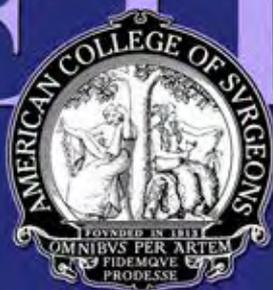


BULLETIN

AMERICAN COLLEGE OF SURGEONS



September 2003
Volume 88, Number 9

Coding for trauma services

Initial inpatient consult

99255

Critical care

99254

Subsequent hosp. moderate

99291

49000

CPT descriptor

99238

99232

44602

Total medicare payment

32110

CPT code



BULLETIN

AMERICAN COLLEGE OF SURGEONS



SEPTEMBER 2003
Volume 88, Number 9

FEATURES

-
- Trauma services: Coding for optimal practice management** **12**
Charles D. Mabry, MD, FACS
-
- Program increases medical student interest in surgical careers** **25**
Michael W. Mulholland, MD, PhD, FACS
-
- Governors' Committee on Chapter Activities: Update** **28**
Lester W. Johnson, MD, FACS
-
- Statement on safety belt laws and enforcement** **32**

DEPARTMENTS

-
- From my perspective** **3**
Editorial by Thomas R. Russell, MD, FACS, ACS Executive Director
-
- Dateline: Washington** **6**
Division of Advocacy and Health Policy
-
- What surgeons should know about...** **8**
The Medicare prescription drug deliberations
Jennifer Razor, JD
-
- Keeping current** **34**
What's new in ACS Surgery: Principles and Practice
Erin Michael Kelly
-
- Socioeconomic tips of the month** **37**
Advice from an ACS coding course instructor
Mary LeGrand, RN

NEWS

-
- College continues efforts in AMA House of Delegates** **39**
Jon H. Sutton
-
- Official notice: Annual Meeting of Fellows, American College of Surgeons** **39**
-

Stephen J. Regnier
Editor

Linn Meyer
*Director of
Communications*

Diane S. Schneidman
Senior Editor

Tina Woelke
Graphic Design Specialist

Alden H. Harken,
MD, FACS
Charles D. Mabry,
MD, FACS
Jack W. McAninch,
MD, FACS
Editorial Advisors

Tina Woelke
*Front cover design
Back cover design*

About the cover...

This month's cover story, page 12, provides surgeons with a crash course in understanding the whirl of evaluation and management services and other *Current Procedural Terminology* codes that surgeons should use when billing for the provision of trauma care. The author of the article, Charles D. Mabry, MD, FACS, offers six lessons in optimal coding for trauma services and four vignettes that demonstrate how these precepts could be applied.

Front cover photo © Craig Brewer/Photodisc/Getty Images. Back cover photo by Chuck Giorno Photography.

Bulletin of the American College of Surgeons (*ISSN 0002-8045*) is published monthly by the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611. It is distributed without charge to Fellows, to Associate Fellows, to participants in the Candidate Group of the American College of Surgeons, and to medical libraries. Periodicals postage paid at Chicago, IL, and additional mailing offices. POSTMASTER: Send address changes to Bulletin of the American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211. Canadian Publications Agreement No. 40035010. Canada returns to: Station A, PO Box 54, Windsor, ON N9A 6J5.

The American College of Surgeons' headquarters is located at 633 N. Saint Clair St., Chicago, IL 60611-3211; tel. 312/202-5000; toll-free: 800/621-4111; fax: 312/202-5001; e-mail: postmaster@facs.org; Web site: www.facs.org. Washington, DC, office is located at 1640 Wisconsin Ave., NW, Washington, DC 20007; tel. 202/337-2701, fax 202/337-4271.

Unless specifically stated otherwise, the opinions expressed and statements made in this publication reflect the authors' personal observations and do not imply endorsement by nor official policy of the American College of Surgeons.

©2003 by the American College of Surgeons, all rights reserved. Contents may not be reproduced, stored in a retrieval system, or transmitted in any form by any means without prior written permission of the publisher.

Library of Congress number 45-49454. Printed in the USA. Publications Agreement No. 1564382.

ACS Insurance Program: Update on major medical products	40
At Clinical Congress: AWS conference to consider emotional intelligence	41
Rural surgeons meeting to be held during Clinical Congress	41
Disciplinary actions taken	42
Hernia operations to be televised live at Clinical Congress	42
NTDB™ data points: The critical aspect of blunt trauma <i>by Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS</i>	43
Practice management consultation available during Congress	45
SAGES/SSAT to present symposium on laparoscopic colectomy	45
Revised medical student guide to residency training now online	46
Computerized drug reference guides available to ACS Fellows	46
Meeting for senior Fellows to be held during Congress	46
Bariatric surgery primer to be featured at Clinical Congress	47
Residency Assist Page debuts on ACS Web site	48
College works to address expert witness issues	48
General sessions to address liability and patient safety issues	50
Highlights of the ACSPA Board of Directors and the ACS Board of Regents meeting, June 6-7, 2003 <i>Paul E. Collicott, MD, FACS</i>	51
Trauma meetings calendar	56

The American College of Surgeons is dedicated to improving the care of the surgical patient and to safeguarding standards of care in an optimal and ethical practice environment.

Officers and staff of the American College of Surgeons

Officers

Richard R. Sabo, MD, FACS, *Bozeman, MT*
President
Amilu S. Rothhammer, MD, FACS, *Colorado Springs, CO*
Second Vice-President
John O. Gage, MD, FACS, *Pensacola, FL*
Secretary
John L. Cameron, MD, FACS, *Baltimore, MD*
Treasurer
Thomas R. Russell, MD, FACS, *Chicago, IL*
Executive Director
Gay L. Vincent, CPA, *Chicago, IL*
Comptroller

Officers-Elect (take office October 2003)

Claude H. Organ, Jr., MD, FACS, *Oakland, CA**
President
Anna M. Ledgerwood, MD, FACS, *Detroit, MI*
First Vice-President
Murray F. Brennan, MD, FACS, *New York, NY*
Second Vice-President

Board of Regents

Edward R. Laws, MD, FACS, *Charlottesville, VA*
Chair*
Edward M. Copeland III, MD, FACS, *Gainesville, FL*
Vice-Chair*
Barbara L. Bass, MD, FACS, *Baltimore, MD*
L. D. Britt, MD, FACS, *Norfolk, VA*
William H. Coles, MD, FACS, *Chapel Hill, NC*
A. Brent Eastman, MD, FACS, *La Jolla, CA*
Richard J. Finley, MD, FACS, *Vancouver, BC*
Josef E. Fischer, MD, FACS, *Boston, MA*
Alden H. Harken, MD, FACS, *Oakland, CA**
Gerald B. Healy, MD, FACS, *Boston, MA*
Charles D. Mabry, MD, FACS, *Pine Bluff, AR*
Jack W. McAninch, MD, FACS, *San Francisco, CA**
Mary H. McGrath, MD, FACS, *San Francisco, CA**
Robin S. McLeod, MD, FACS, *Toronto, ON*
Carlos A. Pellegrini, MD, FACS, *Seattle, WA*
John T. Preskitt, MD, FACS, *Dallas, TX*
Ronald E. Rosenthal, MD, FACS, *Wayland, MA*
Richard R. Sabo, MD, FACS, *Bozeman, MT**
Maurice J. Webb, MD, FACS, *Rochester, MN*
*Executive Committee

Board of Governors/Executive Committee

J. Patrick O'Leary, MD, FACS, *New Orleans, LA*
Chair
Timothy C. Fabian, MD, FACS, *Memphis, TN*
Vice-Chair
Julie A. Freischlag, MD, FACS, *Baltimore, MD*
Secretary
Steven W. Guyton, MD, FACS, *Seattle, WA*
Mary Margaret Kemeny, MD, FACS, *Jamaica, NY*

Rene Lafreniere, MD, FACS, *Calgary, AB*
Courtney M. Townsend, Jr., MD, FACS, *Galveston, TX*

Advisory Council to the Board of Regents (Past-Presidents)

W. Gerald Austen, MD, FACS, *Boston, MA*
Oliver H. Beahrs, MD, FACS, *Rochester, MN*
John M. Beal, MD, FACS, *Valdosta, GA*
Harvey W. Bender, Jr., MD, FACS, *Nashville, TN*
George R. Dunlop, MD, FACS, *Worcester, MA*
C. Rollins Hanlon, MD, FACS, *Chicago, IL*
R. Scott Jones, MD, FACS, *Charlottesville, VA*
M. J. Jurkiewicz, MD, FACS, *Atlanta, GA*
LaSalle D. Leffall, Jr., MD, FACS, *Washington, DC*
Lloyd D. MacLean, MD, FACS, *Montreal, QC*
William H. Muller, Jr., MD, FACS, *Charlottesville, VA*
David G. Murray, MD, FACS, *Syracuse, NY*
David C. Sabiston, Jr., MD, FACS, *Durham, NC*
Seymour I. Schwartz, MD, FACS, *Rochester, NY*
George F. Sheldon, MD, FACS, *Chapel Hill, NC*
G. Tom Shires, MD, FACS, *Las Vegas, NV*
Frank C. Spencer, MD, FACS, *New York, NY*
Ralph A. Straffon, MD, FACS, *Shaker Heights, OH*
James C. Thompson, MD, FACS, *Galveston, TX*

Executive Staff

Executive Director: Thomas R. Russell, MD, FACS
Division of Advocacy and Health Policy:
Cynthia A. Brown, Director
American College of Surgeons Oncology Group:
Samuel A. Wells, Jr., MD, FACS, Group Chair
Communications: Linn Meyer, Director
Division of Education:
Ajit K. Sachdeva, MD, FACS, FRCS, Director
Executive Services: Barbara L. Dean, Director
Finance and Facilities: Gay L. Vincent, CPA, Director
Human Resources: Jean DeYoung, Director
Information Technology: Howard Tanzman, Director
Journal of the American College of Surgeons:
Wendy Cowles Husser, Executive Editor
Division of Member Services:
Paul E. Collicott, MD, FACS, Director
Division of Research and Optimal Patient Care:
R. Scott Jones, MD, FACS, Director
Cancer:
David P. Winchester, MD, FACS, Medical Director
Trauma:
David B. Hoyt, MD, FACS, Medical Director
Executive Consultant:
C. Rollins Hanlon, MD, FACS

From my perspective

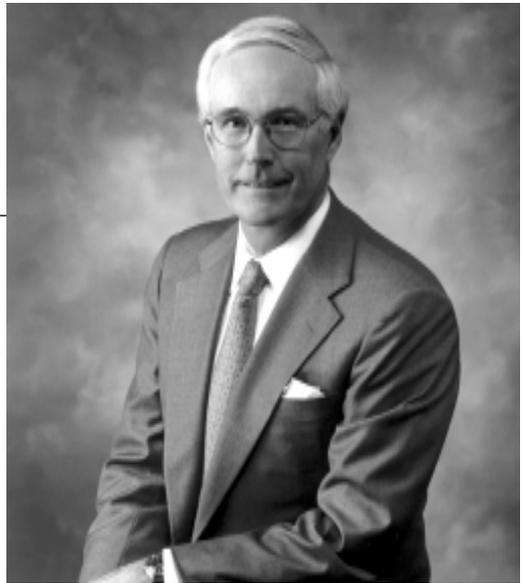
How we train surgeons of the future is one of the most critically important issues currently facing our profession. Yet, whenever surgeons begin to think about changing our existing educational system, all sorts of emotions generally emerge. Some individuals feel that all aspects of their training were absolutely necessary and that the demands placed on them and the commitment of time they were required to make were essential to attaining the goals of acquiring knowledge and technique and of developing maturity and judgment. Other surgeons hold just the opposite point of view and believe that the surgical training of the past was too steeped in tradition, was insensitive, and was overbearing. Thus, the topic of change engages surgeons with widely differing views.

Blue ribbon committee

Recently, the American Surgical Association (ASA) convened a blue ribbon committee to make major recommendations regarding surgical education and training for the future. Staffed by the College's Division of Education, the committee includes representatives of the ASA, the American Board of Surgery, and the American College of Surgeons. This group is one of many that are now gathering to enter into a dialogue about this pivotal topic.

This issue is of great importance because the trainees of today will be the practicing surgeons of tomorrow, and the landscape of practice is one of increasing accountability and responsibility. The emphasis on safety, quality improvement, and the need to eliminate errors in our hospital systems is of paramount importance. A young surgeon entering practice these days must be aware of these demands and must be mature enough to meet the challenges that in-depth scrutiny will levy on practitioners in the future.

All of the surgical specialties face the same issues: how to change their curriculum, how to do so within the time allotted, and how to prepare surgeons to intervene when nonsurgeons provide surgical care. Thus, the surgical specialties are attempting to determine the best way to introduce the core competencies into surgical training, while allowing for the maturation of the individual in the specialty and the ultimate outcome of appropriate board certification.



“Despite the many and various challenges surgeons face today we must not forget the fundamental importance of restructuring our surgical education curriculum to meet the ever-increasing and demanding needs of young trainees, the public, and regulatory bodies.”

Curriculum of the future

Because of the impact of these issues, groups such as the blue ribbon committee are meeting to determine what the curriculum of the future will be. It should be noted that several surgical specialties have developed curriculums over time; however, residents' core educational experiences were based on what came through the hospital on certain days. If the program was long enough, trainees would see a broad spectrum of the disease processes over many years.

New challenges

Training has also been affected by the new regulations enforced by the Accreditation Council for Graduate Medical Education on July 1 of this year. Work hours are now limited to 80 hours per week, with a need for time off after a specific number of hours have been spent in the hospital. Other issues that need to be addressed in the future by all of the surgical specialties are: how long will the residency last, and how many certificates will the learner be allowed to earn?

In the foreseeable future, I believe significant changes will occur in the recertification process and in how surgeons maintain their certification. Their cognitive and technical skills are likely to be tested, not to mention the potential for physical examinations and/or drug screening, as I have alluded to in previous columns.

An essential concept of training will be to interest young medical students in the various surgical disciplines. That does not necessarily mean that we have to clone medical students so that they will be exactly like we were. Rather, we need to introduce them to the broad spectrum of experience a surgical career can provide and the pleasures that career can offer its practitioners. If medical students can become interested in the cognitive and technical intrigue of a surgical career, certain educational experiences may be introduced in the last year of medical school and continued through the first year of residency training. A core curriculum for everyone interested in a career in surgery should be developed to include: the basic tenets of wound healing, infection control, and fluid and electrolyte balance, and basic technical surgical skills, such as insertion of a subclavian catheter, tracheostomy, and cardiopulmonary resuscitation.

What we're doing

The College is interested in developing such a curriculum in cooperation with the various surgical specialties. The individual surgical boards would develop the remainder of the core based on their specialty and the subspecialty interest of the learner.

I believe that the members of the blue ribbon committee should be applauded for their hard work, and I encourage all of the specialties to work together in this important exercise on the future

of surgical education. The blue ribbon committee also has established subcommittees to look at the structure of surgical training, resident work hours and lifestyles, medical student issues, surgical practice issues, and relationships with other groups.

This is a dynamic time in American medicine and surgery. Despite the many and various challenges surgeons face today, we must not forget the fundamental importance of restructuring our surgical education curriculum to meet the ever-increasing and demanding needs of young trainees, the public, and regulatory bodies.

As always, I welcome your feedback and ideas with regard to this important issue.



Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.



***Only GS 02 and GS 10 will be available after September 30, 2003. Please complete CME test for other sessions prior to this date.**

CME online

**Web casts of select
General Sessions**

The Division of Education of
the American College of Surgeons
has made eight General Sessions
available online at:
www.facs-ed.org/

Spring Meeting 2003

***GS 02:** A Town Meeting:
Changes in Surgical Practice—
Getting Ahead of the Game

Clinical Congress 2002

GS 08: New Technology:
What's Proven, What's Not

***GS 10:** Patient Safety **FREE OF CHARGE**

GS 21: Damage Control in Trauma
and Emergency Surgery:
New Applications

GS 23: Programa Hispanico
(Offered in English and Spanish):

- Surgical Management of Breast Cancer
- Status of Liver Transplantation in Latin America
- Bariatric Surgery Update
- Management of Pancreatic Cancer

GS 33: The Ethics of
Entrepreneurialism
in Surgery

GS 34: Should Axillary Dissection
Be Abandoned?

