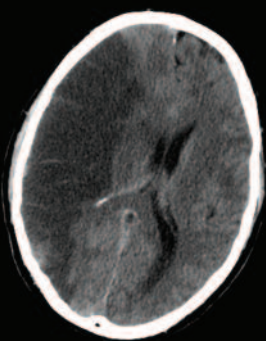


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Health

Eliminated CMS Consultation Codes Affect Neurology Bottom-Line

One-Third of Neurologists Surveyed Say They Are Avoiding Complex Cases

BY LOLA BUTCHER

Six months after the Centers for Medicare & Medicaid Services (CMS) eliminated consultation codes, the Academy and other medical associations are pressing the government to reconsider.

In a June 18 letter to the CMS, the groups said the elimination of consult codes is hurting some physician practices more than expected.

The financial implication for a practice with at least 50 percent Medicare patients will depend on the patient mix — whether they are new or established patients, simple or complex, and inpatient or outpatient, experts said.

James C. Stevens, MD, a neurologist at Fort Wayne Neurological Center in Indiana, said the new CMS coding rules have resulted in a 15 to 20 percent de-



SEVENTY-TWO PERCENT of survey respondents estimated that the elimination of consultation codes had decreased their total revenues by more than 5 percent — 30 percent said their losses exceed 15 percent.

IS TELENEUROLOGY REPLACING THE NEUROLOGIST?

BY ORLY AVITZUR, MD

For the past three years, Paul H. Singer, MD, a neurologist on staff at a small community hospital in an affluent suburb of San Jose, CA, has been receiving a stipend of \$400 for 24 hours of stroke call, alternating the coverage with the other two neurologists. The hospital CEO is now considering replacing them with a teleneurology service for emergency room (ER) call. The administrator argues that emergency room (ER) doctors are reluctant to bother their colleagues, and thus fewer consults — and potential admissions — are being seen. According to the administrators, with a teleneurology service every potential neurological ER patient could be seen.

“He proposed that we three human neurologists see the patients the following day, and provide follow-up care,” Dr. Singer continued. “When we asked why we would wish to do that, he threatened that if we did not, he was sure he could find ‘some hungry young kid’ who would be willing to do it.”

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New National Treatment Center for Soldiers with TBI and PTSD Opens

Hopes to Focus on the Science of Diagnosis and Assessment

BY PEGGY EASTMAN

BETHESDA, MD—A cutting-edge new center for traumatic brain injury (TBI) and post-traumatic stress disorder (PTSD) aims not only to help wounded servicemen and women recover, but also to advance the science underlying diagnosis, comprehensive assessment, and effective treatment.

The \$65 million National Intrepid Center of Excellence (NICoE) is a

72,000 square-foot, state-of-the-art facility on the grounds of the National Naval Medical Center in Bethesda, MD, across the street from the NIH. One day before the official June 24 dedication, the center, funded by private donations spearheaded by

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A KEYSONE OF THE NEW CENTER is a multimillion-dollar advanced neuroimaging area equipped for scanning with the most up-to-date PET, MRI, CT, and MEG.

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ARTICLE IN BRIEF

Neurologists are concerned that telemedicine — originally conceived to provide better access to stroke services in rural and inaccessible locales — may be used to cut costs and neurologists' jobs.

Using telemedicine, patients and their data are evaluated through a high-definition video link and neurologists make treatment recommendations from their offices and homes. Since the initial proposal to use telemedicine for stroke in 1999, its application has been growing at a staggering pace, with improvements in both technology and delivery networks.

Research has shown that telemedicine is valid, accurate, and reliable. Initially intended to address the shortage of neurologists outside of metropolitan and urban sectors, its recent expansion into mainstream use may be a reflection of such success and a consequence of tightening economic pressures on hospitals.

But how and when to use the service is a matter of much discussion. At the crux of the debate lies the question of relative quality. Neurologists, already feeling devalued by regulatory changes, increasingly lament the commoditization of medicine and perceive the assumption by bean counters that video interactions can provide the same service as human encounters as yet another affront.

In 2006, *Neurology Today* first reported that few neurologists had succeeded in negotiating payments for call coverage (See “Stipends for Stroke Call Create New Pressures, Demands on Neurologists,” April 4, 2006.) Four years later, and bolstered by an AAN policy statement supporting reimbursement for the service — www.aan.com/globals/axon/assets/2502.pdf — call stipends are far more common, and their potential rescission, argue some, serves as one more blow to the financial viability of practicing neurologists.

