GEORGIA EPIC

The Newsletter of the Georgia College of Emergency Physicians

Physicians and their families enjoy the Annual Meeting Beach Party.

Viewpoint from the President

Maureen Olson, MD, FACEP

Maureen Olson, MD

WOW! If you weren't at the June meeting in Hilton Head you really missed a fine conference and a wonderful time. We bid farewell to Dr. Steve Holbrook as he stepped down as president and new officers and board members were elected. Steve has given many years of service to GCEP and GEMPAC. We are very grateful for his long term contribution and wish Steve and his family a safe and happy journey as they move to Australia for a year. Sounds like a marvelous family adventure.

This was the second year we presented plaques to groups with 100% membership in ACEP/GCEP. Last year Northside Emergency Associates was the ONLY group in Georgia to have 100% membership and they were presented with the first GCEP Commitment to Excellence Award. At this meeting we were able to present four plaques. Congratulations to Northside Emergency Associates for their second year at 100% membership and congratulations to Emory University School of Medicine's Department of Emergency Medicine, Medical College of Georgia Department of Emergency Medicine, and Athens-Clark (St. Mary's) for achieving 100% membership and receiving their first plaques. Actually, ACEP liked our program and implemented their own. ACEP plaques were presented at the June meeting with the GCEP plaque to be mailed to each group. We hope to have even more groups qualify next year. Remember, to qualify you need all full time eligible physicians who have been with your group a year or more to be members of ACEP/GCEP. Each year a plate with the date on it will be presented to all repeat groups to add to their plaque.

QUIET PLEASE! SILENT AUCTION in progress. Yes, this was our first year to have a silent auction to raise money for GEMPAC. We raised $3,540.00. A very big thank you to Dr. Steve Holbrook for donating a four-day weekend at his house on Lake Hartwell and to Dr. Vida Skandalakis for donating a week at her beach house on St. Simon's Island. Very popular items! A very big thank you goes to Carol Griffin, a professional Georgia artist and wife of Dr. Ralph Griffin, for donating a beautifully framed original oil painting. This caused quite a bidding war. You can view her work at www.carolgriffinfinearts.com. She will do commission work as well. Fortunately, she has agreed to donate another painting next year. Mr. Tripp Martin from Georgia Link, our lobbyist, donated two walking sticks whose heads were made from the door knobs of the Georgia State House taken during the restoration. The bidding on these went right down to the wire. Play ball was on the minds of all those bidding on the four Braves tickets with parking pass that Dr. Matt Watson donated. Sounds like a fun evening for the lucky winner. The Crowne Plaza donated two nights at the resort with all fees and activities. There were posters signed by the original artist as well donated by Tripp Martin. Don't miss out on next year's auction. Plan now to attend the conference in June, 2008.

As we look forward to this coming year forward and expanding our influence, membership and services, I would like to share with you some of the thoughts I have for moving *continued on page 3*

More on the GCEP Annual Meeting Hilton Head Island on page 8

Record Disposal Requirements Under the Business Administration Act (O.C.G.A. §§ 10-15-1 et seq.)

The Governor's Office of Consumer Affairs (OCA) has been notified of several incidences of businesses discarding medical records containing personal patient information without first obscuring or obliterating the confidential information contained therein. OCA therefore wishes to remind those in the medical industry about Georgia's Business Administration Act (BAA), which regulates the proper disposal of customer records that contain sensitive information about a customer's medical condition or certain financial data relating to a customer's account or transaction with a business. According to the BAA, once such records are no longer needed, a business must do one of the following before discarding them:

- Shred the record;
- Erase the personal information contained in the record;
- Modify the record so that the personal information is unreadable;
- Or take actions that will ensure that no unauthorized person will have access to the personal information contained in the records.

Improper disposal of records containing personal information may result in a fine of $500 per record, up to $10,000. For more information, contact Bill Cloud, Governor's Office of Consumer Affairs, at 404-656-3790.

Pearls...to Remember

Physical Exam (PE) Requirements

Examine the Exam! All ED patients must be examined to be coded and billed. According to Medicare Documentation Guidelines a minimum of one body part is required for even the lowest ED E/M code 99281. A 99284 PE typically *requires five to seven body areas or organ systems, while a 99285 requires eight organ systems to be examined. Only organ systems may be used to satisfy the requirements for 99285.

