PRESIDENTS MESSAGE
Fighting the Good Fight

Gregory Cannon, MD, FACEP

One of the activities I wanted to do this year was to reach out to the 5 residency programs in our state and talk to residents about what organized medicine is and what is going on in our specialty. (Don’t worry CMC, we are coming to you in June!) At one point during my talk I discuss why I and other leaders of NCCEP take the time to volunteer with NCCEP. One of the points I try to make is that the battles that were fought 15-20 years ago affect how we as rank and file emergency physicians practice on a day to day basis and how we are reimbursed. The issues we face today and we are advocating for now will affect how they as residents fare over the course of their 30-35 year clinical career. It is not just reimbursement issues but quality of professional practice and public health that are at issue. Along, those lines, I am also happy that our chapter continues to be guided by impressive intellects and abilities. I discussed some of those people a couple of issues ago. In terms of upcoming leadership I believe strongly in those whom we have chosen to lead the college in the next couple of years. I encourage you to review the nominations in this issue and to vote for those who wish to lead.

I am often asked by members of my own group what is going to happen “to us” and what the threats are to the specialty. As many who have been following the events in North Carolina in the last couple of months are aware, we have our work cut out for us. As predicted by many, the legislature and the Governor decided not to expand Medicaid under the Accountable Care Act. This is unfortunate for us as emergency physicians who actually see a disproportionate share of uninsured patients who would otherwise qualify for Medicaid under the new law. Although I understand the argument of the state Republican leadership that Medicaid is a mess and needs to be fixed, it is now on them as the governing majority to fix those issues as soon as possible and then expand the system. It is an issue not just of improved patient care but also of basic hospital viability in rural areas.

See Cannon – continued on page 2
Another big issue that is now on the radar screen is the possibility of managed care companies coming in and contracting with the state to run Medicaid like a capitated system. This could prove disastrous for reimbursement as we have seen how this has played out in states like Tennessee and Florida. It is especially concerning because we have a physician led program called Community Care North Carolina (CCNC) that already has been saving NC Medicaid dollars and is being watched as a model by many other states. We should give CCNC support as a viable alternative to commercially managed Medicaid.

Several members have also expressed concern about the motorcycle helmet bill. This is something that is filed on a recurrent basis but this session the bill appears to have more support. We are following this closely and working hard to keep the bill from being passed. This is just one of several issues that we are following and making sure that the voice of emergency medicine is heard in Raleigh. You can rest assured that as the years go by the North Carolina College of Emergency Physicians will be there working for your benefit and the benefit of our patients.

CANDIDATE FOR PRESIDENT-ELECT

Abhi Mehrotra, MD, FACEP

Dear NCCEP member – thank you for considering me for the President-Elect of NCCEP. I have had the opportunity to be involved in NCCEP & ACEP since my residency and have continued that involvement as faculty at UNC. Over the past few years, I have served as a Councillor from North Carolina (having the privilege of representing NCCEP at the annual ACEP Council meeting) as well as NCCEP Board member and Secretary-Treasurer. I have had the fortune of finding leadership opportunities within NCCEP and ACEP, and am grateful for the continued ability to serve.

I understand that in this time of change, we need continued vigilance from our College – both on a state and national level. I see the opportunity for engagement of our legislators to help shape solutions to the problems on the horizon. Our prior leadership leaves a legacy of success that I hope to continue forward, but need your engagement as we do so. I look forward to our first combined conference with South Carolina and Georgia this June! I would appreciate the opportunity to continue serving emergency physicians and emergency medicine in our state and at the national level. Please e-mail me if I can answer any questions about my candidacy at Abhi@med.unc.edu. Thank you for your vote.

See Candidates – continued on page 4
Let MMP turn your chaos to calm.

If your day-to-day operations are chaotic, Medical Management Professionals (MMP) can deliver state-of-the-art billing processes, sophisticated chart reconciliation, denial management and payor specific coding services to your practice. In fact, it has billed over 93 million visits since its inception. The results for emergency medicine practices are increased revenues, reduced compliance risk and reduced stress for administrators and physicians.

Counter your chaos with a calming force.
CANDIDATE FOR SECRETARY-TREASURER

Bret Nicks, MD, MHA, FACEP

As a member of NCCEP for over a decade, it is amazing to think about how our specialty continues to change and how we have been able to navigate these changes within the State of North Carolina. Through my time as Councillor and then Board Member for the past 6 years, I have seen directly the value that NCCEP brings to the EM providers of our state - and leadership for ACEP as well. With the ongoing changes in health care, having leaders in NCCEP represent EM and our patients is essential. I believe my experience clinically, academically, and administratively will allow me to serve well as the Secretary/Treasurer of NCCEP. Thank you for your consideration.

CANDIDATES FOR BOARD OF DIRECTORS

Matthew Bitner, MD, MEd, FACEP

I am writing to seek re-election to the North Carolina College of Emergency Physicians (NCCEP) Board of Directors and as a Councillor.

I attended the University of Miami School of Medicine, completed my residency in Emergency Medicine and fellowship in Prehospital and Disaster Medicine at Emory University in Atlanta, GA, where I also served as a member of the Board of Directors for the Georgia College of Emergency Physicians. I currently practice as Medical Director/Chief of Emergency Medicine at Maria Parham Medical Center and as a staff Emergency Physician at Duke University Hospital. For the college I serve as the NCCEP Education Committee Chair and as a member of the NCCEP EMS and Nominating Committees.

My last term with the Board has seen dramatic growth. We have steadily grown in membership and I have stewarded the development of the Education initiatives of the College such as the first regional conference, the Coastal Emergency Medicine Conference, as well as representing NCCEP as the Chair of the ACEP Scientific Assembly in Seattle this year. Coordinating the GA, SC, and NC chapters of ACEP to bring you the members a first-class educational opportunity in Emergency Medicine, which I hope you will join us for. My time on the board and initiatives such as these are what have truly shown me the power of collaboration and advocacy.

The role of Emergency Physicians is evolving, from the front doors of the ED to the floor of the council and the steps of capital hill. From bedside care to policy decisions, we must remain engaged. Advocacy is best way to prevent complacency. As a member of the board of directors and a councilor, I would represent our college on a local, regional, and national level, though my continued work with other organizations and national ACEP.

Thank you in advance for your consideration, and I look forward to the year ahead with the North Carolina College of Emergency Physicians.

Jeff Klein, MD

Current Position: Associate Medical Director, Emergency Medical Associates, Lumberton

Medical School: University of North Carolina at Chapel Hill

Residency: Northwestern University Hospital, Chicago, IL

Professional Activities: Member NCCEP, Member ACEP

I am currently pursuing reelection to the NCCEP Board of Directors position. Over the past four years I have had the opportunity to serve as a board member of NCCEP. During this time I have enjoyed meeting with legislators such as Bob Rucho and Thom Tillis. I was honored to be part of the team effort when we passed our great tort reform bill in both the Senate and House two years ago. I have also been part of the reimbursement committee, focusing on protecting Medicaid rates as well as other issues vital to our reimbursement.

