

Pat McCrory, Governor
Charlton L. Allen, Chairman



Bernadine S. Ballance, Commissioner
Linda Cheatham, Commissioner
Bill Daughtridge, Jr., Commissioner
Christopher C. Loutit, Commissioner
Tammy R. Nance, Commissioner

North Carolina Industrial Commission

May 27, 2016

Mr. Jason Strauss
Surgical Care Affiliates, LLC
569 Brookwood Village, Suite 900
Birmingham, AL 35209

Re: IN RE: SURGICAL CARE AFFILIATES' PETITION TO AMEND
RULE 04 NCAC 10J .0103

Dear Mr. Strauss:

The North Carolina Industrial Commission ("the Commission") received a petition for rulemaking from you on behalf of Surgical Care Affiliates, LLC ("the Petition"), on January 29, 2016.

Pursuant to Rule 04 NCAC 10E .0101(a), a petition for rulemaking submitted to the Commission must include the following information:

- (1) the name and address of the person submitting the petition;
- (2) a citation to any rule for which an amendment or repeal is requested;
- (3) a draft of any proposed rule or amended rule;
- (4) an explanation of why the new rule or amendment or repeal of an existing rule is requested and the effect of the new rule, amendment, or repeal on the procedures of the Commission; and
- (5) any other information the person submitting the petition considers relevant.

Pursuant to 150B-20(b) and Rule 04 NCAC 10E .0101(b), the Commission has 120 days to consider whether to grant or deny a petition for rulemaking. Further, "[i]n making the decision, the Commission shall consider the information submitted with the petition and any other relevant information." Rule 04 NCAC 10E .0101(b).

Since its receipt of the Petition, the Commission has thoroughly evaluated and considered the request. Following this evaluation, the Commission has determined that the Petition should be denied, with one member abstaining. The reasons for the denial of the petition are outlined below.

In its Petition, Surgical Care Affiliates, LLC ("SCA") requests that the Commission amend Rule 04 NCAC 10J .0103 to change the base rate applied to payments for services provided by ambulatory surgical

centers from the current Medicare payment rates for ambulatory surgical centers to the current Medicare payment rates for outpatient hospitals. SCA also requests that for those procedures for which the Centers for Medicare and Medicaid Services ("CMS") have not established an outpatient hospital reimbursement rate, the rule should provide for payment of 50% of billed charges up to a maximum of \$30,000. The proposed rule changes are contained in Exhibit 1 to the Petition and are incorporated herein by reference.

More than a year ago, the Commission entered into rulemaking to completely revise its medical fee schedule as directed by the General Assembly in Session Law 2013-410. The Commission published notice of the rulemaking, including a notice of a public hearing and written comment period. SCA provided no input on or objection to the adoption of the rule which it now requests the Commission to amend. The rule in question, Rule 04 NCAC 10J .0103, was approved by the Rules Review Commission on February 19, 2015. SCA did not submit any letters of objection requesting legislative review of the rule. The rule became effective on April 1, 2015. Now, SCA seeks to have the rates that apply to its services increased significantly and, in many cases, doubled. For those procedures not addressed by the Commission's Medicare-based fee schedule, SCA seeks a percentage-of-charges provision despite the statutory availability of usual, customary, and reasonable ("UCR") reimbursement under N.C. Gen. Stat. 97-26(c) and the directive in Session Law 2013-410 for the Commission to move away from its prior percentage-of-charges fee schedule.

The Commission has given thoughtful and careful consideration to the amendments requested by SCA. In addition to the Petition, the Commission reviewed the following relevant information and materials:

- The current Rule 04 NCAC 10J .0103, effective April 1, 2015. See attachment.
- The previous Rule 04 NCAC 10J .0101 in effect prior to April 1, 2015. See attachment.
- Session Law 2013-410 and its directive to the Commission to revise the workers' compensation medical fee schedule using a Medicare-based payment methodology. See attachment.
- The oral and written public comments submitted in the fee schedule revision rulemaking in 2014-15, as well as the materials listed in the notice of rulemaking published in Volume 29, Issue 10, of the North Carolina Register at pages 1192-1196. See attachment.
- Past versions of the Commission's medical fee schedule, as well as past amendments to N.C. Gen. Stat. § 97-26. See attachments.
- The current fee schedule bases and rates for ambulatory surgical services promulgated by a number of other states' workers' compensation commissions that use a similar Medicare-based reimbursement methodology. See attached list.
- *Payments to Ambulatory Surgery Centers, 2nd Edition*, WCRI, Bogdan Savych, May 2016. (Available upon request to WCRI.)
- *Comparing Payments to Ambulatory Surgery Centers and Hospital Outpatient Departments, 2nd Edition*, WCRI, Bogdan Savych, May 2016. (Available upon request to WCRI.)
- CMS rules regarding its Medicare payment system for ambulatory surgical centers and a related study by the General Accounting Office ("GAO").
 - *Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System*, GAO-07-86, November 30, 2006.
 - *Medicare Program; Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs) Beginning in CY 2008*, 72 FR 42470, 42475, August 2, 2007.
- *Analysis of Proposed Changes to the North Carolina Medical Fee Schedule*, National Council on Compensation Insurance, Inc., December 4, 2014. See attachment.

- *Workers Compensation Insurance 2015 Loss Costs Filing*, North Carolina Rate Bureau, August 28, 2015, available at http://www.ncrb.org/Portals/0/ncrb/workers%20comp%20services/Rate%20Filings/8-28-15%20WC%20Loss%20Costs%20Filing_opt.pdf.
- *Analysis of Hypothetical Changes to the North Carolina Medical Fee Schedule Proposed to be Effective October 1, 2016*, National Council on Compensation Insurance, Inc., March 29, 2016. See attachment.

Based on its review of the Petition and the additional relevant information, the Commission's reasons for denying the Petition include the following:

1. The impact of the proposed rule changes would be a significant increase in ambulatory surgical center reimbursement rates that would negate the revisions to the overall fee schedule in 2015. At that time, the Commission considered all of the factors mentioned in Session Law 2013-410: (1) access to quality care for injured workers; (2) reasonable reimbursement for providers; and (3) adequate containment of medical costs, and the Commission sought to strike a balance. The WCRI studies considered by the Commission indicate that, prior to the 2015 medical fee schedule changes, many types of North Carolina physicians were being reimbursed at rates below the national average and that North Carolina institutional providers including hospitals and ambulatory surgical centers were being reimbursed at rates well above the national average for workers' compensation.

In trying to control costs while also ensuring quality care and reasonable reimbursement, the Commission cannot evaluate one set of rates in isolation. The amendments requested by SCA cannot be considered without reference to the entire fee schedule, which was recently revised with due consideration of the fee rates for each type of provider. SCA submitted no information indicating any efforts on their part to work with other stakeholders regarding the requested increase in fees for ambulatory surgical centers.

2. The study reports by WCRI indicate that prior to the 2015 fee schedule overhaul, North Carolina's ambulatory surgical centers received workers' compensation reimbursements that were well above the national average. It was at that time that the General Assembly directed the Commission to move to a Medicare-based fee schedule. SCA's proposed rule changes request reimbursement rates that are significantly higher than the average of the rates currently allowed by other states using Medicare reimbursement standards for workers' compensation cases.

For states that base reimbursement of ambulatory surgical centers on the Medicare ambulatory surgical center rates, the average fee percentage allowed is about 147%. SCA currently receives 210% of the current Medicare ambulatory surgical center rate under the rule it wishes to change to obtain an even higher rate of reimbursement. For states that allow both ambulatory surgical centers and outpatient hospital facilities to be reimbursed using Medicare's outpatient hospital rates, the average fee percentage allowed for ambulatory surgical centers is about 128%. Notably, SCA is requesting 210% of current Medicare outpatient hospital rates for dates of services in 2016, and 200% of current Medicare outpatient rates in 2017 and beyond.

SCA asserts that ambulatory surgical centers provide "better quality outcomes" and that the current fees allowed ambulatory surgical centers are "insufficient" and not "equitable." However, SCA provided no documentation in support of these and similar assertions that would justify an increase so far above the average of the rates of similar states.

3. The March 29, 2016 analysis by NCCI of the proposed rule changes indicated that a change to reimbursement of ambulatory surgical centers services at 210% of current Medicare outpatient rates could cause an estimated increase of \$21M to \$28M in premium dollars to the workers' compensation system in North Carolina. Given that NCCI estimated in 2014 that the fee schedule overhaul in 2015, which involved increases in professional fees and decreases in institutional fees, could save the North Carolina workers' compensation system \$27 million, the requested changes appear to have the potential to swallow most, if not all, of the savings captured in the 2015 rulemaking.

The anticipated effects of the 2015 fee changes figured into both insurance rates and reserves for 2015 and beyond.¹ The requested increase would likely affect insurance rates and result in increased workers' compensation insurance premiums for North Carolina businesses. SCA did not provide documentation showing that the proposed changes would benefit injured workers in any concrete way that would justify a potential reversal of the savings to the system achieved in the 2015 rulemaking.

4. Research indicated that the payment system established by CMS for ambulatory surgical centers is based on the lower relative costs for procedures performed at ambulatory surgical centers as compared to outpatient hospitals.² Although SCA referenced in the Petition administrative burdens and costs associated with workers' compensation cases as a reason for the request increased rates, no evidence was submitted showing that ambulatory surgical centers experience any such costs to a greater extent than outpatient hospitals or other medical providers. The Petition did not provide sufficient relevant documentation or justification for a departure from the Medicare model.

5. SCA's request to return to a percentage-of-charges model for those procedures not addressed by Medicare in its outpatient fee schedule is not persuasive for at least two reasons. First, the institutional fee schedule the General Assembly instructed the Commission to revise was a percentage-of-charges fee schedule that had been converted to a fixed rate schedule when the Commission had to freeze charges in 2013. The percentage of charges model has required adjustments by statute, rule, or Commission order at various points over the last 15+ years due to increases in charges. Second, as mentioned above, the General Assembly anticipated in N.C. Gen. Stat. § 97-26(c) that the Commission might adopt a fee schedule that did not cover every procedure an institution might provide. The statutory provision allowing reimbursement based on UCR charges makes resorting to a problematic percentage of charges fee scheme unnecessary.

SCA further asserted that there is confusion among workers' compensation carriers under the current rule regarding what procedures are reimbursed for ambulatory surgical centers. However, the Commission has not received any fee dispute resolution requests indicating confusion about the ambulatory surgical center rates or what to pay an ambulatory surgical center if the fee schedule does not address a particular procedure. Further, as noted below, several groups representing insurance carriers sent a letter to the Commission objecting to the proposed rule changes.

Moreover, SCA asserts that the proposed rule will benefit the State by requiring the management of only

¹ See generally *Workers Compensation Insurance 2015 Loss Costs Filing*, North Carolina Rate Bureau, August 28, 2015, available at http://www.ncrb.org/Portals/0/ncrb/workers%20comp%20services/Rate%20Filings/8-28-15%20WC%20Loss%20Costs%20Filing_opt.pdf.

² See *Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System*, GAO-07-86, November 30, 2006; *Medicare Program; Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs) Beginning in CY 2008*, 72 FR 42470, 42475, August 2, 2007.

one fee schedule for reimbursement of all outpatient surgical services. For the reasons stated above, the Commission believes that different fee schedules for outpatient and ambulatory surgical center facilities are appropriate. The Commission is unaware of any particular administrative burden to the State in having variation in rates between types of facilities.

SCA stated in the Petition that its request is supported by numerous other groups and organizations, but the Commission has not received any indications of support from other ambulatory surgical centers. The Commission did receive two letters of objection to the proposed rule changes, one from the North Carolina Hospital Association and one filed jointly by 21 entities including insurance carriers, employer and business associations, and insurance carrier associations. A number of letters supporting payment of ambulatory surgical centers at the same rates as outpatient hospitals were received from physicians, almost exclusively practicing with OrthoCarolina, prior to the filing of the Petition.

Based on consideration of the Petition and other relevant information, the absence of persuasive evidence or arguments submitted with the Petition, and for the reasons stated above, the Commission does not find good cause to grant SCA's Petition and the Petition is, therefore, denied. This letter is the Commission's written notice of denial to Petitioner as required by Rule 04 NCAC 10E .0101(c). Information regarding how to appeal the Commission's denial may be found at N.C. Gen. Stat. § 150B-20(d) and §150B-43 *et seq.*

Sincerely,

s/Charlton L. Allen

Charlton L. Allen
Chairman

Attachments

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.

(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.

(i) 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), (f), and (h) of this Rule.

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

(k) 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.

(l) 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.

SUBCHAPTER 10J – FEES FOR MEDICAL COMPENSATION

SECTION .0100 – FEES FOR MEDICAL COMPENSATION

04 NCAC 10J .0101 FEES FOR MEDICAL COMPENSATION (EFFECTIVE JULY 1, 2014)

(a) The Commission adopted and published a Medical Fee Schedule, pursuant to the provisions of G.S. 97-26(a), setting maximum amounts, except for hospital fees pursuant to G.S. 97-26(b), that may be paid for medical, surgical, nursing, dental, and rehabilitative services, and medicines, sick travel, and other treatment, including medical and surgical supplies, original artificial members as may reasonably be necessary at the end of the healing period and the replacement of such artificial members when reasonably necessitated by ordinary use or medical circumstances. The amounts prescribed in the applicable published Fee Schedule shall govern and apply according to G.S. 97-26(c).

