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Q&A
WITH DR. MEDLAW

Underlying Principles of Payment

The COVID-19 crisis has put many practices under great stress as far as payments as patients lose insurance coverage or cannot cover bills. However, it is essential to remember that the underlying principles in these situations have not changed. Let's look at a few questions that came in before the crisis to reinforce these basic points.

Q: *I converted my family practice to all-cash last year and it has worked out well in most cases - I offer very competitive pricing and the time I don't spend dealing with paperwork I can spend with my patients. However, I have one patient who is always behind, and this has continued even on a $20 per month payment plan. I see him at least every 3 months to follow his diabetes, so this is really backing up. He is actually a great patient otherwise, but this non-payment cannot just continue. Can I terminate him now just for non-payment? Can I make payment a requirement for a new appointment?*

Yes, to your first question but no to your second. The situation in which a patient is under active care that cannot be suddenly discontinued, which would be what most doctors understand to be abandonment, does not apply here. With enough notice, termination is possible. As long as you do not breach your fiduciary duty to not abandon your patient, you may withdraw for any reason. However, keeping him in your practice but refusing to see him until he pays is "internal abandonment"—the patient is kept on the rolls of the practice but gets no care. If you keep him on, he is to be treated as any patient would be, regardless of payment status.

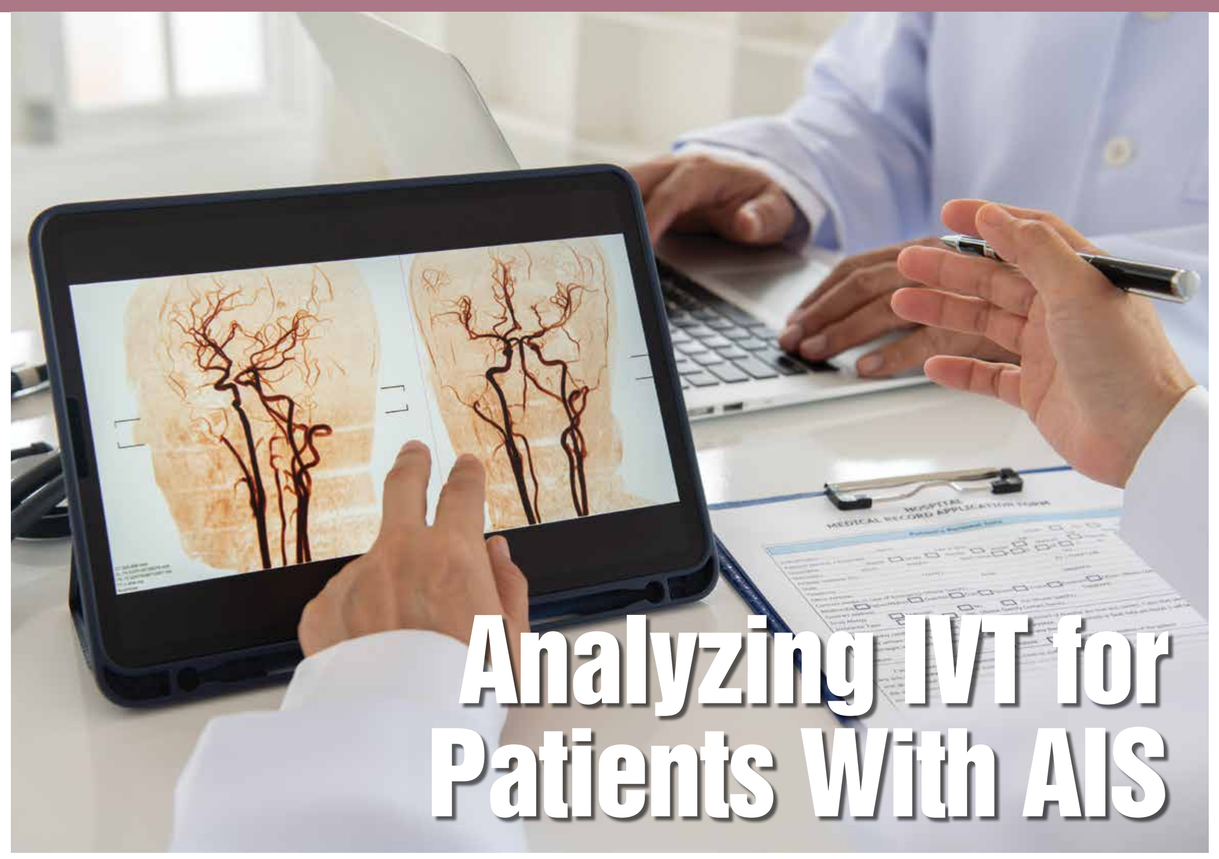
Q: *As a small-town doctor, I have always been lenient on collecting co-pays and dealing with deductibles when patients really cannot afford them. I put a note in the chart of any patient I don't collect on explaining the circumstances. However, I have colleagues who say that it is fraud.*

This can be very risky for you. While AMA Opinion 6.12 says that when the share the patient is responsible for "is a barrier to needed care because of financial hardship, physicians should forgive or waive" it, that is an aspirational ethics statement, and you are still bound by the payor relationships that you have that bind you to collect. If you waive a co-pay, correct your billing to reflect it. There is also the problem of violation of the Anti-Kickback Statute if you do not collect co-pays or apply deductibles to patients in federal healthcare programs. Following the rules with both private and governmental payors should let you keep on helping your patients without risk to yourself.

