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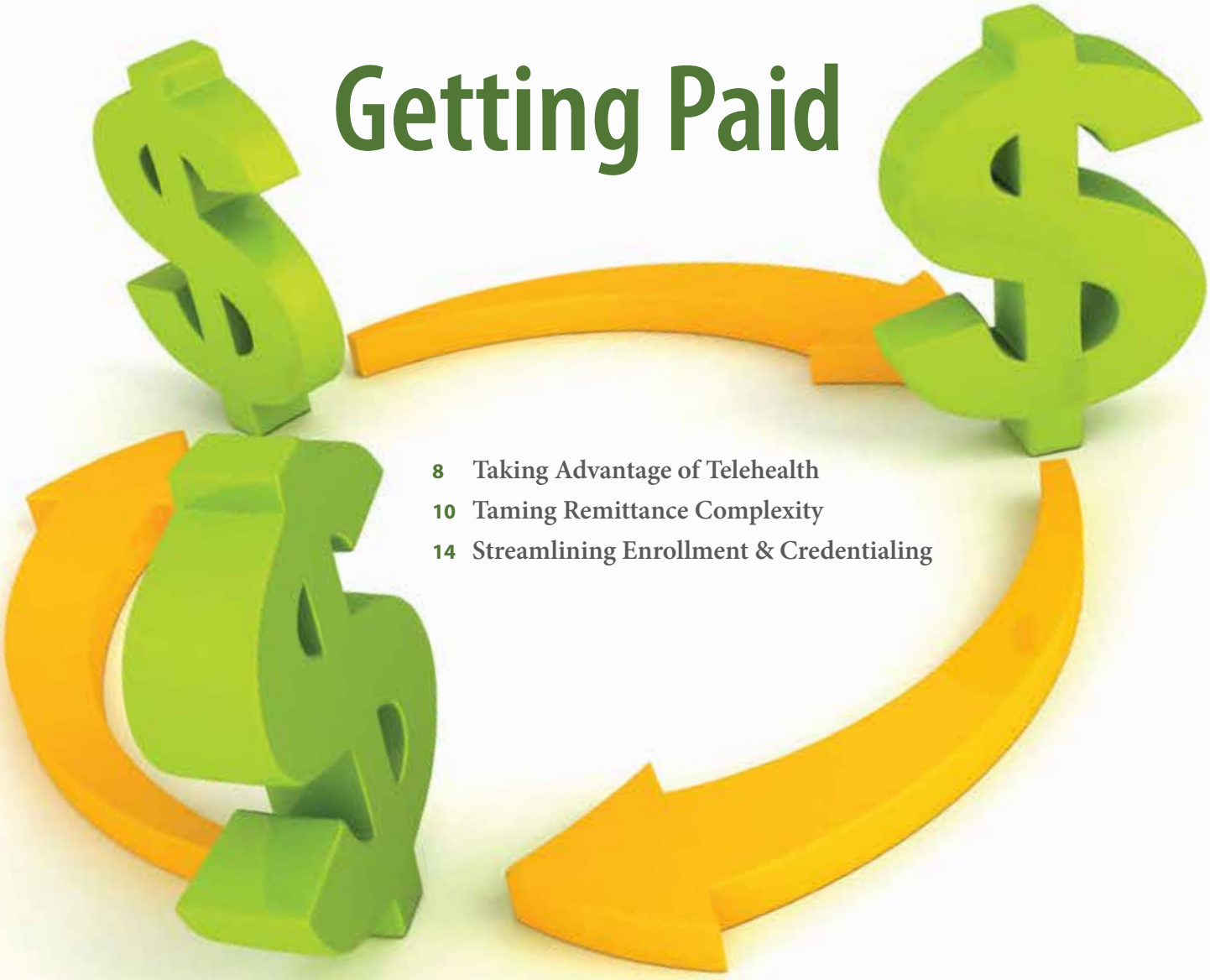
Getting Paid



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MEDICINE

David M. Nowak, Executive Editor
dnowak@slmms.org

James Braibish, Managing Editor
Braibish Communications
editor@slmms.org

Graphic design by Lisa Troehler Graphic Design, LLC

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Getting Paid

Features

Columns

News

Returning to the Physician Office

Installing safety protocols and overcoming patients' fears are essential

By Jason Skyles, MD, President, St. Louis Metropolitan Medical Society 2020

Jason Skyles, MD

The call is for physicians to re-engineer our practices with a focus on enacting safety measures and managing our patients' fears.

The coronavirus pandemic has changed how we deliver health care services and has impacted all of our practices. Until there is an approved medication to treat or a vaccine to prevent COVID-19, we must balance the need to provide necessary services while minimizing risk to our patients, our co-workers and ourselves.

Our patients and our practices have suffered as a result of a near complete shutdown of the health care system for many weeks. By early June, we began the process of re-opening our businesses and providing services. As of early July, certain parts of the country are witnessing a resurgence of the virus. In many areas, we are seeing a lack of concern about the virus, primarily among younger adults. This requires a balance between the economy and public health. As physicians, we need to strike the right balance for the benefit of our patients, our employees and ourselves.

Conversations with members of the Medical Society have informed us that for many physicians, they are seeing their patient volumes returning, albeit slowly. This appears to vary by specialty, and many are not back to the same levels of activity they were experiencing before the pandemic hit. It is unclear at this time how long the pandemic will last, but we need to be available to deliver safe, comprehensive and effective care for our patients.

Patient Concerns

COVID-19 has greatly impacted consumer behavior and attitudes toward health care services according to a study published recently by the Alliance of Community Health Plans (ACHP) and the Academy of Managed Care Pharmacy (AMCP). They partnered with Leede Research to survey more than 1,200 adults aged 18-74 in May 2020, at the height of the pandemic. They found that 72% of U.S. consumers say the pandemic has changed their consumption of traditional health care services, with many delaying in-person care.[1]

These same respondents cite their physician as the most trusted source of information (58%) about the coronavirus, followed by state government (47%) and local health officials (47%). Conversely, trust in their health plan (27%), the national media (25%) and the federal government (18%) was low.

However, while their doctor was viewed as the most trusted source of information, 41% of the respondents are concerned about being able to see their doctor in a safe environment.

More than one-third (38%) of those surveyed said they will continue to delay their medical needs and elective procedures for the near future. More than one-fourth (27%) said they would delay scheduling diagnostic procedures or tests in a hospital setting for at least six months.

During the height of the pandemic, we saw patient visits plummet including ER visits. Patients were scared to come to the hospital even for life-threatening illnesses such as heart attacks and strokes.

While patients are returning to their physicians' offices, what can be done to increase their comfort levels about doing so, as well as encourage them not to continue to delay care?

Putting Safety Protocols in Place

The call is for physicians to re-engineer our practices with a focus on enacting safety measures and managing our patients' fears. Doing these two things will ensure that our patients continue to receive necessary health care.

The implementation and visibility of the additional safety measures will not only help protect our staff and patients, but it will also help to assure them that it is safe to resume normal medical care.

In order for our patients to feel safe returning to hospitals and health care settings, many will need to be assured that the proper safety protocols are in place to protect them during their visit. Even most patients who are dismissive of the virus' threat will appreciate the additional safety protocols. These practices include:

1. Pre-screen all patients for symptoms during scheduling, then screen all patients, workers and visitors for symptoms upon building entry.
2. Develop a plan for how to manage individuals who screen positive.
3. Ensure sufficient PPE for workers and patients. Implement universal masking of health care workers and patients/visitors.
4. Enable social distancing, plexiglass barriers and the use of floor markers.
5. Implement methods to minimize time in waiting rooms; ideally, we would take our patients directly in for their examinations immediately upon arrival.

Hopefully, this will result in a more private and seamless experience for our patients while optimizing safety for all. The implementation and visibility of the additional safety measures will not only help protect our staff and patients, but it will also help to assure them that it is safe to resume normal medical care.

Managing our patients' fears about the virus are just as important as ensuring adequate safety protocols if we want them to return to our clinics. Ways we can help to manage fear include:

1. Provide fact-based information to patients and staff.
2. Reiterate the message that for outpatient visits, the risk is low with appropriate safeguards.
3. Advertise our infection control processes through social media and signage throughout the clinics.

The good news is that many of our practices have made great strides and have re-engineered their office processes to greatly increase patient safety and comfort. The fact is, with all of the additional safety measures in place and increased emphasis on infection control, the physician's office and medical clinic are probably the safest they have ever been. With almost three-quarters of the U.S. population (74%) believing it is likely or very likely there will be a resurgence of coronavirus in the coming fall or winter months,[1] it is even more imperative to seek care now as opposed to delaying services further.

For more specific guidance on COVID-19 prevention for medical offices and other health care facilities, consult the U.S. Centers for Disease Control and Prevention website at https://www.cdc.gov/coronavirus/2019-ncov/hcp/preparedness-checklists.html or https://bit.ly/cdc-facilities.

Jason Skyles, MD, is a diagnostic radiologist with West County Radiology at Mercy Hospital St. Louis.

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NOTICE

ST. LOUIS METROPOLITAN MEDICAL SOCIETY GENERAL SOCIETY MEETING

Tuesday, September 15, 2020
6:00 p.m.

