NOVEMBER/DECEMBER 2010

Maine medicine

MAINE MEDICAL ASSOCIATION

IN THIS ISSUE

Election Brings Big Changes to State House

Legislators, lobbyists, the media, and indeed the public awoke on November 3rd to learn that Republicans will be in control of the Governorship, the Senate, and the House of Representatives. Several recounts are yet to be resolved, but they are not expected to change control of the legislature. One may have to go back as far as fifty years to recall a time when the GOP controlled both houses of the Legislature. And a combined majority in both the House and Senate means that the Republicans will choose a new Attorney General, Secretary of State, Treasurer, and Auditor, the so-called "Constitutional Officers."

Of the five physicians who ran for the legislature (Drs. Sanborn, Pickus, Liebow, Whalen and Kase), only Linda Sanborn, M.D. was re-elected in District 130 which includes portions of Gorham and Buxton. A retired family physician, Dr. Sanborn will be serving her second term and, certainly from MMA's perspective, it is hoped that she will again serve on the Health and Human Services Committee.

We will have to wait for the dust to settle before speculating too much on what can be expected in a Governor LePage administration and in the 125th legislature. But, one thing is sure, the next four years are going to be quite different from the prior eight.

MMA congratulates all the winners in all the races and we look forward to working with them to improve healthcare in Maine.

Maine Medical Association Asks Congress to Halt Your Medicare Payment Cuts

Medicare reductions set to hit as physicians make participation decisions

The MMA has signed a letter with 117 medical and specialty societies and the AMA calling on Congress to take action during the first week of its lame-duck session in November to avert a Medicare physician access crisis. A copy of the entire letter can be found on the MMA website at www.mainemed.com.

Proposed cuts to your Medicare payments of more than 23 percent go into effect on November 30, with an additional cut of 6.5 percent to follow January 1.

Calling for stability and predictability in Medicare payments, the letter outlines the disruption to your practices this year as Congress on three occasions failed to act in time, and Medicare payments were cut by more than 20 percent. It points out the delays in receiving adjustments when payments resumed.

The letter requests a statutory payment update that lasts at least through 2011, thus providing time for Congress to develop a long-term solution.

Review your options

The next payment reduction is scheduled to occur during the period when you may change participation status in Medicare.

"Hundreds of thousands of physicians will be considering whether they can continue accepting Medicare rates at the same time that massive payment cuts are scheduled to take effect. All of our groups agree that the ultimate solution is to permanently replace the Sustainable Growth Rate (SGR) formula with a system that keeps pace with the cost of caring for our nation's seniors," the letter states.

To assist you in making your Medicare participation decision, the AMA has developed the "Know your options: Medicare participation guide."

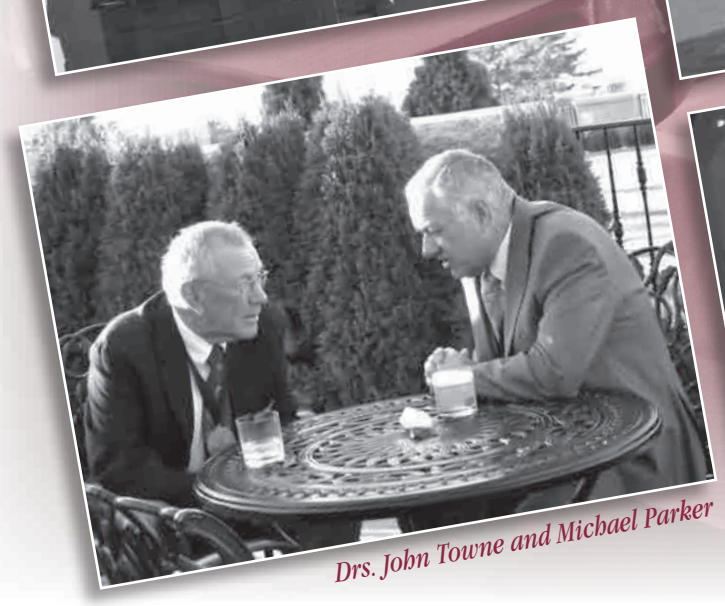
Find the Medicare options kit online at: www.ama-assn.org/go/medicareoptions

157th Annual Session

more photos and captions on page 7

Saturday morning general session

Guy Raymond, M.D. on final stretch of road race



Drs. John Towne and Michael Parker

Patti Bergeron presents 50 year pin to Ken Hamilton, M.D.

Paul Klainer, M.D. recipient of Cushman Award

Erik Steele, D.O., recipient of President's Award for Distinquished Service, with out-going President David McDermott, M.D.

2010 MPAF Honor

The Maine Physicians Action Fund (MPAF) helps ensure that the voice of medicine is heard and effectively represented in the State Legislature.

MPAF would like to thank these Maine physicians who supported our Political Action Committee in 2010 and understand its importance to both their patients and their practice.

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President, MMA

President's Corner

I had a unique opportunity in October to meet leaders in medical education in another country and to help determine a new path for training specialists. I am reminded as I write this column in a hotel room half way around the world from Maine, that despite the political rhetoric being touted by all sides, physicians rise every day to care for our patients and respond to challenges based upon a strong foundation of educational standards and evidence-based medicine.

One hundred years after the Flexner Report, the American Medical Association (AMA) Council on Medical Education commissioned a fresh look at our medical education by the Carnegie Foundation for the Advancement of Teaching. The recently published results of that study call for significant changes that could impact the future of medical education at all levels. We currently use what has been termed the "tea-bag" method of steeping our medical students and residents by immersing them "in hot water" over a specific time period to gain competence. New methods incorporating technology with tried and true techniques for diagnosis and reflection were discussed at a recent conference co-hosted by the AMA and Association of American Medical Colleges (AAMC) in Washington, DC: "New Horizons in Medical Education: A Second Century of Achievement" (for more information: **http://www.medscape.com/viewarticle/730215**).