(b) The Commission's Medical Fee Schedule contains maximum allowed amounts for medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology (CPT) codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems (HCPCS) codes, and jurisdiction-specific codes. A listing of the maximum allowable amount for each code is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.

(c) The following methodology provides the basis for the Commission's Medical Fee Schedule:

- (1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201-99205 and 99211-99215, which are based on 1995 Medicare values multiplied by 2.05.
- (2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.
- (3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.
- (4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.

(d) The Commission's Hospital Fee Schedule, adopted pursuant to G.S. 97-26(b), provides for payment as follows:

- (1) Inpatient hospital fees: Inpatient services are reimbursed based on a Diagnostic Related Groupings (DRG) methodology. The Hospital Fee Schedule utilizes the 2001 Diagnostic Related Groupings adopted by the State Health Plan. Each DRG amount is based on the amount that the State Health Plan had in effect for the same DRG on June 30, 2001.

DRG amounts are further subject to the following payment band that establishes maximum and minimum payment amounts:

- (A) The maximum payment is 100 percent of the hospital's itemized charges.
 - (B) For hospitals other than critical access hospitals, the minimum payment is 75 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
 - (C) For critical access hospitals, the minimum payment is 77.07 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
- (2) Outpatient hospital fees: Outpatient services are reimbursed based on the hospital's actual charges as billed on the UB-04 claim form, subject to the following percentage discounts:
 - (A) For hospitals other than critical access hospitals, the payment shall be 79 percent of the hospital's billed charges. Effective February 1, 2013, the payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
 - (B) For critical access hospitals, the payment shall be 87 percent of the hospital's billed charges. For purposes of the hospital fee schedule, critical access hospitals are those hospitals designated as such pursuant to federal law (42 CFR 485.601 et seq.). Effective February 1, 2013, the critical access hospital's payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
 - (3) Ambulatory surgery fees: Ambulatory surgery center services are reimbursed at 79 percent of billed charges. Effective February 1, 2013, the ambulatory surgery center services are reimbursed at the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.

- (4) Other rates: If a provider has agreed under contract with the insurer or managed care organization to accept a different amount or reimbursement methodology, that amount or methodology establishes the applicable fee.
 - (5) Payment levels frozen and reduced pending study of new fee schedule: Effective February 1, 2013, inpatient and outpatient payments for each hospital and the payments for each ambulatory surgery center shall be set at the payment rates in effect for those facilities as of June 30, 2012. Effective April 1, 2013, those rates shall then be reduced as follows:
 - (A) Hospital outpatient and ambulatory surgery: The rate in effect as of that date shall be reduced by 15 percent.
 - (B) Hospital inpatient: The minimum payment rate in effect as of that date shall be reduced by 10 percent.
 - (6) Effective April 1, 2013, implants shall be paid at no greater than invoice cost plus 28 percent.
- (e) Insurers and managed care organizations, or administrators on their behalf, may review and reimburse charges for all medical compensation, including medical, hospital, and dental fees, without submitting the charges to the Commission for review and approval.
- (f) A provider of medical compensation shall submit its statement for services within 75 days of the rendition of the service, or if treatment is longer, within 30 days after the end of the month during which multiple treatments were provided. However, in cases where liability is initially denied but subsequently admitted or determined by the Commission, the time for submission of medical bills shall run from the time the health care provider received notice of the admission or determination of liability. Within 30 days of receipt of the statement, the employer, carrier, or managed care organization, or administrator on its behalf, shall pay or submit the statement to the Commission for approval or send the provider written objections to the statement. If an employer, carrier, administrator, or managed care organization disputes a portion of the provider's bill, the employer, carrier, administrator, or managed care organization, shall pay the uncontested portion of the bill and shall resolve disputes regarding the balance of the charges through its contractual arrangement or through the Commission.
- (g) Pursuant to G.S. 97-18(i), when the 10 percent addition to the bill is uncontested, payment shall be made to the provider without notifying or seeking approval from the Commission. When the 10 percent addition to the bill is contested, any party may request a hearing by the Commission pursuant to G.S. 9783 and G.S. 97-84.
- (h) When the responsible party seeks an audit of hospital charges, and has paid the hospital charges in full, the payee hospital, upon request, shall provide reasonable access and copies of appropriate records, without charge or fee, to the person(s) chosen by the payor to review and audit the records.
- (i) The responsible employer, carrier, managed care organization, or administrator shall pay the statements of medical compensation providers to whom the employee has been referred by the treating physician authorized by the insurance carrier for the compensable injury or body part, unless the physician has been requested to obtain authorization for referrals or tests; provided that compliance with the request shall not unreasonably delay the treatment or service to be rendered to the employee.
- (j) Employees are entitled to reimbursement for sick travel when the travel is medically necessary and the mileage is 20 or more miles, round trip, at the business standard mileage rate set by the Internal Revenue Service per mile of travel and the actual cost of tolls paid. Employees are entitled to lodging and meal expenses, at a rate to be established for state employees by the North Carolina Director of Budget, when it is medically necessary that the employee stay overnight at a location away from the employee's usual place of residence. Employees are entitled to reimbursement for the costs of parking or a vehicle for hire, when the costs are medically necessary, at the actual costs of the expenses.
- (k) Any employer, carrier or administrator denying a claim in which medical care has previously been authorized is responsible for all costs incurred prior to the date notice of denial is provided to each health care provider to whom authorization has been previously given.

History Note: Authority G.S. 97-18(i); 97-25; 97-25.6; 97-26; 97-80(a); 138-6;
Eff. January 1, 1990;
Amended Eff. July 1, 2014; January 1, 2013; June 1, 2000.

registered mail, certified mail, or in a manner provided by G.S. 1A-1, Rule 4(j)(1)d. The Board may reinstate an expired license upon the showing of good cause for late payment of fees, upon payment of said fees within 60 days after expiration of the license, and upon the further payment of a late penalty of twenty-five dollars (\$25.00). After 60 days after the expiration date, the Board may reinstate the license for good cause shown upon application for reinstatement and payment of a late penalty of fifty dollars (\$50.00) and the renewal fee. The Board may require all licensees to successfully attend and complete a course or courses of occupational instruction funded, conducted or approved or sponsored by the Board on an annual basis as a condition to any license renewal and evidence of satisfactory attendance and completion of any such course or courses shall be provided the Board by the licensee."

SECTION 32.5.(i) G.S. 93D-12 reads as rewritten:

"§ 93D-12. License to be displayed at office.

Every person to whom a license, apprenticeship certificate, or sponsor registration is granted shall display the same in a conspicuous part of his office ~~wherein the fitting and selling of hearing aids is conducted, where the person conducts business as a hearing aid specialist~~ or shall have a copy of such license certificate, or registration on his person and exhibit the same upon request when fitting or selling hearing aids outside of his office."

SECTION 32.5.(j) G.S. 93D-15 reads as rewritten:

"§ 93D-15. Violation of Chapter.

Any person who violates any of the provisions of this Chapter and any person who holds himself out to the public as a ~~fitter and seller of hearing aids~~ hearing aid specialist without having first obtained a license or apprenticeship registration as provided for herein shall be deemed guilty of a Class 2 misdemeanor."

SECTION 33.(a) Industrial Commission Hospital Fee Schedule:

- (1) Medicare methodology for physician and hospital fee schedules. – With respect to the schedule of maximum fees for physician and hospital compensation adopted by the Industrial Commission pursuant to G.S. 97-26, those fee schedules shall be based on the applicable Medicare payment methodologies, with such adjustments and exceptions as are necessary and appropriate to ensure that (i) injured workers are provided the standard of services and care intended by Chapter 97 of the General Statutes, (ii) providers are reimbursed reasonable fees for providing these services, and (iii) medical costs are adequately contained. Such fee schedules shall also be periodically reviewed to ensure that they continue to adhere to these standards and applicable fee schedule requirements of Chapter 97. In addition to the statewide fee averages, geographical and community variations in provider costs, and other factors affecting provider costs that the Commission may consider pursuant to G.S. 97-26, the Commission may also consider other payment systems in North Carolina, other states' cost and payment structures for workers' compensation, the impact of changes over time to Medicare fee schedules on payers and providers, and cost issues for providers and payers relating to frequency of service, case mix index, and related issues.
- (2) Transition to direct billing. – Pursuant to G.S. 97-26(g) through (g1) and applicable rules, the Commission shall provide for transition to direct claims submission and reimbursement for medical and hospital fees, including an implementation timeline, notice to affected stakeholders, and related compliance issues.
- (3) Expedite rule-making process for fee schedule. – The Industrial Commission is exempt from the certification requirements of G.S. 150B-19.1(h) and the fiscal note requirement of G.S. 150B-21.4 in developing the fee schedules required pursuant to this section."

SECTION 33.(b) G.S. 97-26 reads as rewritten:

"§ 97-26. Fees allowed for medical treatment; malpractice of physician.

(a) Fee Schedule. – The Commission shall adopt by rule a schedule of maximum fees for medical compensation, ~~except as provided in subsection (b) of this section, compensation~~ and shall periodically review the schedule and make revisions.

The fees adopted by the Commission in its schedule shall be adequate to ensure that (i) injured workers are provided the standard of services and care intended by this Chapter, (ii)

providers are reimbursed reasonable fees for providing these services, and (iii) medical costs are adequately contained.

The Commission may consider any and all reimbursement systems and plans in establishing its fee schedule, including, but not limited to, the State Health Plan for Teachers and State Employees (hereinafter, "State Plan"), Blue Cross and Blue Shield, and any other private or governmental plans. The Commission may also consider any and all reimbursement methodologies, including, but not limited to, the use of current procedural terminology ("CPT") codes, diagnostic-related groupings ("DRGs"), per diem rates, capitated payments, and resource-based relative-value system ("RBRVS") payments. The Commission may consider statewide fee averages, geographical and community variations in provider costs, and any other factors affecting provider costs.

(b) Hospital Fees. – Each hospital subject to the provisions of this ~~subsection~~ section shall be reimbursed the amount provided for in this ~~subsection~~ section unless it has agreed under contract with the insurer, managed care organization, employer (or other payor obligated to reimburse for inpatient hospital services rendered under this Chapter) to accept a different amount or reimbursement methodology.

~~Except as otherwise provided herein, payment for medical treatment and services rendered to workers' compensation patients by a hospital shall be a reasonable fee determined by the Commission and adopted by rule. Effective September 16, 2001, through June 30, 2002, the fee shall be the following amount unless the Commission adopts a different fee schedule in accordance with the provisions of this section:~~

- ~~(1) For inpatient hospital services, the amount that the hospital would have received for those services as of June 30, 2001. The payment shall not be more than a maximum of one hundred percent (100%) of the hospital's itemized charges as shown on the UB-92 claim form or less than the minimum percentage for payment of inpatient DRG claims that was in effect as of June 30, 2001.~~
- ~~(2) For outpatient hospital services and any other services that were reimbursed as a discount off of charges under the State Plan as of June 30, 2001, the amount calculated by the Commission as a percentage of the hospital charges for such services. The percentage applicable to each hospital shall be the percentage used by the Commission to determine outpatient rates for each hospital as of June 30, 2001.~~
- ~~(3) For any other services, a reasonable fee as determined by the Industrial Commission.~~

The explanation of the fee schedule change that is published pursuant to G.S. 150B-21.2(c)(2) shall include a summary of the data and calculations on which the fee schedule rate is based.

A hospital's itemized charges on the UB-92 claim form for workers' compensation services shall be the same as itemized charges for like services for all other payers.

...."