West County Radiology Group
11475 Olde Cabin Rd., Suite 200
Creve Coeur

Nomination of 2021 Officers, Councilors, and MSMA Delegates
All members are invited to attend.

Agenda

Call to Order
President Jason K. Skyles, MD

Nominating Committee Report
Ravi S. Johar, MD, Committee Chair

The committee will be recommending members for nomination to the following offices:

President-Elect ► Vice President
Secretary-Treasurer ► Councilors (4)

Please note: Due to COVID-19, at this time it is unsure if this meeting will be held in-person or via a Zoom conference. Please watch the SLMMS website for updates. If you are interested in participating, please contact Dave Nowak at dnowak@slmms.org and he will keep you updated.

The Invisible Wounds of COVID-19: The Mental Health Crisis in Health Care Workers

Pandemic brings new risks and fears

By Craig Pearson, PhD, and Jessica A. Gold, MD, MS

Since the start of the coronavirus pandemic, the mental health of health care workers has been at risk. Many found themselves facing novel threats to their personal safety and the safety of those around them—threats that were often drastically different from those they had previously faced in their daily lives and work.

This mounting awareness of danger early in the pandemic was compounded in many cases by medical workers' lack of access to personal protective equipment (PPE).[1] On top of this, as the virus spread across the world, the nature of the day-today work on the ground changed almost overnight. In addition to the regular job stressors, health care workers were dealing with higher than normal reported rates of patient deaths, pervasive fear of the unknown, disagreement regarding best treatment practices, the absence of patients' families on the units, and fears of needing to ration or allocate resources like ventilators or medications, that in many cases did not materialize.[2]

These challenges arrived against a backdrop of physician wellness that was already compromised. Medical students and residents have rates of depression much higher than the general population,[3,4,5] and physician suicide is among the highest of any profession.[6] Physicians also have high rates of burnout across the spectrum, up to 50% in many studies, which has been shown to affect COVID-19 productivity, patient care, and, of course, personal mental health.[7] One study estimated that the annual productivity lost due to physician burnout is equivalent to the loss of seven medical school graduating cohorts.[8] Despite this, many physicians do not receive mental health care or ask for help when they need it. In many cases, they avoid it.[9,10]

Current Stressors

As the pandemic has evolved, so have the stressors. The impact of the novel coronavirus has affected different regions in different ways—whether because of differing caseloads or the financial impact of COVID-19 on medical practices. Hospitals readied themselves to look like Wuhan or Northern Italy or New York City, reassigning staff to perform urgently needed tasks and procedures which, in some cases, they had not practiced in years,[11,12] and preparing wards for an expected surge of COVID-19 patients. But the expected crises did not manifest everywhere in the same ways. Cities locked down, unemployment rose, and patient appointments were cancelled, postponed, or made virtual. Medical research not directly related to the new coronavirus was almost universally stalled. This meant that even in regions with large COVID-19 patient volumes, hospitals were taking substantial financial hits and some employees were forced to take pay cuts.

Now, as cities reopen, patients fear returning to medical institutions for routine or acute care,[13] and it is becoming clear that medicine will be struggling for a long time and some hospitals and clinics might not survive.[14,15] Many will suffer financial and administrative burdens for years to come. Thus, while not every frontline worker's mental health is directly affected by seeing the day-to-day care of COVID-19 patients who are dying at high rates, the risk of developing long-term mental health effects is still high, due to this broad spectrum of stressors.

Dr. Jessica Gold

Jessica ("Jessi") Gold, MD, MS, is an assistant professor in the Department of Psychiatry at Washington University School of Medicine, where she teaches in the medical school and psychiatry residency program and sees patients in her outpatient psychiatry clinic who are transitional aged or are faculty or staff of the university or hospital system. She is a prolific lecturer and author for professional journals. She also has contributed articles to popular media including The New York Times, TIME, *and* Self, *as well as physician media such as* Psychiatry Times, MedPage *and others. She authored the April 3 article on StatNews, "The Covid-19 Crisis too Few Are Talking About: Health Care Workers' Mental Health." Her writings are available on her website, www.drjessigold.com. She can be followed on Twitter, @drjessigold. She can be reached at jgold@wustl.edu.*

Dr. Craig Pearson

Craig Pearson, PhD, is a student at Washington University School of Medicine. He holds his PhD in clinical neuroscience from Cambridge University. He has done extensive work in the field of narrative medicine, including writing, podcasting, and documentary film, all of which are accessible on his website, www. craigspearson.com. He can be followed on Twitter, @CraigSPearson. He can be reached at craigspearson@wustl.edu.

Getty Images/istockphoto

> Given the scale of the pandemic, it seems likely that we will be observing and dealing with its impact on health care workers' mental health for a long time. And the pandemic isn't even close to over.

Even if the worst case scenario does not arise, the fear and anticipation of subsequent surges in COVID-19 cases will profoundly affect the mental health of frontline workers in the coming months and years. For instance, resources in regions with high caseloads, such as New York, were strained to the breaking point at the local peak of the pandemic, whereas elsewhere, like much of the Midwest, hospitals have largely managed to keep up with lower rates of community spread.[16] For workers in these lower caseload areas, this creates a sense of anticipatory anxiety: Are we out of the woods yet? When will a fresh wave hit us? Will it ever come?

The uncertainty of the virus' spread among these populations, combined with alarming, often traumatic images shared by friends and peers on the harder-hit coasts, or throughout social media, can contribute to a sense of constant threat that impairs health care workers' ability to maintain focus and preserve their mental well-being. And, for the harder hit regions that are now rebounding, the fear of a second or third COVID-19 surge contributes to unresolved anxiety. Until we have a more confident plan or treatment or vaccine, it is reasonable to expect that health care worker mental health will be at persistent, increased risk. Anxiety, after all, stems from uncertainty.

Additional Issues

The coronavirus pandemic is not the only ongoing threat to mental health. We are currently in the midst of national political upheaval and civil unrest.[17] While there is concern the widespread protests could lead to additional coronavirus cases, frontline workers must continue to work in the hospitals while doing their best to process the grief that many feel over the sociopolitical climate and, in some cases, a conflict between the wish to protest and the feeling of obligation to maintain recommended physical distancing practices. This also has potential to jeopardize the well-being of physicians, particularly black physicians, who are already taking care of COVID-19 patients who disproportionately look like them.[18]

While we do not have data about mental well-being in physicians by race, the existence of systemic racism is readily observable, along with the fact that underrepresented minorities disproportionately work lower wage jobs, are less likely to have

continued

COVID-19 MENTAL HEALTH RESOURCES FOR PHYSICIANS

- The **Missouri Physicians Health Program**, www.themphp.org, 314-578-9574, offers free, confidential consultation. There is no commitment, monitoring, referral or group presentation required. Virtual appointments are available. "The MPHP is fully committed to doing everything we can to help physicians, residents and medical students stay healthy during this very difficult time," the organization said.
- **Physician Support Line**, 888-409-0141, offers free and confidential peer support to American physicians by creating a safe space to discuss immediate life stressors with volunteer psychiatrist colleagues. This service was launched in March 2020 to help physicians cope with the stress of COVID-19.
- The **American Medical Association** offers mental health tips for physicians, patients and staff, on its website, https://bit.ly/ama-mental-health.
- **Project Parachute**, https://project-parachute.org, is a nationwide network of therapists who will provide a pre-determined series of therapy sessions free of charge. The site will match frontline health care workers with a local therapist licensed in the worker's state.

good workplace benefits, and are more likely to be in direct contact with COVID-19.[19] High risk of infection is known to yield mental health effects in pandemics, and so this is overall an especially high-risk group that needs to be monitored.[20]

It is impossible to predict exactly what the mental health outcomes will be after the pandemic. Preliminary data from China suggests that rates of PTSD, anxiety, and depression will be high.[21,22,23] If we look at the data from past pandemics, it is also true that depression is possible, along with trauma and workplace avoidance,[24] but it is difficult to apply that data to the current moment. We can look to previous studies of imposed quarantine, such as SARS, to infer that those health care workers who do contract COVID-19 and undergo quarantine may be at high risk for depression, substance use and PTSD, even three years after the epidemic.[25]

Yet, we don't know the impact of self-isolation as it has been adopted in 2020, and the scale of this pandemic is much different from those studied in the past. We do know that there are high risks of negative mental health outcomes among those who directly worked with COVID-19 patients, those who contracted the illness or knew someone who did. Also at increased risk are women and those with previous psychiatric histories and substance use histories.[26] These groups should be regularly screened and closely monitored. Given the scale of the pandemic, it seems likely that we will be observing and dealing with its impact on health care workers' mental health for a long time. And the pandemic isn't even close to over.

Action Steps

So, what can be done? Medical institutions have an obligation to support their staff's mental health for the long term and not just implement short term policies. Given the timeline of treatment and vaccine development, it is clear that this is not something that will go away soon. We need to figure out which measures that were put in place temporarily should stay around—hotlines, extra appointments, group therapy, crisis support—and which need to be altered. Not all policies have to be mental health related to help mental health. Institutions can safeguard their workers' physical health with PPE and workplace safety policies, or their sick leave or child care policies.

