



American Association of Oral and Maxillofacial Surgeons



For further information contact:
Jeanne Tuerk, Manager
Governmental Affairs Department
800-822-6637 | jtuerk@aaoms.org

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Federal Affairs

Non-Covered Services Bill Gaining Momentum

In the last issue of AAOMS's Advocacy E-News, AAOMS members were asked to take grassroots advocacy action in support of [HR 3323, the Dental and Optometric Care Act](#). At this time, the bill has gained a bipartisan support base of ten Republicans and four Democrats from eleven different states. The initial grassroots campaign sent out via email by AAOMS resulted in 555 letters sent by fellows and members to their US representatives.

HR 3323 would eliminate insurance companies' ability to cap the fees dentists can charge health plan enrollees for non-covered services. This would also apply to federally-controlled healthcare plans, such as Employment Retirement Income Security Act (ERISA) plans.

There is still time to take action! [Visit the OMS Action Network website](#) to quickly and easily send your US representative a letter urging him/her to cosponsor HR 3323.

Congress Includes Obamacare Tax Delays in Omnibus Package

December 18 is the last legislative day for Congress in 2015. After passing a last-minute, short-term continuing resolution (CR) on December 11 and again on December 16, they afforded themselves extra time to pass an appropriations bill to avoid another shutdown of the federal government. In the wee hours of December 16, [details of the spending package were released](#), which included an extensive tax extender package containing a 2-year moratorium on the 2.3% medical device excise tax and excise tax on premium health plans, also referred to as the "Cadillac" tax.

The repeal of these two ACA taxes has strong bipartisan and bicameral support. While the omnibus bill does not include a full repeal of the taxes, supporters from both parties see a delay as a short-term victory, buying them more time to achieve a total repeal in the future.

Repeal of the medical device tax has been a priority legislative issue for AAOMS since the ACA was enacted in 2010 and one that has been repeatedly advocated for on Capitol Hill during the AAOMS Day on the Hill event and by the AAOMS government affairs consultants in Washington, DC. The inclusion of this 2-year moratorium is a strong victory for our advocacy efforts and proof that the voices of the specialty are being listened to in Congress.

The package also included \$123 million to the Centers for Disease Control (CDC) to combat prescription drug and opioid abuse.

Both the House and Senate passed the bill on the morning of December 18, sending the measure to President Obama. He is expected to sign the bill into law before the funding extension expires on December 22.

Reconciliation Bill Makes Progress; No Final Vote Until 2016

In early December, the Senate voted 52-47 to approve [HR 3762, the Restoring Americans Healthcare Freedom Act of 2015](#). Although the bill passed the House in October, several amendments made in the Senate requires a return to the House for another approval of the final bill before it can be sent to President Obama. With a looming government shutdown and limited legislative days remaining in 2015, the reconciliation bill was put on hold until 2016 to meet its legislative fate. Although it is all but certain that the president will veto the bill, citing its purpose to dismantle key provisions of Obamacare, Republicans see passing the bill through both chambers as a political victory.

State Affairs

State Legislators Gear Up for 2016

As 2015 comes to a close, the state legislatures will take a break for the holidays before convening their 2016 sessions in early January. Bills in [a little more than half of the states](#) that failed to be enacted this year will be carried over to the 2016 session. Meanwhile the Montana, North Dakota, Nevada and Texas legislatures will not meet in 2016. Legislative sessions in Arkansas, Connecticut, Maine, New Mexico, North Carolina and Wyoming will be limited to appropriation or budgetary matters unless an issue is brought up for special or emergency consideration. The shortest session will be held in Wyoming, where the legislature will convene for only 20 days, followed by Arkansas

and New Mexico. Make sure to stay engaged in legislative issues during 2016 by getting involved with your state OMS and dental associations.

Health Information Technology

Providers Must Attest to Meaningful Use or Face Penalties in 2016

Eligible providers who met the requirements of the Medicare [meaningful use program in 2015](#) must attest to their successful completion between January 4 and February 29, 2016 to avoid a payment reduction in 2017. For information on how to register and attest the meaningful use, please visit the [CMS Web site](#). For specific questions regarding participating in meaning use, contact CMS directly at 888/734-6433.

