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EMpulse

Official Publication of the Indiana Chapter of American College of Emergency Physicians

CONGRATULATIONS

James Shoemaker Jr.

MD, FACEP

Elected to the National ACEP Board of Directors during the 2020 Council Meeting

Inside this Issue

A View from the Top

Lauren Stanley, MD, FACEP (INACEP Board President)

Greetings from Indiana ACEP!

As I write this article, COVID19 is showing significant resurgence across the state, and we as emergency physicians are hyper-focused on what we can do better during this wave of cases, with the knowledge and experience gained from the first peak still fresh in our minds. We are somewhat better equipped (with PPE and testing capabilities) and we have slightly more knowledge about what works (and what doesn't) in patient care, but there are still many unknowns when it comes to SARS-CoV-2. I have heard from our colleagues across the state that they are feeling a mixture of anticipation, fatigue, stress, anxiety, and dogged determination to "just keep going." There is talk of vaccination/s being offered to us as first line workers within several weeks, but less talk (so far) about the actual data for said vaccination/s' safety profile and efficacy. As usual, we as emergency physicians are facing the continued uncertainty and deluge of sick patients with flexibility and grace.

While the COVID pandemic marches on, the many other issues facing Emergency Medicine have not disappeared, and we at Indiana ACEP are working to make sure that we are not losing track of these.

The 2021 Indiana state legislative session will be unlike any before, as the Legislature adapts to COVID times. Although many things are up in the air, including which legislative topics will be "hot" in 2021, Indiana ACEP is already working to prepare for items that could affect our profession and our patients.

For example, Indiana ACEP has joined the newly established Indiana Physician Coalition. This is a strategic communications and legislative outreach campaign, initiated by the ISMA with funding from the American Medical Association, which brings together physician societies in Indiana, toward the common goal of countering an expected push for state legislation to expand scope of practice by APRNs and other nonphysician groups. While we acknowledge the importance of nonphysician providers in the ED care team, we also want to convey the importance of a physician-led team. There is strength in numbers, and being involved in this coalition (along with our colleagues in Anesthesiology, Family Medicine, Radiology, Dermatology, the Indiana Osteopathic Association, and others) sends a clear and strong message to legislators in our state.

The response to nonphysician provider "scope creep" is also a high priority on a national level; you may have seen that in an unprecedented move, national ACEP joined with many other organizations (including AAEM, SAEM, AAOEM, EMRA, and others) to release a joint statement of unified support of physician-led patient care and training. Keep browsing this EMPulse to see a copy of the joint statement.

Reimbursement continues to be an item of concern for emergency physician groups across our state, as well as on a national level. On the state level, we will continue to advocate for fair and reasonable "Balance Billing" legislation. Your Indiana ACEP executive team has also engaged with payors to address various policies and procedures that make it difficult or impossible to receive fair, timely reimbursement; see Bart Brown MD, FACEP article for additional information. On the national level, ACEP has aggressively lobbied on behalf of emergency physicians in response to CMS' 2021 Medicare Physician Fee Schedule (PFS) proposed rule, which includes a proposed budget neutrality rule that

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Return to Decorum

by Justin Ritonya MD, FACEP (INACEP Board Member)

I sat down to write this on the eve of the most contentious election of my life. Amidst the most chaotic background of my life. Along with the presidential election we have had a global pandemic, riots, a sharp increase in mental illness and economic volatility to name a few others. Not to mention my kids screaming in the background as I prepare for the 14th of 16 overnights in 3 weeks. Despite all of that, I found myself at peace. As emergency physicians we are not strangers to chaos. In many ways I feel that we thrive in those environments. I can easily say that my enjoyment in the significant drop in volume during the shut-down was very short lived. I would find myself joking with my "ER Family" about missing the frequent flyers and urgent care level complaints. A more depressing observation during that time was the absence of MIs, strokes, septic patients, drug overdoses, et cetera. There were days we could hear a pin drop as we waited for the eventual onslaught of COVID patients. When the first wave of COVID patients began to roll in, the uncertainty of how to handle them was frightening to say the least. But as with everything else we encounter in the emergency department, we adapted. We found a way to make things work. Not only did we make it work, but we did it all as a team.

One of the things I love most about my career is the amazing people I get to work alongside. It seems that everyone who works in the emergency department knows we are a tight family unit who watch after each other. I always thought that despite our diversity of opinions and backgrounds we all had one thing in common, a love of emergency medicine. And sadly, up until now, I thought that was a common bond that was virtually unbreakable. Yet for the past several months, I have watched many emergency physicians sling some of the most hateful and vitriolic rhetoric towards one another. Why is that? It always boils down to one simple theme, both parties have differing opinions. It appears no matter how hard we tried to make an attempt at civil discourse, it would inevitably devolve into screaming matches and ad hominem attacks. I have watched as my "ER Family" broke itself down into tribal warfare, with each side eventually retreating into their own respective echo chambers.