Why is this important to those of us who are struggling to stay current? Do our patients receive the greatest focus of our attention or does the constant barrage of information distract us? In a recent JAMA (Journal of the American Medical Association) commentary, Dr. Shortliffe points out "it is clear to experienced practitioners that the correct answer is information – in the service of their patients."[1] In the same issue, Drs. Sessions & Detsky suggest, "the consequences for even routine decisions by physicians can be profoundly important… For example, the decision to label a patient as ill, prescribe a class of medication, and choose a specific medication can affect spending and patient well-being for years to come."[2]

Our Maine Medical Association is prepared to help you wade through the constant barrage of information and interpret some of the requirements presented by changes in state and federal legislation. First Fridays offer CME at MMA headquarters; recent and upcoming topics include: "Medical Records (Everything You Want to Know)" November 5 and "Medical Legal Seminar (Consent/Capacity Documentation) on December 3. MMA can, upon request, tailor programs to your group's need on Academic Detailing and Pain Management. Initial consultations for contract review or other personal legal questions are available to members by calling the MMA office. For more information about CME offerings near where you practice or in your specialty, visit our website: **http://www.mainemed.com/.**

In addition, MMA offers a conduit for you to help us challenge the status quo and provide input to those who make policy decisions through our work with those holding positions in government as well as leaders in other healthcare organizations in Maine, New England and the AMA. I welcome your input via email to: president@mainemed.com.

(Endnotes)

1 Shortliffe EH. Biomedical Informatics in the Education of Physicians. JAMA, 304(11): 1227-1228
2 Session SY & Detsky AS. Incorporating Economic Reality Into Medical Education. JAMA, 305(11): 1229-1230

Gordon H. Smith, Esq.

Notes from the EVP

As I write this on November 3rd, the immediate impact of the mid-term election nationally and in Maine is just being felt. Voters certainly wanted change and yet in Maine hedged their bets by electing Republicans to the State House but re-electing Democrats Chellie Pingree and Mike Michaud to Congress. Maine voters rarely have put all their eggs in one basket, and nearly elected their third independent Governor in recent history.

With the election over, physicians face a number of immediate challenges such as delaying the nearly 30% Medicare cut and preparing for the challenges of 2011. I urge members to become active and engaged in public policy and in MMA activities. A perfect opportunity is the chance to serve as the "Doctor of the Day" at the State House. Contact Maureen Elwell at the office if you are interested in this excellent opportunity to observe what your elected representatives and MMA lobbyists do every day when the legislature is in session. Bring your family and make a day of it. Maureen can be reached at 622-3374, ext: 219 or through email at melwell@mainemed.com.

As always, I welcome your feedback. It will be a busy year!

Medical Mutual Insurance Company of Maine Risk Management Practice Tip: *Medical Records Documentation Guidelines*

Accurate, complete, accessible and comprehensible medical record documentation is crucial in providing patients with quality care. Pertinent facts, findings and observations including past and present illnesses, exams, tests, treatments and outcomes must be recorded and accessible to patient care providers. From a professional liability perspective, claims that appear clinically defensible become indefensible with inadequate medical record documentation.

Implement the following steps to facilitate creation of a credible medical record. These recommendations are applicable to both a paper and an electronic medical record (EMR).

I. GENERAL

- To validate correct patient, label each hard copy document or make visible on the EMR computer screen two patient identifiers (age, practice number, date of birth).
- Display medication allergy information in an accessible, prominent location. Record the absence of allergies as "No Known Allergies" to confirm allergy information is assessed.
- Utilize a problem list for chronic/significant conditions.
- Record current medications on an accessible tool. Include the drug name, dose, date prescribed and discontinuation date.
- Include in physician encounter notes:
  - Date
  - Problem statement
  - Health maintenance information
  - Positive and negative system findings
  - Unresolved problems/conditions from prior visits
  - Patient non-adherence
  - Treatment plan
  - Patient education
  - Prescriptions including drug name, dose, instructions
  - Follow-up instructions
  - Follow-up appointment
  - Physician signature
- Complete encounter notes at the time of visit.
- Sign, date the patient completed history form indicating review with the patient.
- Address test result and consultation reports.
  - Note the date reports are received.
  - Initial reports and note date reviewed.
  - Indicate patient notification of results (abnormal and normal).
  - As applicable, note follow-up visit scheduled or other action taken.

II. ABBREVIATIONS

To prevent misinterpretation, limit or eliminate the use of abbreviations. For limited use, create a list of acceptable abbreviations.

III. ADDENDUM AND LATE ENTRIES

A late entry is used when a pertinent entry was not entered. An addendum is a late entry used to clarify or provide information not available at the time of a previous entry.

- Document a late entry as soon as possible.
- Do not add after the record has been released.
- Do not use to state opinions, perceptions, or defenses.
- Note the current date and time. Identify the entry as an "addendum" or "late entry."
- For addendums, state the reason for the addendum, referring back to the original entry by date. Identify any source(s) of information that supports the addendum.

IV. VAGUE TERMS

Always record factual information. Use specific language and avoid vague or generalized language such as "patient doing well," "appears to be," "confused," "stable."

V. CORRECTIONS

- Never make corrections after copies of the original record have been released.
- Do not modify or obliterate erroneous information.
- For paper-based records, correct errors by using the SLIDE rule, e.g., single line, initial, date, error.
- For the EMR, identify new entry as a correction, date/time and make visible to anyone with access.

Medical Mutual's "Practice Tips" are offered as reference information only and are not intended to establish practice standards or serve as legal advice. Seek a legal opinion from a qualified attorney for any specific application to your practice.

Physicians Unite in November to Stop the Medicare Physician Payment Cuts

By Cecil B. Wilson, M.D., President, American Medical Association

Looming Medicare physician payment cuts are once again threatening our patients and our medical practices. A massive cut is scheduled to take effect on December 1, followed by an additional cut on January 1. This combined cut of about 25 percent compromises access to care for seniors and forces physicians to make difficult decisions about the continuing role Medicare can play in their practices.