Locally, I am the leader of the cost containment committee at Southeastern Health. We have implemented safe but cost effective order sets for the Emergency Department and have targeted narcotic abuse as well.

I look forward to learning as much as I can and helping Emergency Medicine on the state and national level. It would be a privilege to continue to be a member of the NCCEP Board of Directors.
Eric Maur, MD, FACEP

Although I am relatively new to NCCEP, my past experiences in PA-ACEP, EMRA, and ACEP make me a well-qualified candidate for the NCCEP Board of Directors. As a member of the Board of Directors, I would not only represent all emergency physicians in the underserved western North Carolina region, but also all young physicians throughout the state.

The future of our specialty belongs to the young physicians - not only those who have recently entered practice but those who have yet to begin practice as well. The “Founding Fathers” of Emergency Medicine set our specialty up for greatness, and now it is up to the young physicians to further refine and maintain its success. As such, it is imperative that young physicians have a voice and maintain an active role in shaping this future.

My past experiences and accomplishments speak for themselves. Despite being just four years out of residency, I bring to the table a wealth of experience that many within our specialty will never have the opportunity to achieve.

While in residency, I served for two years on the PaACEP Board of Directors as a resident representative. This provided me with first-hand experience of not only how an ACEP chapter Board of Directors functions, but also the true commitment to our specialty that is made by each board member.

Additionally, I spent two years serving on the Board of Directors of the Emergency Medicine Residents’ Association (EMRA) as the ACEP Representative. In this capacity I was responsible for representing the views of EMRA to the ACEP Board of Directors and for serving as the primary liaison between the two organizations. During my two year term I attended all Board of Directors meetings and activities for both EMRA and ACEP, served as a full member on the ACEP Steering Committee, and represented EMRA on the ACEP Council.

After my term on the EMRA Board, I became more involved with ACEP’s Young Physicians Section, and will serve as a Councillor for YPS for the coming two years. This will mark 8 consecutive years serving the ACEP Council. I was also previously selected for ACEP and EM-RA’a Mini-Fellowship in Health Policy, which provided me the unique immersive experience of spending a month in ACEP’s Washington, DC office. From lobbying on Capitol Hill to attending exclusive meetings in the Eisenhower Executive Building, I’m well prepared to face the leaders in our state and national capitol.

Through these vast experiences, I feel I am well prepared to serve on the NCCEP Board of Directors. Along with this experience also comes extensive knowledge of the challenges facing our specialty today.

As dramatic health care reform becomes a reality, it is imperative that our specialty is well represented on the front lines of this battle ground. As has already been proven in Massachusetts, simply providing health care coverage to everyone does not necessarily guarantee access to care. In fact, it has been shown that providing universal coverage increases the number of Emergency Department visits. Universal coverage does not equal universal access. If universal coverage reimburses at Medicaid rates, many primary care physicians and specialists may simply not take the insurance provided under a universal coverage plan if.

See Candidates – continued on page 6
the reimbursement is too low. This leads to an increased burden on our already crowded Emergency Departments. NCCEP needs to remain at the front lines, ensuring that any solution to provide universal coverage also includes universal access for our patients as well.

Along with increasing access to health care, tort reform must also be implemented. Without tort reform, health care costs in the state will continue to rise, physicians will migrate to states in which tort reform has already been enacted, and access to care will continue to decline. This would cause even greater strains on our already overburdened emergency departments. This is unacceptable and needs to be fixed as soon as possible, for it is not only detrimental to our specialty but also to our patients.

I bring with me a proven track record and leadership ability, demonstrated during my service in the US Navy and on the Board of Directors’ of PaACEP, EMRA, and ACEP. I remain dedicated to serving our College, our community, and our patients, and would graciously welcome the opportunity to serve as a member of your NCCEP Board of Directors.

**Sankalp Puri, MD, FACEP**

I would like to announce my candidacy to serve on NCCEP Board of Directors. After serving as a chief resident and being involved nationally with ACEP and SAEM, I joined Mid-Atlantic Emergency Medicine Associates (MEMA) and have been practicing in Charlotte for over ten years. Over the past fourteen years, I have served on numerous committees for my hospital, my group, and continued to be involved with ACEP. On a local level I have been involved with our local medical society chapter, Mecklenburg Medical Society. I hope to utilize my experience to have an opportunity to serve on a state level and hope to have your support.

**Jennifer Raley, MD, FACEP**

It would be my pleasure to serve on the Board of Directors for NCCEP once again. In my 4 years on the NCCEP board, I have enjoyed learning about the business of Emergency Medicine and how politics impacts on our specialty. I especially like how we can impact it back with organized advocacy! I also enjoy working with other leaders from around the state to continue to ensure access and quality care to all patients who seek emergency medical treatment—those who can afford to pay and those who cannot. This work takes place through a combination of working toward reasonable reimbursements through governmental and private payers, ensuring unimpeded access to care, giving our patients a voice through our specialty advocacy and by helping to improve quality by participating in activities such as EMS protocol recommendations, advising the legislature on emergency care issues and upholding the high standards of our specialty.

I am currently the Vice President for Wake Emergency Physicians in Raleigh NC and previously served as the Chair and Medical Director at our Raleigh Campus. In addition, I served for 2 years on the National ACEP Reimbursement Committee and currently serve on the Reimbursement Committee for NCCEP. I have been the Course Director for NCCEP’s fall conference for the past 5 years and continue to serve on the Education Committee for NCCEP. If I am elected for an additional term, I would work toward a leadership role within NCCEP and expand my involvement with the Reimbursement and Practice Management Committees.

**CANDIDATES FOR COUNCILLOR**

**Matthew Bitner, MD, MEd, FACEP**

See candidate statement page 4.

**Charles Henrichs, MD, FACEP**

It has been my privilege to serve as councillor representing NCCEP at the ACEP Council for a number of years. My experience in ACEP includes past membership on the Steering Committee and Bylaws Committee, as well as other committee and task force membership, and I currently serve on the ACEP Ethics Committee. I have chaired several reference committees at the Council and have served as chair of the Tellers Committee. It has been my great honor to have been a recipient of the Council Meritorious Service Award and the George Podgorny MD Distinguished Service Award.
I continue to approach this service with the same enthusiasm I have always had, applying myself diligently in representing North Carolina. Prior to each Council meeting, I summarize the Council resolutions for that year for the NCCEP Board and NCCEP councillors. Over the years, it has been a distinct privilege to have mentored numerous councillors from our state and from other chapters. NCCEP is well served by the wide range of experience and ability represented by our councillors. I respectfully request your vote to allow me to continue that service.

