From the President
James Ziadeh, MD, FACEP
“The other day I finished watching the first season of a new series on Netflix called “Narcos” which dramatizes the cocaine trade between Columbia and the United States in the eighties and early nineties. The show is narrated by a DEA agent stationed in Columbia whose sole goal is to bring to justice Pablo Escobar, the mastermind behind the entire cocaine industry and at one point, one of the richest men in the world… it got me to thinking about another epidemic this country is suffering from as we speak, which is opioid addiction and abuse.”

Guest Editorial
Margarita Pena, MD, FACEP
“The MCEP Observation Committee meets quarterly to discuss current issues and the common goals of Observation Medicine in our state. One of our goals was to establish evidence-based recommendations of Observation protocols in order to provide consistency and guidance to other Michigan emergency physicians that currently have or are thinking of opening an Observation unit.”

Reimbursement Corner
Lynn Nutting, MPA, CPC & James Blakeman
“Emergency Medicine providers should be well versed in the basics of critical care coding and billing. Typically, what’s missing from general critical care discussions is how to document and code for the more complex scenarios.”

MCEP Resident Case Report
Nana Sefa, MD, MPH; Amanda Stahl, MSIV; Ananda Vishnu Pandurangadu, MD, FACEP; Ryan Fringer, MD, FACEP and Amit Bahl MD, FACEP of the Beaumont Hospital – Royal Oak/Oakland University William Beaumont School of Medicine.

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7 Physicians/Positions Available
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Submissions to the April Newsletter should be received by the Chapter office no later than April 8, 2016.
The other day I finished watching the first season of a new series on Netflix called “Narcos” which dramatizes the cocaine trade between Columbia and the United States in the eighties and early nineties. The show is narrated by a DEA agent stationed in Columbia whose sole goal is to bring to justice Pablo Escobar, the mastermind behind the entire cocaine industry and at one point, one of the richest men in the world.

