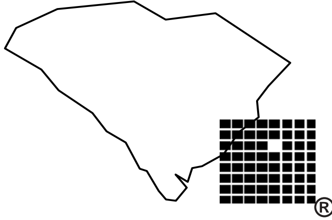

December 2007

PALMETTO STATE EPIC

PUBLISHED BY THE
SOUTH CAROLINA COLLEGE
OF EMERGENCY PHYSICIANS

EMERGENCY PHYSICIANS' INTERIM COMMUNIQUE

CHECK, PLEASE NO FREE LUNCH

Randy L. Reinhardt, MD, FACEP
President

A warm, heartfelt Merry Christmas and Happy New Year to you all! I hope all is well with each of you as we celebrate this magical time of year. There I said it…"Merry Christmas"!

It bothers me that some department stores insist on saying "Happy Holidays", and now someone even wants to take away "HO-HO-HO". The thought of banning "HO-HO-HO" makes me want to have a public temper tantrum. (Rick Bukata said that "pediatric patients are nothing but little adults", and they are. pediatric patients are little adults!"….But, I digress.) Instead of lying on the floor screaming, I have just stopped shopping in those stores. What I wanted to point out is that we are losing our values and the true meaning of Christmas.

Speaking of stores, I recently took my wonderful wife Jo Anne to the mall, something I admit I don't do 'frequently'; or should I say 'rarely'; or is it 'never'. Well anyway, we had a great time being together and hanging out. As we began to check out at Belks she asked if I had the Belk's card.

"Hmmmm....let's see," I said, and began pulling things out of my wallet. There's my Double Cabin Hunt Club card, SC medical license card, SCMA insurance card, gift card to Red Lobster (yum, I've got to use this thing), gift card to Omaha Steaks (even better!), American Express, Visa, MasterCard, ahhhh there's my ACEP card, CVS card, another card, yet another card and oh yeah here's the Belk card!

She took the card, and I began to stuff everything else back into my wallet, but for some reason I stopped when I got to my ACEP card. I paused to examine it closely. There's my name, Randy L Reinhardt, MD, FACEP, my ID number, expiration date and the capitalized word 'ACTIVE'. For some reason I began to wonder why the word 'ACTIVE' was capitalized; what exactly did it mean.

When I arrived home, I got out my Webster's dictionary. Did you know there were 13 definitions for the word 'active'? The first listing was: "characterized by action rather than by contemplation or speculation."

"So," I thought, "what actions do my colleagues take as 'ACTIVE' members? For instance, how many folks from SC went to an ACEP meeting this year? I wonder if they can remember where the meetings were held."

I thought back over the past and wondered how many SCCEP members have attended the Leadership and Legislative Conference in Washington DC, a really impressive program. Now, I could urge you to get involved with SCCEP and attend this amazing conference where you get to visit the nation's capital, congressman and senators. I could assure you it would be an experience you won't forget and that you would learn that everything we do day in and day out has a political agenda to it. I could stress that we either lead or get run over by those who understand politics. But you might not want to be that politically 'ACTIVE'.

So, how else can you be 'ACTIVE' if you decide you don't want to go to Washington? Well, you could join the 911 network, an ACEP email alert system to spread the word about issues meaningful to emergency medicine. You could write your legislators (email is easy and this effort can bring huge returns), squeaky wheels do get oiled! You could write letters to the editor of your local newspaper. You could "Give a shift" to NEMPAC, the National Emergency Medicine Political Action Committee. (NEMPAC is only one third the size of the Trial Lawyers PAC - lawyers are the largest PAC contributors, but NEMPAC has raised more than $700,000 this year to support ACEP's legislative goals.)

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Or, how about becoming 'ACTIVE' in SCCEP? Strengthen us locally, help support our lobbyist and councilors, and recruit more members so we can increase our influence within the state. How about signing up for a SCCEP committee or running for the SCCEP Board? We can use your new ideas to enhance the chapter's activities.