Meaningful Use Reconsideration Period Opens January 2016

Medicare providers who failed to adopt and "meaningfully use" certified electronic health records in 2014 will begin receiving letters in late-December indicating that their 2016 professional fees will be reduced by 2%. While providers will be unable to correct this adjustment for the 2016 payment year, as all reconsideration and hardship information was due in early 2015, they will be able to submit a reconsideration for the 2017 payment adjustment of 3%, which will be based off the 2015 EHR reporting year.

The 2017 reconsideration period will be open from January 1 through February 28, 2016, and all applications will be handled through an informal review process. For information on how to submit a reconsideration request and avoid the 2017 penalty, please refer to your notice from CMS, monitor the CMS Web site, or watch for the information in the January edition of Advocacy eNews. Providers will also be able to apply for a hardship exemption for the 2017 payment adjustment in the second quarter of 2016. We will keep you advised regarding the availability of the application.

Practice Management

American Dental Association's 2016 CDT Anesthesia Code Changes

Revisions to the anesthesia codes appearing in the new 2016 CDT coding manual will ultimately change the way you will report anesthesia services. The following codes have been deleted:

- D9220 - deep sedation/ general anesthesia- first 30 minutes;
- D9221 - deep sedation/general anesthesia- each additional 15 minutes;
- D9241 - intravenous moderate (conscious) sedation/analgesia- first 30 minutes; and
- D9242 - intravenous moderate (conscious) sedation/analgesia-each additional 15 minutes

These codes will be replaced with codes that now reflect "each 15-minute increment" reporting of anesthesia. These new codes are:

- D9223 - deep sedation/general anesthesia - each 15 minute increment.
- D9243 - intravenous moderate (conscious) sedation/analgesia - each 15 minute increment.

Coding Tips:

- 16-30 minutes of anesthesia- the next 15 minute increment may be billed
- Question your carriers how they are deriving the fee, noting there was no change to the code that indicates a reduction of the service rendered
- Practice expenses associated with rendering the service has remained the same - supplies, equipment, drugs, and clinical staff time are incurred in the first 15 minutes, and should be recognized

- Contact carriers to determine how they would like code reported on the claim form. For example, some carriers:
 - may want you to report 30 minutes by using a line-by-line method; or
 - they may require you to put (2) in the quantity box or Units box

REMINDER - "anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remain in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties."

Also taking effect in January is a revision to D9248. Revisions to D9248 made in 2015, which added the term "moderate" in the code's nomenclature, led to the misperception that it was only applicable when the procedure resulted in a moderate level of sedation. In March 2015, the ADA's Code Maintenance Committee issued guidance to the dental community that the code was applicable when the outcome is either non-IV minimal or moderate sedation. With CDT 2016, the nomenclature and descriptor for D9248 was revised to make this clear.

A complete list of CDT and CPT code changes for 2016 may be found in the upcoming January/February issue of the *AAOMS Today Coding Corner*.

Joint Statement on Point-of-Care Imaging

The AAOMS recently signed a [joint statement](#) with the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), American Rhinologic Society (ARS), American Academy of Otolaryngic Allergy (AAOA), American Laryngological Association (ALA), American Broncho-Esophagological Association (ABEA), and the Intersocietal Accreditation Commission (IAC-CT) in support of the in-office use of Cone Beam Computer Tomography (CBCT). This joint statement, which will be used by the coalition for payer advocacy efforts, advocates for private payer acceptance of CBCT technology and reimbursement for all appropriately trained point-of-care imaging providers. The statement is broad enough to be used by all members of the CBCT coalition organizations.

This statement is not intended to contest Medicare's [advanced imaging accreditation](#) or third party payer accreditation requirements.

