New Jersey Academy of Otolaryngology-Head & Neck Surgery
New Jersey Academy of Facial Plastic Surgeons

JUNE 2013

From the Statehouse **Advocacy and Management Group**

NEW JERSEY MEDICAL MARIJUANA: UPDATE

New Jersey's Medical Marijuana Program, run by the Department of Health, has registered 376 severely ill patients to date. During May's Budget Hearings, held by the New Jersey Senate and Assembly, Commissioner of Health, Mary O'Dowd, confirmed that there is currently only one licensed dispensary open in the state. Greenleaf Compassion Center, located in Montclair, is currently responsible for serving all 376 patients. Unfortunately the waiting list to receive prescribed medical marijuana from the Montclair location is extensive.

Five other nonprofit cultivation and dispensary locations were selected by the state two years ago. Four of these five have finally, after much difficultly, found a community willing to host their dispensary. Compassionate Care Foundation in Egg Harbor and Compassionate Care Centers of America Foundation in Woodbridge are "far along" in the vetting process and are expected to open in 2013, according to the Commissioner.

Much attention has also surrounded the Governor's recent comments on the use of medical marijuana by children. In response to a recent Star Ledger report regarding the use of medical marijuana by a two-year old with severe and rare form of epilepsy, the Governor stated that he is "not inclined to allow [children] to have it." According to New Jersey law, a family may purchase medical marijuana on a child's behalf only after receiving the approval of a pediatrician, a psychiatrist and the child's prescribing physician. The Governor's office has voiced concern over the public policy implications of minors having access to legal marijuana.

NJ SUPREME COURT RULES ON MEDICAL MALPRACTICE CASE STANDARDS

New Jersey State Supreme Court recently ruled that physicians called as expert witnesses on a patient's behalf must hold the same credentials as the physician accused of the wrongdoing. This ruling, with a 6-0 decision by the court, was the result of a lawsuit in which an internist was called as an expert witness in a case against both an emergency and family physician. According to Justice Barry Albin of the New Jersey Supreme Court, the Patients First Act of 2004, which addressed escalating medical malpractice insurance premiums, "does not permit [an internist] to testify about the standard of care exercised by a physician practicing in a different specialty."

PHYSICIAN SURVEY LEGISLATION VETOED BY GOVERNOR

Governor Christie has conditionally vetoed legislation that would mandate all physicians to complete a survey as a condition for biennial registration with the Board of Medical Examiners. The legislation was introduced in an attempt to address the lack of comprehensive understanding by the State on physician shortages within New Jersey. Improved data collection can possibly address future physician shortages in both primary care and specialty areas. It is also thought to improve the State's ability to qualify for J-1 visa positions and federal loan repayment funding. The Governor has asked the legislature to revise the legislation so that physicians can voluntarily submit the survey, instead of the current compulsory requirements.

LEGISLATION COULD ALLOW PSYCHOLOGISTS TO PRESCRIBE MEDICATION

The Assembly has passed legislation that would provide psychologists with prescriptive authority. Under the legislation, the psychologist would have to successfully graduate with a postdoctoral master's degree in clinical psychopharmacology from an accredited institution and pass an examination approved by the State Board of Psychological Examiners that is relevant to establishing competence for prescribing drugs.

This legislation is accompanied by various other bills that could threaten patient's safety. Legislation for Physician Assistant's would permit each physician to develop the Physician Assistant's scope of practice independently, and eliminate the need to sign off on charts within a specified number of days. The Advanced Practice Nurse legislation would allow the allied health providers to practice independently without a collaborative agreement with a supervising physician.

COSMETIC TAX ROLLBACK: ANOTHER REDUCTION STARTING JULY 1

Phase II of the rollback on New Jersey's tax for cosmetic procedures will begin on July 1, 2013, as the tax drops from 4 to 2 percent.

In January 2012, the Cosmetic Tax Rollback was signed into law by Governor Christie. This rollback countered the 2004 legislation that explicitly taxed cosmetic surgical procedures by 6%, a measure that never produced the anticipated revenue expected by the government. This action is very significant as New Jersey was one of the first states to institute the tax, which drove business out of New Jersey and prompted patients to go to other states for these procedures. The first phase out of the cosmetic rollback began in July 2012, when the tax was reduced from 6 to 4 percent.

A final rollback will occur in July of 2014, with a complete dissolution of the tax.