So what will you do about all of this? How will you become an 'ACTIVE' ACEP member? I know 'ACTIVE' involves time or money. However, if you look at the big picture you will see a return on your investment in 5 years or less. We must continue to support legislation which affects our practice and combat reimbursement cuts which affect our bottom line. We work harder for less satisfaction and fewer dollars. If we don't step up to the plate who will? There are tens of thousands of dollars on the line for each one of us in the coming years.

Call on your colleagues who don't contribute or donate in one way or another. We need everyone to help, by joining SCCEP, donating to the PAC, or actually going all the way to Washington to lobby.

SCCEP will be there for you! Will you be there for SCCEP? Will you be there for your colleagues? Will they be there for you? We cannot always count on others to carry the load, we are all in this together. Make an investment in your future, in our future. We must all pay our share of the check - 'cause there's no such thing as a 'free lunch'.

Finally, I want to invite you to the Annual Meeting of the South Carolina College of Emergency Physicians. This year, we will have the meeting on February 25 in our central capital Columbia. We will hold elections, honor our colleagues with awards and celebrate our careers with fellow emergency physicians. We plan to invite a dynamic speaker and want your participation at the meeting. Details will be posted on the SCCEP website (www.sccep.org) after the New Year!

Please have a safe and wonderful holiday season. And, MERRY CHRISTMAS!!

Randy Reinhardt MD, FACEP

NPI MEDICARE CLAIM REJECTIONS -- WHAT TO DO

by Pamela P. Bensen, MD, MS, FACEP

Since October, Palmetto GBA, the SC Medicare carrier, has been rejecting Medicare claims if the Medicare legacy number and the NPI number did not match. The AMA unsuccessfully tried to get CMS to delay implementing these rejections.

The SCMA provides these tips to help you submit your Medicare claims:

1. Contact your billing companies, clearinghouses, or administrative staff, to see if they have been contacted concerning problems matching your NPI/UPIN combinations to the Medicare NPI crosswalk.
2. See if your NPPES information shows that your NPI was properly obtained (sole proprietors should have an individual UPIN and an NPI as an Individual [Entity type 1], not as an Organization [Entity type 2]).
3. Ensure the NPPES data are correct, containing Medicare legacy identifier(s) assigned to the provider's record. A physician applying for an NPI would list his/her Medicare UPIN in the "Other Provider Identifiers" section of the NPI application, but would not list the UPIN of the group in which he/she is a member. To view or edit your NPPES record, go to https://nppes.cms.hhs.gov on the CMS website. For assistance, call the NPI Enumerator at 1-800-465-3203.
4. If the NPI(s) was properly obtained and the NPPES information is correct and you continue to get informational NPI edits:
   * Verify your Medicare enrollment information is up to date.
   * If you need to re-enroll or update the enrollment information, submit a complete application.
   * Make sure the Medicare enrollment record reflects the correct Taxpayer Identification Number (TIN) for reporting your income to the IRS on the 1099 form.
5. Beginning March 2, 2008 all 837P and 1500 claims must include an NPI in the primary fields on the claim (the billing, pay-to, and rendering fields). Providers may submit NPI/legacy pairs or the NPI alone, but claims containing only the legacy number will be rejected.
6. If your claims are currently being correctly processed using the NPI/legacy pairs, now is the time to try a few claims with the NPI alone. This test will serve to assure that your claims will successfully process when the NPI alone is mandated

English translation: CMS used to identify physicians by 'legacy' ID numbers (UPINs). Beginning May 23, 2008, all physicians will have to bill using the new National Provider ID (NPI) instead. To guarantee that physicians can be paid after May 23, CMS developed a phase in program (October 07 – March 08) where both legacy and NPI numbers were to be used. During this time, the computer will match the enrollment data on the legacy numbers to the enrollment data on the NPI to see if the data is identical.

Continued on Page 5.........

Medicare -- Its' Impact on Your Practice

by John G. Holstein

Every year physicians deal with the Medicare fee schedule update and a threatened decrease in reimbursement. In 2007, Emergency Medicine rates increased substantially. Will it continue? How long will it last? Herein lies an inherent danger of the Medicare fee schedule: its financial impact on all payers.