GS 40: Management of Metastatic
Disease of the Liver

- Each session is offered separately.
- Printable written course transcripts.
- Audio of sessions.
- Video of speakers' presentations.
- Post-test and evaluation.
- Printable CME certificate upon successful completion.

For more information, contact
Dawn Pagels at dpagels@facs.org.

Dateline Washington

prepared by the Division of Advocacy and Health Policy

GAO reports on medical liability crisis

In July, the General Accounting Office (GAO) released a report titled *Medical Malpractice Insurance: Multiple Factors Have Contributed to Increased Premium Rates*. While the report indicated that a variety of factors have contributed to increasing premium rates around the nation, the GAO found that “losses on medical malpractice claims—which make up the largest part of insurers’ costs—appear to be the primary driver of rate increases in the long run.”

In March, the House of Representatives passed medical liability reform legislation, while the Senate voted against considering a similar bill in July. Surgeons are urged to contact their senators using the College’s Web-based Legislative Action Center at <http://capwiz.com/facs.home/>, to request their support for medical liability reform. Surgeons are also encouraged to review and use the information provided in the College’s Medical Liability Reform Action Guide, at <http://www.facs.org/ahp/proliability.html>, as an aid in their communications with legislators.

Senate committee approves patient safety legislation

On July 23, the Senate Health, Education, Labor, and Pensions Committee unanimously approved S. 720, the Patient Safety and Quality Improvement Act of 2003. Similar to legislation that the House passed earlier this year, S. 720 would create a confidential, voluntary reporting system through which physicians could report information on errors to patient safety organizations (PSOs). The PSOs, in turn, would analyze these data and inform physicians and other providers about system changes that could prevent future harm to patients.

Recognizing that most errors result from systems failures rather than individual mistakes, the legislation is intended to change the current culture of blame. By allowing providers to report medical errors without the threat of lawsuits, it is anticipated that system failures can be identified and new protocols developed to prevent future mistakes. However, these new legal protections for patient safety data would not limit access to information currently available from other sources under existing law.

The full Senate is expected to consider the legislation when it reconvenes in September. To view the College’s letter endorsing S. 720, visit <http://www.facs.org/ahp/views/patsafety.html>.

CMS announces 2004 payment rate hikes

Medicare recently issued three regulations that provide payment increases for inpatient hospital, skilled nursing facility (SNF), and rehabilitation center care effective October 1, 2003. The Centers for Medicare & Medicaid Services (CMS) also issued a proposed notice predicting that hospital outpatient departments will be awarded a 3.8 percent increase in payments effective January 1, 2004. Details on the definite increases include:

- Hospital inpatient care payment rates will increase by 3.4 percent, or \$4.1 billion, with total payments reaching \$98 billion in fiscal year (FY) 2003. Medicare estimates that about \$1.8 billion of the hike is due to the payment increase and other policy changes; the remain-

College advises on quality measurement efforts

ing \$2.3 billion is due to increases in the case mix and inpatient services. Disregarding the outlier overpayments, urban hospitals will experience a 2.8 percent increase in payments and rural hospitals will receive a 5.4 percent hike.

- SNF care will receive a 3 percent annual update to its payment rate, along with an additional 3.26 percent increase to adjust for past underestimations of cumulative market basket forces. This increase in the market basket, or the cost of goods used in SNF care, has been underestimated since its inception in 1989. The two adjustments account for an estimated \$850 million more in payments for SNF stays.

- Inpatient rehabilitation hospitals will receive a 3.2 percent increase in payments, for a total increase of \$187.3 million.

These payment increases stand in stark comparison to predicted 2004 payments for physician services, which will experience an estimated 4.2 percent reduction in 2004 if current policies remain unchanged. Medicare reform legislation that the House passed would change this to a positive 1.5 percent update for both 2004 and 2005. The Senate Medicare reform bill, however, does not contain this language. Surgeons are encouraged to contact their legislators through the College's Legislative Action Center (<http://capwiz.com/facs/home/>) and urge them to stop the scheduled payment cuts and ensure a positive update for 2004.

To read more about the planned payment increases for these facility providers go to <http://www.cms.hhs.gov> to view the applicable press releases.

Aaron Fink, MD, FACS, of Atlanta, GA, has been nominated to represent the College on the Data Integrity Committee of the National Quality Forum (NQF). He joins another College representative, Alfred Cohen, MD, FACS, who represents surgery in the discussions about the best way to measure and report the quality of cancer care.

The NQF brings together organizations representing the interests of consumers, purchasers, researchers, providers, and health plans to identify and determine which quality measures are appropriate for improving and reporting on the value of patient care. To date, the NQF has developed indicators of hospital and nursing home quality and has issued guidelines on safe practices, diabetes care, and serious reportable events. A number of these measures are being tested to determine if they could be used in developing quality-based "pay for performance" systems for physicians and hospitals.

The College continues to emphasize to regulators and payors the need to use risk-adjusted, evidence-based outcomes measures to evaluate quality of care.

What surgeons should know about...

The Medicare prescription drug deliberations

by Jennifer Razor, JD, Government Affairs Associate, Division of Advocacy and Health Policy

Even the most connected Washington insiders would be hard-pressed to make an accurate prediction about the fate of this year's Medicare prescription drug legislation. Although the issue remains cemented at the top of President George W. Bush's domestic agenda, the path to a Rose Garden signing ceremony is cluttered with roadblocks.

When both houses of Congress passed Medicare prescription drug legislation in July, the Prescription Drug and Medicare Improvement Act of 2003 (S.1) and the Prescription Drug and Medicare Modernization Act of 2003 (H.R.1), respectively, all bets were off. However, one certainty remains. Before the legislation makes its way to the President's desk, it must survive the conference committee and then one more vote in each body.

The conference committee is composed of 17 high-ranking members of the House and Senate. These 10 Republicans and seven Democrats are charged with merging the two bills to create just one piece of legislation costing less than \$400 billion to be voted on in identical form by both houses. Since mid-July these members of Congress have been meeting regularly to discuss the details of the two bills, which amount to more than 2,000 pages.

Negotiations are scheduled to wrap up sometime this month. To ensure the success of the bill, conferees will likely take one of two approaches. They will either craft a more moderate bill, borrowing many provisions from the Senate version, in an attempt to attract Democratic, Republican centrist, and leadership votes in both chambers. Or, under an alternative scenario, they will embrace the House bill and try to get the legislation through

the Senate with 51 Republican votes or with 50 votes and a tie broken by Vice-President Dick Cheney.

Either way, surgeons should watch the committee's progress carefully. Many key provisions—including physician payment, coding standards, and self-referrals to specialty hospitals—will be up for discussion. And, until an agreement is reached, the resolution of these issues hangs in the balance.

Q. Does the legislation include provisions to prevent the predicted cut in physician payments?

A. The Centers for Medicare & Medicaid Services (CMS) projects another cut in physician payment next year. In a proposed rule published August 15, CMS projected a -4.2 percent update for 2004. CMS attributes this update reduction to increased volume and intensity of physicians' services and a lower real gross domestic product per capita than previously estimated—two figures that are incorporated into the complicated formula used to calculate annual updates to the Medicare fee physician schedule.

To prevent the cut, section 601 of the House bill aims to ensure future positive payment updates for physicians by providing at least a 1.5 percent increase for the next two years. While the Senate bill fails to expressly fix physician payments, S.1 includes two provisions, sponsored by Sen. Jon Kyl (R-AZ) and Sen. Arlen Specter (R-PA), respectively, which urge Con-

gress to fix the Medicare fee schedule problem to prevent additional cuts in physician payments.

The College strongly supports the House provision to provide positive updates, and the Division of Advocacy and Health Policy is working intensely to ensure its inclusion.

Q. How do the bills address coding?

A. As passed by the House, the legislation includes language that could replace the current *Current Procedural Terminology* (CPT) codes used in the Medicare fee schedule with ICD-10 codes. Section 942 of the House version clears the way for Department of Health and Human Services (HHS) Secretary Tommy Thompson to adopt ICD-10-PCS (a procedure coding system) and ICD-10-CM (a diagnosis coding system) as a standard within one year of the date of enactment of the bill. The Senate-passed version does not contain any references to ICD-10.

The College steadfastly opposes adoption of the new procedure coding system, because it would undercut one of the underlying purposes of Medicare modernization by increasing the regulatory burden that CMS imposes on physicians. In part, this legislation was intended to reduce the unnecessary burdens associated with the Medicare program—not to exacerbate them. The ICD-10 provision would dramatically increase the administrative hassles associated with coding for surgical services. Every physician will be forced to master 170,000 new procedure codes and a foreign vocabulary.

In addition, the transition to this standard would likely require a systemwide disruption to revise all resource-based relative value units (RVUs) used in Medicare's reimbursement methodology, another cost to the government that is also likely to complicate or delay physician payments. The fee schedule accounts for annual government expenditures of more than \$59 billion per year and is tied inextricably to the coding system for Part B services that is currently based, in part, on CPT. With a 17-fold increase in the number of codes, a massive upheaval in the physician payment system would occur. Further, the potential for inaccurate coding would increase exponentially, which could increase fraud and abuse concerns.

The College is working aggressively to prevent the replacement of CPT with ICD-10, arguing that the ICD-10 provision need not apply to physician services.

Q. Will the conferees discuss self-referrals to specialty hospitals?

A. The federal physician self-referral statutes, known as Stark I and Stark II, prohibit a physician from ordering services for Medicare patients from entities with which the physician has a financial relationship. Because S.1 and H.R.1 address this issue differently, the conferees will need to reach an agreement on the issue of self-referrals to specialty hospitals. Section 453 of S.1 would generally exclude specialty hospitals from the Stark II self-referral exemptions for hospitals. In contrast, section 505 of H.R.1 would provide for a one-year study of specialty hospitals.

Physician-friendly regulatory relief provisions in H.R.1

Extrapolation	Section 935(a)	Limit extrapolation to calculate amounts owed as repayment to the program only to cases in which a provider has a high claims error rate or in which documentation education efforts have failed to correct a problem.
Consent settlement	Section 935(a)(5)	Allow physicians additional time to submit information regarding claims in dispute before consent settlements are issued.
Evaluation and management (E/M) service documentation guidelines	Section 941	Establish a process and requirements for developing and testing new E/M code documentation guidelines.
Emergency Medical Treatment and Active Labor Act (EMTALA)	Section 944	Deem services furnished under the prudent layperson standard and according to EMTALA as medically necessary; notify hospitals and physicians when EMTALA investigations are closed; allow peer review organizations to review hospital and physician actions prior to an EMTALA compliance determination being made; modify the requirement for medical screening examinations for patients who do not request emergency department services; and establish an EMTALA advisory committee.
Written advice from contractors	Section 903(c)	Allow physicians who rely on written guidance from contractors to avoid sanctions or repayment requirements if that guidance is in error.
Advance Beneficiary Notices (ABNs)	Section 938	Require CMS to develop ABNs for certain categories of items and services.

The College is advocating closer examination of the relationship between these facilities and quality improvement before Congress acts with regard to the exclusion of specialty hospitals from the self-referral exception. H.R. 1 would appropriately direct the Medicare Payment Advisory Commission (MedPAC) to conduct a study to help answer some remaining questions about this issue. Pursuant to the House language, MedPAC would review the quality of care that

specialty hospitals provide, their impact on general acute care hospitals, the differences in the scope of services they provide, Medicaid use, and uncompensated care furnished, in addition to the concerns regarding excessive self-referrals.

The results of greater study of specialty hospitals would help Congress and the health care industry determine the best course of action regarding the self-referral ban. The College will continue to support more review of this area.

Q. What recommendations are the conferees likely to make regarding regulatory relief for physicians?

A. Both pieces of legislation offer modest reform of Medicare audit practices by guaranteeing physicians specific due process rights, including an equitable right of appeal. Specifically, they better target current Medicare education dollars to provide needed outreach and education to physicians and health care providers on the complexities of Medicare billing.

Although the College appreciates the reforms contained in both bills, the provisions included in the House bill would provide significantly more relief. The College has requested that the conferees adopt the provisions in H.R.1 that would result in regulatory reform in the following areas: extrapolation, consent settlement, evaluation and management (E/M) service documentation guidelines, Emergency Medical Treatment and Active Labor Act (EMTALA), written advice from contractors, and advance beneficiary notices. (See box, p. 10.)

Q. How will electronic prescribing be addressed?

A. Both S.1 and H.R. 1 address the issue of electronic prescribing in sections 121 and 101 respectively. The College is urging the conference committee to adopt the Senate language, which would require that HHS develop and adopt standards for transactions and data elements to enable the electronic transmission of medical information, including prescriptions, by January 1, 2006. In contrast, H.R. 1 would require that all prescriptions be written and transmitted electronically except in emergencies. The College is opposing the House provisions on the grounds that this mandate would create unrealistic technological and financial burdens for many surgeons.

Check the College's Web site, <http://www.facs.org>, for regularly updated information on these and other issues.

Surgeons are encouraged to contact their elected officials regarding any or all of these issues by using the College's Legislative Action Center at <http://capwiz.com/facs.home>. 

Trauma services: Coding for optimal practice management

by Charles D. Mabry, MD, FACS, Pine Bluff, AR



Initial inpatient consult

99255

Critical care

99254

Subsequent hosp. moderate

32M0

99291

44602

CPT code

49000

Total medicare payment

CPT descriptor

99238
99232

Trauma is a common condition treated regularly by most practicing surgeons of all specialties in all parts of the country. Many trauma centers have surgeons on staff who specialize solely in the care of the trauma patient, along with multispecialty trauma teams to help and assist. At the other extreme, a solo general surgeon often functions as the trauma surgeon, the intensivist, and even the triage officer in more rural areas. Trauma occurs with multiple simultaneous presentations to the emergency room at the most inopportune times, frequently in the dead of night. Proper attention to the coding aspects of patient care is essential, especially if the surgeon expects to be reimbursed fairly.

Trauma involves every organ system, and requires the medical as well as the surgical expertise of the attending surgeon. Thanks to modern diagnostic and therapeutic methods, trauma care has evolved, and an intensive care/nonoperative management mode is being used more frequently. Therefore, efficient coding of the care for trauma patients involves knowing about more than just the major surgical procedure codes. Full knowledge of the extent and application of evaluation and management (E/M) codes is essential for the surgeon caring for trauma patients. Therefore, it behooves surgeons who care for trauma patients, from the traumatologist to the solo general surgeon, to learn to use all of the coding tools available to ensure fair and adequate reimbursement for the services they provide.

In practice management audits performed across the U.S., we have found that surgeons (particularly general surgeons) typically undercode E/M visits, and underuse several important coding tools. This article reviews important aspects of these E/M codes, including the proper use of the critical care and consultation codes, of modifiers for coding during the global surgical period, and of the little-used but powerful "coordination/counseling guide" as a method of judging time for appropriate coding.

Finally, to borrow a phrase from the Advanced Trauma Life Support® Course (ATLS®), we will then "put this all together" and present four clinical trauma vignettes that will exemplify these coding lessons and demonstrate the typical reimbursement resulting from correctly using the E/M coding system.

Lesson #1

The ATLS initial survey followed by a secondary survey usually qualifies for coding at an upper-level encounter.

Most surgeons are familiar with and have completed an ATLS course. Basic to that program is the concept of an initial survey, including an AMPLE history (Allergies, Medications currently used, Past illnesses/Pregnancy, Last meal, and Events/Environment related to the injury), followed by a head-to-toe secondary survey. Most emergency medical technicians and nurses also capture the past and social history of a patient in their assessment process. Assuming that the surgeon performs and *fully documents* this initial evaluation and secondary survey, that service should qualify for one of the highest levels of E/M encounters. The level of care that must be documented, using the 1995 E/M guidelines, requires a detailed or comprehensive history and physical exam, plus the patient must require a level of decision making that is at the moderate or high level of complexity.*

This documentation process need not be hard or arduous. Surgeons are allowed to incorporate into their evaluation and history taking all of the information available to them, including the ambulance run sheet, nursing history and evaluation forms, and so on. The surgeon may incorporate this information by either copying/dictating the information, or with a note indicating that they have reviewed it. Remember, however, that if the history taking, physical examination, or decision making is not documented by the surgeon, it didn't occur. Therefore, good documentation by the use of trauma flow sheets (like the ones in the ATLS manual), dictation templates, or other methods is most important. To assist surgeons in coding, Table 1 (p. 14) contains the *Current Procedure Terminology* (CPT)[†] codes and documentation guidelines for the most common and appropriate initial care codes.