*see ACEP FAQ on Evaluation and Management (E/M) Documentation Requirements

The Level 5 Caveat

The definition of 99285 includes the concept that the History, Physical Exam, and Medical Decision Making requirements must be met "within the constraints imposed by the urgency of the patient's clinical condition and/or mental status". Most Medicare carriers require a description of the patient's urgent condition and the physician's thought process. So make sure to document why the severity of your patient's illness precludes performing a full History or Exam.

Laceration Repair

These high RVU procedures are categorized as Simple, Intermediate, or Complex. Remember that not all single layer repairs are automatically considered simple. If the wound is heavily contaminated and requires "extensive cleaning or removal of particulate matter" a one layer repair may be reported as Intermediate.

continued from page 1 the College forward. I hope some of these areas will spark your interest and you will want to get involved. We really do need the help if we want to continue to grow.

PUBLICITY- We need a specific person to head up a publicity committee to get regular articles published in the local newspapers regarding emergency medicine issues such as public service articles or radio or television interviews. Topics like "heat-related illness," "What to do if you suspect you have the flu?," "cold-related illness" or any other positive topic to unmask the mystery of emergency room care. We need to do a better job of spotlighting emergency medicine outside of the political arena. This will not only give us visibility, but will keep the positive side of emergency medicine in the public's mind. Dr. John Rogers has agreed to work on this but he will need people to help him. Remember you won't have to write every article, but arrange for various experts to contribute. Ideally we would like to get something out once a month. This is not just for Atlanta papers, but it is vitally important for us to be visible throughout the state.

MEMBERSHIP BENEFITS- This can be a lot of fun! We need to form a committee to explore ways to add membership benefits on the state level. PERKS! The Georgia Aquarium has already agreed to set up a special plan for us to offer discounts on tickets to GCEP members. Thanks to Mr. Carey Rountree who is the director of marketing for the aquarium. We need to look at other venues throughout the state like car rental, hotel packages, restaurants, Fox Theater, Alliance Theater, and symphony, Six Flags, Callaway, Lake Lanier just to name a few. Hop on board and have a good time creating this!

INSURANCE- An exploratory committee is needed to investigate the possibility of creating a group health insurance, life insurance, disability insurance maybe even long term care package for emergency physician as a group available to members at a discount rate. Similar to what is done by the AMA.

There are many other opportunities to get involved and your willingness to step forward would be greatly appreciated. Contact Tara Morrison via the web site or at taramorrison@bellsouth.net She will contact the appropriate board member to get you started.

REMEMBER A GROUP ONLY NEEDS TO STAY SMALL BECAUSE THEY FAIL TO THINK BIG. This is our time. Let's grab the ball and run with it.

Residency at Emory

by Philip Shayne, MD, Residency Director

The 18 new interns entering Emory Emergency Medicine this summer represent our 33rd class and will join over 350 Emory EM graduates when they finish in 2010. In every sense, these 18 residents represent the type of emergency physicians Emory has been recruiting, training, and turning out since the first two emergency medicine residents graduated in 1977. This group is recruited from all over the country, are academically strong, rich in experience and diverse in backgrounds. And they are all coming to Emory to experience the incredible training grounds of both Grady Memorial Hospital and Emory Healthcare.

Similarly, the 18 graduates of the Emory Emergency Medicine Class of 2007 proudly represent our typical product. These are each well-trained, confident emergency physicians who have had their pick of options for their careers. Despite coming to Emory from all over the country, the majority settle here in Georgia; this year ten have selected community positions in the state, one is staying at Emory as an EMS fellow, and another will start at the CDC. Matt Bitner is starting as an Emory EMS fellow in our Department, and is the recipient of the prestigious and very competitive SAEM/Medtronic EMS Research Fellowship grant. This fellowship will allow him to pursue training in pre-hospital and disaster medicine and simultaneously earn a Masters' in Education. Adrianne Sever is our second resident in three years to secure a competitive CDC Epidemic Intelligence Service (EIS) fellowship and become a member of the CDC's elite surveillance corp. The others choosing to stay in Georgia will be with groups in Atlanta, Savannah, and Columbus.