Q: *How come a hospital can get a patient set up with Medicaid so they can get paid, but I can't pay a premium on a patient's insurance so that it doesn't lapse so that I can get paid?*

You cannot pay for a policy under which you will benefit by the insurer paying you. The hospital, by contrast, is not making a payment and is just assisting the patient to obtain access to what they are eligible for.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney. It originally appeared on SERMO, which retains all rights to it.



Analyzing IVT for Patients With AIS

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Current guidelines from the American Heart Association and American Stroke Association recommend that intravenous thrombolysis (IVT) with alteplase not be used for patients with acute ischemic stroke (AIS) who have unclear or unwitnessed symptom onset time or in patients with symptom onset time exceeding the 4.5-hour window. However, a growing body of research suggests that advanced neuroimaging with validated techniques can guide the selection of patients with AIS who could gain the most benefit from reperfusion therapies regardless of the elapsed time from symptom onset, explains Georgios Tsivgoulis, MD. To determine whether IVT is a safe and effective treatment option for patients with AIS, Dr. Tsivgoulis and colleagues conducted a systematic review and meta-analysis and published their results in *Neurology*.

The study team assessed four randomized clinical trials of patients with AIS with unclear symptom onset time or with symptom onset outside the conventional 4.5-hour time window but with evidence of substantial viable hypoperfused tissue documented by advanced baseline neuroimaging, using either CT or MRI. The reviewed and analyzed trials evaluated the use of IVT with alteplase at a dose of 0.9 mg/kg.

The Data

The study team found that IVT treatment was associated with a higher likelihood of a favorable functional outcome (FFO) at the 3-month mark than guideline-recommended treatments (Table). There was also no significant difference between IVT and recommended treatments in all-cause mortality at 3 months. "IVT in this population is associated with a three-fold higher chance of achieving successful recanalization of the previously occluded intracranial vessel, with a more than 40% increase in the probability of functional independence at 3 months after stroke onset," highlights Dr. Tsivgoulis. "At the same time, IVT treatment in this population is associated with a five-fold increase in the likelihood of symptomatic intracranial hemorrhage (sICH), however, without an increase in the mortality risk."

The team developed forest plots of adjusted associations between IVT and outcomes, including 3 months FFO, 3 months functional improvement, and sICH. The results indicate that IVT was still associated with a higher rate of 3 months FFC, but also with a higher risk of sICH.

Ongoing Research

Research into the safety and efficacy of IVT for patients with AIS who have unclear or unwitnessed symptom onset time or in patients with symptom onset time exceeding the 4.5-hour window is ongoing. Dr. Tsivgoulis highlights two current randomized controlled clinical trials that are evaluating IVT for patients with AIS using tenecteplase instead of alteplase. "One is evaluating the utility of tenecteplase treatment compared with placebo for patients with large vessel occlusion and AIS symptom onset within 4.5 to 24 hours and target mismatch profile on perfusion imaging," he explains. "The other is evaluating the safety and efficacy of tenecteplase treatment for AIS patients with minor deficits and evidence of intracranial vessel occlusion on neuroimaging presenting within 12 hours from stroke onset."

In the meantime, Dr. Tsivgoulis suggests that "the data support a significant benefit in treating eligible patients presenting with AIS with unknown symptom onset time, fluid-attenuated inversion recovery with diffusion-weighted imaging, or patients with symptom onset outside the conventional time window of 4.5 hours and evidence of viable tissue on penumbral imaging. In the absence of a large vessel occlusion amendable to endovascular intervention, clinicians should weigh the patient's disability resulting from presenting symptoms against the potential risk for intracranial bleeding risk and consider prompt intravenous thrombolysis administration in the absence of other contraindications."

Table Overview of Unadjusted Analyses

			Anticipated absolute effects		
Outcomes	**Participants (studies) follow-up, n**	**Certainty of the evidence (GRADE)**	**OR, relative effect**	**Risk with conventional treatment**	**Risk difference with tPA**
mRS score 0-1	831 (3 RCTs)	⨁⨁◯◯ Low[abcd]	1.48	369 per 1,000	95 more per 1,000 (27-165 more)
mRS score 0-2	843 (4 RCTs)	⨁⨁⨁◯ Moderate[abc]	1.42	557 per 1,000	84 more per 1,000 (17-148 more)
sICH	848 (4 RCTs)	⨁⨁⨁◯ Moderate[abce]	5.28	5 per 1,000	20 more per 1,000 (2-86 more)
Mortality	848 (4 RCTs)	⨁⨁◯◯ Low[abcf]	1.75	28 per 1,000	31 more per 1,000 (1 fewer-86 more)
CR	225 (2 RCTs)	⨁⨁◯◯ Low[abcg]	3.29	385 per 1,000	288 more per 1,000 (158-396 more)

Abbreviations: CR, complete recanalization; GRADE, Grading of Recommendations Assessment, Development and Evaluation; mRS, modified Rankin Scale; OR, odds ratio, RCT, randomized clinical trial; sICH, symptomatic intracranial hemorrhage; tPA, tissue plasminogen activator.