*1995 Evaluation and Management Guidelines. Web site: <http://cms.hhs.gov/medlearn/1995dg.pdf>

[†]All specific references to CPT terminology and phraseology are: CPT only 2002 © American Medical Association. All rights reserved.

Lesson #2

Complexity of decision making determines whether to code the higher or highest-level code. Most multiple-trauma or emergency procedures qualify for the highest level of decision making.

Assuming that the initial evaluation is completed and documented, what factors determine whether to use the highest-level code? As the lowest section of Table 1, below, indicates, the history and physical examination components are the same for both of the upper level codes, meaning that decision making becomes the criti-

cal element determining the level of coding.

Decision making has three components: (1) the number of diagnosis or treatment options; (2) the amount and/or complexity of data to be reviewed; and (3) the risk complication and/or morbidity or mortality. In general, the number of treatment options and amount of data to be reviewed is extensive for most badly injured patients. This leaves the level of risk as the final arbiter of level of coding. The Table of Risk from the 1995 guidelines for these upper two levels of risk is provided in Table 2, page 15. As that table indicates, a patient presenting with multiple trauma or requiring emergency surgery

Table 1: Initial evaluation codes for trauma

1995 documentation guidelines for evaluation/management services					
History					
Type of history	History of present illness (HPI)	Review of symptoms (ROS)	Past, family, and/or social history (PFSH)	CPT code Hospital, initial	CPT code Hospital consult
Detailed	Extended (4)	Extended(2-9)	Pertinent (1)	99221	99253
Comprehensive	Extended (4)	Complete (10)	Complete (2-3)	99222/99223	99254/99255
Examination					
Type of examination	Body areas	Organ systems		CPT code Hospital, initial	CPT code Hospital consult
Detailed	An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s).			99221	99253
Comprehensive (8 of 12)	A general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s).			99222/99223	99254/99255
Medical decision making					
Type of decision making	Number of diagnosis or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	CPT code Hospital, initial	CPT code Hospital consult
Low complexity	Limited	Limited	Low	99221	99253
Moderate complexity	Multiple	Moderate	Moderate	99222	99254
High complexity	Extensive	Extensive	High	99223	99255

would qualify for the level of risk being graded as high, thus qualifying the E/M code to be at the *highest* level, assuming the history and physical examination meet the previously mentioned circumstances.

Lesson #3

For patient entry into the trauma system, the surgeon should usually code as a consultant.

Patients enter the trauma system by many routes, but in most cases the end result is one of three management options:

1. Evaluation in the emergency room (ER) followed by admission to the hospital.
2. Observation in the outpatient/ER area.
3. Discharge from the ER with follow up in the office.

In most areas of the country, an ER physician will be involved with the initial triage and perhaps subsequent care of the trauma patient. When the surgeon is called to see the trauma patient, he or she then becomes a consultant to the emergency room physician as long as three simple guidelines are followed. To qualify as a consultation, the encounter must meet the following criteria: (1) the surgeon's assistance must be requested by another physician (or another appropriate source); (2) the request for and need for the consultation must be documented in the patient's medical record; and (3) the consultant must prepare a written report and provide it to the physician requesting the opinion. Because both physicians use a common medical record, such as trauma flow sheets or ER progress notes, it is easy for them to appropriately document the care given and the ra-

Table 2: Table of Risk—Modified for trauma patients

1995 Documentation Guidelines

Level of risk	Presenting problem(s)	Diagnostic procedure(s) ordered	Management options selected
Moderate	<ul style="list-style-type: none"> • Acute illness with systemic symptoms, such as pyelonephritis, pneumonitis, colitis • Acute complicated injury, such as head injury with brief loss of consciousness 	<ul style="list-style-type: none"> • Physiologic tests under stress • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors • Obtain fluid from body cavity 	<ul style="list-style-type: none"> • Minor surgery with identified risk factors • Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors • Prescription drug management • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	<ul style="list-style-type: none"> • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, such as multiple trauma, acute myocardial infarction (MI), pulmonary embolus, severe respiratory distress, peritonitis, acute renal failure • An abrupt change in neurologic status, such as seizure, transient ischemic attack (TIA), weakness, or sensory loss 	<ul style="list-style-type: none"> • Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors 	<ul style="list-style-type: none"> • Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous, or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

tionale for the consultation, and to communicate back to the requesting physician (the ER physician) in written form. The codes used are for an office or other outpatient consultation (codes 99241-99245).

Incidentally, a surgeon may report consultations even if he or she initiates diagnostic and/or therapeutic services during or subsequent to the consultation. Any specifically identifiable CPT code performed on the date of the consultation should be reported separately, using modifier 25.

The use of a consultation code by the surgeon (as opposed to an initial hospital care code) is an important concept because there is a small, but not insignificant, difference in the reimbursement amounts for these codes compared with others the surgeon might use. Table 3 (right) gives the average 2003 Medicare payment for the highest level of the codes the surgeon might consider reporting for these two types of codes. In the case of a surgeon who first performs a consultation and then admits the patient to the hospital, from the Medicare standpoint, the surgeon would charge for the consultation performed, but not charge for the admission (in other words, would not use any of the Initial Hospital Care codes in addition to the Consultation codes). For other insurers, local policies usually follow Medicare policy, but may be different, and the surgeon should consult other insurance carriers' payment policy for advice.

Table 3: Initial encounter for trauma patients

CPT code	2003 MFS descriptor	Medicare payment
99221	Initial hospital care	\$ 65.85
99222	Initial hospital care	109.25
99223	Initial hospital care	151.92
99253	Initial inpatient consult	96.01
99254	Initial inpatient consult	137.95
99255	Initial inpatient consult	189.81

Lesson #4:

Proper use of the critical care codes can be rewarding.

Many surgeons don't know whether to use a critical care code, or the standard E/M codes. In general, the level and length of care that they deliver to a patient justify the use of these codes. There are some important differences in these codes and the usual E/M codes. We will focus on two: the definition and time.

Critical care is defined in CPT as follows:

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient.

- A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition.
- Critical care involves high complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition.
- Examples of vital organ system failure include, but are not limited to:
 - central nervous system failure,
 - circulatory failure,
 - shock,
 - renal, hepatic, metabolic and/or respiratory failure.[‡]

Care given by the trauma surgeon to critically ill patients often fit these criteria.

It is important to note that the determination of critical care is based not only upon the severity of the illness but on time as well. The surgeon must be present at the bedside or immediately available to the patient to qualify for critical care. Time includes the following: coordinating care with other physicians; obtaining a history from others when the patient cannot give a full and comprehensive history; or discussing

[‡]American Medical Association: *Current Procedural Terminology (CPT) 2003*. Chicago, IL: American Medical Association, 2003.

the course of treatment with family members when the patient is unable to participate.

The time does not have to be continuous, but must be measured in increments from at least 30 minutes up to 74 minutes for the base code (code 99291) and 30-minute increments thereafter, using code 99292. Assuming that a surgeon delivered critical care in one 60-minute increment, followed by three 20-minute increments throughout the day, this care would be coded as 99291 \times 1, and 99292 \times 2. The surgeon needs to document the care delivered and the time he or she was in attendance with the patient.

Some other important facts to remember about using the critical care codes include:

- If a patient is in an intensive care area, but either the time spent is less than 30 minutes, or the level of care doesn't meet the above criteria, then the surgeon should use the appropriate level of hospital visit or consult code for the encounter.

- In some instances, surgeons may need to accompany a critically ill patient during transport between facilities. The critical care codes (99291 and 99292) are used for coding this care if the patient is 24 months or greater in age. For patients less than two years old, use the pediatric transport codes (99289 and 99290).

- For any given period of time spent providing critical care services, the surgeon must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

- Critical care and other E/M activities may be provided and coded for on the same patient on the same day. Thus, if a patient was seen earlier in the day and then deteriorated clinically and required subsequent critical care, both the earlier E/M service and later critical care may be reported.

Lesson #5

Use appropriate modifiers to report E/M services not related to the global period of a surgical procedure.

Many surgical procedures have global periods of zero, 10, or 90 days. E/M work related to the global surgical procedure is included in that work value and payment for a given code. However, there are some exceptions to that rule,

which allow payment if the appropriate modifier and diagnosis code are used to report those services.

Modifier -57, Decision for surgery is added to an E/M code if the surgeon sees the patient and then, based upon the evaluation of the patient, decides to proceed with surgery within that day.

Modifier -24, Unrelated E/M service in the global period is used if the surgeon performs an E/M service that is unrelated to a 10- or 90-day global surgical procedure done in the global period. An unrelated diagnosis and diagnosis code must be included with the E/M service that describes the problem for which the E/M service is being performed. For example, when seeing a patient during the global period of a small bowel repair due to injury (ICD-9-CM code 863.30) and who also is diagnosed and treated for a urinary tract infection, it is possible to code for an office visit (code 99212-24) with an ICD-9-CM code different from the one used for the small bowel repair (ICD-9-CM code 599.0, *Urinary tract infection, site not specified*).

Modifier -25, Separate E/M service on same day as surgical procedures is used when the surgeon performs a separate E/M service on the same day as a minor procedure.

This situation typically occurs when the patient undergoes insertion of a central venous catheter (36489) or a chest tube (32020). An unrelated diagnosis should be included with the separate E/M service that describes the problem for which the E/M service is performed.

Lesson #6

Time can be an ally. Use the "Counseling and coordination of care" section of the E/M guidelines to properly code for some of the work provided in caring for trauma patients.

Several codes are useful when time is a factor in determining the level of coding. In many cases, the work involved in coordinating multiple surgeries between other specialists, talking with family members, planning rehabilitation treatment, and so on, falls upon the trauma surgeon as part of the post-trauma phase of care. Many surgeons fail to code appropriately for this

work, because they believe that any E/M encounter must meet the documentation guidelines, or “bullets.” However, even if the bullets or documentation guidelines for the history, physical exam, or decision making are unmet, the work and time spent may be reported and charged for based upon the time spent in that activity.

This aspect of E/M coding, which is called “counseling and coordination of care,” is explained in CPT as follows:

When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital...), then time may be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members... The extent of counseling

and/or coordination of care must be recorded in the medical record.

The standard times for various E/M encounters are included in Table 4, below. As an example, if a hospitalized patient requires 35 minutes of time for that day’s care, which includes at least 18 minutes of counseling and coordination of care, then the surgeon could report those services as a 99233. Of course, this is permissible only if the patient is not in the global period of an operation that the surgeon performed.

These standard times are also important for reporting E/M services in which the surgeon spends more than the typical time of an E/M encounter. This frequently occurs for trauma, where the surgeon is present during the sometimes-long evaluation and stabilization process, but the severity of illness and intensity of care delivered do not rise to the critical level.

Use the prolonged service codes when the face-to-face time for the E/M service exceeds

Table 4: Time-based codes for trauma

CPT code	2003 CPT descriptor	Standard Medicare payment	Coordination/ time (minutes)	Counseling > 50% time
99214	Office/outpatient visit, est.	\$ 56.65	25	13
99215	Office/outpatient visit, est.	91.23	40	20
99222	Initial hospital care	109.25	50	25
99223	Initial hospital care	151.92	70	35
99232	Subsequent hospital care	54.07	25	13
99233	Subsequent hospital care	76.88	35	18
99253	Initial inpatient consult	96.01	55	28
99254	Initial inpatient consult	137.95	80	40
99255	Initial inpatient consult	189.81	110	55
99354	Prolonged service, office	89.76	60	
99355	Prolonged service, office	89.02	Each 30	
99356	Prolonged service, inpatient	87.18	60	
99357	Prolonged service, inpatient addtl. 30 min	87.55	Each 30	

Table 5: Common trauma operations and the average Medicare payment

CPT code	CPT descriptor	Medicare payment
20103	Exploration, penetrating wound, leg	\$ 323.60
49000	Exploratory laparotomy	688.32
38100	Splenectomy	813.90
44602	Small bowel repair, trauma	863.77
44120	Resection small bowel, trauma	943.12
32110	Thoracotomy with hemorrhage control	1,365.73

the time allotted for the highest-level service (level 5) by over 30 minutes. Hence, if the time for an initial inpatient consultation takes greater than 140 minutes, report code 99255 for the consult, then code 99356 for the first 30-60 minutes of additional care, and code 99357 for each additional unit of 30 minutes. To report these services in the office setting, use the appropriate E/M service code, code 99354 (30-60 minutes), and code 99355 (each additional 30 minutes).

Putting it all together

Combining good trauma care of the patient with proper coding by the surgeon.

Finally, let's look at four vignettes and the associated coding to see how these six lessons are properly used (see following pages). We have included the average Medicare reimbursement for 2003 for each of the codes mentioned to give an idea of how well the proper coding would be reimbursed. Remember that the geographic adjustment factor used by Medicare will result in different payments. For comparison purposes, we have also compiled common surgical procedures used in the trauma patient in Table 5, left. You will see

how in many cases, proper use of the CPT code book and coding guidelines will help reimburse the surgeon for work that he or she is already doing.

Conclusions

Often surgeons don't fully capture the value of all that they do for patients because of inefficient use of the current CPT codes and modifiers. Trauma care involves both nonoperative and operative care. Wise use of the existing E/M codes by surgeons can result in improved reimbursement for those caring for these challenging patients. The American College of Surgeons continues to lead the way in educating surgeons on proper coding and to help ensure proper reimbursement for the tremendous surgical care delivered by Fellows of the College.

Special thanks go to members of the ACS General Surgery Coding and Reimbursement Committee for help and advice with developing this article, especially John Gage, MD, FACS; John Preskitt, MD, FACS; Karen Borman MD, FACS; and Jean Harris, Division of Advocacy and Health Policy.

Vignette #1: Motor vehicle accident (MVA) Fractured pelvis—ICU care, no surgery

- 74-year-old male in MVA with fracture of pelvis and associated large pelvic hematoma—surgeon consulted by ER physician as part of trauma protocol.

- Other medical problems: Diabetes, HPTN, and COPD.

- Complete ATLS initial, secondary survey performed by surgeon.

- Stabilized in ER—fluid, blood transfusions, other.

- Central line inserted—36489.

- CT scans of head/abdomen/pelvis.

- Initial evaluation completed in ER, treatment decision made. Level of care coded: 99255, *Complex consult*.

- Admission to ICU: patient stabilized in ICU, after transfusions, vasopressors, IV fluids given, labs rechecked, and so on.

- Time of surgeon in attendance, critical care: 2.5 hours critical care time. Level of care coded: 99291, plus 99292 × 3.

- Follow serial labs, exams.

- Hypotensive episode; surgeon evaluates patient and recommends repeating labs, giving

Coding/reimbursement for Vignette #1

Day	CPT code	Description	Modifier	Medicare payment	Total time	Diag. code	Diagnosis
1	99255	Initial inpatient consult	57	\$ 189.81	70	808.43	Multiple closed pelvic fractures with disruption of pelvic circle
1	99291	Critical care	25	200.11	60	808.43	
1	99292	Critical care, addtl.	25	100.06	30	958.4	Traumatic shock
1	99292	Critical care, addtl.	25	100.06	30		
1	99292	Critical care, addtl.	25	100.06	30		
1	99292	Critical care, addtl.	25	100.06	30		
1	99292	Critical care, addtl.	25	100.06	30		
1	99292	Critical care, addtl.	25	100.06	30		
1	36489	Central line insertion		85.34			
2	99291	Critical care		200.11	60		
3	99233	Subsequent hosp. complex		76.88			
4	99233	Subsequent hosp. complex		76.88			
5	99233	Subsequent hosp. complex		76.88			
6	99232	Subsequent hosp. moderate		54.07			
7	99232	Subsequent hosp. moderate		54.07			
8	99232	Subsequent hosp. moderate		54.07			
9	99232	Subsequent hosp. moderate		54.07			
10	99231	Subsequent hosp. low		32.74			
11	99231	Subsequent hosp. low		32.74			
12	99238	Discharge day management		<u>69.16</u>			
		Total Medicare payment		\$1,857.30			

fluid and blood, and repeating CT scans.

