Volume 29, Issue 1 **Spring 2020**

EMpulse

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

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Inside this Issue

A View from the Top

Bart Brown, MD, FACEP (INACEP President)

Legislative Update

The 2020 legislative session is off to a fast start with multiple bills being advanced that would have a great impact on our specialty and ability to care for our patients. SB3, HB 1004, and HB 1372 all touch on aspects of out of network (OON) billing. In their preliminary drafts they use "rate setting" methods to determine OON payments, enabling insurers to artificially lower payments and remove any incentive for them to offer fair network contract rates. Indiana ACEP has been aggressively pushing for fair reimbursement with use of baseball-style arbitration (IDR) to settle payer/provider disputes. IDR based legislation has a successful track record in New York, whereas government "rate-setting" legislation in California has cut physician reimbursements while narrowing patient networks and access to care. We are also pushing for insurers to directly pay providers and truly remove patients from the middle.

INACEP, working closely with our lobbyist Lou Belch, has been in close contact with the bill's authors and other legislators to advocate for a solution to remove patients from the middle while ensuring adequate payments for emergency services. We have partnered with ISMA and other specialty societies and have been a constant presence at the statehouse. Thanks to your help, we have created a grassroots response from ACEP members and their groups that is having a positive impact on bills. We will continue to use all available resources to ensure the best outcome on this important legislation.

Be prepared for further updates and "calls to action" through ACEP's engaged group emails. Use this opportunity to encourage 100% ACEP membership for your groups.

Managed Care Entity (MCE) Emergency Claim Processing Changes

Effective April 1, 2020, the MCE must, at a minimum, use the State's Emergency Department Autopay List. The MCE must check, at a minimum, the first six diagnoses on an emergency claim against the autopay list. For claims paid at the screening fee or a nonemergency case rate, the MCE must allow a provider to submit records for prudent layperson review within 120 days.

INACEP has been working with FSSA to ensure providers are fairly paid by MCE's. The above changes have been implemented to stop prudent layperson standard work arounds and

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Legislative Update

by Lou Belch, Lobbyist for INACEP

The day this article is being written is the final day of the first half of the legislative session. While there are several bills dealing with health care and health care costs, INACEP is most concerned about two of the bills. They both deal with the issue of surprise billing. **SB 3** and **HB 1004** seek to protect the patient from an out of network surprise bill. Each bill is attempting to solve the problem of surprise billing using slightly different approaches and both approaches are problematic to emergency medicine. Given the nature and the pace of the legislative session, it is not useful to describe the bills here, as they likely will change from the time this is written to the time you are reading.

Instead, we will focus on what elements should be in any bill that treats both the patient and the provider fairly:

- Independent dispute resolution if the provider and payor cannot agree on a payment.
- If the bill contains payment benchmarks, they should be transparent.
- The payor should pay the provider directly.

INACEP leadership, Bart Brown MD, FACEP and Chris Ross MD, FACEP are working very closely with INACEP Lobbyists to find the best solution for Emergency Physicians and their patients.

The session is moving very quickly and must adjourn no later than March 14, 2020.

INACEP will be sending legislative alerts to the membership asking for contacts to legislators as important developments occur.

SB 243 has provisions dealing with streamlined credentialing in Medicaid. The bill also prohibits non-compete clauses in health care provider employment agreements.

A View from the Top

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"primary diagnosis" games the MCE's have been using to downcode claims to non-emergency rates. We support these initial steps taken by FSSA and will continue to monitor this closely.

Educational Updates

1. Midwest Medical Student Symposium (INACEP is a co-sponsor) — Saturday, April 25, 2020
2. INACEP Annual Education Conference — Register before March 30, 2020 to avoid late fees.

As we welcome a new decade, INACEP has been working hard on behalf of you, our patients, and our specialty. Please do not hesitate to contact us with any questions or concerns.

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Conference Update

by Lauren Stanley MD, FACEP (VP & Education Director - INACEP)

Mark your calendars for the Indiana ACEP Annual Conference!

The conference will be April 22-23, 2020, at the Renaissance Indianapolis North Hotel (11925 N Meridian St, Carmel, IN 46032).

