax deductible contribution to heating assistance may contact the United Way of Kennebec Valley at 626-3400. United Way agencies in other parts of the state may be engaged in similar efforts.

The MMA will bring you other information about energy assistance as it becomes available. Please encourage your patients not to wait until after business hours or weekends to ask for assistance!

Upcoming at MMA

DECEMBER 3, 2008	Noon	MMA Operations Committee
	2:00pm	Executive Committee
	5:00pm	Budget & Investments Committee
DECEMBER 4, 2008	3:00pm	Quality Counts/Behavioral Integration Advisory Committee
DECEMBER 10, 2008	6:00pm	Payor Liaison Committee
DECEMBER 16, 2008	8:30am	APIC
DECEMBER 17, 2008	11:00am	Patient Centered Medical Home; Working Group
	1:00pm	Payment Reform Group
	4:00pm	Public Health Committee
DECEMBER 18, 2008	4:30pm	Maine Association of Psychiatric Physicians, Executive Committee Meeting
JANUARY 7, 2009	12:00pm	Aligning Forces 4 Quality, Executive Leadership Team
	2:00pm	Quality Counts Board Meeting
JANUARY 13, 2009	4:30pm	Maine Association of Psychiatric Physicians Executive Committee
	6:00pm	Maine Chapter, American Academy of Pediatrics Board Meeting
JANUARY 16-18, 2009	Weekend	Executive Committee Retreat in Jackson, NH
JANUARY 20, 2009	6:00pm	Maine Association of Psychiatric Physicians
JANUARY 21, 2009	9:00am	Patient Centered Medical Home; Planning Group
	11:00am	Patient Centered Medical Home; Working Group
	1:00pm	Physician Payment Reform Committee

Upcoming Specialty Society Meetings

DECEMBER 10, 2008 — The Woodlands – Falmouth, ME
Maine Chapter, American College of Emergency Physicians
6:00pm – 9:00pm
MMA Contact: Anna Bragdon 207-441-5989 or maineacep@roadrunner.com

JANUARY 23-25, 2009 — Sugarloaf Grand Summit Hotel
Maine Section, ACOG Winter Meeting
Contact: Cindy Croteau 207-662-2749

JANUARY 28-31, 2009 Bethel Inn Resort and Conference Center – Bethel, ME
Downeast Association of Physician Assistants Meeting
MMA Contact: Kellie Miller 207-620-7577 or kmiller@deapa.com

FEBRUARY 5-8, 2009 — Sugarloaf/USA
Maine Urological Association Meeting
MMA Contact: Kellie Miller 207-622-3374 ext: 229 or kmiller@mainemed.com

FEBRUARY 14-15, 2009 — Sugarloaf/USA
Maine Society of Anesthesiologists Meeting
MMA Contact: Anna Bragdon 207-441-5989 or msainfo@roadrunner.com

MARCH 12 - 14, 2009 — Sugarloaf/USA
Contemporary Topics in Orthopedics
www.orthoconference.org
Program Coordinator: Donna Rogers 207-947-8381 ext: 212 or drogers@downeastortho.com

MARCH 20-22, 2009 — Sugarloaf/USA
Maine Otolaryngology Society Annual Winter Meeting
Contact: Rosaleen Moore 207-361-6169

MAY 1, 2009 — Harraseeket Inn – Freeport, ME
Maine Society of Eye Physicians and Surgeons Spring Meeting
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

OCTOBER 2, 2009 — 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 8th Annual Downeast Ophthalmology Symposium)*
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

OCTOBER 2-4, 2009 — Harborside Hotel & Marina - Bar Harbor, ME
8th 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 16-18, 2009 — Jordan Grand Hotel at Sunday River
Maine Chapter of the American College of Physicians Annual Scientific Meeting
MMA Contact: Warene Eldridge 207-622-3374 ext: 227 or weldridge@mainemed.com

Notes from the E VP

Gordon Smith, MMA EVP

While you will hopefully read this article in late November, I am writing it just 24 hours after the election. Whether you are a Democrat or Republican, or an Independent or a member of the Green Party, I think you will agree with me that this election, once again, demonstrates to the world that we live in a free society, where power can shift in 24 hours without a single gunshot being fired. All the harsh rhetoric of the past two years is tossed aside, and suddenly candidates, both the winners and losers, are not only respectful and complimentary of each other, but actually praise their opponents. A remarkable thing. I hope each and every one of you had an opportunity to vote and took advantage of it.

