IEPC

Independent Emergency Physician Consortium

Newsletter

May 2025

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President Pearls

Robert Chavez, MD
President, IEPC

Providence Little Company
of Mary Medical Center Torrance

IEPC

NSA and Payment Leaks

Hello friends and colleagues,

Why don't we take a moment to talk about a topic near and dear to all independent emergency physicians and their groups... Insurance. There are, of course, many types of insurance, but I'm going to mention a few we are all aware of and some of you may or may not have thought of or considered for your group.

As independent emergency physicians, we interact with medical insurance all day, every day. We ensure our families and for our livelihoods, we interact with various insurance companies and products daily.

Then there is medical malpractice insurance. This type of insurance is essential for the practice of emergency medicine. Emergency physicians work with high-risk patients in a chaotic environment with multiple stakeholders vying for our attention all while task switching constantly. In medical malpractice attorney parlance... "Shangri La." An independent group should have a minimum of $1,000,000 (per case)/$3,00,000 (per annual aggregate) claims made malpractice insurance coverage.

If your group is set up as a corporation with corporate executives, these insurance types are important as well. Business and Management (BAM) Indemnity Insurance is a type of insurance that protects companies and their executives from lawsuits and claims related to mismanagement or negligence during business. It covers risks like breach of fiduciary duty, harassment, and other management-related issues. D&O insurance covers an accused company executive in employee lawsuits while EPLI covers the whole company in the event of a lawsuit alleging discrimination, sexual harassment, failure to promote, wrongful termination, invasion of privacy and other employment related misconduct.

Cyber insurance is also critical in this stage of EHRs, group web pages, digital transfer of HIPAA protected medical records and electronic revenue cycle management interfacing with government and private insurance computer systems. Do you think this insurance is not important? Imaging a hack compromising all your group's physician information on your security protected website. Moreover, see how difficult it is to bill when your hospital or RCM company is hacked or hit with ransomware, and your group is unable to bill for 2-3 months. When doing your due diligence, be sure to ask if the Cyber insurance covers third party intrusions.

Strategies for Sustaining Emergency Care in the United States

This RAND Report was funded by the Emergency Medicine Policy Institute with the objectives of (1) assess the current value of emergency care, (2) evaluate the challenges to sustaining emergency care, (3) measure trends in emergency care payments, and (4) identify alternative funding strategies for emergency care.

We share brief highlights of the 167 page report.

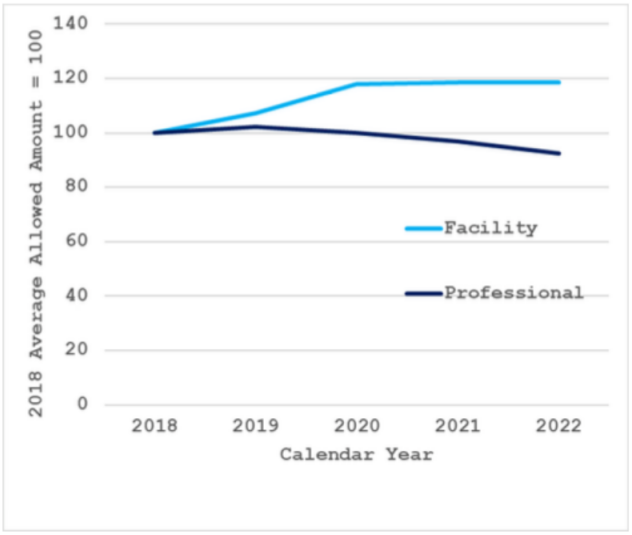
Demographics:

- 30% of all ED visits were due to mental health conditions in 2020, up from 24% in 2016.
- > 1% of ED visits were due to opioid drug use.
- > 3% of ED visits were due to alcohol.
- < 1% of ED patients were homeless in 2020, up from 0.4% in 2016.

Emergency Payment:

- Facility Commercial allowed negotiated payment has increased for facilities and decreased for professionals (see graph below).
- ED physicians were paid 80% of what they were owed for services from 2018 to 2022 based on allowed amounts.
- Insurance payers regularly fall short of delivering full payment for the allowed amount that are due.
- Average inflation allowed of professional fees are falling and not all these amounts get paid.