At the very least, we need to work to change the culture of medicine, to make it one in which vulnerability and emotions are discussed, not hidden. Getting help should be safe and encouraged. We should not be asking on credentialing, licensing, or insurance forms for mental health histories, which only serve to discourage treatment seeking.[27] As a community in health care, it is up to us to finally approach these problems the way we approach the illnesses we treat in our patients—that is, with more than a bandage. A mental health crisis is looming for frontline workers, and we can't keep hiding behind patient care and stoicism for long. For many, the effects are already here.

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Getting Paid During the Global Pandemic

Take advantage of telehealth to generate revenue and serve patients

By Eric Knudtson, CPC

When the topic of "getting paid" comes up, especially during the current pandemic environment, it should be noted that the problem is not a breakdown in the normal payment process. Insurance companies for the most part are not delaying payments across the nation or refusing to pay out; it is actually quite the opposite. Insurance reimbursement is up, especially if your practice or institution has taken advantage of expanded regulations on telehealth.

The underlying issue of "getting paid" has more to do with keeping the patient flow open even if you are limiting your physical appointments. There are other factors as well, such as proper staffing (you may be dealing with sick or quarantined staff members) or new maximum capacity limits within your office. But with the increase in reimbursement for telehealth and the expansion of the type of provider that can take advantage of it, monthly revenue can stay consistent or even increase at a time when many other business verticals are struggling or have closed their doors entirely.

Are You Taking Advantage of Telehealth?

Telehealth, or telemedicine, is relatively new or was not utilized by many providers since there just wasn't a need—until now. The cost of setting up your practice for telehealth was also a factor before reimbursements increased. Many of these barriers have now been removed through the administration's changes to telehealth via the Center for Medicare and Medicaid Services (CMS). With the second wave of COVID-19 coming and the high potential of other restrictions, positioning your practice to start or expand your telehealth operations will be increasingly important. What are some factors to consider? CMS provides specific guidance shown in the following excerpt from their Medicare Telehealth fact sheet.[1]

Eric Knudtson

Eric Knudtson, CPC, is president of Integrity Healthcare Solutions, offering revenue cycle management services to medical practices. He can be reached at eknudtson@IntegrityHealthCommunity.com. The company's website is www.IntegrityHealthCommunity.com.

The underlying issue of "getting paid" has more to do with keeping the patient flow open even if you are limiting your physical appointments.

Types of Virtual Services:

There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries summaries in this fact sheet: Medicare Telehealth visits, virtual check-ins and e-visits.

Medicare Telehealth Visits:

Currently, Medicare patients may use telecommunication technology for office, hospital visits and other services that generally occur in-person.

- *The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians and nutritional professionals.*

- *It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare Telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver [section 1135 (g)(3)] requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.*

In simple terms, what are the changes? Let's look at just a few.

Telehealth Changes

- Limitations on practitioner type have been waived. (**Note**: Each state or insurance may differ, so contact your own payers for further guidance.)
- Other practitioners besides physicians, nurse practitioners and physician assistants can bill for telehealth. This includes physical therapists, occupational therapists and speech language pathologists.
- Audio-only telehealth code set lists have been expanded.
- CMS will allow a variety of therapy-related evaluation and management codes to be billed as telehealth services with an audio-only connection, i.e. over the phone, without requiring real-time video. This includes psychotherapy services, medical nutrition counseling, diabetes self-management training, tobacco use cessation counseling and more. (The full list can be found on the CMS telehealth-eligible code list, which was just updated again on April 30.)
- Payments have increased for audio-only services. (99441-99443)
- CMS is bumping up the payment for these services from the current range of $14-$41 to a range of $46-$110, bringing them in line with payments for similar office/outpatient visits. This payment change will be retroactive back to March 1, 2020.
- Hospitals may bill as the originating site for telehealth, even when the patient is located at home.

Of course, there are many factors to consider. Medicare pays differently than your private payers and negotiated rates are different based on location and payer contract. Your office should verify reimbursement rates individually. Certain states have made emergency changes to the Medicaid guidelines expanding the types of providers and reimbursement. Though the list of eligible entities has expanded, verifying that your specialty can bill for telehealth will be important as well.

Is Telehealth My Only Option to Weather the Storm?

There will always be a percentage of providers for which virtual-based care is not a consideration. To help ensure your doors stay open, proper coding and billing have become increasingly important. For certain procedures it may not be a matter of if you're reimbursed but how much you are reimbursed. Ensuring you are paid at the highest possible rate for services performed could be one way to make up the difference in the drop-off of patient visits or procedures. Partnering with a reputable and proven revenue cycle management company will increase your success.

Regardless of what unfolds in the coming months, take the time now to insulate your practice by considering the various options mentioned in this article. And meet with your office managers or billing companies to ensure your protocols and processes are in place as this paradigm shift continues. As the business owners and leaders in the health care field, the time has never been more appropriate to take the necessary steps for your patients' well-being and your financial future.

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Take Control of Your Payments: Taming Remittance Complexity

Revenue cycle management addresses industry challenges that make it harder to get paid

By Tammy Krebel

The need to optimize revenue cycle management (RCM) has never been more urgent. Health care organizations, particularly physician practices, face significant financial pressures as industry transformation gathers momentum. Unfortunately, for many, the gap between current and desired RCM states is wide. The problem is complex, involving multiple constituencies with agendas that are not always aligned.

Four Trends Driving Complexity

Several powerful industry forces are intersecting to create the complex revenue cycle management landscape we see today:

RCM is adjusting to **rising consumerism as patients assume greater payment obligation**. More than 40% of consumers now have high-deductible health plans.[1] Concern about affordability is high. This trend introduces new risks into the payment equation and places patient financial experience top-of-mind for managers.

The **shift to value-based reimbursement** continues to be an industry imperative. Standard & Poors believes the movement away from fee-for-service is "gaining traction," creating "a major disruption."[2] Cost containment is paramount, and RCM optimization is simply not optional in this environment.

Technologies from robotic process automation to data analytics to mobile payments **offer new opportunities to automate and streamline RCM**. These technologies are in early stages, confronting physician practices and hospitals with questions on how to deploy them effectively.

Health care's consolidation wave has produced larger and more diversified health systems. Consolidation engenders ongoing challenges for RCM in the form of disparate systems, policies and financial arrangements that must be transitioned or integrated between the merging organizations or practices.

Internally, revenue cycle managers must contend with persistent staffing issues that can stymie change. Especially in larger health systems, turnover can be high, leaving entry-level or inexperienced people in positions across the cycle. On the other hand, physician practices often have long-time employees who may resist automation and other optimization strategies.

Multiple Payment Challenges

Navigating this confluence of forces requires clear focus on several optimization barriers:

- **Heavily manual processes.** Notwithstanding growing technology adoption, management of receipt, posting, reconciliation and analysis of payments is still heavily reliant on human labor. Industry estimates suggest that about 50% of remittances in a typical community hospital are paper based. Lockboxes remain ubiquitous and are not going away anytime soon. Manual processing unleashes a cascade of problems: added cost, suboptimal cash flow, fragmentation, errors and potential for negative patient experiences.
- **Siloed systems, multiple transactions.** Most organizations maintain multiple electronic systems—often not tightly integrated—that impact the financial/accounting side of the house. Much hope was invested in EHRs to provide unified RCM processing, but they have not yet lived up to that expectation. With many payments from many patients involving many bank relationships, the lack of a central system impedes automation efforts and induces inefficiencies. Staff has to split aggregated remittances, manually post each one to the appropriate system and work across the multiple systems to ensure accurate reconciliation. It is an error-prone, time-consuming process.
- **New patient demands.** Rising patient self-pay is adding considerable complexity as staff now deals with individual questions concerning amount of obligation, explanation of


Tammy Krebel

Tammy Krebel is senior vice president and specialty division manager for health care, nonprofit and government at CommerceHealthcare. She can be reached at Tammy.Krebel@CommerceBank.com, (314) 746-7301.

charges and billing accuracy. There is also a substantial push to capture payment up front, given evidence that self-pay compliance tends to decline as bills age. Patient frustrations are a distinct risk with downstream financial effect as reimbursement becomes more dependent on satisfaction metrics.

- **Payer reimbursements—are you unknowingly paying too much to get paid?** In addition to their normal practice of sending electronic remittance advice statements with payments that often must be properly disaggregated for accurate crediting, payers are increasingly adopting reimbursement via credit cards. The hospital or practice receives quick payment but incurs additional processing fees of 3-4% upfront and clearinghouse fees of 1-2% on the back end. The resultant burden for an average health system has been estimated at upwards of $1.2 million annually.

- **Analysis and tracking challenges.** Paper-based records and multiplicity of systems are not conducive to consistent tracking. In many instances, manual maintenance of spreadsheets is the norm. That is why an HFMA analyst observed that "revenue cycle directors do not have access to the advanced metrics and analytics needed to monitor and manage revenue cycle performance."[3] Moreover, since most financial institutions permit discrepancy reporting for only 30-60 days, processes such as bank reconciliation become difficult. RCM staff often resort to mass printing of statements or image transfer for later review.

Strategies to Overcome Payment Challenges

Providers can leverage several strategies in response to these multiple payment challenges.