The decision to limit or stop accepting Medicare patients is often gut wrenching for physicians, but it is one we are increasingly forced to make as Congress' mismanagement of Medicare continues. An AMA poll found that about 1 in 5 physicians overall, and nearly one third of primary care physicians, are already restricting the number of Medicare patients in their practice because of low reimbursement rates and the threat of future cuts. Others are taking a hard look at making changes during the current window for modifying participation status within the Medicare system. The AMA has resources on our web site to help you weigh this difficult decision before the December 31st deadline.

My sincere hope is that by working together we can move Congress to prevent the impending 25 percent cut for 13 months through the end of 2011. This reprieve would allow time for the AMA to work with the new Congress on a permanent fix to the impossibly broken physician payment system that has plagued Medicare for too long.

For this to happen, we must all work together to communicate our united message. The first step was a joint letter to Congress from the AMA, medical societies representing 50 states and the District of Columbia, and 65 specialty societies about the need for immediate action to stop the drastic Medicare payment cuts and protect seniors' access to health care. To continue this momentum we need your help.

Please contact your elected officials in Washington, D.C. and let them know that you support an immediate 13-month stop to the Medicare physician payment cuts, as well as permanent reform going forward. We urge you to call your members of Congress this month to encourage them to act. Your support is especially necessary on November 17th, when physicians across the country will join together in calling their members of Congress to urge them to stop the cut. On this "White Coat Wednesday," physicians will speak with one loud voice about the need for Congressional action now – before the 25 percent cut takes effect at the end of this year. You can contact your elected officials by using the Physicians Grassroots Network hotline at (800) 833-6354.

We must also make sure our patients know the affect these cuts will have on their access to health care. Their voices on this matter are critically important and can be amplified through the AMA's Patient Action Network. The AMA has developed a flyer you can distribute and/or hang in your office to educate patients about this issue. With the first wave of baby boomers entering Medicare in January, this broken Medicare payment system now threatens care for a whole new generation of American seniors if Congress does not act.

Thank you for doing your part to bring reform of the Medicare physician payment system to the forefront. The AMA will continue our vigorous work with Congress on policy that helps you successfully care for Medicare patients.

Upcoming Specialty Society Meetings

December 1, 2010 — Dry Dock Restaurant – Portland, ME
6-9pm ***Maine Chapter, American College of Emergency Physicians***
Contact: Anna Bragdon 207-441-5989 or maineacep@roadrunner.com

February 4-6, 2011 — Grand Summit Resort Hotel – Carrabassett Valley, ME
Maine Urological Association's Annual Winter CME Conference
MMA Contact: Maureen Elwell 207-622-3374 ext: 219 or melwell@mainemed.com

February 12 - 13, 2011 — Sugarloaf Hotel – Carrabassett Valley, ME
Maine Society of Anesthesiologists
Contact: Anna Bragdon 207-441-5989 or msainfo@roadrunner.com

March 4-6, 2011 — Rangeley Inn – Rangeley, ME
Maine Gastroenterology Society Winter Meeting
MMA Contact: Gail Begin 207-622-3374 ext: 210 or gbegin@mainemed.com

March 24, 2011 — Harraseeket Inn – Freeport, ME
Maine State Rheumatology Association, Member Meeting
MMA Contact: Gail Begin 207-622-3374 ext: 210 or gbegin@mainemed.com

April 9, 2011 — Harraseeket Inn – Freeport, ME
Maine Gastroenterology Society, Topics in Gastroenterology Conference
MMA Contact: Gail Begin 207-622-3374 ext: 210 or gbegin@mainemed.com

May 6, 2011 — Harraseeket Inn – Freeport, ME
Maine Society of Eye Physicians and Surgeons Spring Meeting
MMA Contact: Shirley Goggin 207-445-2260 or sgoggin@mainemed.com

May 13-15, 2011 — Harborside Hotel – Bar Harbor, ME
American Academy of Pediatrics, Maine Chapter
Controversies in Adolescent Medicine & NNERPA Meeting
Contact: Aubrie Entwood 207-782-0856 or agridleyentwood@aap.net

Upcoming at MMA

November 29	6:00pm – 8:30pm	MMA Legislative Committee
December 1	9:00am – 12:00pm	Maine Health Management Coalition
	1:00pm - 2:00pm	Aligning Forces for Quality, Executive Leadership Team
	2:00pm – 3:30pm	Quality Counts Executive Committee
December 2	8:00am – 4:00pm	Pathways to Excellence (Maine Health Management Coalition)
	6:00pm – 9:00pm	Maine Association of Psychiatric Physicians
December 3	9:00am – 12:00pm	First Friday Educational Presentation: Medical-legal topics
December 6	4:00pm – 9:00pm	Maine Medical Education Trust; Trustee's meeting
December 7	8:00am – 12:00pm	Medical Group Management Assoc.
	1:00pm – 4:00pm	Lifeflight Board Meeting
December 8	2:00pm – 5:00pm	MMA Executive Committee
	4:00pm – 6:00pm	MMA Public Health Committee
	5:00pm – 9:00pm	Maine Osteopathic Association
December 9	1:00pm – 3:00pm	Office of State Coordinator - HIT Steering Committee
December 15	9:00am – 11:00am	Patient Centered Medical Home, Conveners
	11:00am – 1:00pm	Patient Centered Medical Home, Working Group
	1:00pm – 4:00pm	Aligning Forces for Quality, Patient Family Leadership Team
	6:00pm – 7:30pm	Ad Hoc Committee on Governance
	7:30pm – 9:30pm	DEAPA
January 5	9:00am – 12:00pm	Maine Health Management Coalition
	1:00pm - 2:00pm	Aligning Forces for Quality, Executive Leadership Team
	2:00pm – 5:00pm	Quality Counts Board
January 10	4:00pm – 7:00pm	Medical Professionals Health Program Committee
January 19	9:00am – 11:00am	Coalition to Advance Primary Care
	11:00am – 1:00pm	Patient Centered Medical Home, Working Group
	1:00pm – 4:00pm	Aligning Forces for Quality, Patient Family Leadership Team
January 25	2:00pm – 4:00pm	AF4Q – Pressure Ulcer Project
	6:00pm – 9:00pm	ME Chapter American Academy of Pediatrics
January 26	11:30am – 2:00pm	MMA Senior Section
February 2	9:00am – 12:00pm	Maine Health Management Coalition
	1:00pm - 2:00pm	Aligning Forces for Quality, Executive Leadership Team
	2:00pm – 3:30pm	Quality Counts Executive Committee
February 9	5:30pm – 8:30pm	MMA Membership & Member Benefits
February 10	8:00am – 4:00pm	Pathways to Excellence (Maine Health Management Coalition)
February 16	9:00am – 11:00am	Patient Centered Medical Home, Conveners
	11:00am – 1:00pm	Patient Centered Medical Home, Working Group
	1:00pm – 4:00pm	Aligning Forces for Quality, Patient Family Leadership Team