I am writing this in the hopes that we all quickly realize how detrimental this type of behavior is to our profession. That detriment ultimately spills over into our patients and community. Many of us are leaders in our respective communities and medical systems. If we cannot even come together to guide policies surrounding something as simple as masks, than what can we do? To be clear. I am not here to debate mask wearing. However, I feel I do need to remind everyone what we learned in medical school about any statement containing definitives such as 'always' and 'never'. We have all been taught that if we see an answer on a test with those qualifiers, the answer is typically incorrect. Despite that, most debates I see on masks eventually split into the 'always mask' and the 'never mask' groups. The fact that the real answer almost certainly lies between those beliefs gets overlooked now. As both extremes argue back and forth, the less vocal tend not to engage with the emotional arguments. Even if one does present an argument based on factual evidence or sound reasoning, they too will likely be shouted down and forced to pick a side. What does this accomplish in the long run? The answer, quite obviously, is nothing.

It would seem that a significant portion of the animosity is driven in large part by the media (social media definitely included). It appears we have lost our internal filters to the internet. A road-rage phenomenon where people for some reason feel protected behind their keyboards. Of course, this 'protection' could not be further from the truth. What you do and say online is immortalized for all to see. I hope that things will calm down in the coming months but, if they do, I fear irreparable damage among colleagues. I know we I are better than this. We need to regroup and remember that we are, in fact, on the same team. I would argue emergency physicians have an uncanny ability to take in significant amounts of information and formulate an action plan. Our ability to improvise and adapt to the challenging environments we practice in are unmatched. We owe it to our "ER Family" to bring civility and objectivity back into our profession. At the end of the day, we are the leaders of emergency medicine. This type of division among us can only hurt. As we soldier on through the coming months of the coronavirus pandemic, do not let this be a missed opportunity. We owe it to ourselves and our patients to be leaders in these challenging times. Ultimately, the way we accomplish this is to pursue truth, above all else.

2020 has been some year.

When we're finally looking at it in the rear-view mirror, what will we have learned? How will we be different? How will **you** and **your practice** be different? And what will you change going forward?

Is 2021 the year you'll finally hire more staff? Renegotiate your contracts? Restructure your leadership? Add a new location? Outsource your medical billing?

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Fred Osborn Memorial Award —
Excellence in Emergency Medicine Nominations

In 2010, the Indiana ACEP board established an annual award in memory of Dr. Fred Osborn who passed away in 2009. Dr. Osborn contributed extensively to the practice of emergency medicine and to his group, hospital, community and the state. As such, an award was established in his memory to be presented annually at the Indiana ACEP Education Conference in the spring.

The recipients of the award to date have been as follows:

2010 - Peter Stevenson MD, FACEP of Evansville, IN
2011 - David VanRyn MD, FACEP of Elkhart, IN
2012 - Thomas Madden MD, FACEP of Bloomington, IN
2013 - Thomas Gutwein MD, FACEP of Fort Wayne, IN
2014 - Tom Richardson MD, FACEP of Danville, IN
2015 - Randall Todd MD, FACEP of Indianapolis, IN
2016 - Chris Burke MD, FACEP of Carmel, IN
2017 - John McGoff of Indianapolis, IN
2018 - Thomas Heniff MD, FACEP of Boone CO, IN
2019 - Chris Hartman MD, FACEP of Carmel, IN
2020 - James H. Jones MD, FACEP of Zionsville, IN

The Indiana ACEP board is now accepting nominations for this year's consideration. The individual nominees will be evaluated in regard to their leadership, involvement and contributions to their emergency medicine group, hospital, community and state. To nominate a worthy physician, please submit a single typed page detailing the qualifications of a deserving emergency physician whom you know which includes the information included in the template below.

The nominated person must be an emergency physician currently practicing in the state of Indiana and be a current member of Indiana ACEP. The person making the nomination however need not be a member of ACEP nor a physician.

All submissions are due by January 10, 2021 and are to be submitted electronically to sue@inacep.org.

Nominations must include the following information:

Name of Nominating Person
Name of Nominee
Date of Nomination
Nominee's Positions of Leadership
Nominee's Involvement / Contributions to their Group
Nominee's Involvement / Contributions to their Hospital
Nominee's Involvement / Contributions to their Community
Nominee's Involvement / Contributions to their State
Additional Comments are accepted

Please limit submissions to a single, typed page detailing the qualifications of a deserving emergency physician whom you know. ***Please remember:*** ***The individual nominees will be evaluated in regard to their leadership, involvement and contributions to their emergency medicine group, hospital, community and state.***

2021 CONFERENCE UPDATE

INACEP is working diligently to make plans for our annual meeting in the spring if 2021.

Thursday, April 15, 2021 is the tentative date, so please mark your calendars. Because of the ongoing uncertainty with COVID19 we will have a virtual event. At this moment we are still working out the particulars of how this event will look. Sue will send an email out to the membership as soon as we have the details in place.

Stay tuned for updates.

WELCOME NEW INACEP MEMBERS

New Members:

Alexander, Tiffany MD
Colvin, Kevin MD
Patel, Kayur MD, FACEP
Sappington, Dru MD
Schultz, Melissa MD
Smith, Daniel MD, FACEP
Vaizer, Julia MD

Resident Members:

Brenner, Marielle MD
Carroll, Justin MD
Collins, Luke MD
O'Daniel, Michael DO

Medical Students:

Buehler, Sean
Carter, Jeremy MD
Duncheon, Ethan
Geeraert, Rubin
Haque, Lubaba
Hoban, Kathleen
Huffard, Adrean
Lawyer, Evan
Littell, Kaye
Manz, Troy
Miller, Reese
Mongalo, Alejandro
Nwosu, Chiagozie
Persinger, Johah
Powell, Katherine
Swan, Paige
Young, Nicholas
Zafar, Nayab

CONGRATULATIONS
James Shoemaker Jr. MD, FACEP

We are proud to announce that Jamie Shoemaker Jr. MD, FACEP, was elected to the National ACEP Board of Directors during the recent Council meetings.

