What's Happening with the AAPM&R Registry? An Update on Our Spine Data Capture


John M. Lesher
MD, MPH, FAAPMR

John M. Lesher, MD, MPH, FAAPMR
AAPM&R Registry Steering Committee

As the number of health care stakeholders increase and payment for services decrease, we, as physiatrists will need to prove our value within a health care system that at times struggles to understand our role in patient care. Value in health care is a quixotic concept that is more easily quantified by dividing the effectiveness of care by the cost of care (benefit/cost). If we do not demonstrate our value, then the stakeholders who purchase care may simply reward cheaper care instead of value-based care. Value-based purchasing, in which providers are held accountable for both the effectiveness and cost of health care services, will eventually dominate most payment models in economies with limited resources.

> "A core tenet of the AAPM&R Registry is to help physiatrists in different practice settings show value in the care they provide."

To do this, the Registry must first accurately and reliably characterize a variety of conditions (in this article, we'll focus specifically on spine data) through the appropriate usage of ICD-10 codes. Next we must determine the clinical effectiveness of treatment based on validated, prospective patient-reported outcome measures that are minimally burdensome to patients and providers. The Academy's Registry is working on outcome measures and collection of patient demographics based on the PROMIS® 29 (Patient-Reported Outcomes Measurement Information System) and the chronic low-back pain research minimum data set published by National Institute of Health's (NIH) Pain Consortium Task Force. The PROMIS® 29 is a valid, self-administered questionnaire that can be completed in less than 5 minutes[1,2]. Eventually, the Registry will be used to evaluate clinical variables that affect patient outcomes and allow participants to benchmark their care against risk-adjusted outcomes.

Over the past 6 months, the AAPM&R Registry has provided a first glimpse at patient demographic information from participating sites. Specifically, figures 1 and 2 show my practice's BMI and smoking status for 3 common spine diagnoses compared to the entire Registry (currently comprised of 161 members). The next step is to evaluate how these factors, combined with varying treatments, affect PROMIS scores for lumbar spine conditions. Because of its continuous nature, the AAPM&R Registry will monitor changes in patient demographics and ultimately changes in care pathways. Additionally, the design of the Registry allows for the evaluation of heterogeneous populations and the observed outcomes will be representative of what is achieved in real-world practice. Furthermore, additional outcome measures will be added or removed based on new treatment innovations and care metrics.

Currently, there are numerous national and international spine-focused registries that vary in their focus, data procurement and analysis.

> "The Academy's Registry is the only existing registry where data ownership and analysis are solely under PM&R governance."

Additionally, because the AAPM&R Registry is designated a CMS Qualified Clinical Data Registry (QCDR), specialty-specific measures can be created that are unique to physiatry and used to fulfill the Merit-Based Incentive Payment System (MIPS) requirements. This will ensure that the data collected through our Registry is meaningful to the specialty and best able to show the value of the care we provide. We look forward to keeping Academy members up-to-date with Registry progress throughout 2019. ❖

Figure 1

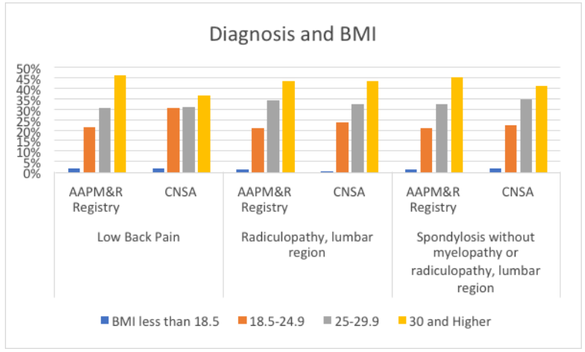
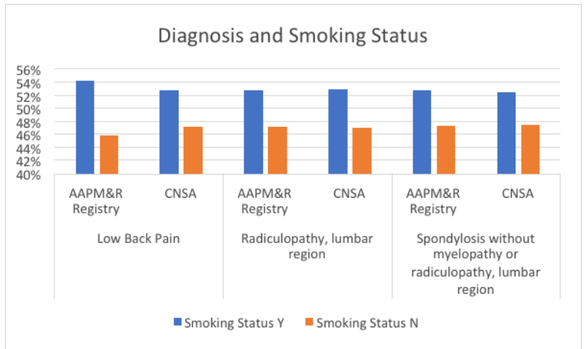


Figure 2



1. Deyo RA, Ramsey K, Buckley DI, et al. Performance of a patient reported outcomes measurement information system (PROMIS) short form in older adults with chronic musculoskeletal pain. Pain Med. 2016 Feb;17(2):314-24.

2. Cook KF, Jensen SE, Schalet BD, et al. PROMIS measures of pain, fatigue, negative affect, physical function, and social function demonstrated clinical validity across a range of chronic conditions. J Clin Epidemiol. 2016 May;73:89-102.

Improving Transparency in Medicare


Marc E. Duerden
MD, FAAPMR

Marc E. Duerden, MD, FAAPMR

Dr. Duerden is President of the Indiana Society of PM&R and a member of the AAPM&R Council of State Societies Presidents. This article represents the professional opinions of Dr. Duerden and are not the opinions of National Government Services, Indiana Medical Examinations, the Centers for Medicare and Medicaid Services, or Anthem.

