

Newsletter for the Members of the Kentucky Chapter

Fall 2017



Daniel J. O'Brien, MD, FACEP
President

[Ashlee Melendez](#)
Executive Director

Phone: 502.852.7874

Fax: 502.852.0066

Bruce Lo, MD, MBA, RDMS, FACEP
President, Virginia College of Emergency Physicians
Payment Questions Add More Pressure in the ER

Imagine going into business knowing that about half of the work you do will be done for free. Not only that, the government mandates that you perform your work and that your business has to remain open all the time (yes, even weekends, nights, and holidays). [Access Full Article.](#)

This article was Published Richmond Times-Dispatch on December 2, 2017.

Random Hypothermia Facts

Martin Huecker, MD, FACEP

Education Committee Chair

Winter brings the challenge of managing hypothermia patients. Below are random, possibly forgotten facts about hypothermia from Auerbach's Wilderness Medicine.

Mild hypothermia (~90-95 OF), Moderate (~84-90 OF), Severe (~ < 84 OF)

Intoxicated patients are trying to fool you. Homeless patients are often hypothermic. Don't diagnose hypothermia with an ECG (Osborne waves).

The tachycardic hypothermic patient should worry you. Look for something else.

Do not forget all of the causes of secondary hypothermia in these categories: decreased heat production, increased heat loss, impaired thermoregulation.

Most hypothermic patients are volume depleted.

Like cirrhosis, hypothermia causes hypo- and hyper- coagulable states.

Paradoxical undressing: "preterminal effort to address impending thermoregulatory collapse."

You cannot predict acid-base abnormalities in hypothermia. Patients are equally likely to be normal, acidotic or alkalotic.

Hyperkalemia is more dangerous in the hypothermic patient.

Esophageal temperature is the most reliable.

Intubation indications in hypothermia are the same as in normothermia.

Hypothermic patients are at risk of compartment syndrome and rhabdomyolysis.

Consider active rewarming in patients with temperature < 90 OF.

Beware of **core afterdrop**. Cool blood from extremities returns to the core after rewarming. A 0.5 OF afterdrop can decrease MAP by 30% and SVR by 50%.

Contraindications to CPR in hypothermia: DNR, lethal injuries, chest wall depression impossible, signs of life, rescuers endangered.

Grave prognostic indicators: temp below 54 OF, pH below 6.5, potassium above 12, intravascular thrombosis.

A child at 57.6 OF with potassium of 11.8 had a complete neurologic recovery. The lowest therapeutic hypothermia survival occurred at 48.2 OF.

KACEP Conference Summary
Ryan Stanton MD, FACEP
PR Committee Chair
KACEP Past President

Thank you for all that participated in our KACEP Annual Meeting Conference this November at Churchill Downs. For those that attended, a great panel of speakers educated on finances, business, careers outside of emergency medicine and an update on ACEP challenges and agenda. We also heard from Kentucky Senator, Ralph Alvarado about the legislative year in review and goals for next year.

Daniel Wrenne with Wrenne Financial in Lexington, KY talked to us about the financial goal of doctors. The focus was on establishing your life priorities and then designing a financial strategy to meet those goals. He talked about some of the mistakes he sees with physicians and some of the strategies to achieve your goals.

Dr. Jeremy Corbett, emergency physician with Central Emergency Physicians and business leader then talked about how emergency physicians are uniquely qualified and positioned to succeed in the business world. The focus was on pursuing your passions and interests which will more likely lead to success. He stressed that you need to foster relationships and connections that can fill in the gaps in business knowledge that are not a standard in our medical education, or seek further education in business and management.

We were also honored to have Dr. Vidor Friedman, Florida emergency physician and ACEP Board member. He talked about some of the challenges we face on the state and national level as well as what ACEP has accomplished for its members. We are in a volatile political and healthcare environment which will impact us all, throughout the house of medicine. He also stressed the importance of emergency physician activity on the state and national level.

The good news, if you weren't able to make the conference, we were able to record these talks and will release them soon. I will post them to YouTube and then send the link out to our membership. We (KACEP Board) felt that the information was incredibly informative and useful, and thus should be available to ALL members. With that in mind, go ahead and "save the date" for November 15, 2018 for our next annual meeting and conference. Next year is all about pediatric emergency medicine and readiness. We will have a great selection of experts that will take your pediatric emergency care to the next level. I hope to fill the room and help advance care for our patients across the commonwealth.



ANTHEM DENIALS
Wes Brewer, MD, FACEP
KACEP Past President

By now many of you will have begun to see a flood of denials for ED visits for patients insured by Anthem. While the denials have been threatened for several months, we really began to see

an increase in denials beginning in late summer. In addition, the denials have also begun in Georgia, Missouri, and Virginia and are scheduled to begin in Indiana after January 1.