Unlike the confidential rates of other insurance fee schedules, which remain the domain of contracts between payers and physicians, the Medicare fee schedule is a federal, public document, published every year. The Medicare fee schedule represents a clear and present danger to every ED practice. This threat goes beyond the payor mix and percentage of Medicare patients.

The industry trend is for non-governmental payers to mirror Medicare. Non-Medicare payers are defining the Medicare fee schedule as the industry reimbursement standard. It is routine today to see payers offer rates at some percentage below Medicare, or at best, some multiple above "current" Medicare rates.

It is an outright insult to Emergency Medicine that payers will actually offer rates "below" Medicare. This is particularly common for Medicare HMO plans, and it makes absolutely no sense. Before you consider this offer, ask yourself who defined the Medicare rates as being fair and equitable? No ED practice should settle for this low rate. Some payers act surprised when this offensive offer is questioned or rejected.

Some payers will attempt to negotiate rates barely above Medicare rates. More importantly, they try to tie their proposed rates to the "current" Medicare fee schedule. Strategy comes into play here, particularly since 2007 saw a good increase for Emergency Medicine. If a practice decides to negotiate rates tied to the Medicare fee schedule, the 2007 rates are more 'reasonable' to use as a baseline. However, negotiated rates should specifically be described as a 'multiple above the 2007 rate'. Remember even if Medicare rates do go up in the future, it is unlikely the increase will be much. More likely the Medicare rates will drop, so the word 'current' can trap you into a contract tied to falling Medicare rate.

What can a practice do to negotiate sound managed-care rates, with non-governmental payers? Always remember the "market" for a practice is the non-governmental payers with whom a practice does "not" have a contract. Market rates, which are those paid by non-contracted payers plus legitimate balance bill payments made by patients, should be the baseline from which you negotiate managed care contracts.

A final point of caution: Do not get trapped into 'most-favored nation' clauses. These clauses ensure 'equal commercial opportunities' which permit the payer to set their rates at the lowest current rates accepted by the practice. In order to comply with this clause, the practice must potentially violate confidentiality restrictions of payers by revealing their rates to the favored payer. This is a no-win situation for a practice. These clauses should be identified and deleted from all contracts.

In summary, the Medicare fee schedule is more than an annual CMS update, because other payers attempt to tie their reimbursement rates to this schedule. ED practices need to refuse to negotiate contracts, which reference the Medicare fee schedule. Instead, tie your rates to the market, non-governmental, non-contracted payment rates plus patient balance bill payments. To prevent financial disasters in the future when Medicare rates fall, never agree to rates tied to the 'current' Medicare fee schedule. If it is necessary to use Medicare rates within a contract, agree to rates tied specifically to the 2007 Medicare fee schedule, and negotiate some acceptable multiple above that schedule.

Note: John G. Holstein is Director of Medical Management Professionals of Healthcare Business Resources. He can be contacted through Susan Kay Asher at 770-551-9753.

In Memoriam

J. Lucian Weatherford, MD
Emergency Physician, Colleague, Friend
1925 - 2007

Dr. J. Lucian Weatherford, age 82, died Sunday, November 25, at McLeod Hospital in Florence.

Survived by his wife Sandra and his fourteen children, Dr. Weatherford was a graduate of the Medical University of South Carolina (1955). He served in the Pacific Fleet of the US Coast Guard during World War II. He was one of the first two ER physicians in South Carolina, one of the first SCCEP members and the very first President of the SC College of Emergency Physicians (1975-1977).

For two years he held the title of "longest practicing ER physician" in the United States.

Over the years, Dr. Weatherford served as an attending physician at a number of emergency departments around the state before retiring from the Carolinas Hospital System.

Memorials may be made to Coward Baptist Church, Romania Missions, P.O. Box 278, Coward, SC 29530.

