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All Medicare fees are par, office, national unless otherwise noted.

PBN Perspectives

As practice laws loosen, nurse practitioner wave rolls across the U.S.

By nearly any metric, these appear to be boom times for nurse practitioners: Their ranks are growing, salaries are up and job searches are through the roof.

Essentially, the demand for nurse practitioners has never been higher. The number of employer-led searchers for nurse practitioners increased 61% over the last calendar year, according to the *2018 Review of Physician and Advanced Practitioner Recruiting Incentives* from search and recruiting firm Merritt Hawkins in Dallas.

*(see **PBN Perspectives**, p. 3)*

Quality Payment Program

7 ways to use MIPS data and scores to change your 2018 success strategy

Data from your 2017 performance in the merit-based incentive payment system (MIPS) is now available and more is on the way. Use the information to improve your performance and your score in 2018.

CMS released MIPS Preliminary Performance Feedback Data on June 7 for those providers and groups taking part in the MIPS part of the Quality Payment Program (QPP). This data is available via your Enterprise Identity Management (EIDM) credentials at the QPP portal. And in July, CMS is

*(see **MIPS**, p. 6)*

Compliance

New CMS request for information suggests changes coming to Stark Law

A request for information (RFI) from CMS asks stakeholders about enforcement of the physician self-referral law in certain delivery models — and appears to be part of a trend toward Stark reform in the agency.

The RFI, "Medicare Program; Request for Information Regarding the Physician Self-Referral Law," is focused on Stark Law aspects preventing physicians from making referrals that are self-dealing — that is, designed to increase their own revenue, either directly or indirectly. CMS' specific issue, as stated in the RFI, is "the effect the physician self-referral law may have on parties participating or considering participation in integrated delivery models, alternative payment models (APMs) and arrangements to incent improvements in outcomes and reductions in cost."

To that end, CMS asks about the effects of the self-referral law on coordinated-care arrangements, such as those in which "a bundled payment from a payor for all hospital and physician services is split between a hospital and physicians based on a predetermined percentage" and "physician incentive payments are available for achieving predetermined metrics" and how it might be altered or the arrangements indemnified to reduce negative effects.

The purview of this RFI would seem to be entities such as APMs and accountable care organizations (ACOs), but Hill-watchers don't expect CMS to stop there. A top D.C. health care attorney who works with the agency and spoke on the condition of anonymity tells *Part B News* that "based on conversations I've had with folks who work at HHS and CMS, … I think they are interested in wider changes. [HHS Secretary Alex] Azar has told me he would love to make significant changes to Stark."

The attorney notes that some questions in the RFI ask readers to "share your thoughts" on the concepts of "'commercial reasonableness," "fair market value" and "take into account the volume or value of referrals" in the physician self-referral law, with no reference to the care-coordination context and conceivably applicable to other arrangements. On those issues, the attorney says, his own firm has argued for more definite standards that would leave providers less vulnerable to judges' subjective interpretation of the law.

Neal D. Shore, M.D., FACS, president of the Large Urology Group Practice Association (LUGPA), says his organization "commends CMS for its efforts to address the barriers created by outdated Stark and anti-kickback laws that prevent physicians from developing value-based care models in line with the transition to a value-based care system."

Comments are due on the RFI by Aug. 24 via *www.regulations.gov*. — *Roy Edroso (redroso@decisionhealth.com)*

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Resource:

- Medicare Program; Request for Information Regarding the Physician Self-Referral Law: *www.federalregister.gov/documents/2018/06/25/2018-13529/medicare-program-request-for-information-regarding-the-physician-self-referral-law*

Ask Part B News

Medicare Advantage plans follow CMS' lead on modifier FY for imaging services

Question: *Modifier* ***FY*** *is now required per CMS for any X-ray taken using computed radiography technology/cassette based imaging. Does anyone have any information about whether the Medicare Advantage plans are following this guideline as well?*

Answer: You're right — on Jan. 1, CMS began requiring the use of modifier FY (X-ray taken using computed radiography technology/cassette-based imaging) with traditional imaging codes (*PBN 11/13/17*). When processed, the modifier reduces payment for the technical component of the code by 7% between 2018 and 2022, and that number jumps to a 10% reduction in 2023 and beyond.

The goal behind the pay reduction is to spur providers to switch to digital radiography technology, and it appears payers outside of traditional Medicare are picking up the policy, as well. "It is my understanding that the Medicare Advantage plans are following the same rules regarding the Imaging and modifier FY," says Margie Scalley Vaught, CPC, a consultant based in Chehalis, Wash.