SECTION 36.(a) G.S. 115D-67.2(b) reads as rewritten:

"(b) The Advisory Board shall consist of 14 ~~members~~ members as follows:

- ~~(1) The President of Gaston College, who shall serve ex officio;~~ officio.
- ~~(2) Four Two members who are residents of North Carolina appointed by the North Carolina Manufacturers Association, Inc.; National Council of Textile Organizations.~~
- ~~(2a) Two members appointed by the Southern Textile Association, Inc.~~
- ~~(3) Two members appointed by the board of the North Carolina Center for Applied Textile Technology Foundation;~~ Foundation.
- ~~(4) Two members appointed by the board of trustees of Gaston College;~~ College.
- ~~(5) Three members appointed by the State Board of Community Colleges;~~ Colleges.
- ~~(6) One member appointed by the dean of the College of Textiles at North Carolina State University;~~ and University.
- ~~(7) The Director of the Manufacturing Solutions Center at Catawba Valley Community College who shall serve ex officio as a nonvoting member.~~

The appointing entities shall attempt to appoint members who are distributed geographically throughout the State; members representing large and small companies; and members from

STATE OF NORTH CAROLINA

BEFORE THE NORTH CAROLINA INDUSTRIAL COMMISSION

DECEMBER 17, 2014

HEARING BEFORE THE FULL COMMISSION

ON

PROPOSED MEDICAL FEE SCHEDULE RULE CHANGES

GRAHAM ERLACHER & ASSOCIATES
3504 VEST MILL ROAD - SUITE 22
WINSTON-SALEM, NORTH CAROLINA 27103
336/768-1152

A P P E A R A N C E S

COMMISSIONERS:

Andrew T. Heath, Chairman and Chair of Panel

Bernadine S. Ballance

Danny L. McDonald

Linda Cheatham

Charlton L. Allen

Tammy R. Nance

I N D E X

SPEAKERS:

PAGE

Meredith Henderson.	2
Kimberly Rowland.	4
Conor Brockett	18

E X H I B I T S

IDENTIFIED ADMITTED

(Henderson) Exhibit Number 1	2	24
--	---	----

P R O C E E D I N G S

CHAIRMAN HEATH: Okay. Good afternoon. This is December 17th, 2014. I'm - my name is Andrew Heath. I'm Chairman of the North Carolina Industrial Commission. Notice was given in accordance with General Statute 150B-21.2 that the Industrial Commission intends to adopt the rule cited as 04 NCAC 10J .0102, .0103 and amend the rule cited as 04 NCAC 10J .0101, .0102, and that's it. The purpose of this hearing is to receive comments from the public regarding these rules as directed by the legislature in Session Law 2013-410 or House Bill 92. We've not yet received written comments from the public, but the record will be open to receive written comments through January 16, 2015. With me today are Commissioners McDonald, Allen, Nance, Cheatham and Ballance. We'd like to thank them for their work on these rules. We'd also like to thank members of the public and various stakeholders who gave us their valuable time and efforts to come up with these proposed rules. We are very much appreciative of everyone's time and efforts. Anyone who wishes to speak at the hearing must sign up to do so with Ms. Henderson. We've gotten two people to sign up so far, but before that, Meredith Henderson, Executive

1 Secretary and rule-making coordinator for the North
2 Carolina Industrial Commission, would you please come
3 up to the podium?

4 MEREDITH HENDERSON

5 MS. HENDERSON: Good afternoon.

6 CHAIRMAN HEATH: Good afternoon. If you'd please
7 tell us your name and position.

8 MS. HENDERSON: I'm Meredith Henderson. I'm the
9 Executive Secretary and the rule-making coordinator
10 for the North Carolina Industrial Commission.

11 CHAIRMAN HEATH: And have you prepared any
12 exhibits that you'd like to be introduced?

13 MS. HENDERSON: Yes - an Exhibit 1, which is the
14 publication of the proposed rules in the November 17th
15 issue of the *North Carolina Register*.

16 (Exhibit Number 1 is identified.)

17 CHAIRMAN HEATH: Thank you. And would you briefly
18 give us some background and list the rules that would
19 be affected by the proposed rule changes?

20 MS. HENDERSON: Yes. The - there are two rules
21 proposed for adoption. That's 04 NCAC 10J .0102, a
22 version to be adopted that would be effective April 1st
23 of 2015 regarding fees for professional services; 04
24 NCAC 10J .0103 also to be effective April 1st, 2015 -
25 proposed effective date - for fees for institutional

1 services. And then we have two proposed rules for
2 amendment. 04 NCAC 10J .0101 proposed to be effective
3 April 1st of 2015, and that is entitled "General
4 Provisions" - or will be entitled "General
5 Provisions." Also, 04 NCAC 10J .0102, the version
6 that is proposed to be effective - newly effective in
7 April 1st of 2015, would be revised as of July 1st,
8 2015; again, fees for professional services. The
9 legislation requiring and authorizing the Commission
10 to make these hospital and physician fee schedules is
11 Session Law 2013-410 or House Bill 92, and that same
12 legislation also exempted the Commission from the
13 certification requirements of General Statute
14 150B-19.1(h) and the fiscal note requirement of
15 General Statute 150B-21.4 for this permanent
16 rule-making. The relevant dates for this rule-making
17 that the Commission has met: The proposed rules were
18 filed within notice of text with the Office of
19 Administrative Hearings on October 24th, 2014. And
20 then on November 17th of 2014 - three things happened -
21 this - the proposed rules were published in that issue
22 of the *North Carolina Register*; the Commission posted
23 the proposed rules on its website as required, and we
24 also emailed a link to the proposed rules to the rules
25 lister (phonetic) on the same date, so as you've said,

1 we've had two speakers sign up so far. There's no
2 requirement to sign up in advance. We just need
3 speakers to clearly state their name when they come to
4 the podium. Okay. That's all I have.

5 CHAIRMAN HEATH: Any questions from Commissioners
6 for Ms. Henderson? All right. Thank you very much.

7 MS. HENDERSON: Thank you.

8 (SPEAKER DISMISSED)

9 CHAIRMAN HEATH: Okay. The first public commenter
10 we have is Kimberly Rowland of One Call Case [sic]
11 Management.

12 KIMBERLY ROWLAND

13 CHAIRMAN HEATH: Could you please state your name
14 and tell us the exact entity that you represent?

15 MS. ROWLAND: Sure. First of all, I'd like to
16 thank you all for allowing me the opportunity to come
17 up before you and speak. I'm Kimberly Rowland, and I
18 represent One Call Care Management. We are a national
19 claims - national organization where we provide
20 services to the injured worker throughout fifty
21 states, so we have business units, such as physical
22 therapy, radiology, home healthcare, all types of
23 services for the injured worker. Durable - we offer
24 durable medical equipment, translation,
25 transportation, so those are the services that we

1 provide for the injured workers throughout the
2 company. One of the main reasons because I don't want
3 to take too much of your time - I know that I only
4 have five minutes to speak. One of the main reasons
5 why I came before you today is to give you guys an
6 opportunity to know what's actually going on behind
7 CMS and Medicare. It seems that there are
8 twenty-three states, with North Carolina included,
9 that utilize Medicare as a component to calculate
10 their fee schedule, and many years ago, that system
11 worked, and it's accessible, and so it worked many
12 years ago. The problem is, is that a few years ago -
13 I want us to go back to maybe 2010. Medicare has been
14 changing their - the relative value units, which is a
15 component that most states use when they're
16 calculating the fee schedule. They're adjusting the
17 relative value units for budget neutrality purposes,
18 so the relative value unit is not a true unit, and
19 it's unfortunate because most states that are
20 utilizing the workers' comp - utilizing Medicare as a
21 means to calculate their fee schedule, they're seeing
22 reductions in certain specialists. So, for instance,
23 over the past three years - three to four years,
24 radiologists have been taking significant cuts as a
25 result of the reduction of the RVU, so when you look

1 at what are the most commonly used codes in radiology
2 for the injured workers, you're looking at your
3 shoulder, lower back and knee. The problem with -
4 that Medicare is having when they're adjusting those
5 codes - again, they're adjusting it for budget
6 neutrality purposes, but then there's also
7 overutilization in those codes with CMS. The disease
8 factors are very different. When you look at
9 Medicare, Medicare is utilized to treat the elderly
10 population, so if someone goes - an elderly person
11 goes and have an MRI of the shoulder, nine times out
12 of ten that's probably arthritis, so you don't need an
13 MRI to rule out arthritis, so that was another reason
14 why they decided to reduce the Medicare RVUs. When
15 you look at an injured worker, an injured worker -
16 it's a different disease state. You're talking
17 musculoskeletal. When they go for an MRI of the
18 shoulder, the knee, or the back, it's often to rule
19 out maybe a rotator cuff, tear, a torn meniscus, a
20 herniated nucleus pulposus, which is a back problem,
21 and you need the MRI to actually determine if surgery
22 is necessary, so when you look at the two different
23 disease states, they're very different, and I believe
24 that there are a lot of states that are just adopting
25 the Medicare RVUs or Medicare component to come up

1 with their fee schedule because it's accessible. It's
2 easy to obtain, but no one is actually looking at what
3 has taken place over the last three to five years with
4 the reduction of the Medicare RVUs. My mother-in-law
5 used to say, you invite fifteen people to a party and
6 twenty-five people show up, well, what do you do with
7 the food? You have to bless it and stretch it. Well,
8 with Obamacare that's taking place, more people are
9 being added into the system in Medicare, but there's
10 no money being added to it, so they have to - for
11 budget neutrality purposes, they have to stretch it.
12 And what's good for Medicare is no longer good for
13 workers' comp, so I just want to give you guys an
14 example of the three most commonly used codes in
15 radiology that's taking a hit, so you have the
16 shoulder, which is 73221. In 2013 and 2014, the fee
17 schedules were 76861. As a result of the reduction in
18 Medicare to the RVUs, in 2015, that fee schedule would
19 be 43474 if the new fees are put into place - the new
20 proposal rules are put into place. The lower back,
21 the 72148 - the fee schedule currently is 89354. If
22 the fee schedule is adopted, that fee schedule goes
23 down to 41070. That's a fifty-four percent reduction.
24 The knee, 73721, currently is at 76871. If the new
25 fees are taken into effect, it would be 43474, which

1 is a forty-three percent reduction. Those three codes
2 make approximately about sixty-five to seventy percent
3 of MRIs that are actually, you know, performed on the
4 patients. When you look at that perspective and you
5 look at the commercial market rates where these codes
6 are being reimbursed, they're significantly lower than
7 what the commercial market rates are going to be, so
8 you're going to have a lot of providers that may
9 decide that they're - they don't want to see a
10 workers' compensation patient, and so that's our main
11 concern. You know, it's - if - and the other thing I
12 want to make you guys aware of - a lot of the doctors
13 or physicians - I know that you had the Medical
14 Society and a few other societies come together and
15 put this plan together, and I appreciate that, and I
16 agree with them to a certain extent, but the problem
17 is that a lot of the physicians that actually treat
18 the injured worker - they don't know what's going on
19 behind the scenes until they receive a check that's
20 been cut in half, so for services rendered - and once
21 they receive the check, it's more, well, what
22 happened? I'm supposed to receive this particular
23 amount for reimbursement. I'm getting this amount.
24 I'm getting \$900 on the commercial market side; I'm
25 getting \$400 from workers' comp when I'm used to

1 receiving \$700. That's a problem, but by the---

2 CHAIRMAN HEATH: Ms. Rowland---

3 MS. ROWLAND: Yes?

4 CHAIRMAN HEATH: ---with the example that you've
5 given, you know, our proposed rule would put radiology
6 services at a hundred and ninety-five percent of the
7 Medicare base amount, which would that not bump it
8 right back up to about where it's currently at?

9 MS. ROWLAND: No. The fees that I just quoted to
10 you - that's what those fees are actually going to be.

11 CHAIRMAN HEATH: At a hundred - at Medicare or at
12 a hundred and ninety-five percent of Medicare?

13 MS. ROWLAND: At a hundred and ninety-five percent
14 of Medicare, those fees would be - yes, those would be
15 the fees because you're doing it a hundred and
16 ninety-five percent, correct? Yes. And - but, see,
17 the thing about Medicare is that no one looked at the
18 RVUs. Medicare uses RVUs, and those RVUs are relative
19 value units, and those RVUs are assigned the tasks
20 that the physicians utilize, their time, the materials
21 that are used, and they're drastically cutting them,
22 so when you take a hundred and ninety-five percent of
23 the Medicare rate, you're still going to find for
24 those codes, those RVUs are going to be reduced
25 drastically, so even at a hundred and ninety-five

1 percent, that's - those are the rates that you're
2 going to receive. Those radiologists are going to
3 receive reductions as a result of that, and that's
4 because of the RVU component.

5 CHAIRMAN HEATH: So it's something that Medicare
6 is doing?

7 MS. ROWLAND: Absolutely.

8 CHAIRMAN HEATH: Okay.

9 MS. ROWLAND: And that's the - that's the issue we
10 have. Years ago, when everyone was utilizing Medicare
11 as a means to calculate their fee schedules,
12 everything was accurate and everything was great, and
13 that was because the way that they calculate their
14 RVUs - they evaluate the positions, they give them
15 surveys, they talk to them, and they compile all this
16 information up, and they come into a calculated
17 formula, but now, even when they do that, they're
18 saying, okay, well, we don't have enough money in our
19 budget for this, and we don't have enough money in our
20 budget for that, so we're going to augment the RVUs.
21 That's not what you're supposed to do. It's not a
22 true value, and that's the - you know, we're fighting
23 this in all over the country now that you - other
24 twenty-three states, so we've been to - I think I've
25 been to twenty states this far with this issue

1 educating everybody. My goal is not to come here to
2 tell you guys how to develop your system. I
3 understand the purpose of trying to reduce costs.
4 Everyone is trying to reduce costs, so while I respect
5 that, I'm just basically here to educate you on
6 actually what's taking - what's going on behind the
7 scenes of CMS because no one really knows what CMS is
8 doing, and CMS is not concerned about the workers'
9 comp world. They could care less about relative value
10 units. It's because the states decide to use them -
11 their methodology. They're not concerned about that,
12 so they're not concerned about taking their RVUs and
13 putting it back to where they're supposed to be. They
14 don't care about that. It's the states that are
15 actually utilizing that, continuing to utilize their
16 system, and so we have to figure out a way how to
17 either augment to offset these issues or find a
18 different methodology, so that's why I'm here, to just
19 basically educate you on what's taking - what's going
20 on behind the scenes at CMS.

