

DECEMBER 2006

PALMETTO STATE EPIC

PUBLISHED BY THE
SOUTH CAROLINA COLLEGE
OF EMERGENCY PHYSICIANS

EMERGENCY PHYSICIANS' INTERIM COMMUNIQUE



Tug-O-War

*Stephen C. Stanfield, MD, FACEP
President*

Recently, members of SCCEP were privileged to sit down for a conversation with Dr. Rick Blum, President of the American College of Emergency Physicians. In attendance were several veterans of ACEP who over the decades have observed the struggles that ACEP has endured. Our discussion focused on many of the dilemmas facing the practice of emergency medicine and the forces that are shaping the future of our practice environment - access to care, reimbursement and tort reform. One of the attendees commented that nothing ever seems to change when it comes to ACEP and that emergency physicians have been talking about the same issues and fighting the same battles for the last thirty years. When is ACEP finally going to win the fight?

As I thought about the pending 5.1 % decrease in Medicare reimbursement that seems to be overturned at the last minute every year, I realized that this physician was correct. We fight the same battles time after time and our situation never improves. We spend fortunes and solicit money from members for PACs and lobbyists and we are in no better of a situation than we were a year ago. Next spring when I go back to Capitol Hill, I will be talking about the same issues I spoke about last year and will, most likely, be speaking to a congressional assistant six months out of college with aspirations of going to law school.

So, why **do** we continue to bang our heads against the proverbial wall? While at first glance this may look like a losing battle, consider for a moment a world without ACEP. Each year our lobbyists and members take-up arms and endure a battle of wits and words with our 'enemies'. The outcome of these battles is often not about gaining new territory but protecting what we already have achieved.

Take Medicare reimbursement for example. Were it not for ACEP and the actions of its members, reimbursement for Medicare would be on track for a 40% reduction over the next 4 years. Instead, each year we have fought for a marginal increase in pay over the preceding year. This is by no means a stellar victory but imagine our situation if inaction prevailed.

On a local level, consider the recent victory in our state in the area of malpractice reform. We must continue to fight this battle. The war is not over when one battle is won; there will be challenges to the legislation we successfully fought for.

Perhaps more appropriate than a military analogy, is one of tug-o-war with ACEP/SCCEP members holding one end of the rope. Every year we pull and the forces on the other end of the rope - trial lawyers, declining Medicare payments or hospital administration blocking rapid admissions - pull against us. Occasionally, we get enough people pulling on our side of the rope to help issues swing in our favor. That is the job of ACEP and SCCEP.

But, we don't just pull on the rope, we "encourage" (or pay) for others to join us. We **pay** for the help of lobbyists at the state and local level to get our message across. We travel to Washington to **ask** congressmen and senators to pull on our side of the rope. We **plead** with members to get involved. We **invite** non member emergency physicians to join us on the rope. We **rally** with other members of the medical team for strength on mutual issues. Most importantly, we **hold the line**.

During the holiday season we often reflect on the events of the past year. Looking back at all of the effort on the parts of so many, I would like to take this opportunity to thank all of you who do get involved no matter what your level of participation. Some members participate by going to the state house and lobbying our legislature; others participate at the national level, working to convince our senators and congressmen to enact legislation to improve the lives of our patients; and some work behind the scenes to fill the gaps left by those away lobbying. But, none of these activities would be possible without the support of those

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members who, though unable to participate personally, support these vital activities through payment of their ACEP/SCCEP dues. All of these contributions have had an enormous impact, making our chapter one of the best in the nation, our specialty the best in medicine.

As we look forward to the challenges of the New Year, I thank you for being on my end of the rope. Hang in there and keep tugging!

ACEP Council Report 2006

Allison Harvey, MD, Steve Grant, MD, Bill Gerard, MD

First, we would like to thank you, our colleagues, for trusting us to represent your interests at the national ACEP council meeting. We are a small chapter with only three councilors, but we make our opinions known! The council meeting is two full days of committee meetings, state of ACEP presentations, strategic planning meetings, elections, and LOTS of voting. With the help of alternate councilor, Pam Bensen, the four of us try to cover as many of the sessions as possible. Following is a quick summary and outcome of the most important issues of interest discussed and voted on at the Council meeting.