As proof, a *Part B News* review turned up multiple instances of Medicare Advantage and commercial carriers announcing that they would adhere to the FY reporting requirements, suggesting the policy change is widespread. Humana, for example, announced that its "plans require providers to follow the appropriate Medicare program guidance for correct coding using modifier FY," according to a December 2017 policy update.

"Providers must append modifier FY to a procedure code for an X-ray service furnished using CR technology," states the policy document, which applies to all Medicare Advantage, commercial insurance and Medicare-Medicaid dual-eligible plan offerings.

Others appear to be limiting the policy to specific plans. Blue Cross Blue Shield (BCBS) of Tennessee announced it would implement the FY policy, although the plan is applying the policy change only to Medicare Advantage members. "Claims for all other lines of business will require these modifiers for informational purposes only," says BCBS Tennessee.

You should check with your regional payers to see whether they're adopting the policy. Chances are your Medicare Advantage payers are — and are withholding payment like CMS — although your commercial plans may be less consistent. — *Richard Scott* (*rscott@decisionhealth.com*)

Resources:

- Humana policy: *www.humana.com/provider/support/claims/payment-policies*
- BCBS Tennessee policy: *www.bcbst.com/providers/bluealert/index.page*

PBN Perspectives

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"That's not a normal number," says Travis Singleton, Merritt Hawkins executive vice president. "It's been on a huge arc."

Ample challenges remain with the American health care system over the next decade: Total spending is on pace to soar from $3.5 trillion in 2018 to $5.7 trillion by 2026, gobbling up just shy of 20% of U.S. gross domestic product. Despite the spending growth, a massive physician shortage is projected to leave the country with as many as 120,000 vacancies by 2030, according to the Association of American Medical Colleges.

The readiness of nurse practitioners to fill any gaps, however, does not appear to be one of those challenges. About 248,000 nurse practitioners toil within the U.S. health care system, a significant increase in licensed professionals over the past decade. It's more than double the 120,000 nurse practitioners who were licensed in 2007, according to data from the American Association of Nurse Practitioners (AANP).

Over the next decade, about 68,000 new nurse practitioners are expected to enter the workforce, further expanding the ranks, says David Wolfe, founder and CEO of recruiting firm NP Now in Charleston, S.C.

Compensation is catching up to demand. Average salaries in 2018 hit an all-time high of $129,000, according to the Merritt Hawkins review, and employers are upping their recruiting incentives, offering an average signing bonus of nearly $12,000.

The increase in nurse practitioners could be a salve for many regions, particularly rural areas that are bearing the brunt of low access to health services on account of physician and other health professional shortages. A recent study from University of Michigan researchers found that nurse practitioners are increasingly likely to operate in underserved and low-income regions. Specifically, the availability of nurse practitioners was 50% higher in counties with the worst health rates than areas with healthier individuals, according to the study appearing in the *Journal of General Internal Medicine.*

Most of NP Now's recruiting efforts for nurse practitioners occur in rural settings, Wolfe says. "About 10 years ago, nurse practitioners really began to rise in rural health care," he adds.

Under the scope: Scope of practice laws

Every state has its own set of regulations governing the autonomy of nurse practitioners and whether they can practice independently or prescribe medications, among other things. In 2017, Illinois and South Dakota passed laws granting nurse practitioners full practice authority, which essentially eschews collaborative practice agreements or supervision requirements that nurse practitioners otherwise would have to engage in with physicians.

To date, 22 states and Washington, D.C., grant nurse practitioners full practice authority, enabling them to "evaluate patients; diagnose, order and interpret diagnostic tests; initiate and manage treatments — including prescribing medications and controlled substances — under the exclusive licensure authority of the state board of nursing," as AANP describes it.

"We're seeing this continued trend of recognizing that it doesn't make sense to legally restrict nurse practitioners," says Tay Kopano, vice president of government affairs with AANP in Washington, D.C.

Many full-practice states are located in the West or Southwest where the "access issue is pretty acute," says Robert Ramsey, attorney with Buchanan, Ingersoll and Rooney in Pittsburgh. Indeed, most of the western half of the nation offers full scope of practice, with just a handful of states granting full practice east of the Mississippi. As the number of full-practice states has grown from 14 in 2010, the trend line remains fairly clear. "I don't see it going in the other direction," Ramsey says.