We are now able to fully integrate each of the five Emergency Departments in the Emory/Grady system into the residents' curriculum. Besides the Emory University Hospital ED, Emory residents treat patients at Emory Crawford Long Hospital, Children's Healthcare of Atlanta at Egleston, Children's Healthcare of Atlanta at Hughes-Spalding, and Grady Memorial Hospital. Emory residents have always had the advantage of the incredible clinical experience at Grady; now up to a third of their time is spent learning the efficiencies of a community ED at Crawford, the high-tech and complicated tertiary population at Emory, and the world class pediatric world of Children's Healthcare of Atlanta at Egleston (ranked the number three children's hospital in the US).

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Leadership

This has been an exciting time for Emory, and we have been incredibly successful in moving faculty into leadership positions where we can advocate for the issues we believe are important for our specialty and our patients. Arthur Kellermann, who has been spending the last year in Washington, DC as a Robert Wood Johnson Policy Fellow, will be returning later this year to Emory as the School of Medicine's first associate dean for health policy. In his new role, Dr. Kellermann will work with the dean on developing public policy, serve as principle advisor on legislative and policy issues, and assist executive leadership in the coordination and management of the School's strategic reactive response as well as proactively planning academic, research, and clinical public policy matters. Clearly this is an area where he excels and his efforts will be a tremendous boon for emergency medicine in the State of Georgia.

Kate Heilpern is continuing as acting chair of the Department of Emergency Medicine as the Medical School conducts a national search for a new chair. In other leadership roles, Sheryl Heron was named interim assistant dean, Medical Education and Student Affairs for the School of Medicine; Douglas Ander was named director of Simulation and will be an assistant dean in the School of Medicine; Douglas Lowery-North MD was named to the Board of Emory Specialty Associates (ESA) and has led the department's efforts to open up the ED at Emory John's Creek, our fourth clinical site; Don Stein PhD was appointed to the Executive Committee of the National Advisory Council for the National Institute on Child Health and Development, and received the Award for Distinguished Scientific Contributions to Behavioral Neuroscience from the International Behavioral Neuroscience Society; Tammie Quest became one of the first EM physicians ever to become boarded in Palliative Care and is taking a leadership role in developing the Palliative Care and Hospice Medicine national certifying examination; Nicole Franks named co-treasurer of the Emergency Medicine Section of the National Medical Association; Deb Houry was elected to the Board of Directors of SAEM (Society for Academic Emergency Medicine), and Kate Heilpern was elected as president-elect for SAEM; Leon Haley is also on that Board; Philip Shayne was elected secretary/treasurer of CORD (Council of Emergency Medicine Residency Directors). Josh Wallenstein is the new president of the SAEM Medical Student Educators Interest Group.

Advocacy

For the third year, we designated a Legislative Day for the Emory Residency Program. Twenty EM residents join GCEP leadership at the State Capitol in talking to Georgia legislators about significant issues facing emergency care in our state Not only are young resident physicians wonderful advocates and fresh faces in front of our legislatures, but this is also an excellent opportunity for residents to see how "sausage is made" and become involved. At the same time in Washington, D.C., Art Kellermann was assigned to Henry Waxman's Congressional Committee on Oversight as part of his RWJ Health Policy Fellowship. Leon Haley testified on behalf of Level One trauma centers to the State of Georgia Trauma Commission. Kate Heilpern was awarded a grant to travel to rural Georgia hospitals to speak to staff about emergency care issues. Sheryl Heron led efforts to educate legislators about issues related to violence against women in Violence against Women Day at the Georgia Capitol. Leon Haley hosted a tour of the Grady Emergency Care Center for Senator Saxby Chambliss to discuss issues related to medical services and trauma care, and Maureen Letts Joyner led an effort to bring faculty and residents to teach Grady High School students about healthcare issues.

Toxicology

The Medical Toxicology Section continues to grow. In addition to directing one of the five busiest Poison Control Centers in the country, the section runs one of the most successful Tox fellowships in combination with the CDC. Two new fellows start this summer, and Director Brent Morgan hopes to expand the Tox fellowship to three per year in 2008. Art Chang, who finished the program in 2006 has joined our faculty and oversees the resident clerkship.

