Georgia College Of Emergency Physicians

EPIC

The Newsletter of the Georgia College of Emergency Physicians

Summer 2008

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or suggestions at:

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Viewpoint from the President

by Maureen Olson, MD, FACEP

Maureen Olson, MD

Inspiration – that's what I'm looking for as I sit here writing this article. I am looking for the "aha moment," the noble single answer to the multitude of complex, perplexing and daunting problems facing emergency physicians. I want to be able to provide you with that one all inclusive single fix. You know the problems and I doubt that you need me to list them for you such as efficiency, door-to-triage time, triage-to-room time, doctor-to-patient time, time to discharge and the ever growing number of patients who leave without being seen; many of whom are probably quite ill. We have Medicaid and Medicare cuts, insurance woes and declining work force issues as well. As I contemplate this I think, when did it all get so complicated? (Marcus Welby didn't seem to have these issues to deal with.) What are the solutions? It became apparent that there is NO "aha moment" that is going to present itself because there is no one single solution. Complex problems are multifaceted and therefore, will require many small seemingly insignificant steps that, when combined, will result in an overall improvement. Team work between physicians, nurses and hospital administrators and all other departments involved in the immediate care of patients will be essential. Everyone will have to be on board and make a commitment to provide their component in a timely and efficient manner. Timely and efficient being defined by each facility depending on their capability. Dr. Peter Viccellio addressed this approach in his lecture at the Georgia College of Emergency Physicians annual meeting in Hilton Head. He presented ways his facility

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Inside This Issue

Reimbursement Report

by D.W. "Chip" Pettigrew III, MD, FACEP, ACEP Reimbursement Committee

Georgia physicians are facing a Medicaid fee cut this summer! It's already the law! For the FY 2009 budget, the Georgia Department of Community Health recommended to our legislators that Georgia physicians receive a raise to 88.5 percent of Medicare's 2007 RBRVS rates for our Medicaid payments. However, during the annual budget approval process and in a final conference committee just before the legislature recessed, the rates for Medicaid fees were reduced to 80 percent of Medicare. That's almost a 10 percent decrease from what was recommended, and over a 5 percent decrease from the previous fee schedule. The faint silver lining for emergency physicians is that, with our 2007 increase in Medicare RBRVS for our Level 1, 2, 4 and 5 E&M services (but decrease in Level 3), we'll only see an overall cut of about $0.41 per Medicaid patient based on the average mix of Medicaid patients across Georgia. For most of us, this will translate into a few hundred dollars per year. The irksome issue is that the state legislature cut our fees! This cut applies to all of Georgia's physicians who see Medicaid patients – so you can count on more of your community's physicians no longer accepting Medicaid patients in their offices. Hopefully, GCEP and MAG will be able to successfully lobby for some relief next year.

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These cuts will likely more than offset if you've participated in Medicare's PQRI program (reporting quality indicators on your Medicare patients). EPs had nine (10 starting this year) specific areas from which to choose three for 2007. Your billing office should be coding and reporting these for you. If you've done a good job of reporting (>80 percent of your eligible patients) then you can get "up to a 1.5 percent bonus" on your Medicare payments. The checks might be "in the mail" sometime this summer (or as late as CMS feels that they can renege on paying physicians for reporting), along with information on how you reported compared with your colleagues. This program could quickly morph from a "reporting" issue to a "payment for performance" issue. Soon you could get monetarily penalized by Medicare if you don't report properly on the indicators, and if you don't "tow the line" performance-wise on what they perceive as a quality measure (e.g., DVT prophylaxis for stroke). More information can be found at www.cms.hhs.gov/PQRI.

Finally, several lawsuits involving payments to physicians for wrongful denials by the named insurance companies, have been settled against major health insurance companies. If you notified that you may benefit from one of these lawsuits (e.g., against Blue Cross/Blue Shield, or Aetna) then you should forward your paperwork to your billing company for them to pursue on your behalf. Some of these insurance companies are continuing to inappropriately deny (or reduce) payments to EPs for services rendered. You should work with your billing company to resolve these issues while the insurance companies are under court order to pay you appropriately.

Pediatric Asthma Update

by Jeffrey Linzer Sr., MD, FAAP, FACEP

Just a reminder as we get into asthma season to make sure your ED's pediatric asthma guidelines are up to date. Remember that children do better with more frequent and higher doses of bronchodilator than adults. A simple dosing scheme for albuterol is 2.5 mg per treatment for children under 15 Kg, 5 mg for over 15 Kg; continuous breathing treatments should be dosed the equivalent of 3 intermittent nebs. Intermittent nebs should be given at 20-30 minute intervals; make sure your protocols don't drag out the treatments over several hours. For most children there is no clinical advantage to using levalbuterol instead of albuterol. Use ipratropium when there is a cough component to the asthma exacerbation or the child is very tight.

For more information check out the CHOA ED asthma carepath at http://www.pediatrics.emory.edu/pem/epg/documents/372

From the President: continued from page 1

handled boarding or inappropriate use of the ED by other specialties. Dr. Shari Welch gave an eye opening lecture on thinking outside the box to solve some of these problems like using a manicure table and cart to care for patients with simple lacerations instead of tying up a bed. There is a saying that if you continue to do what you've always done, you'll continue to get what you always got! I don't have all the answers but I would like to share with you some of the small steps that GCEP is taking to address some of these concerns.

Dr. Ralph Griffin is the chairperson who is heading up our committee on rural medicine. This is a huge task with several strategic components. The committee will begin talking with some of the physicians currently practicing in rural areas of Georgia to see what concerns are and priorities are so that GCEP can begin working in partnership with them to provide help. There is a legislative component to provide incentives to residents to choose a rural setting for their practice and to medical schools to provide rural rotation experiences for their residents and medical students. This project will require many people to participate. Here is an opportunity for involvement.

A multi-track approach was continued this year at the annual conference held in Hilton Head. Our pre-hospital track doubled in size from last year with many positive comments from the attendees. The EMS attendees responded well to the lectures and seem to really enjoy having the courses taught by physicians.

Two years ago we began our "Commitment to Excellence" award for groups with 100% membership in ACEP/GCEP. At that time we had only one hospital group in Georgia that qualified. Since then the numbers have continued to grow and this year we added Emerginet/Summitt to the growing list of groups who have received a "Commitment to Excellence" award. This adds seven more hospitals to this very distinguished group. Congratulations to all. See our list on page 20.

Our silent auction raised over $4,000 for GEMPAC so we can continue to be a recognized force down at the capitol and make appropriate donations. We have many legislative issues that we monitor closely with the help of Mr. Trip Martin, our lobbyist. GEMPAC needs your donations to remain a visible force.

We have revised our website to make it more useful for you and continue to improve our newsletter to provide you with useful information. We are always looking for new and interesting cases to include so don't be shy about contacting us to share a case or report on any projects going on in your area.

WHY you may ask have I listed these after the introductory paragraph about our daunting problems and the need for solutions? Small steps!! Simple steps!! These all add up to a beginning. The beginning may lead us down other roads and paths for solutions that none of us has thought of yet. But without the beginning and the small simple steps we will get what we always got and that is not working. I always make a pitch for membership in a professional organization and for attending meetings like the GCEP annual conference and the ACEP Scientific Assembly. It is through your membership and attendance that new ideas are spawned and small steps are made. Simple? Yes! Effective? Yes. Essential to our survival as a progressive specialty? Absolutely! Don't get left behind. Become part of the solution. We need you. You need us. Our patients need and deserve our very best.

Make a Difference

All of our meetings are open. If you are interested in being more involved, please visit the GCEP website at **www.gcep.org**

ACEP Annual Leadership and Advocacy Conference: A Resident's Perspective

by Mboh Elango, MD

Every year the American College of Emergency Physicians (ACEP) hosts its' leadership and advocacy conference in Washington D.C. For the past several years the chair of the Department of Emergency Medicine here at Emory University School of Medicine has sponsored one resident to attend this unique conference. The goal is to enable a resident with an interest in policy issues to gain invaluable exposure into how emergency physicians come together as a group to speak with a unified voice on issues of importance to emergency medicine.