During one scene in the show, the DEA confronted the very fragile Columbian government requesting that they escalate the war on Escobar. The response from the Columbian government was simple. Why doesn’t the United States Government work to curb the insatiable appetite for these drugs by American society and perhaps the problem would go away? Clearly there were two different points of view. However, it got me to thinking about another epidemic this country is suffering from as we speak, which is opioid addiction and abuse. The scale of this problem is truly staggering and seems to be getting worse. With no shortage of supply from manufacturing getting access to these powerful medications does not appear to be a problem for our society. Some statistics from the American Society of Addiction Medicine from 2015 reveals that 24.6 million Americans aged 12 or older (9.4% of the population) live with substance abuse or dependence. Of these, 1.9 million Americans suffer from prescription opioid abuse or dependence. In 2013, over 100 people died each and every day from an opioid overdose of which 46 deaths can be attributed to prescription opioids. This is also not simply an adult problem. Each day, 2500 adolescents aged 12-17 abuse a prescription pain killer for the first time. In 2012, nearly 260 million prescriptions for narcotic pain medications were written for in this country, enough for every person to have their own bottle of pills. As of 2011, the United States made up only 4.6 percent of the world’s population, but we consumed 80 percent of its opioids and 99 percent of the world’s hydrocodone. To paraphrase Jim Lovell from Apollo 13, “Houston, we have a problem”. I would imagine that every one of us knows either a family member or friend who has suffered from the effects of narcotic abuse and addiction. I’m sure many of you recall the push in the late 90’s to make pain the “5th vital sign”. In fact, in 2001, a new Joint Commission standard made measurement of pain a requirement. There were even threats of sanctioning by state licensing boards if pain wasn’t appropriately treated. This always seemed a bit over the top to me and I think in retrospect, most would agree that the emphasis on pain management was misguided and perhaps contributed to the current epidemic we are now experiencing. I don’t know anyone who wants to see their patient suffer but we can’t throw all common sense out the window when dealing with these powerful medications to satisfy some new measure of the day. As emergency physicians we all too often see the impact of this problem on the front lines whether it be patients presenting with overdoses, withdrawal, or simply to address their acute on chronic pain. I do need to point out that Emergency Physicians are not the cause of this out of control epidemic as some would like to believe. However, we do need to understand the problem and we should practice in a manner that does not contribute to this epidemic. In addition, as Emergency Physicians, we need to be part of the national conversation on opioid addiction and abuse and partner with other medical societies and our elected representatives to find creative solutions to this healthcare crisis. Relative to other states, Michigan is considered a high prescriber of narcotic pain medications, ranking 10th overall in prescriptions written per capita. The number of deaths related to overdose in our state has tripled since 1999, many of which are prescription related deaths. In June 2014, Governor Snyder announced the formation of a bipartisan committee to develop a plan to combat the rampant addiction and abuse problem in our state. In October, Lieutenant Governor Brian Calley, chair of the committee, released the findings and recommendations of the committee. There were over two dozen recommendations, too many to summarize here, but a few recommendations deserve highlighting. The committee recognized that the MAPS system is underutilized and cumbersome, so a recommendation was made to update or replace the existing Michigan Automated Prescription System. Other recommendations included making Naloxone easier to access, developing updated regulations on the licensing of pain clinics, and providing more addiction specialists in the state. I would encourage all of you to visit the Michigan.gov website and read the full list of recommendations if you haven’t already. As Emergency Physicians and Departments, there are ways we can do our part to help prevent this epidemic from escalating. If your department doesn’t already have reasonable prescribing guidelines for opioids, this is a first step. The guidelines can help your physician group adopt a consistent approach to pain management in the ED based on best practices and limit the use of these powerful medications to only the clearest of indications. There are several resources available through the ACEP website, and MCEP has developed its own set of guidelines that you can use as well. There are also a number of assessment tools available to identify high risk patients for abuse. Using these tools, we can focus our educational efforts on the proper use and avoid misuse of these medications to high risk individuals. Also, while we all work in extremely busy departments, making an effort to utilize the MAPS system to identify patients who may be misusing, or potentially diverting, narcotics is an important piece of any comprehensive approach to narcotic management in your department. As noted, efforts to improve this system will go a long way towards making adoption of MAPS successful on a large scale. For some departments, a comprehensive opioid policy includes pain contracts, care plans, and better coordination with outpatient treatment facilities. As Emergency Physicians, we cannot afford to ignore our responsibility in addressing this escalating crisis. I have no doubt that we as a profession will rise to the challenge, as we do on so many issues where patient safety is paramount. Our patients, families, friends and the profession expect no less from us and I know we can deliver.
The MCEP Observation Committee meets quarterly to discuss current issues and the common goals of Observation Medicine in our state. One of our goals was to establish evidence-based recommendations of Observation protocols in order to provide consistency and guidance to other Michigan emergency physicians that currently have or are thinking of opening an Observation unit. In general, protocols should include the following elements to guide which ED patients are appropriate for Observation unit care: Inclusion criteria, Exclusion criteria, Interventions, and Disposition. This protocol is the result of a collaborative effort of the Observation Medicine Committee consisting of Observation medical directors and physicians throughout the state. We are happy to present our first protocol with references for the care of COPD patients in an observation unit.

**COPD PROTOCOL**

**INCLUSION CRITERIA**
- Stable or acceptable vital signs (pulse ox ≥90% with normal home requirements)
- Intermediate response to therapy in ED; improving but still wheezing/symptomatic and high likelihood of further improvement and subsequent discharge home within 24 hours
- No acute mental status changes
- Plan of care established

**EXCLUSION CRITERIA**
- Depressed mental status or altered level of consciousness
- Signs/symptoms of impending respiratory fatigue or failure (ex. High RR, requiring BiPAP, accessory muscle use, PaO2 <60mmHg +/- PaCO2 >50mmHg)
- Significant dysrhythmia, ischemic ECG changes, or Theophylline toxicity
- Findings suggesting an alternative etiology for respiratory symptoms (ex. PE, drug overdose or toxic ingestion) - excludes from this protocol
- Presence of serious active co-morbidities (ex. CHF, pneumonia, new arrhythmia)
- Clinical decline despite 24 hours of outpatient steroids
- ED or Observation Provider concern (ex. similar prior hospitalizations requiring intubation or ICU, requiring continuous nebulized bronchodilator therapy in the ED)