Most of you are aware that I spent quite a bit of time the last few weeks assisting the No on One campaign as we struggled to keep in place the financing package the legislature passed back in April to fund Dirigo and to moderate costs in the individual health insurance market. MMA's position was established as the result of both an Executive Committee vote and the passage of a Resolution adopted at the MMA Annual Meeting in September. Most of the members I have talked with over the past few weeks agreed with this decision and understood the positive public health aspects of taxing beer, wine and soda and dedicating the revenue to health coverage. Obviously the beverage industry disagreed, spending nearly $4 million to get the tax repealed. It was an uphill battle for us, given the discrepancy in resources and spending, and because of the difficult economic times. But we are proud of the campaign we waged and now look forward to working with the Governor, the Legislature and Maine's business community to continue to look for alternatives to the "Savings Offset Payment" which the funding will now revert back to.

Many of Maine's physicians stepped forward to be spokespersons for the campaign, but I want to specifically thank five of our physician-leaders who stepped up to the plate, notwithstanding that the No on One position was not a popular one. Amy Madden, M.D., Jo Linder, M.D., Stephanie Lash, M.D., Lani Graham, M.D. and Lisa Letourneau, M.D. all played important roles in the media and they were all committed and articulate in their remarks.

Whether you agreed or disagreed with the MMA position, which was shared by the Maine Academy of Family Physicians, the Maine Chapter of the American College of Physicians, the Maine Chapter of the American Academy of Pediatrics, the Maine Primary Care Association, the Maine Association of Psychiatric Physicians and the Downeast Association of Physician Assistants, I hope you will agree that our effort was another positive example of physician leadership.

MMA has the best members in the world. We never want to disappoint you. While we were sorry not to win on question one, we are proud of the campaign we waged and believe that the focus we put on health care coverage was very positive.

I am always happy to hear from you. Drop me an e-mail to gsmith@mainemed.com.

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.

Classified Ads

Medical Director Sought:

Mercy Hospital in Portland is seeking a **Medical Director** for Mercy Primary Care. At Mercy Hospital and at our locations throughout greater Portland, you'll find more than the latest technology and highly skilled doctors, nurses, physician assistants, therapists and support staff. You'll also experience the special approach we take to healthcare, recognizing each patient as a whole person-body, mind and spirit.

FMI please contact Ed de Oliveira @ 207-553-6092 or via email deoliveirae@mercyme.com. www.mercyhospital.org

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.

Northern New England Poison Center

In Maine, New Hampshire and Vermont, the Northern New England Poison Center provides immediate treatment advice for poison emergencies. They also provide information about poisons and poison prevention, twenty-four hours a day, seven days a week.

POISON Help™
1-800-222-1222

Joint Commission Alert: Stop Bad Behavior Among Health Care Professionals

Health care is a high-stakes, pressure-packed environment that can test the limits of civility in the workplace. A new alert issued by The Joint Commission warns that rude language and hostile behavior among health care professionals goes beyond being unpleasant and poses a serious threat to patient safety and the overall quality of care. Intimidating and disruptive behaviors are such a serious issue that, in addition to addressing it in the new *Sentinel Event Alert*, The Joint Commission is introducing new standards requiring more than 15,000 accredited health care organizations to create a code of conduct that defines acceptable and unacceptable behaviors and to establish a formal process for managing unacceptable behavior. Several medical staffs in Maine have previously adopted such policies and attorneys at the Maine Medical Association can assist your medical staff in drafting policies that properly balance first amendment rights and institutional needs.

The new standards take effect January 1, 2009, for hospitals, nursing homes, home health agencies, laboratories, ambulatory care facilities, and behavioral health care facilities across the United States. Health care leaders and caregivers have known for years that intimidating and disruptive behaviors are a serious problem. Verbal outbursts, condescending attitudes, refusing to take part in assigned duties and physical threats all create breakdowns in the teamwork, communication and collaboration necessary to deliver patient care. The Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator. To help put an end to once-accepted behaviors that put patients at risk, The Joint Commission *Sentinel Event Alert* urges health care organizations to take action.

Past issues of *Sentinel Event Alert* can be found at **http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm.**

Questions should be addressed to Peter Angood at pangood@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

2009 OIG Work Plan and RAC audits

It's time for Halloween and among other things, that means the Office of the Inspector General (OIG) has published their workplan for 2009. The work plan lists activities that the OIG plans to audit and investigate as it relates to programs of the Department of Health and Human Services. The sections specific to the Centers for Medicare & Medicaid Services (CMS) include Hospitals, Home Health, Nursing Homes, Hospice, and Other Medicare Services (i.e. lab, and ambulance) in addition to Physicians and other Health Professionals.