Nurse practitioners are increasingly striking out on their own, too. About 8,000 nurse practitioner-led practices were operating in 2017, a 100% increase over a two-year period, according to AANP survey statistics. States with full practice authority hold twice as many privately owned practices than states with restrictive laws.

Not all groups support expanded scope of practice efforts. In the fall of 2017, the AMA adopted a resolution calling for a national strategy that would "effectively oppose the continual, nationwide efforts to grant independent practice to non-physician practitioners." In a statement about the resolution, the AMA cited "patient health and safety" as driving factors behind its opposition.

At the time, Joyce Knestrick, Ph.D., president of AANP, said the AMA's resolution "undermine[d] patient choice, access and true coordinated care." Any disagreements between the groups have been quiet since late 2017.

Filling key gaps in care

Several recent studies offer evidence that expanded authority could help crack some of the pervasive challenges plaguing health care. A proposal from The Hamilton Project, an economic policy arm of the Brookings Institution, released in June studied the effects of scope of practice laws on health spending and efficiencies within the health care system. The authors noted that scope of practice "requirements limit the ability to use labor inputs in the most efficient ways possible, raising costs without any corresponding improvement in quality of care."

The question of granting full practice authority "is tremendously economically consequential," says Ryan Nunn, M.D., policy director for The Hamilton Project. One study shows that loosening restrictions on nurse practitioners, and thereby increasing access to the medical practice setting, would save the nation more than $540 million per year in emergency room fees that could otherwise be avoided.

A separate study looks at the quality-of-care issue through the specific lens of diabetes management. Often, groups opposed to fewer restrictions on practice authority cite quality care as a potential obstacle. To find out whether a patient's level of care differed by type of provider, researchers from Yale School of Medicine looked at the long-term management of patients with type 2 diabetes. They assessed several metrics, including blood-glucose levels and medication use, and stratified the results depending on the provider — either a physician, nurse practitioner or physician assistant. Ultimately, they

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Benchmark of the week

Outside of E/Ms, surgical team and injections, NPPs have denial trouble

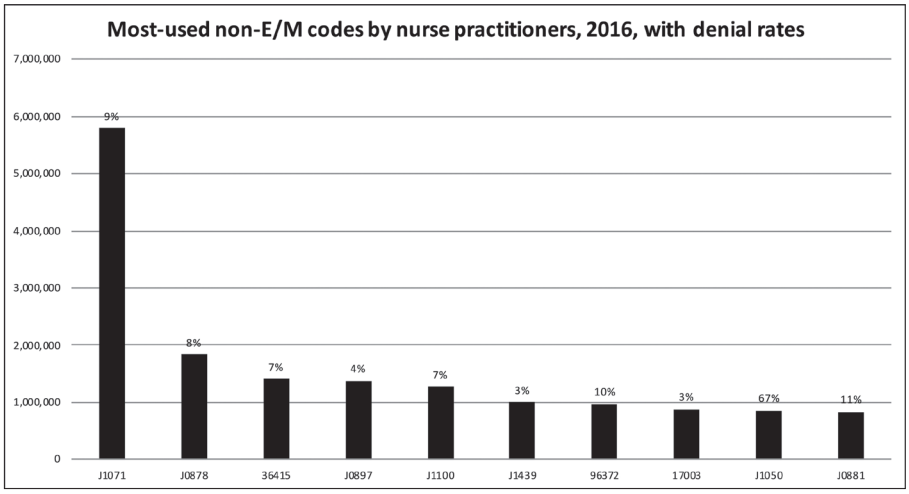
Non-physician practitioners (NPPs) have lower-than-average denial rates on E/Ms, but our analysis suggests they have trouble with other types of codes.