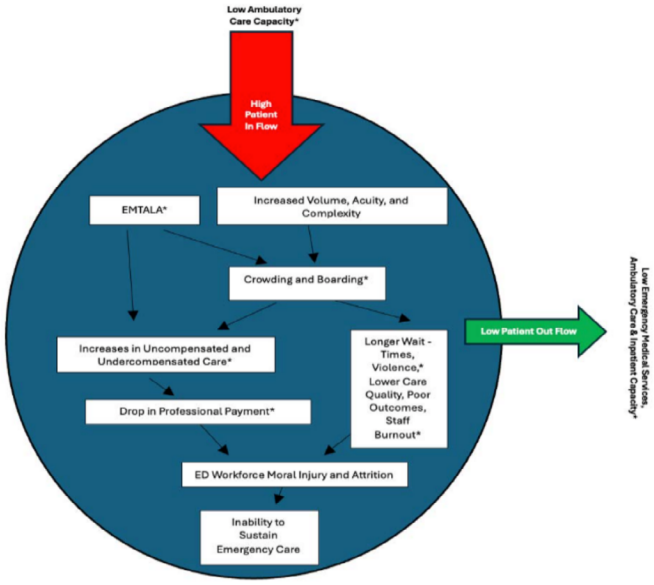
Figure 4.1. Inflation-Adjusted Index of Facility and Physician ED U.S. Commercial Allowed Amounts, 2018–2022



Payment Recommendations:

- Recommendations for Sustaining Emergency Care Value includes EMTALA funding, city and local fund, health system resiliency, ED preparedness and bolster role as a critical national infrastructure.
- Recommendations for Mitigating Challenges include securing EMTALA expanded primary care capacity, financial incentives and penalties for ED boarding, improve hospital space utilization, enforce hospital anti-violence policies.
- Payment recommendations include Medicaid expansion in stages that have not adopted it, minimum ED physician professional fee as a percentage of facility fees, annual inflationary increases to the physician fee, require the insurance company not the hospital or doctors to collect copays, make EMTALA a funded mandate, require EMTALA screening exams regardless of final diagnosis, prohibit retrospective denials.

Figure 6.1. Interrelatedness of Challenges Facing EDs



* Indicates opportunities for intervention, according to our analyses.

To view the full report, click here.

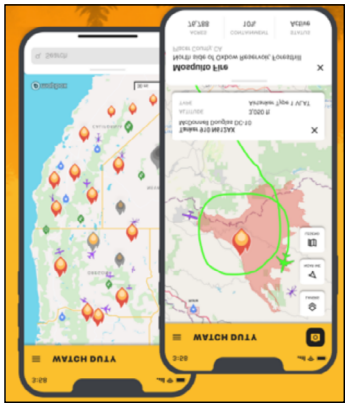
Tips from the Southern California Wildfires

Summary of an Interview with
Dr. Larry Stock, IEPC member,
Antelope Valley Hospital

On January 7, 2025, IEPC member Dr. Larry Stock lost two homes, his and his parents.' The Southern California wildfires killed at least 30 people and destroyed more than 18,000 homes. The Palisades Fire was one od the largest fires and where Dr. Stock lived.

Here are some of his fire victim tips that include: 1. Watching, 2. Preparation, 3. Taking Off, and 4. Recovery.

Tip 1: Watching



Watch duty is the application used by fire fighters and available to the public. This is the best source of tracking the fires, the perimeters, power outages, and more. The other watching source is wind direction. Knowing where the fire was and the wind was going allowed for the best decision on whether to evacuate, fight the fire, or continue to monitor.

Tip 2: Preparedness

It is a good idea to digitize important documents such as Passports and insurance policies and keep them on the cloud. After a fire, you are asked to itemize everything that was lost. Taking a video of your house, including opening drawers and recording the contents makes that process mush easier. That video should be on your phone or on the cloud where is not a victim to the fire. A firesafe is not always fireproof. It is advised to think ahead on what you would take out of your home if you had 5 minutes, if you had 1 or 2 hours. Some people prioritize pictures and

mementos. Others go first for the computer and documents. Larry had one hour and one car load of things to get out.

Tip 3: Taking Off

Emergency Physicians are givers. Our nature and profession are serving and helping others. Being a fire victim, Dr. Stock was in the uncomfortable position of receiving. He evaluated with only the clothes on his back and did not have time to go shopping with all the other tasks that were a priority. He felt like he was dropped off on Earth and had to restart. Larry pivoted from giver to and receiver. His friends provided shelter, clothing, and support in the immediate aftermath.

