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Peter D. Donofrio

Gregory L. Barkley

Henry Ford Health System, gbarkle1@hfhs.org

Bruce H. Cohen

David A. Evans

Gregory J. Esper

See next page for additional authors

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Authors

Peter D. Donofrio, Gregory L. Barkley, Bruce H. Cohen, David A. Evans, Gregory J. Esper, Bryan Soronson, Jeffrey R. Buchhalter, and Amanda Becker

How neurologists are paid

Part 3: Hospital support, Veterans Administration, and neurohospitalists

Peter D. Donofrio, MD

Gregory L. Barkley, MD

Bruce H. Cohen, MD

David A. Evans, MBA

Gregory J. Esper, MD, MBA

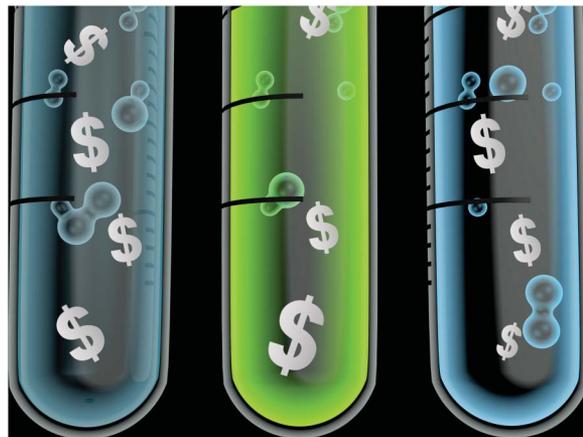
Bryan Soronson, MPA

Jeffrey R. Buchhalter, MD, PhD

Amanda Becker

Abstract

Part 1 of this series focused on factors influencing payment for patient care services and Part 2 described compensation plans for neurologists in private practice and in academic medicine. In Part 3, we review how hospital salary support and appointments to Veterans Administration hospitals contribute to the salary structure of neurologists. We also discuss neurohospitalist care and ways neurologists can potentially increase compensation from on-call pay, telemedicine, and the use of new transitional care and complex chronic care codes. We conclude with an emphasis on the important role of neurologists as team players in a health care system that will rely on efficient coordination of care among many health care workers. *Neurol Clin Pract* 2015;5:412-418



We review how hospital salary support, appointments to Veterans Administration hospitals, and neurohospitalist care may contribute to the salary structure of neurologists and potentially increase compensation.

Hospital salary support

Several models exist for hospital-supported physician compensation. Some hospitals fully employ the physician and billing for professional fees is submitted by the hospital. Another

Vanderbilt University Medical Center (PDD), Nashville, TN; Henry Ford Hospital (GLB), Detroit, MI; Children's Hospital Medical Center of Akron (BHC), OH; Texas Neurology (DAE), Dallas; Emory University (GJE), Atlanta, GA; University of Maryland (BS), School of Medicine, Baltimore; University of Calgary (JRB), Alberta Children's Hospital, Canada; and American Academy of Neurology (AB), Minneapolis, MN.

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Correspondence to: peter.donofrio@vanderbilt.edu

Physician's salaries may be directly supported by industry or foundation grants. Research supported by pharmaceutical and other industries can provide considerable revenue for a department.

model exists where the university, practice groups, and hospital are separate corporate entities. In this case, the university/medical school has a contract with the hospital to fund administration, supervision, and training of residents and fellows and for directing hospital-related centers like the EEG/epilepsy center.

Hospitals commonly pay for service on hospital committees or directorships of laboratories if the commitment and time expenditure is extensive. Examples include service as the medical director of a neurology inpatient ward or intensive care unit, serving as a residency or fellowship director (a minimum of 20% is required by the Accreditation Council for Graduate Medical Education Residency Review Committee for this position), or directorship of a laboratory or a hospital-based program such as stroke. A new source of income is money derived from telemedicine consultations for acute stroke or Parkinson disease management.

Physician salaries may be directly supported by industry or foundation grants. Research supported by pharmaceutical and other industries can provide considerable revenue for a department. Funds can be used to pay the physician directly after the money is transferred to the university or contractually directed toward a physician's salary.

Within an institution or department, the dean or department chairman may use discretionary funds to support a physician's salary. Funds can be used to constitute part of recruitment packages for senior recruits, or as start-up funds for junior faculty, and are intended to be one-time awards and not ongoing salary support. The origin of these funds varies. Philanthropy, while becoming an increasingly important funding source, rarely provides salary support, aside from endowed chairs. In the cases of academic chairs funded decades ago, the revenue from the funds, which may have been considerable at the time the chair was created, has rapidly shrunk in comparison to the faculty's salary. Most philanthropic efforts at medical centers today are directed toward building funds with more emphasis on program development and the promise of research breakthroughs and less emphasis on funding for academic chairs or professorships. It is easier to administer unrestricted gifts compared to an endowed chair, the activities of which may be monitored by the benevolent family for decades.