Keia V.R. Hewitt, MD, FACEP

As the current medical landscape continues to change, it is becoming more evident the importance of engagement and involvement from emergency physicians to better serve our community and patients. As health care decisions are made that potentially can impact the wellbeing of our patients, it is important that clinicians are actively involved in these discussions and to represent the interests of those that are not readily heard. These concerns encompass my viewpoint and rationale for pursuing Councillor of NCCEP.

I am currently involved in numerous community and civic organizations, which allows me the opportunity to represent and pursue the needs of those that I serve. Presently, I am the President of the Charlotte Medical, Dental and Pharmaceutical Medical Society, which continues to protect and safeguard the interests of local fragile populations, since 1900. I have been an active member of ACEP since 2004. Having the opportunity, as a Councillor, would enable me to continue to assist all those that are in need and to make a broader impact on both a state and national level.

I am humbled by the possibility of making a greater difference in the lives of our patients and I appreciate your consideration for Councillor of NCCEP.

Michael Utecht, MD, FACEP

First off, I want to take this opportunity to thank all of you for your support over these past years. Certainly, my experience as an NCCEP board member, NCCEP past president and councillor have been invaluable in understanding the many facets of North Carolina emergency medicine. Currently serving my second term on the ACEP Council Steering Committee has broadened that understanding to the national level as well. However, to truly understand the challenges that we as emergency physicians must face every day I believe that it is my continued community emergency medicine practice for more than 20 years that has proven to be most valuable. Although the road ahead for the practice of emergency medicine is lined with uncertainties, I am confident that with my experience and your support we will assure our continued success.

Coastal Emergency Medicine Conference

June 7-9, 2013

Register online at www.coastalemergencymedicineconference.org
Emergency Medical Associates is seeking **BC/BE EM Physicians** for Southeastern Regional Medical Center in Lumberton, NC

Led by Carolina physicians who know the local culture and are driven to excellence in patient care, satisfaction and developing an award-winning team.

**SOUTHEASTERN REGIONAL MEDICAL CENTER**

- 82,000 ED visits annually
- 69 ED beds
- 337-bed community hospital
- Clinical Decision Unit
- Hospitalists perform all admissions
- Electronic Medical Record
- 50% of all shifts are covered by EM nocturnists
- Full practice support with medical scribes and associate practitioners
- Designated Magnet Hospital for Excellence in Nursing
- Teaching site for physician assistants at Wake Forest University and Methodist University
- Duke University faculty members perform interventional cardiology & cardiothoracic surgery at SRMC

**OUR PHYSICIANS ENJOY**

- Unparalleled Support Allows You to Live the Life You Deserve
- Equity Partnership
- An Equal Voice in Everything We Do
- An Equal Share in Everything We Own

Please Visit Us at the Coastal Emergency Medicine Conference in South Carolina

Contact Us Today
www.EMA.net
McDuffieE@ema.net
(973) 436-5547
3. Communicate clearly when expectations or processes are changing

   a. Involving all those involved in change and clearly stating the value proposition for this change – especially as it relates to the patient when appropriate – will help lessen the stress associated with change … especially in a busy ED.

All of us will agree that in general, being well compensated for the work performed is important. But ensuring that providers and staff feel valued, are challenged appropriately (which speaks for itself in EM), and feel as those they are contributing to something meaningful increases not only the team-based care mentality, but enhances the likelihood of employee retention … even during the uncertainty with the future of healthcare. Here’s to your team!

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**Fayetteville, North Carolina**

Emergency medicine residency-trained, BC/BE physicians are needed to provide care to 96,000 adult patients per year at Cape Fear Valley Medical Center. CFVMC is a 70-bed, state-of-the-art emergency department with full cardiac, stroke and trauma support. 114 hours of daily physician coverage with 94 hours of mid-level coverage. Physician ten-hour shifts: 6am-4pm, 2pm-12am, and 10 pm-8am. Locum tenens physician’s compensation ranges from $225 to $250 per hour subject to credentials. $1m/$3m professional liability coverage with tail, air travel, rental car and lodging are covered. Full-time, permanent positions are available with hospital employee benefits.

**Contact**
CMP Staffing
Karen Winhorst or send resume to
888-930-0542 kwindhorst@CMP-Staffing.com
The NCCEP Reimbursement Committee has been working with the ACEP Reimbursement Committee, the ACEP Ultrasound Section, the ACEP Board of Directors, the EMAF, and other stakeholders over the last year to work to have the ‘automatic’ claim check edits promulgated by McKesson removed. These changes are regarding the bundling of components of the abdominal echo (CPT code 76705) and echocardiogram (CPT code 93308) components of the FAST exam.

Continued on page 16

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<th>CPT</th>
<th>Description</th>
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<tr>
<td>76705</td>
<td>Ultrasound, abdominal, real time with image documentation; limited (e.g., single organ, quadrant, follow-up)</td>
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<td>99281-99285</td>
<td>Emergency department visit for the evaluation and management of a patient …</td>
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McKesson has now reviewed these edits with multiple health plan Medical Directors. Virtually all acknowledged the usefulness of ‘Focused Assessment with Sonogram for Trauma (“FAST”)’ in the proper clinical circumstances. When the Emergency Services Physician performs and interprets this study, as the sole professional, reimbursement for the imaging study and additional E/M services is warranted.

However, several Medical Directors identified health plan policies that are intended to reimburse only the ‘official’ interpretation, or chart copy, of an imaging study, including image documentation. Other Directors expressed additional concerns: duplicate ‘over-read’ interpretations also reported by radiologists; ER physicians reporting 76705 without a Mod -26 (Professional component only); chart notes without a formal chart report; interpretations without image documentation; and confusion with examinations done by radiologist for non-traumatic indications.

Despite this and other concerns voiced by our clients, in consideration of clinical data and market feedback, McKesson will remove these edits, effective with the April, 2013, KnowledgeBase update.

Finally, I would like to invite ACEP to participate in our McKesson Clinical Outreach initiative where we establish ongoing channels of communications for addressing coding and auditing questions directly. One practical approach is to include Kenneth DeHart, MD, the ACEP Advisor to the CPT Panel in this process.

Please let me know if you have comments, questions, or concerns that have not been addressed or resolved.

Sincerely,

Douglas J. Moeller MD
Medical Director, Claims Performance Group, McKesson Health Solutions
Doug.Moeller@McKesson.com
610-993-4333 x1080
The Coastal Emergency Medicine Conference will be held June 7-9, 2013, in Kiawah Island, South Carolina. This first annual regional conference will be jointly hosted by the North Carolina, Georgia, and South Carolina ACEP Chapters, and we hope to have a large turnout of our members. Please register today for this exciting new event. More information, including online registration and the conference agenda, is available on the conference website - www.coastalemergencymedicineconference.org.

Social events will include a golf tournament on Friday afternoon, an opening reception on Friday evening, and a Saturday dinner.

A group room rate is available at the Kiawah Island Golf Resort Villas. Call 1-800-654-2924 to make your reservation, and reference the Coastal Emergency Medicine Conference and that you are a member of the NC Chapter (10276). Room rates are $225/night for a one bedroom villa, or $325 for a two bedroom villa. You must book your room by May 7, 2013, in order to receive the group rate.