We have had no communication from Anthem regarding the criteria for the refusals but it appears to be based solely on retrospective criteria. In short, it appears that they are looking solely at the diagnosis codes. Rumor has it that these denials are all reviewed by a physician reviewer, however many that we have seen have a turnaround time of 3 days without any request for medical records making it seem very unlikely that any review is taking place. There is said to be a list of over 2000 codes on their list of codes targeted for denial. Locally we have seen denials upheld on appeal for cases of abdominal pain and even head injuries. "Chest pain with respiration" is on the list so we are back to the situation that existed 30+ years ago when you went to the ED with chest pain and it was an MI the bill was paid but how dare you have indigestion and not know the difference beforehand. Obviously, these examples are clearly violations of the Prudent Layperson Standard in Section 1302 (b) of the Affordable Care Act. Furthermore, Kentucky Revised Statute 304.17A-580 states in part the following:

An insurer offering health benefit plans shall cover emergency medical conditions and shall pay for emergency department screening and stabilization services both in network and out-of-network without prior authorization for conditions that reasonably appear to a prudent layperson to constitute an emergency medical condition based on the patient's presenting symptoms and condition. An insurer shall be prohibited from denying the emergency room services and altering the level of coverage or cost-sharing requirements for any condition or conditions that constitute an emergency medical condition as defined in KRS 304.17A-500.

So, what can you do to combat this dangerous policy? First of all, wear the white hat and be an advocate for your patients. Nothing moves lawmakers and regulators like the story of a patient (constituent — read voter) who has been harmed. If you become aware of egregious denials that are obviously medical emergencies we need to know. We have been attempting to assemble a file of denials that will assist with pleading our case to regulators. Involve your hospital administration as facility charges are also being denied. Be sure your administrators are aware and that they are using the template developed by the KY Hospital Association to track denials for facility charges. Denials can be reported using the billing hassles log found at this [ACEP website link](#). There are also several factors that may influence whether or not the claim will be paid. We are led to believe that if the patient is referred by another provider that the claim will be paid. This is especially important if the patient is referred in from an urgent care facility or by a nurse-line. And yes, there is an ICD-10 code for referral from another provider. Talk with your IT department and be sure this code is available in your EMR. Document if the patient was sent in by any other provider. Also, remember to document if there is no open urgent care nearby.

Coding can be your friend or your biggest enemy. Within the limits of truth, try to avoid using any “unspecified” codes as these seem to be a big target. Contrary to what we have been taught, sometimes documenting too much can present a problem. We have seen examples in which a thorough provider documented 3 codes that were clear cut unquestionable emergent diagnoses and then documented otitis media as a fourth code causing the claim to be denied.

Be assured that this issue is a top priority with your KACEP Board and we have spent many hours developing strategy in conjunction with national ACEP to combat this issue but we need your help. If you uncover one of these egregious denials use the story to your advantage, tell us, tell your legislator and help your patients. This may also be the time to rethink whether you, your family or employees at your facility should be insured by a company that callously disregards the health of their policyholders.

As always, thanks for all you do for your profession and your patients.

The Impact of EMS: What EMS Can Teach Medical Students About Patient Care

Randall Beaupre, MS3
University of Louisville School of Medicine

Over the hum of the diesel engine a call came through the radio, “131...We have a Code 3: 25 year old white female, possible heroin overdose...” The lights and sirens were flipped on and before I knew it, we were on our way to our second overdose in just as many hours. As a third year medical student at the University of Louisville School of Medicine, I am relatively new to clinical medicine and was completely naïve to the pre-hospital care that patients receive from EMS. I was curious about just what exactly it was EMS did so I decided to devote some of my elective time to figuring it out. I had some pre-conceived notions of what I would learn before starting the EMS elective the school has to offer students like me, but I really had no idea what I was getting into. I was excited to start IVs in the back of an ambulance, bag mask patients in respiratory distress and place ECG leads on a person in cardiac arrest, however, I was in no way prepared for just how much a weeklong elective could change my views of medicine and patient care.

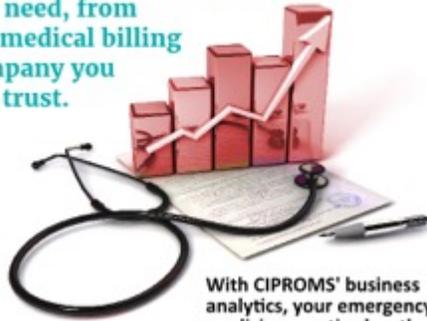
No other experience in medical school has allowed me to literally enter the homes of my patients and insert myself into their lives (if only for a brief moment). I was able to see where

they lived, what kind of food they ate, the conditions they lived in, and even the pets they kept. I was able to see the worry and heart break on the faces of family members as we loaded their loved ones into the ambulance. I was able to see the extreme poverty and equally as extreme wealth and get to experience the neighborhoods that make up this great city that I call home. I was able to see addiction ruin lives and alcohol cause mayhem on the streets. Most importantly, I was able to see these people for who they truly are and not just a set of symptoms and vital signs sitting in front of me on an exam table. I wasn't worried about asking the right questions to properly complete an HPI or remembering all the steps for a neuro exam, but I was awarded the time to talk to these patients like humans and truly learn their stories. I had the opportunity to briefly glimpse into the lives of these people and it was something that I will never forget.