Until recently, academic medical centers (AMCs) have traditionally resisted using evaluation formulas based on relative value unit (RVU) benchmarks. This is primarily due to the academic and research mission of the faculty member's position and the imprecision of tracking clinical effort. In recent years, models have been created to track this activity. One method is the performance-based incentive compensation plan, which is being used at one AMC (B. Soronson, personal correspondence, 2015). The plan is designed to compensate faculty for outstanding clinical and academic performance above national academic norms and to build reserves. It provides an incentive for the faculty to be more clinically productive, allowing them to share revenues that result from increased effort. This plan uses work RVU benchmarks available from the Faculty Practice Solutions Center (FPSC), a joint effort of the University Health Consortium and the Association of American Medical Colleges. The FPSC uses an extract of billing system data from each

participating institution and calculates the RVU values. The benchmarks are provided for 100% of clinical effort; therefore the department must identify true clinical effort for their faculty in order to accurately compare it to the benchmark. Provisions are made on a case-by-case basis for faculty who are outliers in their specialty, e.g., abnormally high volumes linked to having the assistance of fellows or highly paid procedures. A modification of the formula is constructed and a portion of the net collection performance over target is directed to the faculty member as the clinical component of his or her bonus payment.

Academic medical practices in neurology use a wide mix of compensation models. The fee-for-service model, under which AMC's have prospered for decades, results in greater revenue for more delivered services (especially procedures), and has been blamed as a critical driver of increasing health care expenditures. However, in the future, capitation, including the accountable care organization (ACO) model of health care payment, will influence practice attitudes, particularly test and procedural ordering. In an ACO model of care, the profit column from units such as epilepsy monitoring units and stroke units will disappear and their justification will require demonstration of the global value of the service to the medical center compared to other competing areas of health care. In a capitated payment model, the shifting RVU assignment will bring the value to the organization of those interpreting procedures and evaluation and management (E&M) services closer. In this scenario, every neurologist will need to prove his or her value toward care of the patient.

Veterans Administration

Many AMC's are affiliated with Veterans Affairs (VA) hospitals and health care systems. This affiliation began in the late 1940s when the VA recognized that their ability to provide medical services to veterans could not be met by the supply of full-time VA physicians. This relationship between AMC's and the VA is beneficial to both parties, as the VA gains the expertise of specialists and can participate in the training of residents and fellows. The medical school gains additional salary resources, access to a unique patient population, and an opportunity for research grants and contracts funded by the VA.

Physicians in the VA system are paid on a formula based on eighths and a work week of 40 hours. Each eighth is equivalent to 5 hours. Many physicians are hired on a full-time basis by the VA and are not affiliated with the AMC. Usually, a faculty member has to be paid at least five-eighths to be eligible for VA grants and contracts. Since an academic work week often ranges from 50 to 60 hours, VA physicians can be paid full time (eight-eighths) by the VA and work an additional 10–20 hours per week in the AMC. Physicians paid less than eight-eighths are considered part-time VA employees and receive salary and fringe benefits from the VA commensurate with the percentage worked. These faculty receive separate salary and fringe benefits from their AMC for clinical, academic, and research-related duties.

The AMC can also provide medical services to the VA via contract. Contracts are based on an hourly salary and fringe benefit formula or a Current Procedural Terminology basis (using the Medicare fee schedule). Contract revenue is paid by the VA directly to the AMC and funds are used to pay physician salaries and other contract-related costs either directly through the university or through the department's practice plan. Physicians can also provide episodic services to the VA on a fee basis ranging from Medicare rates to 100% of charges. In this case, the VA is billed by the physician (or group) for his or her services.

Neurohospitalists

The advent of hospital medicine has changed the delivery of inpatient care. For the practitioner, the inefficiencies of providing care in 2 locations, often with the need to be physically present in the hospital for an emergency during outpatient hours, drove the primary care

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community to accept the concept of a hospitalist who would care for their patients during hospitalizations. Also empowering the hospitalist movement was the realization that hospitals could increase their revenues by efficient and timely advances in care delivery during acute illnesses.¹

A similar landscape has developed in neurology, whose primary impetus was the requirement for comprehensive emergent care of stroke patients.^{2,3} Because of the pressing demand for immediate interventional therapies for stroke, comprehensive care systems recognized the value of neurologic hospitalists who were on location. Hospitals have recognized the impracticality of physicians commuting between the inpatient and outpatient worlds, as lost time in transit translates into decreased operating income. Approximately 16% of neurologists identified themselves as neurohospitalists in a recent American Academy of Neurology neurohospitalist survey (unpublished data, 2011).