UNDER THE DOME

2008 Overview

by Ted Riley, Esq - Lobbyist
Tara Boone - Paralegal
Riley Pope & Laney, LLC

South Carolina General Assembly

New Members of the General Assembly

*Senator Catherine Ceips – District 46 (Beaufort County)
*Senator Paul Campbell – District 44 (Berkeley County)
*Senator Shane Massey – District 25 (Aiken, Edgefield, McCormick & Saluda Counties)
*Representative Shannon Erickson – House District 124 (formerly Senator's Ceips' House seat)
*Representative Shirley Hinson announced on November 23rd that she is resigning from her House seat (District 92) at the end of November to accept a position at Lowcountry Graduate Center beginning December 1st.
*Representative Heyward Hutson – House District 9 (Converse Chellis vacated the seat in August to become the new state Treasurer)

A Joint Meeting of the Senate Medical Affairs Committee and the House Medical, Military, Public and Municipal Affairs (3M) Committee – was held on November 27 to allow the South Carolina Hospital Association to conduct a presentation on Creating an Effective Partnership for Quality and Patient Safety (S.492/H.3626 - the Ann S. Perdue Heart Patient Safety Act).

The House Ways and Means Committee met on Thursday, November 29. The meeting agenda included a presentation on the current fiscal year and a forecast for fiscal year 2008-2009 by Dr. Bill Gillespie, Chief Economist for the State Board of Economic Advisors.

John Rainey, Chairman of the State Board of Economic Advisors, has stated that next year is going to be slow, and last month the BEA projected a $430 million deficit. Causes of the deficit include the enactment of income tax cuts and the elimination of the grocery tax, increased expenditures for Medicaid and education, and replacing one-time money to pay for recurring expenses.

Governor's Office - Governor Mark Sanford issued a statement on August 6th noting the need to make sure every available dollar already budgeted for infrastructure is going toward its intended purpose before considering new funding streams.

Budget and Control Board - Former member of the House of Representatives Converse Chellis was sworn in as State Treasurer on August 3, 2007.

Henry White resigned his position as Executive Director of the Budget and Control Board the morning of August 3rd. Frank Fusco was named the Board's Executive Director on August 15th and had previously served as Executive Director from 2001 to January 2007.

Funding Opportunities

Competitive Grants - The Competitive Grants Committee is not currently accepting grant applications. The opening date will be at the discretion of the Committee and may not occur until the end of 2007 or early 2008.

Prevention Partnership Grants - The South Carolina Department of Health and Human Services intends to open a second round of Prevention Partnership Grants before the end of the year.

Legislative Issues for 2008

Covering Carolina Collaborative – unites key business, medical, and insurance leaders in an effort to provide affordable health care coverage to every South Carolinian by 2010. Robby Kerr (former Director of the Department of Health and Human Services) is the Executive Director of the Collaborative, and members include Ed S ellers of BCBSSC, Thornton Kirby of the SC Hospital Association, Todd Atwater of the SC Medical Association, Hunter Howard of the SC Chamber of Commerce and others.

Other Issues Include - Cigarette Tax; Immigration and the State Budget – FY 2008-2009

Important Dates for 2008 - NOTE - This is the last year of a two-year session. Any legislation not passed this year will be null and void.

January
8 - First day of the 2008 legislative session
8-10 -- First Ways and Means Budget Subcommittee meetings
15-17 -- Ways and Means Budget Subcommittee meetings
16 – Deadline for announcement of the Governor's 2008-2009 Executive Budget
22-24 -- Ways and Means Budget Subcommittee meetings
29-31 -- Ways and Means Budget Subcommittee meetings

February
5-7 -- Ways and Means Budget Subcommittee meetings
12-14 -- Proviso Subcommittee meetings
15 – Official Board of Economic Advisors forecast review (reluctant to change after this date unless there is a significant economic swing)
18-22 -- Ways and Means Full Committee budget deliberations
26-28 -- FY 2008-2009 Appropriation Bill printed

March
4-6 -- Appropriation Bill placed on House Members' desks
10-14 -- House floor budget deliberations (must be voted out of House before March 31st to avoid extending legislative session)

continued on Page 5.......