In June 2006, the Institute of Medicine released three reports detailing the challenges that the United States faces in ensuring access to emergency medical services. The Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals to treat everyone regardless of their ability to pay, is essentially an unfunded mandate because it does not require the government, insurance companies or individuals to pay for the services rendered. As a consequence, 381 emergency departments closed during the period of 1995-2005 due to cutbacks in reimbursement or payment denials. During that same span of time the number of emergency department visits increased 20 percent from 96.5 to 115 million. The result, which we all see on a day-to-day basis, is the epidemic of overcrowding which leaves many patients "boarded" in the ED, waiting in the waiting rooms or diverted from hospitals, all issues that directly compromise care, patient safety and satisfaction.

One of the principle themes of this year's conference is to raise public awareness and enlist public and bipartisan congressional support for House bill H.R.882 or the Senate version S.1003 (the access to Emergency Medical Services acts of 2007).

One of the key components to this bill is that it will create a bipartisan commission that will examine factors such as overcrowding and medical liability issues which affect the delivery of emergency care. The bill will also authorize additional payment to all physicians who provide EMTALA-related care and create a commission to study boarding and develop guidelines to alleviate this problem.

Admittedly solving these issues related to medicine as a whole will require a combination of public sacrifice and a generous helping of national political will. To achieve this, ACEP has engaged in a vigorous campaign to educate the public as well as our politicians about the critical nature of this issue. Attendees, like myself, were encouraged to become spokespeople for ACEP and were treated to crash courses about how to interact with what are our most invaluable allies in this endeavor, the media, the public and legislators.

During the "One on One" media training session, I learned the value of humor, analogy, emotions and bold action words to create sound bites for a media interview. I also learned the importance of repetition and simplification when answering reporters' questions.

In addition, I learned the importance of staying brief and on message while using a combination of formal arguments and personal stories to make points when dealing with members of congress and their staff. Spending the day on Capitol Hill allowed me to appreciate the importance of constituent visits and individualized letters in the voting pattern of legislators.

Finally, attending lectures on "Disaster preparedness" and "Leadership Dynamics" have enabled me to harness the skills necessary to be a more efficient leader and community advocate in the future.

I have always maintained that at the heart of my desire to learn medicine is a compassionate temper of the knowledge itself as well as the ability to immerse myself wholeheartedly in the service of my patients. This experience reinforced both these convictions as well as the fact that as physicians we play the dual roles of healer and community leaders. As a result of this experience, I now know more than ever that the voice of a physician carries with it considerable weight and there is a power and responsibility that must come with that.

I will forever be grateful to my department chair, Dr. Heilpern for sponsoring me to this conference, to Dr. A. Kellermann for serving as my mentor and guide as well as Dr. Phillip Shayne for making this experience a reality.

What's New in Managing Allergic Emergencies?

by Jeffrey Linzer Sr., MD, FAAP, FACEP

In 2005, the Joint Task Force on Practice Parameters issued updated practice parameters in the diagnosis and management of anaphylaxis.[1] One of the major points was emphasizing that the administration of epinephrine was the primary treatment for these types of allergic emergencies followed by H1 and H2 blockers.

One of the more interesting points was in how the epinephrine should be administered. Traditionally, epinephrine has been given subcutaneously. However, two studies in (children and adults) show that giving epinephrine in the anterolateral thigh appears to provide superior absorption compared with deltoid and subcutaneous injections[2,3] (these studies were not drug company supported). In the pediatrics study, the time to maximum peak concentration was 8±2 minutes given intramuscularly in the thigh versus 34±14 minutes subcutaneously. The peak drug concentration was also higher. Similar results were seen in adults.

Because of the risk of adverse cardiac events, IV and IO epinephrine should be reserved for those patients in uncompensated shock. It appears that the combination of H1 and H2 antihistamines is more effective than using an H1 blocker alone.[4] Because of their slower onset of activity they are consider next-in-line treatment after epinephrine. Diphenhydramine 1 mg/kg (not to exceed 50 mg/dose) may be given IV/IM/PO; oral use should be restricted to mild cases. Second-generation H1 antihistamines (e.g., cetirizine, loratadine) have not been studied in anaphylaxis. Ranitidine 1 mg/kg (not to exceed 50 mg/dose IV or 150 mg/dose PO) has a low side effect profile in children. Oral treatment may be used in mild cases.

Systemic corticosteroids are not indicated for simple urticaria, but in anaphylaxis they may help decrease the risk of rebound or late-phase response. There are no well defined criteria for the need for observation or hospitalization. Prolonged observation is rarely needed in patients with mild urticaria. However, for patients with anaphylaxis there is a consensus that even patients with mild symptoms should be observed for a minimum of 4-8 hours.

For more detailed information go to http://www.emedicine.com/emerg/topic360.htm#ref12

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Medical College of Georgia Residency Update

by Stephen A. Shiver, MD, Emergency Medicine Residency Program Director, Medical College of Georgia

We have mixed emotions this time of year as we say goodbye to another group of residents. We feel blessed to have participated in their training and wish them well in their future endeavors. The Department of Emergency Medicine at MCG continues to impact a diverse geographic area, sending newly trained emergency physicians as far west as Texas and as far north as Maine in 2008. Each of them will be missed!

As we say goodbye, we also say welcome to another group of interns. Diversity is a growing residency theme, with our incoming class hailing from numerous states including California, Ohio, Florida, Arkansas, New York, and of course, Georgia. Of note, we recently received approval from the RRC to have 10 trainees per year and 2008 represents our first intern class at that level. Another first will be the arrival of a U.S. Army resident in July. MCG is joining Madigan Army Medical Center, Brooke Army Medical Center, and Fort Hood Army Medical Center, as an official training venue for U.S. Army medical personnel pursuing postgraduate training in emergency medicine. To help the military meet its ever increasing demand for emergency physicians, our affiliation will likely increase in coming years and in preparation for that we are expanding our residents' involvement at Dwight D. Eisenhower Medical Center this year.

Dr. Larry Mellick stepped down from the program director position in April, 2008. Dr. Mellick has served our department in a number of capacities over the years, including a multi-year term as chairman. We are thankful for his contributions and feel that he leaves the residency positioned well for the future. The new program director is Stephen Shiver, M.D., and the new associate program director is Brad Reynolds, M.D. Both are MCG alumni and have worked within the department for a number of years. The department remains committed to its mission of producing ethical, well-trained emergency physicians prepared to serve the community in private practice or enter into academics upon graduation.

