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

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 quintessential concept that is more than just quantifying 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.

Additionally, because the AAPM&R Registry is designated a CMS quality, specialty-specific measure 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.

Marc E. Duerden, MD, FAAPMR
Dr. Duerden is President of the American Society of PM&R and a member of the AAPM&R Council of Multiple Societies Presidents. This article represents the professional opinions of Dr. Duerden and are not the official positions of either organization. Indiana Medical Examinations, the Centers for Medicare and Medicaid Services, or Anthro. 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.

“A 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 grayly skeleton, appeared and said to him: “I hear you call me, what do you want from me?” 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 want to be granted.

For years, medical regulation agencies have asked Congress to write legislation to increase 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 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 contractors by having an informational 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 contractors 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 request. The LCD request to support 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 will be 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 LCD meetings are open to the public. The Medicare contractors will publicly present the language that the requestor wants to be in the new LCD. The requestor must present a written LCD request and have this sent to the Medicare contractors 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 request. The LCD request to support 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 will be in an advisory capacity to review the medical evidence when the possible LCD is being developed or discussed.

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