In This Issue

2 From the President
Rami Khoury, MD, FACEP
“I’m Dr. Rami Khoury, Michigan College of Emergency Physician President. I’m joined here today by Dr. Brad Walters, who is a physician at William Beaumont Hospital and the Assistant Program Director for the residency program. And today, we’re going to talk about the value of MCEP membership and the value of membership in our association.”

6 Reimbursement Corner
Don H. Powell, DO, FACEP
“Medicare Plus Blue is a managed Medicare product of Blue Cross Blue Shield. Medicare Plus Blue has an automated internal problem creating inappropriate ED denials. The basis of the denial pattern revolves around multiple claims being submitted for a given date of service.”

3 From the Editor
Gregory Gafni-Pappas, DO, FACEP
“Why does MCEP concentrate so much on billing?” a colleague asked me. Another emergency physician asked, “Why does MCEP make its number one priority advocacy for physicians? Shouldn’t it concentrate more on improving patient care?” I love it when others ask these questions because it gives an opportunity to discuss the wide variety of activities MCEP is involved in to improve the lives of patients and emergency physicians alike.”

8 MCEP Resident Case Report
Mark Shievitz, MD and Russell Rae, MD, Beaumont Hospital, Royal Oak MI

4 Legislative Column
Bret Marr, Lobbyist
Muchmore, Harrington, Smalley & Associates
“After an unprecedented Lame Duck session in 2018, the 100th Legislative session has kicked off and Governor Gretchen Whitmer was sworn into office. There are a few new leaders that MCEP works with on a regular basis that need to be introduced.”

Contents
3 Calendar of Events
8 Board Elections
10 Helicopter Bills
11 ACEP Pediatric Committee Takes on High Level Challenges
11 EMRAM Officer Elections

Submissions to the March/April 2019 Newsletter should be received by the Chapter office no later than March 20, 2019.
Khoury: Hi, I’m Dr. Rami Khoury, Michigan College of Emergency Physician President. I’m joined here today by Dr. Brad Walters, who is a physician at William Beaumont Hospital and the Assistant Program Director for the residency program. And today, we’re going to talk about the value of MCEP membership and the value of membership in our association. So, Dr. Walters... why did you become a member?

Walters: Well, it’s clear that I’m older, alright? So, actually things have changed. When I first joined ACEP and my state chapter MCEP, it was way back in the day when emergency medicine was first establishing itself as a specialty and that was the key issue. It was the issue that drove almost everything. We were not a stand-alone board. There was just a huge issue of acceptance of emergency medicine, and that’s why I first joined. Emergency physicians needed to band together to literally establish the specialty. But it changed. It changed for a number of reasons. Certainly politics, reimbursement and the specialty matured. Things changed. I changed. I got older. The issues that confronted me as a younger physician are different than the issues that confronted me as an older physician. But here’s what hasn’t changed. A community of emergency physicians are able to accomplish the mission, what we went into medicine for... care delivery for our patients with greater effectiveness, efficiency and greater innovation as a group, and as a large group in some issues more than we can individually. And so, that has been a driving force that has kept me as a member... that has not changed over time. Even though the specialty has changed, I’ve changed and my needs have changed.