This activity has been planned and implemented in accordance with the Essential and Standards of the Accreditation Council for Continuing Medical Education. The Southern Alliance for Physician Specialties CME (SAPS CME) is accredited by the Medical Association of Georgia to offer continuing medical education to physicians. The Southern Alliance for Physician Specialties CME designates this live activity for a maximum of 15 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.
Guidelines for the Evaluation of Children in the Emergency Department Setting

Physical Abuse

These guidelines provide a brief summary of 1) the recommended evaluation of children in the emergency department setting with concerns for physical abuse, 2) reporting requirements to the Department of Social Services and law enforcement, and 3) referral to a physician/licensed medical provider with expertise in the evaluation of child abuse/neglect.

When it is suspected that any child/adolescent may have been physically abused, it is critical that these children receive a complete physical examination and any diagnostics needed to assist the evaluation. Thorough documentation to include body diagrams/photodocumentation of pertinent physical findings should be included.

We recommend the following approach:

1) OBTAINING THE HISTORY:
   a. Interview caregivers independently of each other and the child. Document who was present for the interviews and the demeanor of the caregivers. Use quotation marks to indicate specific responses being provided by the caregivers.
   b. While detailed interviewing of children should be deferred to professionals with expertise in interviewing children for concerns of abuse, children may be asked open-ended questions to obtain a history and focus for the physical examination. The child, if at all possible, should be interviewed away from accompanying caregivers. Document who was present with the child for the interview, the child's demeanor, and use quotation marks to indicate remarks/responses being provided by the child.

2) PHYSICAL EXAM:
   a. Completely examine the child (include ano-genital area, inside the mouth, between digits, palms & soles). Document any findings or lesions/injuries with photographs (permission not required when part of medical evaluation), if possible, and diagrams, being sure the site of the abnormalities/injuries are clear. Include measurement device with gray scale if possible. An identifying face photo of the child is helpful. Include with patient name, MR#, date taken and by whom.

3) DIAGNOSTICS:
   a. Use skeletal surveys, if a child under 2 years of age has suspicious fractures, bruises, or other injuries. *Do not use "babygrams" (i.e. whole-body x-rays) because of the high rate of false negatives. Skeletal surveys are rarely useful in children >5 years of age and are generally not recommended.
   b. Consider:
      i. Baseline labs. Laboratory screening for coagulopathies with concerning bruising/bleeding. Urine/blood to detect exposure to toxic substances (alcohol, illegal substances, etc.)
      ii. Head imaging (Head CT/MRI) to rule out intracranial injury, particularly if there are neck, facial, ear, scalp injuries, vomiting or altered consciousness present.
      iii. Abdominal trauma with screening labs (Liver Function Tests, amylase, lipase) and/or abdominal CT. Note: Screening labs may be normal in setting of trauma, so if clinical suspicion is high for injury, proceed to abd/pelvis CT.

4) OTHER INFORMATION:
   a. Obtain the medical record, if possible, and look for repeated visits for injuries and other signs of possible maltreatment, regardless of whether history is consistent with physical findings.
   b. If possible, consult with the child's primary care provider to discuss presentation and any concerns.
5) SAFETY/ REPORTING:
   a. Hold the child or admit him/her to the hospital if there are safety concerns, until a child protective services
      worker responds and takes over this aspect of management. N.C. General Statute 7B-308 (Twelve Hour
      Custody) states that any "physician or administrator of a hospital, clinic or other medical facility to which a
      suspected abused juvenile is brought for medical diagnosis or treatment, shall have the right, when
      authorized by the chief district court judge or his designee, to retain physical custody of the juvenile ...
      (Please refer to your medical facility's protocol regarding how to obtain twelve-hour custody)
   b. Make a report to the local county Department of Social Services per the state’s mandatory reporting
      law for suspected child abuse and neglect. The report should be made to the county DSS in the
      county where the child resides. If difficulty in connecting with the county DSS of residence, you may
      contact your local DSS agency to assist in making the report. To locate your DSS, click here:
      http://www.ncdhrs.gov/dss/local/. All citizens of North Carolina who have suspicion(s) of child
      abuse/neglect are mandated reporters.
   c. A report must be made to law enforcement when the child has sustained serious injury or meets G.S.90-
      21.20. The report is made to the law enforcement agency that has jurisdiction in which the medical
      facility is located.

6) REFERRAL:
Refer the child to the appropriate physician/licensed medical practitioner with experience in the evaluation of child
maltreatment in your particular region of the state to ensure that the child’s medical and mental health needs will be
met. The referral physician/licensed medical provider should be immediately contacted and informed of the history
and results of the initial examination. Call The NC Child Medical Evaluation Program at 919-843-9365 if you need
information concerning who provides child abuse/neglect evaluations in your area.

* ACR–SPR PRACTICE GUIDELINE FOR SKELETAL SURVEYS IN CHILDREN (2011)

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Guidelines for the Evaluation of Children in the Emergency Department Setting

**Sexual Abuse/Assault**

These guidelines provide a brief summary of 1) the recommended evaluation of children in the emergency department setting with concerns for sexual abuse, 2) reporting requirements to the Department of Social Services and law enforcement, and 3) referral to a physician/licensed medical provider with expertise in the evaluation of child abuse/neglect.

When it is suspected that any child/adolescent may have been sexually abused, the child should receive a screening exam in the ED that focuses on acute problems (e.g. trauma, vaginal discharge) and, if needed, evidence collection. The child should then be referred to a physician/licensed medical provider with experience in the evaluation of child maltreatment for full evaluation as soon as possible. We recommend the following approach for this screening evaluation:

1) **OBTAINING THE HISTORY:**
   a. Interview caregivers independently of each other and the child. Document who was present for the interviews and the demeanor of the caregivers. Use quotation marks to indicate specific responses being provided by the caregivers.
   b. While detailed interviewing of children should be deferred to professionals with expertise in interviewing children for concerns of abuse, children may be asked broad, open-ended questions to obtain a history and focus for the physical examination. The child, if at all possible, should be interviewed away from accompanying caregivers. Document who was present with the child for the interview, the child’s demeanor, and use quotation marks to indicate remarks/responses being provided by the child.

2) **PHYSICAL EXAM:**
   The child should have a complete physical exam with documentation of any ano-genital/extragenital lesions/injuries. If possible, photographs (permission not required) and diagrams should be utilized to document findings. An identifying face photo is helpful. Include card with patient name, MR#, date taken and by whom.

