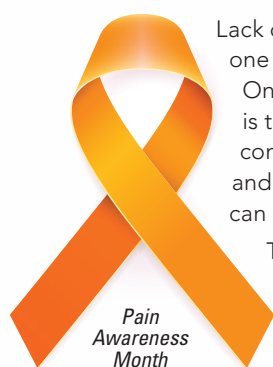


aapm&r annual assembly

It's not too late to join us at the AAPM&R 2015 Annual Assembly! See pages 4–5 to learn more about this year's new content and visit aapmr.org/assembly to register.

September is Pain Awareness Month

Pain Awareness Month was first acknowledged in 2001 to increase awareness about the effects of pain, educate citizens about the advanced treatment options available to help alleviate pain, and provide resources for individuals and families who are struggling with pain management.



Lack of pain management training has been cited as one of the barriers to effective pain management. One of the main goals of Pain Awareness Month is to raise awareness and open the lines of communication between health care professionals and individuals so that pain management issues can be better understood and addressed.

Take this opportunity to learn more about pain management by utilizing your Academy's resources. We have a special pain and spine theme at the 2015 Annual Assembly, an SAE-P focused on pain management, articles on PM&R Knowledge NOW®, and more!

Pain & Spine Theme at the 2015 Annual Assembly

Head to Boston this October for our pain and spine content at the Annual Assembly. We have more than 20 sessions dedicated to pain, as well as a few hands-on workshops. Find out more at aapmr.org/paintheme.

Flip to page 4 for additional Assembly details and new features.

AAPM&R Joins AMA Effort to Address America's Opioid Crisis



Opioid abuse is a serious public health problem that has reached crisis levels across the United States, with 44 people dying each day from overdose of opioids, and many more becoming addicted. Recognizing the urgency and serious impact

of this issue on the health of hundreds of thousands of patients across the country, your Academy has been actively involved in the work of the American Medical Association (AMA)-convened Task Force to Reduce Opioid Abuse.

As one of 27 physician organizations including the AMA, American Osteopathic Association, 17 specialty and 7 state medical societies, as well as the American Dental Association, your Academy is collaborating with other task force members to identify best practices to combat opioid abuse, and implement those practices across the country's health care system.

The task force's initial focus will be on efforts that urge physicians to register for and use state-based prescription drug monitoring programs (PDMPs) as part of the decision-making process when considering treatment options. When PDMPs are fully-funded, contain relevant clinical information, and are available at the point of care, they have been shown to be an effective tool to help physicians identify patients who may be misusing opioids, and to implement treatment strategies including referrals for those in need of further care.

Your Academy fully supports the task force's work and will keep members informed of its ongoing efforts to combat opioid misuse, abuse, overdose, and death from such drugs.

Learn more about how AAPM&R, along with the AMA Task Force to Reduce Opioid Abuse, is addressing America's opioid crisis:

- View the AMA's press release announcing this effort at aapmr.org/advocacy/outreach.
- Read AAPM&R's Position Statement on Opioid Prescribing at aapmr.org/practice/resources/positionpapers—look for "Opioid Prescribing."

A graphic titled "Pain Fast Facts:" featuring a cartoon character being hit by a large black mallet. The character is surrounded by red starburst effects. The text "Pain Fast Facts:" is written in a bold, white font on the mallet head.

- Nearly 100 million Americans experience chronic pain—more than those who have diabetes, heart disease, and cancer combined.
- 83 million Americans indicate that pain affects basic functioning in their everyday lives.
- Workers lose an average of 4.6 hours per week of productive time due to a pain condition.

IN THIS ISSUE...

Member Spotlight: Steven P. Stanos, Jr., DO.
Read about him on **page 6**.

Health Care Reform—Why Should I Care?
Learn more on **page 7**.

The Merit-Based Incentive Payment System (MIPS)—find out what it is on **page 12**.

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What is Contemporary Pain Management?



Bruce E. Becker, MD, MS

In past editorials I've written my thoughts on and experience in managing both acute and chronic pain. The science continues to evolve as do the societal and legal consequences of mismanaged pain. The current resurgence of heroin addiction and consequent heroin overdoses poses a medical and societal threat, as well as a geopolitical problem. At the invitation of the Academy, I've been part of the Steering Committee for a consortium of concerned organizations who have formed the Alliance for Balanced Pain Management. The group is broadly based, and includes patient support groups across the age spectrum, pharma, nursing groups, and other medical societies. The organizational goal is to create public and professional education on the safest and most clinically appropriate ways to manage chronic pain. This includes provider education as well as patient education, and while it is not an opioid-centric project, it certainly does deal extensively with safe prescribing, storage, and disposal of such medications. It is entirely in harmony with the AAPM&R position statement on Opioid Prescribing, which emphasizes safety.¹ But the Alliance stresses the non-opioid options far more, including access to exercise, physical therapy, psychosocial counseling, and support groups. So it has been useful to have an Academy voice participating with this group, emphasizing the importance of rehabilitation, exercise and a functionally-based approach to persons with pain.

I live in Washington State, which legalized medical cannabis use in 1998, so we have had a 17-year history allowing marijuana access, and of course recent legalization of recreational use. But the beginnings of medical cannabis have not been easy. Cannabis is a complex structure of active ingredients, some clearly psychoactive, and others not. While used for over 5,000 years of history for medical, religious and recreational purposes, since 1937, all use has been illegal by federal law. Therefore, research studies have been severely impacted, rendering cannabis' potential medically therapeutic value very controversial.^{2,3} But with societal opinion regarding cannabis evolving over the past 20 plus years, federal schizophrenia regarding policy has also relaxed. The issues remain difficult as the pharmacology of this plant is extremely complex, as is the neurophysiology of pain and the many cannabinoid receptors throughout the central and peripheral nervous systems. A marvelous review of the topic including an overview of a randomized controlled trial (RCT) results was published by our colleague Sunil Aggarwal in 2013.⁴

Only recently in my state has the actual pharmacologic analysis of cannabinoid products been made available. Previously, patients might have been using products that contained substantial amounts of the more psychoactive tetrahydrocannabinol (THC) and relatively less cannabidiol (CBD.) It is now possible to obtain nearly pure CBD, which is essentially devoid of psychoactive effects and offered in sublingual, topical, and vaporized options.

It has long been my opinion that opioids are a weak option for chronic pain. The growing understanding of opioid-induced hyperalgesia, combined with the many other

side effects and social issues dramatically reduced my prescribing patterns.⁵ Recently, my close friend Mike approached me regarding how to best manage his severe spine pain following several spinal fusions as a result of early life spine and pelvic fractures sustained as a pro ski patroller. I spoke about the recent evidence for cannabinoid options, which he was reluctant to try because of his career spent in law enforcement. After much discussion, I accompanied him to the local cannabis dispensary anticipating a head-shop atmosphere, but finding a professional drug store environment. The staff was knowledgeable, friendly, and the clientele broadly based in both age and appearance. We were not the oldest. There were 2 sides to the store, one the strictly medical side, the other the recreational side. On the walls were bulletin boards listing various lab certified constituents of each guaranteed herbicide/pesticide free product, a bit different than my college experience. Mike purchased a topical cream and CBD gel pills. Results have been modest so far, but his use has been far less than recommended. So the jury remains out on this single-subject study.

As described in both Greg Carter's and Sunil's papers, the science is certainly fascinating. It is clear that the endocannabinoid system within our bodies is intimately intertwined with pain and sensory information processing. Cannabis has an excellent safety profile with essentially no LD50, and the research continues to show promise. As physiatrists, our future may well demand our better understanding of cannabis' place in the management of pain. Meanwhile, the value of exercise, attitude, and understanding remain central to the rehabilitative approach to pain management. ♦

—Bruce

1. Position Statement on Opioid Prescribing. 2015; [http://www.aapmr.org/practice/resources/positionpapers/AAPMR Documents/Opioid-Position-Paper-Final-Approved.pdf](http://www.aapmr.org/practice/resources/positionpapers/AAPMR%20Documents/Opioid-Position-Paper-Final-Approved.pdf).
2. Carter GT, Javaher SP, Nguyen MH, Garret S, Carlini BH. Re-branding cannabis: the next generation of chronic pain medicine? *Pain Manag*. 2015;5(1):13-21.
3. Carter GT, Mirken B. Medical marijuana: politics trumps science at the FDA. *MedGenMed*. 2006;8(2):46.
4. Aggarwal SK. Cannabinergic pain medicine: a concise clinical primer and survey of randomized-controlled trial results. *Clin J Pain*. Feb 2013;29(2):162-171.
5. Kaneria A. Opioid-induced hyperalgesia: when pain killers make pain worse. *BMJ Case Rep*. 2014;2014.



Enhanced Member Logins are Here!

Have you visited **aapmr.org** lately? We're happy to announce that enhanced member login capabilities are now available! You can now seamlessly navigate through all of the Academy's web pages, including **me.aapmr.org**, **pmrknowledge.org**, and **physforum.org** without the need to log in more than one time. This means that after initially logging in from any Academy web page, it's quicker and easier to update your member profile, purchase educational activities, access your transcript on **mē®**, or register for live events. We hope this improved functionality will make your web experience more efficient and enjoyable!

To check whether or not you're logged in to the AAPM&R website, look for your name at the top of the web page. If you do not see your name, click the **Sign In** link and enter your email address and password. If your login credentials need to be reset, please use the **Forgot My Password** link from the login page, or contact our Member Services team at (877) 227-6799 or memberservices@aapmr.org during regular business hours (Monday–Friday, 8:30 am–5 pm CT).

