



NC Chapter Update



A Newsletter for the Members of North Carolina ACEP

Spring 2011

From the President Frank Smeeks, MD, FACEP

The Fall has been an exciting time for the North Carolina Chapter! At our most recent Board meeting, our committees updated the board on their various activities including the EMS, Education, Reimbursement, Membership, Legislative and Access to Care Committees. We have many issues we are working on to improve the legislative, regulatory, reimbursement and practice environment for our members. We also discussed the upcoming resolutions for the Scientific Assembly in San Francisco, and concluded with a discussion and presentation from Community Care of North Carolina (CCNC).

Our Councillors participated in the Board meeting and Dr. Henrichs made a presentation regarding all the resolutions so that the Board could give their feedback and recommendations. Our EMTALA Resolution was discussed and the Board Members and Councillors felt strongly that EMTALA and due process need to be raised again in light of different investigations that have occurred at hospitals across the State. Our Chapter co sponsored resolutions to add one voting councillor from SAEM - with the many residencies we have in North Carolina this was seen as a positive addition to the Council. The Chapter also co sponsored the Medication Shortage Resolution (33) which proved timely with President Obama's recent executive order. Please read Dr. Chuck Henrich's recap of the Council meeting for more details on the business of the Council. The councillors representing our state enjoyed a nice evening at Kuleto's Italian restaurant with conference exhibitors from EMA, Anthony "Ty" Hartmann, MD and Mark Riser, MD.

Also attending the Board meeting was Dr. Alan Dobson and John Thompson, from CCNC, Dr. Randy Best, DHHS, and Chris Skowronek, NCHA, who joined the discussion on how the College could partner with CCNC. The budget for the State of North Carolina presents many challenges and with provider rates being a target, the College has made one of its goals this year to partner with organizations such as CCNC, DHHS, and the NCHA to be proactive in addressing these challenges and making sure that Emergency Medicine and Emergency Physicians are at the table when changes to our health care system are discussed and debated.

Please consider becoming more involved in the College by joining a committee, donating to the Emergency Physician PAC, attending June Jam or the Fall meeting or attending one of our future Board of Directors meetings.

North Carolina College of Emergency Physicians



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2011 ACEP Council Meeting Report
By: Frank Smeeks, MD, FACEP and Charles Henrichs, MD, FACEP

This October 333 councillors representing ACEP's 86 component bodies (chapters, sections and this year.



Medical Liability Reform and October 1st, What It Means To You
By: Greg Cannon, MD FACEP, Chair of Legislative Affairs

As you are doubtless aware, medico-legal liability reform became effective as law on October 1st. Thisof Since term effects.





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CMS Issues Final Rule for Medicaid Recovery Audit Contractors (RACs)

By: Ed Gaines, JD, CCP, Chief Compliance Officer, Medical Management Professionals, Inc.

On September 14, 2011, CMS issued its Final Rule for Medicaid RACs pursuant to the requirements of the Patient Protection and Affordable Care Act of 2010 (PPACA), and there are several significant similarities and differences between the Medicaid RAC program and the existing Medicare RAC program.

In Fiscal Year 2010, the Medicare RAC program collected over \$92 million—82 percent in overpayments and 18 percent in underpayments, but in the three-year Medicare RAC Demonstration Program, over \$1 billion in improper payments was recovered.

There are four Medicare RACs that have five year contracts that cover the entire U.S. with contingency fees ranging from 9 percent to 12.5 percent. The Medicare appeal process is uniform across all RAC regions, there are specific limitations on the number of records and frequency of audits and an independent review approval process of RAC issues that occurs before the RAC contractors are permitted to engage in their RAC audits. Since the Medicaid program is co-funded and managed by the states, CMS has provided significant "flexibility" to the states in its Medicaid RAC programs:

Similarities between the Medicare and Medicaid RACs

1. Medicaid RACs must identify overpayments and underpayments and recoup overpayments—and states must adequately incentivize detection of underpayments (although the methodology for that incentive is not mandated).
2. Medicaid RACs are limited to post claim submission review—like Medicare RACs, they cannot conduct pre-payment audits or reviews.
3. 12.5 percent will be the contingency fee ceiling for Medicaid RACs for purpose of federal matching funds—so the states may pay their RACs more, but CMS will not share the overage costs. Percentage contingency fees are mandated as with the Medicare RACs.
4. As with the Medicare RACs, if the provider succeeds in appeal at any stage of the Medicaid RAC appeal, the Medicaid RAC must refund its contingency fee to the state.
5. CMS has required that state RACs limit the number of records reviewed in the audit and the frequency of audits—however, the specific limitations are left to the states.
6. Medicaid RACs will be required to have toll free customer services lines, mandatory acceptance of EMRs on CD or disk, and notification of the overpayment to the provider within 60 days.
7. Medicaid RACs must employ one FTE physician Medical Director and use certified coders for complex reviews unless the state can show grounds that it should be exempted from the coder certification requirements.
8. Whenever the Medicaid RAC has "reasonable grounds" to suspect provider fraud or abuse, the RAC must refer the matter to the HHS OIG.