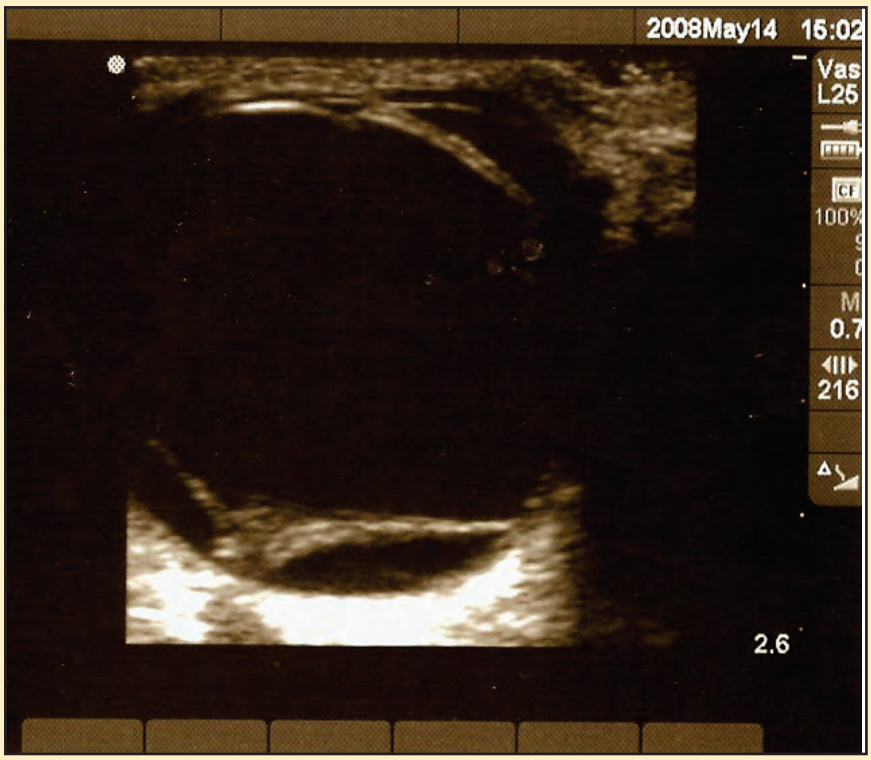
If you would like to learn more about us, we would be delighted to hear from you. Please visit our website at www.mcg.edu/ems/residency or contact Becky Lambert at (706) 721-2613 to request further information.

What Do You See?

by Mary Ann Edens, MD

Presentation: 55-year-old male with a history of a sudden decrease in vision one month prior to presentation.

See Answer on page 10.



GCEP Annual Meeting at Hilton Head Island 2008

by Carl Menckhoff, MD, FACEP

Hilton Head Island was the site of another successful annual meeting for the Georgia College of Emergency Physicians this year. Eighty physicians from all around Georgia participated in the three-day educational assembly at the Crowne Plaza Resort from June 13-15. The GCEP education committee continued with its pre-hospital track this year with about 20 attendees from around Georgia and South Carolina. GCEP also partnered with the ED Benchmarking Alliance (EDBA) creating a third track focusing on ED administrative and efficiency issues.

Conferences covered topics such as:

- ED Boarding issues by Peter Viccellio
- LLSA review by Mary Ann Edens
- Early Goal Directed Therapy in Sepsis by Ted Stetner
- Procedural Sedation by Eric Richardson
- The Data Designed ED by Jim Augustine
- Closed Head Injury by Patrick McDougal

- Interesting Cases from the GA Poison Control by Brent Morgan
- Approach to Legal Cases by David Sklar
- Emerging Infections by Jim Wilde
- Emergency Ultrasound Lecture and Workshop by Matt Lyon and Carl Menckhoff
- and many others.

As always, the Saturday beach party was one of the highlights and was thoroughly enjoyed by all, with great food, drink and dancing for the adults and limboing and arts & crafts for the kids. Prince Pele and his family's Polynesian extravaganza were perfect for the Luau and included dancers, Hawaiian music and fire throwing. This was made even better due to the singing accompaniment by our President Maureen Olson as well as the grass-skirt dancing troupe made up of various female and male attendees.

Whether you attend for the international quality lectures, or the world class relaxation, this conference offers

We ALL Won!

The GEMPAC Silent Auction was held June 14, 2008 in Hilton Head during the GCEP Annual Spring Meeting, and what a success it was! You probably are regretting that you didn't bid on these fantastic items (or others, not mentioned), donated by GCEP members, their families and friends:

- Romantic weekends in Highlands, NC and at the Lake Oconee Ritz Carlton Lodge.
- A room at the Crowne Plaza in Hilton Head for next year's meeting.
- The unique Plantation Quail Hunt in Albany, GA.
- A Disney basket of gifts for the kids and a wine package for the adults.
- Braves tickets and TWO stunning hand-crochet afghans.
- An autographed copy of Dr. John Rupke's book "Anyone, Anything, Anytime, A History of Emergency Medicine."
- And who could forget the gorgeous artwork of Carol Griffin, so generously donated by the artist herself!

An amazing $4000 was donated through this auction, which benefited GEMPAC. ***Many thanks to those whose donations and tireless efforts made this event a huge success!***

Through GEMPAC we are able to support Georgia legislators fight for tougher seatbelt laws and establish an improved trauma network for the entire state. By contributing to GEMPAC, you contributed to health-care for all Georgians because GCEP, through GEMPAC, supports the candidates that support these ideas.

Please contact GCEP if you would like to help or contribute an item for next year's Auction!

something for all practitioners and their families.

The annual meeting will be held at the Sea Pines Resort on Hilton Head Island next year on June 12-14 of 2009. For more information please visit the GCEP website www.gcep.org and to recommend topics or speakers for next year's conference please contact Carl Menckhoff at cmenckhoff@mcg.edu.

2008 Legislative Session: Our Advocacy

by Robert Cox, MD, FACEP

GCEP continued in its role as the emergency physician's advocate during the 2008 legislative session. Our main objective, defeating any attempt at stripping away at the tort reform legislation passed in SB3, was successful. Senator Seth Harp and other trial lawyer champions introduced SB286 last year to change certain provisions relating to the limitation on health care liability claims in emergency medical care. This bill stayed in committee and is dead until they try again next year.

We supported improving the trauma network in the state and Governor Perdue added nearly $59 million to the state's supplemental budget for reimbursing physicians, hospitals and EMS for trauma expenses. None of the suggestions by various legislators for a permanent funding solution passed. Bills introduced included additional car tag registration fees, increased fines for speeders, redlight camera violations fees, additional cell phone fees, and out of country wire transfer fees.

We received word that the FY 2009 budget includes a $9.5 million increase in Medicaid reimbursement rates. At first glance, this seems like great news, but then you read the fine print. By doing some calculations, Dr. Pettigrew found that for the average ED there may be some decrease in monies collected from Medicaid. (See the Reimbursement Column for details) GCEP will work closely this year with key budget leaders to restore any monies lost due to this three-card Monte.

GCEP members testified before the Senate Study Committee on Stroke lead by Senator Don Thomas. Dr. Thomas introduced SB549, which became known as the "Coverdell-Murphy Act, to have the State Office of EMS and Trauma (SOEMS/T) identify hospitals that meet criteria as primary or remote treatment stroke centers. The bill also directs the SOEMS/T to develop a model stroke triage assessment tool and provide for the establishment of protocols related to the assessment, treatment and transport of stroke patients by EMS providers. Governor Perdue signed the bill into law in May 2008.

GCEP Board members participated in the MAG Doctor of the Day Program at the capitol. Drs. Grubbs, Hagues, Cox, Rogers and Segerman served during the week GCEP reserved with the MAG program.

Now is the time to meet with your local legislators to keep our issues fresh in their minds. If you haven't invited them to come to your ED, try it this summer. It's a great opportunity to show them what you do each day and night to make a difference in people's lives. If you need more information on how to make it happen, contact us and we can help you.

An activist judge with ties to trial attorneys has declared the "caps" are unfair and unconstitutional in Georgia. Although his arguments are weak, the defendant physicians and hospitals must petition the Georgia Supreme Court to overrule this egregious act. Stay tuned to the GCEP website for up-to-date information.

What Do You See? from page 7

Answer: Retinal detachment

The most common form of retinal detachment (rhegmatogenous retinal detachment) can be thought of much like the more familiar aortic dissection. That is a hole, tear, or break in the sensory layer of the retina allows fluid from the vitreous cavity to seep in between the sensory and pigment layers and separate them. Risk factors for retinal detachment are Jewish ethnicity, age 40-70 years, hypertension, ocular trauma and history of vasculitis. Typical presentations include flashes of light, multiple floaters, and rapidly expanding shadows. Vision loss is typically described as filmy, cloudy, irregular, or curtain like. Diagnosis is made primarily from history and confirmed with ultrasonography. Emergency department care is minimal and primarily consists of avoiding pressure on the globe. This can be accomplished with goggles, a styrofoam cup or a metallic eye shield. Most importantly, retinal detachment is an ophthalmologic emergency. Prognosis is associated with time of vision loss to time of repair by an ophthalmologist.