The changes to the requirements for Medicare policy development is intended to provide more transparency in the development of a Local Coverage Determination (LCD) or reconsideration of an LCD, but it can be akin to the Aesop fable about the woodcutter.

"An old woodcutter, bent double with age and toil, was gathering sticks in a forest. At last he grew so tired and hopeless that he threw down his bundle of sticks, and cried out: "I cannot bear this life any longer. Ah, I wish Death would only come and take me!" As he spoke, Death, in the form of a grisly skeleton, appeared and said to him: "I heard you call me, what do you want mortal?" "Please, sir," replied the woodcutter, "would you kindly help me to lift these sticks on to my shoulder?"

The moral of the story is that we often change our minds when we get a wish granted.

For years, medical organizations have been asking Congress to write legislation to increase the transparency to the way LCDs were developed. There was a perception that the Medicare policy development process was not providing sufficient transparency when an LCD was developed or was put in place for any particular Medicare jurisdiction.

In order to increase this transparency, Congress passed the 21st Century Cures Act (Public Law No: 114-255). Starting in January 2019, the Centers for Medicare & Medicaid Services (CMS) have made changes to the LCD process.

With the new law, individuals and organizations may request to have an LCD written. When a requester wants to have a new LCD, they may begin the discussion with the Medicare contractor by having an informal meeting to discuss the potential LCD request. These educational meetings, which are not required, can be held either in person or via telephone.

When a formal request for an LCD is wanted, the requestor must present a written LCD request and have this sent to the Medicare contractor in their jurisdiction. The requestor needs to identify the defined Medicare benefit category and present the language that the requestor wants to be in the new LCD. The requestor must include published peer-reviewed evidence with the LCD request to support that the item or service is reasonable and necessary. The requestor must include information that fully explains the relevance, usefulness, clinical health outcomes, or the medical benefits of the item or service.

With the new law, the structure of the Carrier Advisory Committee (CAC) has changed. The Medicare contractors have flexibility on how the CAC are developed. The CAC is to provide a mechanism for the Medicare contractors to have local experts review and assess evidence when developing an LCD. The CAC members serve in an advisory capacity to review the medical evidence when the possible LCD is being developed or discussed.

In order to provide the desired transparency, all CAC meetings are open to the public. The CAC members should understand that their participation on the CAC is voluntary and the Medicare contractors will work to have a variety of CAC members with different backgrounds, education, experience and/or expertise in a wide variety of scientific, clinical, and other related fields. This is where PM&R can provide additional resources to the CAC by having physiatrists from a variety of backgrounds serve on the CAC.

The CAC members need to be aware that when a Medicare contractor consults with them as an expert, they are only there in an advisory capacity and are expected to understand and consent to knowing that his/her opinions may be used, disclosed, and identified in the proposed or final LCD.

The open meetings will also be important, serving as a forum to discuss a proposed LCD. The participants in the open meeting will be expected to provide clinical information that is justified and supported by peer-reviewed evidence. The Medicare contractors will publicly announce when an open meeting is to be held. The members of the CAC may attend the open meetings. The Medicare contractors will keep a recording of the open meeting and a roll of attendees at the meeting.

After the open meetings, the Medicare contractors will provide a minimum of 45 calendar days for public comment on the proposed LCDs. During this time, comments are requested from the clinical and lay community. At the end of the "notice and comment" period, the Medicare contractors will analyze the comments, publish their responses/answers to the comments and make adjustments to the LCD before it is finalized.

This new process for development of an LCD will allow for improved transparency regarding how an LCD is developed. Our Academy will continue to engage in this new process and individual PMR physicians are encouraged to participate in this process and be prepared to provide robust literature to support their opinions. ❖

What Does the Foundation for Physical Medicine and Rehabilitation Do? It Builds Career Success While Improving the Field! PART 1


Bruce E. Becker
MD, MS, FAAPMR

Bruce E. Becker, MD, MS, FAAPMR

As the only philanthropic organization focused on funding research into critical physiatric questions, over its 17-year history, we have given $1,650,000 through grants. Because of the structure and economic limitations of the Foundation, this money has been distributed through a number of our funds in small aliquots, usually to allow the corpus of our funds to be preserved using only the investment interest for distribution. That said, we have funded 105 grants in total to 93 individual grantees. These small grant awards have built into some large career successes for physiatrists across our nation, while demonstrating some significant evidence for day-to-day physiatric principles in patient care.

In the next issue, I will share one career story from a FPMR grantee. This physiatrist has focused on a common physiatric concern—joint function and osteoarthritis—while thinking through the anatomy, biology and pathophysiology leading to this problem. By demonstrating the utility of common and safe physiatric options for prevention and management, our grantee has provided value to our field as a whole. This is one of the key criteria that the Foundation Grants Committee sees as essential. We look for proposals that address important issues of relevance to a broad reach of physiatry, are innovative, are technically-achievable within the grant budget and timeframe, and are potentially capable of attracting larger future grant funds.

Our field with its emphasis on function has tremendous research needs and opportunity. Finding funding for preliminary research is very difficult, and this is exactly where the Foundation puts its energy to elevate our field. In future editorials, I'll bring forward more stories of Foundation successes. In the meantime, please consider your own role in advancing our field through donations to the Foundation. ❖