3) **REMINDERS:**
   a. A SPECULUM SHOULD NEVER BE USED ON A PRE-PUBERTAL FEMALE and RARELY NEEDED IN ADOLESCENTS. If a speculum exam is warranted for any medical reason (unknown source of bleeding, evaluate extent of trauma, remove a foreign body resistant to being flushed from the vaginal vault), the prepubertal child should be examined under general anesthesia/conscious sedation. A CHILD (beyond infancy) SHOULD NOT BE PHYSICALLY RESTRAINED FOR THE PHYSICAL EXAMINATION. Consideration should be given to deferring the exam to the child abuse specialist in cases where it is not immediately medically necessary to examine the child/adolescent and the child/adolescent is unable to cooperate in the ED with the exam.
   b. A NORMAL EXAM DOES NOT RULE OUT SEXUAL ABUSE/ASSAULT.
   c. Current American Academy of Pediatrics’ Guidelines for the Evaluation of Sexual Abuse of Children state that Rape Kits are most productive if performed within 72 hours of the alleged incident (Note: Bedding and clothing can yield evidence for an extended period of time).

4) **DIAGNOSTICS:**
   a. Testing for STIs in prepubertal children can be complex. While cultures for gonorrhea and chlamydia remain the “gold standard”, screening for Gonorrhea and Chlamydia may be done via nucleic acid amplification tests (NAAT’s), which can be performed on a urine specimen. Follow-up repeat testing may be better accomplished by a child abuse medical provider at a subsequent appointment. (Please
refer to the AAP’s Redbook or the CDC’s MMWR for additional information) The child abuse medical provider who will be receiving the referral should be contacted prior to treatment to ensure that a second NAAT can be obtained to confirm a true positive result, and a culture can be sent. All samples testing positive should be saved by the lab for subsequent analysis if needed.

b. Consider serologic testing for Syphilis, HIV, and HBV. Viral cultures for lesions suspicious of HSV.

c. Pregnancy testing should be performed for pubertal children.

d. Consider blood/urine testing if any suspicion of drugs or alcohol was used during the alleged sexual abuse/assault in any age child.

5) TREATMENT FOR SEXUALLY TRANSMITTED INFECTIONS:

a. Prepubertal
i. STI post-exposure prophylaxis is not generally indicated or advised in prepubertal children.
ii. Consider consultation with a pediatric infectious disease specialist to determine if HIV post-exposure is warranted.

b. Pubertal
i. STI prophylaxis should be considered for pubertal patients with particular attention to Chlamydia, Gonorrhea, Trichomonas and HIV. Testing before prophylaxis is always recommended. Consider consultation with a pediatric infectious disease specialist to determine if HIV post-exposure is warranted
ii. Emergency Contraception (Plan B or equivalent) should be offered.
iii. Refer to CDC website on Sexually Transmitted Diseases Treatment Guidelines, 2010: Sexual Assault and STDs for further information on testing and treatment http://www.cdc.gov/std/treatment/2010/sexual-assault.htm

6) “FINAL DIAGNOSIS”: In most cases, the "Final Diagnosis" will not be made in the Emergency Department setting but rather by a follow-up evaluation by the child abuse specialist. Therefore, use caution in the wording of the preliminary assessment (i.e. "no sexual abuse found")

7) SAFETY/ REPORTING:

a. Hold the child or admit him/her to the hospital if there are safety concerns, until a child protective services worker responds and takes over this aspect of management. (N.C. General Statute 7B-308 (Twelve Hour Custody) states that any "physician or administrator of a hospital, clinic or other medical facility to which a suspected abused juvenile is brought for medical diagnosis or treatment, shall have the right, when authorized by the chief district court judge or his designee, to retain physical custody of the juvenile ..." (Please refer to your medical facility’s protocol to obtain twelve-hour custody)

b. Make a report to the local county Department of Social Services per the state’s mandatory reporting law for suspected child abuse and neglect. The report should be made to the county DSS in the county where the child resides. If difficulty in connecting with the county DSS of residence, you may contact your local DSS agency to assist in making the report. To locate your DSS, click here: http://www.ncdhhs.gov/dss/local/. All citizens of North Carolina who have suspicion(s) of child abuse/neglect are mandated reporters.

c. A report must be made to law enforcement when the child has sustained serious injury or meets G.S.90-21.20. The report is made to the law enforcement agency that has jurisdiction in which the medical facility is located.

8) REFERRAL:
Refer the child to the appropriate physician/licensed medical practitioner with experience in the evaluation of child maltreatment in your particular region of the state to ensure that the child’s medical and mental health needs will be met, The referral physician/licensed medical practitioner should be immediately contacted and informed of the history and results of the initial examination. Call The NC Child Medical Evaluation Program at 919-843-9365 or go to http://www.med.unc.edu/cmep/ if you need information concerning who provides child abuse/neglect evaluations in your area.
We are pleased to announce that this collaboration has been successful, and McKesson has agreed to remove these edits. A copy of the letter describing the removal of these edits is below.

It will still be incumbent on our billing agents to carefully monitor EOB’s from commercial payers to ensure that we will be paid for these codes in the future. The letter below can be sent to any payer on appeal if payers continue to bundle these codes.

An even greater victory was earned in this dispute resolution as ACEP has been invited to participate in McKesson’s Clinical Outreach Initiative, which should help preclude future arbitrary and unsubstantiated coding edits.

ACCESS TO CARE COMMITTEE REPORT

The NCCEP ATCC continues to work proactively with NC Medicaid leadership to maintain access to high quality cost effective care for Medicaid beneficiaries. This remains the best viable collaboration to preserve our Medicaid reimbursement rates (which are among the best rates in the country).

The ongoing growth of Community Care of NC and the use of the Medicaid Portal to access records of high Medicaid utilizers, allows us to reduce duplicative (expensive) imaging and other testing and is vital to the present financial viability of the Medicaid safety net. Remember that designated ED staff can access these records in Portal on your behalf, making it easy to use. Medicaid caseworkers can also be accessed by ED staff, facilitating timely follow up.

Call to Action: The House of Medicine in NC must embrace these opportunities to reduce costs and improve the efficiencies of high Medicaid utilizers NOW. This maybe our last opportunity to preserve our reimbursement rates and (hopefully) prevent the NC Legislature from turning over the administration of Medicaid in our state to commercial (for profit) managed care entities. (Look and see what has happened in states like Tennessee and Florida……similar efforts there have been disastrous for patients and providers). Please take this opportunity to sign up for the CCNC Medicaid Portal.

CCNC Provider Portal Sign-up: https://portal.n3cn.org/

Submitted by Charles A. Bregier Jr, MD, FACEP, Chair On Behalf of the Reimbursement and Access to Care Committees

PROPOSED NCCEP BYLAWS AMENDMENT

The NCCEP Board of Directors has recommended a change to the bylaws to allow the option of electronic voting, which must be submitted to the membership for approval. The bylaws may be amended by a two-thirds vote of the membership present at the annual meeting in June.

The bylaws are proposed to be amended as follows (see text in blue). (Note: The language in red was approved at the last membership meeting.)