Dr. William Jaquis, President of national ACEP, will be appearing; he will discuss updates on various ACEP activities/ initiatives, and also give 2 educational talks. Dr. Richard Cantor will give 2 Pediatric Emergency Medicine lectures: he is a well-known national speaker whose talks are always chock-full of pearls (and pitfalls) that can be immediately applied at the bedside, served up with sharp wit that will keep you chuckling throughout. As with past conferences, we will also be featuring popular local speakers including Dr. Elizabeth Weinstein and Dr. Jennifer Sullivan (Walthall), with her unique perspective as a practicing EM/Peds physician as well as Secretary of the Indiana Family and Social Services Administration.

We will again host a forum for ED Medical Directors on Wednesday afternoon after the formal conference schedule has concluded; this is a great opportunity to discuss problems/ challenges, successes, and strategies among other ED Directors from across the state.

Thursday morning will start with an informal group discussion of Community EM cases… please bring your most interesting saves, near-misses, or other notable cases to share with your colleagues around the state, as well as EM residents.

Conference brochures have been mailed to all ACEP members; you can also find information on the Indiana ACEP website and the Indiana ACEP Facebook page. Registration will be primarily online (but paper registration forms are available for download off the INACEP website).

The conference is always a great opportunity to gain some clinical knowledge, earn some CME (10.5 hours), visit with colleagues from across the state, and come away a better Emergency Physician. We look forward to seeing everyone there!

Conference Location and Fees

by Lauren Stanley MD, FACEP (VP & Education Director - INACEP)

The 2020 INACEP Conference Registration is online this year. Go go to ***https://inacep.org/*** to register.

Conference Fees: Fees have remained the same as last year!

Two-Day Registration:

ACEP Member Physician	$325.00
Non-ACEP Physician	$375.00
PA/RN/LPN/NP/ Paramedic	$200.00
Medical student	$20.00
Late fee if after 3/30/20	*$25.00*

One-Day Registration:

	Wed	or Thurs
ACEP Member Physician	$200.00	$160.00
Non-ACEP Physician	$230.00	$180.00
PA/RN/LPN/NP/ Paramedic	$140.00	$100.00
Medical student	$10.00	$10.00
Late fee if after 3/25/19	*$25.00*	*$25.00*

Renaissance Indianapolis North Hotel

A block of rooms has been reserved at the Renaissance Indianapolis North Hotel **(11925 N. Meridian St., Carmel, IN 46032)** for the special rate of $179.00 king or $189.00 double per night.

To reserve your room please call the Renaissance directly at 317-816-0777. Identify the group as "American College of Emergency Physicians – Indiana Chapter". The hotel is only holding rooms through March 29, so please register early to avoid higher costs.

Cancellation Policy

A full refund will be given, provided cancellation is received by **March 30, 2020**. A processing fee of $20.00 will be charged for cancellations received after this date. No Shows will be charged full registration amount.

INACEP reserves the right to conduct its courses based on minimum enrollment. Should cancellation be necessary, it will be done not less than 10 days prior to the course date and each registrant will be notified by email or fax and a full refund following. The Indiana Chapter of American College of Emergency Physicians is not responsible for any cost incurred due to cancellation of a program, such as airline or hotel penalties.

Advocacy 101

by Chris Ross MD, FACEP (Immediate Past President - INACEP)

So, as most of you know from my frequent ACEP engagED communications, I now throw myself into full "amateur lobbyist" mode come wintertime each year. With last year's APRN bills and this year's surprise billing issue, it's been a trial by fire. Through all of this, I've finally found my stride in legislative advocacy efforts. This was an acquired thing for me. I never imagined myself getting involved in legislative advocacy when I first donned the short whitecoat 15 years ago. Nonetheless, here I am! I'd like to share a little bit about what I've learned so I may be able to help you along the way.

1) Be passionate. Be persistent.

Surely there is *something* that really grinds your gears about the way healthcare operates today. Maybe it's EHRs. Maybe it's payor issues. Maybe it's a lack of funding for public health. Or maybe it's something you didn't even know you had a problem with until it's brought to your attention. In any case, advocacy does not feel like a lot of work when you have something that drives you to take action. Find something you're passionate about and start talking about it with others. If you notice the conversation gets your heart rate up, this is your one-way ticket to "advocacy town". Great! You will need that passion to help you be persistent (and patient) with the policy making world and elected representatives. Now that you've found something you're passionate about, let's jump to the next step…

2) Gather some info and know your story matters

Yes, you do need to know about the issues you're planning on talking about, but you probably don't need to know as much as you think you do. While being knowledgeable about the topic will make you feel confident to speak up, realize your role in EM gives you the ability to learn in high pressured situations, talk to people with varying backgrounds, and sets you up with a treasure trove of stories to help the cause. Often pairing up with those more knowledgeable will make it easier in the beginning. Having quick references handy with more depth may be helpful for when you get stuck. One thing you definitely have to be solid on though to be an effective advocate is to know your opposition. Even though you may think you know enough about a topic already, make sure you know the other side of the discussion. Put yourself in their shoes. Surely there's some reason they feel that way. It's much easier to disarm someone from an adversarial view if you can relate to them. Alright, do you have that down? Now on to the most important and final step…

3) Do something!