The resolution to allow members to keep their FACEP designation, even if they were no longer board certified, was soundly defeated. The councilors think that "FACEP" should signify to the public that an emergency physician is board certified. The Council then created a category of "Fellow Emeritus" to apply to current or former fellows who have contributed significantly to ACEP or the specialty of emergency medicine. Board certification would no longer be required to use "FACEP (emeritus)" behind your name, but you would have to be elected by the board of directors.

Other resolutions:

- * After extensive debate on whether or not to add a dedicated "young physician" member to the national board of directors, the resolution was defeated.
- * The Council reiterated its support for the concept of universal health care but NOT a single payer model.
- * Support for the idea of SANE nurses and SART programs was also reiterated. However, triage to select "designated sexual assault centers" was defeated.
- * ACEP has been directed to develop guiding principles and talking points on emergency care of psychiatric and substance abuse patients. These are to be used locally to help states address their problems. It is clear, from talking to councilors from other states, that South Carolina has one of the worst problems in the nation when it comes to emergency care of psychiatric and substance abuse patients.

The Council passes a few really helpful resolutions by:

- * Encouraging ACEP to find a way to offer the LLSA readings as a member benefit.

- * Requesting a task force to study the issue of unavailability of on-call specialists and to propose a comprehensive solution.
- * Requesting a mechanism for publishing the names of emergency physicians who give egregious testimony and expelling them from ACEP. If you know someone who has given egregious testimony, please report it to the ethics board of ACEP (after the case is over)
- * Overwhelmingly supporting a resolution placing responsibility for admitted patients squarely on the shoulders of the admitting physician, regardless of their physical location.
- * Supporting the concept of RN's giving procedural sedation drugs under the supervision of emergency physicians. The ENA president was in attendance and thanked us for our support.

One very contentious issue was the diversion of patients out of the ED. Several hospitals are now requiring their physicians to send non-urgent patients out of the ED, unless they have a 'down payment'. Studies have shown that most of these patients are unable to establish follow-up care within one month. The Council strongly opposed "deferral of care", since the one thing that makes EP's unique is that we will see anybody anytime.

In an emotional ceremony, outgoing president Rick Blum, MD handed the gavel over to Brian Keaton, MD. Another excellent physician, Linda Lawrence, MD was elected president-elect. The Board of directors gained 2 new members, Bob Solomon and Alex Rosaneau, along with the two incumbents Angela Gardner and Nick Jouriles. All candidates were highly qualified and long time council members.

Thank you for your time and trust. We are happy to represent our state at the national level. If you have any questions or issues that you feel are important, please let us know!

SHARE THE KNOWLEDGE

(Tips for Residents and Others)

Dr. Ronald L. Krome shares his words of wisdom from many years of practice in the EMPulse news publication of the Florida College of Emergency Physicians (FCEP). This is a great way to involve long-time leaders in the chapter and to help younger members learn from the voice of experience through a regular column in the chapter's publication.

We would like to provide this service to our emergency medicine residents and are sure that every one of you has at least one or two pearls of wisdom to share with those coming along behind. So, please, send your tips, tricks of the trade, pearls, and other thoughts to Joy Zimmer Joy.Zimmer@PalmettoHealth.org or Pam Bensen pamben@alum.dartmouth.org.

ACEP LEADERSHIP REPORT

Scientific Assembly: Another Successful Year!

ACEP had over 6,000 people in New Orleans; 3,100 four-day registrants, 340 exhibitors with 2,000 of their employees; spouses; and staff. Special thanks to Past President Greg Henry and members who participated in his member-to-member “Promote New Orleans” calling program.

HHS Secretary Michael Leavitt and Louisiana Gov. Kathleen Blanco spoke at the meeting, thanked our members for their dedication and devotion to providing quality emergency care, and said they would work to change issues facing emergency care.

EMF raised \$46,918 at the Council meeting and at its booth in the Exhibit Hall. The online EMF Auction netted over \$14,000.