In the history of Indiana ACEP, Dr. Shoemaker is only the fourth Indiana ACEP member ever to be elected to the National ACEP Board – joining the ranks of John Johnson MD, FACEP, Michael Bishop MD, FACEP(E), and current member J.T. Finnell MD, FACEP.

Dr. Shoemaker has been a leader within the Emergency Medicine community on the state as well as national levels. He has served as Treasurer/Secretary, Vice President, then President of Indiana ACEP (in 2015-2016), and continues to serve as an Ex Officio Board member. In these capacities, he has been active in tackling various issues affecting Hoosier emergency physicians and their patients, particularly fair reimbursement, balance billing, APRN scope of practice, and others. His expertise in these areas has been a huge asset to the state chapter as we advocate for excellence in emergency care for all Hoosiers.

Dr. Shoemaker has also established himself as a leader on a national scale. He has served on multiple National ACEP committees including the Reimbursement Committee, Coding and Nomenclature Advisory Committee, Chapter Relations Committee (of which he is the immediate past chairman), Clinical Resources Review Committee, and National ACEP Steering Committee. His involvement in these varied committees gives him a broad understanding of the workings of the College, and gives him the insight needed to recognize and address the highest-priority issues facing ACEP membership.

In a time when independent Emergency Physician groups are finding it challenging to maintain their independence, Dr. Shoemaker has the unique and valuable perspective of being primarily employed in a private democratic group. He has been a long-time member and leader of Elite Emergency Physicians, Inc., which provides care in several community EDs in northern Indiana. He understands the issues facing EPs in independent groups because he has been there; this makes him well positioned to advocate for similar groups on a national level.

Dr. Shoemaker has developed specific expertise in reimbursement issues. In 2018, he was selected to be an ACEP Reimbursement and Leadership Development (RLDP) Fellow. As fair reimbursement faces assault from all directions, especially from insurers' efforts, Dr. Shoemaker has worked to establish a voice in the conversation between EPs, insurers, and other relevant parties in order to advocate for fair reimbursement.

With his expertise and perspective, Jamie will be a great asset to the National ACEP BOD and we look forward to seeing what he will accomplish in the coming years! Congratulations, Jamie!

BULLETIN BOARD

Organizations or individuals that want their message to reach emergency physicians in Indiana will find the ***EMpulse*** their number one avenue.

The ***EMpulse***, published four times per year, is mailed to members of the Indiana Chapter of the American College of Emergency Physicians.

This highly focused group includes emergency physicians, residents and students.

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The **2020 Ad Deadlines** are:
Feb. 3, May 15, Aug. 4 and Nov. 16 (approximately).

Publication dates are:
Feb. 20, May 29, Aug. 21 and Nov. 21, 2020 (approximately).

Mail: Indiana ACEP,
630 N. Rangeline Road, Suite D
Carmel, IN 46032

Email: sue@inacep.org

Case Study: New-Onset Hyperthyroidism Presenting in Thyroid Storm, Heart Failure, and Atrial Fibrillation

by Mary Blaha, DO, PGY-2, Indiana University Emergency Medicine Residency

Overview

A 49 year-old female with a history of tobacco use but no other medical problems presented to the emergency department (ED) with severe shortness of breath for three days. She had been having feelings of anxiety as well as diarrhea, generalized fatigue, and a 50-pound weight loss over the last six months. She did not have chest pain or infectious symptoms and she denied intravenous (IV) drug use. There was a family history of hyperthyroidism.

Findings and Workup

Physical exam: Physical exam was remarkable for a thin woman with tachycardia, diaphoresis, hypertension, bilateral lower extremity edema, and crackles on lung exam.

EKG: EKG showed atrial fibrillation with rapid ventricular response (afib RVR).

Labs: TSH was undetectable, free T4 was elevated, and troponins were negative.

Imaging: Chest x-ray showed pulmonary edema.

Management

The patient was immediately transported to the resuscitation bay upon her arrival to the ED. She was very tachycardic but otherwise hemodynamically stable. An initial EKG showed that she was in new-onset afib RVR. She was given two doses of IV diltiazem, which converted her to rate-controlled afib. She had crackles on lung exam and lower extremity edema. Chest x-ray showed pulmonary edema. Labs were drawn and revealed an undetectable TSH and an elevated free T4. There was high suspicion for thyroid storm. Cardiology, endocrinology, and ICU were all consulted. It was decided that the patient would be started on an esmolol drip that could be easily titrated and stopped quickly if needed. After the esmolol drip was started, the patient was also given steroids and methimazole. She was admitted to the ICU and she stayed in the hospital for one week. She remained in afib RVR until successful cardioversion. Echocardiogram showed heart failure with a reduced ejection fraction of 35%. After stabilization and discharge from the hospital, the patient is doing well and is following up with both cardiology and endocrinology as an outpatient. She remains on propranolol, methimazole, and cholestyramine.