Practitioners who are considering entering the field of neurohospital medicine should be aware of the requirements. Special board certification is not necessary to shift a career from outpatient to inpatient neurology, unless the hospital employer is seeking comprehensive stroke center status. In that situation, neurovascular boards may be required for at least one neurohospitalist to advance the mission of the institution sponsoring the program. By the nature of their home in the hospital, neurohospitalists often become the hospital's neurology representatives on the local quality committee to ensure that the Physician Quality Reporting System and other performance metrics are implemented and followed. Even though the hours of a neurohospitalist may appear to be attractive, because of the lifestyle fostered by precise prescheduled work hours, shifts often run over their allotted time when demands for patient care are high and when continuity of service is critical for complex and seriously ill patients.

FINAL STATEMENT

Health care is changing rapidly. The old fee-for-service compensation system has been turned upside down. Medicare, Medicaid, and private insurance companies have determined that payment for each patient contact is too expensive, is an unproven benefit to society, and cannot be sustained. The new emphasis will be value-based care, primary care, disease prevention, outpatient medicine, limitation of resource utilization (hospitalizations, emergency room visits, and imaging), and correlation with quality and the outcomes that result. This is the concept behind ACOs, which, if successful, will be the future of medicine. Neurology's participation in this new system of health care will be predicated on teamwork with other doctors, advanced practice providers (APPs), nurses, pharmacists, hospital and office administrators, and traditional vendors; neurologists will have to prove themselves as the preferred provider for a network focused on quality and cost. Presently, almost half (42%) of neurologic practices use nonphysician extenders such as APPs and physician assistants.⁴ This is the key to creating rapid access and evaluation. The transition to the new system of health care will be painful for those neurologists who choose to defend the fee-for-service model. Neurologists who are flexible and understand their consultative role in the ACOs will be most comfortable with the changes. Within this system, neurologists must prove their

worth and seek fair reimbursement for the consultative value they provide to patients. These changes will take place in an environment where the projected shortfall of neurologists will be 19% by 2025.⁴

AMCs will be profoundly affected by changes in health care reimbursement as they receive payments from many sources, all of which are shrinking. Those include E&M services and procedures, graduate medical education funding, research grant funding, and proposed changes to programs such as the disproportionate share hospital payments that help underwrite care of the indigent. The fee-for-service model, under which hospitals and AMCs have prospered for decades, results in greater revenue for more delivered services, and has been blamed as a critical driver of increasing health care expenditures. In the future, capitation, including the ACO model of health care payment, will influence practice attitudes, particularly testing and procedural ordering. In a capitated payment model, the value of the procedures performed by neurologists will be tested and challenged for their contribution to the comprehensive care of the patient. Health care systems in the best position to weather the future of medicine and its changes will be those with a shared mission of the hospital, medical school, and outpatient services and that focus on the unifying mission of patient care, education, research, quality, value, and safety.

An obvious reaction to the reduction in medical care reimbursement is to control expenses by eliminating waste and duplication, fostering innovations that promote improved outcomes, and improving efficiency of delivering health care. Each neurologist, as a team member of a much larger organization, will be encouraged to consider new ways to improve care. This will be the foundation for increasing compensation within the new framework of organized health care.

Neurologists have the potential for increasing reimbursement by pursuing several courses of action: on-call pay, greater participation in clinical trials, medical legal reviews, hospital and clinic committee participation, telemedicine, and advisory committees for outside organizations. Academic faculty can increase revenue by pursuing more and larger grants, becoming master teachers of neurology within their medical schools, evaluating more new patients and consultations, or seeing return visits in a shorter timeframe. Neurologists in both private and academic practice can increase reimbursement by the efficient utilization of advanced practice providers such as nurse practitioners and physician assistants. New opportunities for billing are the transitional care management codes (99495 and 99456) for face-to-face patient visits within 1–2 weeks after discharge from the hospital. For neurologic patients with chronic diseases, neurologists can seek reimbursement using the new complex chronic care codes (99487–99489), which can be billed once per month for non-face-to-face complex care coordination, or the chronic care management code (99490). Use of these codes would be ideal for neurologists who serve as primary care physicians to patients with dementia, amyotrophic lateral sclerosis, multiple sclerosis, and parkinsonism. In addition, neurologists may wish to consider billing practices utilized by physicians in other disciplines of medicine such as charging for no-show patients and late cancellations. This may not be possible in many hospital-based systems because contracts with insurers do not allow billing for services not delivered.