Khoury: I like hearing that... for me, coming into it... I joined when I was in medical school, and I continued through residency and now, as an attending for 15 years. And what I find interesting is my view on it. I’ve always been an advocate, as I’ve become more and more involved, it has become apparent to me that it’s worth every penny. And let’s address the thing that people complain about... our Michigan dues are a little bit more expensive compared to the rest of the country. And ACEP as a whole, if you’re joining from Michigan more expensive. Now, if you’re going to join other associations... let’s say AMA in the Michigan State Medical Society (MSMS), combined it is about the same price. But, what do you really get for that? Well, let’s discuss the things that MCEP has done over a number of years... and this started way back when I was a resident, when we changed to a two-tier payment system through state Medicaid. It helped change the state system to save the state a lot of money, and it included an uptake in physician reimbursement on professional fees for ED physicians. And you knew exactly what you were getting. Which is much better than what you were getting previously. Right there is a financial return on investment. Most recently, with our work with the Michigan Department of Health and Human Services, we asked for an assessment and got an uptake in Medicaid reimbursement on professional fees. This put the equivalent of about $10,000 a year in every ED physician’s pocket throughout the state... if you average it out. This was $10 million more going to emergency physicians. But what does that really mean? It’s a tenfold return on your thousand dollar a year investment. Every single year. That’s pretty incredible. I do know that some of our doctor’s work in private groups and some are employed physicians... but at the end of the day, we all impact each other. Because when you are in an appointment model, your facility actually does an assessment for payment, right? So, they are reimbursed by the federal government and when they are paying you, they have to pay you fair market value. Well if the market value goes up because those around you are getting increased reimbursement... your reimbursement increases and you make more money.

Walters: So, what you’re saying is that no matter what the employment model is... economics is economics and it has to affect you. There is no way you can get around it. But the bottom line is that at the end of the day, the economics affect all of us. And we cannot get away from it. And so, the savings... let’s say... the increases in reimbursement that the Michigan College has been able to facilitate for us, actually becomes meaningful no matter what your employment model is.

Khoury: That is 100% correct. And that’s just the start. The other things that we have done, as we’ve been dealing with opioid laws here in the state of Michigan, and being on the cutting edge and let me rephrase that... Michigan College of Emergency Physicians was the cutting-edge physician association in the state of Michigan that started addressing the opioid epidemic. We were the first to have prescribing guidelines. And to that testament, it allowed us a lot of access in Lansing. And because of that, the reason that physicians can write three days’ worth of an opioid or a scheduled medication, without having to check MAPS, has everything to do with it. MCEP’s ability to negotiate with our legislators made that happen. That is a win for all of us, and I don’t think that people realize how big of a deal that is. Because it is an absolutely huge deal.

Walters: And not only that, this is exactly what emergency physicians are. This is exactly where we stand out. We stand out in areas like gun control, where the NRA said “That’s not in our wheelhouse.” Well, it is exactly in our lane, and the groups that spoke out on that... the American College and the Michigan College, were very eloquent in getting our voice on meaningful issues that affect our patients and the opioid epidemic is another example.

Khoury: And to reiterate that, we have a mixture... if you look at our association, we’re right down the middle. Right wing/left wing... it doesn’t matter. The goal is patients come first, and we have to take care of each other. And what I love about MCEP, and what I love about ACEP is that we do take care of each other. And if you talk to lobbyists around the country and talk to the Beckett Hospital Review, single associations that advocate for one specialty do a much, much better job in advocating because they have one unified goal. If you have multiple goals it becomes very difficult. And as the newest specialty, fighting an uphill battle constantly to get your agenda items is difficult. So, MCEP provides great political value.

Walters: But I would like to take it a step forward, and you mentioned it. It’s taking care of ourselves. I’d like to say that my career has not had its rocky times. But it has. And being able to interact with emergency physicians in various different venues was extremely helpful in keeping the fires that brought me to this specialty and brought me to medicine burning bright. And in keeping that enthusiasm for what I do. I’ve often
WHAT ARE MCEP’S PRIORITIES?

“Why does MCEP concentrate so much on billing?” a colleague asked me. Another emergency physician asked, “Why does MCEP make its number one priority advocacy for physicians? Shouldn’t it concentrate more on improving patient care?”

I love it when others ask these questions because it gives an opportunity to discuss the wide variety of activities MCEP is involved in to improve the lives of patients and emergency physicians alike.

Stated again, MCEP’s priorities are aligned to:

1) Improve the lives of patients.
2) Improve the lives of emergency physicians.

These two items may seem very basic, but the committee structures in place and ongoing work of MCEP revolve around a mission to IMPROVE. Improvement requires a multifaceted approach, and thus there are an enormous amount of activities ongoing to make this happen. Many emergency physicians may see a small snapshot of MCEP’s current activities, such as advocacy or finance, without seeing the overall picture of how everything fits together into a jigsaw puzzle that we are constantly working to solve.