Tip 4: Recovery

There are great frustrations in dealing with fire insurance, government assistance, and rebuilding. They continue to this day and are a full-time job. Larry stayed with friends, an Airbnb, and now is renting a house previously owned by Clark Gable. He is still working on a permanent residence. FEMA and government assistance was promised to many fire victims. One attractive program was through the Small Business Administration offering a $500,000 loan with 3% interest and a 30-year term. Larry describes going through a financial colonoscopy of personal information to apply for this loan. After two weeks of intense application, he was informed that people with good insurance and resources were not eligible. It would have been nice to know that at the beginning.

Larry points out a major benefit of being part of an independent group. His emergency physician partners are his brothers and sisters. They protected him. His group gave him 6 weeks off before returning to a reduced schedule. To his surprise, they also paid him during those 6 weeks as though he was working. That degree of empathy and kindness is rare in the workplace.

Losing a home is a phychosocial and financial toll. It's a trauma. Thankfully, as an emergency physician, having resiliency and ability to make important decisions with incomplete information is our asset. Dr. Stock remains optimistic.

California ACEP Legislative Agenda

Elena Lopez-Gusman

Executive Director, California ACEP

California ACEP members went to Sacramento to lobby their congressional leaders. The following is a summary of the sponsored legislation.

AB 447 (Gonzalez) - Reducing Medical Waste & Saving Healthcare Dollars
Patients often present to the emergency department (ED) with conditions that require administering medication to them while in the ED. Sometimes these medications, like eye drops, inhalers and liquid antibiotics, contain more doses than will be used during the duration of the ED visit, but they cannot be used on another patient. Under existing law, the remaining doses cannot be sent home with the patient they were administered to, so they must be thrown away. Patients who receive these types of treatments leave the ED with a prescription for the same medication that they must pick up and pay for at an outpatient pharmacy to continue treating their condition. Current law results in redundant prescriptions, increased cost to the health system, and increased medical waste. AB 447 allows patients to take home the remaining doses of their multiuse medication.

AB 416 (Krell) - Reducing Delays in Care for 5150 Patients in the Emergency Department
One in 6 patients that comes to the ED has a behavioral health diagnosis. Many of these patients are seeking care voluntarily. Some can be stabilized, treated and discharged home after. Some of them need additional community services and in conjunction with the social worker in the ED, can be connected to those services. Some need to be transferred to an inpatient facility. Because they are voluntarily seeking care, emergency physicians can immediately begin looking for placement. There are additionally a smaller number of people who are a danger to themselves and others and need to be placed on a 5150 hold to ensure they remain safe

and to get an additional assessment and care at an LPS designated facility as required by law. Emergency physicians cannot start looking for an available bed in an LPS facility until the patient is placed on a 5150, which in some places can take many hours, even days. 5150s are placed by county designated authorized individuals. Who is authorized varies by county. Thus, there is a wide disparity in resources available to providers and to patients, and in the difference in time patients wait depending on the county, or even the time of day, or day of the week they are in crisis. Emergency physicians are always present in the ED. AB 416 empowers emergency physicians to care for their patients by allowing them to apply and train to be county designated individuals authorized to write 5150 holds.

Delays in Proposition 35 Funding Are Crushing Emergency Departments

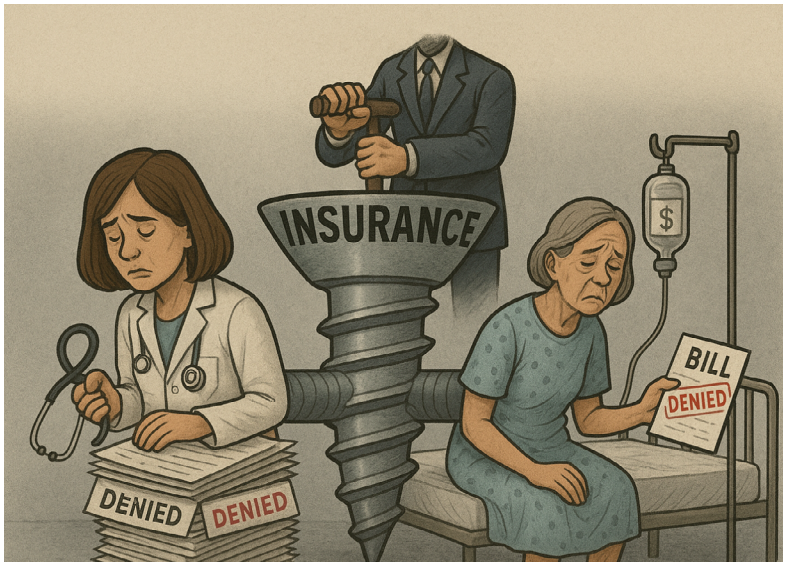
California ACEP respectfully requests the Legislature maintain its commitment to the emergency care safety net and include $100 million for increasing Medi-Cal rates for emergency physicians as previously approved in the 2024-2025 budget.