**INTERVENTIONS (AS INDICATED)**
- Serial vital signs and re-evaluations including mental status evaluation
- Pulse oximetry monitoring
- Cardiac monitoring
- Oxygen
- CXR
- BNP, ECG, cardiac enzymes, ABG
- Scheduled short-acting nebulized beta2-agonists and anticholinergics
- Systemic corticosteroids
- Systemic antimicrobial therapy
- IV hydration
- IV Magnesium sulfate
- Smoking cessation counseling

**DISPOSITION**

**Home**
- Improved clinical symptoms
- Acceptable vital signs, pulse oximetry ≥90% on room air or home O2 and/or at baseline
- No longer needing albuterol ≤q4hrs
- Adequate follow-up plan established and patient education

**Admit**
- Conversion to an Exclusion Criteria
- Subjective worsening and/or failure to improve

**REFERENCES**


**MCEP Observation Committee members:** Margarita E. Pena, MD, FACEP – St. John Hospital and Medical Center, Detroit (Committee Chair); Carol Clark, MD, FACEP – Beaumont Hospital, Troy; Jason Ham, MD, FACEP – University of Michigan, Ann Arbor; Phil Lewalski, MD, FACEP – Detroit Receiving Hospital, Detroit; Wes Martus, MD, FACEP – St. John Macomb-Oakland Hospital, Warren; Kevin Omilusik, MD, FACEP-Munson Medical Center, Traverse City; Ruby Sooch, MD, FACEP and Mark Bacigal, DO–Providence Park Hospital, Novi

Don’t forget to **Save the Date** for the 2016 Observation Medicine –Science and Solutions Conference on Sept 15 and 16 in beautiful Charleston, SC! During this two-day conference sponsored by MCEP you will learn directly from and have an opportunity to network with THE leaders and authors of Observation Medicine. Topics include how to start and successfully manage an observation unit, convincing your administration to start an observation unit, understanding and maximizing reimbursement for observation services, and CMS updates related to observation services, just to name a few. See the MCEP website for more upcoming details about this fantastic conference! §
Critical Care Essentials:
CPT 99291 Initial 30-74 minutes & CPT 99292 each additional 30 minutes

Emergency Medicine providers should be well versed in the basics of critical care coding and billing. Typically, what’s missing from general critical care discussions is how to document and code for the more complex scenarios.

The Basics:
- Did the patient have a “high probability of sudden, clinically significant or life threatening deterioration?”
- Without intervention, would the patient’s condition have further deteriorated?
- Was a vital organ system at risk?

If you answered yes to the above and total time spent on the patient’s care was 30 minutes or more, document total time (can be noncontiguous) and critical care may be billed. Remember to exclude time spent performing separately billable procedures.

OK...BUT WHAT ABOUT...

...When shift change occurs and another ED provider sees the patient too, can we both bill critical care?
- If minimum times were met and there was no overlap of time, both Initial Critical Care, CPT 99291 & Additional Critical Care, CPT 99292 may be billed by separate providers.
- Per CMS, you can not add up the time of two physicians in the same group to meet the 30 minute minimum for Initial Critical Care, CPT 99291.
- Initial Critical Care, CPT 99291 may be reported daily by providers of the same group, if critical care was provided on multiple days of an ED stay by the same or different provider.

...When both an NPP and physician care for the patient, how do we report our time?
- Per CMS, NPPs and physicians cannot share critical care time. Each provider must separately report their time. Keep in mind that time may not overlap, as only one provider can provide critical care to a patient at a time.

...When a patient arrives in ED and later crashes, how do I bill?
- For payers other than CMS, an E/M Level, CPT 99281-99285 plus critical care may be billed on the same day, by the same provider or members of the same provider group, provided the patient is stable upon arrival and subsequently crashes. CMS only allows for one charge, so report the visit with the highest payment/RVU, which is Critical Care.