[a] Premature trial termination.
[b] Blinding performed by institutional facility.
[c] Published protocol not available.
[d] Outcome available in 3 of 4 studies.
[e] Different definitions across trials.
[f] Effect size in both directions.
[g] Outcome available in 2 out of 4 studies.

Source: Adapted from: Tsivgoulis G, et al. *Neurology.* 2020;94(12):e1241-e1248.

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Why We Need a One-to-Many Telehealth Model of Care

This article was originally published in Medical Economics and is written by Jon Bloom, MD.

One thing the COVID-19 pandemic has made clear is that telemedicine is a public health necessity. However, real-time, or synchronous, telemedicine isn't sustainable or scalable. We're already seeing synchronous telemedicine practiced on a small scale put a strain on our healthcare system during COVID-19.

For telemedicine to work at scale, it must also have a one-to-many component. In this model, data can be remotely gathered and consistently monitored over time and then used for timely and targeted communication between patients and providers. This allows care to scale from one-to-one to one-to-many.

Fortunately, a model already exists for how we can use asynchronous, one-to-many remote monitoring at scale for even the hardest-to-reach patients. The health system overseen by the VA is now successfully using asynchronous telehealth right now to ensure patients who cannot or should not visit a VA facility are still able to get the frequent care they need from a distance.

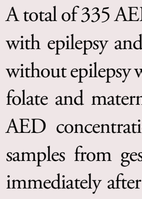
One such example is the effort to remotely monitor veterans at risk for diabetic amputations. Veterans place their feet on the Podimetrics SmartMat for just 20 seconds a day in their home, and the temperature data captured is automatically sent to a care management team to monitor. When early signs of issues are detected, patients and providers are notified so clinical action can be taken quickly, helping to prevent more serious complications.

Such large-scale preventive care could not be achieved through synchronous, one-to-one telemedicine. There simply are not enough doctors available to check in with every patient for even 1 minute every day. However, remote asynchronous systems can gather data over time to help prioritize synchronous telemedicine, ensuring patients receive the care they need when it matters most.

A key takeaway of the current pandemic has been the importance of telehealth; however, for it to be sustainable, we need a combination of synchronous and asynchronous patient monitoring tools that allow for targeted communication. We should expect more healthcare providers to incorporate this kind of model to offer access at scale and save lives.

To read the unabridged version, visit www.medicaleconomics.com.

Preventing Impaired Verbal Abilities after Fetal AED Exposure



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Previous research indicates that most women with epilepsy are dependent on treatment with antiepileptic drugs (AEDs) throughout their pregnancy to prevent epileptic seizures. AED therapy during pregnancy, however, has been associated with impaired neuro-development and behavioral disorders in offspring.

"Poor verbal abilities in early childhood may have consequences for academic achievement, mental health, behavior, and social life both during the school years and into adulthood," says Dr. Elisabeth Synnøve Nilsen Husebye, MD, PhD-candidate. "There is growing evidence of a positive association between maternal folate status during pregnancy and neurodevelopmental outcome in offspring in studies from the general population, but the relationship between maternal folate status during pregnancy and the verbal abilities in the offspring has not been examined previously in children of mothers with epilepsy."

For a study published in *Neurology,* Dr. Husebye and colleagues examined the effect of maternal folic acid supplementation and concentrations of maternal plasma folate and AED on language delay in AED-exposed children of mothers with epilepsy.

A total of 335 AED-exposed children of mothers with epilepsy and 104,222 children of mothers without epilepsy were surveyed. Maternal plasma folate and maternal plasma and umbilical cord AED concentrations were measured in blood samples from gestational weeks 17 to 19 and immediately after birth. Language development at 18 and 36 months was also evaluated.

For those with no maternal periconceptional folic acid supplementation, the fully adjusted odds ratio (OR) for language delay in AED-exposed children when compared with controls at 18 months was 3.9, and at 36 months was 4.7. When folic supplementation was used, the corresponding ORs for language delay were 1.7 and 1.7, respectively. The positive effect of folic acid supplement use on language delay in AED-exposed children was significant only when supplementation was used from 4 weeks before pregnancy through the end of the first trimester.

"Folic acid supplement use early in pregnancy appears to have a preventative effect on language delay associated with *in utero* AED exposure," says Dr. Husebye. "Higher maternal valproate concentrations significantly correlated with a lower language score at age 18 months."