NORTH CAROLINA COLLEGE OF EMERGENCY PHYSICIANS BYLAWS

(Revised wording in red approved by membership June 16, 2012)

ARTICLE I

Name

This Association shall be a non-profit corporation organized under the laws of the State of North Carolina. Upon receiving a charter from the American College of Emergency Physicians this Association shall be a chapter of American College of Emergency Physicians and shall be called the North Carolina College of Emergency Physicians.

Section 1. The principal office of the Corporation shall be in any county at any address within the State of North Carolina as selected by the Board of Directors.

Section 2. The initial registered office of the Corporation is 1300 St. Mary’s Street, Raleigh, North Carolina 27605, and the name of its initial registered agent at such address is Julian D. Bobbitt, Jr.
Section 3. The Corporation may have offices at such other places as the Board of Directors may from time to time de
terminate.

Section 4. The corporate seal of the Corporation shall consist of two concentric circles between which is the name of
the Corporation and in the center of which is inscribed SEAL; and such seal, as impressed on the margin hereof, if
hereby adopted as the corporate seal of the Corporation.

Section 5. Unless otherwise ordered by the Board of Directors, the fiscal year of the Corporation shall be from October
1 to September 30.

ARTICLE II
Purposes

The purpose of this Association (hereinafter “the Chapter”) shall be those set forth in the Bylaws of the American Col-
lege of Emergency Physicians (hereinafter “the College”) and in the Chapter's Articles of Incorporation.

ARTICLE III
Membership

Section 1. The qualifications for membership in the Chapter shall be the same as those for membership in the College.
Candidate members shall not be able to vote or hold office except as described in Article VI of these bylaws and residents
appointed to committees, who shall be entitled to vote on committee business.

Section 2. Membership applications, classifications changes, resignations, suspensions, and expulsions shall be acted
upon by the College.

Section 3. Membership classifications in the Chapter shall be those designated by the College in its Bylaws.

Section 4. All records of the Chapter shall be available for inspection by the membership of the Chapter at any reasonable
time. Such inspection may be made by the member, agent or attorney, and shall include the right to make extracts
thereof. Demand of inspection, other than at a meeting of the members, shall be in writing to the president or the sec-
retary-treasurer of the Chapter.

ARTICLE IV
Dues and Assessments

Section 1. Dues for the Chapter shall be determined by the Board of Directors.

Section 2. Assessments may only be levied by a majority vote of the members present at the annual meeting and then
only if the recommendation for such assessment, as determined by the Board of Directors, has been mailed to the
membership at least thirty (30) days before the meeting.

Section 3. Any member whose membership has been canceled for failure to pay dues or assessments shall not be eligible
to vote or hold office.

ARTICLE V
Meetings

Section 1. There shall be an annual meeting of the Chapter membership, the time and place of which to be determined
by the Board of Directors. Notice of such meeting shall be mailed to the last recorded address of each member at least
sixty (60) days before the time appointed for the meeting.

Section 2. Other meetings of the Chapter may be held from time to time as determined by the Board of Directors. Notice of such meetings shall be mailed to the last recorded address of each member at least sixty (60) days before the
time appointed for the meeting, unless otherwise required by law.

Section 3. The members of the Chapter present at any duly called meeting of the Chapter shall constitute a quorum.
**Section 4.** When not in conflict with these bylaws, the parliamentary procedures outlined in the current edition of Sturgis Standard Code of Parliamentary Procedure shall govern all Chapter meetings.

**ARTICLE VI**

**Board of Directors**

**Section 1.** The Board of Directors shall have supervision, control and direction of the affairs of the Chapter, shall determine its policies or changes therein within the limits of the bylaws, shall actively prosecute its purposes and shall have discretion in the disbursement of its funds. It may adopt such rules and regulations for the conduct of its business as shall be deemed advisable, and may, in the execution of the powers granted, appoint such agents as it may consider necessary.

**Section 2.** The Board of Directors shall be composed of the officers of the Chapter, nine (9) elected directors, and emergency medicine residents currently in programs approved by their respective residency review committees, as described in Section 3 of this article. The number of directors may be increased or decreased from time to time by amendment of these bylaws. The minimum number of directors shall be thirteen (13) and the maximum number of directors shall be twenty (20). Directors must be members of the Chapter.

**Section 3.** With the exception of the resident members, who serve for one year, elected directors shall serve a term of two (2) years and shall be eligible to serve a maximum of three (3) consecutive terms unless elected to the office of president-elect or secretary-treasurer. Four (4) or five (5) elected directors shall be elected at each alternate annual Chapter meeting, or by written ballot without a meeting of the membership as specified in Article X of these bylaws, by a plurality vote of the members voting (with the highest vote-getters being elected to the available positions). No later than one month prior to the annual Chapter meeting, each emergency residency program within the state shall be requested to submit the name of one emergency medicine resident to serve as a non-voting member of the Board of Directors, subject to appointment by the president-elect. One resident member each year, on a rotating basis determined by the Board of Directors, shall be the sole voting member of the Board of Directors. The term of each director shall begin at the conclusion of the annual meeting at which the election occurs, or the conclusion of the first annual meeting after an election by written ballot without a meeting of the membership, or upon appointment as resident member of the Board of Directors.

**Section 4.** The Board of Directors shall meet no less than two (2) times per year at such times and places as approved by the Board of Directors. Notice of all meetings of the Board of Directors shall be sent by mail to each member of the Board at his or her last recorded address at least ten (10) days in advance of such meetings. Board meetings may be conducted by telephone conference call or other electronic medium. A majority of the Board of Directors shall constitute a quorum at any meeting of the Board. Only the voting resident member, not the other appointed resident members, shall be included for the purpose of determining a quorum. Special meetings of the Board may be called by the president or upon written request of one-third (1/3) of the directors.

**Section 5.** Any director, other than a resident member of the Board of Directors, may be removed from office by a three-quarters vote of the members voting at any Chapter meeting of the Chapter membership. A removal must be initiated by a petition signed by no less than one-third of the number of members present voting at the meeting at which the director was elected, or voting by written ballot without a meeting of the membership. Any vacancy created by a recall removal, other than removal of a resident member, shall be filled for the remainder of the unexpired term by a majority vote of the members voting at the meeting at which the recall removal occurs. Nominations for a vacancy created by a recall removal shall be accepted from the floor. Any resident member of the Board of Directors may be removed by majority vote of the Board of Directors; the voting resident member shall be recused from the vote to remove. Any vacancy created by removal of a resident member of the Board of Directors shall be filled for the remainder of the unexpired term at the discretion of and by majority vote of the Board of Directors.

**Section 6.** Any director may resign at any time by giving written notice to the president or to the Board of Directors.
Such resignation shall take effect at the time specified therein, or if no time is specified, at the time of acceptance thereof as determined by the president or the Board.