NEMPAC raised \$95,662 through the Council meeting, the Public Affairs Booth, and pledges made during the NEMPAC Ambassador Phone-a-Thon.

A booth in the Exhibit Hall dedicated to helping local charities garnered about \$12,150 for Mobile Loaves and Fishes, Habitat for Humanity, and St. Thomas Community Health Center (which also received several commitments from various exhibitors to either donate or discount products and equipment).

Board Elections

Incumbents Angela Gardner and Nick Jouriles were re-elected and Alex Rosenau of Pennsylvania and Bob Solomon of West Virginia were elected to the Board of Directors.

Linda Lawrence was elected President-elect by the Council.

The Board selected its officers – Cheri Hobgood, Chair; Nick Jouriles, Vice President; Angela Gardner, Secretary/Treasurer; Sandy Schnieder, EMF Chair; and David Sklar, EMF Chair-elect.

Strategic Plan in Development

The Board of Directors will work on the College’s strategic plan in the next few months, so if you have ideas the College can pursue share your ideas. The Board would like your feedback on things ACEP should and should not be doing.

Report Card Leads to New Residency Program in Oklahoma
Dr. John Sacra and the Oklahoma chapter members used ACEP’s National Report Card on the State of Emergency Medicine to develop talking points and letters to the editors calling for the creation of the first OK emergency medicine residency program. The efforts were successful and the state created and funded the Oklahoma Institute for Disaster and Emergency Medicine at the OU College of Medicine in Tulsa. It will support an emergency medicine residency program and enhance trauma system development, injury prevention research, and the emergency medical response infrastructure.

Town Hall Meetings Kick Off with Great Results

The Connecticut and West Virginia chapters have hosted town hall meetings focused on key issues facing emergency medicine. Both were well-attended by physicians, nurses, EMTs, and state legislators. There was excellent media coverage and the momentum will continue as both states have task forces to address the crowding issue.

ACEP awarded \$5,000 to nine chapters to host town hall meetings to increase awareness of critical issues among state policymakers, the media and the public. In addition to ED crowding and boarding, discussions included disaster preparedness and solutions to ambulance diversion. The remaining events will be in Florida, Kentucky, Maryland, New Jersey, Ohio, Pennsylvania, and Texas.

Web Site Enhancements

www.ACEP.org has some great new features; enhanced personalization of your “My ACEP” page; a new Flash member orientation to review member benefits; and a members-only RRS (Really Simple Syndication) feeds to deliver the latest clinical news to your desktop, with articles from Elsevier, the premier provider of medical news.

Non-Dues Revenue Continues to Grow

- ACEP President Brian Keaton secured \$50,000 from the Robert Wood Johnson Foundation for our Workforce Study.
- OnStar will be an EMS Week and EMF sponsor for at least \$20,000.
- GE Healthcare has agreed to sponsor EMF by donating a portion of their sales of ultrasound equipment, which could raise as much as \$75,000.
- So far, ACEP has been awarded seven grants, totaling \$350,000, of the 18 proposals submitted which totalled \$1.9 million.

National Grant Award Benefits Several Chapters

ACEP worked with the National Disaster Life Support (NDLS) Foundation to secure sub-contracts to four chapters through a Health Resources and Services Administration (HRSA) grant. The Georgia, Maryland, Ohio and Texas chapters each received \$20,000 to devise a strategy to conduct NDLS courses in their state and assist in planning statewide National Incident Management System (NIMS) compliant drills/exercises.

May 2007 NPI Deadline

Physicians must have a national provider identifier (NPI) number to bill Medicare, Medicaid and other payers. CMS has a list of resources to answer your questions. Visit http://www.cms.hhs.gov/NationalProvIdentStand/07_Questions.asp#TopOfPage and access the free application process.

Medicare Carrier Advisory Committee (CAC)

by Pamela P. Bensen, MD, MS, FACEP

After two decades on regional CAC Committees, I am the first to admit that 99% of the material presented does NOT apply to emergency medicine. "Why then," you might ask, "would any emergency physician want to attend a CAC meeting?"

