

Spring 2011
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**New AHA Guidelines:
ABC Rearranged to CAB**

Denis Kuhlmann MD, FACEP, Corporate Medical Director



2010 marked the 50th anniversary of the introduction of modern cardiopulmonary resuscitation (CPR). During the past 50 years, tremendous research has been conducted to evaluate techniques, medications, and devices designed to advance the care of victims of cardiac arrest. The American Heart Association developed the first CPR guidelines in 1966 and since that time, based upon that research, has published frequent updates of the guidelines to help educate the public and medical establishment about the optimal care for patients with cardiac arrest

and other emergency cardiovascular conditions.

In November of 2010, the newest set of guidelines was published by the AHA in a supplement issue of *Circulation*. The following is a summary of the major changes in cardiac arrest and emergency cardiovascular care since the previous 2005 set of guidelines, focusing on adult patients with acute cardiac conditions. It is important to note that they may not apply to all rescuers and all victims in all situations. The leader of a resuscitation team may need to adapt application of these recommendations to unique circumstances.

A major change in basic life support has been to step away from the traditional approach of airway-breathing-circulation (ABC) to instead first establishing high quality chest compressions (chest compressions-airway-breathing CAB).

There are several reasons for this change:

Most survivors of adult cardiac arrest have an initial rhythm of ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT), and these patients are best treated initially with chest compressions and defibrillation than with airway management.

Airway management, whether mouth-to-mouth breathing, bagging, or endotracheal intubation, often results in a delay of initiation of good chest compressions. By changing the sequence to CAB, chest compressions will be initiated sooner and ventilation minimally delayed until completion of the first cycle of chest compressions—30 compressions in 18 seconds. The 30 compressions are now recommended to precede the 2 ventilations, which previous guidelines had recommended at the start of resuscitation.

Fewer than 50% of cardiac arrest victims receive bystander CPR. It is believed that a significant obstacle to bystanders performing CPR is their fear of doing mouth-to-mouth breathing. By changing the initial focus of resuscitation to chest compressions rather than airway maneuvers, it is thought that more patients will receive bystander intervention.

See AHA Guidelines, continued on page 3

New EPA Office Staff



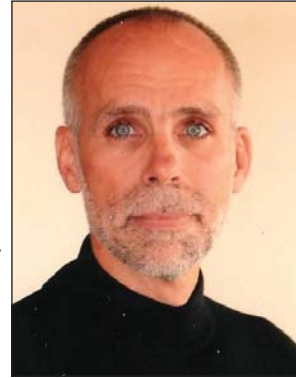
The newest member of the EPA office staff is Brenda Heidemann. Brenda is from Denver, IA. She joined EPA in the role of Senior Accountant on August 23. Brenda has more than 24 years in the accounting field. She has a BA in Accounting from UNI and is a CPA.

Brenda is married with three grown sons and and daughter-in-laws as well as being the proud grandmother of two little girls. She also has two Golden Retrievers, Annie and Bear. When Brenda is not working she enjoys family activities, volleyball and wrestling, boating on the Mississippi, hiking and camping in Colorado, playing the piano, reading. Brenda's favorite part of working at EPA is the people, "truly nice people" she says.

Welcome, Brenda, to the EPA Family!

Physician Spotlight - E.W. Filler

EPA is proud to feature Dr. E.W. Filler as our Spring 2011 "Spotlight Award Physician". The Spotlight Award is given to an EPA provider who consistently exceeds the expectations of their patients, fellow staff and EPA office personnel.



Dr. Filler's interest in Emergency Medicine began while he was in medical school at the University of North Dakota in Grand Forks. His interest in Emergency Medicine continued to grow from there. His time with EPA began in 2003 when he began moonlighting at Prairie Lakes Healthcare System in Watertown, SD. Eventually, in 2008, Dr. Filler joined EPA full-time and also assumed the role of Medical Director at PLHS.

Dr. Filler enjoys many hobbies outside the ED. These include gardening, his hobby farm and flying.

Dr. Filler has had many gratifying experiences in the ED. In fact, when asked Dr Filler said, "too many to articulate!"

When asked, Dr. Filler told us he chose to work with EPA because of "the great staff." He also found the location in Watertown to be favorable to his needs.

In addition, EPA would like to thank the family of Dr. Filler, his wife Susan and daughter Amanda, who is currently in Graduate School. Your support makes it possible for Dr. Filler to be such an outstanding physician.