- **Invest in an appropriate electronic health records system.** To reduce heavily manual processes and optimize payer reimbursement, providers should invest in an EHR that matches its unique specialty. A system that allows for electronic remittance advice (835 transactions) and patient payment file posting is key to operating at top efficiency. Additionally, make it a priority to update the software or configuration of the current EHR to ingest 835s from all payers. This can streamline the posting process and give the posting team more time to work on follow-up items to increase revenue.

- **Focus on electronic enrollments.** It is critical for providers to focus on 835 enrollments and electronic funds transfer enrollments. A truly electronic posting process includes both the remittance and the payments. This approach lowers the cost to receive payments from payers and significantly decreases the time it takes to receive and post payments. For example, some third-party payers are paying with credit cards on behalf of insurance payers. Turning these card payments into an electronic funds transfer (EFT) or check can increase revenue significantly by reducing costly

payment processing. Be aware that many of these payers are charging for EFT payments; take the time to compare if it is worth taking the fee to get paid faster or wait to be paid via check to receive the full payment amount. An enrollment service can provide insight into the complicated enrollment process and do the work on the organization's behalf, as well as provide guidance on the best approach. (Many clearinghouses will do enrollments for 835s but not for payments. Enrolling both is important as it makes it easier to reconcile and gain efficiencies for electronic posting.)

- **Increase profitability through payment automation.** To increase profitability, leaders must focus across the organization. There are ample opportunities to increase revenue through the accounts payable team. The key is to leverage an automated payables system which can remove manual processes and deliver revenue share potential. Organizations that are not utilizing an automated payables system are leaving money on the table every month.

- **Provide patients multiple options to make a payment.** It is best practice to offer patients multiple options to make a payment. The most important is an online portal that allows credit card and automatic withdrawals from a bank account. A link to the portal should be prominently displayed on the patient statement and organization's website. This can result in faster payment and diminish paper and manual processing which is costly and results in delays. The portal should also enable the front office staff to process over-the-counter payments. This can streamline the posting process in the back office and deliver a better customer experience.

- **Offer patient payment plans.** Having patient payment plans both short-term and long-term can be crucial. Short-term payment plans that include auto-debit can increase patient payments as well as improve the overall patient experience. Utilizing a system that automates the setup of the payment plan and executes the automated withdrawal can increase efficiencies and remove the burden of compliance regulations. Offering long-term payment plans to patients with larger bills is also important. However, it is best to have these lending programs managed by an outside vendor who can provide upfront funding and manage billing and collections. This approach can speed cash flow and reduce costs while providing staff more time to focus on patients and follow-up.

continued

Remittance ... *continued from page 11*

- **Outsource receivables process for faster results.** Outsourcing the receivables process to a bank that specializes in health care can speed access to funds, provide better tracking and improve posting potential. A full health care receivables solution can also reconcile funds prior to posting items. This can ease the reconciliation process and create separate posting files for multiple systems while also providing easy reconciliation back to the original payment.

Why Investing in a Remittance Management Platform Makes Sense

Investment in a remittance management platform with the following characteristics tackles the full range of process complexities and delivers far-reaching benefits:

- Significant cost savings via automation of manual processes.
- Better financial reporting through "speed to ledger."
- Greater consistency and accuracy.
- Improved RCM workforce productivity and management of staff.
- Enhanced patient experience: "A fluid and understandable billing process can dramatically reduce consumer confusion while improving overall patient satisfaction."[4]

What to Look for in a System

- Integration with internal and external patient financial and document management systems to permit electronic receipt and transmission of information as well as uploading indexed images.
- Ability to post payments automatically, unbundling aggregated remittances and directing each to the appropriate financial system.
- Full reconciliation features, including electronic funds transfers (EFTs) to electronic remittance advice (ERAs).
- Paperless and streamlined workflows, which requires a dedicated focus on partnering with payers to collect electronic information.
- Tracking, audit trail and analytics tools.

Conclusion

Revenue cycle managers everywhere are indeed pulled in multiple directions with a complex array of challenges. Understanding the issues is the first step, and selection of the right platform from the right partner is key. Taking control of your payments through automation is crucial—and the dividends are substantial.

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MSMA Legislative Update

What happened in the 2020 Legislative Session that will affect Missouri physicians?

Wednesday, September 2
6:00 p.m. via Zoom

This year's Missouri legislative session was full of many uncertainties. Although there was a seven-week interruption to the legislative process due to the COVID-19 shutdown, the MSMA lobbyists worked hard to push through legislation that supports the physicians of Missouri as well as block hostile laws from passing.

SLMMS invites you to join the MSMA lobbying team on Wednesday, September 2 at 6:00 p.m. via webinar to receive a recap of the 2020 Legislative Session and get some insight on how the upcoming election is shaping up for Missouri medicine.

To register, visit www.slmms.org and under Latest News, follow the links to register online. You will receive a link to join the webinar via Zoom in advance of the event. This event is free and open to all physicians, residents, medical students, and others. You need not be a member of SLMMS or MSMA to participate.

Streamlining Enrollment and Credentialing

Ways to ensure that physicians and other providers are eligible for payer reimbursement

By Merella Schandl, MHA, CPMSM, CPCS

In today's fast-changing health care environment, provider enrollment and credentialing are complex but essential functions. This process of practitioners applying to federal and state programs and other health plans for inclusion in provider panels for insurance network benefits is critical to maintain steady patient referrals and cash flow.

Providers must be credentialed, fully enrolled with an effective participation date (health care providers who have entered an agreement with an insurance plan) prior to submitting claims for reimbursement, and often prior to obtaining patient health-related information.

The enrollment process operates under requirements from hospitals, payer plans, the Centers for Medicare & Medicaid Services (CMS), state regulations and accreditation standards. Collaborative efforts between practitioners, provider enrollment and credentialing specialists ensure applications are complete to avoid unnecessary delays.

Provider enrollment and credentialing requires ongoing monitoring and is crucial to practitioner reimbursement for rendering medical services. These processes are time-consuming, costly, and inflict levels of frustration on practitioners seeking applications to hospitals and health plans. In many instances, practitioners are focused on wrapping up their duties and responsibilities prior to leaving their current locations and procrastinate on completing applications required of their new location.

Steps in the Enrollment Process

The steps involved in provider enrollment include (1) collecting all required information, demographics, education and training, licensure (medical and professional) and controlled substance and DEA registrations, board certifications, malpractice insurance, current five-year claims history, work history, etc.; (2) building and continually updating CAQH; (3) obtaining NPI numbers; (4) completing all payer plan applications; (5) releasing applications to payor plans; (6) continually following up with the payer plans until the provider is fully enrolled and receives an effective date; (7) communicating with key individuals affected by the provider's enrollment status (e.g., revenue cycle); and (8) re-credentialing all providers with each payer plan every three years.

Understanding the why behind credentialing and provider enrollment is essential. The integration of hospital-physician models continues to employ surmountable credentialing of new practitioners and becomes increasingly paramount to the entire revenue cycle process. An incredible amount of reimbursement—legitimately due to hospitals and physician practices—is lost due to incomplete or delayed completion of mandatory credentialing.

Problems that can occur internally in the enrollment and credentialing process include: duplication of credentialing information collected from employed practitioners; multiple practitioner contacts by different areas within the same organization; burdensome enrollment processes with payers; employed practitioner data in multiple systems; and a lack of cohesive partnership between credentialing and provider enrollment staff.

Such problems can lead to increased costs, delays in provider enrollment with payers causing reimbursement to be delayed or written off and delays in payer credentialing, affecting dollars-per-day-lost and salary guarantees.

How can credentialing and provider enrollment collectively unify to streamline processes and help practitioners navigate through the pain? We can start by placing work where it belongs.

The first step is to define the problem and clarify why it is a problem. For example, for the last 12 months, process challenges met with workflow inefficiencies (e.g. failure to collect necessary information and documents, engage in duplicative efforts, uptick in on-hold claims, delays in reimbursements, increase claim denials), lack of personnel and not challenging payer delays equate the revenue challenges resulting in potential

continued

Merella Schandl

Merella Schandl, MHA, CPMSM, CPCS, is a senior health care consultant with Anders. She advises physicians, hospitals and managed care organizations on regulatory compliance and credentialing. She can be reached at mschandl@anderscpa.com.

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All indices are unmanaged and investors cannot actually invest directly into an index. Unlike investments, indices do not incur management fees, charges, or expenses.

This is a hypothetical example and is for illustrative purposes only. No specific investments were used in this example. Actual results will vary.

Enrollment ... *continued from page 14*

lost dollars per day totaling $1 million. This drives increased operating costs (labor, IT, office space), lost revenue and low practitioner and patient satisfaction.

Create a blueprint to define your goals for pairing the two areas together—to reduce the amounts of claims on hold and potential lost dollars from $1 million to $0. Set a timeframe for completion that is within six months. Use a survey to gather feedback from the voice of practitioners, practice managers and/or patients (e.g., frustrations with the inability to see patients the first day of practice due to pending PAR with health plans or delayed revenue).

Develop an action plan to transform the current and future state of provider enrollment and medical staff services credentialing. Consider the use of current and future state provider enrollment and credentialing process maps for clarity and to highlight non-value-added processes (e.g., redundant or repeated processes, duplicated sign-off, etc.).