...What are the payment & RVU differences between a Level 5 ED E/M Visit and Critical Care?
- Medicare ED E/M Visit Level 5 = $180.57 / 3.8 Work RVUs / 4.9 Total RVUs
- Medicare Critical Care = $230.71 / 4.50 Work RVUs / 6.31 Total RVUs

...Can we bill critical care and an E/M visit when the patient presents critically ill and is later discharged?
- It happens. CPT allows separate reporting for both an ED visit and critical care for patients who start out requiring intensive management to keep them from decompensating and later resolve to a point where they can go home. For example, the tripoding asthmatic with a failed course of meds who looks dire for the first 1 hours of care might, after careful management and assessment over time, be safely discharged. Documentation must clearly indicate the separate services performed during and after the critical care event, but, when properly distinguished in the chart, both services can be reported for the patient on the same date of service.

...How do I know if I am under or over reporting critical care?
- Consider admission rates. If your practice is admitting many sick patients with high acuity, your percent of Critical Care reporting could be in the high single digits, maybe even low double digits.
- Medicare 2014 BESS Data demonstrates nationally, that 7.6% of ED Visit + ED Critical Care represent critical care charges. The average national admission rate for Medicare patients is about 38-42% so historically the critical care reporting rate on Medicare is about 19% of the admit rate. Since critical care is commonly under-reported, a reasonable rate for your group might be greater than Medicare’s overall percentage relationship to the admission rate.

...If I provide medical direction of an EMS patient from the ED, can I count that as part of my total critical care time?
- The patient has to be immediately available on site to count the time as critical care. Consider billing CPT 99288, Physician Direction of EMS Emergency Service, although generally it is not payable in addition to an E/M Visit or Critical Care.
- If a resident is at the patient’s bedside with me while I perform critical care, can I count that time?
- Teaching time may not be counted, but if the resident is next to you while you perform critical care, the time may be included. You may also not count resident time when you are not present.

...What are the percentage relationships to the admission rate?
- Percentages range from a low single digit rate to a reasonable rate for your group might be greater than Medicare’s overall percentage relationship to the admission rate.

...Are there any conditions that I might want to consider when thinking about billing critical care?
- Active Bleeds, Altered Mental Status, Any Acute Failure, Dehydration / Fluid / Electrolyte Abnormality, Dyspnea, Hypertension, Ingestions, Seizures, Sepsis, Severe Allergic Reactions, Severe Pain, Shock, Strokes, Syncope, Trauma / Injuries §
Hear from and network with the top Observation Medicine leaders and authors

Learn how to start and successfully manage an observation unit

Discover how to capture and maximize reimbursement for observation services

*Workshops* with protocols on starting and expanding observation units

Get the latest updates on the CMS two-midnight rule and 30-day readmissions

Charleston, SC
September 15-16

Approved for 14 hours of ACEP Category I Credits

Register at www.mcep.org
CALLING ALL INTERESTED RESIDENTS………

IT IS TIME FOR THE ANNUAL EMRAM OFFICER ELECTIONS

The offices of President, Vice President, Secretary and Treasurer will be filled. Positions are intended for residents that have demonstrated a commitment to emergency medicine; and through this commitment are interested in furthering the programs, activities, and success of the Michigan Emergency Medicine Residents’ Association.

Elections will be held during the EMRAM Research Day at the CMU Education Building in Saginaw on Tuesday, April 19, 2016. Candidates interested in running for office need to submit their intent to run and the office they are interested in by noon on Friday, April 1st. Candidates should submit a personal statement and photo to be distributed prior to elections. Candidates running from the floor, without prior thought to the responsibilities and duties of office, are strongly discouraged.

If you are interested in running for an office, please contact the Chapter office by phone, 517/3275700 or by e-mail, mcep@mcep.org.
PHYSICIANS/POSITIONS AVAILABLE

BAY CITY, MICHIGAN: MCLAREN BAY REGION, EMERGENCY MEDICINE OPPORTUNITY. Explore an excellent opportunity for a BC/BE Emergency Physician or board certified FP, IM, GS with at least 5 years contiguous Emergency Department experience, to join our group in either a full or part-time capacity at a growing, profitable hospital in Bay City. Since opening a new ED in 2007, patient volume growth has been steady with an expected 45,000+ patient visits this year. McLaren Bay Region has a supportive administration team and progressive medical staff that provides coverage for all of the major specialties. Our group offers a stable contract, sign on bonus for full-time and productivity based compensation package with potential to exceed $200/hour. Current staffing reflects 40 hours physician coverage with mid-level assistance in main ED and Fast Track. Bay City and surrounding communities offer affordable housing and a short commute to major cities and Northern Michigan. If you are interested in this opportunity, please send CV to Kenneth Parsons, M.D., M.P.H., FACEP, at kpmdmph@comcast.net or call 989-894-3145 for more information. [ufn]

