Abstracts

Articles appearing in the February 2018 issue

Expanding incentives for coordinated, patient-centered care: Implications for neurologists

Historically, payment for cognitive, nonprocedural care has required provision of face-to-face evaluation and management as part of general ambulatory or inpatient care. Although non-face-to-face patient care (e.g., care via electronic means or telephone) is commonly performed and is integral to patient-centered care, appropriate reimbursement for this type of care is lacking. Beginning in 2017, Centers for Medicare and Medicaid (CMS) has taken a large step forward in reimbursing an increased number of cognitive care and non-face-to-face codes. CMS has also included language indicating that nonphysician providers (i.e., nurse practitioners and physician assistants) can perform many of these services independently. The 2017 fee schedule thus creates new payments for non-face-to-face, patient-centered services, and may allow neurologists to reach out to more patients through nonphysician providers. As health care in the United States moves toward value-based incentives, these newly supported non-face-to-face services will provide neurologists with new tools to deliver sustainable, high-value care.

[NPub.org/NCP/9018a](https://pubmed.ncbi.nlm.nih.gov/30188188/)

Neuroradiologic manifestations of Erdheim-Chester disease

Background We describe the neuroradiologic features of a cohort of patients with Erdheim-Chester disease.

Methods We assessed patients at Mayo Clinic Rochester between January 1, 1990, and July 31, 2016, with pathologically confirmed Erdheim-Chester disease (n = 53).

Results Neuroimaging, including head CT (n = 17), brain MRI (n = 39), orbital MRI (n = 15), and spine MRI (n = 16), was available for 42 participants. Median age at diagnosis was 55 years (interquartile range 46–66) with higher male prevalence (33:20). Neurologic symptoms were identified in 47% (25/53); BRAFV600E mutation in 58% (15/26). Median follow-up was 2 years (range 0–20) with 18 patients deceased. Radiologic disease evidence was seen in dura (6/41), brainstem (9/39), cerebellum (8/39), spinal cord (2/16), spinal epidura (2/16), hypothalamic-pituitary axis (17/39), and orbits (13/42). T2 white matter abnormalities (Fazekas score ≥1) were present in 21/34 patients. Diabetes insipidus was present in 30% (16/53); 8 had abnormal hypothalamic-pituitary axis imaging. Radiographic evidence of CNS involvement (i.e., dural, brain, including Fazekas score >1, or spinal cord) occurred in 55% (22/40) and was unassociated with significantly increased mortality.

Conclusions Erdheim-Chester disease commonly and variably involves the neuraxis. Patients with suspected Erdheim-Chester disease should undergo MRI brain and spine and screening investigations (serum sodium, serum and urine osmolality) for diabetes insipidus to clarify extent of neurologic disease.

[NPub.org/NCP/9018b](https://pubmed.ncbi.nlm.nih.gov/30188189/)

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