Last but not least, just do something! Previous to my INACEP Presidency, when it came to legislative issues, I spent a lot of time on steps 1 & 2. I'd discuss my concerns with my wife and colleagues, research it a bit and sit there at home with it all stewing around in my brain. My coworkers often had the same concerns as me, but we often felt powerless to change. As a born and bred introvert, the thought of getting out and speaking to a bunch of strangers about something they may or may not care about never really appealed to me much. Of course, there should be no surprise when nothing would end up being done regarding my concerns. Well, after finally getting fed up with just sitting around and talking, I decided to start putting myself out there and talking to the legislators about my concerns. It's amazing how much they care about Hoosiers and want to hear what you have to say. Also, just having the "MD" or "DO" following your name gets you a louder voice than you'd expect and does come with some inherent respect in these conversations. Being an EM physician also means it's easier to "do something" because you get days off during the week. Most other specialties are chugging through clinic or in the OR. They do not have the opportunity to show up between Monday and Friday during banker's hours when everyone else works. That's truly when "the sausage is made" so they say.

Alright, that's advocacy! Remember advocacy doesn't just happen at the statehouse, it also happens at your hospitals and in your own communities. Now, go out, be passionate, be persistent, know the issues and people involved, and just **do something**!

WELCOME NEW INACEP FELLOWS AND NEW MEMBERS

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Scott Wolfe MD, FACEP

Lindsay Zimmerman MD, FACEP

Pemrolizumab-Induced Autoimmune Toxicity Presenting in the Emergency Department as New-Onset Diabetic Ketoacidosis

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

Overview

A 46 year-old male with a history of tobacco use, hypertension, bipolar depression, and stage four non-small cell lung cancer currently being treated with pemrolizumab immunotherapy presented to the emergency department (ED) with nausea, vomiting, and diffuse abdominal pain for two days. He had numerous episodes of non-bloody, non-bilious emesis as well as associated polyuria and polydipsia. He had no other associated symptoms including no fevers, urinary symptoms, sick contacts, or constipation. He had no history of diabetes or hyperglycemia.

Findings and Workup

Physical exam: The patient's vital signs showed slight hypertension but were otherwise within normal limits. The patient looked slightly uncomfortable and was actively vomiting. Physical exam was remarkable for a non-tender abdomen and dry mucous membranes.

Labs: Labs showed hyperglycemia, acidosis, and an elevated anion gap, consistent with new-onset diabetes and diabetic ketoacidosis (DKA).

Imaging: Chest and abdominal x-rays showed moderate stool burden with a non-obstructive bowel gas pattern and no acute cardiopulmonary abnormality.

Management

The patient was stable, so initial management included basic labs as well as x-rays of the chest and abdomen. Basic labs were drawn because the patient appeared uncomfortable with persistent vomiting. Labs returned quickly and showed that the patient was in DKA with no prior history of hyperglycemia or diabetes. The patient was started on an insulin drip per the hospital's DKA protocol and he was admitted to the ICU with both endocrine and hematology/oncology consults. The next day, his anion gap closed and he was transitioned to subcutaneous insulin. He responded well to this therapy and recovered quickly. He was discharged two days later with a new diagnosis of type one diabetes, which was caused by pemrolizumab immunotherapy toxicity. He has followed up outpatient with endocrinology and hematology/oncology. He continues to require insulin and he continues to receive pemrolizumab infusions as his cancer has responded well to this treatment.