21 CHAIRMAN HEATH: I appreciate your comment. I'm
22 not trying to belabor the point here, but I do - I do
23 want to know. For example, the 73221 code---

24 MS. ROWLAND: Yes?

25 CHAIRMAN HEATH: ---is going from 768 down to 434?

1 MS. ROWLAND: Utilizing at a hundred and
2 ninety-five percent of Medicare, yeah.

3 CHAIRMAN HEATH: At a hundred and ninety-five?

4 MS. ROWLAND: Yes.

5 CHAIRMAN HEATH: So at Medicare, it's half of 434.
6 It would be 2?

7 MS. ROWLAND: 2 something - yes.

8 CHAIRMAN HEATH: Okay. Are you seeing that
9 radiologists are not treating Medicare patients?

10 MS. ROWLAND: No, not yet. And are you asking me
11 in other states? In other states - because of this
12 methodology that they're now using with Medicare,
13 other states are starting to complain, especially the
14 doctors. They're saying, we can't - we're not going
15 to take injured workers, and you do have some doctors
16 that are saying, we're not taking Medicare patients
17 either. You know, it's just - it's just too much.

18 CHAIRMAN HEATH: But if they get - if they're
19 getting almost twice as much for an injured worker
20 versus your standard Medicare patient, why - how does
21 that impact?

22 MS. ROWLAND: You have some physicians that are
23 not even taking Medicare. You have some physicians
24 that just only treat your regular patient that has
25 regular insurance, and then you have - and then those

1 that treat your workers - your injured workers.

2 CHAIRMAN HEATH: Right.

3 MS. ROWLAND: And the other thing we have to think
4 about is the dynamic of the injured worker, so you
5 have an injured worker that's irate, that's been out
6 of work, that's losing time, pissed because they have
7 an injury, and they're going to the doctor's office
8 and they're angry, and so you have physicians that
9 have to deal with that, in addition to taking a
10 significant cut, and I just don't - you know, I don't
11 believe it's really fair for the physicians, you know,
12 so it's - they go through a lot. Their goal is to
13 actually treat the injured worker and get that worker
14 back to work, but then they have to deal with the
15 dynamics of that injured worker coming into that
16 facility irate and cantankerous, so those are - those
17 are some of the issues, not to mention the paperwork
18 that's behind all of the scenes. You know, there's a
19 lot of paperwork that the doctors have to deal with in
20 reference to the carriers and getting that paperwork
21 to the carrier back in time so that the carrier can
22 actually adjudicate the claim appropriately. I've
23 been in comp for twenty-five years. I've also
24 adjudicated many claims. I've worked for Liberty
25 Mutual, Royal Sun Alliance Insurance and Cambridge

1 Integrated Services, and I'm also multijurisdictional,
2 so I've been exposed to the medical side, as well as
3 the insurance side, and it's unfortunate, but this is
4 what we're faced with today. So if we - all I'm
5 asking of you, to just take a look at the Medicare
6 RVUs and what's driving Medicare - that's what I'm
7 asking you to do - and to look at what the significant
8 cuts are going to be to the radiologists because,
9 again, a lot of them are not aware until they receive
10 a check.

11 COMMISSIONER MCDONALD: So what is the answer?

12 MS. ROWLAND: Well, there are multiple answers,
13 but it would depend on your - how your facility - how
14 your establishment worked, and we're more than happy
15 to come back and to show you some examples that other
16 states have done to curtail this problem.

17 CHAIRMAN HEATH: Do these solutions involve
18 getting away from a Medicare-based fee schedule?

19 MS. ROWLAND: There are some states where the
20 Medicare is written in their legislation, so they have
21 to utilize legislation, so what we've come up with is
22 ideas where they can go back and tweak the Medicare
23 RVUs to their true value. There are ways where you
24 can adjust the conversion factor, so it really depends
25 on the methodology that the state is currently using,

1 but we've had states, such as Kentucky, that have
2 actually carved out those particular codes that are
3 being significantly impacted and assigning it its own
4 conversion factor so that the radiologists are not
5 taking significant hits, so they're---

6 COMMISSIONER CHEATHAM: Have they---? I'm sorry.

7 MS. ROWLAND: Go ahead.

8 COMMISSIONER CHEATHAM: Have they done that just
9 for workers' comp patients?

10 MS. ROWLAND: Yes, absolutely. Yes, ma'am.

11 COMMISSIONER CHEATHAM: I still am not
12 understanding, though. If workers' comp is half what
13 they were getting last year, and Medicare is going to
14 be half again, so instead of getting \$760, they're
15 going to be getting below \$200 for a straight-up
16 Medicare patient---

17 MS. ROWLAND: Uh-huh.

18 COMMISSIONER CHEATHAM: ---and a state is going to
19 address this, are you telling me they're---? I don't
20 understand the rationale for just addressing it for
21 workers' comp patients versus Medicare, as I would
22 think there would be a huge hue and cry.

23 MS. ROWLAND: No - because Medicare doesn't have
24 an access issue. So my mother is seventy-five years
25 old, right? If my mother has Medicare - or does not

1 have Medicare and she needs an MRI, well, guess what?
2 She's not going to get it. Okay. She's not going to
3 get the MRI either. I would have to come out of my
4 pocket and pay for my mother to have an MRI or she's
5 not going to get it, but when you look at an injured
6 worker, if the injured worker does not get the MRI,
7 then the cost of the claim goes up. The indemnity
8 goes up because that injured worker will probably be
9 out of work longer. You have another bucket that will
10 go up, which is the litigation front, because that
11 person is going to get an attorney, so there are other
12 things that are actually going up that's going to
13 increase the cost of the claim for the injured worker
14 versus an elderly patient. You're comparing oranges
15 to apples, so that's the difference. So, again, I'm
16 not here to say you - the system is wrong. I'm here
17 to ask that you reevaluate and take a look at what's
18 taking place in the CMS world and if utilizing CMS is
19 the best way to go, and if you decide to continue
20 because it's written in legislation, then maybe we can
21 figure out a way to augment so that the doctors are
22 not taking a hit because, today, it's radiology;
23 tomorrow, it could be physical therapy. It could be
24 orthopedic down the road, and you don't want to be in
25 a situation where the system is so messed up because

1 once the doctors leave out of the system, it is very
2 difficult to get them back in because they don't trust
3 it and they don't believe in it.

4 CHAIRMAN HEATH: Thank you very much for your
5 comments. I just have one further question. Does
6 your organization represent the radiology profession,
7 or, if not---

8 MS. ROWLAND: We---

9 CHAIRMAN HEATH: ---what does it represent?

10 MS. ROWLAND: My - our organization - we work on
11 behalf of the payers, so they're the carriers. So the
12 carriers will contact us for services for their
13 injured worker. We direct their care with reference
14 to making sure that they're scheduled with physical
15 therapy, home health services, transportation,
16 translation, so we provide those services. We have a
17 network of providers that are in our network. They're
18 highly credentialed.

19 CHAIRMAN HEATH: But you are not here on behalf of
20 the Radiological Society or---

21 MS. ROWLAND: Well, we---

22 CHAIRMAN HEATH: ---any group of radiologists?

23 MS. ROWLAND: We're here on behalf of One Call
24 Care Management, but we're representing the
25 radiologists that are within our network.

1 CHAIRMAN HEATH: Okay. Any other questions?

2 MS. ROWLAND: Thank you for having me.

3 CHAIRMAN HEATH: Thank you very much for your
4 comments. I appreciate it.

5 (SPEAKER DISMISSED)

6 CHAIRMAN HEATH: Okay. Conor Brockett.

7 CONOR BROCKETT

8 CHAIRMAN HEATH: Could you identify yourself and
9 the organization that you're here on behalf of?

10 MR. BROCKETT: Yes. My name is Conor Brockett,
11 Associate General Counsel for the North Carolina
12 Medical Society.

13 CHAIRMAN HEATH: Thank you.

14 MR. BROCKETT: Good afternoon, Mr. Chairman,
15 members of the Commission. Again, my name is Conor
16 Brockett, with the North Carolina Medical Society and
17 its twelve thousand physician members across the
18 state. I'm also appearing today on behalf of the
19 North Carolina Radiological Society and with the
20 support of many other states' specialty societies that
21 have a distinct interest in workers' comp physician
22 payment rates, including orthopedics, neurology and
23 several others. My brief comments today will focus on
24 some of the changes that you have proposed to Rule 10J
25 .0102, Fees for Professional Services, and

1 specifically the version taking effect on July 1st of
2 2015. I think the overall message that I want to
3 communicate, and one I hope you'll remember, is that
4 the physician community is squarely behind this
5 proposal and hopes that you will see it through to
6 adoption. I'd like to touch first on what we've been
7 talking about so far, which is radiology and the
8 changes that will come under this new rule in July.
9 Under the proposal, the Commission would establish
10 payments for all radiology services at a hundred and
11 ninety-five percent of Medicare. This is the highest
12 percentage that the Commission has been willing, at
13 least in the rule, to apply to professional services
14 in the fee schedule. Also, to talk for a second about
15 the Medicare - using Medicare as the basis, that was a
16 decision that was essentially made for you by the
17 General Assembly, and it was the job of the Commission
18 to go from there and put together a rule that would
19 satisfy the various legislative mandates, the
20 balancing act that you have to achieve so that there
21 is proper access for injured workers, so that the
22 providers are compensated fairly, so on and so forth,
23 and we think you've done that. The Radiological
24 Society and a multi-specialty taskforce that the
25 Medical Society put together looked closely at this

1 specific issue involving radiology payment, and, you
2 know, there is an understanding that it will result in
3 some significant decreases - payment reductions to one
4 group of services within radiology, and those being
5 the diagnostic imaging procedures of CT and MRI. MRI
6 studies, for example, involving the spine would come
7 down, as we've heard, by as much as fifty percent or
8 more. Now if the cuts are steep in this - in this
9 part of the fee schedule, you're probably wondering,
10 why are the radiologists on-board with this? And I
11 think the answer boils down to an acknowledgement or
12 an understanding that for radiology and all
13 physicians, first of all, rates have grown stale, and
14 it's time to bring the overall work comp fee schedule
15 and how we maintain it into the twenty-first century,
16 but more importantly, I think, the best methodology
17 that the state could possibly use for coming up with
18 their payment rates is one bit applies equitably
19 across the entire profession, so we treat radiology
20 services the same way we treat office - you know, your
21 routine office visits, your PT sessions, so on and so
22 forth. And the methodology that you have chosen, as
23 you articulated in the comments that accompanied the
24 proposed rule, seek to drive our fee schedule to the
25 national median of fee schedules that are available in

1 other states. And when we compare the resulting
2 prices that are currently available, we see that some
3 services will be paid more for physicians and some
4 services will be paid less and some services will be
5 paid about the same, but I think at the end of the
6 day, the physicians are comfortable that what you have
7 given us is a modern, reasonable, equitable approach
8 that has not really existed previously or currently.
9 So you've heard one - another perspective today
10 regarding these reductions to CT and MRI, but I think
11 it's important to remember that those concerns are
12 limited to a subset of services within radiology.
13 It's not the whole picture. And those specific
14 services - the MRI and CT - also can serve as a profit
15 area when the rates that are available in the
16 marketplace to the actual imaging providers remain
17 where they are. So, finally, I don't think there's
18 any reason to believe at this point - and I want to
19 underscore this - that these changes to radiology or
20 to the imaging centers will cause them to leave the
21 workers' comp system. We've talked a lot with the
22 Radiological Society about this, and there's no reason
23 to believe that under this new payment methodology
24 that injured workers will have trouble receiving this
25 care or that there will be a participation problem

1 going forward. Another - changing gears slightly, I
2 want to point out and, honestly, thank you all for
3 your willingness to update and publish new rates every
4 year. It will undoubtedly mean some new and
5 different, but not necessarily more work for
6 Commission staff each year, but it will also prevent
7 the situation that we're in now, I think, where we're
8 stuck year after year with the same rates and we don't
9 see any changes, even though the rest of the
10 healthcare marketplace is adapting to those changes
11 and has learned how to adapt to those changes. So
12 regular, transparent updates from the Commission will
13 also require the industry, all the stakeholders to pay
14 closer attention to the work that the Commission is
15 doing as the rate setter and the new revisions to the
16 fee schedule that come out each year, so the hope is
17 that stakeholders will have a better understanding of
18 what the payment rates actually are because we run
19 into problems now and again - and you all are familiar
20 with this - where there's a dispute between a carrier
21 and the provider about what the proper amount should
22 be, and honestly, the Commission ends up in the
23 position of trying to resolve that dispute, so one of
24 the upsides, we think, to this for the Commission will
25 be having to put less resources into resolving those

1 problems. And since publication of the proposed rule,
2 we've identified some other details that could be
3 clearer with the rule, and we plan to share those with
4 you in our written comments which we will submit in
5 the coming weeks. None of the ones - none of what we
6 have seen present any fatal problems, but would only
7 aid in our estimation of the ongoing administration of
8 the fee schedule over time. What we have here,
9 though, is a product of compromise - considerable
10 compromise. The proposed rule involves some pain. It
11 involves some gain for all of the stakeholders who are
12 directly affected by this. It's up and down, so it's
13 not really a perfect solution for anybody or for
14 everybody, but I think it's the result of a healthy
15 process so far, and ultimately, our view is it will
16 make the system stronger in the end and going forward.
17 So I'll just close by thanking each of you for the
18 opportunity to share the physician perspective today.
19 We look forward to participating in the process as it
20 continues. Thank you.