As my role changes from medical student to physician over the next year and a half, it is experiences like this that will shape who I am as a doctor. When a patient arrives to the emergency department overdosed on heroin, I will be thinking about those worried faces of the family members I met as I try to resuscitate their loved one. Or, when a drunk man enters through the doors at 3 am, I just might have a better understanding of how he ended up the way he did. Medicine is so much more than lab values and algorithms and instead is about treating patients by getting to know who they are and where they come from. Spending time with EMS opened my eyes to the humanity of medicine and entrusted me with tools to become the best physician I can be.



**The practice management data
you need, from
the medical billing
company you
can trust.**

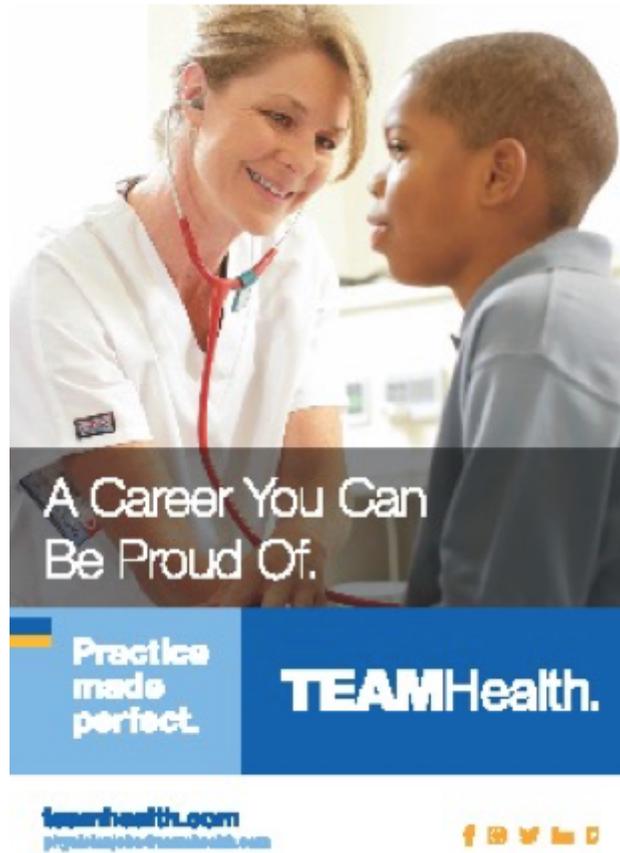


**With CIPROMS' business
analytics, your emergency
medicine practice has the
data you need to ...**

- Monitor prudent lay person denials and other payment issues
- Track and report quality data to government and commercial payers
- Negotiate with hospitals using your payer and patient payment history
- Create physician compensation packages based on work performed
- Determine areas for provider documentation improvement
- Reconcile to hospital census logs ... and reduce lost charges and revenue



3600 Woodview Trace, Suite 400, Indianapolis, IN 46268 | 317.870.0480 | www.ciproms.com



State Legislative Issues for 2018 by Harry J. Monroe, Jr. ACEP Director, Chapter and State Relations

Two years after the nearly miraculous successful retreat by the British army from Dunkirk, Prime Minister Winston Churchill remarked on the first actual British victory of the war by declaring, “Now this is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.”

We may be at a similar point in our legislative battles over balance billing and out of network reimbursement. In many states, policymakers that have been considering the issue for multiple sessions will look to address the issue once and for all. Thus, it will be important that we stand ready to engage an issue that continues to pose a threat to our specialty and most importantly,

access to care for our patients. Certainly, we want to be paid fairly, but we also want to focus on making sure that insurer practices are not causing patients to delay receiving emergency care out of uncertainty as to what the insurer will pay.

ACEP has developed, and is continuing to refine, resources to help states engaging this issue. On [our website](#) you will find numerous documents that will be of help in working on this issue, including talking points, copies of written testimony produced in a number of states, information on why Medicare is not a sound benchmark for determining reimbursement, and many other materials. I would encourage you to take a look.

Additionally, we have worked hard over the last two years to build relationships with other specialty societies and the AMA, based on shared consensus principles and solutions documents that are included on the website, that have helped us collaborate on these issues. In most states that we have engaged, the national collaboration has helped with building alliances at the state level, with the result that the house of medicine has been largely united in our response to legislation. In addition to fighting off bad legislation, we have looked for opportunities to promote positive legislation on the issue, and model legislation has been developed to that end. In addition, to our collaboration with other specialties, another outside organization, Physicians for Fair Coverage, has been formed and has helped to provide and coordinate resources in this fight.

