



Surgical Care Affiliates

Executive Secretary Office

January 29, 2016

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RECEIVED

VIA HAND DELIVERY

Andrew T. Heath, Chairman
North Carolina Industrial Commission
430 North Salisbury Street
Raleigh, NC 27603

Re: Surgical Care Affiliates Petition to Amend Rule 04 NCAC 10J .0103

Dear Chairman Heath:

Please find enclosed Surgical Care Affiliates LLC's ("SCA") Petition to the North Carolina Industrial Commission to amend Rule 04 NCAC 10J .0103. For your convenience, we have included a redline and clean copy of the regulation as it would appear if SCA's amendment is adopted.

SCA's Petition to Amend 04 NCAC 10J .0103 is an alternative to the Request for Declaratory Ruling that is currently pending judicial review in Wake County Superior Court. SCA is pursuing this amendment without waiving the rights asserted in its Petition for Judicial Review in the hope and anticipation that the proposed amendment to 04 NCAC 10J .0103 will be adopted by the Commission.

As I have expressed to you previously, SCA would like to work directly with the Commission on this proposed language and hope that through collaboration we can find an outcome that works for all interested parties, including the State and North Carolina's injured workers.

I look forward to speaking to you and other members of the Commission about this issue in the near future.

Sincerely,

Jason Strauss
Senior Vice President, Surgical Care Affiliates, LLC

**PETITION TO THE NORTH CAROLINA INDUSTRIAL COMMISSION TO AMEND
RULE 04 NCAC 10J .0103**

January 29, 2016

To: North Carolina Industrial Commission
4336 Mail Service Center
Raleigh, North Carolina 27699-4336

Pursuant to N.C. Gen. Stat. § 150B-20 and 04 NCAC 10E .0101, Surgical Care Affiliates, LLC (“SCA”) petitions the North Carolina Industrial Commission (the “Commission”) to amend its Rule 04 NCAC 10J .0103, which addresses fees for institutional services in Workers’ Compensation cases. This proposed amendment addresses the maximum allowable amounts for services provided by ambulatory surgical centers (“ASCs”) in Workers’ Compensation cases under North Carolina’s Workers’ Compensation Act.

In support of this petition, SCA provides the following information:

THE PETITIONER SURGICAL CARE AFFILIATES, LLC

SCA manages six ambulatory surgery centers in North Carolina and has an ownership interest in each of these centers through wholly-owned subsidiary corporations (hereinafter “SCA ambulatory surgery centers”). The SCA ambulatory surgery centers are located throughout North Carolina and include Blue Ridge Day Surgery in Raleigh, Charlotte Surgery Center, Fayetteville Ambulatory Surgery Center, Greensboro Specialty Surgery Center, Surgical Center of Greensboro, The Eye Surgery Center of the Carolinas in Southern Pines, and Eastern Regional Surgical Center in Wilson,

**SCA’S REQUESTED AMENDMENT OF THE COMMISSION’S RULE 04 NCAC10J
.0103**

The Commission’s Rule 04 NCAC 10J .0103 addresses fees for institutional services under North Carolina’s Workers’ Compensation Act and includes a schedule of maximum reimbursement rates for some of the services provided by ASCs. The schedule set forth in this regulation only addresses surgical procedures that are covered under the Medicare program and does not include surgical procedures that are or can be performed in ambulatory surgical centers but are not covered under Medicare. The amendment proposed by SCA addresses procedures that are not currently covered in this regulation and changes the schedule of maximum reimbursement rates for ASCs to align with the reimbursement rates set for the hospital outpatient departments. This alignment of reimbursement schedules allows for site of service decisions to be based solely on clinical judgment, quality outcomes and scheduling efficiency, all for the sole benefit of the injured worker. The Commission has the statutory authority to adopt this proposed amendment under N.C. Gen. Stat. § 97-26(a) of the Workers’ Compensation Act.