21 CHAIRMAN HEATH: So, Conor, just briefly, the sort
22 of three - as I understood the prior comments, sort of
23 the three most common diagnostic imaging codes would
24 have significant decreases in (inaudible). Is it your
25 position that the Radiological Society is aware of

1 those changes and nonetheless is in support of the
2 proposed rules that we have today?

3 MR. BROCKETT: That's our position. Yes, sir.

4 CHAIRMAN HEATH: Okay.

5 MR. BROCKETT: Yes, Your Honor.

6 CHAIRMAN HEATH: Thank you. Any other questions?

7 All right. Thank you.

8 MR. BROCKETT: Thank you.

9 (SPEAKER DISMISSED)

10 CHAIRMAN HEATH: All right. Thank everyone for
11 participating in this public hearing. Again, the
12 period for public comments will be held open through
13 the close of business on January 16, 2015. If you
14 have any further comments, please send them to
15 Meredith Henderson, as directed in the hearing notice
16 on the *North Carolina Register*. The written comments
17 and the comments made at the hearing today will be
18 made part of the public record of these proceedings.
19 We would like to include in the transcript of this
20 proceeding the notice (phonetic) submitted by
21 Ms. Henderson as Exhibit 1 previously.

22 (Exhibit Number 1 is admitted.)

23 CHAIRMAN HEATH: Are there further matters to come
24 before the public hearing? All right. This meeting
25 is adjourned. Thank you very much.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

(WHEREUPON, THE HEARING WAS ADJOURNED.)

RECORDED BY MACHINE

TRANSCRIBED BY: Lisa D. Dollar, Graham Erlacher and
Associates

1 STATE OF NORTH CAROLINA

2 COUNTY OF FORSYTH

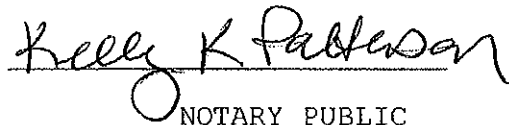
3 C E R T I F I C A T E

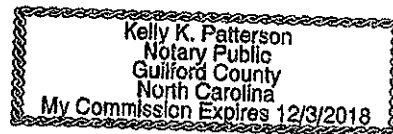
4 I, Kelly K. Patterson, Notary Public, in and for the
5 State of North Carolina, County of Guilford, do hereby
6 certify that the foregoing twenty-five (25) pages prepared
7 under my supervision are a true and accurate transcription
8 of the testimony of this trial which was tape recorded by
9 Graham Erlacher & Associates.

10 I further certify that I have no financial interest in
11 the outcome of this action. Nor am I a relative, employee,
12 attorney or counsel for any of the parties.

13 WITNESS my Hand and Seal on this 20th day of December
14 2014.

15 My commission expires on December 3, 2018.

16
17
18 
19 NOTARY PUBLIC



PROPOSED RULES

Note from the Codifier: The notices published in this Section of the NC Register include the text of proposed rules. The agency must accept comments on the proposed rule(s) for at least 60 days from the publication date, or until the public hearing, or a later date if specified in the notice by the agency. If the agency adopts a rule that differs substantially from a prior published notice, the agency must publish the text of the proposed different rule and accept comment on the proposed different rule for 60 days.

Statutory reference: G.S. 150B-21.2.

TITLE 04 -- DEPARTMENT OF COMMERCE

Notice is hereby given in accordance with G.S. 150B-21.2 that the NC Industrial Commission intends to adopt the rules cited as 04 NCAC 10J .0102, .0103 and amend the rules cited as 04 NCAC 10J .0101, .0102.

Link to agency website pursuant to G.S. 150B-19.1(c):
<http://www.ic.nc.gov/ProposedNCICMedicalFeeScheduleRules.html>

Proposed Effective Date: April 1, 2015 – 04 NCAC 10J .0101, .0102, .0103; and July 1, 2015 – 04 NCAC 10J .0102

Public Hearing:

Date: December 17, 2014

Time: 2:00 p.m.

Location: Dobbs Building, Room 2173, 430 N. Salisbury Street, Raleigh, NC 27603

Reason for Proposed Action: *The Industrial Commission has proposed these four rules to fulfill its statutory duty to periodically review the schedule of fees charged for medical treatment in workers' compensation cases and to make revisions if necessary. The revisions reflected in the proposed rules are intended to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act, that health care providers receive reasonable reimbursement for services, and that medical costs are adequately contained. The Industrial Commission was directed in S.L. 2013-410, s. 33.(a) to base its physician and hospital fee schedules on "the applicable Medicare payment methodologies." The proposed rules are intended to carry out this legislative mandate. There are two versions of Rule 04 NCAC 10J .0102 in order to move the physician and hospital fee schedules out of Rule 04 NCAC 10J .0101 and keep the current physician fee schedule in place until July 1, 2015. The April 1, 2015 version of Rule 04 NCAC 10J .0102 is essentially Paragraphs (b) and (c) of the current Rule 04 NCAC 10J .0101. As required by G.S. 97-26(b), the following is a summary of the data and information sources reviewed by the Commission in determining the applicable fee schedule rates for hospitals and ambulatory surgery centers. Rates were calculated to fall in the estimated median range of workers' compensation fee schedules nationally, based on data available from the following studies and data sources:*

(1) NORTH CAROLINA WORKERS COMPENSATION INSURANCE: A WHITE PAPER REVIEWING MEDICAL COSTS AND MEDICAL FEE REGULATIONS, prepared for the National Foundation for Unemployment Compensation and

Workers' Compensation; prepared by Philip S. Borba, Ph.D. and Robert K. Briscoe, WCP, Milliman, Inc.; May 23, 2013.

(2) CompScope Medical Benchmarks, 15th Edition, for North Carolina, published by the Workers' Compensation Research Institute, August 2014.

(3) North Carolina Hospital Association/Optum Group Health survey data, June 2013 and July 2014.

(4) Review of states' fee schedule structures, nationally and regionally.

Comments may be submitted to: Meredith Henderson, 4333 Mail Service Center, Raleigh, NC 27699-4333; phone (919) 807-2575; fax (919) 715-0282; email meredith.henderson@ic.nc.gov

Comment period ends: January 16, 2015

Procedure for Subjecting a Proposed Rule to Legislative Review: If an objection is not resolved prior to the adoption of the rule, a person may also submit written objections to the Rules Review Commission after the adoption of the Rule. If the Rules Review Commission receives written and signed objections after the adoption of the Rule in accordance with G.S. 150B-21.3(b2) from 10 or more persons clearly requesting review by the legislature and the Rules Review Commission approves the rule, the rule will become effective as provided in G.S. 150B-21.3(b1). The Commission will receive written objections until 5:00 p.m. on the day following the day the Commission approves the rule. The Commission will receive those objections by mail, delivery service, hand delivery, or facsimile transmission. If you have any further questions concerning the submission of objections to the Commission, please call a Commission staff attorney at 919-431-3000.

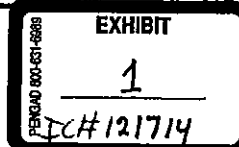
Fiscal impact (check all that apply).

- ☐ State funds affected
- ☐ Environmental permitting of DOT affected
- ☐ Analysis submitted to Board of Transportation
- ☐ Local funds affected
- ☐ Substantial economic impact (≥\$1,000,000)
- ☒ No fiscal note required by G.S. 150B-21.4

***These rules were exempted from the fiscal note requirement of G.S. 150B-21.4 in S.L. 2013-410, s. 33.(a)(3).

CHAPTER 10 -- INDUSTRIAL COMMISSION

SUBCHAPTER 10J -- FEES FOR MEDICAL COMPENSATION



PROPOSED RULES

**SECTION .0100 -- FEES FOR MEDICAL
COMPENSATION**

04 NCAC 10J .0101 GENERAL PROVISIONS

(a) ~~The Commission adopted and published a Medical Fee Schedule, pursuant to the provisions of G.S. 97-26(a), setting maximum amounts, except for hospital fees pursuant to G.S. 97-26(b), that may be paid for medical, surgical, nursing, dental, and rehabilitative services, and medicines, sick travel, and other treatment, including medical and surgical supplies, original artificial members as may reasonably be necessary at the end of the healing period and the replacement of such artificial members when reasonably necessitated by ordinary use or medical circumstances. Pursuant to G.S. 97-26, the Commission adopts a Medical Fee Schedule composed of maximum amounts, reimbursement rates, and payment guidelines. The amounts and reimbursement rates prescribed in the applicable published Medical Fee Schedule shall govern and apply according to G.S. 97-26(c). The Medical Fee Schedule is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.~~

(b) ~~The Commission's Medical Fee Schedule contains maximum allowed amounts for medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology (CPT) codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems (HCPCS) codes, and jurisdiction specific codes. A listing of the maximum allowable amount for each code is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.~~

(c) ~~The following methodology provides the basis for the Commission's Medical Fee Schedule:~~

- (1) ~~CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201-99205 and 99211-99215, which are based on 1995 Medicare values multiplied by 2.05.~~
- (2) ~~CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.~~
- (3) ~~CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.~~
- (4) ~~CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.~~

(d) ~~The Commission's Hospital Fee Schedule, adopted pursuant to G.S. 97-26(b), provides for payment as follows:~~

- (1) ~~Inpatient hospital fees: Inpatient services are reimbursed based on a Diagnostic-Related Groupings (DRG) methodology. The Hospital Fee Schedule utilizes the 2001 Diagnostic Related Groupings adopted by the State Health~~

~~Plan. Each DRG amount is based on the amount that the State Health Plan had in effect for the same DRG on June 30, 2001.~~

~~DRG amounts are further subject to the following payment band that establishes maximum and minimum payment amounts:~~

(A) ~~The maximum payment is 100 percent of the hospital's itemized charges.~~

(B) ~~For hospitals other than critical access hospitals, the minimum payment is 75 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

(C) ~~For critical access hospitals, the minimum payment is 77.07 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

(2) ~~Outpatient hospital fees: Outpatient services are reimbursed based on the hospital's actual charges as billed on the UB-04 claim form, subject to the following percentage discounts:~~

(A) ~~For hospitals other than critical access hospitals, the payment shall be 79 percent of the hospital's billed charges. Effective February 1, 2013, the payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

(B) ~~For critical access hospitals, the payment shall be 87 percent of the hospital's billed charges. For purposes of the hospital fee schedule, critical access hospitals are those hospitals designated as such pursuant to federal law (42 CFR 485.601 et seq.). Effective February 1, 2013, the critical access hospital's payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

(3) ~~Ambulatory surgery fees: Ambulatory surgery center services are reimbursed at 79 percent of billed charges. Effective February 1, 2013, the ambulatory surgery center services are reimbursed at the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

PROPOSED RULES

- (4) ~~Other rates: If a provider has agreed under contract with the insurer or managed care organization to accept a different amount or reimbursement methodology, that amount or methodology establishes the applicable fee.~~
- (5) ~~Payment levels frozen and reduced pending study of new fee schedule: Effective February 1, 2013, inpatient and outpatient payments for each hospital and the payments for each ambulatory surgery center shall be set at the payment rates in effect for those facilities as of June 30, 2012. Effective April 1, 2013, those rates shall then be reduced as follows:~~
- (A) ~~Hospital outpatient and ambulatory surgery: The rate in effect as of that date shall be reduced by 15 percent.~~
- (B) ~~Hospital inpatient: The minimum payment rate in effect as of that date shall be reduced by 10 percent.~~
- (6) ~~Effective April 1, 2013, implants shall be paid at no greater than invoice cost plus 28 percent.~~
- (e)(b) Insurers and managed care organizations, or administrators on their behalf, may review and reimburse charges for all medical compensation, including medical, hospital, and dental fees, without submitting the charges to the Commission for review and approval.
- (f)(c) A provider of medical compensation shall submit its ~~statement bill~~ for services within 75 days of the rendition of the service, or if treatment is longer, within 30 days after the end of the month during which multiple treatments were provided. However, in cases where liability is initially denied but subsequently admitted or determined by the Commission, the time for submission of medical bills shall run from the time the health care provider received notice of the admission or determination of liability. Within 30 days of receipt of the ~~statement bill~~, the employer, carrier, or managed care organization, or administrator on its behalf, shall pay ~~or submit the statement to the Commission for approval the bill~~ or send the provider written objections to the ~~statement bill~~. If an employer, carrier, administrator, or managed care organization disputes a portion of the provider's bill, the employer, carrier, administrator, or managed care organization, shall pay the uncontested portion of the bill and shall resolve disputes regarding the balance of the charges through its contractual arrangement or through the Commission.
- (g)(d) Pursuant to G.S. 97-18(i), when the 10 percent addition to the bill is uncontested, payment shall be made to the provider without notifying or seeking approval from the Commission. When the 10 percent addition to the bill is contested, any party may request a hearing by the Commission pursuant to G.S. 97-83 and G.S. 97-84.
- (h)(e) When the responsible party seeks an audit of hospital charges, and has paid the hospital charges in full, the payee hospital, upon request, shall provide reasonable access and copies of appropriate records, without charge or fee, to the person(s) chosen by the payor to review and audit the records.
- (i)(f) The responsible employer, carrier, managed care organization, or administrator shall pay the ~~statements bills~~ of medical compensation providers to whom the employee has

been referred by the treating physician authorized by the insurance carrier for the compensable injury or body part, unless the physician has been requested to obtain authorization for referrals or tests; provided that compliance with the request shall not unreasonably delay the treatment or service to be rendered to the employee.