There are many ways in which MCEP is working to improve the lives of patients. Through the Quality Committee, MCEP launched the Mind MI Head campaign. This campaign reached over 1 million people to educate providers and parents that Head CT is not necessary in many children with minor head injuries. The campaign was very successful and worked across the state, improving care for our youngest patients. Finally, we had a big victory recently to increase Medicaid fees.

There are also a number of ways in which MCEP is working to improve the lives of emergency physicians. Through the legislative committee, MCEP is working hard on a bill to decrease violence in the ED. This is a rampant problem throughout the country affecting every emergency department. Legislation can help to significantly curtail the levels of violence we are seeing. Through this committee we are also keeping an eye on bills that look to change or do away with no-fault insurance. Through the finance committee we make sure emergency physicians are fairly compensated for their services. We had a big victory recently to increase Medicaid fees. We are also in constant conversation with insurers such as Blue Cross so that appropriate claims are not denied. Though many emergency physicians may not see these efforts first hand, they are certainly reaping the benefits of our constant vigilance.

Finally, through the education committee, MCEP puts on top-notch conferences throughout the year that help EPs stay current with the constant barrage of new information. This year MCEP will put on its first Restorative Retreat, aiming to give EPs a toolkit to improve their day to day lives, while at the same time providing a relaxing environment at Crystal Mountain. It will be taking place May 30 to June 2. Check it out at www.mcep.org/conferences/em-restorative-retreat.

I only touched on a small number of activities MCEP is engaged with for our specialty and the patients we serve. We are not an organization for the few, but we aim to serve the many varied interests of emergency physicians throughout the state of Michigan and the patients who need our care. If you want to learn more about how MCEP prioritizes patient care and emergency physician wellness, please come to one of our board meetings. The next one will be March 6 at 12:30pm at the MCEP headquarters in Lansing. At a minimum, please check out the website at www.mcep.org. You might be surprised by how much we have accomplished in the past and how much we are doing for our future. §

“We make a living by what we get, but we make a life by what we give.”
-Winston Churchill
START OF 100th MICHIGAN LEGISLATIVE SESSION AND WHITMER ADMINISTRATION

After an unprecedented Lame Duck session in 2018, the 100th Legislative session has kicked off and Governor Gretchen Whitmer was sworn into office. There are a few new leaders that MCEP works with on a regular basis that need to be introduced. Governor Whitmer has been a friend to MHSA and MCEP over the years in her many roles in and around state government. A huge supporter of Medicaid expansion and healthcare in general, we look forward to continuing to work with her. She appointed Robert Gordon as her Director of the Michigan Department of Health and Human Services. Director Gordon served in the Obama Administration in D.C. and knows education, budgets and healthcare from a variety of perspectives.

Senator Mike Shirkey was chair of the Senate Health Policy Committee last session but has moved up to the position of Senate Majority Leader. A good friend of MCEP over the years, we look forward to working with his successor as chair of Senate Health Policy, Senator Curt VanderWall from the Ludington/Cadillac area. Senator Pete MacGregor will continue to serve as budget chair for the MDHHS budget committee. Speaker Lee Chatfield just began his two-year term as leader of the House and in doing so as the youngest Speaker in over 100 years. He chose to keep House Health Policy Chair Hank Vaupel in that position. Recall that Rep. Vaupel is the sponsor of our violence in the ED legislation. Representative Mary Whiteford from Allegan County is chair of the House DHHS budget committee.

AUTO NO FAULT
Speaker Chatfield and Senate Majority Leader Shirkey kicked off the session with speeches about auto no fault being their number one agenda item. The Speaker created a special, temporary Select Committee on Reducing Car Insurance Rates, chaired by Clare Representative Jason Wentworth. The Senate did not create a new committee, but Senate Bill 1 was introduced to overhaul the auto no fault system. We expect both leaders to pursue wholesale changes to the system and MCEP will be there to provide input on how the proposed changes could impact the healthcare delivery system in Michigan.