To effectuate these needed revisions to the regulation, SCA proposes that 04 NCAC 10J .0103 be amended so that subsections (g) and (h) and relevant portions of subsection (i) of 04 NCAC 10J .0103 (effective April 1, 2015) are deleted as shown in the attached Exhibit 1 and that the following proposed subsection (g) is substituted to read as follows:

(g) For those procedures for which CMS has established a Medicare rate, the schedule of maximum reimbursement rates for services provided by ambulatory surgical centers (“ASC”) should be the same as the schedule of maximum reimbursement rates for hospital outpatient institutional services as set forth in sub-part (c) above. For those procedures for which CMS has not established a Medicare rate for hospital outpatient institutional services, the maximum allowable amounts for services provided by ASCs shall be 50% of billed charges up to a cap of \$30,000. Charge master increases will be limited to 0% increase for these procedure codes for the first 3 years, or a revenue neutral adjustment will be applied to the percent of charge paid.

See attached, Exhibit 1, Proposed Revised 04 NCAC 10J .0103.

SCA’s proposed amendment to the regulation serves to align payments for ambulatory surgical procedures with the Medicare fee schedule while at the same time acknowledging that Medicare has not created an allowance for certain procedures which are routinely and safely provided to non-Medicare patient in the ASC setting. As such, SCA is proposing a rate for these services that is consistent with the resources and time involved in providing such procedures. This methodology is intentionally structured to ease the burden on the State such that rates typically paid as an episode of care are limited to only the surgical portion of the procedure. In order to limit the uncertainty of the state’s exposure on reimbursement, charge master increases will be limited to 0% increase for these procedure codes for the first 3 years, or a revenue neutral adjustment will be applied to the percent of charge paid.

SCA believes that the Commission may adopt its proposed changes to 04 NCAC 10J .0103 without submitting a fiscal note. Under N.C. Gen. Stat. § 150B-21.4(b1) the Commission is only required to submit a fiscal note if amending 04 NCAC 10J .0103 would have “substantial economic impact.” Substantial economic impact is defined as a rule change that that has an aggregate financial impact on all person affected of at least one million dollars (\$1,000,000) in a 12-month period. Furthermore, under State law the Commission has the authority and discretion to identify the appropriate time frame for its analysis and to assess the baseline conditions against which the proposed rule is to be measured. See N.C. Gen. Stat. § 150B-21.4(b1)(1) and (2).

Because the Commission has the discretion to determine the appropriate timeframe and baseline conditions, it would be appropriate for the economic impact of the proposed regulation to be measured against the 2014 rate structure that was in place for ASCs for at least two reasons.

First, 04 NCAC 10J .0103 failed to include procedures that were previously covered under the 2014 payment scheme for ASCs, a result that was not intended by S.L. 2013-410. Thus the current fee schedule should be viewed as incomplete because it failed to consider the effects the new payment schedule would have on ambulatory surgical services. When the proposed change to 04 NCAC 10J .0103 are compared against the payments received by ASCs in 2014, the proposed amendment would not increase payment rates to ambulatory surgery providers and would have no negative financial impact. In fact, when compared against the 2014 fee structure, SCA’s proposed amendment to 04 NCAC 10J .0103 will result in a reduction in fees paid for ambulatory surgery.

Alternatively, the Commission could also determine that it is exempt from the fiscal note requirement under S.L. 2013-410. Specifically Section 33.(a)(3) of S.L. 2013-410 states that the

Commission is exempt from the fiscal note-requirement of N.C. Gen. Stat. § 150B-21.4 in developing the fee schedule required by the session law. If the Commission's Declaratory Ruling is correct, and ambulatory surgery providers were intended to be covered by S.L. 2013-410, the Commission should also conclude that a fiscal note is not required to adopt SCA's proposed amendment. While SCA's Petition for Judicial Review disputes that S.L. 2013-410 applies to ambulatory surgical centers, it recognizes that the Commission in considering this proposed amendment to the regulation should determine that a fiscal note would not be required to remain consistent with its Declaratory Ruling.