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The Climate of Medical Tort Reform in Georgia Improved by Senate Bill 3

by Matthew Keadey, MD, FACEP

Prior to 2005, the American College of Emergency Physicians (ACEP) considered the state of Georgia (GA) to be in a medical malpractice crisis. The number of tort cases filed per year was increasing as the number of million dollar cases was rising. In February 2005, the Georgia state legislature passed Senate Bill 3 (SB3), landmark legislation which provided for medical tort reform in the state of Georgia. The legislation created a $350,000 cap on single awards and a $1,050,000 cap on aggregate awards for non-economic damages.

More importantly, SB3 set a new standard for negligence in tort cases involving emergency care. Negligence is defined as conduct that falls below the standards of behavior established by law for the protection of others against unreasonable risk of harm. A person has acted negligently if he or she has departed from the conduct expected of a reasonably prudent person acting under similar circumstances. In order to establish negligence as a cause of action, a plaintiff must prove that the defendant had a duty to the plaintiff, the defendant breached that duty by failing to conform to the required standard of conduct, the defendant's negligent conduct was the cause of the harm to the plaintiff, and the plaintiff was, in fact, harmed or damaged. After SB3 was passed, the cause of action for any case in the emergency department and 24 hours thereafter became gross negligence. Gross negligence is the failure to use even the slightest amount of care in a way that shows recklessness or willful disregard for the safety of others.

After SB3, 91% of respondents received a decrease or had no increase in their premiums and the number who lost their medical malpractice insurance (2.4%) significantly decreased.

In 2007 the Georgia College of Emergency Physicians conducted a survey of its members regarding the impact of SB3 on the malpractice climate in the state. One hundred-eighty four responses out of a possible 736 were received (25%). Respondents represented a wide variety of geographic locations in the state and differing types and sizes of emergency departments. Prior to the passage of SB3, 76% felt GA was in a malpractice crisis and 30% were considering leaving the state; whereas after SB3, only 4.8% (16 fold reduction) felt there was a medical malpractice crisis and only 2.8% (10 fold reduction) were considering leaving the state. In addition, before SB3, 68% of the respondents had a greater than 25% increase in their malpractice premiums and 24% had lost their medical malpractice insurance. After SB3, 91% of respondents received a decrease or had no increase in their premiums and the number who lost their medical malpractice insurance (2.4%) significantly decreased. Since the passage of SB3, 19% of respondents feel that their on-call coverage has improved, but the majority feel that it is unchanged or continuing to worsen (78%).

SB3 has improved the medical malpractice climate for emergency physicians in Georgia, but more time is needed to asses its impact. The average time from an alleged act of malpractice to the end of a suit is roughly four years. Many emergency physicians who once were considering leaving the state, retiring or changing to another specialty are now comfortable in their practice settings. Malpractice premium increases have stabilized and in some cases reductions are occurring. This has been echoed by the reductions in annual premium announced by the largest medical liability insurer in Georgia, MAG Mutual. In addition a large number of new insurers have entered the market in Georgia due to the favorable malpractice climate. On-call coverage does not appear to be affected by SB3, but clearly factors other than malpractice risk are involved.

GCEP anticipates that SB3 will come under attack this year. Already, a recent court case in Fulton County has questioned the legality of non-economic caps and during last year's legislative session, a new bill was introduced eliminating the standard of gross negligence for emergency care. It takes money and time to prevent this from happening. You may want to donate a shift to the cause by making a donation to the Georgia Emergency Medicine Political Action Committee. You may also want to write your state senator or congressman, but are unable to find out who they are. Links to both the GEMPAC donation site and a database for state representatives can be found at www.GCEP.org.

Cross Country: Why Doctors are Heading for Texas

Reprinted with permission from The Wall Street Journal, *May 17, 2008*

by Joseph Nixon

Houston — When Sam Houston was still hanging his hat in Tennessee in the 1830s, it wasn't uncommon for fellow Tennesseans who were packing up and moving south and west to hang a sign on their cabins that read "GTT" — Gone to Texas.

Today obstetricians, surgeons and other doctors might consider reviving the practice. Over the past three years, some 7,000 M.D.s have flooded into Texas, many from Tennessee.

Why? Two words: Tort reform.

In 2003 and in 2005, Texas enacted a series of reforms to the state's civil justice system. They are stunning in their success. Texas Medical Liability Trust, one of the largest malpractice insurance companies in the state, has slashed its premiums by 35%, saving doctors some $217 million over four years. There is also a competitive malpractice insurance industry in Texas, with over 30 companies competing for business. This is driving rates down.

The result is an influx of doctors so great that recently the State Board of Medical Examiners couldn't process all the new medical license applications quickly enough. The board faced a backlog of 3,000 applications. To handle the extra workload, the legislature rushed through an emergency appropriation last year.

Now many of the newly arriving doctors are heading to rural or underserved parts of the state. Four new anesthesiologists have headed to Beaumont, for example. Meanwhile, San Antonio has experienced a 52% growth in the number of new doctors.

But if tort reform has been a boon — and it is likely one of the reasons the state's economy has thrived in recent years — it was not easy to enact.

In one particularly grueling fight in the legislature in 2003, an important piece of a reform bill went down to a narrow defeat in the state Senate after a single Republican switched his support to vote against it. Republican Gov. Rick Perry was so incensed that he bolted out of his office in the Capitol, sprinted into the Senate chamber, and vaulted a railing to come face to face with the defecting senator.

That confrontation fizzled, however, and before long Texas succeeded at enacting two simple but effective reforms. One capped medical malpractice awards for noneconomic damages at $250,000, changed the burden of proof for claiming injury for emergency room care from simple negligence to "willful and wanton neglect," and required that an independent medical expert file a report in support of the claimant.

This has allowed doctors and hospitals to cut costs and even increase the resources devoted to charity care. Take Christus Health, a nonprofit Catholic health system across the state. Thanks to tort reform, over the past four years Christus saved $100 million that it otherwise would have spent fending off bogus lawsuits or paying higher insurance premiums. Every dollar saved was reinvested in helping poor patients.

The second 2003 reform cleaned up much of the mess surrounding asbestos litigation by creating something called multi-district litigation (MDL). This took every case in the state involving a common injury or complaint, like silicosis or asbestosis, and consolidated it for pre-trial discovery in one court.

One judge now makes all pre-trial discovery and evidence rulings, including the validity of expert doctor reports, for all cases. This creates legal consistency and virtually eliminates "venue shopping" — a process by which trial lawyers file briefs in districts that they know will be friendly to frivolous suits. Trials still occur in plaintiffs' home counties.

More change sailed through the legislature in 2005; tort reform had become popular with voters and lobbying against it was ineffectual. The 2005 reform created minimum medical standards to prove an injury in asbestos and silica cases. Now plaintiffs must show diminished lung capacity in addition to an X-ray indicating disease.

In sum, these reforms have worked wonders. There are

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Cross Country continued

about 85,000 asbestos plaintiffs in Texas. Under the old system, each would be advancing in the courts. But in the four years since the creation of MDLs, only 300 plaintiffs' cases have been certified ready for trial. And in each case the plaintiff is almost certainly sick with mesothelioma or cancer.

No one else claiming "asbestosis" has yet filed a pulmonology report showing diminished lung capacity. This means that only one-third of 1% of all those people who have filed suit claiming they were sick with asbestosis have actually had a qualified and impartial doctor agree that they have an asbestos-caused illness.