Section 7. Vacancies which occur on the Board of Directors for any reason, other than a recall removal, shall be filled for the remainder of the respective term by majority vote of the remaining directors. **Vacancies of resident members of the Board of Directors shall be filled at the discretion of the Board of Directors.**

ARTICLE VII

Officers

Section 1. The officers of the Chapter shall be the president, the president-elect, the secretary-treasurer and the immediate past president. The president-elect and secretary-treasurer shall be elected by a majority vote of those members voting at the annual meeting of the Chapter or by written ballot without a meeting of the membership as specified in Article X of these bylaws. The president and immediate past president shall succeed to office by virtue of their prior office. The president, president-elect and immediate past president shall serve a maximum term of one (1) year for each office. The secretary-treasurer shall be eligible to serve a maximum of two (2) consecutive terms of one (1) year. The term of each officer shall begin at the conclusion of the meeting at which the election occurs or the conclusion of the first annual meeting after an election by written ballot without a meeting of the membership.

Section 2. Each officer shall serve with voting privileges on the Board of Directors.

Section 3. The duties of the president shall be as follows:

a. The president shall be the executive officer of the Board of Directors.
b. The president shall preside over all meetings of the Chapter and Board of Directors.
c. The president shall be responsible for ensuring that all Chapter contracts with third parties contain a provision disclosing the fact that the Chapter is an entity separate and distinct from the College.
d. The president shall be responsible for ensuring that the Chapter adheres to the policy governing the use of the mark of the American College of Emergency Physicians.
e. The president shall serve a one-year term as a councillor.

Section 4. The duties of the president-elect shall be as follows:

a. In the event of vacancy of the office of president, the president-elect shall perform all duties of the president and shall perform such other duties and have such power as the Board of Directors shall prescribe for both the president’s unexpired term and the president-elect’s full term.
b. The president-elect shall serve a one-year term as a councillor.
c. The president-elect shall succeed to the office of president at the end of the president’s elected term of office.
d. The president-elect shall preside over meetings of the Chapter and Board of Directors in the absence of the president.

Section 5. The duties of the secretary-treasurer shall be as follows:

a. The secretary-treasurer shall keep or cause to be kept a book of minutes at the principal office of the Corporation, or at such other place as the Board of Directors may order, of all meetings of the Board of Directors and membership, with the time and place of holding, whether special or regular, the names of those present, the number of members at the meeting, and the proceedings thereof.
b. The secretary-treasurer shall keep and maintain the membership register of the Corporation and attend to the necessary correspondence and clerical needs of the Corporation.
c. The secretary-treasurer shall have general charge of the corporate books and records and of the corporate seal.
d. The secretary-treasurer shall sign such instruments as may require his or her signature and shall perform all duties incident to the office.
e. The secretary-treasurer shall keep and maintain or cause to be kept and maintained adequate and correct accounts
of the business transactions of the Corporation including accounts of its assets, liabilities, receipts, disbursements, gains and losses.

f. The secretary-treasurer shall deposit all monies and other valuables in the name and to the credit of the Corporation with such depositories as may be ordered by the Board of Directors.

g. An acting secretary-treasurer may be appointed by the Board of Directors to assume the functions of the secretary-treasurer in the absence or disability of the secretary-treasurer until such time as that absence or disability is ended or concluded except as provided elsewhere in these Bylaws.

h. The secretary-treasurer shall serve a one-year term as an alternate councillor. A candidate is not prohibited from running for secretary-treasurer and for an elected term as councillor in the same election at the same meeting or on the same written ballot without a meeting of the membership as specified in Article X of these bylaws. If the individual elected secretary-treasurer is elected councillor in the same election at the same meeting or on the same written ballot without a meeting of the membership as election to secretary-treasurer, the individual elected secretary-treasurer will serve the full two-year term as a councillor while also serving as secretary-treasurer for a one year term except as specified elsewhere in this section. If the individual elected secretary-treasurer is serving also elected to serve a two-year term as an elected councillor and is subsequently elected to an office with ex officio service as a councillor, the second year of the elected term as councillor will be vacated and filled in accordance with these bylaws. If the individual elected secretary-treasurer has a second year remaining in an a previously elected term as councillor, then the individual elected secretary treasurer will serve a one-year term as a councillor while secretary-treasurer.

Section 6. The duties of the immediate past president shall be as follows:

a. The immediate past president shall chair the nominating committee.

b. The immediate past president shall perform such duties as may be prudent and necessary as determined by the Board of Directors.

c. The immediate past president shall serve a one-year term as councillor.

Section 7. Any officer may be removed from office by a three-quarters vote of the members of the same body authorized to elect the officer voting at any meeting of the Chapter membership. A petition for such a removal must be signed by no less than a third of the number of members voting at the meeting in which the officer was elected or voting by written ballot without a meeting of the membership as specified in Article X of these bylaws.

Section 8. Any officer may resign at any time by giving written notice to the president or to the Board of Directors. Such resignation shall take effect at the time specified therein, or if no time is specified, at the time of acceptance thereof as determined by the president or the Board.

Section 9. Vacancies which occur in the office of president-elect and secretary-treasurer for any reason other than expiration of term of office shall be filled by a majority vote of the Board of Directors for the unexpired term only.

ARTICLE VIII
Councillors

One councillor to the College, and one additional councillor for each additional 100 members of the Chapter, shall be elected by the Chapter to a two-year term; the president, immediate past president, and president-elect shall serve ex-officio as councillors with terms of one year each. The secretary-treasurer shall serve ex-officio as an alternate councillor with a term of one year or as a councillor as governed by Article VII, Section 5 of these bylaws. The Chapter shall elect alternate councillors (to serve one-year terms) who will be available for seating if a councillor or the secretary-treasurer is not present. Election of councillors and alternates shall be by plurality vote of those members voting at the annual meeting of the Chapter or voting by written ballot without a meeting of the membership as specified in Article X of these bylaws (with the highest vote-getters being elected to the available positions). Alternate councillors elected in this manner shall be designated first alternate councillor, second alternate councillor, third alternate councillor,
etc. as determined by the decreasing number of votes they received during the election after the positions for councillors are filled. Those elected assume their roles as councillors and alternate councillors at the conclusion of the meeting at which the election occurs or the conclusion of the first annual meeting after an election by written ballot without a meeting of the membership. If necessary, the term of one or more councillors may be adjusted to assure staggered terms. Councillors and alternate councillors may serve unlimited consecutive terms. Vacancies that occur in councillor positions other than by recall removal shall be filled sequentially by the alternate councillors starting with the secretary-treasurer and then the first alternate councillor, etc. Prior to the Council meeting, the Board of Directors may appoint additional members to serve as alternate councillors as needed. At the Council meeting, the president (or in the president’s absence, any member of the executive committee or the chapter executive director) may propose members to be credentialed as councillors/alternates as needed.

**Section 1.** If the Chapter is allotted an additional councillor or councillors by the College due to growth of the Chapter after the annual elections, then the secretary-treasurer followed by the first alternate councillor, etc. shall become the additional councillor(s) until the next annual election.

