



# MISSOURI EPIC

EMERGENCY PHYSICIANS INTERIM COMMUNIQUE  
Missouri College of Emergency Physicians

Fall 2006

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## PRESIDENT'S MESSAGE

As an advocate for emergency physicians and our patients, the Missouri Chapter of the American College of Emergency Physicians is dedicated to the highest standards of emergency medical care delivered with justice and efficiency. In the broad perspective, our services are highly valued within the medical profession and society-at-large. At times, decisions are made which, often unintentionally, impede our mission and require the focused advocacy of the College and all its members. Such a situation exists today.

Some of you may be aware that Missouri recently modified Medicaid Reimbursement levels in a manner that creates a significant discrepancy between the reimbursement for care we provide in the ED and that provided in the office of a primary care physician. For example, a Level 5 office visit for primary care physicians is reimbursed for \$102.58, while a Level 5 ED visit, perhaps for something like a major motor vehicle accident with multiple extremity fractures of intra-abdominal injuries, is reimbursed for \$25. I believe the intent of this was not to punish emergency physicians but rather to encourage Medicaid patients to preferentially go to their primary care physician for "non-emergent" needs. In the absence of a large change in the system, however, I believe it is unlikely that such changes in behavior will occur.

Recently, several members of Missouri ACEP met with Dr. Michael Ditmore, who serves as Director of the Missouri Division of Medical Services\*. Michael Szewczyk, Larry Slaughter, Brian Robb, Betsy Morgan and I met with Dr. Ditmore in Jefferson City to discuss our hope that Medicaid Reimbursement to emergency physicians for Level 1-5 visits be brought into parity with that of office-based physicians. I believe we had a very constructive conversation.

Dr. Ditmore actually has a good understanding from personal experience

*Continued on page 2*

Contact us at:

MoCEP

PO Box 1865

Jefferson City, MO 65102

Phone: 573-636-2144

Fax: 573-635-6258

[betsy@mocep.org](mailto:betsy@mocep.org)



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of what we do clinically. He spent two years at the beginning of his medical career as an emergency physician in Michigan and Wisconsin. However, as a full career as a practicing neurosurgeon has bridged the time between his emergency department days and those of his days with the Missouri Division of Medical Services, some changes have occurred. I believe one of the most significant developments in the last decade is that far fewer of us are hospital employees. Larger facility fee reimbursements from Medicaid do not trickle down to us as most of us are members of independent physician groups or, like me, a separate institution with a contract to provide emergency physician services at a hospital.

We presented to Dr. Ditmore materials which demonstrated the discrepancy of reimbursement for emergency department and office visits in Missouri for conditions with very comparable complexity of medical decision-making. We also provided materials which indicated how Missouri Medicaid reimbursed relative to all states in the nation and in particular, our bordering states with whom we compete for physician recruitment. We emphasized that while all physicians may have an ethical and moral obligation to care for any patients seeking evaluation and treatment, we are unique in that federal EMTALA laws require us to evaluate and stabilize any emergency condition presenting to our department.

I believe Dr. Ditmore was sympathetic to our situation and believed that our expectations were reasonable. We must all keep in mind that this is not his independent decision. While he provides primary oversight and direction of the entire Medicaid program, decisions regarding improved reimbursement procedurally come from the General Assembly, hopefully with the consent of the Governor. Nevertheless, Dr. Ditmore will play an important role in this process. He was helpful in suggesting which members of the General Assembly will be instrumental in our issue. We will be contacting these individuals at the appropriate time. Dr. Ditmore also directed his staff to determine what the increased cost to the state would be if our Level 1-5 reimbursement rates were brought into parity with those of office-based physicians. These will be shared with Betsy Morgan within the perspective of the anticipated state budget.

Finally, and perhaps most importantly, we indicated to Dr. Ditmore our collective willingness to help make Medicaid more efficient. All of us know, perhaps as well as any practicing physician, what works well and what does not with Medicaid. We shared results of a survey conducted by the St. Louis Regional Health Commission which tried to determine why "non-emergent" patients so frequently present to the emergency department. We also shared results of our emergency physician survey of same question. Remarkably, there was significant consistency: convenience, availability, access and quality of care. Dr. Ditmore and the state is readily engaged in trying to improve how health care is provided to Medicaid patients in Missouri. I believe we agreed that emergency physicians can play an instrumental role in that effort and are willing to do so.

I'll keep you updated as matters proceed.