Discussion

Pemrolizumab is a monoclonal antibody that is used to treat solid tumors and melanoma. It works as an immune checkpoint inhibitor. It is well known that autoimmune conditions can result from the use of pemrolizumab and other immune checkpoint inhibitors. While pemrolizumab-induced autoimmune thyroid conditions appear to be most common, other conditions such as autoimmune hemolytic anemia, arthritis, pulmonary fibrosis, Sjogren's syndrome, and bullous pemphigoid have also been described in the literature. DKA and new-onset type one diabetes appear to be reported less commonly, although the incidence appears to be increasing. Similar to the patient described here, another case report describes continued use of pemrolizumab even after multiple autoimmune side effects occurred because the treatment is so effective. It also appears as though once these autoimmune conditions develop, they are permanent. One case report found that pemrolizumab-induced type one diabetes was not improved with steroid administration. This appears to be true for the patient described here, as he remains hyperglycemic at multiple endocrine follow up visits. In general, autoimmune conditions are difficult to diagnose in the ED. ED physicians caring for patients undergoing treatment with pemrolizumab and similar therapies should be aware of these potential side effects. There should be a low threshold to obtain labs as some of these side effects, particularly DKA, are rare but life threatening. Even vague, mild complaints should be further investigated in these patients, as these symptoms could be the first sign of an undiagnosed autoimmune condition.

Conclusion

Pemrolizumab is an immunotherapy used to treat malignancy that is known to cause multiple autoimmune conditions including type one diabetes. These patients can have life-threatening complications, the most concerning of which is DKA. Often, the ED is the first place these patients will present and often these autoimmune conditions are undiagnosed at the time of presentation. Physicians should be familiar with these autoimmune side effects and should have a low threshold to do further work up if these patients present to the ED.

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Surprise Billing

by Tyler Johnson DO, FACEP (INACEP Board Member)

Surprise billing is when a patient receives a bill for healthcare services from a physician or hospital that they thought would be covered by their health insurance. Insurance companies use a system of contracts and networks to control the insurance companies' cost. They use a tactic to place physicians and hospitals "out of network" and will often not pay for the healthcare you sought. When this happens you, the patient or the family get stuck with the bill of sometimes hundreds if not thousands of dollars.

The Indiana General Assembly has decided to take on the challenge of fixing surprise bills. This effort is appreciated. Two bills, one in the Senate SB3 and one in the House HB1004 look to tackle the issue.

Unfortunately, it appears that instead of protecting patients, these house bills have sided with insurance companies to help protect insurance companies record profits. This legislation would give insurance companies the ability to set the rate or otherwise just decide what they want to pay for your healthcare. Insurance would likely continue to collect your tens of thousands of dollars in premium payments while refusing to pay your healthcare bills. This would improve insurance companies already record profits and continue to pad the pockets of insurance executives.

Dealing with stressful health problems is already enough for patients. They should not also have to worry if insurance companies are going to use fine print and hidden language to get out of their obligations to pay. Patients should only be responsible for their individual cost-sharing amounts that include deductibles that are well spelled out. You do not get to decide when you have an emergency and the system cannot expect you to make significant insurance decisions in those situations.

This approach severely threatens the most vulnerable populations in rural areas of Indiana that already struggle to keep the doors of small local hospitals open. Places where some of the most affordable healthcare is already given. We need ideas that safeguard Hoosiers' access to care — not ones that threaten access.

There are several ideas that take the patient out of the middle of this mess. Some states have found that independent dispute resolution systems that makes insurance companies negotiate in a fair and equitable way have helped. Indiana could also be innovative and develop cost effective computer-based models for payment dispute resolution. The patient would never even know any of this is happening. This would take patients out of the middle.

The Changing Model of EMS and Community

by David Hosick, Indiana Department of Homeland Security

The calls come in by the thousands. 911 dispatchers get a request for medical help and send personnel to a location, sometimes not knowing much more than an address.

Hoosier EMS teams are prepared for almost anything. One call may require rushing a patient to the emergency room while another caller simply may involve a disoriented elderly person. Some are true emergencies while many are not. Most can be treated at the scene with a few bandages, some guidance and some TLC. Some of these callers are very familiar to EMS crews, who may have responded to their home many times before.

"On average, EMS agencies perform more than 100,000 runs each year where a patient refuses transport (to the hospital). But they call EMS because they know someone will come," said Dr. Michael Kaufmann, State EMS Medical Director. Many of these people have no other access to healthcare beyond a 911 call.

These calls put a great strain on an EMS system that is already pushed to capacity. Even more of a challenge is the way EMS providers are paid for services. Few Hoosiers understand EMS providers are reimbursed only if they transport the person to the hospital. This cycle leads to higher costs to the patient, crowded emergency rooms and a continuous system that treats symptoms rather than the true problem.