A good question; my only excuse is that when that 1% is mentioned, it is usually very important. Often the item of interest can result either in a loss to emergency medicine or a potential gain, but only if something is done correctly.

Items of interest to emergency physicians from the December Region 4 (SC, AL, FL, GA, KY, MS, NC, TN) meeting were:

a. Medicare has mailed their annual "Dear Doctor do you realize you are over using code "X" letters. The Medicare Progressive Corrective Action (PCA) program, designed to minimize physician coding errors through education and claims scrutiny, generates 'benchmarking' data to measure you against all the rest of us. If you bill a code more than "average" you get a cease-and-desist letter, which disregards your coding accuracy.

These are the letters I wrote about in the last EPIC. Be ware, the program uses quality improvement language to camouflage the underlying purpose, to pay you less. If you get one and you document appropriately and code correctly, do not be intimidated. If in doubt, I am willing to provide a review of your records to help you determine the accuracy of your code usage.

b. You will not get paid by Medicare after May 23, 2007 if you do not have a National Provider Identifier (NPI). Information can be found on the CMS NPI page of www.cms.hhs.gov/NationalProvIdentStand. Apply on line at <https://nppes.cms.hhs.gov> or call for an application 1-800-465-3203.

c. You can sign up for online workshops on coding at www.PalmettoGBA.com/bsc, click link for Learning & Education Online Learning.

d. Medicare will require facility rather than individual practitioner certification to pay for ultra sound procedures.

e. Medicare will not pay for the new shingles vaccine Zostavax™. Only congress can change this. Some physicians are writing a prescription for the patient to take to the pharmacy, then Medicare Part D can pay for it.

f. If you bill for PAs or NPs, make sure you understand the recent, major change in the 'incident to' coding rules brought about by the initiation of Non Physician Provider NPIs.

g. CMS's Comprehensive Error Rate Testing (CERT) program resulted in an adjusted error rate of 5.8% in 2003, down from 14 percent in 1996. "The CERT program combines data analysis with extensive education efforts to health care providers and the private companies that pay Medicare claims." Palmetto GBA is now at 4.2%.

The most ridiculous item of the day - It takes an act of congress to get effective new vaccines approved for Medicare

South Carolina Earns Highway Safety Law Score Of Six

The Emergency Nurses Association (ENA) in association with its Injury Prevention Institute/EN Care has published the first National Scorecard on State Highway Laws: A Road Map to Injury Prevention. The scorecard was designed to advance ways to prevent the 43,000+ deaths seen in the US annually from motor vehicle crashes (MVCs).

Washington, D.C. and the state of Washington were the only locations to receive perfect scores. States were ranked on a scale of one to ten for highway laws that promote safety and injury prevention. Arizona received a score of 2 out of 10. South Carolina rated a 6.

EN Care emphasizes that safe driving is a public health issue. Nancy Bonalumi, RN, MS, CEN, ENA president, said, "While we cannot be free of risk, it is necessary to take all possible steps toward preventing injury." The scorecard aims to enhance collaborative efforts at the local, state and national levels to encourage injury prevention programs and policies to help save lives.

The scorecard is designed to educate legislators and the general public about a state's strengths, weaknesses and level of risk at a time of increased travel during the holiday season. Rankings were based on criteria from five areas of state jurisdiction, the presence of highway safety laws, primary seatbelt laws, child passenger safety laws, graduated driver licensing (GDL), and universal motorcycle helmet laws. A fifth measure evaluated the state's capacity to respond to severe emergencies as determined by the existence of initiatives to establish a statewide trauma system.

South Carolina only received a 6 because it lacks the following laws: universal helmet, booster seats under age 8, child passenger safety to age 16, and GDL passenger restrictions.

The report includes locations with the most/fewest highway safety and injury prevention laws. Six states do not have trauma systems or plans for establishing a trauma system to respond to medical emergencies.

For more information on the scorecard, visit www.ena.org.

CMS Verbal Order Rule Update

On November 27 CMS made the following changes to hospital conditions of participation:

Effective January 26 2007, all (verbal/written) orders must be dated, timed, and authenticated within 48 hours by the physician. This will sunset in five years when electronic records allow for instant authentication. More stringent state laws and hospital policies supersede the CMS rule.