Highlights for the Physician and Provider services include:

- Place of Service Errors
- E/M Services During Global Surgery Periods
- Medicare Practice Expenses Incurred by Physician Specialties
- Services Performed by Clinical Social Workers
- Outpatient Physical Therapy Services Provided by Independent Therapists
- Medicare Payments for Colonoscopy
- Physicians' Medicare Services Performed by Non-physicians
- Appropriateness of Medicare Payments for Polysomnography
- Long-Distance Physician Claims Requiring a Face-to-Face Visit
- Geographic Areas With a High Density of Independent Diagnostic Testing Facilities
- Patterns Related to High Utilization of Ultrasound Services
- Medicare Payments for Chiropractic Services Billed With the Acute Treatment Modifier (AT)
- Physician Reassignment of Benefits
- Medicare Payments for Unlisted Procedure Codes
- Medicare Billings With Modifier GY

Additionally, CMS has begun their Recovery Audit Contractor (RAC) program. By 2010, CMS plans to have 4 RACs in place. Each RAC will be responsible for identifying overpayment and underpayments in approximately ¼ of the country. On October 6, 2008, CMS announced the names of the contractor that will handle the audits in Region A (initially working in Maine, New Hampshire, Vermont, Massachusetts, Rhode Island and New York)--**Diversified Collection Services, Inc.**

The goal of the recovery audit program is to identify improper payments made for services provided to Medicare beneficiaries. Improper payments may be overpayments or underpayments. Hospitals, physician practices, nursing homes, home health agencies, durable medical equipment suppliers and any other provider or supplier that bills Medicare Parts A and B may be reviewed.

The RACs will be paid on a contingency fee basis on both the overpayments and underpayments they find. Each contractor plans to hold Town Hall type meetings in each state with health care providers and CMS staff and representatives

There is some overlap between areas targeted by the 2009 OIG workplan and the focus of the RAC audits. Areas you should review in your practice to ensure correct documentation and coding include:

1. Debridement Coding – Errors in coding for surgical debridement (integumentary codes) versus coding for active wound management (medicine codes)
2. Duplicate Billing – Billing more than once for the same service
3. Stark Violations – Providers referring patients to facilities in which they or their family member has a financial interest
4. Coding for injections in the Physician's office – Incorrect use of codes or units
5. Social Worker Services in the Facility Setting – Medicare Part B does not cover certain social work services that are provided in inpatient settings –hospital/skilled nursing facility
6. Psychiatric Services – Overutilization of outpatient services
7. Medical Necessity – Documentation of evaluation and management services do not support level of service billed
8. E/M services billed during the Global Period – Modifier 24 used with services that should have been included in the global period
9. Place of Service Errors – Physician services performed in the outpatient and/or ASC setting but being billed with an office place of service
10. Incident to Errors – Non-physician providers (PA/NP) performing services for a physician but not following billing guidelines related to patient status or supervision

For more information, feel free to contact The Coding Center at 888-889-6597 or check out the following websites:

2009 OIG Work plan: http://oig.hhs.gov/publications.html.

CMS RAC Web site: www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf.

Evaluation report on the three-year RAC demonstration: http://www.cms.hhs.gov/RAC.

Medical Mutual Insurance Company of Maine Risk Management Practice Tip:

Pediatric Emergency Care

Physician practices that provide care to infants and children need to anticipate a patient may present with a potentially life threatening illness or injury. For a variety of reasons, parents and caregivers may bring a seriously ill or injured child to the physician office instead of the emergency department.

Family practice and pediatric physicians experience emergencies among their patient populations more often than some physicians recognize. Physicians need to ensure appropriate management and stabilization of emergency events encountered in their office. Perceived rarity of office emergencies should not be a reason for a lack of preparedness.

Many providers are misinformed that the availability of emergency equipment and medication in the practice increases liability exposure. In actuality, failure to plan and lack of adequate preparation to provide emergency care may lead to increased liability. The unavailability of potentially life-saving emergency equipment and the lack of proper training can lead to adverse, and sometimes, devastating outcomes. Most practices should consider assessing the most common types of emergency patients seen and adapt their plan to address the events. The importance of being prepared to provide emergency care to stabilize a patient cannot be over-emphasized.

Adequate preparation begins with a thorough office system evaluation to determine the unique characteristics of the office setting and the patients served. Based on this evaluation, a focused plan can be developed that uses strategies designed to meet the specific needs of your patient population based on your resources. The organizational plan for emergency response in the office should include staff roles and responsibilities during an emergency. Include a plan to provide education for all staff on the office emergency response. Conducting mock drills ensures staff learn the response plan and have the opportunity to practice their respective responsibilities.