At the time of this writing, we are also working on developing regional teams of experts that can help provide assistance in terms of legislative interpretation, understanding financial impacts, and advocacy. These should be in place by the time 2018 sessions begin.

We believe that as many as 25 states will see significant efforts by legislatures to address balance billing and out of network legislation this year. If you are facing it in your state, reach out to me [via email](#) or at 972-550-0911, ext. 3204.

In addition to balance billing and out of network issues, there will be many other important issues to address in the coming year. The prudent layperson standard remains under attack in many places by both Medicaid and commercial payers. The opioid epidemic continues to be a critical public policy concern. Of course, what the federal government does about health care, and how that filters down to the state level, promises to require our attention. This will be a busy year at the state house!



ACEP – You make 50 look good!

As we wind down 2017, we kick off a year-long celebration of ACEP's 50th anniversary starting January 2018. Plan to participate in social media campaigns that highlight the highs, lows and life-changing moments in EM. Get hyped for a historical timeline following the history of our specialty as well as anniversary-themed podcasts. Watch for anniversary editions of ACEP Now and Medicine's Frontline in addition to proclamations from members of Congress and sister medical societies. Don't forget to order copy of our commemorative coffee table book featuring the breath-taking photographs that capture a day in the life of emergency physicians collected by famed photographer Eugene Richards. [Book tickets now to ACEP18](#) and our blow-out anniversary celebration in San Diego featuring an interactive history museum showcasing the journey of emergency medicine from battlefield to inner city to rural America to every spot in between.

As we enter 2018, we begin the celebration of 50 years of life saving and boundary pushing. Are you on call for 50 more?

Show Your Commitment to High Standards for Clinical Ultrasound

You have the highest standards when it comes to your clinical ultrasound program. Show that commitment to your patients, your hospital, and your payers with ACEP's Clinical Ultrasound Accreditation Program (CUAP). ACEP's [CUAP](#) is the only accreditation program specifically for the bedside, clinician-performed and interpreted ultrasound. Now also available - accreditation for non-ED clinical settings, including freestanding EDs, urgent care centers and clinics. [Apply Today!](#)

Ensure safety and efficacy of patient care
Meet ACEP's high standards for point-of-care delivery
Use your own policies or draw from expert-reviewed sample documents

Geriatric Emergency Department Accreditation Program

ACEP is gearing up to accredit geriatric emergency departments. The [Geriatric Emergency Department Accreditation Program](#) will be accepting applications after the first of the year. There will be 3 levels of accreditation ranging from a minimal commitment to better elder care to a comprehensive well-rounded robust program. Accreditation shows your patients, your institution and your payers that your ED is ready to provide care to seniors and is a quality program that meets the high standards of the American College of Emergency Physicians. [Find out more](#).

Articles of Interest in *Annals of Emergency Medicine*

Sandy Schneider, MD, FACEP

ACEP Associate Executive Director, Practice, Policy and Academic Affairs

ACEP would like to provide you with very brief synopses of the latest articles in *Annals of Emergency Medicine*. Some of these have not appeared in print. These synopses are not meant to be thorough analyses of the articles, simply brief introductions. Before incorporating into your practice, you should read the entire articles and interpret them for your specific patient population. [Read More](#)

Policy Statements and PREPs Approved by the ACEP Board

The following policy statements and PREPs were approved by the ACEP Board of Directors at their October 2017 meeting.

Policy Statements

[Medical Transport Advertising, Marketing, and Brokering](#) – revised

[Clinical Emergency Data Registry Quality Measures](#) – new

[Mechanical Ventilation](#) – new

[Hospital Disaster Physician Privileging](#) – revised

[Unsolicited Medical Personnel Volunteering at Disaster Scenes](#) – revised

[Sub-dissociative Dose Ketamine for Analgesia](#) – new

Writing Admission and Transition Orders – revised

[The Clinical Practice of Emergency Medical Services Medicine](#) – new

[The Role of the Physician Medical Director in EMS Leadership](#) – new

[State Medical Board Peer Review](#) – new

Pediatric Medication Safety in the Emergency Department – new

[Distracted and Impaired Driving](#) – revised

PREPs

Sub-dissociative Dose Ketamine - new

Writing Admission and Transition Orders – new

Welcome New Members

Mary J Schumacher

Nicholas Peairs

Paul Jackson, MD

Derek Gibbs

John T Midden

**Kentucky Chapter ACEP, P.O. Box 2831,
Louisville, KY 40201**

Copyright © 2017 Kentucky Chapter ACEP. All rights reserved.