- Transfer to radiology for arteriogram of pelvic hematoma.
- Hematoma not bleeding.
- Transfer back to ICU with labs, serial exams by surgeon during remainder of day.
- Total fluid given: Six liters. Total blood transfused: Four units.
- Time of surgeon in attendance, after initial episode, same day: Three discontinuous increments of 30 minutes each, critical care time. Level of care coded: *99292* × 3.
- Total time estimate of surgeon in attendance, day one: 4.5 hours critical care time, including time for discussion of condition of patient with family members.
- Day two: Patient requires intubation and ventilator/fluid management and critical care of one hour total time.

- Total time estimate of surgeon in attendance, day two: One hour of critical care time. Level of care coded: *99291*.

- Days three to five: Patient observed in ICU; patient more stable but requiring decision making of high complexity, but not of critical care standards.

- Total daily time of surgeon in attendance, days three to five: Less than 60 minutes each day. Level of care coded: *99233 level of care* × 3.

- Days six to nine: Patient on floor. Level of care coded: *99232 level of care* × 4.

- Days 10 to 11: Patient continues recuperation on floor. Level of care coded: *99231 level of care* × 2.

- Day 12: Patient ready for discharge home; discharge planning performed. Level of care coded: *99238*.

Vignette #2: MVA Chest, facial, and abdominal trauma—ICU care, and surgical operation

- 32-year-old female in MVA with multiple rib fractures, complex facial lacerations, and abdominal trauma; surgeon consulted by ER physician as part of trauma protocol.

- Complete ATLS initial, secondary survey performed by surgeon.

- Stabilized in ER: Evaluation with CT scan of head, chest, and abdomen, other X rays and labs, administration of IV fluids, and so on. CT scan reveals moderate hematoma of liver. Level of care coded: *99255, Complex consult, modifier -57*.

- Patient stabilized after two hours, admitted to hospital, with patient taken to OR (after stabilization) for surgical repair of facial lacerations.

- Patient has complex repair of 5 cm laceration of scalp and 5 cm laceration of cheek and mouth.

- Patient transferred to ICU for further care and observation of chest/abdominal trauma.

- Total time estimate of surgeon in attendance, day one: Two hours noncritical care

time. Level of care charged/level of care coded: *99255*.

- Day two: Patient requires placement of chest tube for pneumo-hemothorax, hypotensive episode treated with fluids and blood transfusion, and repeat CT scan obtained to rule out increased hemorrhage from liver. Surgeon in attendance and providing critical care.

- CT scan shows no change, patient becomes stable with transfusion and fluid administration.

- Total time estimate of surgeon in attendance, day two: 90 minutes critical care time, not related to repair of facial laceration. Level of care coded: *99291, plus 99292* × 1, *modifier -24*.

- Day three: Patient improved and transferred to floor for further care of chest and abdominal trauma, serial lab, exams, and X rays.

- Total daily time of surgeon in attendance day three: Less than 60 minutes. Level of care coded: *99233, (not related to repair of facial laceration), modifier -24*.

Coding/reimbursement for Vignette #2

Day	CPT code	Description	Modifier	Medicare payment	Total time	Diag. code	Diagnosis
1	99255	Initial inpatient consult	57	\$ 189.81	70	873.59	Open wound of face, other and multiple sites, complicated
1	13121	Repair, complex, scalp, other; 2.6 cm to 7.5 cm				873.51	Open wound of cheek, complicated
1	13132	Repair, complex, forehead, cheeks, chin, mouth, other; 2.6 cm to 7.5 cm				873.59	Open wound of face, other and multiple sites, complicated
2	32020	Tube thoracostomy		212.62		860.4	Traumatic pneumo-hemothorax without mention of open wound into thorax
2	99291	Critical care	24, 25	200.11	60	864.05	Liver injury without mention of open wound into cavity, unspecified laceration
2	99292	Critical care, addtl.	24, 25	100.06	30	864.05	Liver injury without mention of open wound into cavity, unspecified laceration
3	99233	Subsequent hosp. complex	24	76.88		864.05	
4	99232	Subsequent hosp. moderate	24	54.07		864.05	
5	99232	Subsequent hosp. moderate	24	54.07		864.05	
6	99231	Subsequent hosp. low	24	32.74		864.05	
7	99233	Subsequent hosp. complex	24	76.88		864.05	
8	99238	Discharge day management	24	69.16		864.05	
		Total Medicare payment		\$1,066.41			

- Days four to five: Patient improves, chest tube removed and recuperation continues. Level of care coded: *99232 level of care × 2, modifier -24.*

- Day six: Further improvement. Level of care coded: *99231, modifier -24.*

- Day seven: Family arrives from out of town; surgeon holds conference with family

on patient's condition, and so on. Total time for counseling/coordination of care: 20 minutes. Level of care coded: *upcoded to 99233 level, modifier -24.*

- Day eight: Patient discharged home. Discharge planning performed. Level of care coded: *99238, modifier -24.*

Coding/reimbursement for Vignette #3

Day	CPT code	Description	Medicare payment	Total time
1	99255	Comprehensive hospital consult	\$189.81	
2	99232	Subsequent hosp. moderate	54.07	
3	99238	Discharge planning	69.16	
8	99215	Office/outpatient visit, est.	<u>91.23</u>	45
		Total Medicare payment	\$404.27	

Vignette #3: MVA Chest, facial, and abdominal trauma—minor

- 32-year-old female arrives with history of being in MVA with ejection from vehicle, contusions to chest, minor facial abrasions, dental injuries, and abdominal pain and bruising. Surgeon consulted by ER physician as part of trauma protocol.

- Complete ATLS initial, secondary survey performed by surgeon.

- Stabilized in ER. Evaluation with CT scan of head, chest, and abdomen, other X rays and lab, administration of IV fluids, and so on.

- Patient appeared relatively stable after evaluation, and decision made to place the patient in regular hospital bed for continued monitoring by serial exams and laboratory/X ray studies.

- Total daily time of surgeon in atten-

dance, day one: 1.5 hours. Level of care coded: *99255, Comprehensive hospital consult.*

- Day two: Patient appears stable based upon history, physical exam, and lab values; diet/ambulation started. Dental consult obtained. Level of care coded: *99232.*

- Day three: Patient felt to be stable for discharge home with follow-up in office in one week. Discharge planning. Level of care coded: *99238.*

- One week follow-up: Patient seen back for history and exam, requires 45 minutes total physician time, of which 20-plus minutes is for counseling/coordinating dental repair, counseling recuperation from injury, and return to work issues. Level of care coded: *upcode to 99215.*

Vignette #4: Fall at home with multiple trauma, subdural hematoma, long bone fracture

- 74-year-old male arrives at ER with history of falling off of ladder at home, with right femoral fracture, broken ribs, small hemothorax, and numerous small abrasions. Patient has period of unconsciousness at home. Surgeon consulted by ER physician as part of trauma protocol.

- Complete ATLS initial, secondary survey performed by surgeon. CT scan of head reveals small subdural hematoma.

- No abdominal trauma detected, hemothorax stable, and orthopaedics and neurosurgery consult on patient.

Coding/reimbursement for Vignette #4

Day	CPT code	Description	Medicare payment	Total time
1	99255	Comprehensive hospital consult	\$189.81	
1	99356	Prolonged service, inpatient	87.18	
2	99291	Critical care	200.11	
3	99233	Subsequent hosp. complex	76.88	
4	99233	Subsequent hosp. complex	76.88	20
5	99233	Subsequent hosp. complex	76.88	
6	99233	Subsequent hosp. complex	76.88	
7	99231	Subsequent hosp. low	<u>32.74</u>	
		Total Medicare payment	\$784.64	

- Patient stabilized. Trauma surgeon coordinates care plans among other surgeons, and patient admitted to ICU for observation.

- Total daily time of surgeon in attendance, day one: 2.5 hours. Level of care coded: *99255, Comprehensive hospital consult, plus 99356 × 1, Prolonged service, inpatient.*

- Day two: Patient has deterioration of neurological exam, CT scan ordered.

- Patient has subdural hematoma, increased in size on CT scan, and is unstable.

- Patient stabilized by trauma surgeons and neurosurgery reviews patient, CT scans, neurosurgery makes decision to operate on subdural.

- Consultation and coordination of care by trauma surgeon between orthopaedics and neurosurgery, necessitating taking patient to surgery for neurosurgery operation, and delaying orthopaedic operation.

- Total time estimate of trauma surgeon in attendance, day two: 90 minutes critical care time, including discussions with family members about patient's condition, and for coordination of care discussions with neurosurgery and orthopaedics. Level of care coded: *99291.*

- Day three: Patient stabilized from neurosurgical procedure, 30 minutes of time for coordination of care with neurosurgery and orthopaedics, orthopaedic surgery planned for day four. Level of care coded: *upcoded to 99233.*

- Days four to six: Patient recuperating from neurosurgery and orthopaedic procedures, trauma surgeon continues to coordinate care with orthopaedic/neurosurgeon, and counsel with family members. 20+ minutes counseling/coordination time documented daily in chart. Level of care coded: *upcoded to 99233.*

- Day seven: Patient transferred to neurosurgical service; trauma surgeon completes final recommendations and signs off. Level of care coded: *99231.*



Dr. Mabry is a general surgeon practicing in Pine Bluff, AR, and assistant professor, department of surgery, University of Arkansas for Medical Sciences. He is a Regent of the College and a member of the General Surgery Coding and Reimbursement Committee.



Program increases medical student interest in surgical careers



DIGITAL VISION

by Michael W. Mulholland, MD, PhD, FACS,
Ann Arbor, MI

For the 20 years from 1980 to 2000, a higher-than-average percentage of graduates from the University of Michigan (Ann Arbor) Medical School selected surgical fields for their postgraduate training. University of Michigan medical students were very successful in the match when seeking surgical residencies. These observations attested to the positive influences of the surgical faculty as role models for medical students and to opportunities for professional development in surgery that the University of Michigan afforded.

Nonetheless, the nationwide trend in decreasing interest in surgical careers became manifest at the university in the years 2000 and 2001. Not coincidentally, medical student satisfaction with surgical clerkships, as measured by completion surveys, declined significantly over the five-year period before 2000. The students perceived that there was a decreasing personal contact with surgical faculty. Interviews conducted with surgical faculty were virtually unanimous in confirming the student observations. In addition, surgical faculty believed that the increasingly hectic pace of clinical practice left little quality time for student instruction. These observations made it clear that innovative approaches to medical student education should be a high priority for the department of surgery.

“Re-energized” teaching curriculum

In an attempt to reverse these trends, four new job descriptions, to be performed by current faculty, were designed to bring innovation and new energy into the medical student teaching enterprise of the department of surgery. These physicians were funded by the department, which provided salary support equivalent to 25 percent full-time equivalents for each faculty. Job descriptions included:

1. Development of a medical student/faculty interactive curriculum for the third-year surgical clerkship in the areas of general surgery and vascular surgery.
2. Development of a third-year medical student/faculty interactive curriculum for the surgical subspecialties.
3. Development of an intensive mentoring pathway for fourth-year medical students interested in surgical careers.

4. Development of a curriculum in surgical economics and leadership skills.

Topics included areas such as effective communication in teaching, conflict resolution, management principles, negotiation, time management, and medical ethics.

Evaluation of faculty teaching efforts in the promotion process were also made more rigorous for surgical faculty. The belief was that the current tenure track promotion process would function well with teaching accepted as equivalent to basic science or clinical research, for a few select faculty members, in terms of contribution to the academic mission of the University of Michigan. New criteria for promotion were developed that more explicitly recognized excellence in teaching.

Efforts were made to make the surgical faculty much more visible to first and second-year medical students. The department of surgery made a commitment to have a surgical faculty member teaching in every course in the first two years, including those traditionally conducted by the basic science departments. Additional teaching efforts were made in the anatomy course in the form of clinical anatomical correlations. Medical students found the presentation of surgical movies as a teaching adjunct to gross anatomy to be particularly stimulating.

A “meet a surgeon” lunchtime series was initiated for first- and second-year medical students so that they could interact with faculty on a more informal basis. A program for “shadowing” a surgical faculty member was extended to all members of the first- and second-year class. In this program, medical students were typically invited to meet with the faculty on a monthly basis, usually attending operating room cases. A surgical Web site was developed to provide laboratory and clinical mentoring services for first- and second-year students as an additional outreach effort.

Additional outreach programs also focus upon third- and fourth-year medical students. A monthly career development series has been developed, usually conducted over lunch, to familiarize medical students with surgical opportunities. During the summer of the fourth year, a series of meetings are held in the homes of surgical faculty. Topics addressed during these

meetings include the application process, how to write a personal statement, and what happens during the interview.

Outreach and the College

The resources available through the American College of Surgeons have been especially important to our outreach efforts. In October 2002, the department of surgery funded the travel of 31 medical students to the American College of Surgeons' Clinical Congress held in San Francisco, CA. These third- and fourth-year students were selected on the basis of an expressed potential interest in surgery as a career. They were exposed to both the clinical and research forums that were available during the Clinical Congress. The students were also included in the social activities of the department, including the departmental reception and informal dinners with surgical house staff and faculty. The returning students were universal in their view of this experience as a positive influence. They were surprised by the breadth of surgical opportunities, by the positive and upbeat "feel" of the annual meeting, and by the dedication of the College to their future development. This outreach program will be continued in 2003 for the Clinical Congress in Chicago, IL.

Evaluation

In order to judge the effect of these changes and the value of our investment in medical students, defined criteria will be used:

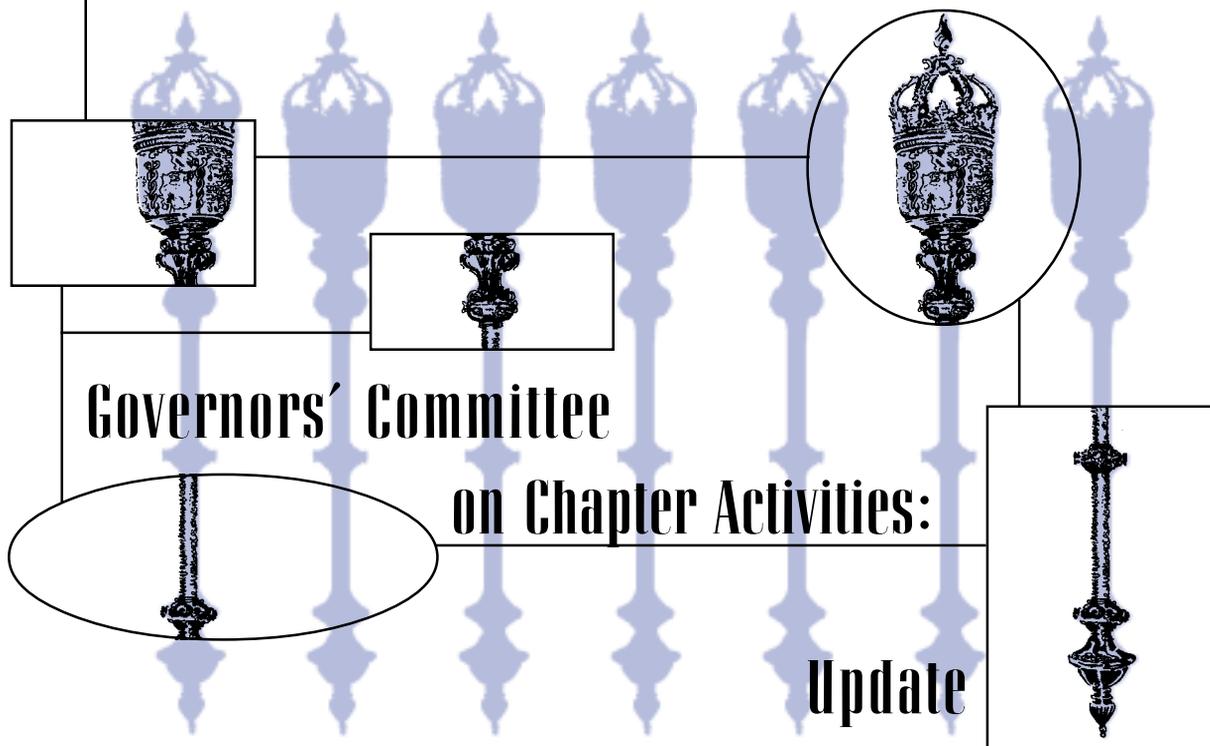
1. Results of medical student satisfaction surveys conducted upon completion of third-year surgical clerkship.
2. Medical student performance on standardized surgical examinations administered at the completion of the surgical clerkship.
3. Medical student performance on specific surgical sections of the comprehensive clinical assessment, given at the beginning of the senior year of medical school.
4. Results of medical student educational surveys administered by the Office of Graduate Medical Education after residency matching.
5. And most importantly, the percentage of University of Michigan medical students entering surgical training upon graduation. In 2003, 24 percent of the University of Michigan gradu-

ating class matched to surgical residencies.