Emergency Equipment and Medications

Supplies should be readily available to the physician or nurse to secure an airway, maintain respiration and support circulation. This includes the ability to properly administer oxygen. Your evaluation will determine the amount of supplies you will need to have on hand. Enough supplies will be needed to maintain the child until the arrival of EMS.

It is imperative that equipment be maintained in working order and that staff, within their scope of practice, are competent in the use of that equipment. To insure that the equipment is in safe, working condition, the emergency cart should be inventoried on a monthly basis with medications evaluated for expiration dates. Maintain a log indicating the date of review. Insure proper working condition of suction devices, laryngoscopes and O2 canisters.

Summary

Adequate planning and preparation for potential pediatric medical emergencies is necessary in any practice that provides care for children. Failure to plan or practice the response may lead to increased liability exposure. Parents expect that necessary equipment and trained personnel are available at the practice to respond to an emergency event involving their child. Is your office prepared to provide care to that child when they arrive?

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.

Public Health Spotlight

Kellie Miller, Director of Public Health Policy, MMA

The Childhood Immunization Crisis in Maine

On October 1, 2008, Childhood Vaccine Providers were given notice by the MeCDC that as of January 1, 2009 the Maine Immunization Program (MIP) will only supply all recommended vaccines to Vaccines For Children qualified (VFC) children only. At the Maine Immunization Coalition recent Press Conference, the Maine Medical Association, Maine Chapter of the AAP, the Maine Primary Care Association and others shed light on this devastating cut back to the cornerstone of prevention.

VFC qualified children are those patients who are before their 19th birthday and fall into any one of the following categories:

1. Have MaineCare for insurance,
2. Are Native Americans,
3. Have no insurance at all, or
4. Have insurance, but the insurance does not cover the vaccine ("under-insured"). ***This means that according to the federal CDC, "children whose health insurance covers the cost of vaccinations are not eligible for VFC vaccines, even when a claim for the cost of the vaccine and its administration would be denied for payment by the insurance carrier because the plan's deductible had not been met.***

Consequence #1 - The out of pocket expense for an infant at the 2, 4 and 6 month visit will cost approximately $450-$600 at each interval, due to high deductible health insurance plans.

Consequence #2 - Due to these changes by the MIP, every child beginning January 1, 2009 will need to be screened for VFC qualification before the state supplied vaccine is administered – yet another administrative burden added to the primary care providers office.

Larry Losey, MD, Brunswick pediatrician and member of the Maine Immunization Coalition addresses the unraveling of the universal funding mechanism, effective January 1, 2009 at the October 2nd Press Conference in Portland

Consequence #3 – Because of funding shortages and not being able to offer vaccines to **all** Maine children, the MeCDC MIP is not allowed to use the funding mechanism that has allowed them to use HMO funds to provide vaccines for children they insure. The HMO carriers will now incur an increased price for the cost of these vaccines, 30% to 40% more, which will be passed along to premium payers, as the CDC pricing is no longer available to health plans.

This set back in funding will make it very difficult to ensure that all Maine children are fully protected from vaccine-preventable diseases. This trend is troubling in a state where childhood immunization rates are already decreasing. Maine had the highest child immunization rates in the country in 1997, and now has plummeted to having the lowest rates in the New England Region.

The Maine Medical Association Public Health Committee's childhood immunization strategies for action include the following and we ask for your support in mobilizing the medical community:

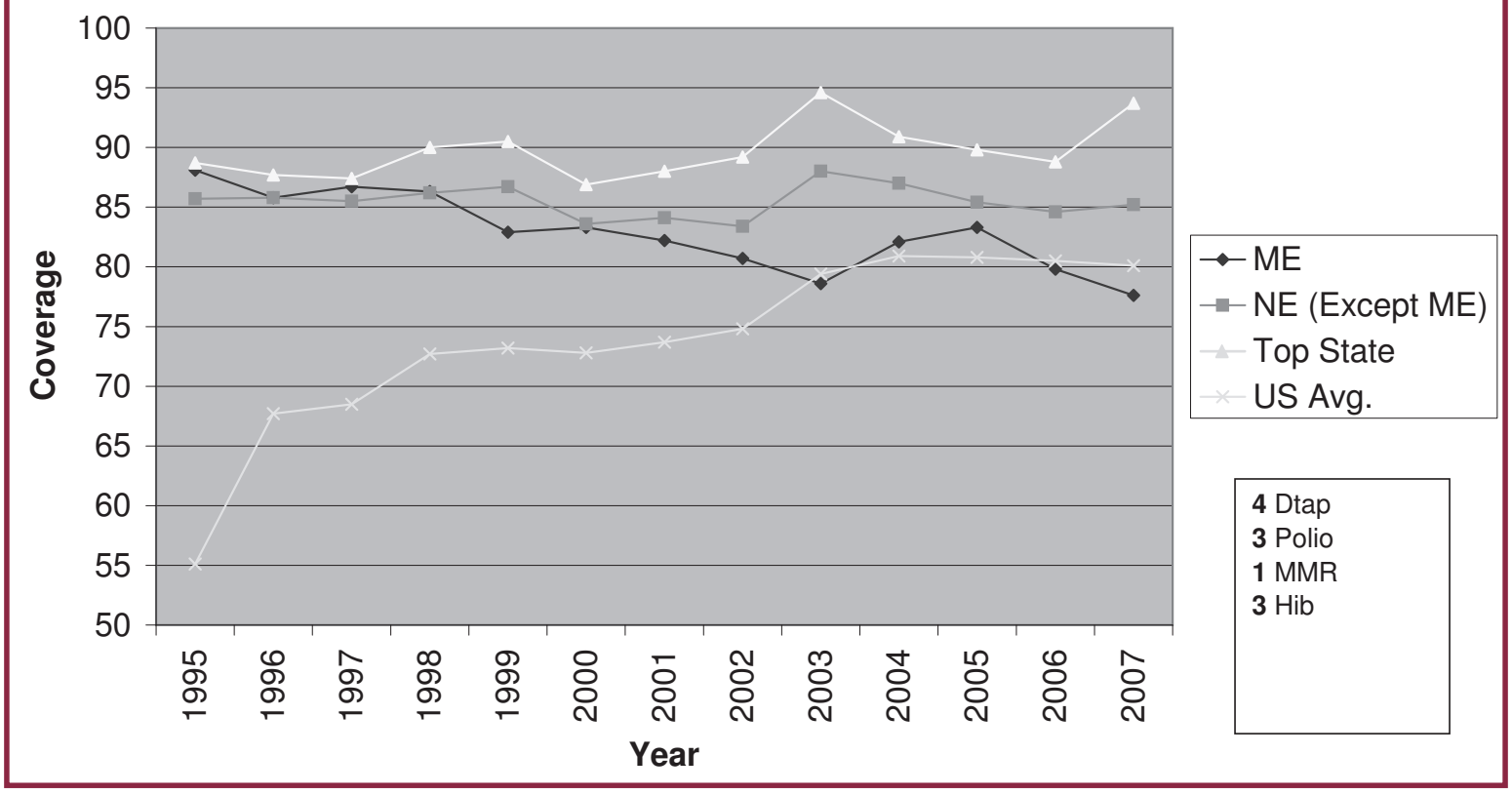
1. Support legislation to increase the state funding level for childhood immunizations to ensure that we reach the 90% immunization rate goal as stated in the Maine State Health Plan 2008-09.
2. Pursue additional legislation to proportionately assess private insurers; to cover all lives up to age 18, including all covered lives in self-insured groups, similar to the New Hampshire legislative strategy.
3. Collaborate with the Maine Immunization Coalition to educate the public on this issue, especially targeting those who have health insurance with high deductibles.
4. Begin discussions with the health plans and the self-insured business community to create a fair and equitable contribution agreement to provide coverage for all children.

MMA President Emphasizes Healthy Weight Initiatives

In other public health news, Stephanie Lash, MD, MMA President is working in conjunction with the Public Health Committee efforts on our Healthy Weight initiatives to provide members with the most useful clinical tools and resources for office use regarding the recognition and treatment of overweight and obesity in our youth. The enclosed insert refers to her Presidential Key Messages and outcomes for healthier communities through MMA member involvement, as well as key links for members to access. Stay tuned for more information in future issues of *Maine Medicine*.

The MMA Public Health Committee will be working diligently on these issues and others during the 124th Legislative Session. Please watch for the unveiling of the public health web page at www.mainemed.com in the near future to receive updates on the childhood immunization issue as well as our healthy weight initiatives. If you have questions or need additional information, don't hesitate to contact Kellie Miller, Director of Public Health Policy at 207-622-3374, ext 229 or kmiller@mainemed.com.

1995-2007 Vaccine Coverage Rate (4.3.1.3)
19-35 Months Old Children
Maine vs. the Nation and the Area



Data/graph provided by the Maine CDC, Immunization Program

2008 MPAF Honor

The **M**aine **P**hysicians **A**ction **F**und (***MPAF)*** and its counterpart the American Medical Association Political Action Committee (*AMPAC*) help ensure that the voice of medicine is heard and effectively represented in the State Legislature and in Congress.