Benefits of Unified Enrollment and Credentialing

Here are just some of the benefits of unifying the enrollment and credentialing processes:

- Medical staff services employ experienced, knowledgeable and skilled credentialing specialists who maintain collegial relationship with practitioners (physician and non-physician practitioners) and their office staff.
- Assures a higher level of regulatory compliance.
- Reduces or eliminates redundancy in provider requests for information.
- Early access to provider data.
- Access to providers for signatures (provider enrollment and credentialing meet with the physician just once).
- Credentialing software platform allows for electronic submission of applications; ability to pre-populate payer plan forms; available payer plan tracking within the credentialing software.
- Utilizing one database for credentialing and provider enrollment streamlines the flow of information; credentialing within the medical staff office or credentialing verification organization conducts all primary source verifications.
- Reap the benefits of sharable data (e.g., licensure status, NPI, board expirations, clinical laboratory improvement amendments, insurance expirations, ability to generate reports based on practitioner effective dates by participating plan/program).
- Ability to email from software.
- Available audit trail for monitoring MSP compliance.

Working with Payers

The steps to ensure timely and efficient provider enrollment and medical staff credentialing are critical to patient care. Commercial insurance networks focus on credentialing and contracting. Applications vary, including the CAQH universal application, state-mandated applications, or unique credentialing applications. MSPs must scrutinize every application submitted for enrollment before submitting to health plans.

When health plans receive provider enrollment applications, they conduct a thorough verification process of the provider to ensure they meet credentialing requirements. Primary or designated source verification is completed in accordance to their policies and procedures. Complete credentialed files are presented to the credentials committee or medical director for approval.

Networks may take up to 90 days or longer to complete the process. Effective PAR dates do not occur until after the contracting phase, which can take an additional 30-45 days after the credentialing is completed. If a provider feels the need to negotiate rates, then contracting is the phase to do so.

Medicare, Medicaid, Tricare and other government health programs are somewhat different. Providers are required to complete standard forms when applying to these programs. Medicare utilizes PECOS for electronic enrollment and for revalidations. The duration for Medicare-completed applications is 60 days; however, practitioners may back bill to their effective date; other health plans do not allow back billing.

CAQH ProView is primarily used by commercial payers to retrieve applications for accurate provider data, which is critical to improving quality, costs and health care delivery. This information is necessary to conduct several essential functions, such as referring a patient to a specialist, paying insurance claims, determining provider sanctions and credentialing providers.

Due to the influx of payer enrollment applications, the time it takes to receive participating effective dates can be considerably long. If the provider enrollment and hospital credentialing process were not initiated at least six months prior to the practitioner's anticipated start date, the risk for claims on hold and lost dollars increases.

Transitioning to a centralized credentialing model will take some time, but the economies of scale are worth the effort.

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The Physician's Role in a Time of Critical Change: Building and Sustaining a Healthy Foundation in Medical Practice

Saturday, October 24, 2020
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Watch for program details and registration information coming soon!

HARRY'S HOMILIES©

Harry L.S. Knopf, MD

ON TIME

Time would be a priceless gift...if only it were for sale!

During the past few months, some of us were given "time." We were at home and confined there. So what did you do with this gift? Did you catch up on reading? Write a novel? Learn to cook or speak a foreign language? If you did any of these—CONGRATULATIONS! But I fear that most of us squandered the time: We watched TV, binged Netflix, or sat and watched the seasons change. OK, you missed it! That chance to do something meaningful. Or have you missed it? The only way to make up for "lost time" is to make better use of the time you are spending now. Forget the past and start creating the future! Hop to it! One day, time will run out...

Dr. Knopf is editor of Harry's Homilies.© He is an ophthalmologist retired from private practice and a part-time clinical professor at Washington University School of Medicine.

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Thank you for your investment in advocacy, education, networking and community service for medicine.

Louis A. Aliperti, MD
12855 N. Forty Dr., Ste. 375, 63141-8657
MD, Tulane Univ, 2014
Born 1985, Licensed 2018 **Active**
Urology

William A. Critchlow, MD
12855 N. Forty Dr., Ste. 375, 63141-8657
MD, Univ. of Missouri-Columbia, 2014
Born 1987, Licensed 2019 **Active**
Urology

Richard E. Gestring, MD
555 N. New Ballas Rd., #220, 63141-6844
MD, American Univ. of Antigua, 2009
Born 1981, Licensed 2014 **Active**
Certified: Psychiatry

Christina A. Gurnett, MD
1 Children's Place, Ste. C, 63110-1002
MD, Univ. of Iowa, 1998
Born 1969, Licensed 2003 **Active**
Certified: Child Neurology

John P. Karageorgiou, MD
3015 N. Ballas Rd., 63131-2329
MD, Vanderbilt Univ., 2011
Born 1985, Licensed 2015 **Active**
Vascular & Interventional Radiology

Veena Krishnan, MD
3 Ranch Lane, 63131-3650
MD, Delhi Univ., India, 1991
Born 1967, Licensed 2004 **Active**
Certified: Internal Medicine

Alicia D. Miller, MD
1001 Chesterfield Parkway East, #201, 63017-2167
MD, Univ. of Nebraska, Omaha, 2002
Born 1977, Licensed 2007 **Active**
Certified: Dermatology

Norman C. Neeb, DO
929 Fee Fee Rd., Ste.100, 63043-3807
DO, Des Moines School of Osteopathy & Surgery,1987
Born 1955, Licensed 1988 **Active**
Certified: Neuromuscular Medicine

David M. Sherman, MD
698 Rustic Valley Dr., 63021-6241
MD, Univ. of Missouri-Columbia, 1988
Born 1960, Licensed 2016 **Active**
Certified: Otolaryngology

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Aboubacar Kaba

Protecting Assets from Lawsuits Under Missouri Law

Tenancy by entirety property, MAP Trust and QST are available tools

By James G. Blase, CPA, JD, LLM

Missouri residents are uniquely positioned by very favorable asset protection laws—perhaps the most favorable in the country. These laws include not only the complete employment of the "tenancy by the entirety" form of asset titling, which allows Missouri married couples to easily protect their assets from lawsuits while they are both living, but also recent asset protection statutes authorizing the Missouri Asset Protection ("MAP" Trust), which was enacted by the Missouri legislature in 2004, as well as the Qualified Spousal Trust ("QST"), which was passed by the Missouri legislature in 2011.

Tenancy by Entirety Property

Tenancy by entirety property is property titled jointly in the name of a husband and wife, in a state which recognizes the same as protected from creditors of either spouse individually, i.e., as opposed to being protected from a joint claim against both spouses.

Missouri is one of only 20 states and the District of Columbia which recognizes tenancy by the entirety property for both real property and personal property. (Illinois recognizes this form of ownership for a couple's principal residence, and Kansas does not recognize tenancy by the entirety for real or personal property.) In Missouri, any property owned in the joint names of a married couple is presumed to be tenancy by entirety property, which is not the case in Illinois.

The only disadvantage to this approach to titling comes after the death of the first spouse, when now the assets are fully subject to the creditors of the surviving spouse, and without additional planning will be subject to probate when the surviving spouse dies. It is also still possible that a successful joint action can be filed against the couple.

Fortunately, Missouri has several other laws which can readily be used to address each of these issues.

James G. Blase

James G. Blase is principal with the law firm of Blase & Associates, LLC in St. Louis County and is also an adjunct professor at Saint Louis University School of Law. Mr. Blase is a frequent lecturer and author on a wide variety of estate planning and tax topics, and is in his 40th year of practice in the estate planning and tax areas. He can be reached at 314-780-6562 or jimblase@blaselaw.com.

The biggest advantage of the MAP Trust is that it protects the assets of single people from lawsuits, as well as married couples.

The MAP Trust

The MAP Trust affords a settlor establishing and funding the same full creditor protection, provided the following trust drafting guidelines are adhered to:

1. The trust must be irrevocable and incapable of being amended by the settlor;
2. The settlor may not be the sole beneficiary of either the income or principal of the trust;
3. The trust must contain a spendthrift clause applicable to the settlor's interest in the trust; and
4. The settlor may not retain a right to receive a specific portion of the income or principal of the trust pursuant to the trust instrument; in other words, any interest of the settlor in the trust must be a discretionary interest only.

Although the settlor may not amend the terms of the MAP Trust, the settlor may redirect where the trust assets pass at his or her death.

The advantages of the MAP Trust over relying exclusively on tenancy by the entirety protections include:

1. MAP Trust assets are insulated from joint lawsuits as well as suits against either spouse;
2. MAP Trusts provide full creditor protection for the surviving spouse, as opposed to tenancy by the entirety titling which provides no protection for the surviving spouse;
3. MAP Trusts provide the only avenue for protection for a single individual, unless the individual is a surviving spouse and his or her predeceased spouse established a spendthrift trust for his or her benefit.

The biggest drawback to a MAP Trust, however, in addition to the fact that it is irrevocable, is that the settlor of the trust should not serve as trustee (although the statute actually does not prohibit this). Thus, a friend or relative would need

to serve as trustee of the MAP Trust, which means that this trustee's permission will be required before any discretionary distributions may be made to or for the benefit of the settlor. For some clients, this is not a big deal; for others, it is a deal breaker.