Screwed as a Doctor and Now as a Patient

Roneet Lev, MD, FACEP

Executive Director, IEPC

At IEPC, as in most emergency medicine organizations, we spend much time defending our reimbursement. IEPC members along with physician groups across California have been in litigation against Blue Cross for systematic payment denial of level 5 visits. The American College of Emergency Physicians (ACEP) and the Medical Association of Georgia sued Blue Cross Blue Shield and Anthem for reclassifying emergency room visits as non-emergent retroactively.



Health plans have a reputation of screwing emergency physicians.

Recently I was on the other end of medicine, as a patient. I have written about that the final emotional aspect of going from doctor to patient in the past. This time I share the financial aspect of being a patient.

In the past year I had a thyroidectomy with a neck dissection and more recently a craniotomy for meningioma. Please don't worry - my medical recovery is great, and I have a great prognosis. It will take more to kill me. But recovering from the financial hassles is worse than any post op pain.

In the stack of mail that I went through while recovering was an insurance denial letter of my Brain MRI. Who denies an MRI to someone with a brain tumor? I saw they listed cause of denial, was thyroid. It had to be a clerical error. I called to clarify. Aetna outsources its medical approval process to eviCore. After several phone transfers, I reached the customer service supervisor who identified herself as my "patient advocate." I was informed that the MRI is indeed denied because they consider it experimental, and they do not cover experimental procedures.

I send a complaint to the California Department of Managed Healthcare saying that Aetna is practicing medicine without a license and interfering with patient care by denying the MRI. To no one's surprise, I never heard back.

How many patients who are not able to defend themselves suffer from egregious denials?

In any case, I can say that I have been screwed by the health plans as a physician and as a patient.

eviCore healthcare (eviCore) has been authorized by the Health Plan to review certain services. We received your request for coverage verification and approval for the following service(s) for the member referenced above.

Procedure	Description	Units Requested	Units Denied
70542	Magnetic Resonance Imaging (MRI), a special picture of your orbit (eyes), face, and neck with contrast (dye)	1	1

Coverage for this service has been denied for the following reason(s):

Your doctor told us that you have been treated for disease in your thyroid (small gland in your neck). An imaging study was asked for. We cannot approve this request because:

Your health plan does not cover the requested study.

I must add that the hospital is not a angel in the medical financial system. Their portion of a thyroid biopsy was $15,067.31. The radiologist charged $229. The hospital charged $869 for a pre operative Chest X-ray. I could not negotiate any of these crazy prices, and I tried. Hospitals still put fear of sending you to collections for non-payment.

As the singer Joe Walsh has said, "I can't complain but sometimes I still do, life's been good to me so far."

2025 IEPC Speaker Series

IEPC
Independent Emergency Physician Consortium

FREE TO ALL FRIENDS OF IEPC!

Time & Date: 9:00 AM - 9:30 AM PT on the fourth Monday of each month.

Membership in IEPC is not required to attend. Advance registration for the meeting is required. After registering, you will receive a confirmation email containing information on how to join the call! To receive a registration link, email admin@iepc.org.

June 23, 2025

ACEP Legislative Updates

Laura Wooster

August 25, 2025

SB 43 and the Expansion of 5150 holds

Mike Phillips

July 28, 2025

Data Updates from EBDA

Dr. Jim Augustine

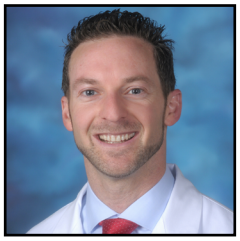
September 22, 2025

Reimbursement and Advocacy Hot Topics in 2025 for Emergency Medicine

Dr. Ed Gaines

October 26, 2025

The EM Labor Market



Dr. Leon Adelman

November 24, 2025

Legal Updates for Emergency Physicians

Andrew Selesnick

IEPC

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