POLICY & PRACTICE

EHR Adoption Advice

Neurologists considering the purchase of an electronic health record product can get some practical tips in a new report from the American Academy of Neurology. AAN conducted a year-long study to evaluate the best EHR products for neurologists working in groups of 25 physicians or fewer. An AAN work group evaluated more than 70 vendors based on a number of factors, such as functionality, end-user satisfaction, the company's financial viability, and the total price tag including implementation and maintenance. Of the vendors evaluated, only seven met the criteria for a comprehensive EHR product. The AAN work group also researched EHR costs and estimated that vendor prices can vary from $1,000 to $50,000 per provider over a 3-year period. Neurologists should create a side-by-side comparison of vendor costs using a 3- to 5-year total cost of ownership of the system, the report recommends. The full EHR product report is available at www.aan.com/professionals/patient/ehr.cfm.

CDC Launches Autism Study

Officials at the Centers for Disease Control and Prevention are launching a multistate study aimed at pinpointing the risk factors for autism spectrum disorders. The $5.9 million study will include about 2,700 children aged 2-5 and their parents. The study will be conducted over 5 years and will look at possible associations with factors such as infections or abnormal responses to infections, genetic factors, the mother's reproductive history, family history of medical and developmental problems, and abnormal hormone function. "We hope this national study will help us learn more about the characteristics of children with [autism spectrum disorders], factors associated with developmental delays, and how genes and the environment may affect child development," according to Dr. José F. Cordero, director of the CDC's National Center on Birth Defects and Developmental Disabilities.

Alzheimer's Disease Research

The Alzheimer's Disease Cooperative Study, a consortium that includes sites in the United States and Canada, will spend $52 million over the next 6 years to test new drugs to treat the symptoms of Alzheimer's disease. The consortium, which is coordinated by the National Institutes of Health and the University of California, will also look into new methods of conducting dementia research. For example, the consortium will investigate whether intravenous immunoglobulin can be used to treat Alzheimer's disease and also will test whether home-based assessments can be used in primary prevention trials with older individuals. "We have learned a great deal from basic and observational research about how Alzheimer's and other neurodegenerative diseases develop," Dr. Richard J. Hodes, director of the National Institute on Aging, said in a statement. "The consortium's work will translate this knowledge in clinical trials of interventions that target the mechanisms underlying Alzheimer's disease."

McClellan Accepts Think Tank Post

Former Medicare Chief Mark B. McClellan has accepted a new post as a visiting senior fellow with the AEI (American Enterprise Institute)-Brookings Joint Center for Regulatory Studies in Washington. The new job will keep Dr. McClellan involved in health care policy issues. He also will remain as an associate professor of both economics and medicine at Stanford (Calif.) University. Dr. McClellan had been on leave from Stanford for several years while working in the federal government. Before taking the post as administrator of the Centers for Medicare and Medicaid Services, Dr. McClellan served from 2002 to 2004 as the commissioner of the Food and Drug Administration. He also served as an economic and health care advisor to President Bush from 2001 to 2002.

NIH Adds Advisors

Officials at the National Institute of Neurological Disorders and Stroke have appointed six new members to its advisory panel of neurologic disorders and stroke. The new members of the National Advisory Neurological Disorders and Stroke Council will review grant applications and advise the NIH. The members, who include patient advocates, scientists, and physicians, will serve through July 2010.

—Mary Ellen Schneider

Trauma Plus TBI Are Costlier Than the Sum of Their Parts

BY ALICIA AULT
Associate Editor, Practice Trends

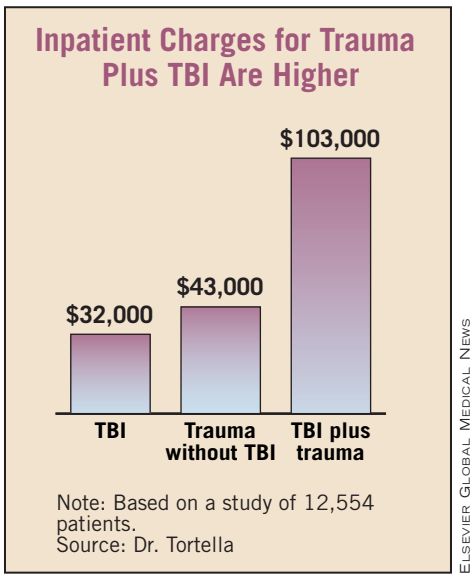
NEW ORLEANS — Charges for traumatic brain injury combined with other trauma are much higher than for trauma alone—and they climb in the months after discharge, a factor that should be taken into account when negotiating reimbursement rates with managed care organizations, Dr. Bartholomew Tortella said at the annual meeting of the American Association for the Surgery of Trauma.