CASS CITY, MI: Seeking a BC/BE Emergency Medicine Physician for a full-time position in our 5,500 visits/year, low volume Emergency Department. This is an opportunity to practice Emergency Medicine in a spacious new Emergency Department with supportive administration and outstanding ancillary staff. We work 24 hour shifts and have an on-call suite for resting at night. The hospital offers competitive compensation which includes comprehensive benefits, CME and PTO. If interested please send CV to Scott Greib, MD, FACEP at sgreib@hillsanddales.org or call 989-912-6296 for more information. [ufn]

DEARBORN, MICHIGAN/DETROIT METROPOLITAN AREA: Excellent compensation available for a clinically superior Emergency Physician to practice at BEAUMONT HOSPITAL – DEARBORN. The ED at this highly regarded facility experiences 80k patient visits annually and is a Level II trauma center. Newly remodeled for the efficient care of a higher acuity patient population, the ED provides an excellent work environment. Work with EM residents during 76 hours of daily physician coverage. Multiple shifts, staffed with capable APCs, also help manage patient flow. Considerate scheduling and EPIC EMR await EM boarded candidate. To confidentially discuss, please contact Sandy George, recruiter, at TeamHealth: 865.560.8421 or send your CV to sandy_george@teamhealth.com. [3-3]

TAYLOR, MICHIGAN/ DETROIT METROPOLITAN AREA: Rewarding opportunity for a qualified Emergency Physician at BEAUMONT HOSPITAL - TAYLOR; excellent compensation available to a physician who is BC/BP in Emergency Medicine. Full-time preferred but part-time will be considered at this 30k patient volume ED. Friendly environment and thoughtful scheduling offered. 35 hours of EP coverage daily plus 20 hours of additional APC ED assistance. To confidentially discuss, please contact Sandy George, recruiter, at TeamHealth: 865.560.8421 or send your CV to sandy_george@teamhealth.com. [3-3]

TRENTON, MICHIGAN/DETROIT METROPOLITAN AREA: Top compensation is available for a talented and motivated board-certified Emergency Physician to care for patients at BEAUMONT HOSPITAL – TRENTON. The ED experiences 33k annual patient visits, is designated as a Level II trauma center, and hosts an Emergency Medicine residency program. With 36 hours of physician coverage, three 12-hour shifts, and an additional ten hours of APC fast track assistance, the ED offers an efficient and satisfying environment to practice in. To confidentially discuss, please contact Sandy George, recruiter at TeamHealth: 865.560.8421 or send your CV to sandy_george@teamhealth.com. [3-3]

PETOSKEY, MI: Northern Michigan Emergency Physicians, PC, a well-established democratic group providing the Emergency Services in Petoskey for 17+ years, is seeking a Full-Time BC/BE Emergency Physician. Stable contract with competitive compensation and benefit package. Excellent reputation and relationship with Administration and Medical Staff. Regional Referral Hospital with comprehensive subspecialty coverage and annual ED volume of 25,000 visits. 4 Physician shifts and 1 APC shift/day. For details contact Kal A. Attie, MD, FACEP at 231-838-2655 / kalattie@mac.com[3-1]

A KUDOS TO...

Kathleen Cowling, DO, FACEP was appointed to ACEP’s Standard of Care Panel for a 3 year team by Dr. Jay Kaplan.

ACEP established this panel to review expert witness testimony to identify and publicize “false, misleading, or without medical foundation” and thus unacceptable according to ACEP’s policy statement, “Code of Ethics for Emergency Physicians.”