2008 Review - Continued from Page 4......

17 – 12:00 noon – Filing opens for party primary and convention candidates for the South Carolina Senate, South Carolina House of Representatives, multi-county district offices, solicitor (circuits 1, 2, 4, 7, 8, 9, 10, 11, 14 and 16), countywide and less than countywide offices

31 – 12:00 noon – Filing closes

April – Senate Finance Committee on the budget (Committee calendar has not yet been set)

15 – Deadline to introduce bills in the House

May 1 – Bills must cross over to the other chamber, or a 2/3 vote is required for potential passage in 2008.

Mid May – Budget conference committee

June

5 – Last day of the 2008 legislative session. Any legislation not passed by 5:00 p.m. will be null and void and must start the legislative process from the beginning in the 2009 legislative session.

10 – Primary Election Day

24 – Primary run-off (if required)

November 4 – General Election Day

NPI MEDICARE CLAIM REJECTIONS (Continued)

Enrollment data is your demographic information. If you signed up for a UPIN using the name 'Dr. John Doe' but signed up for the NPI as 'John Doe, MD', your data is not identical. If the group/individual status or any other information differs from your original sign-up data (and who can remember when that was, let alone what you wrote?) the computer will suspend your claim, Palmetto GBA will notify the billing agent (not the physician), and the claim will not be processed (paid) until the mismatch is resolved.

Between October and November 1, 2007, if the physician enrollment data for the legacy numbers and the NPI were not identical, Palmetto GBA called the billing agent to correct the data. Because so many errors have now been corrected, Palmetto GBA will no longer phone billing agents. Instead, when there is a mismatch, GBA will send a letter to the billing agent and await a response before processing the claim (delay payment).

If your billing agent has not resolved legacy/NPI errors by now, your payments are in suspension until the 'error' is corrected. You need to verify all your enrollment data to make sure it is accurate (see above process). If you fail to reconcile the data, come May 23, 2008, Palmetto GBA will just reject your claims.

If your claims are now in suspension, Barbara Sauls, Palmetto GBA, 803-763-5059 is prepared to help you.

S.C. JOB OPPORTUNITIES

Aiken: Full time position for BC/BP emergency physician, Competitive salary with benefits including CME allowance, health, disability and mal-practice insurance. Potential for full partnership in two years – no buy in. Pension eligibility in approximately one year. Newly renovated ED seeing 50,000 patients with double and triple coverage during peak periods. Immediate scheduling equity. Call 803-643-3965, or send CV to Aiken Emergency Medicine Physicians, LLC. 1840 Huntsman Drive, Aiken, SC 29803. Fax to 803-643-3968 or e-mail to sandy.fuss@gmail.com.

Charleston: Excellent opportunity to join democratic group. Must be EM residency trained and/or EM board certified. Work at two different locations, one hospital and one free standing ER, with maximum 2-3 shifts per month at free standing ER. Compensation is fee for service and shifts are split equitably. For more information contact Baird Oldfield, M.D., FACEP, at 843-797-4595, Fax 843-884-1701, or e-mail sboldfield@aol.com.

CMS Physician Quality Reporting Initiative (PQRI)

Implemented one year ago, the PQRI provides additional (1.5%) reimbursement for physicians who report a designated set of quality measures on claims. A show of physician hands followed by intense discussion at the recent Palmetto GBA, SC Medicare Carrier Advisory Committee indicated that few SC physicians are participating in the PQRI.

The biggest barrier to implementation is well known by CMS, which has done nothing to resolve the problem. For all patients with Medicare as the secondary carrier, PQRI results in rejection of the claim by the primary carriers. It is unlikely that CMS will try to resolve this problem since the PQRI is a JCAHO brainchild imposed by Congress on CMS.

SCCEP Member Reminder
Update Your Contact Information

Please remember to notify ACEP and SCCEP when you have a change in your contact information (address, hospital, phone number, e-mail address). We want to keep you informed in a timely manner - and we can only accomplish this if we have your up-to-date information (particularly your e-mail). I am constantly getting e-mails returned because the address is changed. So PLEASE, include the chapter on your "people to let know of an e-mail change" list. Send changes to sccep@sc.rr.com.