MPAF and AMPAC would like to thank these Maine physicians who supported our political action committee in 2008 and understand its importance to both their *patients* and their *practice.*

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Thank You

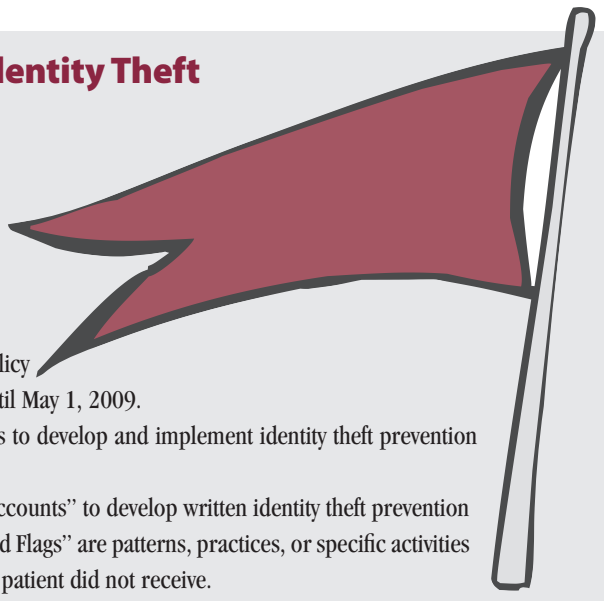
Coalition for the Advancement of Primary Care and Maine Multi-Payer Pilot of the Patient Centered Medical Home

A group of visionary leaders in healthcare in Maine has been meeting since July 2008 to promote the Patient Centered Medical Home in Maine. This group, now renamed the Coalition for the Advancement of Primary Care (CAPC) has come together to provide leadership and guidance to several initiatives aimed at revitalizing and sustaining primary care in Maine. These include the Multi-Payer Pilot of the Patient Centered Medical Home (PCMH). Development of the PCMH Pilot is being led by the Maine Quality Forum, *Quality Counts*, and the Maine Health Management Coalition with support from key stakeholders around the state. Specific details of the Pilot are being developed by a smaller Working Group, which plans to communicate more details about the Pilot within the next month. Initial discussions of the group have resulted in a recommendation that practices wishing to apply for participation in the Pilot will need to meet at least Level 1 designation on the NCQA Physician Practice Connection – Patient Centered Medical Home tool. We plan to identify 10-20 primary care practices from around the state to participate in a 3-year pilot in which they will be paid an enhanced rate for providing value-added primary care services. Details of the alternative payment model are being worked on by a sub-group of payers and employers. Another sub-group is developing the details of how we will engage practices and how the pilot project will be run.

If you are interested in the PCMH model but are not sure where your practice would score on an assessment of medical home functionality, you may want to consider conducting a practice self-assessment, the Medical Home-IQ (MHIQ), a free on-line tool available at www.transformed.com/MHIQ/welcome.cfm. Click on the Medical Home IQ link to start the assessment.

Look for regular updates on the PCMH Pilot and the work of the Coalition for the Advancement of Primary Care in e-mails and newsletters from the Maine Medical Association, the Maine Osteopathic Association, Maine Academy of Family Physicians, Maine Chapter of the American College of Physicians and Maine Chapter of the American Academy of Pediatrics, or check the "News" section of the *Quality Counts* website at www.mainequalitycounts.org.

FTC Announces Six Month Delay In Enforcement of Identity Theft "Red Flag" Rule



Brett D. Witham, Verrill Dana, LLP, Health Law Group and Health Technology Group (bwitham@verrilldana.com)
Alistair Y. Raymond, Verrill Dana, LLP, Business Law Group (araymond@verrilldana.com)

On October 22, 2008, the Federal Trade Commission ("FTC") issued an Enforcement Policy Statement announcing that it will delay enforcement of the new identity theft "Red Flag" rule until May 1, 2009. This six-month delay in enforcement is intended to allow additional time for affected industries to develop and implement identity theft prevention programs and for the FTC to conduct further education and outreach.

The "Red Flag" rule 16 C.F.R. § 681 requires "Creditors" that offer or maintain "Covered Accounts" to develop written identity theft prevention and detection programs to identify, detect, prevent, and respond appropriately to Red Flags. "Red Flags" are patterns, practices, or specific activities that indicate possible identity theft; such as a patient complaint about a bill for services that the patient did not receive.

A "Creditor" is a person who "regularly extends, renews, or continues credit," including the right to purchase property or services and defer payment. The FTC's current interpretation of "Creditor" is very broad. According to one FTC attorney, a Creditor includes anyone who regularly provides services without requiring immediate payment. A "Covered Account" is also defined broadly, and includes "(1) an account primarily for personal, family, or household purposes, that involves or is designed to permit multiple payments or transactions, or (2) any other account for which there is a reasonably foreseeable risk to customers or the safety and soundness of the creditor from identity theft."