The PM&R Corner



Kathleen R. Bell, MD

Greetings from Fort Lauderdale! I have just spent a few days down here at the Military Health Research Symposium with almost 2,000 military, VA, and civilian researchers, research administrators,

and clinicians. Topics included combat and duty readiness, traumatic brain injury and neurotrauma, psychological health, prosthetics, burns, and infectious diseases. As is always the case, there were many topics, even in my own field of neurotrauma that I knew nothing about, exciting new information and amazing new technology. And I kept thinking, where are the physiatrists? I think that perhaps there were 3 of us in attendance. I could not help but think how excited the residents at my program would have been to hear and see these exciting developments. But would they have been excited?

We've had a number of efforts to increase the research preparation for physiatrists. There is the terrific RMSTP training program headed by Dr. Michael Boninger and previously by Dr. John Whyte that serves a select group

of trainees. There are the starter grants awarded by the Foundation for PM&R that address another small group. Many of our residency programs require some sort of scholarly activity that often results in case reports or lectures rather than a research experience. One issue remains that many of our faculty members are not conversant enough in research methods or involved in research to an extent that allows meaningful resident involvement. So many residents (and faculty members) think of research as being a difficult, time-consuming, insurmountable, and joyless enterprise, when in reality, research is a difficult, time-consuming, doable, joyride of an experience, complete with the thrill of discovery, sprinting for the finish line, and ongoing comradery of other clinician-researchers.

I've been thinking that perhaps we need to take a page from our fellow rehabilitation professionals and start looking at how we revise curriculum to include the ability to identify and embark on research that stems from their clinical experiences. Perhaps we need to offer this opportunity to faculty members (education, mentoring, AND small grant funding—see the PORT

program at the University of Michigan for example, www.michr.umich.edu/education/portprogram).

Why am I discussing an understanding of research in the AAPM&R newsletter? As medical practice continues to evolve, we are going to have to understand how to analyze and report our own practice and quality outcomes. We are going to have to understand data from registries and what it does and doesn't say about outcomes. Understanding where data comes from and what to do with it is becoming part of the daily practice of PM&R; big data is not going away. We need to tackle the fear and loathing of research that still lurks.

We can make a good start by attending the AAPM&R Annual Assembly in Boston. There are discussions and presentations on the clinically relevant use of data and its role in our future. In addition, there are plenty of young (and old) researchers who will be presenting their data. Come share some of the research joyride with us during the poster and platform presentations. I can't wait to see you all in Boston. ♦

September is Pain Awareness Month

Continued from page 1

Pain Management SAE-P

Self-Assessment Examinations for Practitioners (SAE-Ps) are valuable tools to help test your knowledge and assess areas of improvement on a variety of clinical topics. Our Pain Management SAE-P describes common etiologies of peripheral pain disorder, recognizes the adverse effects associated with use of opioid medications, identifies the latest concepts of the pathophysiology mechanisms in central and central nervous system pain states, and more. This SAE-P offers up to 8 AMA PRA Category 1 Credits™ and fulfills Part II of your American Board of Physical Medicine and Rehabilitation (ABPMR) Maintenance of Certification® (MOC®)* requirement. Visit me.aapmr.org/catalog for details.

Injured Worker Pain Management Education Available on mē®

Four online slide lectures focused on the injured worker chronic pain management and biopsychosocial treatments are now available on mē® (me.aapmr.org):

- Interdisciplinary Pain Management & Functional Restoration—**presented by James W. Atchison, DO**

- The Assessment of Factors Associated with Delayed Recovery: A Biopsychosocial Paradigm—**presented by Daniel Bruns, PsyD and John Mark Disorbio, EdD**
- Pain Rehabilitation: Changes in Healthcare as an Opportunity for Improving a Continuum of Care—**presented by Steven Stanos, DO**
- Interdisciplinary Rehabilitation of the Injured Worker with Chronic Pain—**presented by Barton L. Goldman, MD**

Each slide lecture is **FREE** and offers 0.50–1.0 AMA PRA Category 1 Credits™. Sign in to me.aapmr.org and access these slide lectures from the Catalog.

Other Pain Resources on mē®

- MOC|3 Pain Management Online Review Course**
- MOC|4 Low Back Pain Practice Improvement Project (PIP)
- More than 25 case studies and 35 PM&R journal articles focused on pain
- We also have a variety of pain podcasts and slide lectures, free for members!

NEW!



PM&R journal articles are available for **FREE** CME credit. Visit me.aapmr.org/catalog and search “Pain” to find these helpful resources.

PM&R Knowledge NOW®

PM&R Knowledge NOW® is your specialty's go-to resource, offering 300+ clinical topics to explore. Visit pmrknowledgenow.org to find more than 45 online articles dedicated to pain medicine/chronic pain, including headaches, phantom pain, lumbar pain, joint pain, and more. ♦

See page 6 for an interview with Steven P. Stanos, Jr., DO, currently serving on the National Pain Strategy (NPS) Task Force.

**The MOC|3 Online Review Courses are not endorsed by ABPMR nor was ABPMR involved in the creation of these study tools.

*Maintenance of Certification® (MOC®) was developed by the American Board of Medical Specialties (ABMS) to improve patient care by ensuring continuous lifelong learning and professional development throughout a physician's medical career. For board-certified physiatrists, the American Board of Physical Medicine and Rehabilitation (ABPMR) sets MOC requirements that are customized to the specialty and ensure compliance with ABMS Standards. Recognizing that physicians participating in that process want a variety of options to meet these requirements, your Academy has developed a series of resources that satisfy the different components of MOC. All Academy tools available to help you meet MOC requirements can be found on mē®.

AAPM&R's Annual Assembly is Right Around the Corner!

If you haven't already registered for the 2015 Annual Assembly in Boston this October 1–4, what are you waiting for?

The 2015 Assembly is your destination this October. Among falling leaves, changing colors, back to school, and football, make the 2015 Assembly part of your fall lineup. We have hands-on, innovative education, networking receptions, and more—just for PM&R physicians! In addition to more than 100 educational sessions focused on a variety of clinical topics, we also have special practice management sessions, led by PM&R experts. This year's theme, *The Physiatry Experience: Success in a Changing Health Care Environment*, is woven in throughout the meeting to help guide your team through the many changes taking place in health care.

Don't miss the learning, networking, and fun this year! We have new highlights, including the Spaulding Rehabilitation Hospital Hackathon, Movement Competition, and the Innovations in Spine Care Summit. Plus, we're bringing back the live Regenerative Medicine course for those unable to travel to Boston. Check out all of the details at aapmr.org/assembly and register now!



President's Reception

John F. Kennedy Library and Museum
Friday, October 2
7 pm–10 pm

TICKETS STILL AVAILABLE!

Join us for our memorable President's Reception at the breathtaking JFK Library and Museum.

- Tour the exhibits for a glimpse of rare, family photos
- Admire the contents of Jackie's famous wardrobe
- Watch JFK's most notable presidential addresses
- Enjoy fresh seafood and cuisine from Boston's eclectic neighborhoods
- Take in the musicality (and antics!) of the Din & Tonics, Harvard's world-renowned a capella singing group

Tickets for members are only \$60—over 60% off the value price!

Tickets must be purchased separately from Annual Assembly registration fees. Transportation will be provided from the Hynes Convention Center to the JFK Library.

Spaces Still Available for Ticketed Sessions!

Visit the web pages below for specific session availability:

Preconference Courses—aapmr.org/preconference

- Fundamentals of Ultrasound
- Coding & Billing Workshop
- Regenerative Medicine: Current Concepts and Brave New Paradigms in the Treatment of Musculoskeletal Conditions

Intensive Workshops—aapmr.org/intensives

- Regenerative Medicine—Stem Cell Treatment in Osteoarthritis: Office-Based Application
- Sports Ultrasound in the Field
- The Ankle in Musculoskeletal Medicine
- Improving Assessment and Maximizing Intervention Options for Patients with Spasticity, Dystonia, and Related Motor Disorders
- MOC|2: Spasticity Live Self-Assessment

Workshops—aapmr.org/workshops

- We're offering more than 50 workshops that cover a variety of clinical topics!

Foundation for PM&R Event— "Proof of the Pudding" Debate

Thursday, October 1
9 pm–9:30 pm



End your day with complimentary coffee and dessert while listening to experts debate a controversial topic picked from the Point/Counterpoint series in the purple journal (*PM&R*). The subject of this interesting and educational program will be the use of interdiskal steroids in the treatment of low back pain. Bradley Goodman, MD and Gwendolyn A. Sowa, MD, PhD will present the pros and cons, while George Kevorkian, MD moderates. Stuart Weinstein, MD, editor-in-chief of *PM&R*, will also present the journal's Best Paper Award.

Experience the Live Regenerative Medicine Course from Your Home or Office



We're excited to bring back an innovative educational format to members—a live streaming course. Participate in the live course on regenerative medicine without leaving your hometown. This year's preconference course—*Regenerative Medicine: Current Concepts and Brave New Paradigms in the Treatment of Musculoskeletal Conditions*—is available to those not attending the 2015 Assembly or those who may be traveling later to the meeting. This course is designed for clinicians with a strong interest in integrating regenerative medicine treatments—in particular, stem cell treatments—into their practice. Upon completion of this course, you will understand how to begin to implement regenerative treatments into your practice. The course will be presented live on September 30 at 7:30 am (ET). Visit aapmr.org/preconference to register.

Stay Updated on the Annual Assembly with Attendee Newsletters and Twitter



To help you prepare before you arrive and to guide you through the Assembly while you're onsite in Boston, your Academy will provide you with frequent electronic, Facebook, and Twitter updates before and throughout the meeting.