Pre-Hospital and Disaster Preparedness

The Emory Section of Pre-Hospital and Disaster Preparedness continues to successfully direct a huge variety of operations, including 911 response for all of Fulton County. New accomplishments include Eric Ossmann's and Alex Isakov's continued success with a HRSA training grant, focusing on simulation-based disaster planning and preparedness; Melissa White, an Emory graduate and prior EMS fellow joined the section as faculty and assumed significant leadership role for College Park EMS; the Section was awarded the new Sandy Springs EMS contract through efforts of Ian Greenwald who also assumes medical direction for several Georgia events, including the ING marathon and Tour de Georgia.

A new Emory University Office of Critical Event Preparedness and Response (CEPAR) is expected to further improve the University's ability to deliver a coordinated and effective response to catastrophic events. Alexander P. Isakov, associate professor of Emergency Medicine was named CEPAR director with an official start date of May 1. The new office, which will report to President Jim Wagner and other senior leadership, will integrate all relevant components of the University in an interdisciplinary approach to the chal-

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lenges of a catastrophe. The office also will partner with the broader community, including local, regional and federal resources to improve outcomes during and after an event. The new center has a broad scope, addressing all hazards, including natural disasters, human-caused catastrophic events and public health emergencies.

Research

Emory Emergency Medicine has three main research arms; clinical, bench and public health. Deb Houry and David Wright have launched a successful new strategic development plan. With a generous grant from Rooms to Go, the department awarded three faculty funding to proceed with novel research topics. Selected this year were: Emily Hirsh, Nicole Franks, and Iqbal Sayeed PhD. David Wright was awarded an NIH Planning grant to prepare for the Multicenter ProTECT clinical trial and NIH NETT consortium for neurologic emergencies. The Coulter Foundation awarded David Wright an additional year of funding to study use of DETECT helmet in Wesley Woods patients, which helps strengthen the department's relationship with Georgia Tech's Biomedical Engineering department. Don Stein received the Erskine Distinguished Lecturer Award from Canterbury University, Christ Church, New Zealand. This allows him the opportunity to deliver a series of lectures highlighting our department's brain injury research. His Brain Lab is conducting extremely promising work on an ischemic stroke model and the effect of progesterone and its metabolites. The BOOST clinical trial of CHF patients was started by Douglas Ander and Daniel Wu, evaluating nesiritide for CHF in the ED. Other cardiac emergency care research projects include those conducted by Bryan McNally with HART, TIME and CARES - having EMS transmit field EKGs to the ED so the ED doc can mobilize a cath team. There are now five collaborating hospitals in metro Atlanta.

International Programs

We were delighted to welcome four physicians from the Republic of Mozambique who were with us for a year to earn their Masters in Public Health as part of the department's NIH Fogarty International program to build injury control research expertise in their country. This is a collaborative venture involving several members of our department, Emory's Division of Trauma and Surgical Critical Care in the Department of Surgery, the Rollins School of Public Health, the University of South Africa (UNISA), and the Department of Violence and Injury Prevention at the WHO. Christie Keyes, a recent graduate of the Vanderbilt program, will be joining our department as our International Emergency Medicine fellow. Other Emory EM international efforts include Scott Sasser and Kate Heilpern's work with Dr. Ken Walker to develop partnership for development of emergency care in Tbilisi, Republic of Georgia. USAID is funding this demonstration project, providing opportunity for EM faculty and staff to travel to Tbilisi and teach EM best practices to ED personnel of new hospitals. There is also potential funding for development of international rotation for our residents. Jeremy Hess was awarded an IPA with the CDC to study health effects of global warming. And Kate Heilpern and Scott Sasser were invited to meet with Emory leaders to consider partnership with hospitals in northern Kenya for development of EM and trauma systems.

We are pleased to be a part of emergency care in Georgia and proud of Emory's contribution. Our new interns are joining a wonderful tradition, will have a vast array of opportunities available to them, and many will elect to stay active in our community. If you are interested in learning more about Emory and our program please visit our web site at em.emory.edu, or contact the department at 404-616-4620.

Evaluating Radiographs from the Floor and Risk

By Pete Steckl, MD, FACEP Risk Management Director Emerginet, LLC

Case Description: A 56 year old male with a history of recent deterioration in health and status post abdominal surgery had a G-tube replaced by a consultant on the floor. Post procedure, the radiology tech was instructed to take the gastrograffin study to the ED for evaluation by the physician. The films were presented to the EDMD with no accompanying clinical data. He had received no contact from the consultant.

