



American Association of Oral and Maxillofacial Surgeons



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### **Federal Affairs**

House of Representatives Passes Bill to Repeal Medical Device Tax, Readies to Pass IPAB Repeal

On June 18, the US House of Representatives passed legislation to repeal the 2.3% medical device tax from the Affordable Care Act (ACA). The chamber passed the Protect Medical Innovation Act ([HR 160](#)) by a vote of 280-140. Prior to the vote, HR 160 was amended to remove language to retroactively repeal the medical device tax and refund companies the money they have paid since the tax took effect in early 2013. The bill now advances to the Senate for consideration; however, President Obama has stated he

plans to veto it if it reaches his desk. Next week, the House plans to hold a similar vote on another piece of legislation important to AAOMS; the Protecting Seniors' Access to Medicare Act ([HR 1190](#)), which would repeal the Medicare Independent Payment Advisory Board (IPAB) from the ACA.

AAOMS members attending the March 2015 AAOMS Day on the Hill advocated for HR 160 during their congressional visits, and more than 400 OMSs across the country have utilized the OMS Action Network grassroots engagement system to advocate support for both bills in letters to their constituent members of Congress. Thank you to all who have already sent letters on these two important issues. Your voice makes a difference! If you haven't yet done so, please [take action today](#) to urge your House member to vote for passage of the IPAB repeal bill.

## AAOMS Sends Letters of Support on Several Legislative Priority Issues

In the first week of June, AAOMS sent 7 support letters to members of Congress who sponsored legislation on the following AAOMS 2015 legislative priority issues:

- Repeal of the excise tax on medical devices ([HR 160](#)) and ([S 149](#)).
- Expanding the use of Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) ([HR 1185](#)) and ([HR 1196](#)).
- Reform of federal antitrust guidelines for health insurance companies ([HR 494](#)).
- Options for Medicare patients and eligible professionals to freely contract without penalty ([HR 1650](#)).
- Amending ERISA to allow for coordination of benefits and assignment of benefits under group health plans ([HR 1677](#)).

These and all other AAOMS comment letters may be found on the government affairs section of the AAOMS [website](#).

## **State Affairs**

### States Take Action Ahead of ACA Ruling

The US Supreme Court is currently considering [King v. Burwell](#), which challenges the legality of federal subsidies provided to individuals in states that did not establish a state-based health insurance exchange. Should the Supreme Court rule that the subsidies are illegal, residents of 37 states will find themselves without assistance in purchasing health insurance and meeting the requirements of the individual mandate. In preparation for the ruling, states are forming contingency plans. [Pennsylvania](#) and [Delaware](#), for example, have submitted plans that would allow the federal government to operate the technology portion of the health insurance exchange while the states would oversee funding, regulations and consumer assistance. Such an arrangement would allow residents from those states to receive premium assistance without incurring the full expense of operating a state-based health insurance exchange. The Supreme Court is expected to issue its ruling later this month.

### Alabama Supreme Court Affirms Tooth Whitening as the Practice of Dentistry

On June 5, the [Alabama Supreme Court ruled](#) tooth whitening is the practice of dentistry. The decision reaffirmed a lower court ruling that prevented non-dentists from offering the service in the state. The case stemmed from cease and desist letters received in 2013 by non-dentists offering tooth whitening services. The plaintiffs in the case argued that the state's Dental Practice Act was overly broad, unreasonably favored dentists, and eliminated competition. The court, however, agreed with the defendants that there are numerous actual or potential health and safety risks associated with teeth whitening and that the provisions of the Dental Practice Act protect patient safety.

## **Health Information Technology**

Time is Running Out – Apply for 2016 Meaningful Use Payment Adjustment Hardship Today!

The Centers for Medicare and Medicaid Services (CMS) has [opened the hardship application period](#) for providers to avoid the 2016 payment adjustment period for failure to meaningfully use certified electronic health records and a 2% reduction on provider services fees. **Providers have until July 1, 2015 to [submit their application](#)** and all applications will be considered on a case-by-case basis. Each hardship exception is valid for one payment year, so even if you received an exemption for 2015 you will need to reapply. It has also been announced that in no case may a provider be granted an exception for more than 5 years. For more information, please contact CMS directly at 888-734-6433 or visit the [CMS Web page on payment adjustments](#).

## **Practice Management**

### Enrollment Delay for Providers Who Prescribe Part D Drugs

Medicare will soon require prescribing physicians to either be enrolled or formally opted out in order for their patients' prescriptions to be covered under Medicare Part D. The regulation's enforcement date has been delayed from June 1, 2015 to January 1, 2016 to allow providers more time to submit enrollment applications or valid opt out affidavits so that beneficiaries' access to treatment is not interrupted. Although the enforcement date has been delayed, the AAOMS encourages physicians to either enroll into Medicare and have a valid enrollment record in PECOS or have valid opt-out affidavits on file with their Medicare contractor if prescribing Medicare Part D prescriptions. In order for Medicare to pay for prescriptions for beneficiaries under Medicare Part D, a dentist must do one of the following:

- Enroll as a Medicare provider by completing form 855-I
- Enroll under Medicare only for the purpose of prescribing Part D drugs for Medicare beneficiaries by completing form 855-O
- Opt-out of the Medicare program by completing the Medicare Opt-out affidavit. An example of the affidavit can be found on the [AAOMS website](#).