Randy Jotte, MD

President, Missouri Chapter of the American College of Emergency Physicians

*\*Longtime department employee Steve Renne of Columbia was appointed interim director of the state Medicaid program after last week's announcement that director Michael Ditmore was retiring. Renne has been the department's deputy director since 1989.*

CPT Code	99281	99282	99283	99284	99285 Updated
Alabama	\$ 13.00	\$ 21.00	\$ 42.00	\$ 66.00	\$ 104.00 5/17/2006
Alaska	\$ 23.91	\$ 39.64	\$ 89.02	\$ 138.89	\$ 217.50 5/17/2006
Arizona	\$ 16.70	\$ 27.73	\$ 62.29	\$ 97.24	\$ 152.35 5/18/2006
Arkansas	\$ 22.00	\$ 35.00	\$ 53.90	\$ 71.50	\$ 83.75 5/17/2006
California	\$ 15.18	\$ 24.38	\$ 44.60	\$ 68.35	\$ 108.08 5/17/2006
Colorado	\$ 16.91	\$ 26.06	\$ 47.74	\$ 73.02	\$ 115.13 5/18/2006
Connecticut	**	**	\$ 34.80	\$ 79.56	\$ 79.56 7/12/2006
Delaware	\$ 16.67	\$ 26.41	\$ 59.33	\$ 92.61	\$ 145.07 5/17/2006
Florida	\$ 14.23	\$ 22.04	\$ 40.62	\$ 62.20	\$ 98.01 5/19/2006
Georgia	\$ 17.28	\$ 27.00	\$ 54.80	\$ 84.21	\$ 132.41 5/18/2006
Hawaii	\$ 15.42	\$ 23.95	\$ 48.05	\$ 73.66	\$ 115.85 5/23/2006
Idaho	\$ 15.22	\$ 25.30	\$ 56.67	\$ 88.57	\$ 138.40 5/19/2006
Illinois	\$ 14.35	\$ 24.20	\$ 32.20	\$ 44.00	\$ 69.25 5/17/2006 *
Indiana	\$ 15.25	\$ 23.74	\$ 43.82	\$ 66.93	\$ 105.28 5/19/2006
Iowa	\$ 15.61	\$ 29.03	\$ 59.23	\$ 91.19	\$ 143.37 7/17/2006
Kansas	\$ 18.53	\$ 28.89	\$ 55.23	\$ 85.06	\$ 133.42
Kentucky	\$ 15.97	\$ 24.71	\$ 45.51	\$ 69.53	\$ 109.43 5/19/2006*
Louisiana	\$ 16.20	\$ 19.80	\$ 35.23	\$ 38.70	\$ 49.50 05/19/2006*
Maine	\$ 15.30	\$ 19.42	\$ 31.65	\$ 49.43	\$ 77.39 5/19/2006
Maryland	\$ 17.07	\$ 28.26	\$ 63.48	\$ 99.06	\$ 155.08 5/24/2006
Massachusetts	\$ 12.01	\$ 19.85	\$ 44.58	\$ 69.52	\$ 108.77 5/25/2006
Michigan	\$ 45.58	\$ 45.58	\$ 45.58	\$ 45.58	\$ 45.58 5/17/2006
	\$ 104.81	\$ 104.81	\$ 104.81	\$ 104.81	\$ 104.81
	\$ 9.47	\$ 15.72	\$ 35.31	\$ 55.12	\$ 86.34
Minnesota	\$ 25.10	\$ 30.90	\$ 37.46	\$ 50.98	\$ 73.38 05/19/2006*
Mississippi	\$ 14.12	\$ 23.74	\$ 53.37	\$ 83.39	\$ 130.62 6/13/2006
<b>Missouri</b>	<b>\$ 16.00</b>	<b>\$ 19.00</b>	<b>\$ 23.00</b>	<b>\$ 24.00</b>	<b>\$ 25.00 5/22/2006</b>
Montana	\$ 20.53	\$ 25.20	\$ 53.31	\$ 83.05	\$ 129.87 5/23/2006
Nebraska	\$ 18.22	\$ 31.95	\$ 47.93	\$ 56.80	\$ 92.30 5/23/2006
Nevada	\$ 13.85	\$ 22.77	\$ 51.69	\$ 80.31	\$ 125.54 5/23/2006
New Hampshire	\$ 15.00	\$ 22.00	\$ 36.00	\$ 54.00	\$ 84.00
New Jersey	\$ 16.00	\$ 23.50	\$ 23.50	\$ 32.30	\$ 32.30 05/25/2006*
	\$ 14.00	\$ 20.60	\$ 20.60	\$ 25.00	\$ 25.00 5/25/2006
New Mexico	\$ 20.25	\$ 28.22	\$ 57.57	\$ 88.61	\$ 139.32
New York	\$ 25.00	\$ 25.00	\$ 25.00	\$ 25.00	\$ 25.00 7/17/2006
North Carolina	\$ 14.30	\$ 23.76	\$ 53.25	\$ 83.19	\$ 134.35 05/23/2006*
Ohio	\$ 11.62	\$ 18.12	\$ 34.55	\$ 53.21	\$ 83.41 05/17/2006*
Oklahoma	\$ 15.75	\$ 26.01	\$ 58.46	\$ 91.33	\$ 142.90 5/26/2006
Oregon	\$ 14.94	\$ 24.85	\$ 55.54	\$ 86.78	\$ 135.15
Pennsylvania	\$ 20.00	\$ 35.00	\$ 35.00	\$ 50.00	\$ 50.00 5/25/2006
Rhode Island	\$ 15.48	\$ 17.91	\$ 38.00	\$ 59.20	\$ 92.55 5/25/2006
South Carolina	\$ 12.70	\$ 20.97	\$ 47.11	\$ 73.59	\$ 115.12 5/19/2006
South Dakota	\$ 27.43	\$ 34.79	\$ 47.40	\$ 71.90	\$ 109.00
Tennessee	\$ 17.10	\$ 26.61	\$ 53.71	\$ 83.70	\$ 130.81 8/9/2006
Texas	\$ 22.06	\$ 34.84	\$ 47.07	\$ 68.87	\$ 85.63 5/26/2006
Utah	\$ 12.65	\$ 24.92	\$ 42.11	\$ 64.60	\$ 113.61
Virginia	\$ 24.37	\$ 19.59	\$ 44.02	\$ 68.71	\$ 107.62 5/25/2006
Washington	\$ 10.09	\$ 16.74	\$ 37.61	\$ 58.47	\$ 91.72 7/21/2006
Washington, DC		\$ 17.42	\$ 30.86	\$ 48.17	\$ 75.02 5/25/2006
West Virginia	\$ 12.04	\$ 20.47	\$ 47.26	\$ 73.44	\$ 114.15
Wisconsin Non-PC	\$ 19.21	\$ 21.04	\$ 21.83	\$ 25.93	\$ 35.91
	\$ 19.79	\$ 21.67	\$ 22.50	\$ 26.70	\$ 36.99
Wyoming	\$ 17.68	\$ 49.90	\$ 53.96	\$ 84.22	\$ 131.60