Discussion

This is a classic case of undiagnosed and untreated hyperthyroidism leading to thyroid storm, afib RVR, and heart failure. Thyroid storm is rarely seen but can lead to great morbidity and mortality. It can be particularly difficult to diagnose if the patient does not have a known history of hyperthyroidism. Patients in thyroid storm can present with hypertension, tachycardia, fevers, diaphoresis, neurologic symptoms, GI symptoms, and signs of heart failure. Most patients with thyroid storm have sinus tachycardia; atrial fibrillation only occurs in 10-35% of people. Thyroid storm can be precipitated by infection, pregnancy, amiodarone use, and medication noncompliance. The treatment for thyroid storm typically involves multiple medications given in a stepwise fashion. The use of a beta-blocker such as propranolol is employed first to inhibit peripheral adrenergic effects. Next, medications such as methimazole or propylthiouracil (PTU) are used to inhibit new thyroid hormone synthesis. Steroids such as hydrocortisone or dexamethasone are then used to decrease peripheral conversion of T4 to T3 as well as to combat any coexisting adrenal suppression that may be present. Both propranolol and PTU can also decrease this hormone conversion. After giving beta-blockers and PTU/methimazole, potassium iodide or lithium can be used to inhibit hormone release. Finally, cholestyramine is often used as an outpatient to inhibit thyroid hormone absorption. It can be particularly difficult to treat patients in thyroid storm with coexisting heart failure as too much beta-blockade can lead to cardiovascular collapse. This is the reason the short-acting beta-blocker esmolol was chosen for the patient in this case. The Burch-Wartofsky Point Scale can be used to predict the likelihood that a patient is in thyroid storm. Scores of greater than 45 are highly suggestive of thyroid storm and the patient should be managed with rapid and aggressive treatments in the ICU. The patient described in this case had a score of 75.

Conclusion

Thyroid storm can lead to great morbidity and mortality. Patients can present in a hyperadrenergic state with afib RVR, heart failure, as well as with GI and neurologic symptoms. Emergency department treatment is done in a stepwise fashion with resuscitation, beta-blockade, PTU/methimazole, and steroids. Emergency medicine physicians should maintain a high index of suspicion and should have a low threshold to check a TSH level in patients with new-onset heart failure and new-onset atrial fibrillation. If patients have heart failure in the setting of thyroid storm, a short-acting beta-blocker such as esmolol should be used and slowly titrated to prevent cardiovascular collapse.

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2020 ACEP Council Meeting Update

by Lauren Stanley, MD FACEP (INACEP President)

Representatives from Indiana ACEP participated in the annual Council meetings on October 24-25. This year, the Council meetings occurred virtually. Sue Sedory, who took over as ACEP's Executive Director this year, presented a summary of the College's stats and accomplishments, including:

- the College has >40,000 members for the first time in ACEP history
- *Annals of Emergency Medicine*'s impact factor has increased to 5.799, and is ranked #1 of 31 global EM scientific publications
- ACEP saw an 168% increase in media coverage over the past year, with >300% increase Jan-June. This increased visibility is reflective of coverage of both COVID-related and non-COVID topics.

Dr. Mark Rosenberg, who took the helm as President of ACEP, gave an inspiring talk about what he envisions for his term. He introduced the concept of the Innovation Center, which would explore cutting-edge solutions to some of the most pressing issues facing emergency physicians, including: wellness, diversity & inclusion, workforce, reimbursement and balance billing, pandemic readiness, future of emergency medicine (including Telemedicine), health equity, pain and addiction, palliative care, membership value, and much more.

A highlight of this year's Council meeting was the election of one of Indiana's own, Dr. Jamie Shoemaker, to the National ACEP Board of Directors. Dr. Shoemaker has been active in ACEP on both the state and national levels for years, and has developed a particular expertise in reimbursement, having been an ACEP Reimbursement and Leadership Development Program Fellow. He is a problem-solver and advocate for both patients and EPs, and we look forward to seeing what he accomplishes as a Board member. Indiana ACEP can be proud of the fact that we now have two members on the National ACEP BOD: Dr. Shoemaker as well as Dr. JT Finnell, who was elected in 2018.

During the Council meeting, many Resolutions were adopted that stand to benefit our specialty. Two were authored by Indiana ACEP members. Dr. Sara Brown co-authored a Resolution titled "Supporting the Development of a Seamless Healthcare Delivery System to Include Prehospital Care."

This Resolution calls for prehospital care to be included as a seamless component of health care delivery rather than merely a transport mechanism. It challenges ACEP to advocate for appropriate payment of EMS services to include all clinical services separate from transport; and for ACEP to collaborate with other stakeholder organizations to promote legislation that would allow for appropriate reimbursement of prehospital care.

Dr. Shoemaker authored a Resolution titled "Adverse Impact of Healthcare Insurers on Emergency Medicine Reimbursement & Optimal Patient Coverage." This Resolution addresses the many barriers created by insurers to obstruct fair reimbursement for emergency care, and the undue financial burden left on patients. It calls for ACEP to create a task force to study the financial influence health insurers have over EPs, to advocate for higher standards and additional scrutiny of health insurer spending, and to work with other stakeholders (such as the AMA) in holding insurers accountable.

A Resolution titled "Creating a Culture of Anti-Discrimination in our Emergency Departments and Healthcare Institutions" drew broad support. It calls for ACEP to encourage training to combat discrimination for all clinicians, and to "explore frameworks for integrating anti-discrimination into our emergency departments and institutions at all levels including, but not limited to, patients, families, medical students, staff, trainees, staff physicians, administration, and other stakeholders."