The ED physician, in evaluating the x-rays, noted a tube in the vicinity of the stomach with dye seeming to conform to the general stomach outline. He read it as appropriately positioned and the patient was returned to his room. On the basis of this reading the patient was fed through the G-tube.

The next morning the radiologist over-read the film and noted the tube to be outside the lumen of the bowel and, in fact, subcutaneous. The floor was immediately called and all feeding was discontinued. The patient subsequently passed away 2 days later.

From Dobhoff feeding tube placements to post central line chest x-rays, radiographs seem to arrive from elsewhere in the hospital on a regular basis for our interpretation. We, more than any other specialty outside of radiology, are charged with making critical decisions on the basis of radiographs and are generally comfortable in that role. Nevertheless, the evaluation of these films in isolation without accompanying clinical information rightfully causes some angst amongst many of us.

Though the pressure in the busy ED to "glance and go" is great, an appreciation of the increased risk we incur in reading these films is very important. While studies have shown that ED physicians read x-rays with great precision, it is clear that accompanying clinical context contributes greatly to our diagnostic accuracy. Notably, the films that arrive from the floor lack this vital component and hence should be considered more prone to error. When therapeutic decisions are based on these readings the potential for morbidity also increases. What, if anything, can be done to minimize our diagnostic error and risk?

The simple answer is to obtain the missing clinical context where you can. Taking the time to do some detective work is often helpful in verifying the question that is being asked. If, on investigation, the question is clear and simple, as in the chest x-ray to be evaluated post central line placement for pneumothorax, a quick chat with the x-ray tech may be all that is needed. If, on the other hand, the question is more complex as in the chest x-ray sent from the ICU requesting evaluation for sudden dyspnea with hypoxia more aggressive maneuvers are in order. This scenario is far more precarious as we are asked to venture out of the confines of x-ray interpretation and instead answer a clinical question. Taking on this task alone without benefit of records or patient evaluation is very hazardous and should be handled cautiously, if at all. Should we agree to take on this task, an immediate call to the official ordering physician is in order to elicit his knowledge of the circumstances surrounding the ordering of the test and to involve him in the requisite clinical decision making that must follow. Importantly, it is most prudent under these circumstances to limit one's analysis to radiographic reading alone without venturing into the realm of clinical diagnosis. In all cases your specific reading and discussion with the attending needs to be documented on a progress note that ultimately gets forwarded to the chart.

Feeding tube placement evaluation also involves some increase in risk. Because therapeutic feeding is being based on one's evaluation, the consequences of a misread are obvious. Many physicians feel comfortable giving orders for feeding on the basis of their interpretations. Others will attest to no more than the presence of the tube below the diaphragm. A middle of the road risk minimizing strategy may be to involve the ordering attending in the process by reporting your impression to him/her and allow them to give the order to feed as they see fit. Again, documentation of the discussion specifics is imperative. Finally, as in the G tube study case above, appreciate that appearances can be deceiving and if there is any uncertainty as to location, the prudent course is to withhold feeding of the patient until correct placement can be verified by the radiologist.

GCEP Annual Meeting at Hilton Head

by Dr. Carl Menckhoff, MD, FACEP, FAAEM

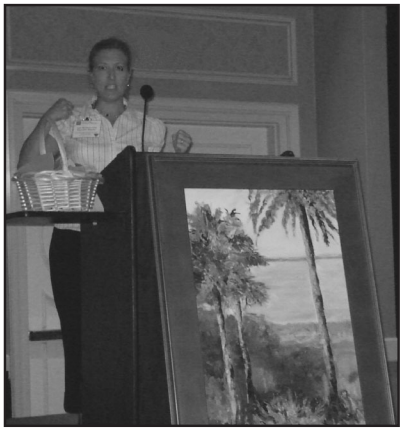
Hilton Head Island was the site of another successful annual meeting for the Georgia College of Emergency Physicians this year. 80 physicians from all around Georgia participated in the 3 day educational assembly at the Crowne Plaza Resort from June 8-10. This year for the first time, the GCEP education committee created a pre-hospital track geared toward pre-hospital providers. We had 10 providers attend that track with outstanding reviews from all. GCEP will be incorporating the pre-hospital track again next year and are looking to reach out to a larger and larger number of pre-hospital providers.

