

# September 11<sup>th</sup>, 2001

The terrorist attack on New York's World Trade Center.

It is important that we all join together as a whole to continue to show our  
Support and respect for our fallen Firefighters, Police and EMS personnel involved in

This tragic incident

## Appointment of New EMS Medical Director Jeff Barnard, Executive Director OMD

On July 3<sup>rd</sup>, the Pinellas County Medical Control Board (MCB) *recommended* Dr. John McPherson to the Board of County Commissioners (BCC) for the position of EMS Medical Director. On the evening of July 17<sup>th</sup> the BCC, acting as the Pinellas County EMS Authority *appointed* Dr. John McPherson to the position of Medical Director. The appointment was to become effective immediately.

### Dr. McPherson's Background:

Dr. McPherson is married and currently resides in Brevard County, Florida. He is an emergency medicine physician who is currently working at both Holmes Regional Medical Center Emergency Department and Palm Bay Community Hospital Emergency Department since 1991. He received his Doctorate in Medicine at the University of Pittsburgh in Pittsburgh, PA as well as his Masters in Public Health. He is currently working on his Masters in Business from Florida Institute of Technology. He did his residency at the University of Florida Health Science Center in Jacksonville, Florida where he also served as Chief Resident for a year.

## Today's EMS

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Dr. McPherson is actively making arrangements to relocate to Pinellas County, Florida. He will begin his first On-Line Medical Control shifts in September as MD-1. The OMD has already communicated this change to the EMS infrastructure including the availability of his Curriculum Vitae (CV) on the **Medcontrol.com** web site. Once we settle in with Dr. McPherson's new appointment, the office anticipates having a dinner reception and outgoing farewell for Dr. Pettyjohn.

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**VISIT OMD's WEBSITE at [www.medcontrol.com](http://www.medcontrol.com)**

The Office of the Medical Director is continuing to update and provide clinical information to the healthcare team through the Internet. We encourage each clinician and administrator who has access to the Internet to join us in this endeavor by filling out a simple user application found on the "Members" page on the site.

The information and the data posted in this area will not be available to individuals outside the EMS system. So far, the information posted has proven quite beneficial to providers and individual clinicians. Please join the other **246 members!**

### Information posted so far:

- The most up to date equipment inspection forms used within the EMS system
- Various operational forms
- CME calendars
- The Medical Operations Manual with Acrobat Reader
- FREE EMS screen saver
- The meeting minutes of various EMS constituent groups
- Current issues of the "Today's EMS" newsletter
- A new and more powerful site search engine has been installed

- You can retrieve a list of documents with Keywords or phrases
- Other web site links important to our system's operation

We continue to have many ideas for this area; please continue to give us your comments and feedback. Email us at [cyberomd@aol.com](mailto:cyberomd@aol.com) and let us know what you'd like to see on our site.

## **Medicare and Mileage Documentation**

*by Jade E. Brown, Sunstar PBS Manager*

Documentation serves many purposes for healthcare organizations. Principally, it serves to memorialize the patient encounter and to convey all aspects of that encounter to other healthcare professionals caring for the patient. It also provides a source for continuous quality improvement, regulatory compliance programs, governmental reporting, research requirements, risk management and reimbursement functions.

Our current healthcare environment demands a higher quality of documentation from ambulance providers. Documentation standards have assumed a new importance, as limited healthcare resources have become a major issue. It is critical that we document all aspects of the patient encounter accurately for clinical and reimbursement purposes.

Medicare covers ambulance transportation if certain criteria are met. Basically, three coverage requirements must be met before payment may be considered.

1. The patient must be transported in an appropriate vehicle with the appropriately trained crew
2. The origin and destination must be approved by Medicare
3. The patient must have a medical condition that makes riding in an ambulance as opposed to other means of transportation medically necessary. For an ambulance to be deemed reasonable and necessary, the patient's condition must be such that any other method of transportation would be detrimental to the patient's health. If another method of transportation could be used without endangering the patient's health, Medicare reimbursement cannot be made, even if other means of transportation was not available.

As a general rule, Medicare covers local transportation to the nearest appropriate facility which is equipped to provide the care needed for the illness or injury involved. For hospital services, it means that a medical specialist is available to provide the necessary treatment required to treat the patient's condition. The fact that a particular physician does not have staff privileges in a hospital is not a consideration in determining "appropriate facilities". Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or specialist does not qualify under the definition of appropriate facilities.

An institution is not considered an appropriate facility if there is no bed available. Medicare will presume that there are beds available at the local institutions unless the ambulance provider furnishes evidence that the institution did not have a bed available at the time of the transport. That's one important reason why the County has the Office of the Medical Director track hospital services, diversions, bypass, and closures, etc.

Occasionally, the institution to which the patient is initially transported may not have adequate facilities to provide subsequent care required by the patient. An example of this is when a chest pain patient who is delivered to the closest emergency department now must be transported to another hospital STAT (heart catheterization).