There were simply too many impactful Resolutions to be able to list them all here. From establishing standards for emergency physician access to PPE (and holding hospitals accountable for meeting these standards), to restricting the word "Resident" to physician trainees, to calling for transparency in Billing and Collections, to beefing up Telehealth services (especially in disaster situations), and everything in between, the Council heard testimony on many valuable Resolutions. It was a productive and engaging Council session, despite the virtual format.

If you are interested in serving as a Councillor or Alternate Councillor during a future session, please contact any of the leadership team or Board members; all voices are welcome!

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Reimbursement Battle Part 2

by Bart Brown MD, FACEP (INACEP Immediate Past President)

ACEP Strikes Back

Advocating for fair reimbursement for our members is always a top priority for INACEP. Unfair reimbursement schemes threaten group and physician compensation, particularly during an unprecedented pandemic with unpredictable patient volumes. There are many other non-financial problems chronic underpayment can cause. It negatively affects physician well-being and job satisfaction and contributes to burnout. It affects the ability of groups to hire new physicians and provide ideal staffing coverage.

In my last article, I highlighted many of the schemes insurers have implemented to avoid fairly paying providers and shifting costs to the patients they cover. These tricks combined with a pandemic and economic devastation for many created a perfect storm for insurers to take in outlandish profits. Insurers continue to use the tactics described in the last article to underpay providers and fuel their profit growth. They will continue to manipulate the novel covid-19 pandemic to justify large premium increases, burdening employers and patients with higher costs. Finally, the looming return of "surprise billing" issues locally and nationally will be weaponized to vilify providers and facilities seeking fair payment as the root cause of "surprise bills" to their patients.

In response to feedback and concerns from INACEP members, I will turn this into a 3 part series to highlight all the steps we are taking to advocate for fair payment and prepare for other reimbursement challenges we will face after the election. I will address commercial payor issues in this installment.

INACEP Efforts to Mitigate Bad Payor Behavior

1. INACEP frequently meets with insurers to amend and/or repeal unfair tactics and policies. We are successful in most cases, but novel and repackaged versions of these tactics continue to pop up, like a continuous game of "whack a mole". We have recently met with Anthem and UHC representatives to address policies using unjust prepayment audits and a policy using a 3rd party company using formulas based on the final diagnosis to downcode visits.
2. We combine resources with other groups with expertise in coding and reimbursement including EDPMA to identify and address problematic policies and insurer behavior.
3. We frequently advocate for Indiana Emergency Physicians to deal with reimbursement issues they share with us. I plan to send a poll to INACEP members to better identify areas or common issues, so we can advocate more efficiently for you.
4. We have a strong relationship with national ACEP. JT Finnell and Jamie Shoemaker both currently serve on the board of directors. Jamie recently served as one of ACEP's reimbursement fellows and we have multiple INACEP members serving vital roles on ACEP committees dealing with reimbursement issues. Coalitions of state chapters, ACEP committees, and ACEP Leadership collaborate to address national and state level reimbursement issues. Toolkits are created for common issues and are available to individual chapters and members.
5. We submitted 2 important resolutions at the recent ACEP council meeting, both successfully adopted. The first resolution directs the college to evaluate and quantify the impact of the Insurer reimbursement behavior on our specialty. This objective data will be available to members and will help guide a coordinated response to these issues. The second resolution directs the college to advocate for recognition and reimbursement of non-traditional EMS care like community paramedicine.

Tips for Challenging Pre-payment and 3rd Party Audit Tactics

1. Look closely at audit language in existing contract—if contract does not specifically allow for pre-payment audit, challenge these tactics. If contract does not specifically allow for use of 3rd party companies for audits, challenge this behavior. **Enforce contract terms.**
2. Discuss possible changes to these rights via amendments to policies and procedures to address pre-payment reviews, 3rd party company audits, and other concerns.
3. Insist on clear and fair process for providers to appeal down-coded charts.
   A. Require immediate payment at lower level for down-coded charts the provider appeals (for example paying a level 4 fee for down-coded level 5 charts the provider is appealing. Payment of the remainder can be determined by a fair appeal process).
   B. Allow providers to electronically submit chart to reduce unnecessary workload and paper waste.
   C. Insist on clear and fair timeframes for appeal process with a mandatory response from insurer.
   D. Do not allow the insurer to avoid paying at lower level if they reject the appeal. Make sure this is done in a reasonable timeframe.
4. Consider referral of unresolved issues to Insurance Oversight Bodies—this may be of some benefit for non-ERISA plans, but states do not have control over ERISA plans.