***All MMA Committee Meetings are now being offered through WEBEX*

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MMA Welcomes Our Newest Corporate Affiliate:

W.B. Mason & Co.

We appreciate their support!

Thanks to 2010 Sustaining Members

Thank you to the following individuals who have shown their support for the MMA's long-term growth by renewing at an additional sustaining membership level.

Russell DeJong, M.D.
Michael Szela, M.D.

Medical Simulation Learning Facility Recently Opened

Maine Medical Center recently opened its Hannaford Center for Safety, Innovation and Simulation, an 18,000-square foot medical simulation learning facility, at the hospital's Brighton Campus in Portland, according to a press release from the center.

The facility includes operating and trauma rooms, a skills lab, where students practice procedures such as stitching sutures or performing colonoscopies, and patient rooms where students can build their patient communications skills and develop a patient and family-centered bedside manner. Actors are used to portray patients, and are trained to behave or respond in specific ways during "patient exams."

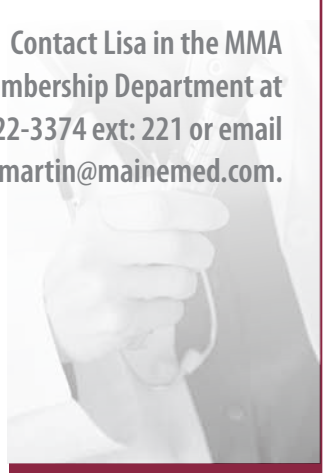
The facility also houses a dozen medical, life-like mannequins that breathe, sweat, blink, bleed and exhibit symptoms of minor or major injury, as well as mild to life-threatening diseases.

The $5.82 million facility was funded in part by a $500,000 donation from The Hannaford Charitable Foundation.

Invite a Physician to Join MMA

Encourage your colleagues to become a 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.



Quality Counts *by Lisa M. Letourneau, M.D., MPH, Executive Director, Quality Counts*

Lisa M. Letourneau, M.D., MPH

November is American Diabetes Month, so thought I would tell you about our efforts to promote improved care and outcomes for Maine people with diabetes. We're all familiar with our state's frightening statistics- more than eight percent of adults have diabetes. Yet those who suffer from the disease receive only 45 percent of their recommended care-less than half of the safe, effective care they need. American Diabetes Month creates an opportunity for us to revisit how we care for people with diabetes and to continue to provide them with tools they can use to manage their health and ensure they are receiving high-quality care.

As you may recall, about a year ago we introduced the Maine Diabetes Pathway, a communication and education tool for people with diabetes that was developed using recommendations from national experts on diabetes care. The Pathway is a collaborative effort of the Maine Aligning Forces for Quality (AF4Q) initiative, which is supported by the Robert Wood Johnson Foundation, along with the Maine Center for Disease Control and Prevention, and numerous diabetes educators, clinicians, and other key stakeholders around the state. The Pathway was created for common use across healthcare and community settings with consistent, action-oriented messages for people with diabetes in order to:

- Empower people with diabetes to build confidence and develop self-management skills;
- Support adherence to evidence-based American Diabetes Association (ADA) treatment guidelines; and
- Encourage patients with diabetes to partner with their care team to achieve best results.

Since its introduction, we've disseminated electronic and print versions of the Pathway brochure to healthcare providers, church and community representatives, diabetes educators, and many others throughout the state. Thousands have used it to get a better understanding of what constitutes quality diabetes care and to foster improved communication between patients and providers.

The Pathway is also posted on the *Quality Counts* website, as part of our Diabetes Resource section (http://www.mainequalitycounts.org/diabetes.html), along with separate PDFs of provider and patient self-care checklists and many other resources. "A Checklist for Your Doctor Visit" outlines specific steps for staying healthy and "A Checklist for You" can be used by patients and providers to work together to get the best possible diabetes care and outcomes. Both checklists can be printed as one-page documents for easy use. Overall, these and the other resources on our website will help to empower people with diabetes to cultivate self-management and be confident when speaking with providers, to encourage a partnership with patients and providers, and to promote quality, guideline-compliant care.

In addition to these resources, the Pathways to Excellence program works with doctors to report on the quality of diabetes care. Learn more about it on the Maine Health Management Coalition website at www.getbettermaine.org. We know that quality care is care that works and is based on the best medical research we have.

This important effort will not succeed without your assistance. We hope you will use and share the Maine Diabetes Pathway with your patients. We can provide print copies at no cost to Maine providers --they may be ordered by sending an email to info@mainequalitycounts.org. Be sure to specify the number requested and your practice setting. Please feel free to download and disseminate the Pathway and checklists electronically as well. We also encourage you to visit the Maine Health Management Coalition website at www.getbettermaine.org and find out more about Pathways to Excellence.