Differences between the Medicare and Medicaid RACs

1. Medicaid RACs must have an "adequate" appeal process; states may adopt the Medicare RAC appeal process or create their own. Significantly, states have discretion to include administrative or judicial review as part of their appeal process.
2. Medicaid RACs will have discretion to exclude Medicaid managed care entities (MCEs) from their RAC program—this could be a significant carve out in states such as Florida where most of the Medicaid is processed by Medicaid MCEs.
3. Medicaid waiver states such as Tennessee and California will not be exempted from the Medicaid RACs.
4. Provider "discussion periods" or informal reviews of the RAC findings will not be mandated to by CMS; similarly, states will not be required to reveal RAC appeal data in sharp contrast to the Medicare RAC program.
5. States have the discretion to provide patient notification after final claims resolution including appeals and administrative review but may notify patients before the provider's appeal process is completed.

6. If a claim is under review by another program contractor, e.g. PERM contractor or MIC, then that claim should not be reviewed by the Medicaid RAC.

Conclusion

This Final Rule for Medicaid RACs is effective January 2, 2012, and you should stay tuned for state-sponsored provider education and training on the particulars of that state's new Medicaid RAC program.



ACEP's 2010-11 Outstanding Speaker of the Year

Congratulations to Dr. Kirk Jensen, MD, MBA, FACEP of Rocky Mount, NC for being selected as ACEP's 2010-11 Outstanding Speaker of the Year. This award recognizes "a single faculty member who has consistently demonstrated teaching excellence through performance, versatility, and dependability during ACEP educational meetings throughout the year." Dr. Jensen was officially presented with his award during the Faculty Appreciation and Speaker Awards Luncheon at the ACEP Scientific Assembly in October.



New ACEP Fellows

The NCCEP Board of Directors would also like to extend its congratulations to the following members on achieving Fellow status in ACEP:

- Jose Guillermo Cabanas Rivera, MD, FACEP
Raleigh, NC
- Kiernan T. DeAngelis, MD, FACEP
Holly Springs, NC
- Jeffrey D. Ferguson, MD, FACEP
Greenville, NC
- Keia Hewitt, MD, FACEP
Charlotte, NC
- Douglas K. Holtzman, MD, FACEP
Chapel Hill, NC
- Stanley E. Koontz, MD, FACEP
Ernul, NC
- Todd M. Listwa, MD, FACEP
Charlotte, NC
- Courtney H. Mann, MD, FACEP
Raleigh, NC
- Noelle Simon McLaurin, MD, FACEP
Durham, NC
- Jonathan Millard, MD, FACEP

Fort Mill, SC

- Sankalp Puri, MD, FACEP
Charlotte, NC
- Julie G. Verchick, MD, FACEP
Pinehurst, NC
- Anthony J. Weekes, MD, FACEP
Weddington, NC
- Stacie J. Zelman, MD, FACEP
Winston-Salem, NC



Clinical News

COPD Exacerbations Twice as Common in Winter

Exacerbations and deaths among patients with chronic obstructive pulmonary disease follow a pronounced pattern of seasonal variation, according to an analysis of data from a randomized, controlled trial.

[Read the entire article online.](#)

Bacteria Ride Along on Many Hospital Uniforms

Some people wear their hearts on their sleeves. Doctors and nurses wear a lot more there, it seems. Sixty percent of doctors' hospital uniforms and 65% of nurses' uniforms tested contained potentially pathogenic bacteria in at least one place, according to research published in the American Journal of Infection Control.

[Read the entire article online.](#)

Focus On: The Cyanotic Neonate

"Focus On" is an ongoing series of articles that examine common complaints that present to the emergency department or highlight new literature or treatment options.

Learning Objectives for this article include the ability to recognize and treat uncommon presentations of common pathology and common presentations of rare pathology, discuss the presentation, evaluation, differential diagnosis and treatment of the cyanotic neonate. The physician will be able to discuss the pathophysiology of the transition from fetal to newborn circulation, explain the significance of the hyperoxia test and discuss the management of a neonate with methemoglobinemia.

[After reading the article, take the CME quiz online.](#)



Welcome New Members

Samuel Jan Chang, MD
Devin Bustin, MD
Ryan Christensen, MD
Susan Ney Miller, MD

Gregory C. Peters, MD
Robert T. Dahlquist, MD
Margaret Gipson Hauck, MD
Stephen M Keller, MD

Cory Forbach, MD

Marin Hinzpeter, MD

Kirsten Ward, DO

Leonyasia Watson, MD

Erin Nicole Boyd, DO

Scott T. Goldston, MD

Itifat Husain, MD

Joshua T. James, MD

Katherine Mahoney-Tesoriero, MD

Anjni Patel

Samuel A Lazoff

Stephen Shaheen

Tracy Kane

William A Carter

Nathan Whitmore

Amy H Radzom

Maneesha Agarwal, MD

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