Dr. Cowling is the Emergency Medicine Program Director at CMU College of Medicine as well as an MCEP Past President.§
NON-TRAUMATIC SPLENIC RUPTURE

Introduction
A 25-year old Caucasian male presented to the emergency department after a near-syncopal episode. That morning he awoke with left shoulder pain, epigastric, and right flank pain. After taking a shower, the patient became lightheaded and fell to his knees without any loss of consciousness or injury. He denied previous history of syncope, any recent trauma, or fatigue. The review of systems was negative. He has a history of irritable bowel syndrome and no surgical history. He reported that he is a college student, drinks alcohol occasionally and denied tobacco or illicit drug use. He did not take any medications or have any allergies.

ED/Hospital Course
Initial vitals on arrival included: BP 112/58, HR 86, Temp 36.6°C, RR 18, SpO2 100% on room-air, pain 4/10. On exam, he was alert and oriented, appeared thin and mildly pale. His HEENT, cardiac, pulmonary, and neurological exams were benign. His abdomen was soft, epigastrium was minimally tender, and bowel sounds were normal. His initial labs were remarkable for: hemoglobin 12.0, AST 105, ALT 168, total bilirubin 1.6, glucose 179, and a normal troponin and lipase. EKG was unremarkable. Due to his elevated LFTs, a right upper quadrant ultrasound was obtained. It demonstrated: a normal gallbladder, a moderate amount of complicated free fluid in all four quadrants, and splenomegaly measuring 13.7cm. A CT abdomen/pelvis with IV contrast was immediately obtained and revealed: free fluid, a sentinel clot sign around the enlarged spleen (measuring 13cm) and a 1cm, posterior splenic laceration (see Figure 1). The patient and his vital signs remained stable throughout his entire ED course. Repeat hemoglobin at 4 hours was 8.6. The patient received IV fluids and two units of PRBCs. The patient was admitted to the ICU and managed non-operatively. Over the next two days the patient remained stable and his hemoglobin trended up. The follow-up laboratory evaluation revealed: negative Monospot test, positive EBV IgG and IgM, and negative HIV/ Hepatitis B and C/ANA/VDRL. The patient was discharged home in stable condition on day 3 of his hospital stay.

Discussion
Although the spleen is the most common intra-abdominal organ that can rupture with blunt abdominal trauma, rupture of the spleen in the absence of trauma is very rare. Non-traumatic splenic rupture (NSR) has been associated with pathologic and non-pathologic spleens [1-3]. A systemic review of NSRs showed that 7% of the 845 cases had completely normal spleens with the remaining 93% having some form of splenic pathology [4]. The top three causes of splenic enlargement that lead to NSR include hematologic malignancies, viral infections and inflammation [1-3]. Viral causes, such as EBV and CMV, make up almost 15% of pathologic causes of non-traumatic splenic rupture. It is not uncommon to have multiple of these pathologic processes occur within a patient [4]. Our patient had pathologic enlargement of his spleen from acute infectious mononucleosis.

Diagnosing NSR is challenging, and is often missed or made accidentally, as was the case in our patient [5]. Several signs and symptoms present in our patient were red herrings, which warrant closer analysis. The patient’s complaint of left shoulder pain (Kehr sign) the morning of his presentation suggests left hemi-diaphragm irritation from the NSR. Furthermore, our patient’s near-syncopal episode was possibly due to acute vagal simulation from the initial contact of blood with the peritoneal cavity [6]. The maximal vagal stimulus was likely transient, demonstrated by the fact that our patient returned to baseline after a brief near-syncopal episode. Additionally, the absence of tachycardia can also be explained by the elevation of his baseline enteric vagal tone due to the continued presence of blood in the peritoneum [6]. The lack of tachycardia can also occur in a well-conditioned athlete who presents with states of shock [6]. Another important point to note is that a straightforward application of the San Francisco syncope rule at initial presentation would have been negative [2]. A quick bedside ultrasound can reveal the presence of free fluid in the abdomen to help with the diagnosis. Bedside ultrasound can be positive with a little as 100 ml of free fluid in the abdomen with a 90% sensitivity and 99% specificity [8].