CMS Publishes 2016 Physician Fee Schedule Final Rule

The Centers for Medicare and Medicaid Services (CMS) published the final rule for the 2016 Physician Fee Schedule on October 20, 2015 under the Medicare Physician Fee Schedule (MPFS). The final rule includes several updates to the Medicare Payment Initiatives, Opting-out of Medicare, Appropriate Use Criteria (AUC), the Physician Compare website, and the identification of misvalued codes. Following are some highlights from the final rule:

- **Physician Quality Reporting System (PQRS)** - CMS establishes the same criteria for satisfactory reporting that was established for the 2017 PQRS payment adjustment, which is generally to require the reporting of nine measures covering three National Quality Strategy domains. If an individual EP or group practice does not satisfactorily report or satisfactorily participate in PQRS for 2016, a 2% negative payment adjustment will apply to covered professional services furnished by that individual EP or group practice during 2018. CMS is also continuing to apply the value based modifier with penalties up to -4%. For more information about participating in PQRS in 2016, visit the [AAOMS website](#).
- **Value Based Modifier (VBM)** - Through the Valued-based modifier, physician's and other EPs are able to receive either downward adjustments, no adjustments, or upward adjustments based on their performance on quality. The adjustments are based on how well the physician's or EP's provide high quality and efficient care while successfully reporting in the PQRS system.
- **Opting-out of Medicare-** Section 106(a) of MACRA indicates that valid opt-out affidavits filed on or after June 16, 2015 automatically renew every 2 years.
- **Appropriate Use Criteria (AUC)** - CMS is establishing which organizations are eligible to develop or endorse AUC, the evidence-based requirements for AUC development, and the process CMS will follow for qualifying provider-led entities. In the proposed rule, CMS noted that AUC and clinical decision tools must be

in place by January 2017; however, in the final rule they recognize that timeline is not feasible. While they do not formally say, it appears it may be delayed until 2018.

- **Physician Compare Website-** CMS finalized that it will make the following 2016 measures available for public reporting on the physician compare website:
 - All PQRS measures for individual EP's and group practices,
 - All CAHPS for PQRS measures for groups of 2 or more EPs who meet the specified sample size requirements and collect data via a CMS specified CAHPS vendor,
 - All ACO measures
- **CMS to identify misvalued codes-** The final rule set a target for CMS to identify any misvalued codes in the fee schedule for calendar years 2017-2020.

The AAOMS will continue to provide the membership with updates and changes to all of these programs. Visit the [CMS website](#) for more information.

Mandatory Value Based Modifier Adjustments Coming by 2017 for All Providers

The Value Based Modifier (VBM) is an adjustment made on a per claim basis to Medicare payments for items and services rendered under the Medicare Physician Fee Schedule (PFS). Through the VBM, physicians and other Eligible Professionals (EPs) are able to receive either downward adjustments, no adjustments, or upward adjustments based on their performance on quality. The adjustments are based on how well the physician's or EP's provide high quality and efficient care while successfully reporting in the PQRS system. According to the Patient Protection and Affordable Care Act, the VBM must be applied to all physicians and physician groups by January 1, 2017. The VBM adjustments will be in addition to the PQRS and Meaningful Use (MU) penalties applied to those who do not successfully meet each program's criteria.

In 2017, Medicare will apply the VBM to physician payments under the Medicare PFS for physician solo practitioners and physicians in groups of 2 or more EPs. Based on how well the physician or EP reported on the PQRS measures for the associated calendar year, the Centers for Medicare and Medicaid Services (CMS) will determine the adjustment amount by using a quality tiering system; higher value gets higher pay; lower value gets lower pay. Physician groups with between 2 to 9 EPs and physician solo practitioners can receive an automatic negative payment of -2.0% up to a 2.0% upward payment adjustment. Physician groups with 10 or more EPs can receive an automatic negative payment of -4.0% up to a 4.0% upward payment adjustment. Quality tiering is mandatory for groups and solo practitioners subject to the Value Modifier in CY 2017. In 2019 and beyond, the value-based payment modifier will be replaced by the merit-based incentive payment system (MIPS).

For more information on the VBM, visit the [CMS website](#).