Diabetes is a devastating, often deadly disease. And the numbers of those who suffer from it in our state are increasing. We're glad to have your support in our efforts to promote improved care and outcomes for Maine people with diabetes.

Thank you for your help!

Public Health Spotlight

Jessa Barnard, J.D., Director of Public Health Policy, MMA

The MMA Public Health Committee held a busy and productive meeting on October 13, 2010. Co-chairs, Drs. Norma Dreyfus and Lani Graham led the discussion of ongoing as well as new public health issues facing Mainers.

Top on the Committee's agenda was formulating its priorities for 2010-2011. As it works to solicit and develop new priorities, the Committee is maintaining its current four priorities:

1. Addressing toxins in the environment, including monitoring and participating in the State's implementation of the Act To Protect Children's Health and the Environment from Toxic Chemicals in Toys and Children's Products, enacted in 2008;
2. Immunization financing, including participating in the implementation of the Act to Establish the Universal Childhood Immunization Program, which provides universal immunization coverage to children in the state by purchasing and making available to health care providers every vaccine for childhood immunization that is recommended by the U.S. Center for Disease Control and Prevention Advisory Committee on Immunization Practices;
3. Strengthening the public health infrastructure, including participating in the Statewide Coordinating Council for Public Health and encouraging physicians to become involved in their local public health districts; and
4. Addressing the health effects of climate change through local, state and federal advocacy and education.

The Committee will also continue its work with the Maine Public Health Association's tobacco and obesity policy committees (formerly initiatives of Health Policy Partners) to reduce smoking rates and improve the health and wellness of Mainers. After discussing ongoing initiatives, the Committee discussed emerging public health issues, including brain trauma from sports, changing Maine's consent laws to reduce barriers to HIV testing, and community concerns regarding "smart meters" installed by electric companies.

As they decide whether to replace or add to their priorities, the Committee would like to hear from all specialty societies and individual physicians with their suggestions for the pressing public health issues that the Committee should address in the coming year. Please submit suggestions to Jessa Barnard at 207-622-3374, ext. 211 or jbarnard@mainemed.com. For more information about the Committee's current areas of focus, see: www.mainemed.com/public/.

The Committee's next meeting is scheduled for December 8th from 4:00pm-6:00pm at the MMA offices or via call-in. The Committee will continue its discussion of 2011 priorities and plan for the upcoming legislative session. All interested MMA members are invited to participate. The proposed 2011 meeting dates are: February 9th, April 13th, June 8th, August 10th, October 12th and December 14th.

As a final reminder as we enter the flu season, the Public Health Committee Co-Chairs and Dr. Stephen Sears, the Maine state epidemiologist, encourage all Maine physicians to receive an influenza vaccination this year and to create policies regarding vaccination among your staff.

For more information, visit:
http://www.preventinfluenza.org/profs_workers.asp

From the State Epidemiologist

By Stephen D. Sears, M.D., M.P.H., State Epidemiologist, Maine Center for Disease Control and Prevention

Stephen D. Sears, M.D.

Healthcare Acquired Infections: Everyone's Concern

In 2002, there were 1.7 million hospital-acquired infections (HAIs) and 99,000 HAI-related deaths in the U. S. The sheer magnitude of these numbers created new pressures on hospitals and other healthcare organizations. The increased public awareness has resulted in federal and state mandates for hospital reporting of processes used to prevent infections and the actual rates of infections.

There has been much media coverage of Methicillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile infections acquired in healthcare facilities. More recently, a carbapenemase producing Klebsiella pneumoniae is causing concern among medical personnel. A new NDM-1 (New Delhi metallo-beta-lactamase producer) has recently been reported in three states in the U.S., and is just another example of newly emerging multidrug resistant organism. As an intestinal organism, the NDM gene could spread to other organisms in the gut, and the fear is that it could rapidly spread within the community.

In 2009, the Maine Center for Disease Control and Prevention and the Maine Infection Prevention Collaborative developed an HAI Prevention Plan. The three priority areas identified in the plan are: MRSA-HAI reporting, central line associated bloodstream infections, and surgical site infection prevention. All hospitals in Maine are currently enrolling in the federal National Health Safety Network (NHSN) and all hospitals will be reporting healthcare acquired MRSA infections as of January, 2011.

The Collaborative has been working on specific areas of HAI prevention, namely:

1. hand hygiene
2. antibiotic stewardship
3. preventing central line infections
4. surveillance of multiple drug resistant organisms
5. validation of HAI data collected

Physicians, as part of the healthcare team, can be instrumental in preventing such infections. In particular, the central line insertion practices (CLIP) and the surgical care improvement project (SCIP measures) were instituted to prevent HAIs. It must be remembered that the least expensive and possibly most effective means of controlling HAIs is **handwashing**. With the winter months on the way, handwashing can cause chapped hands, so be sure to apply lotion after washing to keep the skin intact.

Resources:

Klevens, Edwards, Richards, et al. Estimating health care-associated infection and deaths in US hospitals, 2002. Public Health Rep. 2007; 122(2): 160-166.
http://www.cdc.gov/ncidod/dhqp/pdf/ar/MDROGuideline2006.pdf
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Evaluation and Management (E/M) Pitfalls to Avoid

By Laurie Desjardins, PCS, CPC

By now every provider should know the "rules" for coding patient visits (E/M). But every once in a while it's a good idea to remind everyone of some of the nuisances, I mean nuances, of documentation required when billing E/M services.

Chief Complaint (CC)

- Every encounter must include a CC, even inpatient hospital and nursing facility rounding.
- If the CC is not documented or easily inferred from the documentation, the service is not codable or billable.
- CC of follow-up is not sufficient. F/U for Hypertension is okay

History – Be wary of over documentation. Not every visit requires a detailed or comprehensive history. But if it does, accurate documentation is especially important:

Requirements: Detailed History = History of Present Illness (HPI) 4+, Review of Systems (ROS) 2-9, Past Family Social History (PFSH) 1

Comprehensive = History of Present Illness (HPI) 4+, Review of Systems (ROS) 10+, Past Family Social History (PFSH) 3

- All three elements must meet or exceed the level exactly. Failure to document one element of the History appropriately automatically drops the entire History level.