Annual Assembly attendees will receive newsletters 1 month out, 3 weeks out, and 1 week out from the start of the meeting. Each night during the meeting, registrants will receive newsletters providing a quick list of the next day's activities, as well as quick links to course handouts and maps. You can also stay connected to Annual Assembly updates during the meeting by visiting aapmr.org/aaonsite for up-to-date information, just for attendees. Don't forget to like us on Facebook ([facebook.com/aapmrinfo](https://www.facebook.com/aapmrinfo)) and follow us on Twitter @AAPMR—use #AAPMR2015 when searching or tweeting. Use Twitter to meet up with friends, comment on events, or ask questions.

Can't Stay for the Entire Meeting?

Register for a single day pass instead! Check out our schedule of events at aapmr.org/aa2015schedule and choose the day you prefer.

DON'T MISS OUR NEW HIGHLIGHTS FOR 2015!

Spaulding Rehabilitation Hospital Hackathon: Hacking Rehabilitation

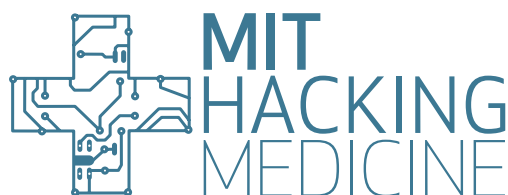
September 25–26, 2015

NEW FOR 2015!

AAPM&R and Spaulding Rehabilitation Hospital, in collaboration with MIT Hacking Medicine, invite entrepreneurs, designers, engineers, and health care professionals to come together for this 2-day event that focuses on the development of innovative solutions for rehabilitation medicine challenges. Innovators from all physiatry specialties will come together to exchange ideas, form teams around shared interests, and build solutions to various health challenges. This is your opportunity to meet, ideate, and hack with like-minded health care professionals. Don't miss your chance to be part of this cutting-edge concept!

To be considered, complete the registration form at aapmr.org/hackathon.

Apply early, as space is limited. You will receive a confirmation email if you are selected to participate. (Please note that walk-ins are not allowed.) There is no fee to sign up, however, we encourage you to register for the Annual Assembly. For more information on the Spaulding Hackathon, please email Dr. David Binder at dbinder@partners.org.



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Physical Medicine and Rehabilitation

SPAULDING
REHABILITATION NETWORK

Movement Competition

NEW FOR 2015!

Movement
COMPETITION

AAPM&R is hosting a new Movement Competition sponsored by Allergan at the 2015 Annual Assembly!

Attendees will be encouraged to engage in friendly competition by measuring the distance traveled each day, tracked via a pedometer or mobile app, and entering the distance into an easy-to-navigate website. You'll also be able to visit the Movement Competition booth each day during the meeting to log your distance traveled. The names of attendees logging the greatest distance will appear on leader boards each day throughout the Assembly.

Prizes will be awarded to the top movers! Join the fun and get motivated to MOVE during #AAPMR2015! Conference attendees will receive complete details closer to the meeting. Visit pmrmoves.us for the most up-to-date information!

Sponsored by  **ALLERGAN**

NEW FOR 2015!

AAPM&R Innovations in Spine Care Summit

Designing for Transformation: Stories, Principles, and Practical Ways to Innovate for a Better Future

Rachel Brakke, MD (Director); Robert Mecklenburg, MD (Keynote)

Friday, October 2: 1 pm–5 pm

Join us for this inaugural event highlighting the role of innovation in delivering spine care! This half-day session will offer insight on how practical ideas for redesigning spine care evolved into a system transformation. We are offering a lineup across the spectrum of spine care models from newly developed to mature models. Attendees will take away knowledge to change their current practices while also becoming the specialty's first community of inspiration for shaping the future of spine care. ♦

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Steven P. Stanos, Jr., DO

Steven P. Stanos, Jr., DO

Medical Director of the Swedish Pain and Headache Center, Swedish Medical Center in Seattle and Medical Director of Occupational Medicine Services at Swedish Spine, Sports, and Musculoskeletal Medicine, Swedish Medical Group

AAPM&R member Dr. Steven P. Stanos, Jr., DO, currently serves on the National Pain Strategy (NPS) Task Force. Read our interview with Dr. Stanos as he discusses why the NPS was created, the impact of NPS to AAPM&R members, important takeaways, and more.

1. Can you provide some background information on the National Pain Strategy and why it was developed?

In 2010, under congressional mandate, the National Institutes of Health (NIH) contracted the Institute of Medicine (IOM) to study and make recommendations in order to increase recognition of pain as a significant public health problem in the U.S. The 2011 IOM report on pain, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, called for “a transformation in pain prevention, care, education, and research” and recommended development of a “comprehensive population health-level strategy” to address critical issues in the report. Important conclusions of the report included estimates of cost of pain in the U.S. at more than \$600 billion, a need to increase scientific knowledge of chronic pain as a disease, improvement in population related evidence on the prevalence, onset, and impact of pain, as well as improving pain management with a shift in focus to a biopsychosocial model. The report recommended greater collaboration between primary care clinicians, pain specialists, including the need for expanding multidisciplinary approaches in all settings of care (rural, primary care, multispecialty, and tertiary care).

Under HHS, an Interagency Pain Research Coordinating Committee (IPRCC) was formed to oversee creation of a National Pain Strategy (NPS). Over a 2-year period, committees were developed, including “working groups,” to study and develop specific recommendations as part of the larger NPS report. Working groups comprised a broad array of public and private organizations, including health care providers, insurers, people with pain, and advocates. The expert working groups produced interrelated sets of objectives with specific action plans in 6 areas.

Those 6 defined “working groups” include:

1. Population Research
2. Prevention and Care
3. Disparities
4. Service Delivery and Reimbursement
5. Professional Education and Training
6. Public Education and Communication

The NPS draft report was released April 2, followed by a 60-day public comment period by the Federal Register. The final NPS release is pending and under review by HHS.

2. Can you talk about how you came to be involved in the development of the National Pain Strategy?

I became involved with the NPS after being invited by the Interagency Pain Research Coordinating Committee. I have been active with the American Academy of Pain Medicine, serving on the Board and as treasurer. I have published guidelines in the area of chronic pain management, including functional restoration and rehabilitation approaches to comprehensive pain management care. I served as medical director for the Center for Pain Management at the Rehabilitation Institute of Chicago (RIC) through 2014. Along with the team at RIC, our pain rehabilitation program received a Centers of Excellence Award for multidisciplinary care by the American Pain Society. We also gave lectures around the U.S. regarding our pain management program to payers, medical groups, and associations. All of those factors helped us to be active in this area of pain management, inter- and multidisciplinary care. I also served on the Service Delivery and Reimbursement Panel.

3. In addition to you representing physiatry, who else participated on these panels?

The clinical experts invited to serve on the panels all had unique expertise in cancer and chronic pain management. Most of the clinician members were pain management specialists (i.e., physicians, nurses, ARNPs). Other members included epidemiologists, federal agencies (DoD and VA), FDA, CMS, Centers for Disease Control and Prevention, insurance industry, and the National Institutes of Health.

4. What do you think the impact will be to our members?

The NPS will help to increase a value-based biopsychosocial approach to pain management, improve the study of pain, help to identify disparities in care, establish registries that help to better understand prevalence and impact of chronic pain across the U.S. population. The emphasis is on shifting care toward a disease management approach, less on pain reduction but more on improved function. Both of those goals are innate to a physical medicine and rehabilitation approach. NPS may help shift pain care and incentivize team-based approaches. NPS may help to incentivize aspects of PM&R-based care that has, in the past, been poorly supported by insurance or reimbursed such as physical and occupational therapy, and behavioral health. There will be a great opportunity for physiatrists to step into greater leadership roles at the clinical and administrative level.

5. Is there opportunity for PM&R to get involved in the implementation of the National Pain Strategy?

Yes, after final approval, there are a number of feasibility and proof of concept studies supported by NPS initiatives that will help to better understand how current hospital systems, clinics, and government agencies are implementing value-based programs to improve clinical outcomes. Hopefully our Academy can use this opportunity to communicate to NPS the unique focus we share in understanding functional approaches to care.

Jim Atchison, DO, has put together a panel discussion for this year's Annual Assembly and has invited Linda Porter, the lead from NIH on the NPS. Join us for session 501, “A Round Table Discussion of the American Pain Strategy Report and its Potential Effect on Rehabilitation Physicians and Providers,” on Friday, October 2 from 7 am–8:30 am. This will be a great opportunity for our members to be updated at the highest level on the pending NPS document, recommendations moving forward, and hopefully stimulate interest in our members to get involved in future NPS-related projects. Physiatry can help to increase awareness of NPS goals at a local level, in their community, and in the facilities that they practice.

6. What are the important takeaways you want members to be aware of?

All 6 panels have developed comprehensive recommendations. All physiatrists should spend a short period of time reviewing the report. The 2 panel recommendations most pertinent to physiatrists include Service Delivery and Reimbursement and Prevention and Care. Our Academy has submitted a comment letter on the draft NPS, which you can find on the AAPM&R website at aapmr.org/advocacy/reimbursement-advocacy. ♦

Health Care Reform, Part I—Why Should I Care?