COSTS UP, QUALITY DOWN

Robert S. Gould, MD, who practices in densely-populated Silicon Valley and is one of the two other neurologists at the same suburban hospital as Dr. Singer, said: “In underserved areas, perhaps there is justification, but in a large, populous area, it is an expediency that is a disaster waiting to happen. Expediency is driving up the cost and driving down the quality of medicine.”

In this area, teleneurology is inexcusable,” Dr. Gould maintained. “I can’t wait to tell a patient, ‘You pay more for your insurance this year, and you pay the same for a teleneurology consult as a juxtoneurologist. You just get less... again.’”

Neurologists in other parts of the country feel that they’re being placed in similar predicaments. Mercerville, NJ, solo neurologist, Scott M. Weaner, DO, who watched his hospital’s neurologist staff members dwindle from 12 to four in two years, is among them. When the administration proposed using teleneurology during nights and weekends, Dr. Weaner and his colleagues suggested that rather than pay for this service, the hospital would be better served by paying the staff neurologists to do the call, both for stroke and for service. Dr. Weaner estimates that the cost of teleneurology, based on the admission rate of the hospital, would roughly equal \$450 per day, the amount he has proposed as a stipend. If they refuse to accept the offer, he would be in favor of pulling out of call. (They are awaiting a formal response to this proposal).

“In previous times, doctors fought for call because it was a benefit to the practice,” he pointed out, “but the benefit no longer exists, and we should not be forced to work for free.”

But giving up call and the reluctance to get up in the middle of the night is part of the problem, many neurologists say. Aventura, FL, neurologist, Leonard V. Cohen, MD, head of the stroke service at his hospital, cautioned: “From my perspective ‘tele’-everything is becoming a reality, and in some respects we are to blame — we could own stroke management, but neurologists want to sleep in their cozy beds and leave the in-

convenience of being woken up at all hours of the morning to others,” he observed. “We should be 100 percent involved with stroke care from admission through hospitalization to discharge.”

Dr. Cohen acknowledges that doing so takes a lot of effort, dedication, and inconvenience, but believes that many neurologists are just not up to the task. “I certainly think this has a part to play in why teleneurology is becoming more prevalent; our lack of cooperation just forces the hand of hospital administrators to look at alternatives,” he said. Dr. Cohen, whose group of four currently receives a stipend of \$550 per day for sharing call in a nine-person rotation with others, noted: “The influx of teleneurology would really hurt us, but we would be relatively impotent against it.”



DR. LEONARD DASILVA:
“We’re contracted by the hospitals because they don’t have neurologists on staff, or because their neurologists have not agreed to take call, or because they weren’t responding in a timely manner, and the hospital was unable to achieve stroke center status or maximize potential tPA patients.”

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SPECIALISTS ON CALL

Leonard D. DaSilva, MD, a former neurohospitalist in practice since 2002, has

been serving as director of neurology for Specialists On Call (SOC), the largest and busiest teleneurology practice in the United States. The company covers over 100 facilities — from small rural hospitals to large suburban hospitals — located throughout 10 states. Forty-six neurologists, both private practice and academic, have been employed to answer their calls, five full-time, and the rest part-time, working a minimum of 32 hours per month.

Fully outfitted with SOC video equipment and laptops and credentialed by their hospital clients, they perform around 1,000 consults a month, 30 percent general neurology and 70 percent stroke. The frequent general neurology cases involve encephalopathy, seizures, intracranial hemorrhage, and migraine. The clients pay a one-time contracting fee that covers installation, training and credentialing, and the monthly fee is based on a combination of factors including the number of beds, ER volume, and acuity, with the average 150-bed hospital paying about \$8,000 per month.

Mitchell J. Rubin, MD, who practices neurology in a five-person group in Lumberton, NJ, works part-time for SOC as a medical director and covers shifts. He is credentialed in 95 hospitals and licensed in nine states. The company provides malpractice coverage for medical errors and technology failure, but has yet to undergo a lawsuit. The neurologists all participate in quality assurance, and every tenth consult is randomly selected to be reviewed by peers.

“Nevertheless, there’s no way that teleneurology will replace a bedside neurologist,” Dr. Rubin insists. “We are wonderful at stroke care and can reproduce an NIH stroke scale well, but there are any number of things that we can’t do as well as in person. ...I can’t examine reflexes, do a sophisticated sensory exam, or adequately evaluate a comatose patient,” he said.