(j)(g) Employees are entitled to reimbursement for sick travel when the travel is medically necessary and the mileage is 20 or more miles, round trip, at the business standard mileage rate set by the Internal Revenue Service per mile of travel and the actual cost of tolls paid. Employees are entitled to lodging and meal expenses, at a rate to be established for state employees by the North Carolina Director of Budget, when it is medically necessary that the employee stay overnight at a location away from the employee's usual place of residence. Employees are entitled to reimbursement for the costs of parking or a vehicle for hire, when the costs are medically necessary, at the actual costs of the expenses.

(k)(h) Any employer, carrier or administrator denying a claim in which medical care has previously been authorized is responsible for all costs incurred prior to the date notice of denial is provided to each health care provider to whom authorization has been previously given.

Authority G.S. 97-18(i); 97-25; 97-25.6; 97-26; 97-80(a); 138-6; S.L. 2013-410.

04 NCAC 10J .0102 FEES FOR PROFESSIONAL SERVICES (Proposed Eff. APRIL 1, 2015)

(a) The Commission's Medical Fee Schedule contains maximum allowed amounts for professional medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology ("CPT") codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems ("HCPCS") codes, and jurisdiction-specific codes. A listing of the maximum allowable amount for each code is available in the Medical Fee Schedule on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.

(b) The following methodology provides the basis for the Commission's Medical Fee Schedule:

- (1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201-99205 and 99211-99215, which are based on 1995 Medicare values multiplied by 2.05.
- (2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.
- (3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.
- (4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.

PROPOSED RULES

Authority G.S. 97-25; 97-26; 97-80(a).

04 NCAC 10J .0102 FEES FOR PROFESSIONAL SERVICES (Proposed Eff. JULY 1, 2015)

(a) The Commission's Medical Fee Schedule contains maximum allowed amounts for medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology (CPT) codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems (HCPCS) codes, and jurisdiction specific codes. A listing of the maximum allowable amount for each code is available on the Commission's website at

<http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.

(b) The following methodology provides the basis for the Commission's Medical Fee Schedule:

- (1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201-99205 and 99211-99215, which are based on 1995 Medicare values multiplied by 2.05.
- (2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.
- (3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.

(4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.

(a) Except where otherwise provided, maximum allowable amounts payable to health care providers for professional services are based on the current year's Medicare Part B Fee Schedule for North Carolina as published by the Centers for Medicare & Medicaid Services ("CMS") ("the Medicare base amount"), including subsequent versions and editions.

(b) The schedule of maximum reimbursement rates for professional services is as follows:

- (1) Evaluation & management services are 140 percent of the Medicare base amount;
- (2) Physical medicine services are 140 percent of the Medicare base amount;
- (3) Emergency medicine services are 169 percent of the Medicare base amount;
- (4) Neurology services are 153 percent of the Medicare base amount;
- (5) Pain management services are 163 percent of the Medicare base amount;
- (6) Radiology services are 195 percent of the Medicare base amount;
- (7) Major surgery services are 195 percent of the Medicare base amount;
- (8) All other professional services are 150 percent of the Medicare base amount.

(c) Anesthesia services shall be paid at no more than the following rates:

- (1) When provided by an anesthesiologist, the allowable amount is three dollars and eighty-eight cents (\$3.88) per minute up to and including 60 minutes, and two dollars and five cents (\$2.05) per minute beyond 60 minutes.
- (2) When provided by a certified registered nurse anesthetist, the allowable amount is two dollars and fifty-five cents (\$2.55) per minute up to and including 60 minutes, and one dollar and fifty-five cents (\$1.55) per minute beyond 60 minutes.

(d) The maximum allowable amount for an assistant at surgery is 20 percent of the amount payable for the surgical procedure.

(e) Using the Medicare base amounts and maximum reimbursement rates in the Paragraphs above, the Commission will publish annually an official Professional Fee Schedule Table listing allowable amounts for individual professional services in accordance with this fee schedule. The Professional Fee Schedule Table, including all subsequent versions and editions, is incorporated by reference. The allowable amounts contained in the Professional Fee Schedule Table will take effect January 1 of each year. The Professional Fee Schedule Table is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in Rule 04 NCAC 10A .0101.

(f) Maximum allowable amounts for durable medical equipment and supplies ("DME") provided in the context of professional services are 100 percent of those rates established for North Carolina in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") Fee Schedule published by CMS. The Commission will publish once annually to its website an official DME Fee Schedule Table listing allowable amounts for individual items and services in accordance with this fee schedule. The DME Fee Schedule Table, including all subsequent versions and editions, is incorporated by reference. The allowable amounts contained in the DME Fee Schedule Table will take effect January 1 of each year. The DME Fee Schedule Table is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in Rule 04 NCAC 10A .0101.

(g) Maximum allowable amounts for clinical laboratory services are 150 percent of those rates established for North Carolina in the Clinical Diagnostic Laboratory Fee Schedule published by CMS. The Commission will publish once annually to its website an official Clinical Laboratory Fee Schedule Table listing allowable amounts for individual items and services in accordance with this fee schedule. The Clinical Laboratory Fee Schedule Table, including all subsequent versions and editions, is incorporated by reference. The allowable amounts contained in the Clinical Laboratory Fee Schedule Table will take effect January 1 of each year. The Clinical Laboratory Fee Schedule Table is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in Rule 04 NCAC 10A .0101.

(h) The following licensed health care providers may provide professional services in workers' compensation cases subject to

PROPOSED RULES

physician supervision and other scope of practice requirements and limitations under North Carolina law:

- (1) Certified registered nurse anesthetists;
- (2) Anesthesiologist assistants;
- (3) Nurse practitioners;
- (4) Physician assistants;
- (5) Certified nurse midwives;
- (6) Clinical nurse specialists.

Services rendered by these providers are subject to the schedule of maximum fees for professional services as provided in this Rule.

Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410.

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

(a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services are 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 for a claims payment that Medicare would make, but excludes 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 defined by the 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") are 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 as in Addendum AA, Final ASC Covered Surgical Procedures for CY 2014 and Addendum BB Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2014, published in the December 10, 2013 publication of the Federal Register, or its successor.

(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.

(i) 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), (f), and (h) of this Rule.

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

(k) 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.

(l) 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.

Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410.

TITLE 13 – DEPARTMENT OF LABOR

Notice is hereby given in accordance with G.S. 150B-21.2 that the Department of Labor intends to amend the rules cited as 13 NCAC 13 .0101, .0203, .0205, .0210, .0213, .0303, 13 NCAC 15 .0307, and repeal the rule cited as 13 NCAC 07F .0206.



December 29, 2014

RECEIVED
JAN 02 2015
Executive Secretary Office

Meredith Henderson
4333 Mail Service Center
Raleigh, NC 27699-4333

Re: 04 NCAC 10J .0101, .0102, .0103

Dear Ms. Henderson:

On behalf of the North Carolina Retail Merchants Association (NCRMA) and its affiliated workers' compensation insurance company, First Benefits Insurance Mutual, Inc., I am writing to strongly support the administrative rules (04 NCAC 10J .0101, .0102, .0103) concerning physician and hospital fee schedules published by the North Carolina Industrial Commission (Commission) in the *North Carolina Register* on November 17, 2014.

In 2011, the North Carolina General Assembly reformed North Carolina's workers' compensation system, which began with the passage of Session Law 2011-287 "Protect and Put NC Back to Work." Session Law 2011-287 attempted to re-center the pendulum of the indemnity portion of the workers' compensation system with major changes to lifetime benefits, definition of suitability or employment and the creation of a vocational rehabilitation program while also subjecting the appointment of Commissioners to legislative approval and the Commission to the Administrative Procedures Act. While the indemnity portion of the workers' compensation system was reformed, the cost of the medical benefit side of the system continued to increase to the point that North Carolina had become an outlier. Some providers were being paid far less than the median of states and others paid well in excess of the median of similarly situated providers in other states. It is important that a balance be struck where providers are paid fairly to ensure access to injured workers to valuable and necessary health care that will ultimately result in the injured worker being returned to employment.

While I understand that a provider group has raised issues with the proposed fee schedule, including providing comments at the Commission's Public Hearing, we urge the Commission to stay the course and adopt these rules as initially published. As stated by the Commission in its rule-making filing, these proposed "rates were calculated to fall in the estimated median range of workers' compensation schedules nationally" based upon data available from comprehensive studies. Additionally, these rates contained within these proposed rules were the result of a nearly two-year negotiation between the medical and hospital community with the business and insurance community.

We applaud the transition to a Medicare payment methodology as required by Session Law 2013-410, as this will bring payment for North Carolina's workers' compensation system in-line with surrounding states and other states that North Carolina competes with for job creation. In some instances, providers will see an increase in their respective rates, while others will see a decrease. We therefore urge the adoption of the proposed rules as published by the Commission on November 17, 2014.

Sincerely,

A handwritten signature in black ink, appearing to read "Andy Ellen", with a long, sweeping horizontal line extending to the right.

Andy Ellen
President



NORTH CAROLINA HOME BUILDERS ASSOCIATION

P.O. BOX 99090 • RALEIGH, N.C. 27624-9090

PHONE (919) 676-9090 • TOLL FREE 1-800-662-7129 • FAX (919) 676-0402

www.nchba.com • www.21buildingexpo.com

2015 NCHBA OFFICERS

January 6, 2015

JAN 08 2015

President
SEAN SULLIVAN
Black Mountain, (828) 669-4343
sean@livingstoneconstruction.com

President-Elect
BRIAN PACE
Charlotte, (704) 365-1208
bp@pacedevelop.com

First Vice President
GARY EMBLER
Concord, (704) 361-7720
gembler@nitblockhomes.com

Vice President, Region I
HIRAM WILLIAMS
Surf City, (910) 328-1404
hramwac@aol.com

Vice President, Region II
GLENN MORRISON
Winterville, (252) 347-4699
Glennmorrison3@gmail.com

Vice President, Region III
SEAR HOLMES
Garner, (919) 333-6109
sholmes2@bellsouth.net

Vice President, Region IV
RALPH DOGGETT
Burlington, (336) 263-2175
ralph.doggett@yahoo.com

Vice President, Region V
DANNY ADAMS
Pinehurst, (910) 295-1504
danny@danicladams.com

Vice President, Region VI
NICOLE GOOLSBY
Cornelius, (704) 892-9131
nicole@nionhomes.com

Vice President, Region VII
JASON HEDRICK
Lexington, (336) 746-4388
jason@hedrickcreativebuilding.com

Vice President, Region VIII
MICKEY PRUITT
Jefferson, (336) 877-7518
pruittm@yahoo.com

Vice President, Region IX
STONEY STORY
Morganton, (828) 443-3774
stoneystory@hotmail.com

Vice President, Region X
THOMAS MCCLAIN
Mills River, (828) 242-3465
Thomas@homesweethomewnc.com

Secretary/Treasurer
KATHY CRAVEN SNODGRASS
Winston-Salem, (336) 726-7810
kathy.snodgrass@piedmonting.com

Immediate Past President & NAHB Executive Committee State Rep.
J. GARY HILL
Greensboro, (336) 420-5893
jgaryhill@triad.rr.com

NAHB Executive Committee
BUDDY HUGHES
Lexington, (336) 240-3097
hucon@plmc.net

Executive Vice President
MIKE CARPENTER

Meredith Henderson
North Carolina Industrial Commission
4333 Mail Service Center
Raleigh, North Carolina 27699-4333

RE: Proposed NCIC Medical Fee Schedule Rules/ 04 NCAC 10J .0101, 04 NCAC 10J .0102, 04 NCAC 10J .0103

Dear Ms. Henderson:

I write on behalf of the almost 14,000 member firms which comprise the North Carolina Home Builders Association (NCHBA) and the more than 10,000 policyholders insured by Builders Mutual Insurance Company in support of the adoption of the proposed rules.