These data have been collected prospectively from the beginning of this experiment. The program has been funded for five years. If these interventions are considered successful, they will certainly be recommended for continuation. 

Dr. Mulholland is
Frederick A. Collier
Distinguished Professor and chair, department of surgery,
University of Michigan
Medical School, Ann
Arbor.





by Lester W. Johnson, MD, FACS, Rayville, LA

Since the College established the Governors' Committee on Chapter Activities (GCCA) in 1972, the committee has devoted itself to assisting chapters with membership recruitment, education programming, management, and administration. Currently, there are 22 members of the GCCA. These individuals include two liaison members from the International Relations Committee and one liaison member from the Executive Committee of the Board of Governors.

In 1995, under the leadership of Richard Fratianne, MD, FACS, four subcommittees were appointed. This division of responsibilities has benefited the GCCA, as well as the chapters. The four current subcommittees are Advocacy and Coalitions, International Activities, Meetings and Organizations, and Recruitment and Diversity. The GCCA meets annually at the Clinical Congress. Teleconferences have been particularly useful in conducting subcommittee meetings.

The remainder of this report reviews the current activities and objectives of each of the subcommittees. It concludes with a philosophical overview of the role of the individual chapters of the American College of Surgeons.

Advocacy and Coalitions (A&C)

Richard Lynn, MD, FACS, serves as Chair of this subcommittee, which was formed in October 2002 as a part of the reorganization of the Board of Governors' (B/G) standing committees. The B/G Executive Committee expressed the need for the College's chapters to become much more involved with state-level issues and activities. Thus, the new A&C Subcommittee was appointed. The first year of operation for the A&C Subcommittee has been very active. Members have conferenced with Chris Gallagher, Manager, State Affairs, in the College's Washington Office and Jon Sutton, State Affairs Associate, in Chicago, IL—both of the Division of Advocacy and Health Policy—to discuss the chapters'

Table 1: Leadership development

Activity	Number of chapters				
	Small	Medium	Large	Total	Percent*
Send one or more representatives to annual leadership conference	10	12	17	39	81%
Send one or more young surgeons to annual leadership conference	10	12	16	38	79
Send chapter executive to leadership conference	0	7	9	16	33
Contributed \$500 or more to ACS endowment funds	5	6	14	25	52
Achieved Life Membership in ACS Fellows Leadership Society	0	0	2	2	4
Select and send at least one resident to Clinical Congress	1	3	5	9	19

Table 2: Council representation—Special interest

Special interest representatives	Number of chapters				
	Small	Medium	Large	Total	Percent*
Young surgeons	11	13	19	43	90%
Association of Women Surgeons	2	4	11	17	35
Resident	3	7	11	21	44
Retired	4	3	10	17	35
Cancer liaison	6	8	11	25	52
Committee on Trauma	11	13	19	43	90

*N = 48.

concerns regarding the professional liability insurance crisis. The A&C Subcommittee also received updates on the proposed *Office-Based Surgery Principles*, which, when completed, will be shared with state-level regulatory agencies governing surgery. In addition, the A&C Subcommittee has monitored the appointment of StARs—State Advocacy Representatives—with the goal of having at least one StAR in each chapter. These individuals will serve as principal representatives when important state legislation needs to be addressed.

Dr. Lynn has distributed a letter to the Governors-at-Large and chapter presidents to inform them of this new GCCA subcommittee. The subcommittee intends to examine chapters' involvement with state-level advocacy activities and determine how improvements can be made. Finally, the A&C Subcommittee is examining how chapters may assist the College's Committee on Trauma in developing and implementing statewide trauma systems.

Meetings and Organization (M&O)

Erwin Thal, MD, FACS, serves as Chair of this subcommittee, which is responsible for identifying characteristics of successful chapter organizational structures and education programs. The subcommittee then communicates this information to the chapters. The subcommittee also provides new ideas and topics that should be presented at chapters' education programs. This input may, in turn, help unify surgical specialists on topics of broad appeal or shared concerns.

Under Dr. Thal's leadership, the M&O Subcommittee has completed a Chapter Performance Checklist project. The checklist is intended to provide an inventory of chapters' current activities, as well as to provide a gauge to measure chapters' performance. Of the 65 U.S. chapters that were included in the "performance review," 48 responded.

The responses to the Chapter Performance Checklist were tallied by grouping chapters by size. Total responses included:

Table 3: Continuing Medical Education—Types of programs

CME programs	Number of chapters				
	Small	Medium	Large	Total	Percent*
Provided Category 1 credit via ACCME sponsor	6	8	15	29	60%
Conducted 1-8 CME hours per year	3	5	9	17	35
Conducted 8-15 CME hours per year	3	5	8	16	33
Conducted more than 15 CME hours per year	3	2	1	6	13
Provided 4-8 hours “hands-on” CME credit	0	2	2	4	8
Provided CME program for residents	3	7	9	19	40

Table 4: Advocacy activities

Activity	Number of chapters				
	Small	Medium	Large	Total	Percent*
Participated in Capitol Hill Visit program with ACS staff	3	10	11	24	50%
Accessed the Legislative Action Center to send letters to Congress	0	2	6	8	17
Participated in state-level advocacy by communicating with state legislators	7	8	13	28	58
Participated in state medical society advocacy committee(s)	7	10	15	32	67
Contacted state surgical specialty societies regarding advocacy issues	1	3	10	14	29
Participated in Medicare Carrier Advisory Committee activities	2	8	10	20	42

*N = 48.

Size of chapter	Number responding
Small chapters (less than 399 total members)	14
Medium chapters (400-999 total members)	15
Large chapters (more than 1,000 members)	19

Of the performance data collected, Tables 1-4 (pages 29-30) contain information that may be of most interest to the College’s membership.

During the next year, the M&O Subcommittee intends to improve the performance checklist form. In addition, the subcommittee’s activities also will include: (1) encouraging chapters to conduct ACS off-site education programs (for example, coding, practice management, information technology, sentinel node biopsy, ultrasound, and so forth); (2) encouraging all domestic chapters to support the Candidate and Asso-

ciate Society of the American College of Surgeons (CAS-ACS); and (3) providing assistance and support to chapters that express interest in merging with another ACS chapter(s) or local/regional surgical society.

International Activities (IA)

Desmond Birkett, MD, FACS, serves as Chair of this subcommittee, which is also new. Created in 2002, the IA Subcommittee is intended as a “forum” to provide opportunities for the international Governors to meet and exchange reports on their international chapters’ activities.

The first meeting of the IA Subcommittee was held last October, and at least 16 international Governors attended. It was agreed that this forum should be continued, and the 2003 session has been scheduled for Wednesday, October 22, during the Clinical Congress in Chicago, IL.

In the future, the IA Subcommittee will be examining strategies, programs, and activities to enhance the College’s relationships with its inter-

national chapters and Fellows. In addition, the IA Subcommittee will be responsible for identifying strategies to recruit international surgeons for Fellowship in the College. The IA Subcommittee will also seek to establish new international chapters.

Membership and Diversity (M&D)

Eddie Hoover, MD, FACS, serves as Chair of this subcommittee, which is responsible for making recommendations on membership recruitment and retention at both the national and chapter levels. With assistance from Governors representing the Association of Women Surgeons and the National Medical Association, the M&D Subcommittee also makes recommendations on strategies to enhance the College's recruitment activities aimed at women and minority surgeons.

In early 2003, the M&D Subcommittee identified 20 Fellows that were added to the chapters' online Speakers Bureau. In October of this year, the M&D Subcommittee plans to submit a resolution to the Board of Governors that seeks to encourage the College's Program Committee to achieve greater diversity among invited speakers at ACS education programs. This resolution should be considered an action affirming the Diversity Statement of the College that was passed in 2002.

Future activities of the M&D Subcommittee include: (1) monitor and report on diversity initiatives in the medical profession; (2) maintain liaison with the recently established Committee on Diversity Issues and the Committee on Women's Issues; (3) examine how mentoring programs may be implemented at the chapter level; (4) examine whether affiliate membership in the ACS should be extended to nonsurgeons who participate in patient care in the OR (for example, medical students, perioperative nurses, certified registered nurse anesthetists, surgical technicians, physician assistants, and so forth); (5) discuss the potential for transferring the activities of the existing committees on applicants to the chapters; and (6) examine an existing list of services currently available to Fellows and make recommendations on services and/or activities that should be expanded, developed, or dropped.

New philosophy

The Governors' Committee on Chapter Activities was formed by the College to help chapters become more effective. Its current members believe that initiatives at the chapter and state levels in such venues as tort reform and trauma systems evolution are examples of how the chapters may indeed help the College achieve its goals. For better or worse, much of that which we are asked to promote and defend for our patients and our profession is decided within the political process of our great democracy. If, as it has been said, all politics is local, then we at the state and chapter level must become both more active and effective. Surgeons have learned from bitter experience that the faith and hope of our profession lie upon the individual shoulders of those within the bonds of its membership. We as individual surgeons and individual chapters no longer have the luxury of asking the College to accomplish for us those missions that we are more capable of accomplishing for ourselves. □

Acknowledgments

The author wishes to thank all the members of the committee for their efforts during the last year. On behalf of all the members of the GCCA, I would like to thank Thomas R. Russell, MD, FACS, ACS Executive Director; Paul E. Collicott, MD, FACS, Director of Member Services; and Rhonda Peebles, Chapter Services Manager, for their guidance and assistance.

Dr. Johnson is professor of clinical surgery, Louisiana State University (LSU) Health Science Center, Shreveport, and chief of surgery, LSU Health Science Center, Monroe, LA. He is Chair of the Board of Governors' Committee on Chapter Activities.



Statement on safety belt laws and enforcement

The American College of Surgeons' Committee on Trauma, through its Subcommittee on Injury Prevention and Control, prepared the following Statement on Safety Belt Laws and Enforcement in order to educate surgeons about the important differences between primary and secondary laws and to encourage surgeons to support primary restraint legislation in their respective states.

The statement was approved by the Board of Regents at their June 2003 meeting.

Over 42,000 deaths occur each year on roadways in the U.S., and an estimated 3 million people are injured. Seatbelts have been shown to significantly reduce morbidity and mortality following motor vehicle crashes, but in 2002, only 75 percent of motor vehicle occupants were restrained. Increasing the national seat belt use rate to 90 percent would prevent an estimated 5,536 fatalities, 132,670 injuries, and save the nation \$8.8 billion annually. Currently, every state but New Hampshire has seat belt legislation, but only 19 jurisdictions have primary seat belt laws. Primary seat belt laws have been shown to significantly increase seat belt usage.

Whereas:

- Safety belts are the single most effective safety device in preventing serious injury and death in motor vehicle crashes.
- Safety belts, when used properly, reduce the risk of fatal injury to front seat passengers by 45 percent and the risk of moderate to severe injury by 50 percent.
- “Primary” safety belt laws allow a citation to be issued whenever a law enforcement officer observes an unbelted driver or passenger. “Secondary” safety belt laws require the officer to stop a violator for another traffic infraction before being able to issue a citation for not using a safety belt.
- “Primary” safety belt laws have been shown to increase safety belt use up to 24 percentage points in the year following implementation.

-
-
- Strong legislation and effective enforcement are crucially important to the success of safety belt laws.

Therefore:

The American College of Surgeons supports legislation enacting standards for “primary” safety belt laws and their effective enforcement.

References

1. The Presidential Initiative for Increasing Seat Belt Use Nationwide. November 2001. DOT HS 809 349. NHTSA Web site: www.nhtsa.dot.gov/people/injury/airbags/bua4threport/status.html#2. Accessed 5/6/2003.
2. Viano DC: Restraint effectiveness, availability and use in fatal crashes: Implications for injury control. *J Trauma*, 38:538-546, 1995.
3. Zador PL, Ciccone MA: Automobile driver fatalities in frontal impacts: Air bags compared with manual belts. *Am J Pub Hlth*, 83:661-666, 1993.
4. Mitchell JL, Remington PL: Research shows effectiveness of safety belts. *WMJ*, 100(3):4, 2001.
5. Evans L: The effectiveness of safety belts in preventing fatalities. *Accident Anal Prev*, 18:229-241, 1986.
6. Campbell BJ: Highway Safety in 2010: Compromising among values. In: Stammer ME (ed.): *Highway Safety at the Crossroads*. New York, NY: American Society of Civil Engineers, p. 279-289, 1988.
7. National Highway Traffic Safety Administration: *The Case for Primary Enforcement of Safety Belt Use Laws*. Washington, DC: NHTSA. DOT/HS 808, 32, 1995.
8. Ulmer RG, Preusser CW, Preusser DF, Cosgrove LA: 1995. Evaluation of California’s safety belt law change from secondary to primary enforcement. *J Safety Res*, 26(4):213-220, 1995.

Keeping current

What's new in *ACS Surgery: Principles and Practice*

by Erin Michael Kelly, New York, NY

Following are highlights of recent additions to the online version of *ACS Surgery: Principles and Practice*, the practicing surgeon's first and only Web-based and continually updated surgical reference. See the box below for a special announcement for ACS Fellows, Associates, and Candidates.

Keeping current in 2003 with *ACS Surgery: Principles and Practice*

ACS Surgery 2003 is the only American College of Surgeons-sponsored textbook of general surgery. Order your copy today to receive a free three-month trial to the online version at www.acssurgery.com—a \$50 value. For only \$199, you can be among the elite group of surgeons who subscribe to the only continually updated surgery textbook, *ACS Surgery*. (ACS members save \$30 over the regular price of \$229.) Updated monthly online and annually in print, the *ACS Surgery 2003* volume features 40 percent new and updated information to provide the most contemporary views on best practices and technique. Minimize complications, lower expenditures, and increase patient satisfaction with this unique reference—the only one with an accompanying online CME program. Call 1-800/545-0554 today to order your copy and be sure to request offer number S39S001C.

- Prefer online access only? For ACS Fellows, Associates, and Candidates, we are pleased to offer a \$20 discount on annual subscriptions to the online version of the textbook; you pay only \$179, instead of the customary \$199 rate. Visit www.acssurgery.com/learnmore.htm for more information and to save \$20 now.

- Free, convenient *ACS Surgery* updates by e-mail—no subscription necessary. Each month we'll bring you a synthesis of the latest contributions from the *ACS Surgery* team of master surgeons, and we'll do it for free. Simply visit http://www.acssurgery.com/wnis/wnis_sign.htm to register to receive "What's New in *ACS Surgery*" by e-mail.

II. Common presenting problems

13. *Pulsatile abdominal mass*. Timothy A. Schaub, MD, and Gilbert R. Upchurch, Jr., MD, FACS. In their updated chapter, the authors describe the evaluation of the patient with a pulsatile abdominal mass and give special attention to the patient with a suspected abdominal aortic aneurysm (AAA). Presentation, history, and physical examination are discussed. The workup of the stable patient with a pulsatile abdominal mass is extensively discussed. The preoperative evaluation of candidates for nonemergency AAA repair is also considered in detail, and the complications of AAAs are presented.

Symptomatic or ruptured aneurysms sometimes mimic other acute medical conditions and, therefore, are part of multiple differential diagnoses. The following conditions all may be confused with ruptured AAAs: perforated viscus, mesenteric ischemia, strangulated hernia, ruptured visceral artery aneurysm, acute cholecystitis, acute pancreatitis, ruptured appendix, ruptured necrotic hepatobiliary cancer, lymphoma, and diverticular abscess. Fortunately, a ruptured AAA is rarely misdiagnosed. Moreover, most patients who do undergo an operation for a misdiagnosis either benefit from or at least are not harmed by the operation, which should alleviate some potential concerns about taking an aggressive approach to a suspected ruptured AAA.

Conversely, AAAs may mimic other disease processes: in one study, nearly one in five patients with symptomatic AAAs in an emergency department were originally diagnosed as having nephroureterolithiasis. Patients who have urologic symptoms but whose urinalysis is normal may benefit from an AAA workup; radiologic evidence of ureteric involvement is present in as many as 71 percent of patients with an AAA. Subscribers to *ACS Surgery* may view the full text of "Pulsatile abdominal mass" at www.acssurgery.com.