Dr. Tortella, a trauma surgeon and professor of surgery at Drexel University, Philadelphia, presented an analysis of claims for 12,554 adults who were hospitalized for blunt or penetrating trauma from January 2003 to February 2005.

The data came from managed care claims tabulated by Ingenix Inc., a consulting subsidiary of UnitedHealth Group. The database included only charges, not actual costs, and was more representative of the South and Midwest than the North and West, said Dr. Tortella, who is also global trauma program director at Novo Nordisk Inc.

Dr. Tortella and his colleagues looked at charges for isolated trauma, isolated traumatic brain injury (TBI), and combined trauma and TBI. There were 8,203 patients with isolated trauma, 2,133 with isolated TBI, and 2,218 with trauma combined with TBI. The mean age was close to 50 years for each of the cohorts. The Abbreviated Injury Scale (AIS) at initial injury was 2.25 for trauma without TBI and 2.55 for isolated TBI. Half of the combined trauma and TBI group had an extremely high AIS score (16 or higher); the mean for the group was 2.98.

Although most patients with severe trauma were treated at level I trauma centers, 40% overall—and almost half of isolated trauma or isolated TBI patients—did not go to a trauma center, he said.



ELSEVIER GLOBAL MEDICAL NEWS

The combined trauma and TBI patients spent about 10 days as inpatients than did isolated trauma or isolated TBI patients, and 5 of those days were spent in the intensive care unit, he said.

Analysis of inpatient charges showed that isolated TBI was lowest at $32,000, trauma without TBI ran $43,000, and combination charges were $103,000.

In the months after discharge, outpatient costs were surprisingly high, Dr. Tortella said. For trauma without TBI, those charges ran $11,600, and for isolated TBI, they were $9,300. For combined trauma and TBI, outpatient and ancillary charges were $16,000.

"If you're not building [those charges] into the cost structure you negotiate with the insurers, that's a large opportunity for you to lose money," he said.

Novo Nordisk funded the study. ■

Medicare Cuts Reimbursement For Neurostimulator Devices

Medicare will decrease reimbursement by 3%-9% in 2007 for implantation of various neurological devices under a final rule issued in early November.

The cuts are included in the Hospital Outpatient Prospective Payment System rule for 2007. Not much has changed since the Centers for Medicare and Medicaid Services (CMS) first proposed the rule in August, so surprises are few.

Although CMS will increase the overall payments to hospitals—averaging a 3% rise for outpatient services—some procedures are slated for cuts, primarily those involving neurologic devices.

With the 3% increase, Medicare will pay at least $32 billion to hospitals for outpatient procedures in 2007.

The agency has expressed concern that outpatient costs are rising precipitously—an estimated 12% in 2005 and 9% in 2007—mostly because of growth in volume and intensity of services. The increase in costs affects not only Medicare's overall budget but also seniors who, with 25% copayments for outpatient services, will face increasingly larger out-of-pocket burdens, said CMS.

The agency said it will reduce payments for implantation of a neurostimulator by 7% to $11,500 for 2007. CMS has reduced its payments for neurostimulator implantation each of the last 2 years. And, whereas CMS has generally increased payments for implantation of the lead and electrodes that are attached to the stimulators, in 2007, the agency is reducing coverage by 10% from $14,900 to $13,500.

Other procedures will be getting a boost, including implantation of drug infusion reservoirs (60% increase), drug infusion devices (16% increase), and pain management catheters (11% increase).

Finally, hospitals will not have to begin reporting on outpatient quality in 2007. CMS lifted that requirement, which was proposed in the initial rule and would have required reporting on certain measures in order to receive the increase in overall payments. Instead, the agency has postponed that requirement until 2009. In the meantime, CMS will develop outpatient-specific quality measures.

The American Hospital Association applauded the delay. "The AHA is pleased that CMS will develop quality measures specifically for the outpatient setting and has correctly given hospitals ample time to implement a reporting system for hospital outpatient services," AHA executive vice president Rick Pollack said in a statement.

—Alicia Ault

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