The biggest advantage of the MAP Trust is that it protects the assets of single people from lawsuits, as well as married couples. As such, the availability of the MAP Trust for residents of Missouri who are single should be raised at every opportunity.

Married couples should also be made aware that the MAP Trust is the only technique which will provide full asset protection against joint lawsuits as well as suits against the surviving spouse.

The QST

A QST is simply a modified version of the traditional revocable trust agreement or agreements married couples have executed in the past. The purpose of the QST is to treat any property transferred to the trust as though it was tenancy by entirety property for creditor purposes, whether the property is transferred to a joint QST or to a two-separate-shares version of the QST (the latter of which essentially amounts to nothing more than one separate revocable trust for each spouse).

If a QST satisfies all of the statutory requirements, any property transferred to it thereafter has the same immunity from the claims of the separate creditors of the couple as would have existed if the couple had held that property as husband and wife as tenants by the entirety, so long as the property, proceeds, or income continue to be held in trust by the trustee of the QST. The QST will therefore not avoid joint claims against both spouses.

The statute makes clear that the exempt status exists only while the husband and wife are both alive and remain married. Thus, after the death of the first spouse, the special tenancy by the entirety protection no longer exists. However, if the "two-share version" of the QST is employed by the couple, the decedent spouse's share of the QST will remain creditor protected for the surviving spouse, as a standard "spendthrift trust." The surviving spouse can then elect to establish a MAP Trust at that time, with his or her own separate share assets.

Where estate taxes are an issue, married couples are commonly required to divide property previously held as tenants by the entirety in order to minimize estate taxes. In the past this process destroyed the creditor protection which tenants by the entirety property ownership possesses for claims against only one spouse.

Under the new law, however, if properly structured and funded, a "two-share" QST can not only minimize or eliminate the married couple's potential estate tax liability, but it will also protect all of the trust property from the claims of future creditors of either spouse.

Note that—similar to tenancy by the entirety—a QST does not protect against joint claims against a married couple. Unlike tenancy by the entirety property, however, the two-share QST should at least protect approximately one-half of the couple's assets from creditor attack after the first spouse to die's death. The two-share QST therefore has utility even if the couple is not in a taxable estate situation.

Tenancy by entirety property is property titled jointly in the name of a husband and wife, in a state which recognizes the same as protected from creditors of either spouse individually, i.e., as opposed to being protected from a joint claim against both spouses.

Significantly, a two-share QST can accomplish its goals without destroying the status of the transferred property for Missouri marital property purposes, in the event of a divorce. Under prior law, dividing property between two revocable trusts would potentially have had marital property consequences.

Limitation on Asset Protection Strategies

Remember that no Missouri asset protection strategy will avoid existing or reasonably foreseeable creditor situations. This would include not only the transfer of assets to a MAP Trust, but also the transfer of individually owned assets into tenancy by the entirety form.

Also, for federal bankruptcy purposes there is a potential five-year waiting period before transfers to a MAP Trust will become effective as against creditor claims in bankruptcy. There is likewise no guarantee that the Missouri asset protection laws will be effective if a claim is brought in another state.

Not to Be Overlooked

The favorable asset protection laws in Missouri should not be viewed as a substitute for other forms of insurance protection, including umbrella insurance and malpractice insurance. Joint claims against a married couple may still occur, and the result of malpractice and other claims may be a garnishment against the individual's future wages, etc.

Business and real estate owners should continue to consider utilizing a corporation, limited liability company or other entity in order to insulate the owner from personal liability for suits involving the business or real estate.

Litigation Basics: You've Been Served, Now What?

What you need to know about the steps in the medical malpractice process

By Brandy K. Simpson, JD

Black's Law Dictionary defines litigation as "the process of carrying on a lawsuit." This simple definition does not come close to describing the long and overwhelming process and the effect it has on those who are involved.

As an initial matter, what is medical malpractice? At the most basic level, it is the failure of a physician to exercise the level of skill, diligence and judgment that a reasonable physician would have exercised under the same or similar circumstances. Whether or not a defendant physician met the standard of care in a given set of circumstances is the question attorneys and physicians spend years trying to answer.

Yes, I said years. Go ahead and settle in; litigation is not a quick process. Though there are always exceptions, you should expect a lawsuit to last at least two to three years. If it happens to get resolved sooner, count that as a win.

In medical malpractice cases, the plaintiff has the burden of proving by a preponderance of the evidence that the defendant physician breached the standard of care causing or contributing to cause the damage of which the plaintiff is claiming.

While no two lawsuits are exactly the same, the litigation process is fairly consistent and predictable in many regards. Though there are numerous intricacies with each aspect of litigation, an overabundance of exceptions, and many grey areas. If you've been sued, here's what you need to know.

Service

You or your practice have been served with a medical malpractice or wrongful death lawsuit regarding care provided to a patient or former patient; now what? Stay calm. Lawsuits are practically inevitable in the practice of medicine in today's society.

Remind yourself of the education, training and expertise that qualifies you to practice medicine and provide the best care to your patients day after day. Then, once the initial shock has worn off, prepare to defend yourself.

Brandy K. Simpson

Brandy K. Simpson, JD, is an attorney with Baker Sterchi Cowden & Rice, LLC, specializing in medical malpractice defense along with premises liability, personal injury and products liability matters. She can be reached at bsimpson@bscr-law.com.

Most importantly, remember the clock begins ticking from the date of service, so it is important to contact your insurance carrier, employer or attorney as soon as possible. From the date of service, a defendant in Missouri has 30 days to file responsive pleadings in the appropriate court.

Go ahead and settle in; litigation is not a quick process. Though there are always exceptions, you should expect a lawsuit to last at least two to three years.

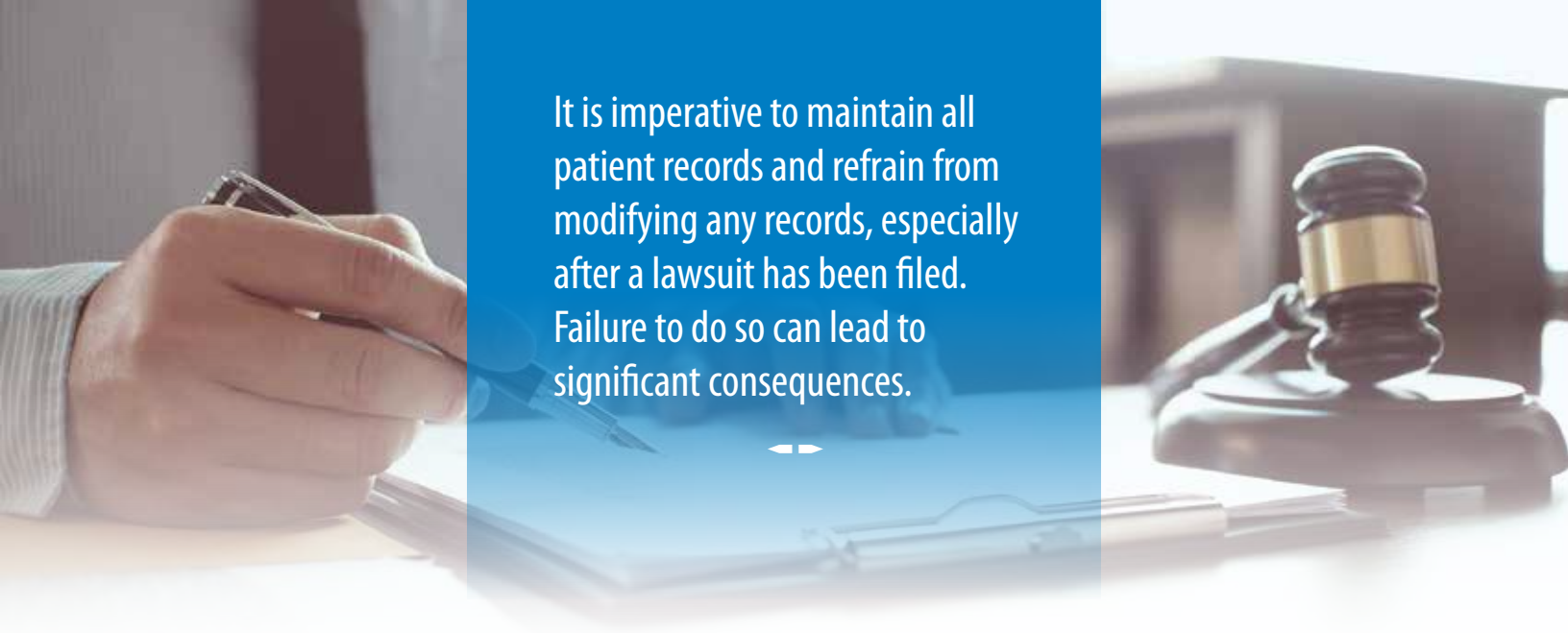
While this may include filing an answer responding to the allegations set forth in each paragraph of a plaintiff's petition, there are also a variety of available motions that can and should be filed in the appropriate situations. That said, please know there are a very limited number of circumstances in which you should expect a lawsuit to be dismissed at the outset.