Drugs/biologicals must be kept in secure areas and locked whenever possible, which balances the need for accessibility on crash carts with the obvious need for securing them.

The DRG Corner – Urosepsis

By Pamela P. Bensen, MD, MS, FACEP

Eliminate "Urosepsis"

Abbreviations used in this article:

CMS – Centers for Medicare and Medicaid Services, formerly the Health Care Finance Administration (HCFA)

CPT – Current Procedure Terminology

DRG - Diagnosis Related Groups

Emergency physicians can provide a value-added service to their hospitals with no additional effort.

Medicare reimburses hospitals using the DRG system. DRG coding, like ED CPT coding, depends on physician documentation in the chart. For correct coding, the coder codes only what the physician writes.

In 1983, in an attempt to simplify the system used to pay hospitals for services to Medicare beneficiaries (i.e. decrease payments), CMS (then HCFA) implemented the DRG system. Under this program, coders at the hospital read the physician's documentation and determine "what, after study, occasioned the patient's admission"; this is known as the 'principal diagnosis'.

Using 'coding terminology' for disease entities, the coder can then assign an ICD-9CM diagnosis code that drives the DRG for that principal diagnosis. The DRG is a group of medical conditions costing approximately the same to treat.

The DRG is submitted to Medicare and hospital payment is calculated using a 'relative weight' (one is assigned to each DRG) and the hospital's 'blended rate' (a hospital-unique, annually-calculated dollar figure which takes into consideration regional and local factors influencing the cost of providing care to a patient).

What can you, as an emergency physician, do to help your hospital?

First, suspend your need to be logical because the DRG system defies physician logic. Next, accept the fact that 'coding terminology' and 'medical terminology' share the same words but attach different meanings to the words. Finally, use the right words, what I call the 'magic words' to communicate the accurate medical diagnosis in terms the hospital coder will best understand to select the correct DRG.

Although the coder will use the discharge summary to select the principal diagnosis, **the words you select for the admission diagnosis can alter the terminology the attending uses or provide a clue to the coder to query the attending about the principal diagnosis.**

"Urosepsis" is an excellent example of a word with two meanings. Physicians use the word "urosepsis" to denote a condition where the patient is septic from or with a UTI.

However, in coding terminology 'urosepsis' codes to the DRG for urinary tract infections. CMS recognizes only the first half of the word "urosepsis", the 'uro' or 'UTI'. Coding protocol does not see the 'sepsis' part of "urosepsis" and does not acknowledge the severity of illness or the additional work (intensity of service) associated with sepsis. The UTI DRG has a lower relative weight (reimbursement).

Physicians know that a **septic** patient (DRG 416) is significantly different from one with a simple UTI (DRG 320). Help your hospital get paid for the septic patient, **eliminate the word "urosepsis" from your vocabulary !** If the patient is septic from or with a urinary tract infection, write your diagnosis, **'sepsis and urinary tract infection'**. If it is a simple urinary tract infection, write UTI.

Ed Leap to Contribute Articles for EPIC

If you have enjoyed Dr. Edwin Leap's column, "Second Opinion", in EMNews, you will be glad to hear his enthusiastic reply in response to our invitation to contribute to future SCCEP EPICs, "I'd love to contribute! I love writing, but especially love being able to speak to (and for) all of my dear friends and colleagues in our specialty."

In addition, Ed has offered to speak at SCCEP events stating, "I'd love to entertain my fellow South Carolina docs."

A self-published author, Ed's book "Working Knights" is available at the ACEP book store. His book, "Cats Don't Hike", stories about family and home life lifted from his Greenville News articles, is available at Booklocker.com and online bookstores such as Amazon. His books are even finding their way into hospital gift shops.

Recently Ed has been working with an aspiring filmmaker Sheila Langford, a nurse in the Anderson ED, on a film series called 'Stolen Scrubs'. They are interviewing ED nurses and docs with at least 10 years experience. The series is a documentary about their most memorable experiences, both good and bad. Ed thinks, "it could be a very fun, and very cathartic/healing thing for people to recognize their commonality on film."