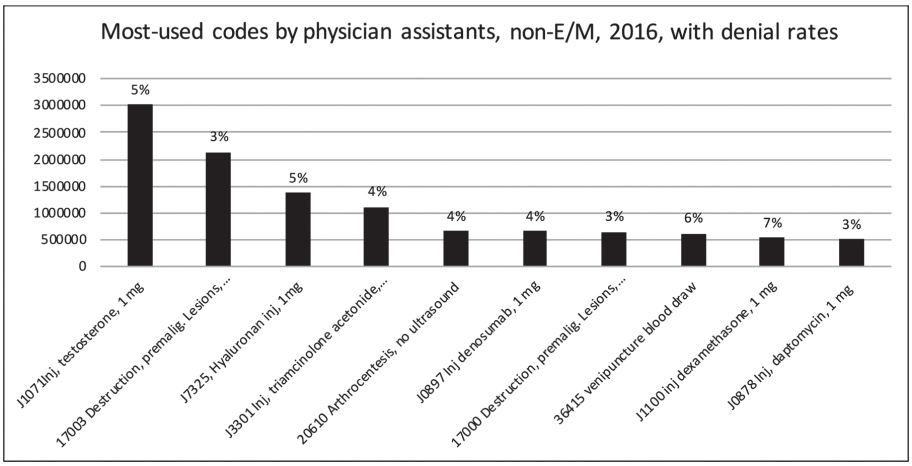
NPPs have increasingly been claiming E/M codes under their own national provider identifiers in recent years. In 2016, the most recent year of Medicare data available, major specialties performed fewer E/Ms while nurse practitioners (NPs) and physician assistants (PAs) performed more of them (*PBN 1/8/18*). NPPs had pretty good denial rates with E/Ms — the denial rate on **99201** for all providers, for example, was 34%, and for 99211 it was 13%, but for NPs the rates were 16% and 15%, respectively, and for PAs it was 10% for both.

For the 10 office outpatient E/M codes (99201-**99215**), the overall denial rate was 5% for all providers, 5% for NPs and 4% for PAs. NPPs also have low denial rates when doing procedures as part of a surgical team and billing services with the modifier **AS** (Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery), a *Part B News* analysis shows (*PBN 11/6/17*).

But when you move beyond E/M and surgical team services, it gets trickier. On codes across the board, NPs in 2016 earned a 19% denial rate — but when you remove the 10 office/outpatient E/M codes from the mix, that shoots up to 23%. For comparison purposes, for all specialties the overall denial rate on all codes is 15%, and without office E/M codes it's 16%. Remove as well the hospital inpatient and observation E/M codes and discharge management codes (**99217-99239**), and NPs are up to 24%. Similarly, the denial rate on all PA claims is 20%, and without the E/M codes it's 24%; without the hospital codes, it's 25%.

But, as the J code results below suggest, injections seem safe for NPs and PAs — notwithstanding the bad mark NPs get here on **J1050** (injection, medroxyprogesterone, 1 mg). Medroxyprogesterone, also known as Depo-Provera, is a hard sell for anyone and drew a 59% denial rate across the board in 2016 (*PBN 7/6/15*). Nurse practitioners were denied only 10% of the time on injection codes, and for physician assistants the rate is 8%; for all providers, the denial rate in J codes is 9%, — *Roy Edroso* (*redroso@decisionhealth.com*)





Source: Part B News analysis of Medicare claims data

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found few changes, according to the study appearing in the March 2018 issue of *American Journal of Medicine*.

"The results of our study demonstrate that primary care nurse practitioners and physician assistants provide blood glucose control that is comparable to that of physicians for patients who had newly diagnosed diabetes with fours years of follow-up," says Yihan Ying, M.D., clinical instructor of medicine at Yale School of Medicine in New Haven, N.H.

Ying and his colleagues conducted the study in part to determine whether quality-care concerns may arise within Veterans Affairs clinics, which opened up practice authority to nurse practitioners in 2017. The results, he says, may have wider implications than diabetes management.

"Many factors play into the shortfall of [the] physician workforce, particularly in primary care," Ying says. "The Veterans Affairs model for use of nurse practitioners and physician assistants may be broadly useful to help meet the demand for primary care providers in the United States." – *Richard Scott* (*rscott@decisionhealth.com*)

Resources:

- Journal of General Internal Medicine: *https://link.springer.com/article/10.1007%2Fs11606-017-4287-4*
- AANP practice authority map: *www.aanp.org/legislation-regulation/state-legislation/state-practice-environment*
- Hamilton Project paper: *www.hamiltonproject.org/assets/files/AdamsandMarkowitz_20180611.pdf*
- Merritt Hawkins review: *www.merritthawkins.com/news-and-insights/thought-leadership/survey/2018-survey-of-physician-and-advanced-practitioners-recruiting-incentives*

MIPS

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expected to announce final scores and data filings for 2017 MIPS participants.

Smart providers are using that data to re-think their current MIPS efforts for 2018 attestation. Attorney Kyle Haubrich at the Sandberg Phoenix firm in St. Louis says he's gotten a lot of calls about the preliminary data. "Some clients say, 'Our scores look good, but we want to improve them for next year,'" he says. "Or I'll get clients who say, 'Our scores were not so good, and we want to improve them for next year.'"