**WHY SCA IS REQUESTING THE AMENDMENT OF THE COMMISSION'S RULE
AND THE EFFECT OF THE AMENDMENT ON THE PROCEDURES OF THE
COMMISSION**

The amendment of 04 NCAC 10J.0103 is requested by SCA for two reasons:

First, the fee schedule in the Rule adopted by the Commission effective April 1, 2015 does not cover all procedures that are being performed and can be performed in ambulatory surgery centers. Currently, injured workers are receiving these surgical services in more expensive inpatient settings. Receiving these services in an inpatient settings often takes longer to schedule than scheduling the same procedure in an ambulatory surgical center, as a result the current regulation causes injured workers to be delayed in receiving needed surgical services. The failure to address all surgical procedures in the fee schedule has also resulted in confusion and a failure of some carriers to provide any reimbursement to the SCA ambulatory surgery centers for procedures it has traditionally provided to injured workers because they are not covered under the Medicare fee schedule.

Second, reduction in rate for ambulatory surgical services in the fee schedule contained in the current version of 04 NCAC 10J .0103 is insufficient to meet the requirements set forth in N.C. Gen. Stat. § 97-26(a). Ambulatory surgery centers are currently not being reimbursed equitable fees and injured workers are not being provided services consistent with the timing or standard of care intended by the Workers' Compensation Act. Furthermore, because SCA and other free standing ambulatory surgery centers were not involved in the process of developing new fee schedules that are set forth in the regulation, the Commission did not have all information that would have been useful in determining reimbursement for ambulatory surgery centers, which would include the administrative burdens related to scheduling, approval, claims processing and collections, the additional expenses related to caring for traumatic injuries in a timely manner, and the financial risk related to delayed payment due to litigation that is carried by a provider when caring for injured workers. It should also be noted, that ambulatory surgery centers who treat injured workers have significantly better quality outcomes and drive return to work metrics down. The amendment being proposed by SCA should have a positive effect on the procedures of the Commission because it will eliminate the confusion that currently exists whereby some insurance carriers have and continue to determine that some procedures currently being performed at ambulatory surgery centers are not covered in the current fee schedule. In addition, the proposed fee schedule for ambulatory surgery centers will have the added positive effect of lowering the costs for some surgical procedures that are currently provided in inpatient settings by ensuring that those procedures can be reimbursed in ambulatory surgical centers at a lower cost. This proposed regulation has also been drafted to allow the State, on an ongoing yearly basis, to manage only one fee schedule across all outpatient surgical settings.

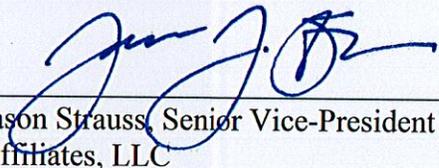
SCA's Petition to Amend 04 NCAC 10J .0103 is an alternative to SCA's Request for Declaratory Ruling that is currently pending in Wake County Superior Court. SCA contends that its Request for Declaratory Ruling is meritorious and should have been granted by the Commission. SCA is pursuing this alternative, without waiving its rights as asserted in its Petition for Judicial Review, in the hope and anticipation that its proposed amendment, will be adopted by the Commission and will provide a consistent and comprehensive reimbursement fee schedule for the foreseeable future.

OTHER RELEVANT INFORMATION

This Petition for the Amendment of the Commission's Rule is supported by numerous other groups and organizations and SCA anticipates that other indications of support will be forthcoming.

In conclusion, SCA strongly urges the Commission to grant this Petition and initiate a rule-making proceeding to amend the ambulatory surgery fee schedule for Workers' Compensation cases to include all services allowed and provided by ambulatory surgical centers which are not included in the Medicare fee schedule and to include a sufficient reimbursement amount for procedures provided by ambulatory surgical centers.