\* Same as previous year

No information for North Dakota and Vermont

\*\* Based on clinic rev codes

Below represents a comparison of Emergency Physician reimbursement compared with Internal Medicine/Family Practice office reimbursement for similar leveled patient care. Disparities in reimbursement are evident in the examples below. MOCEP will strive to achieve parity with Medicaid reimbursement in the outpatient setting for emergency physicians.

<b>Emergency Department Services</b>	<b>Missouri Medicaid Reimbursement 7/01/2006</b>	<b>Office or Other Outpatient Services</b>	<b>Missouri Medicaid Reimbursement 7/01/2006</b>
<b>99281</b> Emergency department visit for a patient for removal of sutures from a well-healed, uncomplicated laceration	\$16	<b>99201</b> Initial office visit with a 5-year-old female to remove sutures from simple wound placed by another physician	\$21.52
Emergency department visit for a patient with several uncomplicated insect bites	\$16	Initial office visit for a 50-year-old male from out-of-town who needs a prescription refill for a nonsteroidal anti-inflammatory drug	\$21.52
<b>99282</b> Emergency department visit for a child presenting with impetigo localized to the face	\$19	<b>99202</b> Initial office visit for a 13-year-old patient with erythematous, grouped, vesicular eruption of the lip of three days duration	\$38.23
Emergency department visit for a patient with a minor traumatic injury of an extremity with localized pain, swelling, and bruising	\$19	Initial office visit for a 25-year-old patient with single season allergic rhinitis	\$38.23
<b>99283</b> Emergency department visit for a patient with an inversion ankle injury, who is unable to bear weight on the injured foot and ankle.	\$23	<b>99203</b> Initial office visit for a 19-year-old football player with three-day-old acute knee injury; now with swelling and pain	\$56.93
Emergency department visit for a well-appearing 8-year old who has a fever, diarrhea and abdominal cramps, is tolerating oral fluids and is not vomiting	\$23	Initial office visit for a 50-year-old female with dyspepsia and nausea	\$56.93
<b>99284</b> Emergency department visit for a female presenting with lower abdominal pain and a vaginal discharge	\$24	<b>99204</b> Initial office visit for a 34-year-old female with primary infertility for evaluation and counseling	\$80.62
Emergency department visit for an elderly female who has fallen and is now complaining of pain in her right hip and is unable to walk	\$24	Initial office visit for initial evaluation of a 63-year-old male with chest pain on exertion	\$80.62
<b>99285</b> Emergency department visit for a patient with a complicated overdose requiring aggressive management to prevent side effects from the ingested materials	\$25	<b>99205</b> Initial office visit for an adolescent referred from ER after making suicide gesture	\$102.58
Emergency department visit for a previously healthy young adult patient who is injured in an automobile accident and is brought to the emergency department immobilized and has symptoms compatible with intra-abdominal injuries or multiple extremity injuries	\$25	Initial office visit for a 60-year-old male with previous back surgery, now presents with back and pelvic pain, two-month history of bilateral progressive calf and thigh tightness and weakness when walking, causing several falls	\$102.58