Emergency Medicine at 31,000 Feet!

by Sam Kini, MD, FACEP

It was 6 am on Monday, March 6th. I was on a Delta red eye flight from Las Vegas to Atlanta. It was a smooth ride. Most passengers, myself included, were dozing under the dim lights.

Suddenly over the speakers, I heard, "Is there a doctor on board?"

I jumped from my seat and saw a flight attendant a few rows behind me helping a 66-year-old gentleman who had had a near syncopal spell. Sitting on the floor in the narrow isle, he was sweating profusely. He was weak, pale, cold and clammy. However, he was awake and answered most of my short and rapid questions, denying chest pain, belly pain, vomiting, diarrhea and back pain.

I asked him about heart medication, a history of diabetes, pain medication, and blood thinners. When he denied them too, I felt somewhat reassured. I asked him if he had had too much alcohol. He denied it and volunteered that he had a "twinge" in his lower abdomen and a stent in his left ureter for stones.

As I thought to myself, "Great! Either stone or aneurysm," my hand went straight to the epigastrium in search of an aneurysm. I didn't feel a pulsatile mass; he was not tender.

I wrapped an old-fashioned blood pressure cuff around his arm and got a blood pressure of 60. "Wow! I have my work cut out for me!"

I immediately lay him down flat on his back and had one of the passengers, who happened to be a nurse, raise his legs to try to improve his blood pressure. I asked her to monitor his pulse and blood pressure and keep me informed. I looked in the "first aid kit" the flight attendant had on his lap. I sifted through the first aid box and found a sterile needle and an alcohol wipe and tape.

I was on my knees at the head end of "my patient" to check his airway, breathing and carotid pulse. As I kept reassuring the patient, I unbuttoned his shirt just in case "cardiac massage" (which I was hoping I would not have to do!) was needed. I looked at his neck for an IV and the patient kept showing me his left hand, which had no visible veins at all due to poor circulation. I saw a reasonable external jugular vein and I inserted the needle. I got blood return and grabbed the end of the I.V. line leading from the single 500cc bag of saline available on the plane. I attached the line to the needle and saline started flowing.

The flight attended asked if I wanted the pilot to make an emergency landing! I asked him how far we were from Atlanta. When he told me 45 minutes, I replied, "Let's go to Atlanta as planned."

Within a few minutes, my patient was feeling better; his color returned and his skin became warmer; the sweating had stopped. He asked me where I was from and when I told him that I am a physician from Charleston working at MUSC, he said "Good for you"! He acknowledged that he was from Charleston as well. Then he told me that he himself was a physician!! I thought to myself "thanks for telling me", but instead said, "Glad to meet you".

They announced preparations for landing. I sat in the seat next to my patient with the seat belt around my waist, the fingers of my left hand on the 'doctor-patient's' carotid, the I.V. line and saline bag raised high in air in my right hand, and the oxygen cylinder clutched between my knees!

Needless to say, we landed safely at the Atlanta airport. Waiting EMS personnel hurried on board and quickly loaded the patient on their narrow chair. The doctor/patient must have given a smile to his fellow passengers as I heard applause! He was finally wheeled off the plane after I gave report to the paramedic. My patient looked at me and said "Thank you Dr. Kini! I feel much better!" Oh what a satisfying moment for me!

As I deplaned, the woman pilot smiled at me, thanked me and said, "Doctor, you may not have realized it but we were speeding." I thanked her team for all the help.

And, as I walked out of the plane I thought to myself, **"This Is Emergency Medicine! Hallelujah!!"**

Note: Dr. Kini is Associate Professor, Division of Emergency Medicine, at the Medical University of South Carolina

ACEP POLL ON CRITICAL ISSUES FACING EMERGENCY PATIENTS

The results of the ***ACEP Poll on the Critical Issues Facing Emergency Patients*** was released October 9, 2007. This survey, which took place August 29-September 19 ranked the top issues facing our specialty on both the state and national level.