Example: Failure to document 10 ROS drops to the level of History to Detailed (HPI 4, ROS 9, PFSH 3 = Detailed)

Medical Decision Making (MDM) - This is the provider's thought process quantified.

- It's acceptable to document Rule-out or suspected diagnoses (remember it is inappropriate to list these for billing) – they help support the thought process and may add to level of complexity
- 2 of 3 areas of MDM (# of Diagnosis, Data and Risk) must be met or exceeded to reach level of MDM

Data Reviewed is the area where most physicians don't document all that they do.

- Things that add to the complexity of data reviewed but rarely get documented:

Review of chart – It's not enough to indicate the chart was reviewed as there must also be comments on what was pertinent from that review. Or if that isn't done, but history is obtained from someone other than patient and is documented it also adds to the complexity of the provider's overall medical decision making. i.e., If mom in exam room with 12+ year old and provides additional info, that counts. So does husband who provides additional history during his wife's exam.

The Time Factor: If more than 50% of the time spent face-to-face with the patient is for counseling or coordination of care, then time can be used as the determining factor for coding the service.

- Documentation requirements for using Time as the key factor in code selection:
- Indicate the total face-to-face time spent with the patient
- Time spent counseling or coordinating care
- A description of what was discussed must also be detailed

Example of Time Documentation: Place of Service: Subsequent Hospital Visit

Chief Complaint: Discussion of Prognosis

Discussed prognosis regarding metastatic cancer and the apparent failure of treatment with patient and family. Hospice, respite care, pain management, etc…

35 minutes-to-face & on floor with patient and family. Greater than 50% of time spent in discussion above.

Code: 99233

Things to consider when thinking about time:

- Services that are strictly coded based on time include: Discharge Services (both Hospital and Nursing Home), Critical Care
- Services that have no time element include: Emergency Department services, Preventive Care exams

New versus Established Patient

- A new patient is one who has not received any professional services from the provider or any provider of the same specialty in the same practice within the previous 3 years.
- Both the AMA and CMS agree that professional services are defined as "those face-to-face services rendered by a provider and reported by a specific CPT code(s)."

Consultation Confusion

Using Medicare as the gold standard, the documentation requirements for consults are:

- A request for a consultation from an appropriate source and the need for consultation must be documented in the patient's medical record.
- After the consultation is provided, the consultant prepares a written report of his/her findings, which is provided to the requesting physician. Specifically, in the office setting, "the consultation report is a separate document communicated to the requesting physician or qualified NPP." (See the CMS Manual System Pub. 100-4, Ch. 12, Subsection 30.610 for more information.)

Guidelines for Consultation Services

To ensure adherence with the consultation guidelines, consultants should:

- Get the request in writing. If written request is not received, confirm with the referring office what type of service is being requested (consultation or transfer of care).
- Request a copy of the patient's notes from the requesting practitioner prior to the visit, if at all possible, to confirm that the request is documented.
- The 3 R's of the consultation must be documented in the record (Request from whom, Render opinion, Respond in writing).
- Note that a written response must be a letter back to the requesting physician with the exception of a shared medical record such as a hospital chart or shared medical record where a letter is not necessary. (A "cc" at the bottom of the note is generally not considered as sufficient to support the separate documentation as noted by CMS.)

Gordon H. Smith, Esq., MMA EVP, with The Learning Center Team (L-R Laurie Desjardins, PCS, CPC, Jana Purrell, CPC-I, CEMC, Maggie Fortin, CPC, Carol Cherry, RN, BSN, CPC, missing from photo Hayat Lutes, CPC)

- The consultant's office should maintain the above information in the patient's chart since the onus of proof is on the consultant.

Significantly, Identifiable Services

- Every invasive or manipulative procedure includes some element of exam to determine the patient is healthy and can withstand the procedure. If the evaluation is above and beyond this exam then it can be considered "significant, separately identifiable."

How Do You Document "Significant, Separately Identifiable?"

- The note for evaluation and management services should be distinct from the procedure note.
- Evaluation and Management must be greater than the pre/post service work for the minor procedure.
- Example:

Document the visit (e.g. SOAP format)
Part of the assessment and plan will be the decision to do the procedure
Document the treatment/procedure separate from SOAP note
S (History)
O (Exam)
A (Assessment – Medical Decision Making)
P (Plan – Medical Decision Making)
Procedure Note: (minor or mini op note) May be part of the same dictation

Medical Record Documentation (in General):

- Be sure that the record clearly indicates all services performed and the medical necessity for the level of service you are billing for.
- Diagnostic tests should be documented in the patients chart not just on the Super Bill.
- Legibility – if you can't read it how do you expect others to.
- Coder's Mantra: if it's not documented, it was not done (no credit for inference).

All of us in healthcare know that it's all about the patient. Hopefully by keeping some of these simple rules in mind providers will also be paid appropriately for the good care provided.

Stop the Flu - It Starts with You!

Recognizing that influenza infection in health care workers can lead to outbreaks with serious consequences for patients, the Maine Medical Association's Public Health Committee and the Maine Center for Disease Control and Prevention are committed to increasing influenza immunization rates among Maine's medical staff.

The MMA Public Health Committee and MeCDC encourage all Maine physicians to receive the influenza vaccination this year and to create policies regarding vaccination among your staff.

For more information, visit: **http://www.preventinfluenza.org/profs_workers.asp**

Norma Dreyfus, MD, MMA Public Health Committee Co-Chair

Lani Graham, MD, MPH, MMA Public Health Committee Co-Chair

Stephen Sears, MD, MPH, State Epidemiologist, MeCDC

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Andrew MacLean, Esq.

Legislative Update

Election 2010 Recap: Balance Of Power Shifts To Republicans In Augusta; What Will This Mean For Health Care Policy In Maine?