## PRIMARY SAFETY BELT SUMMIT — NOVEMBER 14, 2006

We have a chance to save almost 90 lives a year in Missouri by enacting a primary safety belt law. The primary Safety Belt Partners, a committee formed under the Missouri Coalition for Roadway Safety, is hosting a statewide summit to examine how to get a primary safety belt law passed in Missouri and save 90 lives a year.

**WHO:** Supporters of a primary safety belt law or those who want to learn more about the issue.  
**WHAT:** Will explore ways to enact a primary safety belt law in Missouri.  
**WHEN:** November 14, 2006  
**TIME:** 8:30 a.m. to 3:00 p.m. (lunch will be served)  
**WHERE:** Stoney Creek Inn, 2601 South Providence Road, Columbia, Missouri

### FOR MORE INFORMATION:

Primary Safety Belt Partners  
 Missouri Coalition for Roadway Safety  
 611 East Capitol Avenue, Suite 3  
 Jefferson City, Missouri 65101  
 (573) 636-8167  
 E-mail: [mosafety@mchsi.com](mailto:mosafety@mchsi.com)

### **Blueprint for Safer Roadways 2006 Conference**

Date: November 28-30, 2006

Where: Adam's Mark Hotel, St. Louis

For more information go to:

<http://www.savemolives.com/06conference/default.htm>

## FORENSIC MEDICINE SECTION APPROVED

The ACEP Board of Directors just approved the newly proposed Forensic Medicine Section! Congratulations to all, and especially the two individuals who worked so hard to make this a reality – Dr. Weaver (a MoCEP member) and Dr. Green!! ACEP will now begin the recruiting process, and hopefully have 100-dues paying members prior to December 31, 2006 which is the cut-off date for councillor eligibility for next year's *Scientific Assembly*.

Anyone interested in becoming a member of the ACEP Forensic Medicine Section can sign up through the ACEP web site at [www.acep.org](http://www.acep.org) or call membership services at 1-800-798-1822.

## EMPLOYMENT OPPORTUNITY

NES Healthcare Group, Inc. is seeking Emergency Medicine Physicians for full-time, part-time or moonlighting opportunities at Ray County Memorial Hospital in Richmond, MO. Located 35 miles east of Kansas City, MO, this Emergency Department has an annual volume of 5,900. Qualified candidates must be Board Certified or Board Prepared in Emergency Medicine, Internal Medicine or Family Practice, have a current state license, and ACLS training. PGYIII residents welcome. Shifts are 12 hours, 7a-7p, 7p-7a, maximum 24 hours per shift. NES offers excellent hourly rates, comprehensive malpractice insurance and flexible scheduling as an independent contractor.

Contact Genevieve Pizzo 800-394-6376 [gpizzo@neshold.com](mailto:gpizzo@neshold.com) or fax CV 631-265-8875. [www.neshold.com](http://www.neshold.com)

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 St. Louis  
[jotter@msnotes.wustl.edu](mailto:jotter@msnotes.wustl.edu)

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[mjszewczyk@aol.com](mailto:mjszewczyk@aol.com)

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 Joplin  
[drbware@sbcglobal.net](mailto:drbware@sbcglobal.net)

Charlotte Ransom, MD  
 Truman Med Ctr/Univ MO-KS  
 Roeland Park  
[charlotteransom@hotmail.com](mailto:charlotteransom@hotmail.com)

Kevin Journagan, MD  
 Richmond Heights

## RESIDENT'S CORNER

The day of July 19<sup>th</sup> started like any other day in St. Louis, but ended like no other the city has ever seen. On this warm summer day a strong thunderstorm with tornado strength winds passed through St. Louis causing widespread destruction. Emergency services throughout St. Louis were forced in a short period of time to mobilize and unite to deal with this real disaster scenario.