County COVID-19 Distribution in Indiana

Below results are as of 11/08/2020, 11:59 PM

Weekly Score

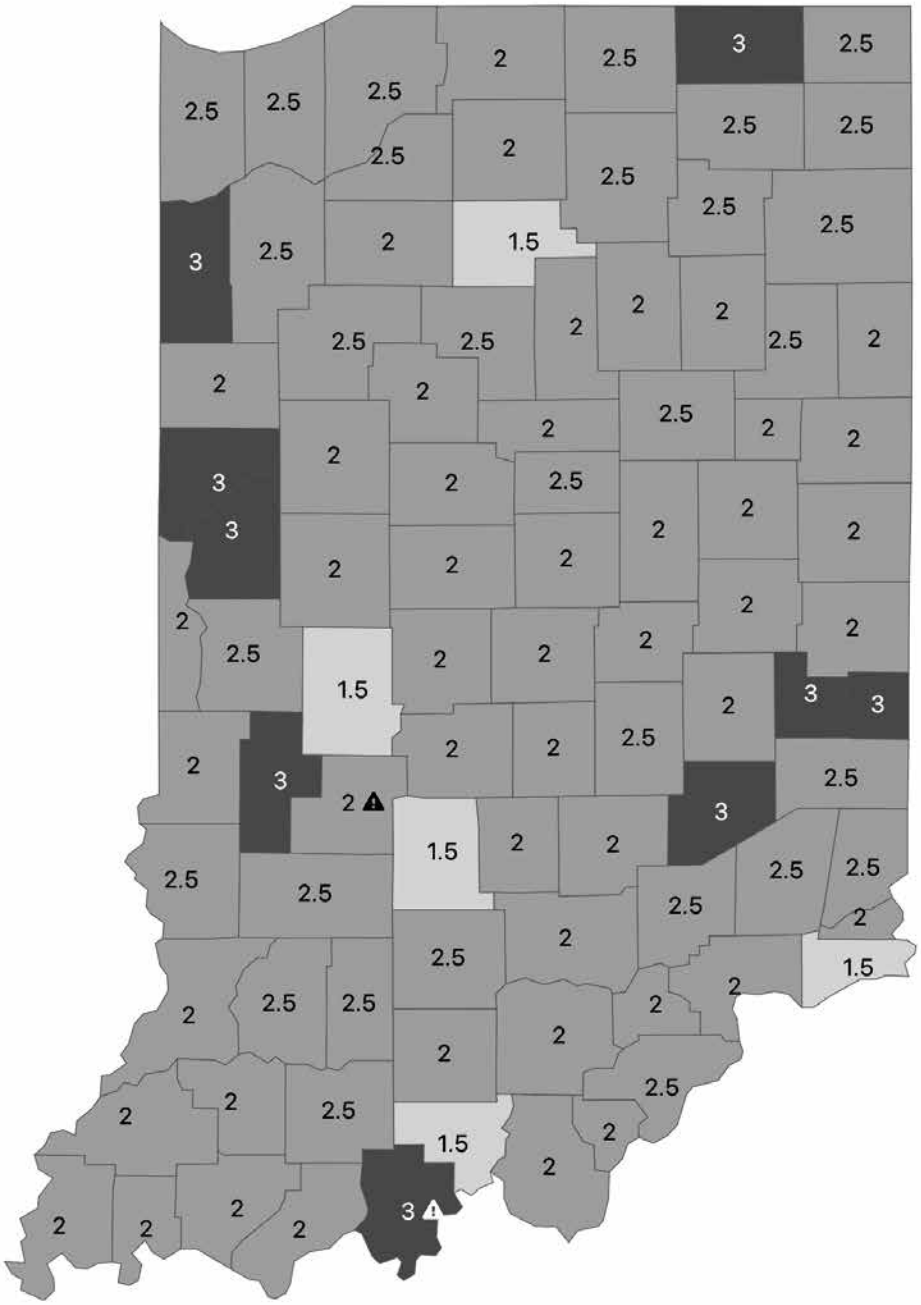
- Yellow (1 and 1.5)
- Orange (2 and 2.5)
- Red (3)

Weekly Cases Per 100,000 Residents

- 10 to 99 new cases(1)
- 100 to 199 new cases(2)
- 200 or more(3)

7-Day All Tests Positivity Rate

- 5% to 9.9% (1)
- 10% to 14.9% (2)
- 15% or greater (3)



Wellness Resources

Be Well Indiana

Get The Support You Need

The following links immediately connect you to a wide variety of resources. You'll speak or text with someone who can help get you what you need.

Be Well Crisis Helpline

Speak with a trained counselor 24/7 regarding stress, anxiety, loneliness or mental health strains due to the COVID-19 pandemic. Service is free and confidential.
Call: 211
Enter Your Zip Code and Press: 3

Indiana 211

A free, confidential service that connects Hoosiers to local resources and services for food, housing, utility bill support and more across Indiana.
Call: 211
Text: Your Zip Code to 898-211
(M-F, 8am – 5pm)

Crisis Text Line

Free, 24/7 support from a trained crisis counselor.
Chat: Text **HOME** to 741741

Indiana State Department of Health

COVID-19 Medical Call Center Call with COVID-19 medical questions or concerns. Call: (877) 826-0011

National Domestic Violence Hotline

Help for if you or someone you know is experiencing violence.
Call: (800) 799-7233
TTY: (800) 787-3224
Chat: Text **LOVEIS** to 22522

National Addiction & Recovery Helpline

Free, confidential treatment referral and information for individuals and families.
Call: 800-662-HELP (4357)
TTY: 800-487-4889

The Disaster Distress Helpline 24/7

Immediate crisis counseling for stress, anxiety, depression and more.
English
Call: (800) 985-5990
TTY: (800) 846-8517
Chat: Text **TalkWithUS** to 66746
Spanish
Llama: (800) 985-5990 (Llama y prensa "2")
Charla: Texto **Hablanos** to 66746

Suicide Prevention Lifeline

Confidential, 24/7 support for those experiencing emotional distress or considering hurting themselves.
Call: (800) 273-TALK(8255)
TTY: (800) 799-4889

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Healthcare Tech Trends for 2020

by JT Finnell MD, FACEP (INACEP Ex Officio Board Member)

These past few months have brought new realities to the way we learn and practice. Who would have imagined during the unexpected snowstorm in Denver last year that we'd be hosting an "Unconventional" ACEP 2020? While we are almost through 2020, I thought it might be fun to review the predictions given to us from 2019 for 2020. Which of the following predictions has come true?