A "pit doc" in Seneca, Ed has much in common with each of us coupled with an uncommon ability to put our experiences into words which make us laugh, sigh, shake our heads, and appreciate that someone out there understands. Look for "Leaps of Logic" in future SCCEP EPICs.

Note: EPIC Editors are always looking for interesting articles, cases, viewpoints. And we welcome your comments and suggestions. What would YOU like to see in YOUR newsletter? Please, let us know!

Larry's Trivia Corner

by *Laurence H. Raney, MD, FAAEM, FACEP*

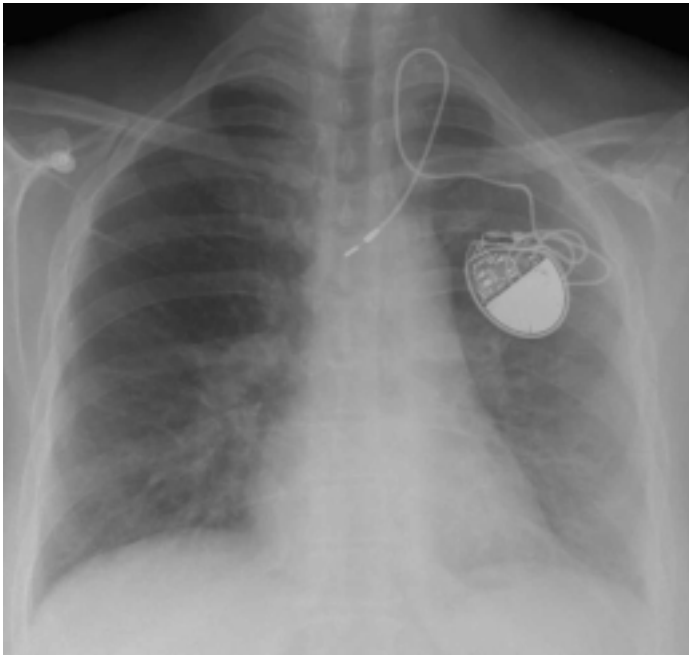
Twiddler's Syndrome



A 64 year old woman presented with syncope. Her heart rate was in the 40's and she was diagnosed with tachy-brady syndrome and had a pacemaker inserted.

A week later she again presented to the ED with the complaint that her abdomen was 'jumping'. I thought she was a bit crazy until her physical exam showed that, indeed, her abdomen was intermittently rhythmically 'hiccupping'!!

I knew her history and suspected the finding, which was confirmed by this CXR.



Twiddler's syndrome was originally described in 1968 as a complication of the then relatively new internal pacemakers. It is not a common complication and is felt to occur when the patient deliberately or unconsciously spins the pacemaker (usually recently inserted) in a large-sized pocket. The leads become twirled around the generator and pulled back. The pacemaker begins pacing the phrenic nerve causing the 'jumping abdomen'. Creation of a smaller surgical pocket and/or adding extra sutures to the fascia can prevent this from occurring.

This patient had her pocket opened, new pacer wires inserted, and additional sutures put in.

Originally published on EMedHome.com; used with permission from Rick Nunez.

Bounty Hunter Demo Recovers \$54 million for Medicare

The Medicare Modernization Act of 2003 directed the Department of Health and Human Services (HHS) to test another group of recovery audit contractors (RACs), to identify Medicare "miss-payments" and recoup overpayments. A 3-year demonstration in Florida, California and New York, began in March 2005. RACs are paid a percentage of what they recoup. Providers protested because RACs only looked for overpayment.

For fiscal year 2006 (10/1/05 - 9/30/06), auditors found \$303.5 million in improper payments — both overpayments (97%) and underpayments (3%) and \$54.1 million has been recovered and returned to Medicare. The recouped dollars represent \$68.6 million in overpayments minus \$14.5 million in expenses incurred recovering the funds.

Seventy-eight percent (78%) of overpayments were for inpatient hospital care. Physician, ambulance and lab overpayments were only 6%. The AMA asked Congress to discontinue this demo.