M. Kate Stinneford, RN, JD | AAPM&R Health Policy Manager

There can be no doubt that the health care system in the United States is undergoing an epic transformation. Everyone is talking about ways to decrease the costs of necessary care, improve quality, and make the health care experience better for the patient. The Institute for Healthcare Improvement (IHI) described this constellation of objectives as “The Triple Aim.”* (There have been rumors of a 4th component being added—provider satisfaction—but nothing definitive so far). Health care providers should not underestimate the impact of the changes occurring in health care. In some ways, the Triple Aim requires physicians to turn their concept of practicing good medicine on its head. For physicians who have long been accustomed to providing care and advocacy for individual patients, the new concentration on population health will not be an easy transition. As the IHI said in its concept design for the Triple Aim, “If the experience of the individual is the primary driver of the Triple Aim system, the health of the population and the per capita cost become constraints. Individuals cannot get all the services that they might want or perhaps even need.”¹

Health care reform is perhaps one of the best examples of a concept known as “disruptive innovation.” In their paper on the subject, Omachonu and Einspruch described disruptive innovations (also called radical, revolutionary, transformational, or non-linear) as “innovations that disorder old systems, create new players and new markets while marginalizing old ones, and deliver dramatic value to stakeholders who successfully implement and adapt to the innovation.”² They went on to propose that there are 5 key stakeholders in health care innovation, as shown in the chart below:³

Stakeholders	Needs, Wants, and Expectations
Physicians and Other Care Givers	Improved clinical outcomes, improved diagnosis and treatment
Patients	Improved patients’ experience, improved physiological well-being, reduced waiting time, reduced delay
Organizations	Enhanced efficiency of internal operations, cost containment, increased productivity, and quality and outcomes improvement
Innovator Companies	Profitability, improved outcomes
Regulatory Agencies	Reduced risks and improved patient safety

The needs, wants, and expectations of each stakeholder must be taken into consideration when planning innovation. To ignore any one of them amplifies the risk that you will be one of the existing stakeholders that is marginalized. That is not to say you must agree with or implement suggested changes by other stakeholders but, at a minimum, you need to be aware of trends and changes that are already occurring in health care.

There are multiple reasons why physicians might want to actively participate in some of the disruptive innovations occurring in health care, or even to test out one or more of their own. The first reason, as outlined above, is to ensure that physicians are not marginalized during the process of transformation. Though it is impossible to predict the future, many of the societal changes, as well as the changes in health care that have already taken place, will not allow for a return to the status quo. The best thing physicians can do is to remain flexible and keep up as much as possible with the new ideas and information that are spilling out like a waterfall.

Another reason is that the Affordable Care Act (ACA) served to jump-start massive changes in the way health care is reimbursed, which in turn has led to the need for providers to adapt. Instead of fee-for-service, CMS and other payers plan on basing payment on the value created by the service. CMS has already begun a multitude of demonstration programs to test out new models for payment and practice, and large insurance companies are partnering with integrated systems to do the same.

There are aggressive timelines for the implementation of these new types of payment. For example, early in 2015, CMS announced the following timelines:

30%	of Medicare fee-for-service payments in Alternative Payment Models (APM) by 2016
50%	of Medicare fee-for-service payments in Alternative Payment Models (APM) by 2018
85%	of Medicare fee-for-service payments linked to quality or value by 2016
90%	of Medicare fee-for-service payments linked to quality or value by 2018

The private health insurance carriers are also leading the way in several transformative projects related to the Triple Aim. For example, several large insurance companies have come together with representatives from providers, patients, payers, and purchasers to create “The Health Care Transformation Task Force.” Its mission is to find better ways to achieve the Triple Aim in health care, and to better align public and private sector interests. Their payer and provider members (which include such large systems as Advocate Health Care and Trinity Health) have committed to “put 75% of their respective businesses operating under value-based payment arrangements that focus on the Triple Aim by January 2020.”⁴ Physicians must be part of the conversation in determining how these ideas for change are implemented, both for their own sake and for the sake of the often vulnerable population they serve.

One of the recent health care trends provides another reason for physicians to prepare for innovative payment and practice models—the move in medicine towards lower cost health care providers. I would consider this an example of disruptive innovation. Fifteen years ago, researchers at *Harvard Business Review* (HBR) discussed how disruptive innovations work, saying “Many of the most powerful innovations that disrupted other industries did so by enabling a larger population of less-skilled people to do, in a more convenient, less expensive setting, things that historically could be performed only by expensive specialists in centralized, inconvenient locations.”⁵

The HBR article then looks at how to determine what sort of medical problems could be entrusted to a lower-skilled provider without decreasing quality. The authors visualize medical care as being in tiers, advancing from the simplest to the most complex medical problems. The lowest tiers contain medical problems where diagnosis and treatment can be rule-based—accurate data leads to an unambiguous diagnosis which is treated with proven therapeutics. In the middle tiers, they classify medical diagnosis and treatment as being based on pattern recognition—no single piece of data is sufficient, but a constellation of symptoms falls into a recognizable pattern and can often be treated with standardized protocols. At the highest tiers are the complex medical problems which need clinical problem-solving skills by someone with a higher level of clinical skills.⁶

*The IHI Triple Aim framework was developed by the Institute for Healthcare Improvement in Cambridge, MA (www.ihl.org).

Continued from page 7

The authors postulate that less skilled providers could certainly provide care in the lower tiers, while the higher tiers require a physician level of care. The article goes on to recommend that the health system follow this advice and start using more non-physician practitioners, such as advanced practice nurses. This certainly appears to be the direction that health care is headed. In 2014, the American Association of Nurse Practitioners noted that there were more than 205,000 licensed nurse practitioners in the United States.⁷ As of April 15, 2015, the Kaiser Family Foundation reports that in 33 states (including the District of Columbia), nurse practitioners may diagnose and treat patients with no physician supervision required. In 24 of those states, nurse practitioners also have independent prescribing authority.⁸ The number of nurse practitioners is expanding rapidly, and so is the scope of what they are allowed to do. The same is true for other allied health professions. For example, in Wisconsin, a physical therapist does not need a referral or prescription from a medical doctor to give care, and is permitted under their scope of practice to do certain procedures one might have expected to be limited to physicians, such as needle EMGs, surface EMGs, nerve conduction studies, and rehabilitative ultrasound imaging (rui) as long as they have the skills and education to do so. Although opposition by physicians is strong (especially by psychiatrists), psychologists have gained prescribing authority in 3 states and are actively working to obtain it in other states. The trend in health care is definitely in the direction of allowing practitioners with neither the education nor the training of physicians to perform functions formerly limited to licensed physicians.

A fourth reason for looking at new ways to practice is the rapid advancement of technology. A more recent article in *Harvard Business Review* examines the effect that personalized technology will have on the doctor-patient relationship. The authors describe how new companies are focusing on creating a better experience for the health care consumers by allowing them to receive care at home or at work, and to have access to their own individualized health care advice.⁹

Even if you are not a technophile, you can pretty much count on your patients wanting to take advantage of new technologies they have seen or read about. One of the current hot topics is what are often called “wearables.” Examples already in use include the Apple Watch, fitness monitors, and pacemakers that can be analyzed by phones. Just a few days ago, the *Chicago Tribune* ran a story on Allstate Insurance’s attainment of a patent that will not only allow them to track how drivers use their cars, but can also be programmed to obtain information on physical attributes such as pulse, blood pressure, respirations, and even an ECG. Owners of an Apple Watch can purchase a “HealthKit,” which will allow them to download health related data to an app, which in turn is transferred to an Epic system and merged with any other health records they may have on Epic. A company called Owlet has come out with a “smart sock,” which sends information such as the baby’s heart rate and oxygen levels to a parent’s Internet-based device.

In 2012, an article in the *Journal of Neuroengineering and Rehabilitation* discussed many wearable sensors and systems that could be useful in rehabilitation, such as a device that could monitor real-time functional upper extremity ability in the patient’s home.¹⁰ Among other things, the authors discuss how those working in wearable technology have evolved from working on sensors to working on systems, which can lead to an enhanced ability to do remote monitoring of patients in the home or in community settings. It would be interesting to see how much farther such systems have evolved in the last 3 years. Although 3 years may not seem like enough time to make a lot of difference, in this age of Internet start-ups and technology innovators, progress is measured in weeks or months rather than years.

Finally, even if the reforms made by the ACA had not come along, the advent of “Big Data” in the health care setting has the potential to change practices in ways we are only beginning to understand. The volume of data being collected now is almost unimaginable, thanks in large part to the technology discussed previously. In a conference paper on the subject of Big Data and the Internet of Things, the authors state:

“Big data then comes from a variety of sources, in very large amounts, and often in real-time settings. This trend is largely driven by the pervasive diffusion and adoption of mobile devices, social media tools, and the Internet of Things (IoT) enabled by radio frequency identification (RFID) and other RF-related tracking and sensor devices... [I]t is generally believed that an Internet of Things will become ubiquitous in the coming decade, which will generate massive amounts of data that must be analyzed in order to generate value for individuals, organizations, entire industries, and ultimately society.”¹¹

(The Internet of Things refers to a network of objects interconnected through the Internet, such as the “wearables” previously discussed. Estimates of their numbers predict anywhere from 20 billion to 75 billion of those interconnected objects will be in use by 2020.¹²)

Of course, the mere collection of massive amounts of data does no good—the data must be analyzed, manipulated, and otherwise structured into a useable format in order to be worth anything. This is not a simple matter. As one researcher explained, data mining (sifting through and organizing the data at hand) “aims to discover previously unknown interrelations among apparently unrelated attributes of datasets by applying methods from several areas including machine learning, database systems, and statistics.”¹³ In the same paper, the authors note that “An organization willing to use analytics technology frequently acquires expensive software licenses, employs large computing infrastructure, and pays for consulting hours of analysts who work with the organization to better understand its business, organize its data, and integrate it for analytics.” Obviously, this is not an endeavor for the faint of heart (nor the weak in pocket)!