Here were a few of the Healthcare Tech Trends to Watch in 2020:

1. Wearables

Once the realm of early adopters, wearables were poised to help healthcare professionals collect a wealth of data from a widening and more diverse user pool. The idea of remote patient monitoring, in which these devices track metrics such as blood pressure and glucose levels, and via fitness trackers and tools such as the Apple Watch that can identify an irregular heart rhythm. To date, the wearable movement continues to pose significant interoperability and interpretation challenges.

2. Artificial Intelligence (Augmented Intelligence)

Increasingly, AI is becoming a part of healthcare. As threats increase in number and severity, AI can be employed to recognize unusual behaviors on a network, watch for fraud threats, and predict malware infections based on previously identified characteristics.

Chatbots are being developed for help with minor ailments. These AI tools can also be used to create algorithms that help clinicians offer further insights into their patients. Unfortunately, many of these tools remain segmented, which presents another barrier to fully comprehensive care.

The Reality: The AI hype is over

While venture capital funding poured into artificial intelligence healthcare startups—these AI companies raised $864 million in the second quarter of 2019, the next generation of AI healthcare companies will have a hard time getting funding. Digital health and AI healthcare will need to focus on delivering better outcomes and solving problems right in front of them.

3. Telehealth

More doctors, health systems, and medical specialties will be providing telehealth services. During the COVID pandemic, insurers have been able to offer reimbursements to telehealth providers — as the scope of telehealth continues to expand — the benefits will become more evident. Future research should be focused on the best use of these tools. While these tools will likely increasingly go beyond a patient's typical providers to encompass a wide range of care needs, patients in rural or underserved areas who may require the care of a specialist or a team of physicians could increasingly have access to specialized care.

Telehealth is attracting new players.

As mainstream adoption of telehealth continues, Teladoc, one of the leaders in the telehealth space, is now eyeing virtual primary care, according to their company CEO Jason Gorevic. The company is also moving into chronic care management and behavioral health.

CVS, Walgreens, Amazon, Best Buy through its Tyto Care partnership, and Walmart are moving into virtual care services. Humana launched a new virtual primary care service with telehealth company Doctor on Demand and Warby Parker offering virtual care services.

4. Virtual Reality

The technology that some may assume to be purely for gamers may be finding a role in healthcare. Imagine senior living residences implementing VR to help their memory care patients "visit" a favorite vacation spot, or enjoy touching scenes of animals and nature. The idea that VR could be used in EDs as a mode of distraction. (for patients, not staff…) VR could be used to educate or to explain a treatment plan to a patient.

5. 5G

The arrival of 5G could transform healthcare delivery by boosting speed and capacity while reducing latency. This robust network will be crucial for transmitting large medical images, supporting telehealth initiatives and remote patient monitoring tools, and complex uses of AI, AR, and VR.

The focus on the social determinants of health is growing.

Ride-hailing company Uber launched Uber Health in 2018 to focus on non-emergency medical transportation. The platform saw 400% year-on-year growth in the second quarter of 2019 compared to the second quarter of 2018. Uber sees the non-emergency medical transportation market as a $15 billion opportunity in the U.S.

New players in healthcare will only continue to accelerate. You have to make a bet: to either build, buy, or partner. Technology is no longer just about supporting the business; technology is the business. Big tech companies like Google and Facebook are rapidly moving further into healthcare, and industry incumbents need to be ready for accelerating the change.

A final thought: How could we use this digital opportunity to improve the College's digital future? Could we enlist presentations from Cerner, EPIC, Google, Apple, Uber, Amazon, and others? (Think TED talks). We need to think creatively and out of the box to move us forward and partner with others to resolve this and future pandemics with our specialty on the front line.

Joint Statement Regarding Post-Graduate Training of Nurse Practitioners and Physician Assistants

Released September 3, 2020

The undersigned representatives of Emergency Medicine physicians are unified in their support of physician-led patient care and training. Although all who provide care in the Emergency Department setting must be appropriately trained, education of emergency medicine resident physicians and medical students must not be compromised or diluted. The terms "resident," "residency," "fellow," and "fellowship" in a medical setting must be limited to postgraduate clinical training of medical school physician graduates within GME training programs. Physicians must lead patient care teams and actively shape standards for education and scope of practice of non-physician providers. Hospitals or employers should not create or advertise post-graduate training of nurse practitioners or physician assistants in the emergency department without explicit involvement and approval of the emergency medicine departmental and residency leadership.