Respectfully submitted this 29th of January, 2016



Jason Strauss, Senior Vice-President Surgical Care
Affiliates, LLC

EXHIBIT 1

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

(a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services shall be based on the current federal fiscal year's facility-specific Medicare rate established for each institutional facility by the Centers for Medicare & Medicaid Services ("CMS"). "Facility-specific" rate means the all-inclusive amount eligible for payment by Medicare for a claim, excluding pass-through payments.

(b) The schedule of maximum reimbursement rates for hospital inpatient institutional services is as follows:

- (1) Beginning April 1, 2015, 190 percent of the hospital's Medicare facility-specific amount.
- (2) Beginning January 1, 2016, 180 percent of the hospital's Medicare facility-specific amount.
- (3) Beginning January 1, 2017, 160 percent of the hospital's Medicare facility-specific amount.

(c) The schedule of maximum reimbursement rates for hospital outpatient institutional services is as follows:

- (1) Beginning April 1, 2015, 220 percent of the hospital's Medicare facility-specific amount.
- (2) Beginning January 1, 2016, 210 percent of the hospital's Medicare facility-specific amount.
- (3) Beginning January 1, 2017, 200 percent of the hospital's Medicare facility-specific amount.

(d) Notwithstanding the Paragraphs (a) through (c) of this Rule, maximum allowable amounts for institutional services provided by critical access hospitals ("CAH"), as certified by CMS, are based on the Medicare inpatient per diem rates and outpatient claims payment amounts allowed by CMS for each CAH facility.

(e) The schedule of maximum reimbursement rates for inpatient institutional services provided by CAHs is as follows:

- (1) Beginning April 1, 2015, 200 percent of the hospital's Medicare CAH per diem amount.
- (2) Beginning January 1, 2016, 190 percent of the hospital's Medicare CAH per diem amount.
- (3) Beginning January 1, 2017, 170 percent of the hospital's Medicare CAH per diem amount.

(f) The schedule of maximum reimbursement rates for outpatient institutional services provided by CAHs is as follows:

- (1) Beginning April 1, 2015, 230 percent of the hospital's Medicare CAH claims payment amount.
- (2) Beginning January 1, 2016, 220 percent of the hospital's Medicare CAH claims payment amount.
- (3) Beginning January 1, 2017, 210 percent of the hospital's Medicare CAH claims payment amount.

~~(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register ("the Medicare ASC facility-specific amount"). Reimbursement shall be based on the fully implemented payment amount in Addendum AA, Final ASC Covered Surgical Procedures for CY 2015, and Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2015, as published in the Federal Register, or their successors.~~

~~(g) For those procedures for which CMS has established a Medicare rate, the schedule of maximum reimbursement rates for services provided by ambulatory surgical centers ("ASC") should be the same as the schedule of maximum reimbursement rates for hospital outpatient institutional services as set forth in sub-part (c) above. For those procedures for which CMS has not established a Medicare rate for hospital outpatient institutional services, the maximum allowable amounts for services provided by ASCs shall be 50% of billed charges up to a cap of \$30,000. Charge master increases will be limited to 0% increase for these procedure codes for the first 3 years, or a revenue neutral adjustment will be applied to the percent of charge paid.~~

~~(h) The schedule of maximum reimbursement rates for institutional services provided by ambulatory surgical centers is as follows:~~

- ~~(1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility-specific amount.~~
- ~~(2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.~~
- ~~(3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.~~

(h) If the facility-specific Medicare payment includes an outlier payment, the sum of the facility-specific reimbursement amount and the applicable outlier payment amount shall be multiplied by the applicable percentages set out in Paragraphs (b), (c), (e), and (f), and (h) of this Rule.

(i) Charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.

(j) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping ("DRG") payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.

(k) For specialty facilities paid outside Medicare's inpatient and outpatient Prospective Payment System, the payment shall be determined using Medicare's payment methodology for those specialized facilities multiplied by the inpatient institutional acute care percentages set out in Paragraphs (b) and (c) of this Rule.

*History Note: Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410;
Eff. April 1, 2015.*

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History Note: Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410; Eff. April 1, 2015.