Each cause of action has a statute of limitations which restricts the time that can pass between the date of the alleged negligence or the date the injury is discovered and the date the lawsuit is filed. Missouri has a two-year statute of limitations for medical malpractice claims and a three-year statute of limitations for wrongful death cases.

The statute of limitations is governed by Missouri Revised Statute § 516.105 which provides:

> "1. All actions against physicians, hospitals, dentists, registered or licensed practical nurses, optometrists, podiatrists, pharmacists, chiropractors, professional physical therapists, mental health professionals licensed under chapter 337, and any other entity providing health care services and all employees of any of the foregoing acting in the course and scope of their employment, for damages for malpractice, negligence, error or mistake related to health care shall be brought within two years from the date of occurrence of the act of neglect complained of…."

There are limited exceptions where the statute of limitations can be extended past two years from the date of the alleged negligence. These exceptions include instances of a retained foreign body, failure to inform a patient of test results, or in cases where the patient is a minor.



The statute of limitations is one of the first aspects of the case that will be evaluated by your attorney. If the case was not timely filed, this is one of the few instances where a case could be dismissed early in the litigation process.

Pleadings

A lawsuit is initiated by the filing of a petition which sets forth a plaintiff's allegations against the defendant physician. In Missouri, a health care affidavit by a provider certifying the merit of a case is also required, though the affidavit is not required to be filed concurrently with the petition.

Affidavit requirements are set forth in Missouri Revised Statute § 538.225 which states:

> 1. In any action against a health care provider for damages for personal injury or death on account of the rendering of or failure to render health care services, the plaintiff or the plaintiff's attorney shall file an affidavit with the court stating that he or she has obtained the written opinion of a legally qualified health care provider which states that the defendant health care provider failed to use such care as a reasonably prudent and careful health care provider would have under similar circumstances and that such failure to use such reasonable care directly caused or directly contributed to cause the damages claimed in the petition.

While the statute seems straightforward, questions frequently arise regarding whether an expert's specialty or practice is similar enough to the specialty or practice of the defendant physician against whom he or she is offering an opinion. For example, a primary care physician is unlikely to be qualified to testify in a case alleging negligence during a surgical procedure.

A plaintiff has 90 days after the filing of the petition to file the required affidavit and, for good cause shown, can file the affidavit up to 180 days after the filing of the petition. This can be frustrating for defendant physicians who have lawsuits pending against them for six months with no confirmation that the plaintiff has found a "legally qualified health care provider" to render an opinion against them in support of the alleged negligence.

Investigation

Once a lawsuit has been filed, investigating the underlying allegations will be the first order of business. This is the point at which all records regarding patient care will be reviewed and analyzed in an attempt to identify potential issues. It is imperative to maintain all patient records and refrain from modifying any records, especially after a lawsuit has been filed. Failure to do so can lead to significant consequences.

During the investigation phase, defense counsel will retain experts in the medical specialties at issue in the case. The pertinent medical records will be reviewed by the experts, and initial opinions will be rendered. The same process is employed by the plaintiff's counsel. In addition to the defendant medical provider(s), medical experts are the individuals who will speak to the standard of care in a given set of circumstances.

Most importantly during the investigation phase, you will have an opportunity to meet with your attorney and discuss the medical care at issue and any concerns you may have. It is important to be honest and forthcoming with any and all information that may be related to a patient's care. The information you have to offer is important, so your attorney can adequately and successfully defend you and the medical care at issue. The information divulged in such discussions with your attorney is protected by the attorney-client privilege.

Discovery

Discovery is the name given to the multiple mechanisms for "discovering" information from the opposing party or co-defendants. Interrogatories, requests for production of documents and requests for admission are the most common forms of discovery utilized throughout the litigation process. Interrogatories are a series of written questions to be answered in writing, under oath by the party to whom they are served.

continued

Requests for production of documents require a party to produce specified documents for inspection and copying. Most commonly in medical malpractice cases, this includes all medical and billing records related to the patient's care. This can also include pertinent medical literature, CVs of medical providers and policies or procedures maintained by a hospital or clinic which may be applicable to the care at issue.

Requests for admissions are a mechanism by which a party attempts to have an opponent admit the truthfulness of a statement of fact, so that proof of that fact will not be necessary at trial.

The discovery process can be long and tedious, but it is one of the most important aspects of litigation. From a defense standpoint, it gives defendant medical providers the opportunity to learn more about a plaintiff's claim, review a plaintiff's medical history, identify other treating physicians and potential witnesses, and confirm the extent of the plaintiff's alleged injuries and claims for lost wages.

Depositions

Depositions can be crucial in a medical malpractice case. While a case is unlikely to be won based on deposition testimony alone, it may be possible to lose a case at deposition. At the most basic level, a deposition is a witness' out-of-court testimony, taken under oath, that is then reduced to writing (and sometimes video) for use in discovery or trial.

A deposition gives opposing counsel the opportunity to question a physician about the facts of a case, educational background, prior lawsuits, involvement in professional societies, clinical expertise and a variety of other areas that may be pertinent to a given case or a given set of circumstances.

Depositions can be anxiety-provoking for some, but with proper preparation, witnesses can learn to navigate the difficult issues.

Settlement/Trial

At the conclusion of discovery and depositions, the parties and their attorneys should have a good understanding of the strengths and weaknesses of their case. At this stage, decisions are made regarding whether a case should be settled, or the parties are at an impasse and will proceed to trial.

Parties can settle cases informally through their counsel or formally through mediation. Whether or not parties participate in settlement negotiations is generally up to them and their insurers; however, there are some judges who require participation in mediation.

If settlement is not an option or settlement negotiations are unsuccessful, the case will proceed to trial. The trial itself can take days or weeks and will be conducted in front of a twelve-person jury in Missouri. At the conclusion of the trial, nine of twelve jurors must agree to reach a verdict.

Unfortunately, even after the conclusion of a trial, the case may not necessarily be over. There may be post-trial motions and an opportunity for appeal.

Effects of COVID-19 on Litigation

Despite the seemingly straightforward nature of the litigation process, I would be remiss to not mention the elephant in the room. Providers should certainly expect COVID-19 to impact litigation. However, the full extent of the disruption and changes to the litigation process are currently unknown.

Attorneys, courts and bar associations have already begun speculating that access to the courts may be affected following their reopening. Criminal matters with procedural deadlines will likely take precedence over civil matters, which tend to be less time-sensitive.

Additionally, there is a chance there will be an influx of lawsuits against hospitals, long-term care facilities and individual health care providers. Many states have already issued executive orders providing immunity to health care providers caring for COVID-19 patients. However, Missouri has not yet issued such an order.

Finally, the "standard of care" may not be so "standard" in COVID-19 lawsuits. While the standard of care generally means the degree of skill and care ordinarily used under the same or similar circumstances by members of the defendant's profession, the "same or similar circumstances" analysis has drastically changed due to the shortages of personal protective equipment (PPE), ventilators and testing capabilities, among other things.

As the COVID-19 pandemic continues to unfold, the legal system, like the health care system, has had to make changes. However, the ways and extent to which the legal system will be affected post-COVID-19 is yet to be seen.

For continued updates regarding the effect of COVID-19 on litigation, visit the Baker Sterchi Cowden & Rice, LLC Healthcare Law blog found on the firm's website at https://www.bscr-law.com.

Conclusion

Litigation is a process. Unfortunately, for the parties, it is a long process. A basic understanding of the process can only help your chances of success.

Let your attorneys help you with the legal process, and in return help them learn the nuances of the medical treatment at issue in a case so they are better prepared to defend you. Ask questions, be prepared and stay engaged. Know you can and will get through it. ◄

Robert E. Bolinske, MD

Robert E. Bolinske, MD, an allergist, died April 25, 2020, at the age of 95.

Born in Appleton, Wis., Dr. Bolinske earned his undergraduate and medical degrees from Marquette University. He completed his internship and residency at Saint Louis University, followed by a fellowship in allergy at Ohio State University. Dr. Bolinske served in the U.S. Air Force from 1954-1956. He was a clinical professor at Saint Louis University and maintained an allergy practice for more than 40 years. He was a longtime volunteer for the allergy clinic at SSM Health Cardinal Glennon Children's Hospital. He joined the St. Louis Metropolitan Medical Society in 1959.

Dr. Bolinske was predeceased by his wife Anne; SLMMS extends its condolences to his children Mary Jane Driscoll; Kathryn Bolinske; Janet Bolinske; Ellen Gunn and Robert Bolinske, Jr.; his nine grandchildren; and his great-grandson.

Ronald P. Wilbois, MD

Ronald P. Wilbois, MD, an obstetrician/gynecologist specializing in reproductive endocrinology, died May 14, 2020, at the age of 82.

Born in Chicago, Ill., Dr. Wilbois earned his pharmacy degree from the University Of Illinois-Chicago College of Pharmacy and began his career as a registered pharmacist. He later earned his medical degree at the University of Illinois-Chicago College of Medicine, and completed his internship and residency at Barnes-Jewish Hospital. Dr. Wilbois served in the U.S. Army from 1965-1967. He was an instructor in obstetrics and gynecology at Washington University School of Medicine, and for many years operated an infertility/IVF clinic at Missouri Baptist Medical Center. He joined the St. Louis Metropolitan Medical Society in 1972.