Although at an average of \$267 per day for a 150-bed hospital, the fee is less than the average on call stipend, neither Dr. Rubin nor Dr. DaSilva have observed a situation in which their services have supplanted neurologists for purely

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Viewpoints

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and interaction with congressional staff. Apply for the Palatucci Advocacy Leadership Fellowship, a four-day intensive training program for neurologists on how to pursue advocacy matters important to them.

As we enter this evolving health care landscape — buoyed by the 2010 health reform law — there are ample opportu-

nities for neurology residents to get involved. Clearly, the new legislation will have an impact on our success as we begin our careers. And so we must assume leadership as advocates to shepherd neurology as we enter and participate in the new and changing health system. •

Dr. Johnson is a fourth-year neurology resident at the University of Rochester Medical Center in New York. •

For more information about the Palatucci Advocacy Leadership Forum, visit www.aan.com/go/advocacy/active/palf. The 2011 Forum will take place Jan. 13-16 at the Rancho Bernardo Inn in San Diego, CA. The application deadline is Sept. 19, 2010.

For more information about advocacy programs through the AAN, see www.aan.com/go/advocacy

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economic reasons.

“We’re contracted by the hospitals because they don’t have neurologists on staff, or because their neurologists have not agreed to take call, or because they weren’t responding in a timely manner, and the hospital was unable to achieve stroke center status or maximize potential tPA patients,” explained Dr. DaSilva, who reports that their guaranteed response time is within 15 minutes.

The hospital clients are free to call as many times as they like as part of their monthly fee — the company does not bill patients — while their physicians continue to charge their regular consult fees. For example, he said, one hospital in southern New Jersey, which has not had a neurologist on staff for five years, is one of their busiest clients and among the highest tissue plasminogen activator (tPA) providers in the entire state. SOC helps triage the patients and hospitalists generally take over their stroke admissions in the morning.

“It’s a win-win situation for everyone,” Dr. DaSilva said. “In most situations, even when neurologists have resisted our arrival, within a short time they recognize the advantages. They don’t get interrupted in their offices, they can come in after hours and still get paid,” he explained, adding that typically as the local neurologists’ business increases both in the office

and in the hospital, they change their tune.

‘AN OMINOUS FUTURE’

David A. Nye, MD, a general neurologist who has been practicing almost 30 years at a large multispecialty clinic in Eau Claire, WI, foresees an ominous future. “Certainly having a neurologist ‘on the

ground’ is preferable, and those of us working here would prefer not to be displaced, but money drives policy, so we should, like good futurists, consider the repercussions,” he said.

“We tend to think of telemedicine as a way for referral centers to reach out to outlying areas, but economically it makes more sense for it to be occurring between hospitals in the US and physicians in oth-

er countries where the cost of living and the salaries physicians can expect are lower,” he pointed out.

“A neurologist in Mumbai, for example, could take overnight stroke call at several small US hospitals simultaneously during what would be his daytime hours, and he could make more than he does seeing patients in his own country while

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TELEMEDICINE: IS THERE ROOM FOR COMPROMISE?

Salt Lake City neurologist Robert A. E. Summerfield, MD, and five others at one of his hospitals, were able to negotiate a call stipend of \$1300 per day with the hospital CEO four years ago, promising to work towards the goal of a comprehensive stroke center and not to see outpatients on call days.

Since then, the hospital has had many more admissions for stroke and for other neurologic diagnoses as well. It’s been so successful that their CEO recently gave them a raise and suggested that they themselves offer telemedicine to outlying hospitals without neurology coverage with their hospital acting as a hub. “In our situation, we were able to set up an arrangement that was to our liking because we acted as a group and we stood our ground,” Dr. Summerfield said. •

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charging less than an American neurologist does.”

Licensure is currently a barrier, Dr. Nye pointed out. Nevertheless, he added, “Given the current undersupply of neurologists and the rapidly dwindling numbers willing to take stroke call, I could see

strong pressure from hospital administrators on lawmakers to make that easier. Who says we can’t be outsourced?”

For now, Specialists on Call is responding to the demand, projecting more than 12,000 consults and over 800 tPA cases in 2010. Their clients have found the service to be so successful that they’ve requested other specialists at their hospitals, and the company is now adding telepsy-

chiatry, telepediatrics, and teleorthopedics to this Brave New World menu. •

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Telemedicine is increasingly being provided by mobile robots these days, with companies expanding their services from telestroke to general neurology, even at hospitals with neurologists on staff. For more on this topic, read “Sending Robots to Do a Neurologist’s Job” in the upcoming issue of *Neurology Today*.