CMS has a file available on their website which [identifies those physicians and eligible professionals](#) who are enrolled in Medicare or have an approved opt-out status. For more information on Medicare enrollment, visit the Coding and Reimbursement page of the [AAOMS website](#).

### The AAOMS PQRS Wizard

The 2015 reporting period for the Physician Quality Reporting System (PQRS) is underway. The AAOMS *PQRSWizard*, a fast, convenient, and cost-effective online tool, can help you collect and report quality measures and submit them to the CMS. The *PQRSWizard* webpage offers a full instructional video. The PQRS Wizard will recommend a reporting product based on your practice. Please visit the AAOMS website for more information on both the [PQRS program](#) and the [PQRS Wizard](#) and see how they may help you avoid the 2017 Medicare payment reduction.

### Rendering, Ordering or Referring Services for Medicare Beneficiaries: Are You Sure You're Eligible?

Many OMSs may not be aware that they are not eligible to render, order, or refer services for Medicare beneficiaries because of their Medicare enrollment status. The CMS requires all physicians and non-physician practitioners who render or order items or services, or refer Medicare beneficiaries to other Medicare providers or suppliers for services, to have current enrollment records in Medicare or to have submitted a valid opt-out affidavit. If you have not enrolled or properly opted out, CMS does not consider you eligible to render, order or refer Medicare services.

A current enrollment record is one that is in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) and also contains the physician/non-physician practitioner's National Provider Identifier (NPI). A physician or non-physician practitioner who renders, orders, or refers and who does not have a current enrollment record that contains the NPI, will cause the claim submitted by the Part B provider/supplier who furnished the ordered or referred item or service to be rejected. Providers may enroll in Medicare via the CMS 855-O, CMS 855-I, or CMS 855-B or may formally opt out by submitting an opt-out affidavit to their local Medicare carrier.

- [CMS 855-O:](#) For Eligible Physicians and Non-Physician Practitioners Who Only Order or Refer Services
  - For physicians and non-physician practitioners who do not and will not send claims to a Medicare carrier for the services they furnish. Physicians who complete this application cannot bill the Medicare beneficiary for any services performed that would have otherwise been covered by Medicare.
  - This application should only be submitted if the physician or non-physician practitioner renders excluded Medicare services and only plans to refer those beneficiaries to another Medicare physician, or order covered services for the Medicare beneficiary such as Part D prescriptions, surgery, pathology, or radiology.
- [CMS 855-I:](#) For Physicians and Non-Physician Practitioners Who Render Covered Services
  - For physicians and non-physician practitioners who are interested in enrolling in the Medicare program and/or who may already be enrolled in the Medicare program, but have not submitted the 855-I for since 2003.
  - This application should be submitted by those who plan on treating Medicare beneficiaries and submitting claims to Medicare for the services rendered.
- [CMS 855-B:](#) Medicare Enrollment Application for Clinics, Group Practices, and Certain Other Suppliers
  - A medical practice or clinic that will bill for Medicare Part B services (e.g., group practices, clinics, independent laboratories, portable x-ray suppliers).
  - Ambulatory surgical centers, group clinics or practices.
- [Opt-out Affidavit:](#)
  - For physicians and non-physician practitioners who are interested in providing care to Medicare beneficiaries, but do not want to submit claims to Medicare.
  - This affidavit should be submitted to one's local Medicare carrier when a physician or non-physician practitioner would like to forgo Medicare claims and enter into a private contract with each Medicare beneficiary they treat. The private contract must explain that they have opted out and will not submit claims to Medicare, therefore the Medicare beneficiary is responsible for payment. **Opt-out periods are two years, therefore an affidavit must be submitted every two years if an OMS wishes to continue to privately contract with Medicare beneficiaries.**
  - Physicians and non-physician practitioners who opt-out must refer any Medicare beneficiaries to a Medicare provider if the beneficiary chooses they do not want to be responsible for payment.
  - Opted-out provider are permitted to refer and order services such as pathology, radiology, and Part D prescriptions since formally opted out providers are added to Medicare's provider database.

*Note: Opting-out of Medicare also applies to Medicare Advantage (MA) Plans and therefore may indirectly affect your plan participation with some dental plans, if those dental plans offer coverage under MA plans at an extra premium. Some dental plan contracts contain "all products" clauses which obligate a provider to accept beneficiaries from all of that plan's products, including MA Plans. One's decision to opt-out of Medicare and inability to submit to MA dental claims may be a contract violation causing termination from that dental plan. Also, contact any hospitals you may have hospital privileges with. The AAOMS has become aware that many hospitals will not allow physicians or non-physician practitioners who have hospital privileges to be opted-out of Medicare.*