VIOLENCE IN THE EMERGENCY DEPARTMENT
MCEP will continue to make this our highest priority as a college. With the new Legislature starting, we have to begin the process over again of educating lawmakers and staff about the growing problem of violence against staff and physicians in the emergency setting. We will need help from MCEP members to talk to their state representative and senator at some point this spring. Stay tuned for further action updates. §

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Contact, Stephanie Luedke for more details stephanie.luedke@aurora.org • aurora.org/doctor
Michigan EM Assembly
July 28-31, 2019
Grand Hotel, Mackinac Island
MEDICARE PLUS BLUE DENIAL PATTERNS

Medicare Plus Blue is a managed Medicare product of Blue Cross Blue Shield. Medicare Plus Blue has an automated internal problem creating inappropriate ED denials. The basis of the denial pattern revolves around multiple claims being submitted for a given date of service. Their current program will only allow a single payment for a given date of service. Issues arise when other claims fall on the same day. The plan will pay the first claim submitted and deny all others despite different service lines, specialties or even TIN’s. An example would be that a patient is seen in their primary care office and referred to the ED. Medicare Plus Blue receives the primary care physicians claim first and then denies the ED professional service claim as “claim already paid for DOS”. These claims must be appealed. This has been an issue since late 2017. A Medicare Plus Blue service representative was present at the October 2017 Michigan Third Party Payer Day. They acknowledged the issue and assigned it as a high priority status. Unfortunately, this is still occurring. It can be challenging to identify these claims as some will present with incorrect denial codes. The denied claim may initially present secondary to an un-specified diagnosis code. The final reason for denial only then to be determined after discussions with client services. Furthermore, the denial may or may not identify what other services the claim is denying against. In many instances the Blues representatives will accept a spreadsheet of the mass denials. Since this is a potential high volume issue the Blues representatives can send direct transmittals to request claims reprocessing and payments. The transmittal request can take 60 days. The issue has also reportedly been escalated to the Blue Cross data analytics and research teams. §

Take home points-
1. Look for specific denial patterns that may reflect an issue with the carrier
2. Establish frequent contact with your individual client representative for quicker resolution processes
3. Attempt to rectify issues on a mass basis vs claim by claim basis

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• NEW THIS YEAR!  Option to tour state-of-the-art Observation Units in a community or university hospital setting.
• Learn how to make the case that your hospital needs an Observation Unit.
• Featuring two tracks - BEGINNERS:  Starting an Observation Unit & ADVANCED: Optimizing and Growing Your Observation Unit.
• Learn how to design, appropriately staff and successfully manage an Observation Unit using evidence-based best practice.
• Discover how to document and maximize reimbursement for observation services.
• BACK THIS YEAR!  Innovations and Research in Observation Medicine.

September 12-13, 2019
Sheraton Atlanta Hotel, Atlanta, GA
Visit www.mcep.org for further information

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September 12-13, 2019
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Visit www.mcep.org for further information
UNINTENTIONAL CAFFEINE OVERDOSE CAUSING RHABDOMYOLYSIS, AKI AND HYPOKALEMIA

Mark Shievitz, MD and Russell Rae, MD
Beaumont Hospital, Royal Oak MI

INTRODUCTION:
Caffeine containing products are frequently consumed on a daily basis as a stimulant and to help ward off fatigue. Caffeine can be consumed as a beverage as well as in pill and powdered form. The average cup for coffee contains 115-175mg of caffeine per 330mL or 11oz (1). Caffeine belongs to the Methylxanthines plant derived alkaloid group, which also contains theophylline and theobromine (1). Methylxanthines stimulate endogenous catecholamine release and also inhibit phosphodiesterase, increasing levels of cAMP resulting in smooth muscle relaxation, peripheral vasodilation, myocardial stimulation, skeletal muscle contractility and CNS excitation. Bioavailability of oral caffeine is 100% and peaks within 30-60 minutes (1). The half-life is 4.5 hours in healthy adults (1). Lethal doses are estimated at 150-200mg/kg and may occur with serum concentrations above 80 micrograms/mL (1). The caffeine toxidrome includes severe nausea, emesis, and cardiac dysrhythmias, which may be predisposed by hypokalemia. Acute respiratory distress syndrome (ARDS) and seizures can also occur with toxic caffeine ingestions.