The volatile mood of the electorate was reflected in state races this year. Although it was not clear on election night, by mid-day on November 3rd it was apparent that the Republican Party had won the Blaine House and both chambers of the Maine Legislature. Not since the mid-1960s have Republicans had such control of Maine state government and all those who work in or around the seat of government in Augusta await with great interest the new policymakers and their governing priorities. Members of the 125th Maine Legislature will take office in early December and will begin the work of their First Regular Session the week after New Year's Day. Governor-elect Paul LePage's inauguration likely will take place in early January.

On the day after Election Day 2010, the MMA is assessing the political landscape for organized medicine in Washington, D.C. and Augusta for the next two years. Maine's two members of the U.S. House of Representatives, Chellie Pingree (D-1st District) and Mike Michaud (D-2nd District), withstood challenge with relative ease, but they will take their positions in the next Congress as members of the minority. President Obama and Congressional Democrats struggled to articulate to voters' satisfaction the need for health care reform and to defend enactment of the *Affordable Care Act* (ACA) on a party line vote.

Waterville Mayor Paul LePage (R) succeeded in his gubernatorial bid winning not quite 40% of the vote followed closely by Eliot Cutler (I) and by a greater margin over three other challengers. Republicans will control the Maine Senate in the 125th Legislature with at least 20 seats to 14 seats for the Democrats and 1 unenrolled member. A recount is anticipated in the race between incumbent Senator Lawrence Bliss (D) and challenger Joe Palmieri (R) in Senate District 7, Cape Elizabeth and part of South Portland, but for the moment this seat is one of the Democrats' 14. You can find a list of the apparent Senate winners on the Maine Senate web site at: http://www.maine.gov/legis/senate/senators/candidates/ApparentWinnerList2010.pdf.

The biggest surprise of Election Day was the Republicans' apparent seizure of control of the Maine House of Representatives. As of November 3rd, the composition of the Maine House appears to be 77 Republicans, 73 Democrats, and 1 unenrolled member. Second-term incumbent Linda Sanborn (D-Gorham), a retired primary care practitioner, will be the only physician in the 125th Legislature. You can find a list of the apparent House winners on the Maine House web site at: http://www.maine.gov/legis/house/125cand/apparwin.htm. Assuming the Republicans maintain control of both chambers of the legislature through any possible recounts, they will be in a position to elect four Constitutional Officers – the Secretary of State, Attorney General, Treasurer, and Auditor – for the first time since the 1960s. Members of the Republican caucus also will be jockeying for the two key legislative leadership positions – the Speaker of the House and President of the Senate. These positions, along with caucus leadership positions, committee chairmanships, and committee assignments should be determined some time in December.

The MMA also will be anxious to learn those individuals appointed to key health policymaking roles in the new gubernatorial administration and new legislature and the health care policy initiatives they identify as priorities.

The MMA's Legislative Committee is scheduled to meet on Monday, November 29th to review the election results and to discuss the MMA's legislative agenda for the 125th Maine Legislature. In addition to the MMA's legislative agenda, the Committee expects significant action on health care issues in the new legislature, including a challenging biennial state budget, implementation of the federal *Affordable Care Act* (ACA), and the future of the Dirigo Health Program. During the First Regular Session, legislators are not limited in the number of bills they can submit and the deadline for submission of bills is Friday, December 17th at 4:00 p.m.

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 26, 2011. 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://maine.gov/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.

Discover ICD-10-CM

Cramming might have worked in college or med school; it doesn't bring success in the real world. So, while a deadline of 2013 for ICD-10 seems far away, it's set in the future so you can do proper preparation and training. The best advice from experts: Make use of this time because the deadline will not be moved.

Why retire ICD-9?

The problem was space. The 30-year old International Classification of Diseases known to us as ICD-9 simply ran out of space for new codes, making it unable to accurately reflect advances in medical knowledge or technology. The changeover will impact all physicians in every specialty.

ICD-10, which other countries have used for a long time, has undergone "clinical modification" for use with inpatients in the U.S. Offering thousands of new diagnosis codes, ICD-10-CM has improved descriptions to greatly enhance code selection, though you will routinely use only a small section of the codes available.

How will ICD-10-CM work?

With ICD-9 you likely had one code to describe an encounter; ICD-10 may offer 150 or more codes to allow for greater clinical detail and specificity when communicating diagnoses and procedures.

The Centers for Medicare & Medicaid Services (CMS) already has a mapping system on its website to help you with the transition. Called "general equivalency mappings" or GEM, the system will help you convert an existing ICD-9 code to the new ICD-10 code and vice-versa.

The AAPC, which educates and credentials coders, also has a helpful conversion tool, the ICD-10 Code Translator, on its website at www.aapc.com/ICD-10/codes.

Check them out and start practicing with codes you use frequently.

Consider that you'll need to run both ICD-9 and ICD-10 together on your systems for a while to handle appeals and other things. You may need to turn each system off and on as needed to follow-up on old claims or requests for payback.

While the compliance deadline for ICD-10 if October 1, 2013, you have plenty to do before that date. Here are some suggested steps:

- Conduct an impact analysis
- Contact vendors, trading partners and payers
- Install vendor upgrades
- Conduct internal testing
- Update internal processes
- Do staff training
- Conduct external testing with vendors
- Do it: Convert to ICD-10-CM

Plan now to budget for implementation costs like systems changes, resource materials and training. Start asking your vendors if they will charge for the upgrades and when those upgrades will be available.

Also see the article below for details about a recently announced code freeze set to precede ICD-10 implementation.

Plenty of helpful resources already exist; *Maine Medicine* will pass along more in the coming months.

Learn more about ICD-10 implementation at www.csms.org, click on Practice Info You Need.

MMA wants to hear from you!