SLMMS extends its condolences to his wife Carol D. Wilbois; his children Kristy Howard and Kim Allen; and his four grandchildren.

Patrick C. Hogan, MD

Patrick C. Hogan, MD, an obstetrician/gynecologist, died May 31, 2020, at the age of 94.

Born in Dublin, Ireland, he was a graduate of the National University of Ireland and received his medical degree from the University Medical College in Dublin. He came to the U.S. in 1951 for additional training at St. Joseph's Infirmary in Atlanta, Ga., and completed a residency in ob-gyn at SSM Health DePaul Hospital and the former St. Louis County Hospital. Dr. Hogan delivered thousands of babies in the St. Louis area in his nearly 40 years of practice. He was a former president of the National Catholic Physicians Guild, and was a past president of the medical staff at the former St. Joseph's Hospital in Kirkwood. He joined the St. Louis Metropolitan Medical Society in 1959.

SLMMS extends its condolences to his wife Madonna Jean Hogan; his children Patrick Hogan and Sean Hogan; and his four grandchildren.

Stanley L. London, MD

Stanley L. London, MD, a general surgeon specializing in sports medicine, died June 8, 2020, at the age of 94.

Born in Springfield, Ill., he earned his undergraduate and medical degrees at Washington University, then completed an internship at Barnes Hospital and his surgical residency at the former Jewish Hospital of St. Louis. He served for two years as a physician in the U.S. Navy.

Dr. London enjoyed a lifetime association with sports as an accomplished athlete, coach and physician, and was inducted into eight different athletic halls of fame. He was the team physician for the St. Louis Hawks professional basketball team for 14 years, then became the head physician for the St. Louis Cardinals for 30 years, caring for many of the best athletes in the game. He also served one term as president of Major League Baseball's physician organization. He joined the St. Louis Metropolitan Medical Society in 1966.

SLMMS extends its condolences to his wife Jacqueline Garrell London; his children James London, Cindy Krelle, and David London; his four grandchildren; and his five great grandchildren.

2020-2021 Alliance Officers

The SLMMS Alliance has installed officers for the 2020-2021 year. Co-presidents are Angela Zylka and Jo-Ellyn Ryall, MD. Other officers are: Kelly O'Leary, vice president-health; Dr. Ryall, vice president-legislation; Gill Waltman, vice president-foundation and recording secretary; Sue Ann Greco, vice president-membership; Sandra Murdock, treasurer; and Jean Raybuck, corresponding secretary. Alliance community education activities in schools have been suspended due to COVID-19.

PARTING SHOTS

COVID-19 Makes Us Think in the Box

By Richard J. Gimpelson, MD

COVID-19 made us prisoners to "experts" who think they know everything; we must abandon independent thought and automatically follow their advice. This behavior must be carried out even if it means giving up constitutional rights.

In addition, our only rule for treating our patients is "evidence-based." We are not allowed to use empiric therapy or our clinical experience where success has been observed. In some states, this independent treatment may result in professional sanctions. Politicians and bureaucrats have more control in the treatment of COVID-19 than physicians. There are published articles and presentations, that physicians with large experience involving patients on certain medications have shown no or low incidence or rapid recovery from COVID-19, e.g., hydroxychloroquine. However the results are condemned for failure to do double blind studies. On the other hand, Henry Ford Hospital in Detroit just published a study showing decreased death rate and more rapid recovery among inpatients started on hydroxychloroquine.[1]

The rules that we are supposed to follow:

- Wear a mask.
- Do not touch yourself or anyone else.
- Maintain social distance of six feet from other people.
- Do not gather in large crowded groups.
- Stay at home as much as possible.
- Close schools.
- Close businesses (unless politicians claim they are essential).
- Close medical offices (only see patients by virtual imaging and communication).
- Close hospitals except to treat severely ill COVID-19 patients.
- Only do emergency surgery.
- Others that I may have overlooked.

Dr. Richard J. Gimpelson

Richard J. Gimpelson, MD, is a retired gynecological surgeon and past SLMMS president. The opinions expressed in this article do not necessarily represent the opinion of the Medical Society. Send comments on this column to editor@slmms.org.

Many physicians and hospitals have obediently followed the politically generated rules, much to the detriment of many patients. Patients also created problems for themselves because they were afraid to go to ERs for fear of contracting COVID-19. However, in my opinion the worst cases of thinking in the box occurred in New York City and state. The federal government constructed a hospital with many beds for COVID-19 patients in the Jacob Javitz Center and also provided a large Navy hospital ship for the same purpose. Instead of being sent to these facilities, somehow large numbers of elderly with COVID-19 were sent to nursing homes where other highly susceptible residents became infected, resulting in overwhelming mortality compared to the rest of the country.

Some hospitals may have been overwhelmed with COVID-19 patients, but it is unlikely that there were not empty beds in most hospitals. Since most COVID-19 patients did not need surgery, and we all know that none of our hospitals are so packed with emergency surgery that there are not available operating rooms.

Why think out of the box? Ask yourselves the following questions because patients are not being seen for thorough history and/or physical. What has been the increase of depression, suicides, domestic violence? How about the failure to make earlier diagnosis of cardiac disease, cancer, serious infections, and other treatable serious illnesses? How about the delay in emergency care because patients are instructed to call their primary care physician before going to the ER? I suspect many of the primary care physicians are so overwhelmed with phone calls that they are suffering from sleep deprivation. What about people with undiagnosed severe pain that could be helped with modern medicine? Do not forget all the suffering from pain or disability as a result of delayed surgery or physical rehabilitation. Just because someone does not have COVID-19, they still deserve first-class medical or surgical care.

Doctors, nurses, technicians, medical assistants, surgical assistants, custodial personnel and other hospital employees need to think how they can work out of the box. I am sure that even some hospital administrators can think out of the box to provide necessary medical care. No matter how creative we can think out of the box, there are weak links that need to be addressed:

1. Personal protective equipment
2. In-hospital treatment equipment
3. Experts demanding "evidence-based" proof before any care can be rendered

The solution to these weak links is not insurmountable. Begin aggressive production of personal protective equipment to protect first responders and direct care personnel. Stockpile the equipment to ensure availability for future pandemics so treatment can be immediate. The same stockpile of hospital-based treatment equipment can be available immediately. Evidence-based treatment is always the best approach, but physicians should be allowed to prescribe empiric therapy if their clinical observation has shown possible benefit and close observation and careful patient screening has minimized adverse events.

Note: I recommend the Journal of American Physicians and Surgeons *summer 2020 issue for an excellent review of the current information regarding medical and psychological aspects of COVID-19.*

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The above is the opinion of the author and does not represent the opinion of the Medical Society.

Alternative Viewpoint

By Christopher A. Swingle, DO

I will not start by offering more regurgitated trite observations or pseudo-profound quotes about "The times, they are a blowin' in the wind" or other such nonsense: You have spent the better part of the last four months inundated with bland reassurances from Madonna, Bank of America and Doritos that, "we're all in this together." You have also read somber emails about shared sacrifice from hospital administrators leading by example by changing their winter vacation plans from skiing in Gstaad to skiing in Steamboat. The yearning for a simpler time, i.e., January, is entirely understandable.

There is reasonable concern that, nationwide, certain elected officials that have developed a twinkle in their eye when given the chance to dictate to their constituency. The spittle-flecked response of "Oh, yeah? You're not the boss of me! I'm not going to wear a seat belt either!" from a segment of nominal adults is equally troubling. I am not going to get any more political than to say it is entirely possible to be both bothered about maintaining our constitutional rights and want to see prevention measures implemented to stem the consequences of COVID-19.

There is plenty of evidence that the recommendations of public health officials on the national, state and local levels have been effective in stopping the spread of the virus. A hair salon in Springfield, Mo., could have been an epicenter; instead their mask-wearing is credited with stopping any further infections when one of the stylists tested positive.[1] Stay-at-home orders have a demonstrable correlation with lower rates of COVID-19 hospitalizations,[2] as well as attenuating the rate of case increase.[3]

Back in March, I saw several popular articles contrasting St. Louis' successful response to the 1918 Spanish Flu with other major cities. While St. Louis' response was by no means perfect,[4] Dr. Max Starkloff[5] was a one-physician army up against a distracted and weary public with inadequate medical supplies (sound familiar?). Still, his efforts bore fruit and our metro area "flattened the curve" 100 years before it became a catch phrase. He did the best he could with the limited knowledge available; our colleagues in the public health sector are doing the same.

Perhaps what is different now is the number of voices claiming to be an authority. Whether its corporations with focus-group tested messages, hospital administrators who never had a case study quite like this in business school, or a crazy relative on Facebook assuring us all that this is one big hoax perpetuated by Bill Gates, physicians have plenty of competition for the title of "expert." Our profession fortunately still has considerable reserve of goodwill from the public and elected officials; we would be foolish to stop speaking out and leading by example now.

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Dr. Christopher A. Swingle

Christopher A. Swingle, DO, is a nuclear medicine radiologist with West County Radiology at Mercy Hospital St. Louis. He is a member of the St. Louis Board of Health and Hospitals and a past president of SLMMS. He can be reached at caswingle_do@yahoo.com.