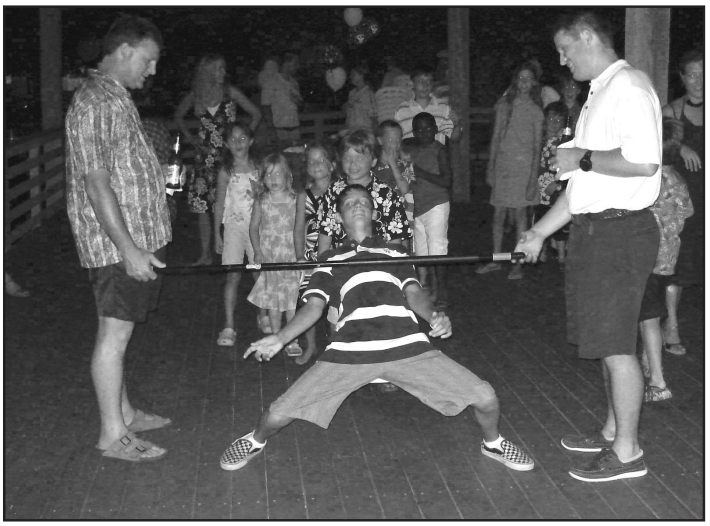
Conferences covered topics such as: LLSA review, End Tidal CO2 monitoring, Pulmonary Embolism, Introduction to Tactical Medicine, Approach to Pediatric Fever, How to Make the Decision Between Ground and Air Transport, Special Considerations in Pediatric Trauma, Care of the Stroke Patient, and many others. This year also marked the 4th annual Emergency Medicine Jeopardy competition, with teams from Emory, MCG and the courageous community docs. The competition was exciting with the team from MCG taking the title of jeopardy champions for the first time.

As always, the Saturday beach party was a great success and was thoroughly enjoyed by all, with great food, drink and dancing for the adults and face painting, hula hooping and arts & crafts for the kids.

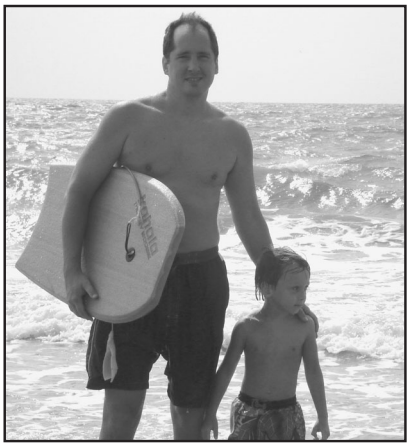
Whether you attend for the international quality lectures, or the world class relaxation, this conference offers something for all practitioners and their families.

The annual meeting will be held at the Crowne Plaza Resort on Hilton Head Island again on June 13-15 of 2008. 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.





GCEP Annual Meeting Hilton Head Island



House Votes to Eliminate 9.9 Percent Medicare Physician-Payment Cut

Earlier this evening, the House of Representatives voted 225-204 to approve H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act of 2007. This legislation includes provisions that eliminate the scheduled 9.9 percent Medicare physician payment reduction for 2008 and the 5 percent reduction for 2009. Instead, the bill includes a 0.5 percent payment increase for physicians in each of these years.

In addition, the legislation repeals the sustainable growth rate formula on which Medicare reimbursement is based, and provides six seperate service categories, each targeting growth rates. Nurmerous other provisions in the 471-page document affect medical groups, including:

- Reauthorization of the State Children's Health Insurance Program (SCHIP)
- Changes to the Medicare Advantage program
- An increase in the tobacco tax

This bill will now proceed to a conference with the Senate-passed SCHIP bill, which does not now contain any provisions relative to Medicare physician payment. The differences between the two bills must be reconciled; then both the House and the Senate must approve a conference agreement before the legislation goes to the president for signature.

Residency at Medical College of Georgia

by Stephen A. Shiver, M.D., Assistant Residency Director, Brad Reynolds, M.D., Assistant Residency Director, and Larry Mellick, M.D., Residency Director, Department of Emergency Medicine, Medical College of Georgia

Shorn locks. There is an epidemic of acute alopecia in the Emergency Department at the Medical College of Georgia (MCG). Early reports suggest that the malady is limited to a number of male faculty members who are involved in the residency training program in some capacity. Not even the chairman was spared. "Embarrassing, but exciting," declared one recent victim. Never before in human history has there been such enthusiasm over baldness.