The FTC expressly references health care and medical identity theft in its Red Flag guidelines and many health care providers may fit the definition of a Creditor that offers or maintains a Covered Account simply by permitting patients to pay for services by means of payment plans, third party insurance payments or monthly invoices. Although a "one-time" transaction might not constitute a Covered Account, a typical patient account that results in debt or provides for multiple transactions or payments probably does. Many health care providers, however, are not aware that they may be subject to the Red Flag rules by virtue of the expansive definition of "Creditor." In September, the American Medical Association requested clarification from the FTC regarding the interpretation of the term "Creditor." The FTC has not responded to the AMA's request as of the submission date of this article.

The FTC requires a Creditor to periodically determine whether it offers or maintains Covered Accounts. If a Creditor offers or maintains a Covered Account, it must institute an identity theft prevention and detection program to address the risks of identity theft. The program must include reasonable policies and procedures to (1) identify Red Flags and incorporate them into the program, (2) detect and respond appropriately to Red Flags, and (3) periodically update the program. In addition, Creditors must ensure that service providers (such as third-party billing agencies) have reasonable programs for detecting, preventing, and mitigating the risks of identity theft.

Fortunately, the Red Flag rules allow for "flexible implementation." For example, programs can utilize policies and procedures that are "reasonable" in light of the Creditor's activities, the types of Covered Accounts, and the risk of identity theft. The FTC has stressed that programs do not necessarily need to be complex or technology-driven. In fact, a health care provider may incorporate existing policies, procedures, and technology.

With identity theft an increasing concern in the health care industry, health care providers should consult with their legal counsel to ensure that they are prepared to meet the requirements of the FTC's Red Flag rule before the new enforcement date.

Maine Public Employees Retirement System (MainePERS) Medical Board Physician Recruitment

The MainePERS is seeking additional consulting physicians to join our Medical Board. We are particularly interested in physicians with certifications in internal medicine, orthopaedics and neurology. MainePERS administers a disability retirement program for eligible members. The primary purpose of the MainePERS Medical Board is to review medical records of adults who are applying for disability benefits, and to advise the System on the types and status of the applicant's conditions. A team of Specialists, who coordinate the administrative case management aspects of the program, assists the Medical Board. The Medical Board consists of retired, semi-retired and active practice physicians representing internal medicine, psychiatry, cardiology, orthopaedics, otolaryngology, neurology and occupational medicine.

Consulting physicians receive records a week in advance for review and analysis. Medical Board meetings are scheduled on Thursdays at MainePERS Augusta office. Reimbursement on an hourly basis includes case review, travel and board attendance time.

Physicians interested in exploring this opportunity are encouraged to contact MainePERS directly:

Marlene McMullen-Pelsor
MainePERS
46 State House Station
Augusta, Maine 04333-0046
Marlene.McMullen.Pelsor@mainepers.org
207-512-3100
800-451-9800

Committee on Loan and Trust Administration Approves Loans to Maine Medical Students

The Maine Medical Education Foundation is a 501(c)3 entity designed to loan funds to Maine residents enrolled in or accepted by approved medical schools. The MMEF Committee on Loan and Trust Administration, chaired by Dr. Mark Bolduc of Waterville, met on Wednesday, July 9, 2008 to review 57 loan applications. Listed below are students who will be receiving loans from the MMEF this year.

Congratulations!

MMEF LOAN RECIPIENTS	MEDICAL SCHOOL
Laura Amar-Dolan	Dartmouth
Jonathan Ashcroft	St Georges University
Catherine Avener	UVM
Lewis Barnett	UNE
Angus Beal	UVM
Christopher Bloomberg	UNE
Aaron Bos	UVM
Jonquille Bouchard	UNE
Michael Patrick Bowley	Boston University School of Medicine
Jodi Brown	Mid Western University-Azcom
Kenneth Christian	UVM
Jacob Crothers	Tufts
Myra Cyr	UNE
Alison Daigle	Lake Erie College of Osteopathic Medicine
Rosamund Davis	UVM
Jessica Deane	UVM
Sarah Decker	Dartmouth
William Demmons	Saba University
Adam Duquette	UNE
Theodore Elsaesser	UVM
Emily Estell	UNE
Mellory Giberson	UVM
Megan Greenleaf	UVM
Judith Griffin	Columbia University
Ryan Guay	UNE
Elizabeth Hewett	Dartmouth
Brett Hiendlmayr	Ross University School of Medicine
Edward Hunt	St Matthews
Zahraa Ibrahem	St Matthews
Stephen Kelleher	Yale
Danae Kershner	UNE
Michael Larochelle	UVM
Nicholas Larochelle	UVM
Brandon Libby	Dartmouth
Anna Liberatore	UVM
Brian MacLaughlin	Georgetown University
John Martel	UVM
Leah Morey	Tufts
Matthew Morgan	UNE
Lindsey Nadeau	UVM
Emily Parent	UNE
Laurel Parker	Tufts
Glen Poisson	St Matthews
Dwight Pringle	Jefferson Medical College
Heather Robbins	Tufts
Abigail Sanders	Dartmouth
Jeremy Silver	UVM
Jennifer Steinkeler	Tufts
Jacob Stinson	UNE
Christopher Sweeney	Stony Brook University School of Medicine
Craig Szela	Harvard
Michael Voisine	UNE
Kristen Mae Wagner	UNE
Scott Walmer	UNE
Maria Weinstein	UNE
Lauren Wendell	UVM
Eric Worthing	UVM