NARRATIVE:
This is a case of a 23 year old male who unintentionally overdosed on powdered (anhydrous) caffeine resulting in severe metabolic and physiologic derangements in the attempt to stay awake, work and play video games. He presented to the emergency department approximately 25 hours after having ingested anhydrous caffeine. His presenting complaints included intractable nausea and vomiting, abdominal pain, tremors and palpitations. The patient stated that he took 3 tablespoons (15g) with the appropriate dosage being 1/200th of that. His initial vital signs were as follows: temperature 97.5F, HR 125, RR 20, BP 125/80, SPO2 96% on RA, weight 56.7kg (125lbs). Physical exam was notable for tachycardia and generalized abdominal tenderness. IV access was established and the patient was given 2L normal saline boluses, Zofran for nausea, Ativan for agitation, and labs were drawn including drugs of abuse panel, alcohol, acetaminophen level, salicylate level, CMP, magnesium, lipase, CBC, and CK. Poison control was contacted who recommended supportive care, cardiac monitoring and beta blockers as required. Lab findings were notable for creatine kinase of (CK) of 37029, potassium (K) of 3.0, magnesium (Mg) 1.6, blood urea nitrogen (BUN) 16 and creatinine (Cr) 1.11 (Cr 0.75 one year prior) aspartate aminotransferase (AST) 513, alanine aminotransferase (ALT) 131, WBC 31.6, UA with 2+ blood and only 4-10 RBCs, caffeine level of 119.6 micrograms/mL, and negative alcohol, acetaminophen, salicylates and drugs of abuse panel. The patient was started on a bicarbonate drip, supplemented potassium and magnesium, and required further dosages of anti-emetics while in the ED. The patient required a 3-day hospital admission for symptomatic support, cardiac monitoring and further electrolyte supplementation prior to being discharged home.

DISCUSSION:
The patient ingested 256mg/kg of powdered caffeine. His caffeine level returned 119.6 micrograms/mL. The range of lethal doses in adults varies. However, severe symptoms have been noted after ingestions of 150-200mg/kg or serum levels greater than 80micrograms/mL (1). This patient’s caffeine level exceeded that value and was drawn 25 hours after the initial ingestion. Fatal dysrhythmia and death were likely avoided given that the patient was an otherwise healthy young male without underlying cardiac or renal disease. The patient presented with the classic Methylxanthine sympathomimetic toxidrome including tachycardia, tremors, agitations as well as severe gastrointestinal complaints. Multiple doses of anti-emetics were required to help ameliorate the nausea and vomiting consistent with the literature (1).

Rhabdomyolysis appears to be a very rare complication of lethal caffeine ingestions documented only to be greater than 1200 in one case (3). This patient was found to have a CK of 57029. AKI was noted as the patient had a creatinine bump from 0.75 one year prior to 1.11 and myoglobinuria was noted on UA (2+ blood with only 4-10 RBCs). Rehydration is the mainstay of treating myoglobin nephropathy. Our patient received 2L NS boluses followed by a bicarbonate drip. Urinary alkalinization is thought to solubilize the myoglobin and help with excretion (4). Potassium has to be closely monitored as hypokalemia can become more severe with the alkalinization, which can predispose patients to cardiac arrhythmias (1). There is, however, a lack of prospective evidence that urinary alkalinization or forced diuresis with Lasix provides benefit to protect from myoglobin nephropathy (5). Our patient was found to be hypokalemic at 3.0, which was low, likely from intractable emesis. It is recommended to maintain urine output at 2mL/kg/hr achieved by crystalloid infusion (5).
CONCLUSION:
Caffeine overdose can cause severe rhabdomyolysis and electrolyte disturbances. The most common cause of death from caffeine overdose is a fatal dysrhythmia (1). If rhabdomyolysis is found, aggressive IV hydration with crystalloids is necessary to prevent myoglobin nephropathy. There does not appear to be any additional benefit of using sodium bicarbonate drips or forced diuresis to prevent kidney injury (5). §