2011 Medicare Conversion Factor Results In Reduction In Fees For Emergency Physicians

Julie Koch-Hoth, RN, CCS-P

On December 29th, 2010, CMS released Transmittal 828 of the CMS Manual System. This transmittal instructed Medicare carriers and intermediaries to use a conversion factor of 33.9764 when calculating the 2011 physician fee schedule. Although congressional action avoided the 25 percent cut to Medicare Payment, the conversion factor was modified due to changes to the Medicare Economic Index (MEI). The MEI change resulted in increased practice expenses and malpractice RVUs and lower work RVUs to maintain budget neutrality.



For emergency physicians, this will lead to a two to three percent reduction in fees for evaluation and management codes.

AHA Guidelines

Continued from page 1

Pulse checks by lay rescuers should not be attempted because of the difficulty of detection and the frequency of false-positive findings, which can delay the time to first chest compressions. Instead, it is recommended that lay rescuers should assume that an adult who suddenly collapses, is unresponsive, and not breathing or is only gasping—has had a cardiac arrest. They should activate the emergency response system and begin chest compressions.

Pulse checks by healthcare providers have been de-emphasized in importance. These pulse checks are often inaccurate and produce prolonged interruptions in compressions. If pulse checks are performed, they should take no longer than 10 seconds to determine if pulses are present. If no pulse is found in 10 seconds, chest compressions should be resumed immediately.

The use of quantitative waveform capnography for confirmation and monitoring of endotracheal tube placement is now a Class I recommendation in adults. When quantitative waveform capnography is used for adults, guidelines now include recommendations for monitoring CPR quality and detecting return of spontaneous circulation based upon end-tidal (ETCO₂) values.

For symptomatic or unstable bradycardia, intravenous infusion of chronotropic agents is now recommended as an equally effective alternative to external pacing when atropine is ineffective

Patients with V-Fib or pulseless V-Tach should receive chest compressions until a defibrillator is ready. Defibrillation should then be performed immediately.

Transcutaneous pacing of patients who are in asystole has not been found to be effective and is no longer recommended.

Atropine is no longer recommended for routine use in patients with pulseless electrical activity or asystole.

Good basic life support with immediate recognition of sudden cardiac arrest, activation of the emergency response system, early performance of high quality chest compressions with minimal interruption, and rapid defibrillation of shockable rhythms is again emphasized as the foundation for successful cardiac life support.

Reference: *Circulation*. Volume 122, Issue 18, Supplement 3. November 2, 2010.

EPA Launches New Website

EPA launched its new website in late December 2010. The sleek new design and layout are some of the most noticeable changes to the new site. EPA enlisted the help of Gipper Design, based in Denver, CO to help get the new site up and rolling. Josh Gipper, head of Gipper Designs is an Iowa native.

The new website still has favorite features such as the Continuing Education feature and links to the current newsletter. The update site is much easier to navigate for first time viewers and due to some technical changes it can be updated much more frequently when new opportunities are available for physicians and mid-level providers.

Visit the new website today at www.epamidwest.com!

Emergency Practice Associates Presents

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For Medical Directors and Nurse Managers

May 9-10 2011

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Waterloo, IA

Contact Don Bradley to register

dbradley@epamidwest.com



Medicare Conversion

So what can you do?

Contact EPA for a fee schedule review and a coding distribution analysis to insure you are maximizing your reimbursement.

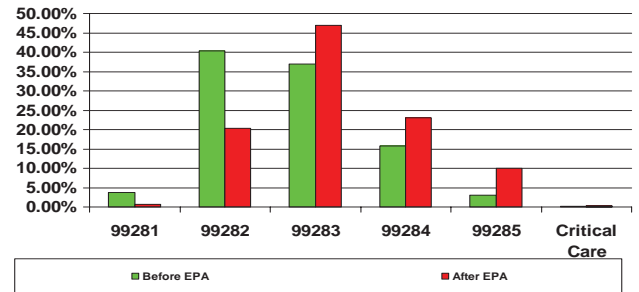
New for 2011- Critical Care Facility Coding

Facilities can now report ancillary services when coding Critical Care. The CPT Editorial Panel revised its guidelines and is no longer bundling procedures such as x-rays, pulse oximetry, blood gases etc. (Does not apply to physician coding- these services remain bundled.)

CMS is not providing any additional payment this year but will be collecting the data for future payment.

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Hospital A
Coding Comparison



PO Box 1260 ~ Waterloo, IA 50704