In the silica MDL, there are somewhere between 4,000 and 6,000 plaintiff cases. In the four years since the cases were consolidated under the MDL, 47 plaintiffs have filed a motion to proceed to trial based on a medical report indicating diminished pulmonary capacity. Of those 47, the court has certified 29 people as having diminished lung capacity. This, too, is less than 1% of all the "silicosis" claims made in Texas. No one has proven the real cause of his illness to be silica, as no case yet has been certified for trial.

Before the asbestos and silica MDLs were created, non-malignancy plaintiffs settled with defendants for anywhere between $30,000 to $150,000 per case. No one knows how many bogus cases were settled in the state with large cash payments. Lawyers who specialized in defending those cases say there were tens of thousands.

The full costs of large settlements and runaway malpractice suits may never be known. But it is clear that the costs were paid for by consumers through the increased price of goods, by pensioners through diminished stock prices, and by workers through lost jobs. Another group often overlooked is those who are priced out of health care, or who didn't receive charity care because doctors were squeezed by tort lawyers. Frivolous lawsuits hit the uninsured the hardest.

Texas recently became home to more Fortune 500 companies than New York and California. Things are trending well for the Lone Star State. Anecdotally, we can see that while doctors are moving in, trial lawyers are packing up and heading west. They're GTC — Gone to California.

Mr. Nixon, a former member of the Texas House of Representatives, is a senior fellow at the Texas Public Policy Foundation.

Judge Strikes down Caps on Med-Mal

This article was previously printed in the Medical Association of Georgia's Ñewsletter, April/May, 2008.

Three years after the General Assembly enacted SB3 to place a cap on non-economic damages in Georgia, a trial court judge has ruled the cap unconstitutional. (The trial court judge is also expected to address whether the gross negligence standard for emergency department medical care is unconstitutional in a subsequent order.)

The plaintiff, who was injured when he fell off a ladder, contends he was rendered a quadriplegic as a result of the malpractice of the hospital, emergency room doctors and radiologists. With limited discovery, the trial court reasoned, "…that given the near certainty that a jury would award non-economic damages well in excess of the statutory cap in this case if the plaintiffs recover a verdict, the caps here have an immediate and present impact on the proceeding."

The trial court found that the cap on non-economic damages violates the equal protection clause of the Georgia Constitution. It stated, "Equal protection simply prohibits the legislature from making invidious distinctions and enacting classifications that lack a sufficient justification." The court found that, "The principal distinction the legislature made is between persons suffering personal injuries from tortfeasors generally, and persons who suffer from one specific group of professional defendants." The court went on to say that, "…the statute effectively puts substantial limitations on the rights of the poor and middle class to recovery while leaving the right to virtually unlimited recoveries unimpeded for the wealthy." And the court noted that, "…the limitation on non-economic damages falls instead, on the poor, the unemployed, the elderly, the homemaker who does not work outside the home, and others with little earnings."

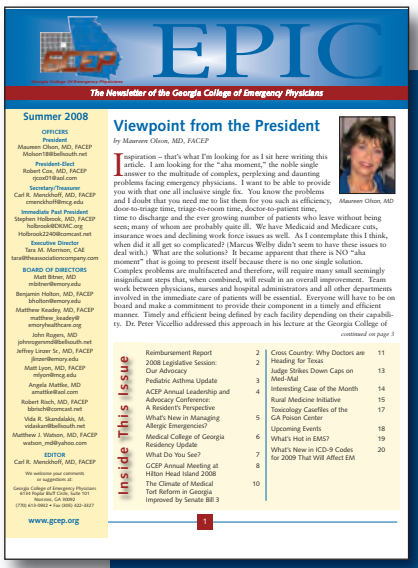
MAG believes that the court's arguments are flawed in several ways. While some may argue the statute might have originally created a divide between the "haves" and "have nots," an award for lost earnings is restitution the individual would have received in the absence of the tortuous conduct. This point of law is designed to make the plaintiff whole in a relative (i.e., pre-injury conditions), fact-based way – not to become a windfall for the plaintiff.

The court went on to say that, "…the statute effectively puts substantial limitations on the rights of the poor and middle class to recovery while leaving the right to virtually unlimited recoveries unimpeded for the wealthy."

"Georgia's residents have been well served by SB 3 when in comes to increased access to health care," says MAG President Jack M. Chapman Jr., M.D. "And we are disappointed with the trial court's decision as we believe it jeopardizes access to heath care for patients in the state." Dr. Chapman also stresses that, "Physician services are far more accessible today than they were in 2005, the year SB 3 was enacted. This law has been extremely effective in reducing professional liability premiums and reinforcing critical health care needs like obstetrical and general surgery services in the state."

MAG will continue to manage this priority issue on behalf of its members so the people who live in Georgia have access to quality health care and increased peace of mind.

Contact MAG General Counsel Donald Palmisano via e-mail at dpalmisano@mag.org in the event you have questions. A copy of the judgment is available www.mag.org


EPIC

The Newsletter of the Georgia College of Emergency Physicians

Summer 2008

Viewpoint from the President

Inside This Issue

www.gcep.org

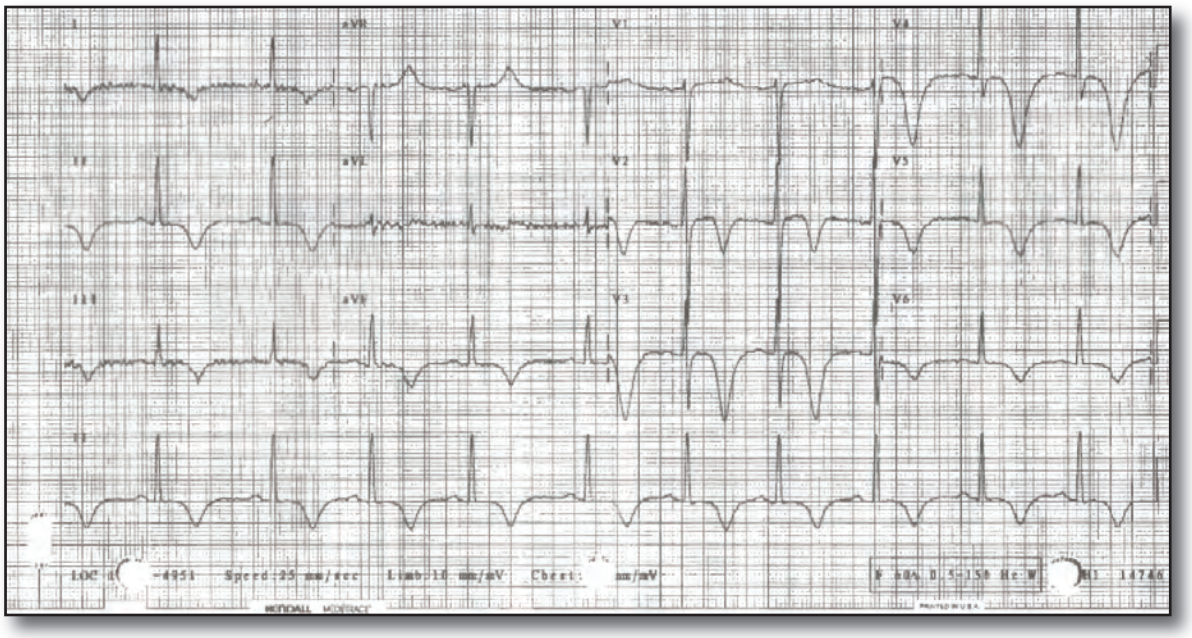
Seeking Contributions!

Interesting case
Medical update
Medico-legal
Billing
Legislative
Other.....