The top performers are looking for paths to that sweet exceptional performance money in 2020 for their 2018 performance, says Haubrich. Currently, if you have a 60% performance score in MIPS, you're eligible for the 5% positive payment adjustment in 2020. But if you score 70% or above, you're eligible for the bigger exceptional performance bonus — which is $500 million divided among all exceptional performers. Top performers are looking for ways to goose their scores, and the data gives them a jump on the competition by showing them where they should improve, says Haubrich.

The poorer performers, of course, have been shocked into consciousness by the preliminary reports that

they'll probably receive a negative payment adjustment in 2019, and they're hoping not to repeat the experience. "I'm also getting calls from people who just got these notices and realize, apparently for the first time, there is something called MACRA [Medicare Access and CHIP Reauthorization Act, which created the Quality Payment Program], and they didn't report," Haubrich says.

Optimize your use of data these 7 ways

Whether you did well or badly in 2017, don't just celebrate or panic — use these tips to turn the data to your advantage.

- **Work the benchmarks.** Benchmarked quality measures return more points as your performance increases, depending on which decile (literally, division by 10) you fall into based on national performance on each measure (*PBN 3/6/17*). If a look at your scores reveals you're within striking distance of a decile that would boost your score in any particular measure, "develop a strategy to closely monitor [those] benchmarks and ensure you are achieving higher than the national average," says Linda DiBenedetto, practice advisor, payer initiatives for McKesson Specialty Health.

- **Don't report everybody.** Under MIPS, your filings have to reflect 60% of your patient population, up from 50% last year, says Douglas J. Jorgensen, D.O., founder and principal of Patient360, a qualified clinical data registry (QCDR). But — and this is something many providers don't know — if you have performed measures on more than 60% of reportable patients, you can pick which patients you want to report. "You could do an analysis of your patients and remove the 39% you don't want," says Jorgensen. And there's no law saying you can't choose the patients whose adherence or outcomes are most likely to boost your score. For example, "if I have a bunch of noncompliant diabetics and I'm trying to report optimally, I'd rather report the compliant ones."

Also, it doesn't have to be the same 60% for all measures; you can pick one group for Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, for example, and another for Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%).

- **Just because you can report it doesn't mean you have to.** Likewise, you don't have to report every measure for which you're eligible — or even every method. "We had an ortho program reporting CAHPS [Consumer Assessment of Healthcare Providers and Systems]," says Jorgensen. "They were using it for their own clinical improvement purposes, but when I removed it from their MIPS reporting, their score went up 10 points. … They wanted it for ethically sound [self-analysis] purposes, and they can still do that, but it was hurting them fiscally. I suggested a measure to replace it with and they said, 'but that's easy.' I said, 'it's OK' — and it bumped their score considerably."

- **Explore QCDR measures.** Not doing great with the measures on offer by CMS? You're in luck if you work with a QCDR because it doesn't rely on CMS' measures — it develops measures of its own, tailored to a specialty or subspecialty group with whom it works (*PBN blog 3/6/18*). Jorgensen's Patient360 has developed several measures with the Maine Osteopathic Society relating to several categories including substance use/management — one Jorgensen picked because "I own a pain and addiction recovery practice and we didn't have many measures we could report on for pain medicine and addiction recovery, so we wrote some."

There are 896 entries in the spreadsheet CMS provides (*see resources*), and if you see one you like that your own QCDR doesn't offer, don't despair. Sometimes QCDRs make deals to authorize other QCDRs to use their measures. Also, if you have enough pull with them, your QCDR may entertain your own suggestions, or that of a group you belong to, and develop a measure tailored to your needs.

Note: Make sure you're using benchmarked QCDR measures, says Jorgensen; until CMS gives those measures their imprimatur, they're only worth three points maximum, rather than up to 10 points. So if your QCDR makes a new one for you, it may be a year or more before it's eligible for the extra points.

- **Get proactive.** If you look at your scores and find quality shortfalls — or, as Jon Harris-Shapiro of Continuance Health Solutions Inc. in Peapack, N.J., calls them after the public health term, "hot spots" — in areas where patient compliance or adherence is a factor, you should develop a plan that addresses the issue with your patients.