MMA wants to hear from you!

Issues or concerns you would like to see addressed by the MMA:

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Please provide your name and telephone number or e-mail address so that we may contact you if clarification or further information is needed.

Telephone:_____

E mail:_____

Return to MMA via fax at 207-622-3332.

Thank You

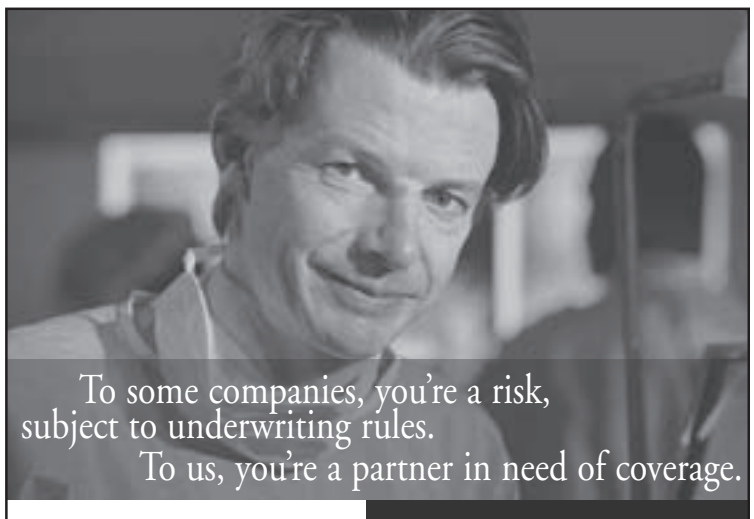
MMA'S Web Site Lists Statewide CME Programs

Looking for seminars to fulfill your continuing medical education (CME) requirements? The Maine Medical Association can help.

Our web site, www.mainemed.com has a page that provides a listing of upcoming CME-accredited programs. Information for each CME activity includes the name, speakers, date(s), location, and contact person for inquiries/registration. Most of the listings are from institutions/organizations that are accredited through the Maine Medical Association as Providers of Continuing Medical Education.

This is another way the Maine Medical Association is looking to serve you, our members, by providing a resource for CME needs. The listing can be found at www.mainemed.com/cme.

Organizations seeking to list their seminars on the MMA web site should contact Shirley Goggin at sgoggin@mainemed.com or call 207-445-2260.



AMA Survey Results Say Doctors Think CMS PQRI Needs Improvement

On October 29, 2008, the American Medical Association (AMA) released the results of its survey of physicians on Medicare's Physician Quality Reporting Initiative (PQRI).

The survey results present the views of physicians who participated in the first year of the PQRI. The voluntary PQRI enacted in 2006 makes physicians and other practitioners eligible for bonus payments of as much as 1.5% of their Medicare charges by submitting quality data for services provided between July and December 2007. Similar incentive payments are available based on the entire year in 2008 and the incentive payment will be increased to 2% in 2009 and 2010.

The survey results include the following:

- 6 out of 10 physicians rated the program "difficult;"
- just 22% were able to download the feedback report for their practice;
- physicians want more emphasis by CMS on early education and feedback;
- physicians want CMS to develop a process for appeal of CMS judgments on inaccurate reporting;
- of those who were able to download their feedback reports, fewer than half found the information instructive;
- of those who asked for assistance from CMS, 59% rated the agency's responsiveness as "none to low;" and
- physicians who began reporting in July 2007 did not receive a feedback report until 12 months later, making it nearly impossible to fix any problems during the second year.

A Medical Group Management Association (MGMA) survey of physicians from September 2008 also revealed strong physician dissatisfaction with the program.

You can read the AMA's press release on the survey results on the web at: http://www.ama-assn.org/ama/pub/category/print/20208.html.

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