If you would like to contribute to the EPIC please contact: Tara Morrison at tara@theassociationcompany.com

Interesting Case of the Month

by Wakili Yarima and Carl Menckhoff, MD



Ms. XX is a 65-year-old African-American female who was brought by her family to the emergency department for evaluation of "bilateral lower extremity weakness" that had been worsening over the past several months. She had been having more difficulty ambulating even with the aid of her walker and had remained sedentary for most of the time. She also had a history of recurrent falls which the family attributed to her 'generalized weakness.' Additionally, she has had occasional episodes of urinary and stool incontinence. Per patient's husband, most of the decline in her activities of daily living had occurred after discharge from a prior psychiatric admission in a few months prior.

A ten-point review of systems did not reveal any episodes of dizziness, syncope, headaches, cough, hemoptysis or weight loss. The patient also denied any palpitations, chest pain or diaphoresis. She admitted to auditory hallucinations.

Her past medical history is significant for hypothyroidism, depression, schizophrenia (chronic paranoid type) and degenerative joint disease. There was no significant surgical history.

She had no known drug allergies and her daily medications include Zyprexa 7.5 mg daily, Lithium 300 mg three times daily, Synthroid 125 mcg daily, Propranolol 10 mg three times daily and Oxybutynin 1 gram daily.

She smoked 'occasionally' but denied the use of alcohol or drugs. She is married and lives with her husband. Her family history is positive for cervical carcinoma in her mother and her brother has also been diagnosed with schizophrenia.

At presentation to the ED, her blood pressure was 145/51, pulse 61, respiratory rate 18, temperature 36.3 C, and her oxygen saturation was 100% on room air.

General physical examination revealed an elderly African-American female who was pleasant but with incoherent speech. The rest of the physical examination was unremarkable except for a soft, systolic ejection murmur. Gait was not examined due to the patient's inability to cooperate for the cerebellar examination.

Initial laboratory results revealed a slightly supratherapeutic serum Lithium level of 1.47 (normal is 0.60 to 1.20). Serum electrolytes, cardiac enzyme biomarkers, a complete blood count and urinalysis were within normal limits. Her EKG showed diffuse, deep T-wave inversions and QTc prolongation of 514. A chest x-ray was not obtained in the ED.

The patient was subsequently admitted for further evaluation and management. Lithium and Zyprexa were held. She was seen in consultation by the cardiology service, which recommended daily EKGs, and concurred with the decision to withhold Zyprexa and Lithium due to the prolonged QTc.

In view of her interesting EKG findings coupled with her presenting symptomatology, a head CT scan was obtained. The CT scan showed metastatic brain disease. Further work-up revealed a primary lung cancer and she was promptly referred for further management.

continued on page 16

Toxicology Case Files of the GA Poison Center

by Wafa'a Al-Khamees, International Toxicology Fellow, Georgia Poison Center

A 23-year-old male was wheeled into the ED by his friend with a history of nausea, vomiting and abdominal pain several hours after an acute aspirin ingestion (60 tablets of 325 mg/tab) in a suicide attempt

On examination the patient was diaphoretic with the following vital signs T:102F, HR:133, RR:28, BP:100/50. Lungs were clear, cardiac exam revealed a regular tachycardia, and his abdomen was mildly tender.

Blood was drawn and IV access was obtained. A portable chest X-ray was normal. Based on the patient's history and symptoms urinary alkalinization with sodium bicarbonate infusion was started.

Lab result were as follows:

Na+	=	140 mEq/L	HCO3	=	8
pH	=	7.35	Glu	=	66 mg/dl
K+	=	3.0 mEq/L	BUN	=	20
PCO2	=	12 mmHg	Cr	=	0.9
Cl-	=	105 mEq/L	ASA	=	pending
pO2	=	95 mmHg			

Around three hours after ED presentation the patient's mental status deteriorated and he was intubated for airway protection. His initial aspirin level drawn at the time of presentation was 82 mg/dl.

THE QUESTIONS:

1. How would you set this patient's vent settings?
2. Does your patient need emergent dialysis? What are the indications?
3. How does urinary alkalinization work and what is the proper way to attempt urinary alkalinization in this patient?
4. What might contribute to the ineffectiveness of urine alkalinization in this patient? Why?
5. Explain the acid base disturbance in salicylate overdose

See answers on page 19

continued from page 15

DISCUSSION:

EKG is generally used to evaluate and diagnose cardiac conditions. However, several studies have been conducted in which certain EKG abnormalities were linked to acute or chronic intracranial processes such as subarachnoid hemorrhage and intracranial tumors. Abnormalities of the T and U waves and prolongation of the QTc interval are the most commonly seen features. This patient had diffuse T wave inversions and QTc prolongation on her presenting EKG.

In a study that was published in the *Archives of Neurology* by Koepp et al, entitled Electrocardiographic changes in patients with brain tumors, it was noted that lesions of limbic structures do exert cardioarrythmic effects which gives rise to these EKG abnormalities.

Other articles have even gone a step further to attempt to provide prognostic value of the QTc intervals in both acute and chronic cerebral processes. In the study by Assmann and Mueller, they theorize that the longer the QTc intervals, the worse the prognostic outcome.

It is known that certain drugs, especially Lithium, can prolong QTc intervals and cause diffuse T wave inversions. However, it is also prudent to have a high index of suspicion that these EKG abnormalities can also be caused by intracranial processes such as in this patient.

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Rural Medicine Initiative

by Ralph Griffin, MD

GCEP Plans to Partner with EP's Working in Rural EDs to Better Understand Practice Issues and to Improve Care.

Hospitals in rural areas of Georgia and the U.S. often have great difficulty staffing Emergency Departments (EDs) with emergency physicians. Previous data makes it clear that physicians not residency trained in emergency medicine, in particular family physicians and general internal medicine physicians, provide significant staffing of rural EDs. ACEP National Workforce studies reveal that nationwide 38% of ED clinicians are physicians who are not residency trained in emergency medicine. However, that percentage is 67% in rural hospitals.

In the past, there has been significant separation of physicians working in rural (typically lower volume) EDs from those working in metropolitan or higher volume EDs. Clearly the provision of emergency medical care is an essential public service nationally and physicians who are not residency trained in emergency medicine will continue to be a vital part of the ED workforce. However, many emergency physicians who work solely in metropolitan or high volume EDs do not really understand the distinct and different challenges of providing emergency care in rural America.

The Georgia College of Emergency Physicians desires to partner with physicians practicing in emergency departments in rural locations in Georgia. During 2008 GCEP plans to finalize a strategic plan to partner with physicians working in rural EDs and to begin early implementation of that plan. The objective is to ensure that high quality emergency care is readily available from competent and qualified providers working in all Georgia EDs, regardless of whether in rural or metropolitan hospitals. Some "strategies" for achieving this objective are now being discussed and include the following possibilities for consideration:

- Surveying physicians working in rural Georgia EDs to better understand their concerns and priorities.
- Educational outreach to physicians working in rural Georgia EDs (procedural "skill labs" have been mentioned as a possibility.)
- Working with Georgia medical schools and residency programs to develop rural emergency medicine electives or possibly required rotations.

The objective is to ensure that high quality emergency care is readily available from competent and qualified providers working in all Georgia EDs, regardless of whether in rural or metropolitan hospitals.

- Explore telemedicine partnering opportunities between smaller rural EDs and higher volume EDs in Georgia.
- Work with the GCEP lobbyist (Trip Martin) to arrange meetings with Georgia legislators to discuss financial assistance, school loan forgiveness, or medical malpractice insurance coverage for physicians if they work in rural Georgia EDs.

Many other possibilities may also be considered. GCEP is reaching out to every Georgia physician who might be interested in this initiative. We seek your input and help. In particular, for any physician practicing emergency medicine in a rural Georgia ED, WE GREATLY NEED AND ENCOURGE YOU TO JOIN US IN THIS ENDEAVOR! If interested, you may contact any of the following:

Ralph Griffin, MD griffin.ralph@mccg.org

John Roger, MD johnrogersMD@bellsouth.net

Robert J. Cox, MD rjcox01@aol.com

Maureen Olson, MD Molson18@bellsouth.net

Please help us reach beyond stereotypical boundaries to embrace a need and develop a meaningful program which could benefit many patients treated in emergency departments throughout Georgia and thereby also benefit all who are dedicated to providing that care.