Pertussis

If you suspect pertussis, call the Health Dept to see if lab testing is indicated. The health dept tests high risk contacts, per director Leigh Beasley MD. including:

- a. people with babies in the home who haven't been immunized
- b. pregnant women who will deliver soon
- c. kids in a classroom where none of the pertussis PCRs have come back positive.

The 2 equally acceptable Zithromax treatments for adult pertussis are (SC DHEC recommended) 500 mg daily for 6 days and (UpToDate and Sanford's) a 'Z-pack' regimen...500 mg on day 1, 250 mg days 2-5. ID specialist Dr. Potts says either is acceptable, and the generic Z-pack is the least \$.

Dr Beasley asks that you treat all close contacts, not just symptomatic ones. Waiting for symptoms means that that person is a real case and the contact circle grows. Please treat close contacts as soon as they are identified, even if they're asymptomatic

There are 2 phone numbers for questions about pertussis:

- a. The Health Dept...260-4358
- b. The "Epi-Pager" (medical consults/after hours questions): 1-866-298-4442. At the tone, dial in your phone number, and they will call you right back.

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Emergency Physicians

Editor: Joy Zimmer

Medical Editor: Pamela Bensen, MD,MS, FACEP

EPIC is sent to emergency physicians in South
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WELCOME NEW MEMBERS AND TRANSFERS

Following is a list of new members and transfers who have
joined the chapter since the last EPIC was published. We
welcome them to South Carolina and SCCEP.

Keith T. Borg, MD, PhD - Charleston
John Cacace, MD, FACEP - Murrells Inlet
Jon C. Carter, MD, FACEP - Charleston
Shane Cole, MD - Resident, PHR
Lara C. Dean, MD - Resident, PHR
Christopher A. DiOrio, DO - Huntersville, NC
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Christopher McCrae, MD - Sullivans Island
Daniel McManus - Student, MUSC
B. Garrick Messer - Student, USC
D. Scott Moore, DO, MS - Beaufort
Kevin J. Noreika, DO - Beaufort
David G. Olson, MD - Greenville
Jeremiah Ostmeyer, MD - Resident, PHR
Thomas A. Pollehn, MD - Lexington
Angie Qualio, DO - Resident, PHR
Joseph M. Ratliffe, MD - Pawleys Island
Gregory A. Rimmer, DO - Fort Mill
Angel L. Rochester, MD - Duncan
James Ross, MD - Lancaster
Daniel L. Schwerin - Student, MUSC
James R. Shennan, MD - Lexington
Erik A. Trosclair, MD - Resident, PHR

CONGRATULATIONS NEW FELLOWS!

Amanda S. Battista, DO, FACEP - Myrtle Beach

Gregory Hoffman, MD, FACEP - Greenville

Peter D. Hyman, Jr, MD, FACEP - Florence

New Life Fellows

Sarvotham Kini, MD, FACEP - Mt. Pleasant

Linda H. Rhyne, MD, FACEP - Sumter

Ralph M. Shealy, MD, FACEP - Mt. Pleasant

Nathanial J. Stewart, MD, FACEP - Columbia

Joseph V. Stewart, Jr, MD, FACEP - Lexington

Steven J. Taylor, MD, FACEP - Mt. Pleasant

Donald L. Troub, DO, FACEP - Orangeburg

SCCEP CALENDAR OF EVENTS

SCCEP ANNUAL MEETING

February 21, 2007

Columbia, SC

(Meeting Notice to Be Mailed in January)

SCCEP ORAL BOARD COURSE

March 23-24, 2007

Charleston, SC

www.theoralboardcourse.com

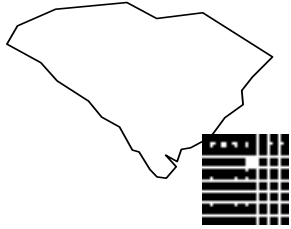
LLSA COURSE

April 16-17, 2007

Charleston, SC

(Details Will Be Mailed Out In Near Future)

SCCEP EMERGENCY ULTRASOUND COURSES
For dates and locations - www.emergencyultrasound.com



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