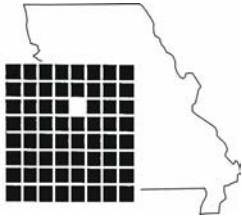
In the first wave after the storms, the city emergency departments, chiefly Barnes Jewish Hospital and St. Louis University Hospital, were presented with the injured from the destruction caused by the storms. With three buildings in St. Louis collapsing, the Barnes ED was hit with multiple trauma patients at the same time. The patients included a patient who had a portion of a building fall on him leaving him with a spinal cord injury and a patient with arterial damage to his arm after a window fell on him. The emergency department staffs were challenged by this initial surge. However, it would be what would ensue that would be the greater challenge.

As the storm passed through St. Louis, up to 1.1 million people were left without power. The areas hardest hit were those in the city of St. Louis, especially in the poorer areas of North St. Louis. These following days brought temperatures above 100 degrees. The emergency departments in St. Louis served as the safety net for the city providing a place for those that needed medical care as well as those that needed air conditioning, food, and water. Multiple hospitals in the St. Louis area were left without power limiting the number of options for medical care. The patient volumes in the city ED's over the next few days skyrocketed. At Barnes Jewish Hospital, additional emergency physicians, nurses, and support staff worked in attempt to keep up with the swell of patients. The surge of patients included the frail, elderly, shut-ins, and patients needing electrical devices such as refrigerators for insulin. Barnes Jewish Hospital opened two nursing units and brought in more staff to take care of the increasing number of inpatients. The inpatient wards were full with many patients admitted from the emergency department, but also with 26 patients transferred from nursing homes without electricity. The internal medicine service brought in extra residents to take care of this surge in patients. Barnes Jewish Hospital had 125 more patients than usual during the height of the surge. Across the city at Saint Louis University the hospital encountered similar challenges. The patients were similar with an increase in trauma patients in the initial phase followed by the surge of patients unable to cope without electricity. Local nursing homes without power contacted the emergency department in hopes of transferring patients to the ED. The hospital improvised by opening up an extra area of their cancer center to accommodate these patients. When some of Saint Louis University's outpatient facilities lost power and were shut down, the nurses from these centers were sent to take care of these inpatient nursing home patients. The Saint Louis University emergency department used surge staffing for the days following the storm and as the volume decreased returned to normal staffing.

The emergency medical services also worked tirelessly to serve the citizens of the St. Louis area. EMS providers from St. Louis County and beyond were dispatched to help take care of the surge from the city of St. Louis. All of the providers involved worked around the clock in extreme heat and humidity to provide care for those left without power.

The emergency medicine community of St. Louis definitely learned many lessons during the time following the storms. As the weather cooled down and power slowly returned to the city, the surge of patients slowed approximately four days after the storm. While there were definite problems during this time great strides were made towards disaster preparedness. The lessons learned will provide a solid base while we prepare for future natural disasters, terrorist attacks, or the global flu pandemic.

K e v i n            A .            J o u r n a l            M . D .  
E m e r g e n c y            M e d i c i n e            R e s i d e n t  
Barnes Jewish Hospital/Washington University



## MISSOURI EPIC

213 E. Capitol Avenue, Suite 200  
Jefferson City, MO 65101

## MISSOURI EPIC

### **Community Emergency Department Study Opportunity!!!**

In 2005 MoCEP awarded a resident research grant to Harpartap Sandhu, MD to partially fund the development of a novel, interactive website to explore clinician decision-making. The website has now been completed and data collection is underway from a variety of academic and community ED's around the United States and Canada. The website consists of five actual ED cases of older adults presenting with acute abdominal pain. Physician-participants are asked to move through the cases as if actually caring for these patients in their own ED. After reviewing the history and physical exam, the physician-participants have the opportunity to view a video clip of the patient before ordering diagnostic tests including labs and imaging studies. As in real-life, only those studies ordered will be provided. Following completion of the five cases is a brief survey. Answers are anonymous and all five cases with the survey are usually completed in 30-45 minutes.

We lack funding to reimburse busy clinicians for their time in completing this survey, but would like to solicit your time. The benefits of wide-scale participation among practicing Missouri EM physicians include enhanced understanding of our state practice patterns, potential heterogeneity, and similarities. In addition, the interactive website developed has not been previously described and if proven successful might be used for multiple other questions such as the assessment of chest pain, altered mental status, or septic patients not to mention the influence of ever-present distractions like telephone calls and sleep deprivation. Please participate in this state-wide project.

If interested, please call (314-362-7979) or e-mail ([carpenterc@msnotes.wustl.edu](mailto:carpenterc@msnotes.wustl.edu)) the principle investigator, Christopher Carpenter, MD, FACEP.