



American Association of Oral and Maxillofacial Surgeons



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Federal Affairs

[Key Dates for Congressional Action in 2009](#)

[President-elect Obama Promotes Health Care Reform Discussions](#)

State Affairs

[AAOMS Governmental Affairs Staff Prepares for a Busy Year](#)

Practice Management

[2009 Medicare Physician Fee Schedule: Highlights Include Payment Bonus for e-Prescribing and Limits on Retroactive Billing](#)

[Rental Network Model Legislation](#)

[HIPAA Security Oversight has Fallen Short](#)

Federal Affairs

Key Dates for Congressional Action in 2009

January 2009 is going to be a busy month in Washington, DC. A new administration and legislature are set to be sworn in and the stage will be set for federal action on health care issues. Some of the highlights next month include:

- January 6, 2009: 111th Congress is sworn in

- January 6, 2009: U.S. House of Representatives & U.S. Senate in session for legislative business
- January 20, 2009: President-elect Barack Obama sworn in as the 44th President of the United States

Leadership in both chambers are currently assigning legislators to key committees. This process will continue until all open House and Senate seats have been filled, at which point AAOMS will post the final key committee rosters on aaoms.org. It is also expected that President-elect Obama will deliver his first State of the Union address in early February.

AAOMS will closely monitor the actions of the new federal leadership and will continue to advocate for the advancement of the association's legislative priorities.

President-elect Obama Promotes Health Care Reform Discussions

During the last two weeks of the year, supporters of President-elect Obama are set to host over 4000 listening sessions to discuss health care reform in small group settings. Attendees do not have to identify their employers or affiliations for these gatherings and it is expected that physicians, insurers, pharmaceutical company representatives and reform advocates will attend. The goal is to fulfill the President-elect's promise of promoting "health care reform that comes from the ground up."

These meetings provide an opportunity to have your voice heard by the incoming administration. If you hear of one in your town, consider attending on behalf of the specialty. For more information, please visit the transition website at <http://change.gov>. If you attend one of these meetings, AAOMS would like to hear about it. Please contact the AAOMS Governmental Affairs staff at (800) 822-6637 to provide your feedback.

State Affairs

AAOMS Governmental Affairs Staff Prepares for a Busy Year

In 2008, AAOMS governmental affairs staff tracked 322 bills and 321 regulations from all 50 states and DC. With nearly every state legislature coming back into session after the first of the year, we expect to be very busy this session tracking pertinent legislation affecting oral and maxillofacial surgeons. We are projecting that nearly 160,000 bills will be introduced this year, of which over 25,000 will be health care related. Expect roughly one-third of these bills to be enacted this year, as health care reform will be a major topic of discussion at both the federal and state levels – particularly as the uninsured population grows due to the economic downturn. Expected health care legislation will address Medicaid/SCHIP funding, health IT, office-based surgery regulation and insurance oversight, just to name a few. With single party control of both chambers of the state legislature and the governor's mansions in 27 states, legislation has the potential to move very quickly. AAOMS staff will be working with our state lobbyists and association presidents to monitor the progression of any relevant legislation and to assist the states when needed.

Practice Management

2009 Medicare Physician Fee Schedule: Highlights Include Payment Bonus for e-Prescribing and Limits on Retroactive Billing

The 2009 Medicare Physician Fee Schedule (MPFS) includes provisions that provide payment bonuses to providers who e-prescribe and limits on retroactive billing. The MPFS also sets forth that the Centers for Medicare and Medicaid Services (CMS) will work with the AMA's Resource Based Relative Value System Update Committee (RUS) to identify misvalued codes and states that moderate conscious sedation codes are once again carrier priced.

The e-prescribing clause makes providers eligible for a 2% bonus if 10% of their total Part B payments come from a list of 33 office-based service codes (including E/M visits). In order to qualify, providers must successfully report that they e-prescribed, or attempted to e-prescribe, 50% of the time during those eligible situations. Prescribers will report one of three G codes on claims with one of the 33 codes as a denominator. Numerator codes are G8443 (prescription by e-prescribing), G8446 (some prescriptions handwritten); or G8445 (prescription not generated at encounter). G8446 would only be used if a provider has access to e-prescribing, but writes or phones in a prescription due to requirements under state or federal law; a pharmacy system is unable to receive an electronic transmission; or if a patient requests that the script be handwritten. Computer based fax transmissions are considered a valid form of electronic prescribing. E-prescribing bonus payments decrease to 1% for 2011 and 2012, falling to 0.5% in 2013.

Beginning in 2012, any provider who does not e-prescribe will be penalized 1% of total Medicare payment. The penalty increases to 1.5% in 2013 and 2% in 2014 and every year thereafter. There are many resources available to assist providers in making the transition to e-prescribing. For additional information, see [Medicare's Practical Guide to the E-prescribing Incentive Program](#), the [Clinician's Guide to Electronic Prescribing](#) (a paper produced in collaboration between CMS, the American Medical Association and other organizations), the December 15 *American Medical News* article titled "[Medicare e-prescribing: How to receive your 2% bonus](#)" and an AMA list of FAQs titled "[Understanding the basics of Medicare's electronic prescribing incentive program.](#)"

As mentioned above, the 2009 MPFS also limits a provider's ability to retroactively bill Medicare. A provider cannot bill more than 30 days prior to either the date Medicare receives and processes the provider's enrollment application, or the date a provider started furnishing services at a new location or address in the case of those providers already enrolled in Medicare. CMS will use the later of these two dates. CMS' new internet based Provider Enrollment Chain and Operation System (PECOS) will help with the new restrictions allowing providers to enroll or update their information online. The processing time will be shortened to 30-45 days as compared to the previous 60-90 days for paper applications.

To view the [Rule](#) in full see the November 19th Federal Register.

Rental Network Model Legislation

Due to the recent adoption of laws in Colorado, Connecticut, Florida, Indiana and Ohio, OMSs practicing in these states are now, to some degree, protected against rental network PPOs and illegitimate discounted payment for their services. Other states are also considering legislation following the model set out by the National Conference of Insurance Legislators (NCOIL) and promoted by the American Medical Association. According to a November 26th NCOIL [press release](#), the [Rental Network Contract Arrangements Model Act](#) provides guidance to states balancing "desired access to preferred provider organization (PPO) networks with transparency of physician reimbursement. It allows unlimited

“downstream” rentals of PPO contracts and physician discounts, while ensuring that network access information is available to providers.” The NCOIL is an organization of state legislators whose main area of public policy concern is insurance legislation and regulation. For more information on rental networks see the article titled [Silent and Rental Network PPOs: Identification and Prevention](#) on [aoms.org](#).

HIPAA Security Oversight has Fallen Short

The U.S. Department of Health and Human Services’ (HHS) Office of the Inspector General issued a [report](#) on October 27 that finds CMS has fallen short of its charter to enforce the Health Insurance Portability and Accountability Act’s (HIPAA) security provisions. The report states that “limited actions” by CMS have “not provided effective oversight or encouraged enforcement of the HIPAA Security Rule by covered entities.” In general, the report takes issue with CMS’s “complaint driven enforcement” process. CMS, according to the HHS’ IG, relies on complaints to identify the organizations it might investigate. The report contends that reliance on complaints alone has proven ineffective for finding organizations that have failed to comply with the security rule.