**Section 2.** The duties of the councillors shall be to attend the meetings of the Chapter (as governed by Article V of the Chapter bylaws), the Chapter Board of Directors (as governed by Article VI of the Chapter bylaws), and the Council of the College (as governed in Article VII of the College bylaws), and to represent the Corporation there at.

**Section 3.** A councillor may be removed from office by a three-quarters vote of the members voting at the annual meeting of the Chapter membership. A petition for such a removal (recall) must be signed by no less than a third of the number of members voting at the meeting in which the councillor was elected or voting by written ballot without a meeting of the membership as specified in Article X of these bylaws. A vacancy created by recall removal shall be filled by majority vote of the members voting at the meeting at which the recall removal occurs. Nominations for a councillor vacancy created by a recall removal shall be accepted from the floor.

**ARTICLE IX**

**Committees**

The president may appoint such committees as he or she deems necessary.

**Section 1.** The Executive Committee shall consist of the president, president-elect, immediate past president and the secretary-treasurer and may conduct such business as arises between meetings of the Board. Such actions shall be ratified at the next Board meeting.

**Section 2.** The president shall appoint annually a Nominating Committee to be chaired by the immediate past president (with additional voting members to be the president, president-elect and two other members of the Board of Directors). It shall be its duty to present to the members at a meeting thereof, or by written ballot without a meeting of the membership as specified in Article X of these bylaws, one or more nominations, for the occurrence of specific open positions, for the offices of president-elect, secretary-treasurer, for the Board of Directors, and for councillors. The report of the Nominating Committee shall be published or distributed at least 30 days prior to the election meeting or the dissemination of the written ballot without a meeting of the membership as specified in Article X of these bylaws.

**ARTICLE X**

**Voting Procedures**

**Section 1.** Voting by the membership on any matter, including other than the election of directors, officers, or councillors, is to be conducted at the annual meeting of the Chapter membership or at another meeting of the membership as determined by the Board of Directors as specified in Article V of these bylaws. Election by the membership of officers, directors, and councillors may be conducted at the annual meeting of the Chapter membership or by written ballot without a meeting of the membership if authorized by the Board or Directors. The Board of Directors
shall determine the nominating and voting procedures in conjunction with other applicable portions of these bylaws. Absentee ballots, except in the case of elections conducted by written ballot without a meeting of the membership, are to be provided to the membership at least 30 days prior to the annual meeting and must be received in the Chapter offices at least two days prior to the annual meeting. A member may rescind his or her absentee ballot for the meeting to which the absentee ballot applies and may then participate in any voting that may take place. Floor nominations are not permitted at the annual meeting.

Section 2. Elections and votes specified in this Article may be conducted by electronic means, including elections by written ballot without a meeting of the membership, in accordance with the North Carolina Nonprofit Corporation Act and in a manner specified by the Board of Directors. In the case of elections by electronic means, written ballots in non-electronic format shall be provided to members who request them in accordance with the procedures set forth by the Board of Directors. Proxy voting shall not be permitted under any circumstances except as required by law or by the Articles of Incorporation. The quorum for elections by written ballot without a meeting of the membership shall be 10% of the membership as specified on a record date fixed by the Board of Directors.

ARTICLE XI
Indemnification

The Chapter will, by resolution of the Board of Directors, provide for indemnification by the Chapter of any and all of its directors or officers or former directors or officers against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding, in which they or any of them are made parties, or a party, by reason of having been directors or officers of the Chapter, except in relation to matters as to which such director of officer or former director or officer shall be adjudged in such action, suit, or proceeding to be liable for negligence or misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability for negligence or misconduct.

ARTICLE XII
Approval of Bylaws and Amendments

Section 1. These bylaws shall not be become effective until approved by the Board of Directors of the College.

Section 2. These bylaws may be amended by a two-thirds vote of the membership present at a meeting of the Chapter, provided that the proposed amendments have been distributed to the membership of the Chapter at least thirty (30) days prior to the meeting. Whenever the Bylaws of the College are amended in a manner that requires (as specified in the Bylaws of the College) revision of the Chapter bylaws, the Chapter Board of Directors shall have the power to amend the Chapter bylaws, without a vote of the membership, to the degree necessary to comply with Bylaws of the College.

Section 3. Amendments to these bylaws shall be submitted in writing to the College, by registered mail, return receipt requested, no later than 30 days following the adoption of such amendments. No amendment shall be of any force or effect until it has been submitted to and reviewed by the Board of Directors of the College, provided, however, that such amendment shall be considered to be approved if the Board of Directors fails to give written notice of its objection thereto within ninety (90) days following receipt.

Section 4. These bylaws must at all times be consistent with the Bylaws of the College. Should the Bylaws of the College be changed in such a manner as to render these bylaws inconsistent therewith, then these bylaws shall be amended immediately to eliminate said inconsistency.

Section 5. The Chapter adopted the latest revision of these current bylaws on June 19, 2010 June 16, 2012. Revised: June 25, 2005 June 19, 2010
North Carolina College of Emergency Physicians

2013 Elections

Election Rules:
• Regardless of the method of voting, you must vote for the specified number of candidates for each position. *Ballots submitted without the correct number of votes for each position will be voided.*
• Your NCCEP membership must be current (dues paid through ACEP).

For Absentee Ballots:
• You may fax your absentee ballot to: (919) 882-1563.
• You may mail your absentee ballot to: Post Office Box 12946, Raleigh, NC 27605.
• Absentee ballots must include your name and address.
• Absentee ballots must be received no later than 5 pm on June 4, 2013, to be considered.
• If you are unsure if you will be able to cast your ballot at the annual meeting, complete the absentee ballot. Your absentee ballot will be pulled if you are present and vote at the annual meeting.

Note:
• All new NCCEP Board members must sign the ACEP Member Expert Witness Reaffirmation Statement.
• All NCCEP Councillors are expected to attend, at a minimum, the September meeting and one additional Board meeting per year. Councillors may attend in person or participate by phone.

President-Elect (vote for 1 candidate)
☐ Abhi Mehrotra, MD
☐ _______________________________

Secretary-Treasurer (vote for 1 candidate)
☐ Bret Nicks, MD
☐ _______________________________

ACEP Councillor (vote for 3 candidates)
☐ Matthew Bitner, MD
☐ Charles Henrichs, MD (I)
☐ Keia V.R. Hewitt, MD
☐ Michael Utecht, MD (I)
☐ _______________________________
☐ _______________________________
☐ _______________________________

Board of Directors (vote for 5 candidates)
☐ Matthew Bitner, MD (I)
☐ Jeff Klein, MD (I)
☐ Eric Maur, MD
☐ Sankalp Puri, MD
☐ Jennifer Raley, MD (I)
☐ _______________________________
☐ _______________________________
☐ _______________________________
☐ _______________________________
☐ _______________________________

* (I) = Incumbent

Name __________________________________________________________________________________
Address __________________________________________________________________________________
Moved?
Be sure to send us your new email and snailmail address.
EPIC newsletter available on-line at www.nccep.org