REFERENCES:

FROM THE PRESIDENT (Continued from Page 2)

often said, if you get several physicians from the same shop in a group, to what does the conversation devolve? Well, we’re bitching about something. Administrators... the electronic medical records... the nurses, whatever. But if you get a bunch of physicians from different areas of the country, different hospitals... the conversation elevates. It’s interesting patients. It’s problem solved. It’s, “Oh, my. Those people have the same issue I have. I thought that I was the only one.” These are meaningful moments in a physician’s life, that allow you a longevity which now for me... spans 36 years.

Khoury: So, to finish... I would like to say MCEP and ACEP represent physician wellness. MCEP and ACEP represent comradery. MCEP and ACEP are family. When I come here, I learn a lot. I gain a lot and in addition to that, I bring back cutting edge things to my own department. That’s just a start. If you look back to what the message has been throughout the years, you’ll see that: We have to lead. We have to be active. We have to show, in a professional and excellence kind of way, that we are judged as emergency physicians. We are judged as MCEP. Whether you are a member or not.

Walters: No physician got to where they were by themselves. There were people and organizations that helped and pushed them along. The Michigan College and the American College of Emergency Physicians have been just that for me. Not the only ones, but important ones.

Khoury: So, to finish off in our 50th anniversary here at the Michigan College of Emergency Physicians, I would like to thank all the amazing godfathers of emergency medicine, that helped start this college. And who helped start our national college. I would like to ask our young physicians and our residents coming up to continue this lifelong endeavor. Thank you. §
HELCOTER BILLS

By: Michael Fill, DO

As you are walking to your car after a busy night shift, you pass the COO of your hospital in the hall. Attempting to be polite, you wish her a cheerful “Good Morning, how are you?” She turns to you, smiling and says, “Aren’t you one of the ED docs?” As you affirm her question, she blurts out, “Have you heard about this new helicopter bill in Michigan? How will this affect our transfers of patients out of our facility?”

Michigan House Bills 5217, 5218, and 5219 (Public act 383, 384, and 385) were signed into law by the Governor in late 2018. These bills stem from concerns that have arisen in other states with regards to “balance billing” of air ambulance (primarily helicopter) services. Reportedly, in other states, there have been cases where a patient has been transferred by air ambulance, and their insurance has not covered the total charges of the air ambulance service. In certain cases, the patient has received bills from air ambulance services, which have reportedly ranged in the tens of thousands of dollars. These bills primarily address those patients who are determined to be “non-emergency” patient transports. The bills define an “Emergency Patient” as that which is outlined in the public health code. The Michigan Public Health Code defines an “Emergency Patient” as:

“An individual with a physical or mental condition that manifests itself by acute symptoms of sufficient severity, including, but not limited to, pain such that a prudent layperson, possessing average knowledge of health and medicine, could reasonably expect to result in 1 or all of the following:

a. Placing the health of the individual or, in the case of a pregnant woman, the health of the patient or the unborn child, or both, in serious jeopardy.

b. Serious impairment of bodily function.

c. Serious dysfunction of a body organ or part.”

The bills stress that non-emergency patients should be transported by ground ambulance unless transportation by air ambulance is deemed medically necessary. If it is deemed medically necessary that a patient be transported by air ambulance, the sending hospital is responsible for:

1. Ensuring that the air ambulance service is a participating member of the patient’s health benefit plan.

2. Disclosing to the patient or patient representative if the air ambulance ordered participates with their health benefit plan AND that the patient has a right to be transported by a method other than air ambulance.