Are there solutions? Yes, of course, but they won’t necessarily be easy. Your Academy has formed a workgroup—the Innovative Payment and Practices Workgroup (IPPM)—to work on many of the issues facing physiatrists in these uncertain times. Members of IPPM include: Peter Esselman, MD (Co-Chair); Stuart Glassman, MD (Co-Chair); Steven Flanagan, MD; Benton Giap, MD; Anthony Lee, MD; Raj Mitra, MD; Robert Rondinelli, MD; Chris Standaert, MD; and Santosh Thomas, MD. In subsequent articles in *The Physiatrist* and in the *PM&R* journal, we will publish articles about innovative practice and payment models for physiatrists in general, as well as publishing some actual case studies of innovative work being done by some of your colleagues. At the AAPM&R 2015 Annual Assembly, one of the offerings will be the **AAPM&R Innovations in Spine Care Summit**, where some of your colleagues will talk about their experiences in designing a few different kinds of new models for spine pain interventions. And we would love to hear more from those of you (I know you’re out there!) who have dipped a toe in the whole value-based reimbursement model. AAPM&R aims to be a key resource for physiatrists as you wade into these turbulent waters. To do that well in an era of such rapidly changing forces, we need to be aware of what you are experiencing in “real life.” ♦

Visit aapmr.org/spinesummit to learn more about the Innovations in Spine Care Summit being held on Friday, October 2.

See page 9 for references.

Frank H. Krusen, MD

Elizabeth Sandel, MD, AAPM&R Historian



Frank H. Krusen, MD, the Academy's fourth president, delivered the first honorary Walter J. Zeiter Lecture at the AAPM&R Annual Assembly in 1969. His lecture, *Historical Development in Physical Medicine and Rehabilitation During the Last Forty Years*, chronicled the field's challenges and successes, the uniqueness of our contributions, and the opportunities ahead:

The development of our field over the last forty years has been so remarkable that last year I was able to report to our federal legislators that, "Research in rehabilitation medicine is a distinctive branch of scientific investigation, employing a unique body of knowledge, special techniques, and directed toward special goals...Rehabilitation medicine deals primarily with consequences of disease and severe trauma. Much of our research is devoted to a complex, many-faceted regimen of patient management. Such research is intensely demanding and is capable of producing more exact results that is usually assumed."

(Testimony presented to the U.S. Senate Subcommittee on Appropriations for Labor, Health, Education, and Welfare, June 26, 1967.)

In the 46 years since Krusen delivered these words at our Annual Assembly, we have greatly expanded our contributions to medical research and the practice of medicine. This year's Annual Assembly, *The Physiatry Experience: Success in a Changing Health Care Environment*, will be a celebration of these unique contributions. During the plenaries, President Kathleen Bell, MD; Doris Kearns Goodwin, PhD; Hugh Herr, PhD; and Stuart Altman, PhD (who will give the Zeiter lecture) will provide a larger historical context for the celebration. Don't miss it! ♦

Krusen FH. Historical Development in Physical Medicine and Rehabilitation During the Last Forty Years. *Arch Phys Med Rehabil* 1969; 1-5. <http://www.pmrjournal.org/content/historyarticles>.

Please contact Dr. Sandel if you have any interest in contributing to the history of AAPM&R and the specialty of PM&R: esandel@ucdavis.edu.

ERWIN G. GONZALEZ, MD

2015 Frank H. Krusen Lifetime Achievement Award

American Academy of Physical Medicine and Rehabilitation

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John Ditunno MD John Downey MD Alberto Esquenazi MD Steve Flanagan MD Gail Gamble MD Bruce Gans MD
Steve Geiringer MD Steve Gnatz MD Ronald Gonzalez-Segarra MD Robert Gotlin DO Martin Grabois MD
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In celebration, contributions were made to the **FOUNDATION FOR PM&R**

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The American Academy of Orthopaedic Surgeons' Evidence-Based Guideline on Treatment of Osteoarthritis of the Knee: Practice Implications on Viscoelastic Supplementation Injections

Thiru Annaswamy, MD; Mark Ellen, MD; and Richard Zorowitz, MD

In the October 16, 2013 issue of *The Journal of Bone & Joint Surgery* (American), the American Academy of Orthopaedic Surgeons (AAOS) published an Evidence-Based Guideline on Treatment of Osteoarthritis of the Knee. The Clinical Practice Guidelines Committee (CPGC) of the American Academy of Physical Medicine and Rehabilitation (AAPM&R) undertook a critical review of the guideline to determine whether the guideline could be endorsed, affirmed, or rejected for use by the membership of AAPM&R.¹ The CPGC felt that while the guideline was useful for practitioners who evaluated and managed patients with osteoarthritis of the knee, it did not agree with a recommendation that stated "We cannot recommend using hyaluronic acid (HA) for patients with symptomatic osteoarthritis of the knee (Strength of Recommendation: Strong)."² Your Academy voiced its concerns with regard to this specific recommendation during the peer review phase, and again after the guideline had been published; however, AAOS continues to stand behind the methodology/meta-analyses it used as the foundation for this recommendation. This negative recommendation also had additional implications, as the Academy's liaison to the AAOS Appropriate Use Criteria (AUC) Writing Committee for OA of the Knee wasn't even able to address this as an available treatment option for non-arthroplasty treatment of knee osteoarthritis. After much discussion, the CPGC affirmed, but could not endorse the guideline.

The recommendation in the 2013 guideline marked a significant change in practice from the previous guideline, published in 2008, in which AAOS issued a neutral recommendation for the use of viscosupplementation for the treatment of pain associated with knee OA. While many reviewers expressed their concerns about the 2013 recommendation, AAOS clarified that "The strength of this recommendation was based on lack of efficacy, not on potential harm..."

The methodology that AAOS used to create the guideline defined a **strong** positive recommendation as "the benefits of the recommended approach clearly exceed the potential harm, and/or that the strength of the supporting evidence is high..." On the other hand, a **strong** negative recommendation was defined as "the quality of the supporting evidence is high. A harms analysis on this recommendation was not performed."

We believe that the wording of the recommendation may have been constrained by the methodology. First, AAOS altered the language so that the recommendation reads "we cannot recommend using hyaluronic acid for patients with symptomatic osteoarthritis of the knee..." This syntax goes against the usual phrasing of "We recommend..." as stated on pg. 4 in the guideline.

Second, while the strength of the evidence was "high," figures 85–91 (pg. 847–853 in the guideline), in fact, demonstrated that the use of viscosupplementation in a majority of the studies demonstrated some benefit. The problem lay in the fact that many of the studies did not meet the threshold for "Minimal Important Difference (MID)" units,³ defined as "the average change between the treatment and control groups taking into account the degree of dispersion within each of the 2 groups..." As a result, the recommendation may have warranted a limited (the strength of the supporting evidence is unconvincing, or that well-conducted studies show little clear advantage to one approach over another) or an inconclusive (a lack of compelling evidence that has resulted in



an unclear balance between benefits and potential harm) strength.

Finally, AAOS concluded the recommendation by stating that "Future research using clinically relevant outcomes, sub-group analyses, and controls for bias are needed." This suggested that the recommendation could be influenced in either direction if new information was available. This is more consistent with a **limited** or **inconclusive** rating, rather than a **strong** rating, whose implication denoted that "a clear and compelling rationale for an alternative approach is present" for the recommendation to be changed.

Recently, the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS) published a draft report of a review of the evidence on intra-articular injections of HA in individuals with degenerative joint disease of the knee.⁴ The draft report concluded that there was a small and statistically significant effect of HA on function, but did not meet the minimum clinically important difference.⁴ The report further stated that no conclusions could be drawn from the

available literature on delay or avoidance of knee replacement (KR) through the use of HA.⁴ This 'inconclusive' evidence statement is a more appropriate reflection of the available evidence. The AHRQ draft report also recommended that large, randomized controlled studies were needed to more definitively answer the question regarding the efficacy of HA.

Viscosupplementation is used in clinical practice in a variety of scenarios and for a variety of appropriate, individually important, outcome measures. Some of these measures include: delaying knee replacement surgery, alleviating pain and improving function in patients in whom steroid injections are relatively contraindicated, alleviating pain and improving function in patients in whom other effective non-surgical interventions are unavailable, or have been tried without success. Research studies that looked at such outcome measures and viscosupplementation's ability to improve a patient's condition as evaluated by such outcome measures may not have been reviewed in this guideline because it was limited to a few outcomes.

The AAOS guideline acknowledged this issue by stating that “The lack of clinically significant outcomes in viscosupplementation treatment groups could be due to the inability to distinguish responders from non-responders. Additionally, it might be that current, widely used outcome measures are not broad enough in scope to detect such improvements as, for example, family reported gains in functional autonomy in patients who themselves report no effect.” Another issue might be the use of saline injection as a control group in these studies, because any fluid injection into a joint might alter the joint biomechanics resulting in some perceptible improvement to the patient. This may reduce the effect size of any treatment effect observable in an HA intervention group.

As a result of the recommendation, there have been reports that insurance companies now are denying coverage for injections of viscosupplementation. Considering the issues above and the implications of restricting the use of viscosupplementation for knee osteoarthritis, AAPM&R urged AAOS to consider amending the recommendation to be **limited** or **inconclusive**, rather than the **strong** recommendation of “not using” this treatment option. However, this guideline is now final. The impact that the guideline has on clinical practices

of individuals and institutions can still be modified, so as to allow for utilization of viscoelastic supplementation with appropriate justification in certain clinical scenarios.