NCHBA, in cooperation with other interested parties, has been engaged in a more than two-year effort to bring about needed changes in the current workers compensation medical fee schedule. The genesis of this effort began with the passage of HB 709 (Session Law 2011-287) which, among other important reforms, subjected the rules of the North Carolina Industrial Commission (Commission) to the Administrative Procedures Act for the first time. In the process of developing the instant rules, a broad stakeholders group (representing medical providers, employers and employees) was established. Agreement among that group led to the enactment of Session Law 2013-410, s. 33 (a) which directed the Commission to adopt a new fee schedule based on "the applicable Medicare payment methodologies." The Commission's Chairman then requested that the parties meet together in an effort to arrive at a consensus. After considerable discussion among the parties which included a two-day mediation, consensus was ultimately achieved resulting in agreement among the parties which gives rise to these rules.

While we understand that one particular provider group is apparently dissatisfied with the result, we strongly urge the Commission to adopt the rules as proposed. The rules enjoy the support of the major organizations representing medical providers, employers and employees. We believe the rules strike an appropriate balance to ensure that injured workers are provided an appropriate standard of services and care, that health care providers receive a reasonable reimbursement for services, and that medical costs are adequately contained for employers.

Sincerely,

J. Michael Carpenter
Executive Vice President & General Counsel
North Carolina Home Builders Association

*LUGENE A. GULLEDGE (1964)
C. PHIL ROBINSON, JR. (1966)
CARL W. JOHNSON (1967)
JOHN CROSLAND, JR. (1968)
*J.M. DAUGHTRIDGE (1969)
*HOMER BARRETT (1970)
*JAMES W. LESTER (1971)
CHARLES C. McLAURIN (1972)
J. VAUGHN KLUTTS (1973)
*Deceased

*C.L. REAVIS (1974)
JOHN T. BELL (1975)
*WILLIAM T. BOYD (1976)
LARRY HAMBRICK (1977)
J. RAY SPARROW (1978)
SHERRILL FAW (1979)
MARK E. TIPTON (1980)
M. DURWOOD STEPHENSON (1981)

J. WATTS ROBERSON (1982)
*NELSON CALLAHAN (1983)
*PAUL O. TROLLINGER (1984)
RICK BATCHELOR (1985)
BURL LANCE (1986)
LARRY SUMMER (1987)
HERSCHEL REDDING (1988)
JAMES FORD (1989)

STEVE NASH (1990)
HARRIS B. GUPTON (1991)
RUSS DAVIS (1992)
CHUCK MILLER (1993)
CHARLES MULLEN (1994)
ROBERT INGRAHAM (1995)
DAVID PRESSLY, JR. (1996)
DONALD W. REISWORTH (1997)

GEORGE HENSON (1998)
ROBERT YATKO (1999)
DANNY ADAMS (2000)
JONATHAN ELLIOT (2001)
DON CROOM (2002)
GREG ISENHOUR (2003)
RICK JUDSON (2004)
BUDDY HUGHES (2005)

DAVE STORMONT (2006)
PAUL MULLICAN (2007)
RAY RHODES (2008)
FRANK WIESNER (2009)
LYLE GARDNER (2010)
BILL DALEURE (2011)
ERIK ANDERSON (2012)
J. GARY HILL (2013-14)



Property Casualty Insurers
Association of America
Advocacy. Leadership. Results.

Trey Gillespie
Senior Workers Compensation Director

January 7, 2015

Meredith R. Henderson
General Counsel
North Carolina Industrial Commission
4333 Mail Service Center
Raleigh, NC 27699-4333
meredith.henderson@ic.nc.gov

**Re: Proposed Amendments 04 NCAC 10J .0101, .0102, and .0103 Fees for Medical Compensation
Public Hearing: December 17, 2014**

Dear Ms. Henderson,

Property Casualty Insurers Association of America (PCI) respectfully submits the following comments to the formal proposal to amend 04 NCAC 10J Fees for Medical Compensation rules .0101, .0102, and .0103.

Property Casualty Insurers Association of America (PCI) is a trade association representing over 1000 property and casualty insurance companies. PCI members write over \$210 billion in annual premium including 36% of the commercial insurance market and 39% of the private workers compensation insurance market.

PCI supports the adoption of the proposed amendments to the Fees for Medical Compensation relating to fees for professional services and fees for institutional services as drafted by the Industrial Commission. The proposed rule amendments comply with the legislative mandate as found in S.L. 2013-410 s. 33(a) by creating new medical fee schedules based on current Medicare payment methodologies. In addition, the proposal is consistent with negotiated agreements reached between the medical and hospital community and the business and insurance community over a two-year period of time. The proposal will make reimbursement of medical expenses in the North Carolina workers compensation system consistent with reimbursement levels in other jurisdictions. In addition, the proposal creates a stable methodology for reimbursement of medical expenses in the future.

PCI urges the Commission to adopt the proposed rule amendments as published on November 17, 2014.

Respectfully submitted,

Trey Gillespie
PCI
1504 San Antonio St.
Austin, TX 78701
512-366-5430
trey.gillespie@pciaa.net

Insurance Federation Of North Carolina

January 7, 2015

Meredith Henderson

North Carolina Industrial Commission

4333 Mail Service Center

Raleigh, North Carolina 27699-4333

JAN 08 2015
Executive Secretary Office

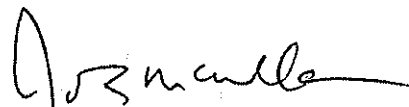
Re: Proposed NCIC Medical Fee Schedule Rules: 04 NCAC 10J.0101, 04 NCAC 10J.0102, and 04 NCAC 10J.0103

Dear Ms. Henderson:

The Insurance Federation of North Carolina (IFNC) is the state trade association of the major property and casualty insurance companies writing in North Carolina. We also have as our members the major national property and casualty insurance trade associations. Over the past several years, IFNC has participated with a broad stakeholder group including representatives of employer and employee associations as well as the state's medical providers to develop a medical reimbursement system that is more consistent with reimbursement schedules in other jurisdictions and is fair to the medical provider community. These efforts included the support of legislation in 2013 that directed the Industrial Commission to adopt a new fee schedule based on the "applicable Medicare payment methodologies."

Following the passage of that legislation, the interested parties continued to work together and, at the request of the Commission's Chairman, participated in a two-day mediation that was successful in reaching an agreement that resulted in the proposed rules. These rules have the support of the major organizations representing the medical provider community as well as the major organizations representing the employers and employees. On behalf of the industry that pays workers compensation medical bills across this country, IFNC urges the Commission to adopt the proposed rules under consideration.

Sincerely yours,



Insurance Federation of North Carolina

By: John B. McMillan

Phone: (919) 834-9773 . Fax: (919) 834-9802
Glenwood Plaza . 3605 Glenwood Avenue, Suite 220 . Raleigh, NC 27612
www.insurancefederationnc.com

811767.JBM.MISJBM.00004

January 9, 2015

Meredith Henderson
North Carolina Industrial Commission
4333 Mail Service Center
Raleigh, North Carolina 27699-4333

**RE: Proposed NCIC Medical Fee Schedule Rules/ 04 NCAC 10J .0101, 04 NCAC 10J .0102,
04 NCAC 10J .0103**

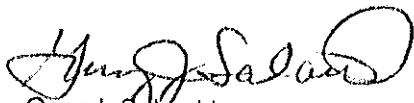
Dear Ms. Henderson:

I write on behalf of the North Carolina Chamber and its more than 35,000 members who employ 1.2 million North Carolinians.

The NC Chamber, in cooperation with other interested parties, has been engaged in a more than two-year effort to bring about needed changes in the current workers compensation medical fee schedule. The genesis of this effort began with the passage of HB 709 (Session Law 2011-287) which, among other important reforms, subjected the rules of the North Carolina Industrial Commission (Commission) to the Administrative Procedures Act for the first time. In the process of developing the instant rules, a broad stakeholders group (representing medical providers, employers and employees) was established. Agreement among that group led to the enactment of Session Law 2013-410, s. 33 (a) which directed the Commission to adopt a new fee schedule based on "the applicable Medicare payment methodologies." The Commission's Chairman then requested that the parties meet together in an effort to arrive at a consensus. After considerable discussion among the parties which included a two-day mediation, consensus was ultimately achieved resulting in agreement among the parties which gives rise to these rules.

While we understand that one particular provider group is apparently dissatisfied with the result, we strongly urge the Commission to adopt the rules as proposed. The rules enjoy the support of the major organizations representing medical providers, employers and employees. We believe the rules strike an appropriate balance to ensure that injured workers are provided an appropriate standard of services and care, that health care providers receive a reasonable reimbursement for services, and that medical costs are adequately contained for employers.

Sincerely,



Gary J. Salamido
Vice President, Government Affairs



2101 L Street NW
Suite 400
Washington, DC 20037
202-828-7100
Fax 202-293-1219
www.aiaa.org

VIA ELECTRONIC MAIL

January 9, 2015

Meredith R. Henderson
Executive Secretary
North Carolina Industrial Commission
4333 Mail Service Center
Raleigh, NC 27699-4333

Re: Proposed NCIC Medical Fee Schedule Rules 04 NCAC 10J.0101,
10J.0102, and 10J.0103

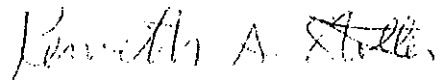
Dear Ms. Henderson:

The American Insurance Association ("AIA") hereby expresses its strong support for the adoption of proposed rules governing Fees for Medical Compensation, Professional, and Institutional Services (04 NCAC 10J.0101, 10J.0102, and 10J.0103). In 2013, AIA's members wrote more than \$500 million in workers' compensation insurance in North Carolina, accounting for 37% of the market.

The proposed rules reflect agreements negotiated between the business/insurance community and the medical and hospital associations regarding the appropriate mechanisms and reimbursement levels for compensating medical treatment delivered in the workers' compensation system. The proposed rules satisfy the admonition in G.S. §97-26 that physician and hospital fees be based on the applicable Medicare payment methodologies and ensure that (i) injured workers are provided the standard of services and care intended by the Workers' Compensation Act; (ii) providers are reimbursed reasonable fees for providing these services; and (iii) medical costs are adequately contained.

Accordingly, we believe the proposed rules offer the most viable and broadly accepted means for modernizing the Commission's approach to medical services reimbursement, and we strongly support their adoption. Should you have any questions about these comments, please call me at (202) 828-7167.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Kenneth A. Stoller". The signature is written in a cursive, slightly slanted style.

Kenneth A. Stoller
Assistant General Counsel
American Insurance Association

cc: Ron Jackson, AIA Southeast Region Vice President
John McMillan, Manning Fulton



January 12, 2015

Ms. Meredith Henderson
Executive Secretary
North Carolina Industrial Commission
4333 Mail Service Center
Raleigh, NC 27699-4333

JAN 14 2015
Executive Secretary Office

Re: Support for Proposed NCIC Medical Fee Schedule Rules: 04 NCAC 10J.0101, 04 NCAC 10J.0102, and 04 NCAC 10J.0103

Dear Ms. Henderson:

The Employers Coalition of North Carolina (ECNC) consists of the non-profit employer associations in our state with over 2,500 member employers. We strongly support the Industrial Commission's proposed NCIC Medical Fee Schedule Rules 04 NCAC 10J.0101, 04 NCAC 10J.0102, and 04 NCAC 10J.0103 because they meet the Industrial Commission's statutory requirements to adopt a medical fee schedule that ensures injured workers are provided adequate care, that providers are reimbursed reasonable fees and that medical costs are adequately contained.

It is unusual in this political arena for diverse stakeholders to sit down together on an issue and actually reach a compromise after two years and many meetings. Physicians, hospitals, service providers, employers, and the insurance industry (with involvement of lawyers for claimants and defendants) reached an agreement because: 1) extensive research established how other states handle their medical fee schedules; 2) the hospitals and physicians provided in depth education on the many reasons for the variations in their reimbursements and 3) the realization that all the stakeholders would have some provisions within the final agreement they would not like. The leadership of Chairman Heath with two days of mediation was key in completing the process.

Please share our appreciation and support with the members and staff at the Industrial Commission for their work on these important proposed rules. All the stakeholders will benefit from a long overdue update of the medical fee schedules.

Sincerely,

George W. Ports, III
Sr. Executive, Government Relations
Employers Coalition of North Carolina



January 14, 2015

Via Email

Andrew Heath, Chairman
North Carolina Industrial Commission
4333 Mail Service Center
Raleigh, NC 27699-4333

RE: 04 NCAC 10J.0102 Fees for Professional Services (Proposed July 1, 2015)

Dear Chairman Heath:

I am writing on behalf of MedQuest, Inc., a wholly-owned subsidiary of Novant Health, Inc. operating 24 outpatient diagnostic imaging facilities across North Carolina, to express my substantial concern with proposed reimbursement rates for radiology services, cited in 04 NCAC 10J.0102, the "Notice of Proposed Industrial Commission Rules" dated November 17, 2014.