Spleenic injury is classified on a scale of 1 to 5, from the least to the most severe, see Table 1 [9]. The treatment of NSR could be either non-operative
or splenectomy depending on the grade of the injury and the patient’s hemodynamics. Grades 1 and 2 are managed mostly conservatively, whereas grades 4 and 5 are managed mostly operatively. Due to the immunosuppressive effects of splenectomy, there has been a recent push toward conservative treatment.[10]

Conclusion
Emergency physicians should always keep NSR on their differential diagnoses whenever they are evaluating patients for abdominal pain, since the diagnosis could easily be missed. Additionally, this case reveals that the absence of tachycardia or signs of shock do not rule out NSR. §

References

Table 1

<table>
<thead>
<tr>
<th>Grade</th>
<th>Injury Type</th>
<th>Injury Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Hematoma: Subcapsular, nonexpanding &lt;10% surface area</td>
<td></td>
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<tr>
<td></td>
<td>Laceration: Capsular tear, nonbleeding &lt;1cm parenchymal depth</td>
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<tr>
<td>2</td>
<td>Hematoma: Subcapsular, nonexpanding, 10-50% surface area</td>
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<tr>
<td></td>
<td>Intraparenchymal, nonexpanding, &lt;5cm diameter</td>
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<tr>
<td></td>
<td>Laceration: Capsular tear, active bleeding; 1-3cm parenchymal depth not involving a trabecular vessel</td>
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<tr>
<td>3</td>
<td>Hematoma: Subcapsular, &gt;50% surface area or expanding.</td>
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<tr>
<td></td>
<td>Ruptured subcapsular with active bleeding; Intraparenchymal hematoma &gt;5cm or expanding</td>
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</tr>
<tr>
<td></td>
<td>Laceration: &gt;3cm parenchymal depth or involving trabecular vessels</td>
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<tr>
<td>4</td>
<td>Hematoma: Ruptured intraparenchymal hematoma with active bleeding</td>
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<tr>
<td></td>
<td>Laceration: Laceration of segmental or hilar vessels producing major devascularization (&gt;25% of spleen)</td>
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<tr>
<td>5</td>
<td>Laceration: Completely shattered spleen</td>
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<tr>
<td></td>
<td>Vascular: Hilar vascular injury which devascularized spleen</td>
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### MCEP Calendar of Events

<table>
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<tr>
<th>Date</th>
<th>Event Description</th>
<th>Location/Address</th>
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<tr>
<td>April 19, 2016</td>
<td>EMRAM Research Forum/SIMWARS CMU Education Bldg. Saginaw, Michigan</td>
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<tr>
<td>April 23, 2016</td>
<td>Mock Oral Boards Sinai-Grace Hospital Detroit, MI</td>
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<td>April 25, 2016</td>
<td>SaveMIHeart Livingston County Howell, MI</td>
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<td>April 29-30, 2016</td>
<td>APLS Munson Medical Center Traverse City, Michigan</td>
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<td>May 4, 2016</td>
<td>Board of Directors Chapter Office Lansing, Michigan</td>
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<td>May 15-18, 2016</td>
<td>ACEP Leadership Conference Washington, DC</td>
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<td>July 31 – August 3, 2016</td>
<td>Michigan EM Assembly Grand Hotel Mackinac Island, Michigan</td>
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<td>August 1, 2016</td>
<td>Board of Directors Grand Hotel Mackinac Island, Michigan</td>
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<td>August 4, 2016</td>
<td>Residents’ Assembly The Johnson Center Howell, Michigan</td>
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<td>August 18, 2016</td>
<td>ED Leadership &amp; Management Course The Johnson Center Howell, Michigan</td>
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<td>August 25, 2016</td>
<td>SaveMIHeart Livingston County Howell, MI</td>
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<td>Observation Medicine Course DoubleTree Hilton Hotel Charleston, South Carolina</td>
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<td>September 27, 2016</td>
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<td>October 3, 2016</td>
<td>MCA Conference Grand Traverse Resort Traverse City, Michigan</td>
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<tr>
<td>October 4, 2016</td>
<td>Michigan Trauma Conference Grand Traverse Resort Traverse City, Michigan</td>
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### APLS: The Pediatric Emergency Medicine Course with Simulation Lab

**April 29-30, 2016**

**Munson Medical Center, Traverse City, MI**

Visit www.mcep.org for registration and more information.
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