Get involved!

GCEP is here to serve the emergency physicians and emergency patients of Georgia. If you would like to get involved, please visit us at www.gcep.org

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TEAMHealth Southeast

Contact Rita Offenberg at TeamHealth Southeast
about these Georgia opportunities in
Albany, **Americus**, **Griffin**, and **Monroe**.
800.424.3672, ext. 2906,
rita_offenberg@teamhealth.com

Albany, Palmyra Medical Center—200-bed facility with ED volume of 24,000. Mid-level coverage 7 days a week. High acuity and excellent back-up. The city of Albany fosters small town warmth and friendliness and is close to Columbus and 80 miles north of Tallahassee, Florida.

Americus, Sumter Regional Medical Center—Make a difference in the life of a community as you provide care in a new, modular hospital. The new home for Sumter Regional Medical Center will include approximately 65 inpatient rooms, a labor and delivery/obstetrics/nursery unit, 8 CCU rooms, 4 operating suites, and a fully functional, 24-hour ED that is supported by 10 hours a day of MLP coverage.

Griffin, Spalding Regional Hospital—38,000-volume, 21-bed Level II ED, moderate- to high-acuity cases, adjacent radiology and laboratory facilities available 24 hours, and two medical helicopter services supporting patient transfer. 38 hours of physician coverage and 12 hours of MLP coverage provided each day. The quiet, tree-lined streets and established neighborhoods make Griffin an excellent place to call home, and Atlanta is just 40 miles away.

Monroe, Walton Regional Medical Center—Excellent opportunity for an experienced medical director at this 77-bed facility with an annual ED volume of 22,000. MLP coverage, 7 days a week and a large number of internal medicine cases. The city of Monroe is 45 miles east of Atlanta and 20 miles west of Athens.

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ECC of TEAMHealth

Contact Leslie Teeple at ECC of TeamHealth
about these Georgia opportunities in
Chatsworth, **Dalton**, **Fort Oglethorpe**,
Jasper, and **Thomson**.
800.577.7707, ext. 7214,
leslie_teeple@teamhealth.com

Chatsworth, Murray Medical Center—Brand new, state-of-the-art ED! The facility's parent corporation also contracts with Murray County to provide ambulance service for the community. ED patient volume is 16,500.

Dalton, Hamilton Medical Center—41,000-volume Level II trauma center. Brand new state-of-the-art facility with 41 hours of physician coverage and 36 hours of MLP coverage a day. Twice named as a Top 100 hospital, quality care is this medical center's hallmark. In place is a hospital medicine group, a great medical staff, numerous centers of excellence, superior diagnostics, a fully accredited laboratory, an MRI center, and an advanced computer radiology system.

Fort Oglethorpe (Chattanooga area), Hutcheson Medical Center—Located in one of Georgia's fastest growing communities, this 32,000-volume ED has 36 hours of physician coverage and 24 hours of MLP coverage a day. Minutes from Chattanooga!

Jasper, Piedmont Mountainside Hospital—Recently named Hospital of the Year by the Georgia Alliance of Community Hospitals, this 35-bed, acute-care facility combines today's technology with personal care. Single coverage is provided for this 13,500-volume ED less than one hour from Atlanta.

Thomson, McDuffie Regional Medical Center—28-bed facility with an 11,500-volume ED located near Augusta in east Georgia. With thousands of miles of lakes and shoreline, Thomson offers pleasure boating, fishing, sailing, and great scenery for a family picnic.

Toxicology Case: The Answers from page 16

1. How would you set this patient's vent settings?
The patient should be hyperventilated. A normal respiratory rate setting would allow the PCO2 to increase towards normal. This would further decrease the pH and potentially make the patient sicker by causing more salicylate to enter the brain.

2. Does your patient need emergent dialysis? What are the indications? Yes, he needs the dialysis and the indications are:
Acute renal failure
Acute lung injury
Progressive deterioration in vital signs
Severe acid-base disturbance
Central nervous system dysfunction
CHF
Hepatic compromise with coagulopathy
Salicylate concentration of >100mg/dl in acute ingestion

3. How does urinary alkalinization work and what is the proper way to attempt urinary alkalinization in this patient? The pH-dependent increase in urinary elimination is ascribed to "ion trapping" the filtering of both ionized and nonionized salicylate by renal tubules while reabsorbing only the nonionized salicylate.

The idea of ion trapping by alkalinization depends on the fact that salicylate is a weak acid. As pH increases, more of the drug is in the ionized form. Ionized molecules penetrate lipid-soluble membranes less rapidly than do nonionized molecules because of the presence of polar groups on the ionized form. Consequently, weak acids, such as salicylates, may accumulate in an alkaline urine in an ionized form and will not be reabsorbed by the kidney tubules.

Fluid deficits should be corrected with normal saline boluses. Alkalinization may be achieved with an IV bolus of 1-2 mEq/kg sodium bicarbonate, followed by an intravenous infusion of 3 ampules of sodium bicarbonate (132 mEq) in 1 L of 5% dextrose in water (D5W), to run at 1.5-2 times maintenance, to achieve a urine output of 3-5 mL/kg/h. Urine pH must be maintained at 7.5-8.0 and arterial pH should not be allowed to rise above 7.55.

4. What might contribute to the ineffectiveness of urine alkalinization in this patient? Why?
Hypokalemia, which is a common complication of salicylate poisoning, can prevent urinary alkalinization. Hypokalemia can make urinary alkalinization ineffective because in the hypokalemic patient, the kidney preferentially reabsorbs potassium in exchange for hydrogen ions, decreasing urinary PH. Urinary alkalinization will be unsuccessful as long as hydrogen ions are excreted into the urine. Thus, appropriate potassium supplementation to achieve normokalemia may be required in order to alkalinize the urine.

Volume depletion is another possibility that should not be overlooked.

5. Explain the acid base disturbance in salicylate overdose. Adult patients acutely poisoned by salicylates characteristically present with two primary acid base disturbances: anion-gap metabolic acidosis and respiratory alkalosis. Although metabolic acidosis begins with the earliest stages of toxicity, a primary respiratory alkalosis typically predominates initially. Frequently in pediatric salicylism the metabolic acidosis predominates.

Salicylates cause their characteristic (mixed) acid-base disturbances by different mechanisms:

-Salicylates stimulate the respiratory center, leading to hyperventilation and respiratory alkalosis.

-Salicylates are weak acids, which contribute to the acidosis.

-Salicylates interfere with the Krebs cycle and mitochondrial oxidative phosphorylation, limiting production of ATP, and leading to anaerobic metabolism and subsequent increases in lactate and pyruvate production.

-Increased fatty acid metabolism (as a consequence of uncoupling of oxidative phosphorylation) cause lipolysis with ketoacidosis.

-In compensation for the initial respiratory alkalosis the kidneys excrete bicarbonate, which later contributes to the metabolic acidosis.

-Inhibition of liver lactate elimination.

-Renal dysfunction by salicylate leads to the accumulation of sulfuric and phosphoric acids

What's Hot in EMS?

by Matt Bitner, MD

Well, really it is what's COLD in EMS that has people talking today. I am referring to pre-hospital initiation of therapeutic hypothermia (cooling the victim to a core temperature of 32-34°C for 12-24 hours) for victims of out of hospital cardiac arrest who have a return of spontaneous circulation. With somewhere between 600-1000 out of hospital cardiac arrests occurring daily in the United States, and almost half of these victims never making it to the hospital, it is essential that pre-hospital providers offer them the best chance not only for survival, but also for a good neurological outcome.