Therefore, the patient must be transported and admitted to a second institution that does have appropriate facilities. In such cases, the services may be covered, provided the institution to which the patient is transferred and admitted to is in the same locality, and that all other medical necessity coverage conditions are met. If the patient is transported past an appropriate facility or institution, the mileage beyond the closest appropriate facility is a non-covered service and Medicare requires the additional mileage to be billed to the patient.

If a patient is transported for any non-medical reason, (e.g. to be closer to family members or to receive services from his/her own personal physician) the claim must be clearly noted and Medicare will deny all services. Under this circumstance, the patient may be billed for all services provided.

In the circumstances mentioned above, Medicare requires the service provider to notify the patient prior to transport of situations where coverage may be denied. This notification is a federal regulation with which EMS/ambulance services must comply.

Ambulance service is an integral and essential part of the healthcare continuum. Sunstar EMS was built on the foundation of providing our citizens with reliable ambulance services and excellence in patient care. Delivered with fiscal responsibility.

Complete and precise documentation serves to strengthen that foundation. Sunstar personnel are committed to providing accurate clinical and billing information to better serve our customers.

**Sources: First Coast Service Options, Inc. Medicare Guidelines for Ambulance Services Education and Outreach Dept. Specialty Book, April 2000; American Ambulance Association Documentation Guide, January 2001**

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### Vasopressin for VF and Pulseless VT

Vasopressin is a potent vasoconstrictor that has found new use in resuscitation. You may know that it's main use before was controlling variceal bleeding. The drug works differently than epinephrine (it is not a catecholamine) that works directly on smooth muscle V1 receptors so it theoretically does not have the negative effects of epinephrine such as increased myocardial oxygen demand. Vasopressin (a.k.a. Antidiuretic hormone or Pitressin) can be used in place of epi in VF and pulseless VT as a one-time dose of 40 units IV. Its half-life is between 10 and 20 minutes. After the first dose of Vasopressin, you continue with your antiarrhythmatics and defibrillation as before. After 10 minutes, you may return to epi and dose at (1mg IV q3-5 minutes).

In several small studies, Vasopressin was found superior to epinephrine in survival to hospital rates (not in survival to discharge rates). It looks promising as a new treatment for VF/Pulseless VT, but only time and additional studies will tell how beneficial it will be.

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### Medication Questions

**Q:** If Epinephrine and Lidocaine have been administered via the endotracheal tube to a cardiac arrest patient without IV access and IV access subsequently becomes available, should Amiodarone be given as then next antiarrhythmic?

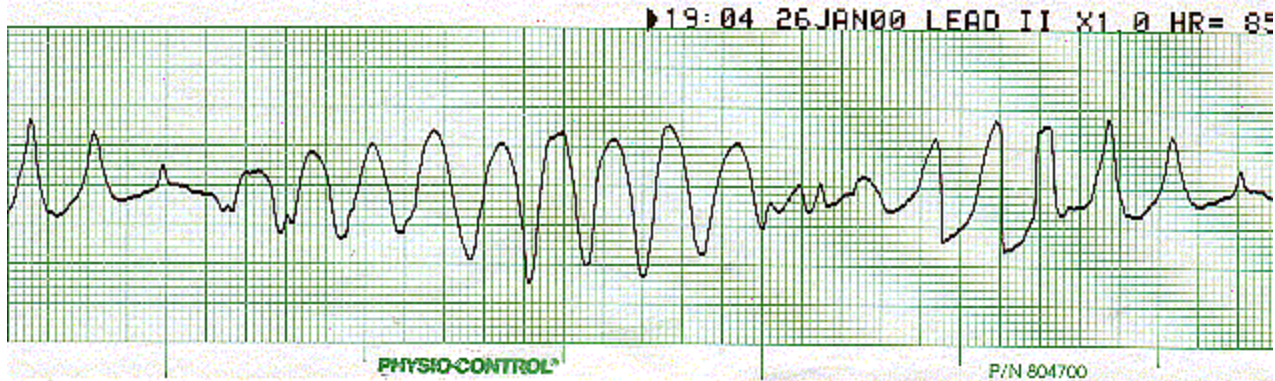
**A: Yes. The American Heart Association states that after the initial three stacked shocks and either vasopressin or epinephrine have been given,**

Continued on next page

“consider antiarrhythmics” (Amiodarone, Lidocaine, Magnesium, Procainamide).

The AHA does not specifically state that one drug must be given first. However, the AHA identifies Amiodarone as a Class IIB (acceptable; fair supporting evidence) and identifies Lidocaine as Class Indeterminate (not recommended; not forbidden). Magnesium is recommended as Class IIB for hypomagnesemic state and Procainamide is recommended as a Class IIB only for intermittent/recurrent VT/VF. Keep in mind that Indeterminate recommendations may be altered with new information from ongoing clinical trials.

1Circulation. Guidelines 2000 for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Vol 102, no 8, p 1120-124, 1147; Aug 22, 2000



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