Patients and families are beset with a bewildering array of billing and payment issues, particularly the elderly, who have multiple chronic medical problems and may not fully understand the system. This is compounded when patients have cognitive impairments. Topics difficult to understand include copays, deductibles, coinsurance, multiple tiers of medication coverage, and supplemental insurance. Physicians must maintain composure, compassion, and support during office visits and understand that the patient's frustration is not directed toward them, but reflects the complexity of health care provision and compensation.

In analyzing how neurologists are paid, one must not lose sight of the primary mission of neurologists, whose choice of a career in medicine should remain altruistic. Their commitment

to medicine is to provide care to all people, regardless of the ability to pay, and never to deny services for monetary reasons. Patients and referring doctors are our clients, making customer service a top priority. One of a neurologist's responsibilities is to fight for the medical rights of patients. Reimbursement and compensation are important issues, but should not supersede obligations to care for patients with neurologic disorders.

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AUTHOR CONTRIBUTIONS

Peter D. Donofrio: drafting/revising the manuscript, acquisition of data. Gregory L. Barkley: drafting/revising the manuscript. Bruce H. Cohen: drafting/revising the manuscript, study concept or design. David A. Evans: drafting/revising the manuscript, acquisition of data. Greg Esper: drafting/revising the manuscript. Bryan Soronson: drafting/revising the manuscript. Jeffrey Buchhalter: drafting/revising the manuscript, study concept or design. Amanda Becker: drafting/revising the manuscript.

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P.D. Donofrio serves on scientific advisory boards for CSL Behring, UCB CellTech, and Baxter; has received funding for travel or speaker honoraria from Talecris Pharmaceuticals; serves on the editorial board of *Muscle & Nerve*; receives research support from CSL Behring; and has received honoraria from the AAN for speaking activities and serving on committees. G.L. Barkley receives a stipend from the AAN for time spent at the AMA-RBRVS Update Committee (AMA-RUC) as a representative of the AAN; receives research support from NeuroPace and NIH (National Institute of Neurological Disorders and Stroke, NICHD); and has received honoraria from the AAN for speaking activities and serving on committees. B.H. Cohen serves on scientific advisory boards for Stem Cell Transplantation for MNGIE (nonprofit), Neurofibromatosis Consortium, and the Department of Defense, and as Chairman of the External Advisory Board of Clinical Protocols; serves on the editorial boards of *Pediatric Neurology* and *Mitochondrion*; serves as Editor for *Motive Medical Intelligence*; serves as a consultant for Stealth Biotherapeutics and Mitobridge; serves/has served on speakers' bureaus for Transgenomic Labs, Courtagen Labs, and United Mitochondrial Disease Foundation; serves as a consultant to Health and Human Services for the Division of Vaccine Injury Compensation Program; receives research support from NIH, Edison Pharmaceuticals, Raptor Pharmaceuticals, Stealth Biotherapeutics, and Reata Pharma; has received reimbursement for travel expenses related to scientific study management; has provided expert testimony in medico-legal cases; and has received honoraria from the AAN for speaking activities and serving on committees. D.A. Evans has received funding for travel from Merz Pharmaceuticals; serves on the editorial review board for *MGMA Connection*; is Chief Executive Officer of Texas Neurology; serves as a consultant for Merz Pharmaceuticals and Allergan; and has received honoraria from the AAN for speaking activities and serving on committees. G. Esper receives compensation for Executive Education as an affiliate professor for HEC Paris School of Business; receives research support from the American Association of Medical Colleges; has provided expert testimony in medico-legal cases; and has received honoraria from the AAN for speaking activities and serving on committees. B. Soronson has received funding for travel or speaker honoraria from the Society of Clinical Research Associates, Medical Group Management Association, Texas Neurological Society, and Campbell Alliance; serves as a consultant for Raleigh Neurology and Texas Neurology; and has received honoraria from the AAN for speaking activities and serving on committees.

J. Buchhalter serves on scientific advisory boards for NIH, Charlie Foundation, and IDIC 15; has received funding for travel or speaker honoraria from and serves as a consultant for Eisai Ltd, Lundbeck, and Upsher-Smith Labs; serves on the editorial boards of *Clinical Neurology News* and *Pediatric Neurology*; receives research support from Alberta Health Services; and has received honoraria from the AAN for speaking activities and serving on committees. A. Becker is Senior Director, Medical Economics & Quality for the American Academy of Neurology. Full disclosure form information provided by the authors is available with the **full text of this article at Neurology.org/cp**.

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