EMS services, especially in rural communities, are fading quickly due to lack of funding, low salaries and no revenue source to keep ambulances on the road. The number of ambulances in one Indiana district is down nearly 30 percent due to this antiquated funding model. The service areas for some EMS providers has dwindled while other providers no longer transport patients between hospitals.

Although EMS is listed by statute as an essential function in Indiana, the system does not receive the same recognition and funding as other components of other essential government functions. "Even though EMS provides healthcare, it is reimbursed more as a transportation benefit rather than a healthcare benefit," Kaufmann added.

For the second consecutive year, the Indiana General Assembly is talking about monumental changes to the EMS system. Last year, a new law allowed the Indiana EMS Commission to establish and define the Mobile Integrated Healthcare, also known as community paramedicine, model in Indiana. This is a system that 33 other states have adopted (in some fashion) to provide supportive services and resources to patients who come in contact with EMS teams. This includes social work, substance abuse resources, mental health, chronic disease management and more.

More than a dozen Indiana communities have established community paramedicine programs using private or grant funding. A bill under consideration this year would decouple reimbursement and transportation by EMS to provide a wider range of funding sources that coincide with more proactive health treatment during emergency runs.

Community paramedicine flips the traditional EMS model on its head. It is designed to help EMS services keep pace with the evolution of medical care to more preventive treatment. A proactive healthcare approach that gives EMS the training and resources to holistically treat the diverse issues they encounter only makes sense: financially, medically and from a community wellness perspective, experts say.

Among the measured benefits experienced nationally with these programs are decreased admissions to the hospital; decreased costs of treatment to patients, better integration of EMS into the healthcare system and increased savings to commercial insurance companies.

"Right now, EMS is regarded as part of public safety. This change would put EMS squarely in the middle of public safety and public health and healthcare," Kaufmann said.

"This is about getting patients the right care at the right time," said Dr. Dustin Holland, medical director for Community Paramedicine at Hendricks Regional Health.

"These programs reduce non-emergency 911 calls, which are bad for the patients and bad for the community because it over-utilizes emergency services," he added.

Hendricks Regional used $100,000 in private support to establish its paramedicine program in July 2019 as a partnership with Hendricks EMS agencies. The idea was borne from the first responder community discussing the runs they see every day and the need for a more efficient method to treat patients, add capacity to EMS crews and reduce expensive transport and hospital bills. A paramedic is paired with a social worker to ensure patients who opt in or are referred to the program are connected with the right resources to, hopefully, provide tailored care and avoid future emergency runs.

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The Changing Model of EMS and Community

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Holland said about 50 patients have "graduated" through the program, which has shown a "dramatic reduction in those patients calling 911 and going to the hospital or ER."

Leroy Snyder, a community paramedic for Ball Memorial Hospital in Muncie, said he now spends his workday out of the office on home wellness checks in the six counties served by his community paramedicine program. These home visits, which can last 10 minutes to two hours, typically provide a complete checkup and allow Snyder to ensure the person is in a safe environment.

"Our patients can sometimes be lonely and like to talk, which I think is a good thing because that helps us build trust with them," Snyder said. "Then, when there's an emergency, they're more likely to call me directly before heading into the ER."

Parkview Health's Mobile Integrated Health program got its start five years ago first by working closely with patients who were at risk of sepsis. The program now works with cardiovascular patients, home health care, nursing homes and other patient populations. It was funded by a state grant for two years but now operates independently.

"This has impacted our recidivism a great deal," said Chad Owen, director of Flight EMS and Communications. "It has mitigated our transfers to the hospitals and allows us to treat some of these people at their bedside."

The Indiana EMS Commission is working to provide guidance and structure to communities seeking to establish their own community paramedicine programs in the future. Organizers of these programs say sustainable funding and a true needs assessment of the community are essential.

"This is the way healthcare is moving, to more preventive care and efforts to keep people out of the hospital when possible," Owen said.

Two critical data points illustrate the necessity to not only reduce emergency medical runs but also reduce hospitalizations: Since 2005, 160 rural hospitals have closed. This, coupled with an aging population and serious shortage of EMS workers, puts an estimated 60 million people at risk of nobody answering the 911 call for medical help, according to a study done the University of North Caroline Cecil G. Sheps Center for Health Services.

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