Conclusions

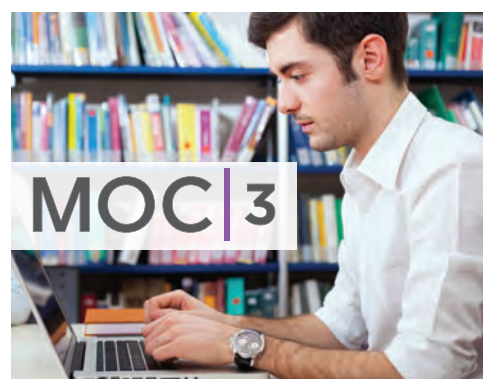
The AAOS evidence based clinical practice guideline “Treatment of Osteoarthritis of the Knee” that states that “We cannot recommend using hyaluronic acid for patients with symptomatic osteoarthritis of the knee (strength of recommendation: strong)” is limited by the methodology used in creating it. We recommend that individual clinicians and institutions not overly restrict and instead continue to consider the use of viscosupplementation for treatment of knee osteoarthritis, and to use appropriate evidence-based principles to make treatment decisions. Further research looking at clinically meaningful outcome measures and comparing viscoelastic supplementation products head-to-head to steroid and other injectable products might provide answers to clarify these questions. ♦

ACKNOWLEDGMENTS:

We acknowledge the valuable contributions and assistance provided by the AAPM&R Clinical Practice Guidelines and Evidence Committee members and staff, in the preparation of this manuscript.

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The Merit-Based Incentive Payment System (MIPS)—What Is It?

Kavitha V. Neerukonda, JD, MHA | AAPM&R Director of Quality & Research Initiatives

In April 2015, President Barack Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 or “MACRA,” Public Law No. 114-10. Generally speaking, MACRA ends physician payment incentives (and penalties) under the Meaningful Use program (MU), the Physician Quality Reporting System (PQRS), and the Value-Based Modifier (VBM)—replacing them with a new program called the Merit-Based Incentive Payment System or “MIPS.” MIPS intends to consolidate and strengthen the financial impacts of these programs while continuing each program’s respective performance measurement and reporting mechanisms. However, there will still be many complicated and continually changing Centers for Medicare and Medicaid (CMS) rules to follow, understand, and implement. Under MACRA, physicians will be able to opt out of the MIPS program if they participate in an alternative program involving slightly higher payments in return for participation in certain Alternative Payment Models, or “APMs.”

What’s the Timeline for Reporting?

For 2015 and 2016, physicians will continue to report the MU, PQRS, and be subjected to the VBM as separate programs. There is a 2-year lag from performance year to payment year. For 2015 reporting, incentives and penalties will be realized in 2017. For 2016 reporting, incentives and penalties will be realized in 2018. MACRA states that incentives and penalties for MIPS will begin in 2019. Based on past experience with MU and PQRS, the anticipated first performance year for MIPS will begin in 2017—making 2019 the year any payment adjustments will be made. CMS will define the performance years for MIPS in a final rule anticipated to be published at the end of 2016. This means a great deal of planning must be done prior to the final rule being published. One curious fact is that MU Stage 3, which is proposed to begin in the 2017 performance year, will only be measured under the MIPS program, due to the timing of its first performance year. The chart below—provided by the American Medical Association—describes the reporting year and penalties for the next 2 years as we transition to MIPS.

FFS Penalty Risks, Bonuses, Updates Compared

Year	Current Law				H.R. 2 PL 114-10		
	Max P4P Penalties	Max P4P Bonuses	Update	Sequester	Max P4P Penalties	Max P4P Bonuses	Update
2014	-2%	1.5%	0.5%	-2%	No change	No change	0.5%
2015	-4.5%	+4.89 VBM 2015 bonus	-21%	-2%	No change	No change	0.5% on 7-15
2016	-6%	VBM		-2%	No change	No change	0.5%
2017	-9% or more	VBM		-2%	No change	No change	0.5%
2018	-10% or more	VBM		-2%	No change	No change	0.5%
2019	-11% or more	VBM		-2%	-4%	4% (x3?) +10*	0.5%
2020	-11% or more	VBM		-2%	-5%	5% (x3?) +10*	0%
2021	-11% or more	VBM		-2%	-7%	7% (x3?) +10*	0%
2022	-11% or more	VBM		-2% (thru 2023)	-9%	9% (x3?) +10*	0%

Top bonus could triple if many physicians get penalties and extra \$ are available to increase bonuses. Exceptional Performers could earn another 10% funded with \$500m a year in new money.

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Who is Eligible for MIPS?

For the first 2 years of MIPS, the following Medicare Part B providers are eligible professionals:

- Physicians, physician assistants, nurse practitioners, clinical nurse specialists, and nurse anesthetists.

For the third and all following years, the subsequent providers become MIPS-eligible:

- Physical or occupational therapists, speech-language pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and dietitians or nutrition professionals.
- Some components of MIPS, such as PQRS, already support group reporting; however, other parts of MU do not. CMS final rules will need to define how group reporting will influence overall scores for MIPS.

Exclusions from MIPS

There are 3 exclusions of providers from MIPS eligibility:

- Providers participating in an APM, as defined by MACRA, are not subject to MIPS.
- CMS will define a low-volume threshold that includes a combination of minimum Medicare patients, service volume, and/or billings below, which a provider is excluded from MIPS.
- Providers who enroll in Medicare for the first time during a performance year are exempt from MIPS until the next subsequent performance year.

Public Reporting of MIPS

Each MIPS-eligible professional’s MIPS score will be available on the physician compare website. For the first time, consumers will be able to see their providers rated on a scale of 0–100, and how they compare to peers nationally. This level of transparency goes well beyond the current information available publicly about physicians.

How MIPS Consolidates MU, PQRS, and the VBM Programs

MIPS simplifies the application of incentives and penalties for the MU, PQRS, and VBM programs while continuing to measure performance as specified by each of the 3 programs. Total scoring for MIPS will range from 0–100. Eligible professionals will receive scores under 4 MIPS categories:

- MIPS Meaningful Use (MU) Category Score:** An eligible professional can earn a maximum of 25 points for complying with MU requirements in the performance year.
- MIPS Quality Category Score (PQRS):** An eligible professional can earn a maximum of 30 points for meeting mandatory PQRS quality reporting requirements and the VBM quality measures.
- MIPS Resource Use Category Score:** The MIPS resource use category score (maximum 30 points) will be determined by the VBM cost measures.
- NEW MIPS Clinical Practice Improvement Performance Category Score (maximum 15 points):** This category is not yet fully defined by CMS, and likely will not be until the final rule is published in 2016. CMS will solicit recommendations from stakeholders to identify activities, in at least the following categories, to satisfy this requirement: Expanded Practice Access, Population Management, Care Coordination, Patient Safety and Practice Assessment, and Participation in APMs. Although this is a broad list, MACRA states that an eligible professional in a practice certified as a patient-centered medical home (PCMH) or “comparable specialty practice” will then be given a maximum score of 15 for the practice improvement category. Or, MACRA states, if the eligible professional participates in an APM, then the minimum score must be 7.5 and not 0 for this category, therefore giving APMs a slight advantage in the overall MIPS scoring. ♦

Quality Reporting Tied to Payment for 2015 and Beyond

Kavitha V. Neerukonda, JD, MHA | AAPM&R Director of Quality & Research Initiatives

Physical medicine and rehabilitation (PM&R) is a top 5 specialty to receive an upward adjustment for the 2015 Value-Based Modifier (VBM) Program. In June 2015, the Centers for Medicare and Medicaid Services (CMS) published the 2015 Value-Based Payment Modifier Program (VBM) Experience Report releasing the top 5 specialties receiving an upward and downward adjustment. PM&R ranked as a top 5 specialty and will receive an upward adjustment along with gastroenterology, dermatology, endocrinology, and obstetrics/gynecology. The VBM Program is designed to reward higher quality care delivered at lower cost tied to performance in the Physician Quality Reporting System (PQRS). In January 2015, CMS began applying the Value-Based Payment Modifier (VBM) to physician payments under the Medicare Fee Schedule for performance in the 2013 calendar year. Physicians in groups with 100 or more eligible professionals¹ had the option to elect to have their VBM calculated using the quality-tiering method where their 2015 Medicare Part B payments could be adjusted upward, downward or remain unchanged depending on their performance on quality and cost measures in 2013. The quality and cost measures reported through the Physician Quality Reporting System are the only measures used to calculate the VBM. CMS reports that performance on quality drove differences in payment adjustments under quality-tiering than did performance on cost.

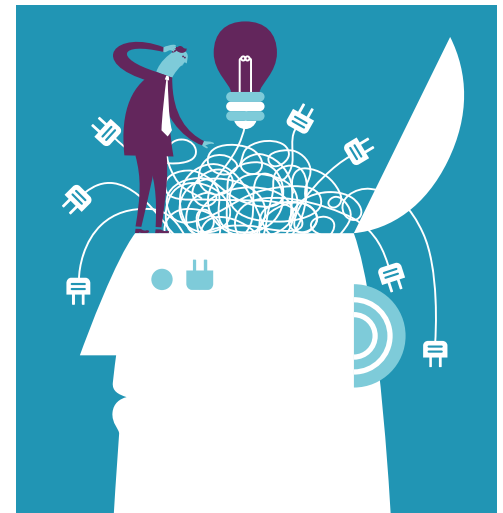
Among the physician groups receiving an upward adjustment, these groups were more likely to report PQRS through the CMS Group Reporting Web Interface or a qualified registry. These groups were also more likely larger, with more physicians than non-physicians, with more attributed beneficiaries per physician, and with physicians more likely to treat lower-risk beneficiaries than groups that received a neutral or downward payment adjustment.