Since the publication of "Hypothermia after Cardiac Arrest" (HACA) and the Bernard study of induced hypothermia in the *New England Journal of Medicine* in 2002, there has been significant talk of the use of hypothermia to improve neurological outcomes in victims of cardiac arrest (they showed a relative risk reduction of 25-30% towards a good neurological outcome). The 2005 AHA consensus statement went on to endorse therapeutic hypothermia for victims of cardiac arrest as a IIa/IIb recommendation (depending on presenting rhythm).

While this is becoming more of a mainstream intervention in the ED and the Intensive care units, it has yet to be widely deployed in the pre-hospital environment. However, some experts in the field of resuscitation believe that pre-hospital induction of hypothermia is a way to overcome "institutional inertia."

Furthermore, it is a simple procedure to initiate for pre-hospital providers. A Pittsburgh study of cardiac arrest victims found that the average temperature when they had a patient with ROSC was 35-35.5°C and Bernard, et al. and Virkkunen et al. found that the infusion of cold IV fluids dropped core temperature 1.6-1.9°C. This means that pre-hospital providers can possibly get a victim of out of hospital cardiac arrest, who has return of spontaneous circulation and meets inclusion criteria, to goal core temperature with a simple infusion of "iced" IV fluids.

However, the key to success for the agencies, the hospitals, and most importantly the patient is that this process must be continued for the full 12-24 hours or the neuroprotective benefit is nullified. A partnership between pre-hospital providers, emergency departments, intensive care units, and nursing is critical in this endeavor and is key to its success. The first pilot program in the Metropolitan Atlanta area for pre-hospital hypothermia will soon be underway.

References/Further Reading:

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What's New in ICD-9 Codes for 2009 That Will Affect Emergency Medicine

by Jeffrey Linzer, Sr., MD FACEP

There will be more then 350 new and revised ICD-9-CM codes that will go into effect this October 1. It's important to remember that these codes have been added to be able to better track illness and injury.

There have been major changes in several areas. For example, there is a new code for secondary diabetes mellitus (249). This can be used to identify those patients who have diabetes due to another disease process (e.g. cystic fibrosis, pancreatitis) or chemical exposure (e.g. chronic steroid use). There has been an expansion of headache (339) and migraine (346) codes. Examples of the new headache codes includes "Acute post-traumatic headache" (339.21) and "Headache associated with sexual activity" (339.82). There is also a new 5th digit to identify patient with leukemia in relapse. Another major revision is in codes for skin conditions related to Erythema multiforme and Stevens-Johnson syndrome (695).

There is an entire new set of codes to identify patients exposed to various hazardous agents, but who not have any signs or symptoms of illness or injury:
V87.01 Contact with and (suspected) exposure to arsenic
V87.09 Contact with and (suspected) exposure to other hazardous metals
V87.11 Contact with and (suspected) exposure to aromatic amines
V87.12 Contact with and (suspected) exposure to benzene
V87.19 Contact with and (suspected) exposure to other hazardous aromatic compounds
V87.2 Contact with and (suspected) exposure to other potentially hazardous chemicals
V87.31 Contact with and (suspected) exposure to mold
V87.39 Contact with and (suspected) exposure to other potentially hazardous substances

It is important to note that many V-codes can be used as the primary diagnosis and will be reimbursed by third party payors.

Other new codes for more common problems seen in the ED include:
Malignant pleural effusion (511.81), Other specified forms of effusion, except tuberculosis (511.89);
Hematuria, unspecified (599.70), Gross hematuria (599.71), Microscopic hematuria(599.72);
Functional urinary incontinence (788.91);
Ventilator associated pneumonia (997.31);
Disruption of traumatic wound repair (998.33);
Extravasation of vesicant chemotherapy (999.81), Extravasation of other vesicant agent (999.82);
Encounter for screening for risk of pre-term labor (V28.82);
Noncompliance with renal dialysis (V45.12);
Wheelchair dependence (V46.3)

As of this writing the final addenda had not been released. Go to http://www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm to get the latest updates.

The new, revised and deleted codes are effective October 1, 2008. There is no grace period.

GCEP Welcomes New Members

New Members
Carlos Buchhammer, MD
Hesiri M. Fernando, MD
Jorge Mujica, MD
Chuc V. Pham, MD
Nalini K. Ramaiya, MD
Wilfredo Rios, MD

New Member Candidates
Gan Su
Helen R. Levey
Jonathan S. McWhorter
Tiffany Sanders
Yusef P. Williams
Dareema Jenkins

Kirk A. Munsayac
Jedd T. Salamat

New Member Resident
Joaquin Zalacain, MD

Where Are They Going?

MCG Residents:	Going to:
David Brosnahan, MD	Aiken, SC
Kristina Chanslor, MD	Dallas, TX
Darren Cohen, DO	Pembroke Pines, FL
Colin Coor, MD	Rockport, ME
Michael Coussa, MD	Sanford, FL
Alan Dennington, MD	Dallas, TX
Cline Jackson, MD	Cartersville, GA
Brian Leal, MD	Charleston, SC
Elizabeth Renwick, MD	Columbia, SC

Emory Residents:	Going to:
Angela Bogle, MD	Kansas City, MO
Michael Dinerman, MD	Atlanta, GA
Michelle Dumler Lall, MD	Detroit, MI
Mboh Elango, MD	Atlanta, GA
Michele Flagge, MD	Sacramento, CA
Samuel Graitcer, MD	Atlanta, GA
Michael Greenberg, MD	Atlanta, GA
Krista Jahnke, MD	Atlanta, GA
Noelle Jennings, DO	Atlanta, GA
Alicia Knowles, MD	New York, NY
Andre Matthews, MD	Atlanta, GA
Sudave Mendiratta, MD	Chattanooga, TN
Tene Osahar, MD	Charlotte, NC
John Perrin, MD	Charlotte, NC
Bridget Quinn, MD	Boston, MA
Sienna Steckel, MD	Atlanta, GA
Tamaurus Sutton, MD	Atlanta, GA

Upcoming Events

BDLS/ADLS/ADLS-I
July 22–25, 2008
Augusta, GA MCG
www.mcgcom.com or Contact Kathy Dunn at 706-721-1008

EMS Academy Refresher Course
August 4–6, 2008
Augusta, GA MCG
www.mcgcom.com or Contact Kathy Dunn at 706-721-1008

SMA Annual Scientific Assembly
August 7–9, 2008
Nashville, TN Southern Medical Association
www.sma.org

BDLS/ADLS/ADLS-I
August 11–15, 2008
Warner Robbins, GA MCG
www.mcgcom.com or Contact Kathy Dunn at 706-721-1008

LLSA Prep (3 years)
August 15, 2008
Augusta, GA, MCG
Contact Kathy Dunn at 706-721-1008

Tactical Emergency Medical Support (TEMS) Course
August 18–22, 2008
Columbus, GA
Contact: 910-577-0321

Annual Georgia EMS Conference
August 26–29, 2008
Savannah, GA GAEMS
www.ga-ems.com

Oral Board Review Course
September 6–7, 2008
Las Vegas, NV
SCCEP
www.theoralboardcourse.com

Emergency Medicine Oral Board Review
September 7–11, 2008
Hilton Head, SC
Staten Island University Hospital
www.emoralboards.com

Tactical Operator Care 1
September 23–24, 2008
Atlanta, GA MCG
www.mcgcom.com or Contact Kathy Dunn at 706-721-1008

ACEP Scientific Assembly
October 27–30, 2008
Chicago, IL American College of Emergency Physicians
www.acep.org

2008 AMA Interim Meeting of the House of Delegates
November 8–11, 2008
Orlando, FL AMA
www.ama-assn.org/

Difficult Airway Course
November 14–16, 2008
Atlanta, GA Airway Management Education Center
www.theairwaysite.com

If you would like to have an event listed in the EPIC, please contact Tara Morrison at tara@theassociationcompany.com

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