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

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

_____

_____

_____

Comments / feedback on what MMA is doing: _____

_____

_____

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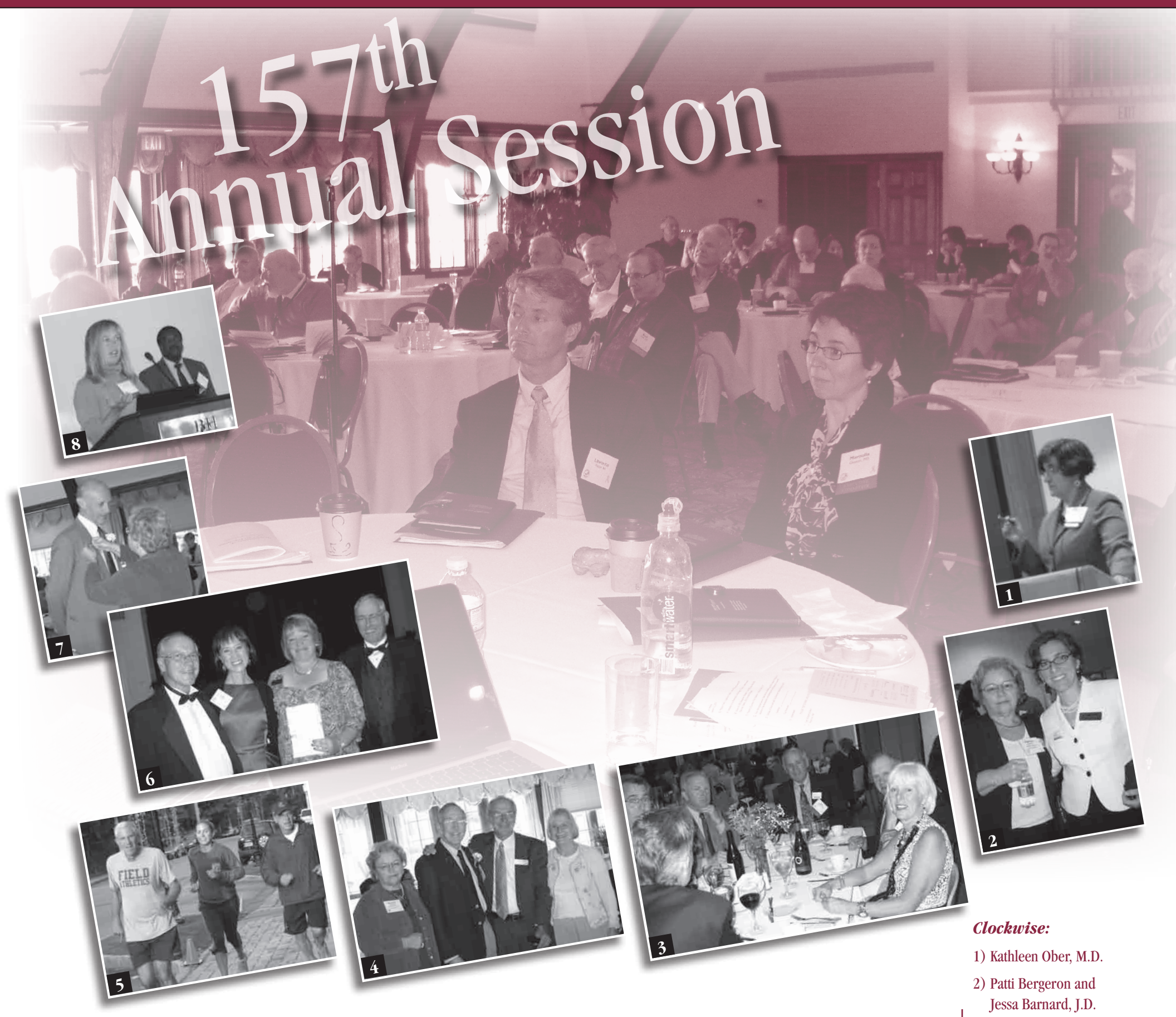
Please provide your name and telephone number or e-mail address so that we may contact you if clarification or further information is needed.

Name: _____ Telephone: _____ E mail: _____

157th Annual Session



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Clockwise:

1) Kathleen Ober, M.D.
2) Patti Bergeron and Jessa Barnard, J.D.
3) Table at Annual Executive Committee Dinner (Nancy Makin, Charles McKee, John Makin, M.D., Ed Kane, Eric Shultz, Andrew MacLean)
4) Patti Bergeron, Burtt Richardson, M.D., Gordon Smith and Gladys Richardson following Dr. Richardson receiving his 50 year pin
5) Josh Cutler, Erica Smith, and Gordon Smith finish Road Race
6) Gordon Smith, Terry Gerritsen, Maureen Elwell and Jacob Gerritsen, M.D.
7) Patti Bergeron pins Dr. Holzworth
8) Lauren Coleman, M.D. opens Saturday CME session

Save the date for the 158th Annual Session

September 9-11, 2011

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MMA/BOLIM

Chronic Pain Project Home Study

Treating Chronic Pain in Maine:
Improving Outcomes, Recognizing Adverse Effects of Medications, Preventing Drug-Related Deaths

Maine physicians and other clinicians struggle to treat chronic pain conditions effectively and compassionately. The task is particularly difficult for primary care providers working in rural areas, who do not have ready access to specialty consultation in chronic pain or addiction medicine. The issue of diversion is perplexing to professionals who have been trained to engage with patients in trusting and healing relationships. This CME offering undertakes to give clinicians useful guidance in both the treatment of chronic pain, including use of opioid medication, along with safeguards to ensure that diversion is kept to a minimum, and issues of addiction, when they co-occur with chronic pain, are recognized and addressed effectively. Due to the generosity of the Board of Licensure in Medicine, there is no cost associated with this course and the Board's funding has recently been continued for an additional year.

This monograph (available at mainemed.com) is estimated to require two hours to read. **The accompanying post-test must be submitted and successfully completed in order to obtain two Category I CME credits. The course will be available until October 1, 2011, after which it will be either updated or terminated.**

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