Allow me to elaborate. There is somewhat of a tradition within the residency training program to offer various incentives for improving performance on the American Board of Emergency Medicine In-Training Examination. The incentives have taken myriad forms in the past, such as providing additional funds for national conference attendance, textbook purchases, etc. However, the residents have developed their own favorite incentive, which is where the hair loss comes into play.

A number of faculty members from within the department have been recruited annually by the residents to make the "alopecia pledge." Providing that the residents in aggregate perform above a certain predetermined standard on the In-Training Examination, all those making the pledge will lose their locks. Being quite intelligent, the faculty agreed to a safe level of participation - the bar was set impossibly high. Through this ingenious plan, the residents would be encouraged to perform their best and the faculty would not be at any real risk. Or so they thought.

Unfortunately, or fortunately depending on one's viewpoint, the bar was not set quite lofty enough. As a group, the residency performed better than at any time in our training program's history. The threshold was set at 80 percent correct and the residency score was 80. Needless to say, the residents were elated. The official shearing ceremony was held during one of our weekly conferences and the residents got to showcase their barber skills. Judging from the results, our resident staff could use a little training in the hair styling arena. However, fun was had by all and we congratulate the residents on their outstanding job this year!

July brings more change than any other month for an academic training program and this year is no exception. We are about to say farewell to another outstanding group of seniors and welcome an incoming group of enthusiastic interns. Mixed emotions reign supreme. We are sad to see the seniors leave but are comforted by our confidence in their abilities and by the friendships that have been made over the past three years. We know that as they disperse from Augusta they will represent our program well in disparate regions of the country. It is their time to become leaders and, no doubt, they will do so. Conversely, the hot steamy weather of late June in Augusta means nine new members of our family will soon be arriving. The match was exceptionally kind to us this year and the newcomers have the distinction of possessing the strongest academic credentials of any intern class in our history.

The residency leadership feels blessed to have such a talented group of residents and we realize that it is our responsibility to ensure that every ounce of potential is tapped. We are a forward looking, optimistic group and feel strongly that the best years for our training program are yet to come. No one is resting. On the contrary, we continue to pump increasing amounts of academic iron in order to improve our program's overall fitness level.

Though much change has occurred over the past year, including a new program director and the addition of a second assistant program director, the residency has adapted nicely. Obviously, change brings challenges as well as opportunities and our experience over the past 12 months reflects this truth.

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Medicare Physician Quality Reporting Initiative

by Dr. Richard Wild

Statute and Overview

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by the Centers for Medicare & Medicaid Services (CMS). CMS has titled the program the Physician Quality Reporting Initiative (PQRI).

PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. Eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007 may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare Physician Fee Schedule services submitted during the reporting period.

CMS is developing and implementing 'pay for performance' to encourage the provision of high-quality, cost-effective care for of Medicare beneficiaries. To view the legislative language and see a detailed list of eligible professionals, visit the CMS PQRI website; http://www.cms.hhs.gov/PQRI.

Specifications

In 2007, PQRI reporting is based on 74 unique measures associated with clinical conditions that are routinely represented on Medicare fee-for-service claims through the use of diagnosis codes from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and procedure codes from the Healthcare Common Procedure Coding System (HCPCS). See www.cms.hhs.gov/PQRI for specifications document.

PQRI Quality-Data Codes

There are specific PQRI quality-data codes associated with each of the 2007 PQRI measures. PQRI quality-data codes are CPT® II codes, though temporary G codes will be used on an exception basis where CPT Category II codes have not yet been developed. PQRI quality-data codes translate clinical actions so they can be captured in the administrative claims process. For example, PQRI quality-data codes can relay that:

- The measure requirement was met.
- The measure requirement was not met due to documented allowable performance exclusions (i.e., using performance exclusion modifiers).
- The measure requirement was not met and the reason is not documented in the medical record (i.e. using the 8P reporting modifier).

Integration of PQRI Quality-Data Code Reporting Into Your Care Delivery Process

1. Select measures that address the services they provide to patients. Consider conditions treated and types of care provided.
2. Define team roles to measure and plan your approach to capture quality data for reporting.
3. Modify workflows and billing systems to accurately capture quality-data codes.
   - Explore worksheets or other tools for data capture.
   - Discuss systems capabilities with software vendors.
   - Test systems.