"Look at medication adherence," says Harris-Shapiro, such as in the Adherence to Antipsychotic Medications for Individuals with Schizophrenia quality measure. "If you get a report on the patient's non-adherence in the third quarter, you can't go back and reinvent their history. That horse is out of the barn." But going forward, if you have a system in place that tells you when the patient is supposed to refill the prescription, you can check on her — and if there's a problem, you can fix it then instead

of after months of noncompliance. "We can call and ask what the problem is," says Harris-Shapiro. "Is it side effects? Then we change the meds. Is it getting to the pharmacy? Then how about mail order?"

The same thing applies to measures that require patients to get tested at intervals, such as the Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) measure.

- **Get the team on board.** When you have the results, tell your people where you're not performing and explain how important performance is to the future of the practice, says DiBenedetto. "Engage the entire care team, both clinical and financial, and create a task force focused on identifying and implementing areas of continual improvement." Providers particularly should be reminded of how the MIPS scores affect their and the practice's Physician Compare scores. "Get them involved in implementing clinical care standards and improvement activities," says DiBenedetto. "Recognize top performers and outline how they achieved their score."
- **Think about cost.** The MIPS cost measure is not in the 2017 data, but it is 10% of your score this year and will go up to 30% soon, so while you're making plans, you should think about changes that will affect the overall spending on beneficiaries attributed to you, which is how CMS calculates that score, says Theresa Hush, CEO and co-founder of Roji Health Intelligence in Chicago (*PBN 1/22/18*).

"To bring it down, they'll have to actually look at the spending reports and the big culprits like outpatient service, post-acute, ER," says Hush. "A high number of admissions on ambulatory conditions speaks to the lack of primary care intervention — like diabetes gone amok and heart failure."

To address that, your providers may need to go to a "shared-decision model" of care to get patients to engage more in the treatment plan, says Hush. "Today, the doctor says, 'Here's what we're doing,' and the patient goes off and doesn't do it," says Hush. "Because they didn't own it." — *Roy Edroso* (*redroso@decisionhealth.com*)

Resources:

- QPP Portal: *https://qpp.cms.gov/login*
- QCDR measures list: *www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Qualified-Clinical-Data-Registry-QCDR-Measure-Specifications.xlsx*

Editor's note: *DecisionHealth has two resources to help you improve your MIPS scores. Check your 2018 performance so far with the on-demand webinar* ***Mid-Year MIPS Checkup for Claims-Based Submissions: Get on Track to Succeed at MIPS 2018!*** Visit www.codingbooks.com/ympda062118 *for more information. Use the comprehensive guide* ***2018 MIPS Answers*** *to avoid penalties and secure bonuses.* Learn more at *www.codingbooks.com/topic/billing-payment/2018-mips-answers*.

HIPAA

6 steps to protect your practice when a patient's attorney requests records

The recent news reports that three men claiming to represent President Donald Trump, including an attorney from the Trump Organization, raided the medical offices of Trump's long-time personal physician and took Trump's records is a good reminder that third parties don't have an automatic right to patient records even when they say they do.

Practices must follow HIPAA rules when an attorney requests a patient's records. Here are six tips to protect your practice:

1. **Keep your records in a secure place or manner, such as in a locked area or encrypted.** This will greatly reduce the chances that someone can storm in (or break in after hours) and get his hands on the records, says attorney Michael Kline, Fox Rothschild, Princeton, N.J.
2. **Carefully review each patient request for release of records in whatever form it comes and make sure that it comports with HIPAA's requirements.** You'll be liable if you allow the release when you shouldn't have — or send the records to the wrong place.
3. **Make sure that staff understand a patient's right to access versus a HIPAA authorization.** "Use the Bornstein incident to make the training relevant," suggests attorney Elizabeth Litten, also with Fox Rothschild.
4. **Don't give up your original records.** Comply with your state law pertaining to record retention, says Kline.
5. **Don't provide more than what the patient is asking for.** HIPAA requires providers to disclose only the minimum necessary amount of data to accomplish the intended purpose, points out Litten. A provider can provide a patient's entire medical record, but only if the patient access request or HIPAA authorization instructs the provider to do so.
6. **Don't be intimidated into violating HIPAA.** You'll be the one found liable, not the patient or third-party bully, even if it's an attorney threatening you. In the unusual situation of goons storming in to take records, as Bronstein has claimed, he should not have simply capitulated, says Kline. "He should have called the police. Call 911," Kline says. — *Marla Durben Hirsch* (*askpbn@decisionhealth.com*)

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