“PM&R RANKED IN THE TOP 5 FOR RECEIVING UPWARD PAYMENT ADJUSTMENTS UNDER THE PQRS AND VBM PROGRAMS IN 2015 BASED UPON 2013’S PERFORMANCE.”

The PM&R physician groups receiving the upward adjustment are among the few that, besides registering for the PQRS Group Reporting Option and meeting the minimum reporting options for PQRS in 2013, elected quality-tiering and scored among the higher-performing groups—meaning at least average performance on quality and cost measures and better than average performance on quality, cost or both. Of note, PM&R Group Practices, along with the other top specialties, scored among the best for high quality and low cost, especially for the administrative claims-based quality outcomes measures included in the care coordination domain of the PQRS program.

While PM&R physicians in large group practices fared well in the 2015 VBM Program, quality-tiering was optional and the number of PM&R physicians effected by this is small. In the current 2015 reporting year subject to the VBM in 2017, quality-tiering is not optional and all eligible PM&R physicians will be effected by quality-tiering. This CMS report shows reporting via a registry or other web-interface results in better scores, likely due to automatic checks and balances to assure data submitted to CMS is accurate. It also shows that PM&R physicians are scoring among the highest for care coordination—an area the specialty has an opportunity to be a national leader in. Finally, it shows that PM&R physicians can report successfully and potentially receive an upward adjustment under the PQRS and VBM programs as they currently stand. However, the opportunity still exists to develop PM&R-centric outcome measures to highlight the uniqueness of the specialty and how it improves the outcomes of the patients it serves. ♦

¹ Eligible professionals consist of physicians, practitioners, physical or occupational therapists, quality speech-language pathologists, and qualified audiologists.



Use PQRSwizard® to Report Your Quality Data

PQRS **Measures Groups** are now open for 2015 registration. Visit the Academy's website (www.aapmr.org/PQRS) to learn more about PQRS (Physician Quality Reporting System) and the PQRSwizard®—the Academy-Sponsored PQRS Registry Reporting Vendor.

Utilize Your Academy's PQRSwizard® Tool

Save time and report your quality data through the PQRSwizard®, the most efficient method of reporting data. This web-based approach offers an easy, step-by-step wizard to help you quickly validate and submit your quality data to the Centers for Medicare & Medicaid Services (CMS) for incentive payment.

By utilizing PQRSwizard® for your reporting needs, you benefit by:

1. Receiving discounted access as an AAPM&R member
2. Reporting data retrospectively on PQRS measures



You have until **February 26, 2016** to avoid up to a **4% penalty**.

Visit aapmr.pqrswizard.com to learn more and start reporting.

Be sure to check out the 2015 PQRS Measures for Psychiatry PDF at aapmr.org/pqrs.

Concussion SAE-P Now Available!

AAPM&R has created a new Self-Assessment Examination for Practitioners (SAE-P) focused on concussions and mild traumatic brain injury.

This SAE-P offers 8 AMA PRA Category 1 Credits™ and helps fulfill your ABPMR MOC Part II Requirement.

Members receive 30% off! Visit me.aapmr.org to learn more.

EAST

Brick, NJ: Staff Physiatrist (Inpatient & Outpatient)—Shore Rehabilitation Institute (SRI) is an acute rehabilitation hospital located in Brick, NJ and comprised of 40 acute inpatient rehabilitation beds and outpatient services. SRI is a JV between Meridian Health and JFK Health. SRI is seeking a full-time Physiatrist to join an established Physiatry group with academic affiliations at UMDNJ. Responsibilities include inpatient management and outpatients at SRI and consultation services. Botox/Baclofen experience is preferred. Please contact: Donna McCourt; P (732) 836-4530; F (732) 836-4531; Email: dmccourt@meridianhealth.com.

Englewood, NJ: A well established orthopaedic practice is looking for a motivated BC/BE PM&R physician to lead our pain management program. PM&R physician will be responsible for initial patient assessment and management of non-surgical care including medical pain management. Practice is located in northern New Jersey less than 10 miles from Manhattan with hours Monday through Friday. Excellent salary and benefits. Email: ksheridan03@hotmail.com.

Marion, VA: Smyth County Community Hospital (SCCH) and Mountain States Medical Group (MSMG), located in beautiful Marion, Virginia, are currently seeking an experienced, board certified, physical medicine and rehabilitation (physiatrist) medical director to work full-time in the SCCH In-Patient Rehabilitation (IPR) unit. The PM&R medical director must have a strong interest in patient-centered commitment to excellence. Candidate must also possess excellent interpersonal and communication skills with a desire to market the facility to local providers, case managers and patients. 35–40% of medical director's time will be spent doing necessary physician-to-physician marketing. The remaining 60–65% of time will be providing direct medical care to the patient's on the IPR Unit. Hospital-based physiatrist experience preferred but not required. Other responsibilities include: interest in stroke and neuro-rehabilitation as well as medically complex patients (with hospitalist support). Ability to work with SCCH rehabilitation team, including physician and/or advanced practitioner. Desire to be a positive contributor to local and system medical community. Desire to live locally and be a part of the thriving community of Marion, Virginia. Familiarity with evolving rules and regulations that affect rehabilitation. Primary focus of patients will be on stroke rehabilitation and others include: medically complex patients, hip fractures, amputees and trauma patients. Incentives: competitive annual salary, generous sign-on bonus, relocation and educational loan assistance, paid malpractice, full benefits, CME, and PTO. Please contact us to discuss schedule and call details. Please contact: Tina McLaughlin, CMSR, MSHA Senior Physician Recruiter, NE Market (JMH, RCMC and SCCH); O (276) 258-4580; mclaughlint@msha.com. View online job tour: www.mshajobtour.com/smyth.

Morgantown, WV: Physiatrist to join a well-established independent private practice with 25 years of experience that includes a caseload of medically complex inpatient rehabilitation patients. No nights and minimal weekend workdays. Excellent pay and benefits offered. The candidates should possess the following qualifications: advanced medical training with MD or DO, B/E or B/C in physical medicine and rehabilitation, WV license to practice medicine, or ability to obtain license, demonstrable experience with program development, leadership skills and ability to build a team to advance the practice. About Morgantown, WV—located in the north central region of West Virginia, Morgantown offers the cultural diversity and amenities of a large city in a safe, family-friendly environment. It is a unique setting with strong influences from West Virginia University (home to the state's largest medical school and level 1 trauma center). The Mon. Co. area is home to nearly 150,000 residents with approximately 30,000 students attending WVU. Close to Pittsburgh (74 miles) and Washington, DC (206 miles). Contact Candace DaFonzo at biundo@biundomedica.com or send CV with cover letter to Russell Biundo, MD, Inc., 1160 Van Voorhis Rd, Morgantown, WV 26505, or email.

Newtown, PA: BC/BQ physiatrist to join established private practice in Bucks County, PA. Candidate must have focus on inpatient care and interest in stroke, brain injury, and/or neurorehabilitation. Inpatient services provided at JCAHO-accredited 50-bed rehabilitation hospital; consultations at 373-bed hospital/regional trauma center and subacute SNF's. Outpatient practice includes: general musculoskeletal, EMG/NCV, non-spinal injections (ultrasound-guided), and non-surgical pain management and spine care. Offering competitive compensation and benefits package including pension plan, health, dental, life insurance, and malpractice. Salary plus incentive. Great potential for motivated individual with excellent interpersonal skills to join a well-respected, patient-centered practice of 1 MD and 1 NP. Interested candidates should email resume and cover letter to manager@bucksrehabilitationsspecialists.com.

New York, NY: Growing multi-discipline orthopaedic Manhattan based group seeking an experienced board eligible or board certified physiatrist to serve in a key role and provide high quality patient care. Epidural (lumbar and cervical) training preferred. Start date August 2016. Competitive salary based on experience. Health benefits and 401(k) plan available. If interested please send CV to pthaler@highlineortho.nyc.

MIDWEST

Green Bay, WI: Great opportunity to join a physician-owned and led multi-specialty group. The current department consists of 6 board certified physical medicine and rehabilitation physicians. The practice will encompass the full spectrum of general physical and rehabilitative medicine with mostly outpatient clinics, multidisciplinary spine care and pain management, EMG's and injection opportunities available, but not required. Small amount of inpatient rehab with shared call schedule of approximately 1:6. Contact Information: Dolly Willems, Physician Recruitment (888) 277-3832 ext 1182; dolly.willems@prevea.com; www.joinprevea.com.

OH: Looking for an interventional or a musculoskeletal (MSK) noninterventional BE/BC physiatrist to join a rapidly growing outpatient multidisciplinary musculoskeletal/pain practice located in northeastern Ohio. The ideal candidate has excellent communication skills, is a team player and has an interest in MSK/pain medicine and EMG/NCVs. We are a private practice group with a hospital affiliation. Excellent benefit package and bonus potential. Please contact bmehtamd5@gmail.com for more information.