II. Common presenting problems

14. *Pulseless extremity and atheroembolism.* Vicken N. Pamoukian, MD, and Cynthia K. Shortell, MD, FACS. The authors describe the pathophysiology, etiology, and clinical evaluation of acute limb ischemia, including staging and diagnostic testing. Their chapter surveys the treatment approaches to acute lower-limb ischemia, including anticoagulation, thrombolysis, thrombectomy, and embolectomy and revascularization. The clinical evaluation, diagnostic testing, and treatment of atheroembolism are also discussed.

In their discussion of acute limb ischemia (ALI), the authors review the characteristic signs and symptoms of ALI, which may be summarized as the six Ps: pulselessness, pain, pallor, poikilothermia, paresthesia, and paralysis.

1. Pulses should be palpated and documented. Any previous documentation should be noted.
2. Pain should be documented with regard to severity, area, and progression.
3. Pallor may be seen in the early stages, followed by cyanosis.
4. Poikilothermia may propagate the cascade through its vasoconstrictive effects. The level of coolness and pallor is typically one level below the point of occlusion on the arterial tree, and it should correlate with the pulses or signals found. As always, baseline documentation should be done so that the progression or resolution of the process can be tracked.
5. Paresthesia is an essential finding. The earliest sign of tissue loss is the loss of light touch, two-point discrimination, vibratory perception, and proprioception, especially in the first dorsal web space of the foot.

6. Paralysis, if present, is an indication of advanced limb-threatening ischemia. The extent of paralysis must be determined. The intrinsic muscles of the foot are affected by ischemia of the vessels around the ankle. Dorsiflexion and plantar flexion of the foot are functions of muscles that rely on blood supplied by the popliteal and superficial femoral arteries. Loss of dorsiflexion and plantar flexion indicates that blood flow is cut off at a higher level and signals that more tissue may be at risk. Subscribers to *ACS Surgery* may view the full text of "Pulseless extremity and atheroembolism" at www.acssurgery.com.

II. Common presenting problems

15. *Diabetic foot.* Cameron M. Akbari, MD, FACS, and Frank W. LoGerfo, MD, FACS. In their updated chapter, the authors describe the evaluation and management of the diabetic foot. Clinical evaluation is discussed, and the assessment of clinical findings is described in detail. Revascularization, continued wound care, secondary foot procedures, and preventive foot care also are discussed.

For example, depending on the situation, the authors suggest a number of options for revascularization. As a rule, arterial bypass grafting is required for restoration of the foot pulse. Proximal bypass to either the popliteal artery or the tibial and peroneal arteries may restore foot pulses, and preference should be given to these vessels if they are in continuity with the foot. Often, however, because of the presence of more distal obstructive disease, bypass grafting to the popliteal or even the tibial artery will not restore the foot pulse. In such cases, restoration of pulsatile flow to the foot may be accomplished with autogenous vein bypass grafts to the paramalleolar or inframalleolar arteries (such as the dorsalis pedis). The vein graft can be prepared as an in situ graft, a reversed graft, or a nonreversed graft, without any significant difference in outcome; the choice of approach should be based on the patient's particular vascular anatomy. Subscribers to *ACS Surgery* may view the full text of "Diabetic foot" at www.acssurgery.com.

V. Operative management

35. *Fundamentals of endovascular surgery.* Jon Matsumura, MD, FACS, and Joseph Vijungco, MD. This chapter describes fundamental endovascular techniques that the skilled vascular surgeon must master. Drs. Matsumura and Vijungco describe choice of access site, and discuss puncture of femoral, brachial, and axillary arteries, as well as translumbar puncture, together with troubleshooting for these procedures. Placement of guide wires and sheaths, catheterization techniques, and use of vascular stents are described, and postprocedural management of the arterial access site is discussed.

For example, attempts to puncture the common femoral artery sometimes result in puncture of the common femoral vein, signaled by the appearance

of dark, nonpulsatile venous blood. If this occurs, one should note the position of the original stick, move the needle 1 to 2 cm laterally, and reinsert the needle. At times, especially when pulse pressure is low, arterial blood may be dark and resemble venous blood. If it is unclear whether the blood is coming from an artery or a vein, a small amount of contrast agent should be gently injected into the needle by hand so that its location can be confirmed. Subscribers to *ACS Surgery* may view the full text of “Fundamentals of endovascular surgery” at www.acssurgery.com.

VI. Special perioperative problems

12. Antibiotics. Nicolas V. Christou, MD, PhD, FACS. In this newly updated chapter, the author describes the principles of antimicrobial therapy. Antibiotic selection for infections in surgical patients is discussed, adverse reactions to antimicrobial agents are detailed, and the major groups of antimicrobials are described as well.

To make a rational decision regarding empirical therapy, the surgeon must be familiar with the organisms that are likely to be encountered when a particular infection (such as an intraabdominal abscess) is suspected. Selection of the agent or agents is based on the history, the physical examination, the infection’s likely site of origin, the host defense status, the overall clinical severity of the infection, and the host’s response. Definitive therapy is initiated after the host response to the infection and to the empirical treatment has been monitored and the results from the microbiology laboratory—specifically, identification of the isolated organisms and the minimal inhibitory concentrations of various antimicrobial agents—have been assessed.

Subscribers to *ACS Surgery* may view the full text of “Antibiotics” at www.acssurgery.com.

Looking ahead

New and revised chapters scheduled to appear as online updates to *ACS Surgery: Principles and Practice* in the coming months include the following:

- “Stroke and transient ischemic attack,” by Thomas S. Maldonado, MD, and Thomas S. Riles, MD, FACS.
- “Preparation of the operating room,” by Rene Lafrenière, MD, CM, FACS; Ramon Berguer,

MD, FACS; Patricia C. Seifert, RN; Michael Belkin, MD, FACS; Stuart Roth, MD, PhD; Karen S. Williams, MD; Eric J. De Maria, MD, FACS; and Lena M. Napolitano, MD, FACS.

- “Acute cardiac dysrhythmia,” by Caesar Ursic, MD, and Alden H. Harken, MD, FACS.
- “Disorders of water and sodium balance,” by Richard H. Sterns, MD. 

Mr. Kelly is editor, *What’s New in ACS Surgery: Principles and Practice*, *WebMD Reference*, New York, NY.

Socioeconomic tips of the month

Advice from an ACS coding course instructor

by Mary LeGrand, RN, Chicago, IL

This month's column responds to some of the questions commonly raised during the coding workshops the past year.

Q. What factors do I need to consider to accurately report a procedure or code combination?

A. It is important to ask yourself several questions when coding a surgical case. Let's look at a few and why they are important:

- *How many surgeons were involved, and what were their roles?* It is important to know if the surgeon operated alone or with a cosurgeon or an assistant surgeon. Dictate the name and role of each physician who participated in the case. Cosurgeons are responsible for dictating their own operative notes, while assistant surgeons do not dictate operative notes.

- *Are any of the procedures distinct and separate?* Sometimes it is possible to report procedures in combination with other procedures if the physician performed them during different sessions, through a separate incision, or at a different site. Append modifier -59, *Distinct procedural service*, to report services that are not normally reported together, but are appropriate under the circumstances.

- *Is the patient in a global period for this surgeon or another surgeon in the same practice?* This tells us whether the physician needs a modifier for proper reimbursement of services that may be appropriately reported during the global period of another procedure.

- *Is the physician planning future surgery during the global period?* Here the physician is "think-

Around the corner

October

- 2004 ICD-9-CM code changes effective October 1. The 90-day implementation period during which Medicare will allow claims to be submitted with the 2003 and the 2003 ICD-9-CM code versions begins.
- Quarterly update to 2003 Medicare fee schedule effective October 1.
- Quarterly update to 2003 Correct Coding Edits effective October 1.
- ACS-sponsored basic (SC 10) and advanced (SC 13) coding and practice management (PG 28) courses for surgeons during ACS Clinical Congress in San Francisco, CA. To register for these courses, go to <http://www.facs.org/clincon2003/index.html>.

ing like a chess player." If the physician plans to return the patient to the operating room for additional procedures during the global period, the physician indicates this intention in the indications for surgery paragraph in the first operative note. This affects modifier use on subsequent procedures during the global period.

Q. If an evaluation and management (E/M) service is reported with a surgical procedure, should we document a separate E/M and surgical procedure?

A. It is appropriate to report an E/M service if it is a significant, separate service rendered on the same day as a minor procedure, or the decision for surgery was made on the same day or day before a major procedure. Append modifier -25, *Significant, separately identifiable evaluation and management service by the same physician on the day of a procedure*,

All specific references to CPT terminology and phraseology are: CPT only 2002 © American Medical Association. All rights reserved.

to the E/M performed on the same day as a minor procedure, when the E/M is a significant separate service. Append modifier -57, *Decision for surgery*, to the E/M when the E/M is appropriately reported the same day of or the day before a major procedure.

Q. **An orthopaedic spine surgeon asked my surgeon to do the retroperitoneal access for an anterior lumbar interbody fusion. Do I report this procedure as cosurgery (using the same codes as the orthopaedic surgeon), or should I report CPT code 49010, *Exploration, retroperitoneal areas with or without biopsy(s)*?**

A. The correct way to report this is as a cosurgery. The orthopaedic surgeon and your general surgeon will both report the primary procedure as cosurgery, using the exact same CPT code with modifier -62, *Two surgeons*. The approach to the spinal procedure is included in the definitive procedure, thus each surgeon is performing distinct separate procedures. If the physician performs additional level fusions and the two surgeons continue to function as cosurgeons, they may also report the appropriate add-on procedures using the cosurgeon modifier.

Q. **A patient presented to our office at the request of his primary care physician for evaluation of rectal pain and bleeding. I evaluated the patient and determined that the patient had a rectal abscess, which I drained at that time. May I report a consult service and the incision and drainage of the rectal abscess?**

A. Both services may be reported. CPT code 46050, *Incision and drainage, perianal abscess, superficial*, has a 10-day global period. Append modifier -25, *Significant, separately identifiable evaluation and management service by the same physician on the day of a procedure*, to the consultation code. This E/M is a significant separate service, as it resulted in the decision to perform the surgical incision and drainage.

Q. **Our surgeon performed a colon resection with colostomy and plans to do a takedown of the colostomy in six to eight weeks. Is the takedown included in the primary procedure?**

A. This situation offers an excellent example of a staged procedure. The physician indicates in the first operative note his plan for the staged procedure. His second operative note begins, "patient underwent colon resection with colostomy and as previously planned, patient returns to the operating room for takedown of colostomy or other procedure." Append modifier -58, *Staged or related procedure or service by the same physician during the postoperative period*, to the second procedure to indicate that it was planned prospectively, or staged. The global period will restart, and you would expect 100 percent reimbursement for the second or staged procedure.

Q. **A patient underwent rubber band ligation of hemorrhoids three weeks ago. He came in today for a problem unrelated to the hemorrhoids. Do I need to use modifier -24 on the E/M service?**

A. Rubber band ligation of hemorrhoids has a 10-day global period. Because the patient is being treated three weeks after the surgery, he or she is no longer in the global period. The physician should report the appropriate E/M code without appending modifier -24, *Unrelated evaluation and management service by the same physician during a postoperative period*. 

This column responds to questions from the Fellows and their staffs and provides useful tips for surgical practices. Developed by the College staff and consultants, this information will be accessible on our Web site. If you would like to see specific topics addressed in future columns, please contact the Division of Advocacy and Health Policy by fax at 202/337-4271, or e-mail HealthPolicyAdvocacy@facs.org

Ms. LeGrand is a consultant with *KarenZupko & Associates, Inc.*, a physician practice management consulting firm in Chicago, IL. You may contact her at 312/642-5616 or via karenzupko@aol.com.

College news

College continues efforts in AMA House of Delegates

by Jon H. Sutton, State Affairs Associate, Division of Advocacy and Health Policy

The annual meeting of the American Medical Association (AMA) House of Delegates (HOD) took place June 15-19 in Chicago, IL. The meeting offered delegates from national specialty and state medical societies the opportunity to discuss and vote on policy matters of concern to the "house of medicine." The College continues its role in the HOD process, weighing in on a number of issues of concern to the surgical community.

Office-based procedures

The College represented the surgical community in supporting the adoption of office-based surgery (OBS) principles as incorporated in AMA board of trustees (BOT) Report 23. The principles listed in BOT 23 were originally developed and unanimously supported by a work group of 35 organizations convened in March by the AMA and the College (see the July 2003 *Bulletin*, p. 12, for more information; the principles are available at <http://www.facs.org/ahp/views/patsafety2.html>).

Because the trustees' report had the enthusiastic support of many different specialty societies and the reference committee, the College anticipated that the OBS principles would sail through the remainder of the HOD approval process. However, a handful of individuals voiced differing opinions during

floor consideration, resulting in the report being referred back to the trustees for further discussion and guidance.

Payment for technology

The College joined with the American College of Emergency Physicians and the American College of Obstetricians and Gynecologists in cosponsoring a resolution regarding payment for advanced technology. The resolution directs the AMA to vigorously oppose actions by medical insurers that result in denial of payment for services simply based on the size of the medical equipment used during the procedure.

The impetus for the resolution

was recent insurance company decisions to deny reimbursement for handheld ultrasound devices. The resolution, which was unanimously adopted by the HOD, expresses the medical community's belief that physicians and patients should be allowed to benefit from advances in medical technology. The College's cosponsorship of this resolution reflects the organization's continuing leadership and support in securing appropriate reimbursement for ultrasound services.

The 80-hour workweek

The Accreditation Council on Graduate Medical Education's (ACGME's) resident duty-hour

OFFICIAL NOTICE

Annual Meeting of Fellows, American College of Surgeons

In accordance with Article I, Section 6, of the *Bylaws*, the Annual Meeting of the American College of Surgeons is called for two o'clock in the afternoon of Thursday, October 23, 2003, at the McCormick Place Lakeside Center.

This session constitutes the annual business meeting of the Fellows, at which time Officers

and Governors will be elected, and reports from officials will be presented. Items of general interest to the Fellows will also be presented. Each Fellow is respectfully urged to be present.

John O. Gage, MD, FACS
Secretary,
American College of Surgeons
August 1, 2003

limits were a prominent topic of discussion. A report by the AMA Council on Medical Education (CME) report, as well as a strong resolution from the Young Physicians Section, called for the organization to monitor the enforcement of these standards and their effect on postresidency physicians. The College succeeded in adding a recommendation to the CME report that the AMA work with the ACGME to objectively evaluate the impact of the new standards upon patient care and safety.

Quality of care

The Surgical Caucus of the AMA focused on the issue of enhancing quality surgical care with ACS Delegation Chair LaMar S. McGinnis, Jr., MD, FACS, providing a history of the

College leaders in AMA activities

LaMar S. McGinnis, Jr., MD, FACS, ACS Delegation Chair, *Atlanta, GA*

Charles Logan, MD, FACS, *Little Rock, AR*

Richard Reiling, MD, FACS, *Charlotte, NC*

Amilu Rothhammer, MD, FACS, *Colorado Springs, CO*

Tom Whalen, MD, FACS, *New Brunswick, NJ*

Chad Rubin, MD, FACS, ACS Representative to AMA YPS, *Columbia, SC*

ACS Delegation Liaison: Jon Sutton, State Affairs Associate, ACS Chicago Office; tel. 312/202-5358, or e-mail jsutton@facs.org.

College's activities in this area. In addition, Dr. McGinnis gave an overview of the National Surgical Quality Improvement Program (NSQIP)—a risk-adjusted outcome reporting system for major surgical operations within

the Department of Veterans Affairs (VA) health system. The College continues to work closely with the VA in its recent efforts to test the reporting system in other settings.

ACS Insurance Program: Update on major medical products

The Trustees of the American College of Surgeons Insurance Program approved a rate increase for participants under age 65 and their dependents on the Conventional Major Medical product and on the Cost Advantage Major Medical product of 25 percent and 30 percent, respectively, effective October 1, 2003. There will be no increase for members age 65 and over at this time. The premium rates for these products are based prima-

rily on the actual claim experience of the ACS risk pool, which recently has not been favorable.