Lisa A. Moreno, MD, MS, MSCR, FAAEM, FIFEM
President
American Academy of Emergency Medicine [AAEM]

Fiona E. Gallahue, MD
President
Council of Residency Directors in Emergency Medicine [CORD]

Haig Aintablian, MD
President
AAEM Resident and Student Association [AAEM/RSA]

Hannah R. Hughes, MD, MBA
President
Emergency Medicine Residents' Association [EMRA]

Robert E. Suter, DO, MHA
President
American College of Osteopathic Emergency Physicians [ACOEP]

James F. Holmes, Jr., MD, MPH
President
Society of Academic Emergency Medicine [SAEM]

Christina L. Hornack, DO
President
ACOEP-Resident Student Organization [ACOEP-RSO]

Andrew B. Starnes, MD, MPH
President
SAEM-Residents and Medical Students [SAEM-RAMS]

Bill Jaquis, MD
President
American College of Emergency Physicians [ACEP]

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would cut the Medicare conversion factor by 10.6% to the lowest rates seen in 25 years. Anticipating that CMS would make this proposal, ACEP had advocated for CMS to increase the value of ED E/M codes. CMS responded: in its proposal, CMS included ACEP's recommendation to increase ED E/M code reimbursement. The increase in the value of these codes would cause your payments to bump up by approximately 3 percent; after taking into account this increase and other adjustments, the overall reduction to emergency medicine would be 6 percent, significantly less than the 10.6 percent cut to the conversion factor. On a broader level, ACEP has been vocal in its message to key Congressional committee members, requesting the budget neutrality requirement be waived altogether. If Congress were to respond, emergency medicine reimbursement would actually increase by around 3 percent, instead of decrease by 6 percent.

Suffice to say, our work at Indiana ACEP is not limited to responding to the COVID pandemic. However, we know that is occupying a large portion of our collective headspace as emergency physicians. Although there may not be as many "Healthcare Hero" signs dotting our front yards now as there were in March, know that your hard work is noticed and appreciated. We at Indiana ACEP stand behind you and are here to assist you. Stay safe and well this winter!

Legislative Update

by Lou Belch, Lobbyist for INACEP

In response to the COVID Pandemic, the Legislative Council created the Legislative Continuity Committee to make recommendations on legislative operations during the Public Health Emergency.

The Legislative Continuity Committee met again on October 28th to continue planning for conducting the 2021 legislative session. The committee discussed how the House of Representatives would operate in the Indiana Government Center South building, and the current plan calls for the establishment of permanent staff working space, four committee rooms, and using the auditorium as the House chamber. The remainder of the committee focused on what precautions should be required of individual legislators. Members debated requiring weekly testing and mandatory face coverings—while some suggested that self-screening, social distancing, and sanitation would be sufficient. Ultimately, the decision regarding face coverings likely will be left to leadership in each chamber. It also was heavily stressed that legislators will need to be physically present in order to vote.

House Republican Majority Floor Leader Rep. Matt Lehman announced that he is drafting a bill that will give the legislature greater flexibility regarding some legislative deadlines that are currently in statute (such as the current requirement that the 2021 session must Sine Die no later than midnight on April 29). Leader Lehman has made his intention clear that these modifications will only apply to the 2021 legislative session and will sunset prior to the 2022 legislative session. Other possible changes in the 2021 session likely will touch on the frequency that the House and Senate meets and the potential start date of session.

There are also discussions about limiting the number of committee hearings each committee may have, as well as the issues that must be addressed. There are only two issues the General Assembly must address in 2021, The State Budget and drawing Congressional and Legislative District maps based on the 2020 Census. All other issues could wait until 2022, particularly if the pandemic impact in Indiana worsens.

Elections

One hundred twenty-five legislative seats (100 House, 25 Senate) were up for election in 2020. Thirty-one House seats and nine Senate seats were uncontested, leaving 69 contested House and 16 contested Senate races. Supermajority control for the Republicans in both chambers was at stake with House Republicans. However, House Republicans gained four seats increasing their supermajority to 71 - 29. With the loss of one seat, the Senate breakdown is now 39 - 11 with a Republican supermajority.

Seats that Flipped:

- SD 30 flipped from Republican to Democrat with Fady Qaddoura defeating Incumbent John Ruckelshaus.
- HD 7 flipped from Democrat to Republican with Jake Teshka defeating Incumbent Ross Deal.
- HD 15 flipped from Democrat to Republican with Hal Slager defeating Incumbent Chris Chyung.
- HD 19 flipped from Democrat to Republican with Julie Olthoff defeating Incumbent Lisa Beck.
- HD 35 flipped from Democrat to Republican with Elizabeth Rowray defeating Incumbent Melanie Wright.
- HD 66 flipped from Democrat to Republican with Zach Payne defeating Incumbent Terry Goodin.
- HD 89 flipped from Republican to Democrat with Mitch Gore defeating Incumbent Cindy Kirchhofer.

Of most interest to INACEP members is the defeat of Rep. Cindy Kirchhofer. She was the Chair of the House Public Health Committee. With the retirement of Rep. Ron Bacon and the defeat of Rep. Dolyene Sherman, there are now three vacancies on that Committee. The appointment of a new Chair and new members of the Committee will be made by the Speaker of the House.


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Indiana Chapter
American College of Emergency Physicians

630 N. Rangeline Road, Suite D
Carmel, IN 46032

Phone: 317-846-2977
Fax: 317-848-8015
Email: inacep@inacep.org

/IndianaACEP
@IN_ACEP

If you are still receiving this paper copy of the *EMpulse* and would rather receive it by email only, please contact Sue and let her know: **sue@inacep.org**

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