Legal Report **Kern Augustine Conroy & Schoppmann, PC**

DOBI Issues Bulletin Regarding Out-Of-Network Breast Reconstruction Surgery: The NJ Department of Banking & Insurance (DOBI) has issued Bulletin No. 13-10, Network Access and Adequacy - Reconstructive Breast Surgery to address recurring instances of the inability of patients to obtain in-network benefits for the services of non-network surgeons performing breast reconstruction as part of the surgical procedure in which a mastectomy is performed. DOBI notes that, in some cases, carriers have been declining patient requests to use out-of-network surgeons, asserting the availability of in-network surgeons. However, the in-network surgeons frequently do not perform, or are not qualified to perform, the particular type of requested reconstructive surgery. DOBI states that covered persons should not have to file medical necessity appeals in order to receive these specialized services at the in-network level of benefits where in-network breast reconstruction surgeons do not perform the procedure requested or are not associated with the team of network surgeons who perform the mastectomy.The State's standards for carrier network access and adequacy require access to specialists who provide medically necessary specialty care. For example, if the necessary service is reconstructive microsurgery, plans must provide access to reconstructive micro surgeons or approve the use of out-of-network micro surgeons. According to DOBI, plans may not deny requests for the use of out-of-network providers who can provide services at the same surgery session if an in-network provider is not available to provide the services at the same surgery session, either because they do not work with the surgeon who performs the mastectomy or they do not perform the required surgical procedure. See the Bulletin at:
http://www.state.nj.us/dobi/bulletins/blt13_10.pdf.

Report Decries Increase in Medicare-Reimbursed Blepharoplasty: A recently published report by the Center for Public Integrity charges that the number of blepharoplasty procedures billed to and paid by Medicare has "skyrocketed" and that the medical necessity for many of the procedures does not meet Medicare requirements, or that the surgeon and patient conspired to meet the requirements for Medicare coverage of the procedure. Despite arguments denouncing the report, surgeons should be aware that the report has gained the attention of the media and members of Congress. In addition, some CMS contractors have conducted pre-payment review of these claims, resulting in a high level of denials based on insufficient documentation to prove that the surgeries were reasonable and necessary. See the report at: http://www.publicintegrity.org/2013/05/28/12713/eyelid-lifts-skyrocket-among-medicare-patients-costing-taxpayers-millions?utm_source=5.29.13&utm_campaign=11713&utm_medium=email. To review New Jersey's Medicare Contractor Novitas' Local Coverage Decision on blepharoplasty, including documentation requirements, see: https://www.novitas-solutions.com/policy/mac-ab/l27474-r9.html.

Claim Denials Delayed for Ordering/Referring Providers: CMS has temporarily delayed the May 1, 2013 start date for denying Part B claims that fail the ordering/referring provider edits. Once CMS does activate the edits, these claims will not be paid if a billed service requires an ordering/referring provider and the ordering/referring provider: 1) is not identified on the claim; 2) is identified on the claim, but is not enrolled in Medicare; or 3) is identified on the claim, but is not of a specialty that is eligible to order/refer. CMS has issued a rule proposal, discussed below, which clarifies that physicians enrolling solely as ordering/referring providers do not have Medicare billing privileges and cannot bill Medicare.

CMS Proposes Changes to Incentive Reward Program & Enrollment: CMS has issued a rule proposal that will change the CMS Incentive Reward Program potential reward amount, for information on individuals and entities who

engage in acts or omissions resulting in sanctions, from 10% of the overpayments recovered in the case or $1,000, whichever is less, to 15% of the final amount collected applied to the first $66,000,000 for the sanctionable conduct. The proposal also revises the Medicare enrollment process to further protect against program fraud by: 1) expanding the instances in which a felony conviction can serve as a basis for denial or revocation of enrollment; 2) enabling CMS to deny enrollment if the enrolling physician, provider or owner had an ownership relationship with a previously enrolled provider or supplier that had a Medicare debt; 3) allowing revocation of Medicare billing privileges if the physician or provider has a pattern or practice of submitting claims for services that fail to meet Medicare requirements; 4) providing a 60 day limitation on the period in which a revoked physician can submit claims for services furnished prior to the revocation letter's date; 5) make re-enrollment bars effective beginning 30 days after notice of revocation; and 6) allowing physicians only one chance to correct all deficiencies that serve as the basis for revocation through a Corrective Action Plan. Comments on the proposal (http://ow.ly/l6TL8) can be made through June 28, 2013.

OIG Issues New Cautions on Exclusion: The U.S. Dept of Health & Human Services' Office of Inspector General (OIG) has issued *Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs* **(**http://oig.hhs.gov/exclusions/files/sab-05092013.pdf). The Bulletin updates and supersedes the OIG's earlier bulletin on the same topic issued in 1999. A physician practice that makes any claims that are based on the work of an excluded person, where any part of the services is reimbursed by a federal healthcare program, is subject to civil monetary penalties. The Bulletin provides guidance on: the scope of the payment prohibition, potential Civil Monetary Penalty liability, and best practices for screening against the List of Excluded Individuals & Entities (LEIE) to ensure that physicians do not employ or contract with an excluded individual. The Bulletin also advises physicians on how to use the OIG's Self Disclosure Protocol to self-disclose the employment of or contracting with an excluded person. Physician practices should be conducting initial and annual screening of all personnel. Contact Kern Augustine prior to making any disclosures to the OIG, or for additional information on this subject.

For more information on the above items, contact Bob Conroy (conroy@drlaw.com) or Denise Sanders (sanders@drlaw.com) at Kern Augustine Conroy & Schoppmann. Or call KACS at 1-800-445-0954.

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