WI: Midwest physiatry opportunity. No call, heavy EMGs and minimal pain. This is an attractive outpatient practice that will work in collaboration with a busy, 4-physician orthopedic group as well as our primary care team. While current demand will enable you to hit the ground running, there is also potential to grow the back pain and/or sports medicine component if you wish. Full-time; 36 patient hrs/week. No call schedule, no nights or weekends. Primarily non-operative musculoskeletal cases. Heavy EMG panel. Will have the support of a neurologist and a pain medicine physician. Ideal locale for an outdoor enthusiast. Located in a popular Wisconsin vacation destination that is surrounded by crystal-clear lakes, stately forests and miles and miles of hiking, biking, snowmobile and ski trails. With Ministry Health Care, you will enjoy leading edge technology, state-of-the-art facilities, a collaborative work environment, a lucrative compensation package and most importantly...balance. But don't just take our word for it, hear it from our clinicians at www.ministryhealth.org/recruitment. For more information contact Brad Beranek at (715)342-7998 or mmgrecruitment@ministryhealth.org.

WEST

Boise, ID: Idaho Physical Medicine and Rehabilitation is seeking a board certified/board eligible physiatrist to join its well established and highly respected practice. This is a great opportunity to join a busy private rehabilitation practice in Boise, Idaho. The majority of our patients have acute/sub-acute injuries. IPMR has 2 outpatient clinics in the region and an ambulatory surgery center. In addition, we staff the rehabilitation unit at St. Luke's Rehab Hospital. Boise is a lovely medium-sized community, the center of the gem state with breathtaking scenery within an easy drive to world class outdoor activities, not to mention an affordable cost of living and a wonderful place to raise a family. Established in 1984, IPMR consists of 7 board-certified physiatrists and is locally recognized for the delivery of physical and rehabilitative medicine. We are expanding the scope of our practice to better meet the needs of our hospital partners and community. We offer a competitive compensation and benefit package. If you'd like to be part of an extraordinary team, please send your resume to: Michael Sant MD, CEO. Email: admin@idahopmr.com. Website: www.idahopmr.com.

Phoenix, AZ: The Orthopedic Clinic Association, PC (TOCA) in Phoenix, has an opening in Dr. Christopher Huston's Interventional Fellowship Program for the fall of 2016. Salary and benefits competitive. Potential partnership opportunity at the end of the fellowship program with ancillary service revenue and surgery center ownership available. Interested applicants please send your CV and personal statement to chuston@tocamd.com.

Phoenix, AZ: The Orthopedic Clinic Association, PC (TOCA) in Phoenix, has an immediate opening for a Fellowship trained non-operative musculoskeletal or sports medicine physiatrist. Expertise in interventional ultrasound is a requirement for this position. Salary and benefits competitive. Partnership track available. No level 1 call. Email: elederman@tocamd.com.

Phoenix, AZ: The Orthopedic Clinic Association, PC (TOCA) in Phoenix, currently has an immediate opportunity for a physical medicine and rehabilitation physician with a fellowship in interventional spine. Guaranteed salary and partnership track. No level 1 call. Opportunity available for ancillary service revenue and surgery center ownership. Email: elederman@tocamd.com.

SOUTH

Atlanta, GA: Growing metro Atlanta 9 provider PM&R practice seeks BC/BE full-time physician to grow existing outpatient practice. Excellent salary and benefits including paid time off, CME, health insurance, and 401(k) plan. Georgia license a must, interventional not required, must be able to handle high daily patient volume. Aprima EMR system experience a plus. Send CV in confidence to: Fax (770) 399-9449 or email practiceadmin@attackback.com. Visit: www.attackback.com for more information on our practice. ♦



KEIPERSPINE™

Established Spine Neurosurgical practice seeking ABPM/ABMS Interventional Physiatrist.

This position will include both office-based and interventional pain management of the impaired spine. New patient consultations, EMGs, other office-based pain management services. Referrals for screening and consultations come from KeiperSpine neurosurgeons, and other community physicians.

Contact: info@keiperspine.com.

HEALTH POLICY NEWS AT A GLANCE

*The Latest News on Academy Action***QUALITY** (Continued from page 16)

- On July 29, 2015, your Academy joined 13 other medical specialty societies in sending a letter to Elise Berliner, PhD, director of the Agency for Healthcare Research and Quality's (AHRQ) Technology Assessment Program. The letter addresses concerns regarding the recently published AHRQ technology assessment *Pain Management Injection Therapies for Low Back Pain*, requesting that due consideration be given to these concerns, and that several aspects of the report be revisited to ensure that the best available evidence is addressed scientifically in order to provide an accurate assessment of the procedures reviewed. Your Academy thanks Scott Horn, MD and Annie Purcell, MD for representing AAPM&R in this effort.
- The AAPM&R Clinical Practices Guidelines Committee reviewed 2 guidelines from the American Academy of Neurology: Etanercept for Post-Stroke Disability and Botulinum Neurotoxin for the Treatment of Blepharospasm, Cervical Dystonia, Adult Spasticity, and Headache Guidelines.
- Dr. Subhadra Nori will represent your Academy on a CMS/RTI technical expert panel looking at developing a discharge to community measure for the post-acute care settings.

- Dr. Steven Flanagan will co-chair the American Academy of Neurology's Stroke and Stroke Rehab Measure Update Work Group. Dr. Richard Harvey will represent your Academy as a member of this work group.
- The National Quality Forum is soliciting committee members to develop/update pediatric quality measures. The Evidence-Based Practice Committee has deemed this a priority activity and is working to identify Academy representatives for this committee.
- The National Quality Forum is soliciting nominations for their Disparities Standing Committee which will look at risk adjustment of performance measures for socioeconomic status (SES) and other demographic factors. The Evidence-Based Practice Committee has deemed this a priority activity and is working to identify Academy representatives for this committee.
- The AAPM&R Evidence Committee is reviewing evidence related to the American College of Occupational and Environmental Medicine (ACOEM) low back and neck pain guideline recommendation for injection therapy.





aapm&r

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ORGANIZATION
U.S. POSTAGE
PAID
PERMIT NO. 6585
CHICAGO, IL 60601

Published 10 times a year as a service to
the members of the American Academy of
Physical Medicine and Rehabilitation.

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Subscription rate for members is \$20,
which is included in the dues.

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HEALTH POLICY NEWS AT A GLANCE

The Latest News on Academy Action

REIMBURSEMENT

- Your Academy is reviewing and working on comments on the Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016. Comments will focus on the role of physiatrists in chronic care management and changes to the incident-to definition. Comments are due to CMS on September 8.
- On July 20, your Academy attended the Complex Rehab Technology (CRT) Exposition and Demonstration, Promoting Independence for People with Disabilities: Educational Display of Individually-Configured Complex Rehab Technology, which was hosted by the United Spinal Association, the National Multiple Sclerosis Society, and the National Coalition for Assistive and Rehab Technology (NCART), in coordination with the offices of Representatives Jim Sensenbrenner and Joe Crowley. We spoke with members of Congress and congressional staff on the importance of CRT and the benefits it provides to people with disabilities and the restrictions competitive bidding would have on these products.
- On July 29, your Academy attended a discussion session with CMS, hosted by the American Medical Association, to discuss the Agency's proposed quality changes for CY-2016, including the addition of utilization data to the Physician Compare website and changes to the value-based payment modifier program.
- On August 5, your Academy attended a discussion session with CMS, hosted by the American Medical Association, to discuss the Agency's proposed payment policy updated for CY-2016, including the addition of the trigger point codes to the misvalued codes list, a change in the definition of incident-to, and support of additional care coordination codes.
- Your Academy reviewed and prepared a comment letter on a proposed new Local Coverage Determination (LCD) on lower limb prostheses from all 4 of the Medicare DME contractors (meaning it will be effective across the nation). The proposed LCD has some troubling changes and limitations.
- Your Academy has been invited to participate in an AMA-convened work group to discuss implementation of the alternative payment model provisions of the Medicare Access and CHIP Reauthorization Act (MACRA). The inaugural meeting will be held this month.

LEGISLATION

- Your Academy is actively participating in congressional office visits in support of *Enhancing the Stature and Visibility of Medical Rehabilitation Research at the NIH Act* (S. 800 & H.R. 1631). Recent efforts have focused on members of the House Ways & Means Health Subcommittee. This bipartisan piece of legislation seeks to improve, coordinate, and enhance medical rehabilitation research at NIH. NIH conducts and supports approximately \$300 million in rehabilitation research annually, \$70 million of which is supported by the National Center for Medical Rehabilitation Research (NCMRR).
- Three bills have recently been introduced that offer various proposals for Medicare bundled payments for integrated care in both acute and post-acute care settings. The 3 bills take different approaches to bundled payments and direct the (HHS) Secretary to develop requirements for qualified entities to receive bundled payments. A qualified entity is a corporation, partnership, or limited liability company (LLC) that is authorized by a group of providers of services and suppliers. Your Academy is currently reviewing and analyzing the bills and reaching out to congressional offices and advocacy partners to discuss the different approaches presented in each of the bills.

STATE ADVOCACY

- In August, your Academy attended the AMA-convened State Advocacy Roundtable, which included attendees from 35 state medical associations and 26 national medical specialty organizations. Topics included the opioid epidemic, telemedicine, employed physicians, Medicaid managed care, and strategies for protecting the physician-patient relationship.
- The Council of Society Presidents & CAC Representatives Meeting at the 2015 Annual Assembly in Boston will be held on Saturday, October 3, from 4 pm–5:30 pm.

QUALITY

- Dr. KR Poduri will represent your Academy on a CMS technical expert panel looking to develop a Drug Regimen Review measure for the post-acute care settings.
- Dr. Robert Werner will represent your Academy on the AAOS Appropriate Use Criteria (AUC) Writing Panel for carpal tunnel syndrome.
- Your Academy hosted a PQRS webinar on July 17, 2015. The archived webinar can be found at aapmr.org/webinars.

(Continued on page 15)

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