Many of the responses highlighted the overcrowding issues facing EDs nationwide:

- *"Overcrowding, access to specialty physicians and similar practice issues are a concern, but not yet a crisis".*
- Top ranked concern re patient care is "*not enough staffing or resources to effectively care for all ED patients*".
- My ED is overcrowded - *"Frequently"*
- In the past year, crowded conditions in my ED have - *"Increased significantly"*
- Boarding of admitted patients in the ED in my hospital happens - *"Frequently"*
- The most patients boarding in my ED at any one time have been - *"11-20 patients"*

The complete survey and results can be downloaded from the ACEP Website (www.acep.org)

PALMETTO STATE EPIC --

the newsletter of The South Carolina College of Emergency Physicians

Editors: Joy Zimmer
Pamela Bensen, MD, MS, FACEP

EPIC is sent to emergency physicians in South Carolina. The opinions expressed in this newsletter are not necessarily those of the Chapter or the American College of Emergency Physicians.

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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.

John N. Burling, MD - Bluffton
Matthew P. Fox, MD - Greenville
Luke D. Baxley - Student, MUSC
Margaret Prescott - Student, MUSC
Emerson A. Juan, DO - Greer
David C. Smith, II, MD - Spartanburg
Yenney E. Meza, MD - Surfside Beach
David M. Ronan, MD - Spartanburg
Marc Tuel, DO - Simpsonville
Kenneth W. Vaughn, MD - Duncan
Joel Waldrop, MD - Sumter

RECOGNIZING NEW FELLOWS

Congratulations to the following newly elected Fellows who were recognized at the ACEP Convocation Ceremony at the Scientific Assembly in Seattle.

Keith T. Borg, MD, PhD, FACEP - Charleston
Eric A. Brown, MD, FACEP- Columbia
Mac H. Nowell, MD, FACEP- Chapin
William H. Richardson, III, MD, FACEP- Columbia
Leanna F. Thorn, MD, FACEP - Florence
Frederick T. Warner, MD, FACEP - Charleston

RECOGNIZING SCCEP LIFE FELLOWS & LIFE MEMBERS

Life Fellows

James M. Alexander, MD, FACEP - Greenville
Pamela P. Bensen, MD, FACEP - Anderson
Ralph D. D'Amore, MD, FACEP - Greenwood
Sarvotham Kini, MD, FACEP - Mt. Pleasant
Terrance P. McHugh, MD, FACEP - Columbia
Luis Quintero, MD, FACEP - Simpsonville
Ralph M. Shealy, MD, FACEP - Mt. Pleasant
N. John Stewart, MD, FACEP - Columbia
Joseph V. Stewart, MD, FACEP - Lexington
Robert E. Swetnam, DO, FACEP- Santee
Steven J. Taylor, MD, FACEP- Mt. Pleasant
Donald L. Troub, DO, FACEP - Orangeburg
Thomas R. Vajen, MD, FACEP (Retired) - Hilton Head

Life Members

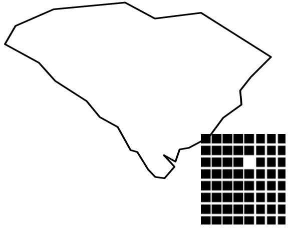
Robert W. Bankov, MD, FACEP - Varnville
Melvin R. Hecker, DO, FACEP- Conway
Joseph D. Losek, MD, FACEP - Mt. Pleasant
Afolabi Oguntoyinbo, MD - Beaufort
James I. Raymond, MD, FACEP - Columbia
Ileana M. Rivera-Pena, MD, FACEP (Retired) - Charleston
James M. Twombley, MD - Dillon
Dennis A. Wheeler, MD, FACEP - Orangeburg

SCCEP CALENDAR OF EVENTS

SCCEP ORAL BOARD COURSE
March 31 - April 1, 2008
Quality Suites, Charleston, South Carolina

SCCEP ANNUAL MEETING AND DINNER
Monday, February 25, 2008
Columbia, South Carolina
Final Details to be Announced

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



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