3. Obtaining signed notice that the patient or patient representative was advised as above.

4. Provide a good faith estimate of cost of transporting the patient.

A hospital that violates the above is liable to the air ambulance company for the difference between what the patient’s insurance pays and the amount charged to the patient by the air ambulance company.

The bills only mention the Emergency Patient in that the air ambulance service must accept the amount paid by the patient’s health benefit plan as the amount paid in full (i.e. the air ambulance service cannot “balance bill” the Emergency Patient).

So, now when a member of your hospital’s “C suite” asks you about the new laws pertaining to air ambulances, you will be prepared. If you have any questions regarding these laws, or anything else EMS related, your MCEP EMS committee is here to help! Please feel free to contact any one of us at mcep@mcep.org.

1 PUBLIC HEALTH CODE (EXCERPT) Act 368 of 1978. Sec. 20904 (9)
ACEP PEDIATRIC COMMITTEE TAKES ON HIGH LEVEL CHALLENGES

How many adolescent mental health patients are currently being boarded in your ED awaiting inpatient hospitalization? What is the current vaccination rate in your community? Are your pediatric trauma patients still routinely being “pan-scanned”? These and many other concepts we deal with daily are complex, interdependent, multi-dimensional issues that are thorny and complicated to solve. Yet rather than become paralyzed by these and other challenges, the ACEP Pediatric Committee is identifying stakeholders across the country to work on these and other demanding issues to improve our ability to optimally care for our patients.

At the Scientific Assembly this past October, the Committee met to align this year’s objectives, which are germane to us all. Highest priority falls to addressing the mental health crisis of adolescent suicidality and need for resources to care for these patients. Champions from the Committee and throughout ACEP including the BOD recognize this as an issue of utmost importance, yet also one of the most complicated of our time. Given the complexity of this issue, ACEP identifies the need to engage all stakeholders to push for significant and lasting change. Other issues the Committee is addressing include the opioid epidemic and managing pediatric pain, the role of antitussive medications in children, telemedicine in pediatric emergency care, and antibiotic stewardship. Furthermore, the Committee is reviewing policy regarding the death of children in EDs, the role of emergency physicians in the care of children, and preparedness of EDs to care for children.

An updated policy statement created by ACEP, AAP, and the ENA regarding readiness to care for pediatric patients can be found at: https://www.annemergmed.com/article/S0196-0644(18)31167-3/fulltext. As 83% of all pediatric patients seek care in community EDs, this document serves as an excellent resource for all. Readiness is improving according to the National Pediatric Readiness Project, with emerging evidence of improved outcomes for pediatric patients based on ED readiness scores. Recommendations go well beyond simply maintaining the equipment needed to care for children, but focus on developing expertise in delivering care. High level recommendations include identifying both a nursing as well as physician Pediatric Emergency Care Coordinator (PECC), developing competency assessment for providers, performing pediatric quality and performance improvement, developing pediatric specific policies and protocols, and promoting safe care within the ED.

ACEP offers great opportunity for providers to improve their pediatric care yearly at the annual Advanced Pediatric Emergency Medicine Assembly, this year taking place March 19-21 in Anaheim, CA. Offerings include a pre-conference “PEM Essentials” for updates of common conditions such as fever, trauma, shock, asthma, and status epilepticus; a procedure lab to review advanced airway management, IO placement, umbilical lines, etc; and finally, the two-and-a-half day advanced conference covering topics such as “Cannabis for Dummies” by Richie Cantor, as well as appendicitis diagnosis and management, major head injury, neonatal resuscitation update, and the critically ill obese child. The Pediatric Committee will be meeting during the conference, and guests are welcome. More information can be found at: https://www.acep.org/pem.

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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 16, 2019. 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 5th. 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. Officer descriptions can be found at www.mcep.org.

If you are interested in running for an office, please contact the Chapter office by phone, (517) 327-5700 or by e-mail, mcep@mcep.org.

News & Views 11 January/February 2019
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