The Trustees feel that New York Life Insurance Co., the insurer, and CBCA Administrators, the plan Administrators, provide quality services to our members. However, the approximate 850 plan participants is a relatively small risk pool and, as a result, the College's products may not always be cost-competitive when compared to other

products that have a much larger risk pool as a basis for their rate setting. If premium cost on your major medical coverage is a concern, the Trustees encourage you to compare the American College of Surgeons Insurance Program major medical cost with other products available to you in the market. Our members should make the appropriate decision that best suits their insurance needs.

At Clinical Congress

AWS conference to consider emotional intelligence

The Association of Women Surgeons' (AWS) annual half-day conference is scheduled for Sunday, October 19, during the first day of this year's Clinical Congress in Chicago, IL.

The conference's keynote speaker, Christine Mockler Casper, will provide attendees with an understanding of emotional intelligence (EI) and how it is critical for facing reality, applying ethical standards, increasing effectiveness, and developing leadership.

The presentation will focus on how EI can assist you in creating a culture of trust, commitment, authenticity, and effective decision making. Increased EI will allow you to have well-timed inspiration (your own actions), lead (social awareness), influence (read situations) and confront issues. Attendees will leave with an EI

assessment and tools to allow them to implement EI principles to meet their current leadership challenges.

Attendance at this conference provides three CME credits. The first 50 registrants will receive a complimentary copy of Ms. Casper's book, *From Now on With Passion: A Guide to Emotional Intelligence*.

The AWS networking luncheon and annual business meeting will follow the keynote address and is included in the AWS conference registration fee. Other AWS programs providing networking opportunities in conjunction with the Clinical Congress include:

- Awards reception and dinner, Sunday, October 19, 6:30–9:15 pm; the AWS awards ceremony will take place at the Signature Room on the 95th Floor of the John Hancock Center. A

separate registration fee is required.

- Complimentary networking breakfast, Wednesday, October 22, 7:00–9:00 am; AWS will host a complimentary networking breakfast for members and nonmembers. No registration is required. See the Sunday/Monday issue of the *Clinical Congress News* for more details.

Plan to visit the AWS booth #2339 at the ACS exhibition hall located at the Lakeside Center at McCormick Place. Visitors may obtain information regarding AWS programs, learn more about the profession, and network with peers.

Interested individuals may visit the AWS Web site at <http://www.womensurgeons.org/2003fallconf.htm> to download a registration form, or call the AWS headquarters office at 630/655-0392 for more information.

Rural surgeons meeting to be held during Clinical Congress

Thomas R. Russell, MD, FACS, ACS Executive Director, and Paul E. Collicott, MD, FACS, Director of the College's Division of Member Services, plan to meet with Fellows who serve a rural or small-town patient base during the Clinical Congress.

They hope to learn more about the particular interests and challenges of rural Fellows in a round table discussion about what the College can do for and with our Fellows serving such a specialized population.

The meeting is scheduled to

take place Tuesday, October 21, 2003, 4:00–5:30 pm, in the Hilton Chicago and Towers Hotel, Stevens 3/4, Lower Level. Fellows who wish to participate in the program should contact Kate Early at tel. 312/202-5281 or via e-mail at kearly@facs.org.

Disciplinary actions taken

In February the Board of Regents censured a plastic surgeon from New York, NY. This surgeon was the subject of a consent order in May 2002 that was issued by the New York State Board of Professional Medical Conduct and confirmed a limited censure and reprimand following allegations of negligence.

The following disciplinary actions were taken by the Board of Regents at their June 7, 2003, meeting:

- James Benjamin Burke, MD, a plastic surgeon from Birmingham, AL, was expelled from the College. Dr. Burke voluntarily surrendered his license to practice medicine in June 2002 following allegations of un-

professional conduct that included immoral, unprofessional, and dishonorable conduct with patients.

- Pankaj T. Desai, MD, a plastic surgeon from New Hartford, NY, was expelled from the College. This action followed suspension of his medical license in the State of New York after being found to “constitute an imminent danger to the health of the people of this state.”

- Kevin R. Ham, MD, an otolaryngologist from Independence, MO, was expelled from the College. This action followed the revocation of his Missouri medical license in February 2000, the revocation of his American Board of Otolaryngol-

ogy certification in April 2000, and a felony conviction in September 1999.

- An obstetrician/gynecologist from Wahpeton, ND, had his Fellowship restored to full status after being on probation since February 2002. This Fellow was placed on probation after being charged with violation of Article VII, Sections 1(b) and (f) of the ACS *Bylaws*. His medical license was suspended and he was subsequently placed on probation with restrictions in Minnesota and North Dakota. This surgeon’s licenses in both states have since been restored to full and unrestricted status.

Hernia operations to be televised live at Clinical Congress

The Committee on Video-Based Education will feature live, interactive, closed-circuit televised operations from five sites during this year’s Clinical Congress in Chicago, IL. This special program will take place Monday, October 20, 1:00–4:30 pm, and will feature five different inguinal hernia procedures performed by renowned surgeons in New York, NY, Chicago, IL, Los Angeles, CA, Bedford, TX, and Freehold, NJ.

Michel Gagner, MD, FACS, New York, NY, will serve as coordinator and presiding officer

for the event. A special panel of discussants will interact with the operating surgeons and comment on the operations. Panelists include: Cassim T. Degani, MD, FACS, Mississauga, ON; Robert J. Fitzgibbons, MD, FACS, Omaha, NE; J. Barry McKernan, MD, FACS, Marietta, GA; and Ira M. Rutkow, MD, FACS, Freehold, NJ.

Operation I: Open Repair, Shouldice Technique—Michael A.J. Alexander, MB BS, FACS, Toronto, ON; Operation II: Laparoscopic Repair TAPP—

Robert W. Sewell, MD, FACS, Bedford, TX; Operation III: Open Lichtenstein Repair—Parviz K. Amid, MD, FACS, Los Angeles, CA; Operation IV: Laparoscopic Extra-Peritoneal Hernia Repair—George S. Ferzli, MD, FACS, Staten Island, NY; and Operation V: Open Mesh Plug Repair—Keith W. Millikan, MD, FACS, Chicago, IL.

Further information may be obtained by contacting Gay Lynn Dykman at 312/202-5262 or e-mail gdykman@facs.org.

NTDB™ data points

The critical aspect of blunt trauma

by Richard J. Fantus, MD, FACS, Chicago, IL, and John Fildes, MD, FACS, Las Vegas, NV

Last month we highlighted the fact that the majority of trauma records contained in the *2nd Annual Report of the National Trauma Data Bank™ (NTDB)* resulted from blunt injury mechanisms. Looking at the resource-intensive nature of trauma, it comes as no surprise that victims of significant blunt forces are a major consumer. Blunt trauma more commonly produces multiple organ system injuries when compared with penetrating trauma. These multiple blunt injuries and their sequelae often lead to intensive care unit stays. The graph at right illustrates that while motor vehicle-related injury accounted for 38 percent of trauma records, this group used more than half of all the intensive care unit days.

Being a heavy user of system resources, motor vehicle-related injury is clearly a major public health concern. Reengineering vehicle design with the advent of airbags and, more recently, the black boxes that will autodial 911 after a crash to initiate the post-trauma medical care sooner will help to lessen the impact of motor vehicle crashes.

Newer roadway designs with concrete barrier medians reduce the frequency of head-on collisions. However, once injury occurs, only so much can be done to restore the patient to their



Proportional distribution of total hospital length of stay, grouped by mechanism of injury defined in Appendix B. Total N = 250,995. Total hospital length of stay = 1,387,237 days.

preinjury state. Prevention efforts aimed at promoting seat belt use, graduated drivers licenses for new teenage drivers, and avoiding driving while impaired are of paramount importance in trying to attack this problem. There is a role each one of us can play in trying to combat motor vehicle-related injury.

Throughout the year we will be highlighting these data through brief reports that will be

found monthly in the *Bulletin*. For a complete copy of the *National Trauma Data Bank Annual Report 2002*, visit the ACS Web site at <http://www.facs.org/dept/trauma/ntdbannualreport2002.pdf>.

If you are interested in submitting your trauma center's data, please contact Melanie L. Neal, Manager, NTDB, at mneal@facs.org.



CREATE YOUR OWN ID/PASSWORD

for "Members Only" area of ACS Web site

Can't think of your ACS ID number when you want to visit the "Members Only" side of the College's Web site? Your days of frustration are now over.

The College has updated the Members Only section to allow you to set your own user ID and password to access its many features. To make that change, go to the College's home page at <http://www.facs.org> and click on the "Members Only" link at the top of the page.

You will still need your ACS ID when you log in for the first time. You can then enter your user ID, password, and security questions. If you forget your password the next time you visit the page, you can recover your password online by answering your previously set up security questions.

While you are in the "Members Only" area, please check to be sure that your mailing address, telephone numbers, and e-mail address are both current and accurate. Be assured that the College does not provide your e-mail address to outside entities. E-mail addresses are used only for College communications.

Practice management consultation available during Congress

The American College of Surgeons' Division of Advocacy and Health Policy will sponsor a practice management consultation booth during the College's 89th annual Clinical Congress in Chicago, IL.

Fellows with questions concerning practice management issues, such as coding and re-

imbursement, HIPAA compliance, group mergers, and contract negotiations, are welcome to schedule a free 30-minute consultation. The consultations are being provided by Tom Loughrey of Economedix, a highly regarded consultant in the field of practice management.

Appointments will be ac-

cepted on a first-come, first-served basis. Appointments will be available October 20–22, 8:00 am–12:00 noon and 1:00–4:00 pm. To schedule a private consultation, please contact Irene Dworakowski by October 15 via e-mail at Idworakowski@facs.org, or by calling 202/672-1507.

SAGES/SSAT to present symposium on laparoscopic colectomy

The Society of American Gastrointestinal Endoscopic Surgeons (SAGES), in cooperation with the Society for Surgery of the Alimentary Tract (SSAT), will hold a seminar during this year's Clinical Congress in Chicago, IL, entitled Laparoscopic Colectomy: Why Are We Waiting? The seminar will be held Wednesday, October 22, beginning at 5:15 pm, in the Hyatt Regency Hotel.

The program will focus on the

following: Laparoscopic Colectomy and Cancer—Where Are We Now? (explaining the embargo—reasons to wait, what studies show, reasons to not wait, oncologic impact of the laparoscopic approach); Laparoscopic Colectomy and Benign Disease: Where Are We Going? (what happens when the results arrive/guidelines, starting off on the learning curve, simplifying advance procedures).

Tonia Young-Fadok, MD,

FACS, Scottsdale, AZ, will serve as chair for the seminar. Invited faculty include Heidi Nelson, MD, FACS; Morris Franklin, MD; Larry Whelan, MD; Steve Wexner, MD, FACS; and Peter Marcello, MD, FACS.

For more information, please contact SAGES, 11300 Olympic Blvd., Ste. 600, Los Angeles, CA 90064; tel. 310/437-0544, fax 310/437-0585, e-mail mikki@sages.org, Web site <http://www.sages.org>.



Change your address online!

Just visit www.facs.org
and go to the "Members Only" tab

Revised medical student guide to residency training now online

The online resource, *So You Want To Be a Surgeon: A Medical Student Guide to Finding, and Matching with, the Best Possible Surgery Residency*, has been updated and is now available on the College's Web site at <http://www.facs.org/residencysearch/index.html>.

Hosted by the ACS Division of Education, this online, con-

temporary version of the popular "Little Red Book" has proved to be an invaluable resource for medical students seeking opportunities in graduate medical education. The revised online version of this helpful reference includes a searchable database containing a complete list of accredited surgical specialty resi-

dency programs, as well as a section devoted to assisting students in choosing a residency program that may be the best fit for them.

For further information, contact Bryan E. Palis, Division of Education, Data Management Unit, at 312/202-5263, or via e-mail at bpalis@facs.org.

Computerized drug reference guides available to ACS Fellows

Two computerized drug reference guides—one for handheld devices and a Web-based desktop system—are now available to Fellows of the College through ePocrates, a leading provider of continually updated clinical reference tools.

ePocrates Rx Pro is the first handheld drug reference guide to

provide comprehensive information such as dosing, common uses, drug interactions, and adverse reactions on more than 400 alternative medicines. ePocrates Rx Online is a new Web-based desktop version of ePocrates Rx that can be referenced from any computer with Internet access.

Members of the College may receive a 25 percent limited-time discount on ePocrates premium clinical reference products by visiting <http://www.facs.org/members/members.html#epocrates>. This offer ends September 30, 2003.

Meeting for senior Fellows to be held during Congress

A special meeting for retired and soon-to-be retired Fellows will take place in conjunction with this year's Clinical Congress in Chicago. Scheduled for Tuesday, October 21, 1:45 pm–3:00 pm, the meeting will be held in the Waldorf Room, Third

Floor, at the Hilton Chicago.

Hosted by Robert E. Berry, MD, FACS, the meeting will focus on specific issues of interest to senior Fellows. A panel of Fellows will explore whether the College might consider providing specific services tailored

to meet the needs of its senior membership. If this topic is of interest to you, please plan to attend and participate. If you have a specific issue you would like the panel to address, please contact Dr. Berry at valber@att.net.

Bariatric surgery primer to be featured at Clinical Congress

A postgraduate course entitled Bariatric Surgery Primer (SC16) will be featured at this year's annual Clinical Congress in Chicago, IL. Henry Buchwald, MD, PhD, FACS, a pioneer and leading advocate of bariatric surgery, and Sayeed Ikramuddin, MD, a leading laparoscopic bariatric surgeon, will serve as Chair and Associate Chair of the course.

A stellar, world-renowned faculty has been assembled: George Cowan, MD, FACS; Walter Pories, MD, FACS; Christine Ren, MD, FACS; John N. Halverson, MD, FACS; Robert E. Brolin, MD, FACS; Michel Gagner, MD, FACS; Scott A. Shikora, MD, FACS; J. Patrick O'Leary, MD, FACS; Marie-Claire Buckley, MD, FACS; John C. Alverdy, MD, FACS; Mary Lou Walen; and Walter Lindstrom, Esq. In addition to the didactic sessions, six interactive, live surgery broadcasts and panel discussions will be featured, including operative surgery by Dr. Ren; Dr. Gagner; Philip R. Schauer, MD, FACS; Kelvin D. Higa, MD, FACS; James K. Champion, MD, FACS; and Douglas Hess, MD, FACS.

A special evening presentation and dinner are included, with a talk on biliopancreatic diversion/duodenal switch by Aniceto Baltasar, MD, Alcoy Alicante, Spain, president of the International Federation of Surgery for Obesity.



Dr. Buchwald

This intense, two-day course will provide participants with a broad overview of bariatric surgery. Upon completion of this course, participants will be able to describe the epidemiology, etiology, and incidence of morbid obesity and outline the physiologic basis for bariatric surgery. Criteria for identification of appropriate surgical candidates will be outlined and various bariatric procedures, such as laparoscopic adjustable gastric banding, vertical banded gastro-

plasty, gastric bypass, and duodenal switch will be presented. The pre-, intra-, and postoperative care associated with each procedure will be described, along with the possible postoperative complications and their appropriate management and prevention strategies.

In addition, principles underlying a multidisciplinary approach to bariatric surgery and the consequences of post-bariatric surgery weight loss will be discussed. The course will also include presentations on insurance, billing, coding, and liability issues related to bariatric surgery.

The sessions will take place Tuesday, October 21, 8:00 am–12:05 pm (Session I); 1:30–4:40 pm (Session II); 6:30–8:45 pm, Special Lectureship and Dinner (Session III); Wednesday, October 22, 8:00–9:50 am (Session IV); 10:10 am–5:30 pm, live interactive TV presentations (Session V).

Further information is currently available on the College's Web site at www.facs.org/dept/hba/workshops/pmworkshop.html.

Residency Assist Page debuts on ACS Web site

The Residency Assist Page (RAP) has been added to the College's Web site to address a spectrum of issues related to the restrictions on the duty hours of residents that were recently mandated by the Accreditation Council for Graduate Medical Education and implemented July 1, 2003.

Developed by the College's Division of Education, this section is specific to surgery and should serve as a unique resource for surgery program directors and others as they con-

sider changes in residency programs to ensure optimum educational outcomes under the new guidelines.

Richard H. Bell, MD, FACS, and Debra A. DaRosa, PhD, serve as editors of this online section. The editorial board includes Gary L. Dunnington, MD, FACS; Timothy C. Flynn, MD, FACS; James M. Hassett, MD, FACS; and Marc K. Wallack, MD, FACS.