PQRI Participation Strategies: Reporting Quality Data

- The CPT Category II code, which supplies the numerator, must be reported on the same claim as the payment ICD-9-CM and CPT Category I codes, which supply the denominator of the measures.
- Multiple CPT Category II codes can be reported on the same claim, as long as the corresponding denominator codes are also on that claim.
- The individual National Provider Identifier (NPI) of the participating professional must be properly used on the claim.
- Multiple eligible professionals with their NPIs may be reported on the same claim with each quality-data code line item corresponding to the services rendered by the professional for that encounter.
- Submitted charge field cannot be blank.
- Line item charge should be $0.00; if a system does not allow $0.00 line item charge, use a small amount like$0.01.
- Entire claims with a zero charge will be rejected.
- Claims must reach the National Claims History (NCH) file by February 29, 2008 to be included in the analysis.
- Quality-data code line items will be denied for payment but then passed through to the NCH file for PQRI analysis.
- Claims that are resubmitted only to add CPT Category II codes will not be included in the analysis.

Ensuring Success

- Utilize the PQRI website, *www.cms.hhs.gov/PQRI* for educational resources and a 2007 PQI tool kit.
- Reporting started July 1, 2007.
- Report on as many measures as possible.
- Report on as many eligible patients as you can to decrease the probability of being subject to the bonus cap.
- Ensure that quality codes are reported on the same claim as the diagnosis and CPT I codes.

Important Measures for Emergency Medicine

Although CMS does not intend any one measure to be specialty specific, and suggests that medical specialty societies advise their members on appropriate measures, it would appear that the following measures would be most applicable to emergency medical practice:

Measure
28, Aspirin on arrival for acute myocardial infarction.
29, Beta-blocker at time of arrival for AMI
34, Stroke and stroke rehabilitation: t-PA considered
35, Stroke and stoke rehabilitation :screening for dysphagia
54, EKG performed for non-traumatic Chest Pain
55, EKG performed for syncope
56, vital signs for Community-Acquired pneumonia (CAP)
57, Assessment of O2 Sat. for CAP
58, Assessment of mental status for CAP
59, empiric antibiotic for CAP (bacterial)

Physicians may determine that other measures are also appropriate to their particular practice. CMS wants to remind physicians that when three or more measures are applicable to a practice, then three measures must be reported at the 80% level in order to quality for a bonus. This would likely apply to most emergency practices. The more applicable measures the physician reports on, the higher the number of total reporting instances will be and the more likely that the physician will receive the full 1.5% bonus on all Medicare allowed charges for the reporting period.

Residency at Medical College of Georgia

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Most of the major overhaul has been accomplished and 'fine tuning' is all that is needed at this point. In essence, all of the changes have been made with the ultimate goal of becoming stronger academically. At the same time, leadership is cognizant of the clinical strengths for which our program and our graduates are already well known. Rather than simply preserving the clinical strength, significant effort is being expended in improving this area as well. We pursue an ideal balance between the academic and the clinical realms, effectively blurring the lines of separation and merging the two into one.

Technological adjuncts continue to be a focus of the residency. Leadership feels strongly that new technology offers the opportunity to streamline the residency process and produce a better trained emergency medicine physician. We are close to our goal of becoming paperless. Everything from monthly duty hour reports to procedure logs is now organized and available online. Of particular interest to the residents, the technology is allowing the goal of obtaining more real time feedback from multiple sources to become a reality.
Our residents now receive unfiltered feedback involving both daily and monthly evaluations online without the delay inherent in a paper system. Likewise, faculty evaluation by the residents occurs via the same mechanism. Other recent additions to our technological armamentarium include an audience response system in the main lecture hall and a large, flat screen television with high speed internet access in the morning conference room. These recent additions will allow for more interactive presentations both weekly in a grand rounds format as well as daily in a more informal, conference type setting.

We remain proud of our past but more excited about our future. We have a dynamic, forward-thinking department that is more committed than ever to resident education. If you would like to learn more about us, we would be delighted to hear from you. Please contact the residency at (706)721-2613 or visit our website at: www.mcg.edu/resident/em/.

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