Information to be made available through the RAP includes: editorials accompanied by se-

lected references; examples of practical solutions; reactions to the topics covered in previous columns; and responses by the editors to questions posed by program directors. The goal of the editors is not to be prescriptive, but to offer helpful suggestions that may be adapted to meet the specific needs of individual programs. An overview of the goals of RAP and further information is available at <http://www.facs.org/education/residencyassist.html>.

College works to address expert witness issues

Because itinerant plaintiff expert witnesses who provide inappropriate and inaccurate testimony are still commonplace, there is a need for an expanded and comprehensive database to track such testimony. To that end, the ACS is working with IDEX—a national network of more than 3,800 defense law offices, corporations, and governmental entities sharing expert witness information. The network's database contains more than 800,000 records of experts who have been involved in cases throughout the U.S. Typically, 4,500 to 6,500 new records are added every month.

IDEX states that it can provide:

- Expert witness case history.
- Transcript/document archival searches.
- Abstracts of articles/books written by the expert or naming an expert.
- "Challenges to Exclude an Expert" search.
- Information on professional disciplinary action taken against an expert's license to practice.
- Scientific literature research information on cases similar to that of the client.
- Assistance in locating an expert to help build a defense.

If you are named as a defendant in a lawsuit, the College recommends that either you or your counsel contact IDEX at

800/521-5596 concerning the plaintiff expert witness in your case. When calling, advise the representative that you are a Fellow of the American College of Surgeons. IDEX will send you the appropriate form to request the testimonial history of a particular itinerant plaintiff expert witness. A modest fee will be required only if the search succeeds in finding a case history. Any additional documents that are available through IDEX will be noted in the report, along with the additional fees that would be required to obtain copies.

Active participation by the defendant surgeon cannot be overestimated.

Profiles in Leadership

Julius H. Jacobson II, MD, FACS

Fellow of the American College of Surgeons since 1961. Vascular surgeon. Has endowed four surgical and medical professorships and an ACS annual Innovation Award. Author of *The Classical Music Experience*.



"I have been fortunate to have a rewarding career in surgery. For that I am indebted to the institutions that gave me an excellent education and to the ACS for allowing me to make my early work known. I am grateful that I am able in some measure to repay these debts and I strongly believe that each one of us is obliged to 'give back.'

"The ACS is a finely administered organization that educates and maintains professional standards for those who care for you and those you love. Beyond altruism, then, it is clearly in your self-interest to contribute to the ACS. At the same time, you will further the advances in surgery that will ultimately benefit patients worldwide.

"Of the many organizations in which I participate, the ACS has done more than any other to widely disseminate advances in knowledge."

Dr. Jacobson supports the College financially through active membership in the Fellows Leadership Society.

For information about joining the Fellows Leadership Society, please contact the College's Development Office via telephone at 312/202-5376, via e-mail at fholzrichter@facs.org, or by visiting the ACS Web site at www.facs.org.



We invite you to consider joining Dr. Julius Jacobson in the Fellows Leadership Society of the American College of Surgeons.



General sessions to address liability and patient safety issues

Three general sessions at the forthcoming Clinical Congress in Chicago, IL, will address liability and patient safety issues and their impact on today's practicing surgeons.

- Patient Safety in Clinical Surgery (GS 21) will take place Tuesday, October 21, from 8:00 to 10:00 am. Panelists will address a variety of issues related to patient safety as discussed in the *Patient Safety Manual*. William C. Nugent, MD, FACS, Lebanon, NH, will serve as moderator for the session.

Scheduled topics/presenters are: Legal Issues in Patient Safety Promotion, by Bryan A. Liang, MD, PhD; Organizing for Safest Health Care: Institutional Learning, Memory, and Intelligence, by Stephen D. Small, MD; The 80-Hour Workweek: How Will This Impact Patient Safety?, by Paul Friedmann, MD, FACS; Patient Safety Claims of Clinical Information Systems, by Jonathan C. Silverstein, MD, FACS; Educational Interventions to Enhance Surgical Patient Safety, by Ajit K. Sachdeva, MD, FACS, FRCSC; and Measuring Appropriateness: Clinical Application of National Guidelines, by Dr. Nugent.

- The Surgeon and the Law: Medical Liability Crisis—Different Viewpoints (GS 41) will take place

Wednesday, October 22, from 1:00 to 3:00 pm. Paul F. Nora, MD, FACS, Kenilworth, IL, will serve as moderator of the session.

For the past 25 years, physicians have been coping with the effects of a flawed system to deal with medical injuries. The current system is unjust, inefficient, and unfair. This fault-based system, despite many efforts at reform, has led to our current crisis. Physicians are being forced to restrict their practices, relocate, or prematurely retire. As a consequence, access to care is being threatened. This session will present different viewpoints about the cause and possible remedies to the medical liability crisis.

Scheduled topics/presenters are: Plaintiff Bar's Position on Medical Liability Reform, by Todd A. Smith, JD; Views of Organized Medicine, by Donald J. Palmisano, MD, FACS; and A Novel Approach to Possible Reform Initiatives, by Philip K. Howard, JD.

- A Surgeon's Guide to Risk Management (GS 50) will take place Thursday, October 23, from 8:00 to 11:00 am. Bruce L. Allen, MD, FACS, San Mateo, CA, and F. Dean Griffen, MD, FACS, Shreveport, LA, will serve as moderators of the session.

The course will again examine the surgeon's individual

responsibility to evaluate and improve personal performance as it relates to patient safety. Scheduled topics/presenters are: The Psychological Trauma of Being Sued, by Sara C. Charles, MD; Legal Claims Doctors Can Face: Medical Malpractice and Beyond, by William J. Rogers, JD; and The Work-Up of the Defense to a Medical Malpractice Case: What Should the Surgeon Expect from an Attorney?, by Thomas J. Donnelly, JD.

Further information regarding these sessions at the Clinical Congress may be obtained by contacting Ruth Shea at College headquarters, tel. 312/202-5413, e-mail rshea@facs.org.



Highlights of the ACSPA Board of Directors and the ACS Board of Regents meeting

June 6-7, 2003

*by Paul E. Collicott, MD, FACS,
Director,
Division of Member Services*

American College of Surgeons Professional Association (ACSPA)

ACSPA-SurgeonsPAC

In its first eight months, the ACSPA-SurgeonsPAC raised \$131,000 from 635 Fellows, Associate Fellows, and Candidates. Planning has begun for ACSPA-SurgeonsPAC fundraising events during the 2003 Clinical Congress. The ACSPA-SurgeonsPAC has contributed to the campaigns of 23 federal candidates since January. Of particular note, the PAC organized a May 8 fundraising event for KOMPAC, House Speaker Dennis Hastert's (R-IL) political action committee, and a May 21 event for Rep. John Murtha (D-PA), a key supporter of medical liability reform.

Members of the PAC's Board of Directors have volunteered to attend local meetings, and staff are educating surgeons who participate in the Washington Chapter Visit Program about PAC activities. On June 24, during the Chapters/Young Surgeons Leadership Conference in Washington, DC, the PAC Board of Directors met with the Health Policy Steering Committee to review the status of key issues on surgery's legislative agenda, and to review the events of the 108th Congress. The PAC Board members also visited with their legislators along with others who are participating in the Leadership Conference.

American College of Surgeons (ACS)

Bylaws change

The Board of Regents approved a change in the *Bylaws* that will allow all Governors who fill unexpired terms to serve a full three-year term. In the past, Governors who filled such terms served until the expiration of the term of their respective predecessors.

College logo

The Board of Regents approved in principle a proposal regarding a "slogan logo" that can be used by Fellows to indicate membership in the College. The final logo design and guidelines governing the logo's use will be submit-

ted for approval by the Regents at their October 2003 meeting.

Dues forecast

The Board of Regents approved the Finance Committee's recommendation that there be no dues increase for 2004. However, the Finance Committee recommended that a procedure to implement dues increases be structured by the Board of Governors. The Regents approved this recommendation.

Development Program

As of May 15, 2003, the College has received 1,531 gifts totaling \$1,318,519. These figures represent an increase over the same period last year.

Under the leadership of Amilu S. Rothhammer, MD, FACS, the committee arranged for a delegation to meet with the senior management of several corporations. These high-level discussions were initiated to establish and strengthen relationships between the College and industry. Additional meetings are being planned to explore program support possibilities.

Executive Committee/Board of Regents

Following are but a few of the actions taken by the Executive Committee during its interim meeting on April 1, 2003. The Executive Committee, and subsequently the Board of Regents, approved:

- The sale of the Nickerson Mansion to the Richard H. Driehaus Foundation.
- The College's continued participation in an effort led by the Health Coalition on Liability and Access.
- A contribution to aid the efforts on professional liability reform led by the Coalition for Affordable and Reliable Health Care.

Statement on disaster and mass casualty management

The Board of Regents approved an ACS Statement on Disaster and Mass Casualty Management, which was developed by the newly formed Ad Hoc Committee on Disas-

ter and Mass Casualty Management of the Committee on Trauma. The ad hoc committee members believe that surgeons should be an integral part of disaster planning and management and that the College should be an advocate for educating surgeons in this area. The statement was published in the August issue of the *Bulletin* (p. 14).

Statement on safety belt laws and enforcement

The Board of Regents approved an ACS Statement on Safety Belt Laws and Enforcement (see p. 32). The statement was developed by the Subcommittee on Injury Prevention and Control of the Committee on Trauma to support the enforcement of safety belt laws as an important way to decrease fatalities and the severity of injuries that occur with motor vehicle crashes.

ACS Surgical Volunteerism Award

The Board of Regents' Honors Committee gave final approval of the recipients of the first ACS Surgical Volunteerism Awards. The Governors' Committee on Socioeconomic Issues, chaired by Andrew L. Warshaw, MD, FACS, solicited nominations for this award from the ACS membership. The award is offered in recognition of individuals or organizations making significant contributions to surgical care through organized volunteer activities.

Member benefits

Contract negotiations with PDA Verticals are now complete. Members will be allowed to purchase personal data assistants (PDAs) and software at a discount. The PDAs may allow members to more actively monitor their practice patterns and results.

Education

The Subcommittee on Resident Education is making plans to implement a special program for residents at the 2003 Clinical Congress in Chicago, IL, similar to the extremely successful medical student program that was

offered at the 2002 Congress in San Francisco, CA. The program will include brief presentations on topics of general interest—such as practice management, effective negotiation, contracting, conflict resolution, leadership, and management of personal finances—that will be followed by a reception each day. Residents will receive guidance in selecting specific sessions from the Clinical Congress scientific program, receive a complimentary *Syllabi Select* CD-ROM, and be offered passes to certain didactic postgraduate courses on a space-available basis.

A second project of the subcommittee will involve the presentation of a highly coveted, national Resident Award for Effective Teaching. This award will be given annually to a resident who has already achieved local recognition for exemplary teaching from his or her department and institution.

The new Bariatric Surgery Primer Course will be offered during the 2003 Clinical Congress. The course was successfully conducted during the 2003 Spring Meeting of the College in New York.

The Stereotactic Breast Biopsy Course will be redesigned to further emphasize skills in interpreting breast imaging studies. Also, an advanced course will be offered for the first time during the 2003 Clinical Congress.

A new CD-ROM, *Ultrasound for Surgeons: The Basic Course*, is in the final stages of production. The course includes online scoring and offers the opportunity to obtain a Category 1 CME Certificate online, upon successful completion. This CD-ROM will replace the *Basic Ultrasound Course* currently offered at the Clinical Congress and Spring meeting, and will facilitate basic training in ultrasonography.

A new page on “Education Resources” has been created within the Web page of the Division of Education on the College’s Web site. A new Web page is being developed to help surgery residency program directors address various educational goals within the new paradigm of restricted resident duty hours. Also, the seven sessions from the

2002 Clinical Congress continue to be available online for Category 1 CME credit.

JACS

Since January 2001, the *Journal of the American College of Surgeons* (JACS) has provided 29,632 CME-1 credits online. JACS is available online at: <http://www.journal.acs.org>.

Communications

Plans to revamp the ACS Resource Center are complete. The center will be divided into two areas: the ACS Member Information Center and the ACS Program Center.

The Member Information Center will be located near the entrance to the Technical Exhibit Hall. Among other things, it will consist of:

- An area for a “Meet the ACS Leaders” function—individual Officers and Regents will be available in this area Monday through Wednesday 12:00–1:00 pm.
- A conference room area where Fellows can meet with coding and practice management consultants.

The Program Center will be created for the Technical Exhibit Hall. It will include ACS product-related programs such as SESAP, National TRACS®, ATLS®, JACS, and ACS-PA-SurgeonsPAC. In addition, a section called ACS Sponsored Programs will be created for commercial vendors with whom the College has a business relationship: WebMD, the ACS Insurance Trust, The Doctors Company, PDA Verticals, and other companies that have a product to sell.

The former ACS Publications Booth will be renamed ACS Products and Services. This booth will offer for sale: ACS publications, ACS slide sets, *Syllabi Select* CD-ROMs, Clinitapes, videos from Ciné Med, and merchandise featuring the ACS logo.

ACS headquarters

The Society for Thoracic Surgeons has exercised its option to occupy the remaining space on the floor it is currently located on

within the headquarters building in Chicago, IL. The American Association for Vascular Surgery/Society for Vascular Surgery began occupying space in July, with September planned as the anticipated completion date.

JCAHO

A multi-organizational meeting was held in Chicago, IL, regarding wrong-site surgery. The College has received numerous telephone calls from institutions and surgeons who have adopted and adhered to the College's statement on correct-site surgery. They have been "flagged" because they are not following the more stringent rules of the JCAHO, which require *all* sites to be marked prior to proceeding with an operation. Meeting participants concluded that a consensus statement is needed in order to establish a

proper procedure for the reviewers to follow, rather than the "no mark, no cut" rule that is currently being imposed.

At the March 28-29, 2003, meeting of the JCAHO board of commissioners, the National Patient Safety Goals were reviewed. It was noted that compliance in surveyed hospitals is improving, but many surgeons are still failing to mark planned surgical sites preoperatively.

During the March meeting, the board endorsed transitioning to all *unannounced* triennial surveys by 2006. Also at this meeting, it was reported that the CMS was exploring the possibility of greater collaboration with the JCAHO as there is an interest in trying to accelerate the pace of adoption of the electronic medical record in health care organizations.

Visit us at the Clinical Congress: Booth #1501-A

Smile.

The lowest rates ever on ACS 10-Year Term Life!



When was the last time you heard *the lowest rates ever*? Well, it hasn't been anytime recently.

ACS is pleased to continue our competitive pricing and guarantee it for the next ten years. Get up to \$2 million coverage for yourself, and \$1 million for your spouse, with no benefit reduction due to age and it's renewable to age 75.

To learn more right now, click on **www.acs-insurance.com** and select *New 10 Year Term Life* from the menu for complete details on features, cost, eligibility, exclusions, limitations and renewability.

You may email our *New* email address, **acsinsurance@cba.com** or call **1-800-433-1672**. With so much uncertainty these days, this plan is definitely something to smile about.



American College of Surgeons
INSURANCE PROGRAM



Underwritten by
New York Life Insurance Company
New York, NY 10010
on policy form GMR

Super preferred rates are for best health risks. Economical preferred and standard rates are also available. Policies are only available in the United States and Canada. Not available in all states.

Trauma meetings calendar

The following continuing medical education courses in trauma will be cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees.

- Advances in Trauma, December 12-13, 2003, Kansas City, MO.

- Trauma and Critical Care—2004, March 22-24, 2004, Las Vegas, NV.

- Trauma and Critical Care—2004 Point/Counterpoint XXIII, May 24-26, 2004, Atlantic City, NJ.

Complete course information

can be viewed online as it becomes available through the American College of Surgeons Web site at <http://www.facs.org/trauma/cme/traumtgs.html> or by contacting the Trauma Office at 312/202-5342.

Next month in *JACS*

The October issue of the *Journal of the American College of Surgeons* will feature:

Original Scientific Articles

- Accuracy of Sentinel Lymph Node Biopsy
- Gastric Bypass versus Gastric Banding

Education

- Work Hours Reform

Policy

- Professionalism in Surgery

What's New in Surgery

- Gynecology and Obstetrics
-