The proposed changes will severely affect our facilities' ability to provide high quality diagnostic imaging services to workers' compensation patients. I am deeply troubled by the commission's proposal which, if implemented, which would grossly undervalue the role of outpatient diagnostic radiology within the healthcare delivery system. I believe that the drastic reduction in reimbursement for radiology services will greatly reduce patients' access to quality outpatient diagnostic imaging.

The proposed reimbursement represents a potentially devastating reduction in the reimbursement of services whose costs of delivery continue to rise. Providing Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) services requires substantial investment in equipment, facilities and in professional services. The costs of each are rising year over year, yet the proposed reimbursements represent reductions of upwards of 60% effective July 1, 2015, with no reduction in the cost, quality or value of the services provided.

Diagnosing work-related injuries through quality diagnostic imaging is a critical first step in treating workplace injuries and ensuring a quick return to work. Endangering access to a quick, quality, effective diagnosis by drastically cutting the reimbursement for imaging could have the unintended consequence of increasing the length of time it takes injured workers to return to work and the overall cost of claims for such injuries.

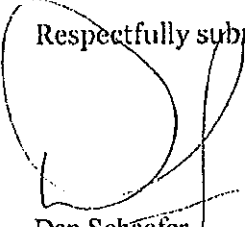
The diagnostic imaging industry has, over the years, been asked by CMS to bear a much greater share of Medicare reimbursement cuts than other specialties. Beginning with the implementation of the federal Deficit Reduction Act, imaging services have been subject to numerous legislative and policy changes that have greatly reduced reimbursement rates since 2007. Since 2007,

Medicare has reduced payments for advanced diagnostic imaging fifteen times. Many advanced diagnostic imaging codes have decreased 50% or more since 2007. Several of these changes are based on inaccurate data, and simply do not reflect the real cost of providing high quality diagnostic imaging services. As a result, shifting the workers' compensation fee schedule to a percentage of current Medicare causes a more material adverse outcome for MRI and CT service providers compared to other service lines and specialties. Imposing workers' compensation reimbursement cuts of this magnitude could force many diagnostic imaging providers into hard decisions about whether they can continue to accept workers' compensation patients, particularly among providers making the capital investments necessary to operate a high quality imaging center.

Recommendation: Due to the material adverse implications of shifting from a basis of 1995 Medicare to current Medicare, which drastically and disproportionately decreases reimbursement for MRI and CT services critical to diagnosing workplace injuries, I respectfully recommend that the Commission increase the proposed percentage of current Medicare payable after July 1, 2015 from 195% of current Medicare for Radiology to a percentage that will yield a revenue neutral result, thus protecting access to quality diagnostic imaging services for North Carolinians suffering from workplace injuries.

I appreciate the opportunity to voice my opposition to the proposed July 2015 cuts to the Radiology Fees for Professional Services cited in 04 NCAC 10J.0102. Should you have any questions, please do not hesitate to contact me either via phone (678-992-7245) or email (dschaefer@medquestmail.com).

Respectfully submitted,



Dan Schaefer
Chief Operating Officer

DS: cpg

January 16, 2015

Ms. Meredith Henderson
Executive Secretary
North Carolina Industrial Commission
4333 Mail Service Center
Raleigh, NC 27699-4333
meredith.henderson@ic.nc.gov

Re: Comment in Support of Proposed Fee Schedule Rules, 04 NCAC 10J .0101, .0102, .0103

Dear Ms. Henderson,

The North Carolina Industrial Commission is charged with adopting a schedule of medical fees for the workers' compensation system. In doing so, the Commission is required by law to strike an important balance: the fee schedule must ensure that injured workers can receive the care they need; medical providers must be compensated at reasonable rates; and medical costs must remain adequately contained. Our current fee schedule has grown stale since its adoption in the mid-1990s, both in terms of how it values medical services and in how the Commission maintains it. Simply put, the fee schedule no longer strikes the necessary balance. The time is right to make considerable changes, and we applaud the Commission for taking these initial steps.

The undersigned medical associations – representing thousands of physicians across North Carolina who regularly provide medical care to injured workers – have reviewed the proposed revisions and wish to express our collective support. We encourage the Commission to proceed with the adoption of these rules.

We would like to highlight and briefly discuss multiple provisions contained in proposed Rule 04 NCAC 10J .0102 – Fees for Professional Service (eff. July 1, 2015) ("Rule .0102").

- *Payment Rates.* Paragraph (b) of Rule .0102 establishes basic payment rates for all categories of professional services ranging from 140%-195% of Medicare. We understand that the Commission assigned percentages to each category that, based on the available literature, reflect the national median of payment rates for each category. We anticipate, therefore, that this methodology will also result in North Carolina's professional rates moving to the national median in the aggregate – a significant improvement that will also more closely reflect today's costs of providing medical care. According to the most recent WCR! analysis, North Carolina now ranks 41st out of the 43 states that have adopted professional fee schedules. Better rates will help to drive more physicians to participate in the workers' compensation system.
- *PAs, NPs, and other providers.* Physicians have cited difficulties when involving physician assistants, nurse practitioners, and other members of their care teams in treating workers' compensation patients. More specifically, medical practices encounter varying requirements from the carrier community about when (if ever) one of these providers may treat patients and be compensated. Paragraph (h) of Rule .0102 effectively clarifies that physicians may rely on other providers so long as scope of practice laws are followed, and that the rates for services

provided by those individuals are also subject to the Rule. This is a welcomed provision that will allow medical practices to care for their patients more efficiently without compromising quality.

- *DME Fee Schedule.* We are pleased that the Commission proposes to create and maintain a dedicated fee schedule for durable medical equipment (DME). While only a small number of medical practices supply DME, those that do typically encounter major burdens with billing and payment for these items. By adopting Medicare's list of maximum allowable amounts for DME, we anticipate that the Commission will have no reason to require that providers substantiate their requested payment amount for most items with mailed/faxed paper invoices.

We believe the revised fee schedule rules strike the necessary balance, and will move our workers' compensation system forward. North Carolina's physicians have appreciated the opportunity to participate in the discussions and negotiations of the fee schedule that have spanned the last several years, and we appreciate the opportunity to provide these comments to you today.

Should you have any questions, please do not hesitate to contact any of our organizations.

Sincerely,

North Carolina Medical Society
The NCMS Workers' Comp Fee Schedule Task Force
North Carolina Chapter, American College of Physicians
North Carolina College of Emergency Physicians
North Carolina Medical Group Management Association
North Carolina Neurological Society
North Carolina Orthopaedic Association
North Carolina Psychiatric Association
North Carolina Radiological Society
North Carolina Society of Anesthesiology
North Carolina Society of Pathology
SouthEastern Atlantic College of Occupational & Environmental Medicine



16 January 2015

**Meredith Henderson, Executive Secretary
North Carolina Industrial Commission**

Re: Request for Comments on Proposed Fees for Medical Compensation

We appreciate the opportunity to provide written commentary on the proposed changes to rules 04 NCAC 10J.0101, 0102, and .0103. After a review of the proposed rules, and consideration of those rules in an operational context, we would like to provide the following comments.

The proposed changes do not explicitly state whether Medicare rules and guidelines should be incorporated into the process for determining reimbursement rates, if at all. The existing North Carolina Medical Fee Schedule already includes specific rules for reimbursement of physician services, but similar expectations are not in place regarding institutional services. If it is the intent of the NCIC that all applicable Medicare rules and guidelines apply when determining reimbursement, with the exception of pass-through payments as outlined in section 04 NCAC 10J.0103 item (a), we suggest adding language making that distinction. Following is an example from Texas' rules that includes such language:

Texas Administrative Code Title 28, Part 2, Chapter 134, Subpart E, Rule §134.403

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

04 NCAC 10J .0103 Fees for Institutional Services (a)

This section does not specify whether the NCIC will publish reimbursement or if the values must be derived from Medicare tables. This is important to know as far in advance as possible if payers will be required to build the values themselves. The level of effort to do the calculations and program them into bill review systems is much larger when the CMS tables must be used as compared to loading files where another party has already determined the values. Additionally, because payers are used to the NCIC publishing fee schedule values or pricing bills on their behalf, they may not have the tools or the infrastructure to implement Medicare calculations. Having advance notification as well as detailed and clear delineations of what portions of Medicare are being adopted would be extremely helpful.

If the NCIC will publish the values, please include language similar to the professional section, 04 NCAC 10J.0102 (e), "...the Commission will publish annually..." in section 04 NCAC 10J.0103. If the intent is for payers and bill review companies to build values from Medicare's tables, that specific expectation

should be included since it is a variance from what will occur for professional fees. It is uncommon for a jurisdiction to publish rates for some services and not for others.

04 NCAC 10J .0103 Fees for Institutional Services (k)

"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."

Because DRG is specific to inpatient services, this statement clarifies that payers should not make payment at an amount greater than the fee schedule for inpatient bills, but does not address outpatient and ASC services. Something similar should be included in the final rule to address non-inpatient bills. Medicare's reimbursement rates are determined without respect to billed charges so it is not uncommon for payment to be greater than charge on outpatient and ASC services. When a state-specific mark up is added, that possibility is even greater.

Additionally, because outpatient reimbursement is determined at the service level, it is possible that individual services could have a reimbursement greater than the individual charge. This may or may not result in overall payment being greater than the billed charge. Tennessee has addressed this in a supplement to their workers' compensation rules. The line-by-line basis piece is most important if the intent is that all services should be paid at the fee schedule rate regardless of billed charge **as long as** the total bill payment does not exceed total bill charges:

III. Tennessee Medical Fee Schedule: Medical Services

E. Outpatient Services (Including Emergency Room Care If Patient is Not Admitted)

The lesser of the provider's bill, a contracted amount, or the maximum allowable per the MFS should be determined based on the entire bill rather than a line-by-line basis

If the intent is to never allow payment for a service at an amount greater than the billed charge, that specific direction should be included in the final rule.

Thank you for the opportunity to provide comments on the proposed fee schedule rules. Please feel free to contact me directly if there are any questions about the comments submitted.

Sincerely,



Leann Lewis

Coventry Workers' Comp Services

Office: 615.984.7296

Email: lxlewis@cvty.com

cc: Francine Johnson, VP, Coventry Workers' Compensation Services



North Carolina Hospital Association
Serving North Carolina's Hospitals & Health Systems

January 16, 2015

Meredith Henderson
North Carolina Industrial Commission
4333 Mail Service Center
Raleigh, North Carolina 27699-4333

RE: Proposed NCIC Medical Fee Schedule Rules/ 04 NCAC 10J .0101, 04 NCAC 10J .0102, 04 NCAC 10J .0103

Dear Ms. Henderson:

On behalf of NCHA, Inc., which represents 140 hospitals and healthcare systems in the State, I am writing regarding the proposed medical fee schedule revisions published in the above-referenced rule.

NCHA, the North Carolina Medical Society and numerous other business and insurers stakeholders were involved in an extensive review and discussion of rates and rate methodologies for workers compensation hospital and medical fee schedules over the past two years in an effort to find a balanced solution to rates. All stakeholders also jointly funded our own study on rates and rate methodologies and reviewed existing studies, group health data, State Health Plan data, and many other sources.

The facility rate changes, particular on the outpatient side, have a significant financial impact on hospitals. Nevertheless, as many of the others have already noted, we all agree that the proposed rates fall near the median nationally and within ranges seen in other states. The phase-in of facility rates between now and 2017 also helps address the impact of the changes. The proposed rules reflect the stakeholders' understanding and agreement on median rate levels, as well as payment methodologies that are consistent with the 2013 legislation requiring new fee schedules.

We believe the rates as proposed in the rule meet the Commission's statutory requirement for rates that ensure appropriate access to care for injured workers, while balancing adequate reimbursement with the duty to control medical costs.

If you have any questions, please feel free to contact me at (919) 677-4227.

Sincerely,

A handwritten signature in black ink that reads "Linwood Jones". The signature is written in a cursive style with a large, stylized "L" and "J".

Linwood Jones
General Counsel



Triangle Orthopaedics

120 William Penn Plaza
Durham, North Carolina 27704

January 16, 2015

Ms. Meredith Henderson
Executive Secretary
North Carolina Industrial Commission
4333 Mail Service Center
Raleigh, NC 27699-4333
meredith.henderson@ncic.nc.gov

Re: Official Comment in Support of Proposed Fee Schedule Rules

Ms. Henderson,

I write today on behalf of Triangle Orthopaedic Associates, P.A. (TOA) main headquarters located in Durham, North Carolina. Our practice provides care to an estimated 6000 workers' compensation patients each year, commonly providing evaluations, physical therapy and rehabilitation care, imaging, surgical procedures, etc. As indicated above TOA's main headquarters is located in Durham, however our geographic outreach expands to 11 counties in North Carolina including; Durham, Orange, Vance, Chatham, Person, Granville, Caswell, Alamance, Wilson, Wake, and Halifax.

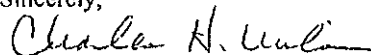
After closely monitoring the Industrial Commission's progress in reforming its medical fee schedule over the last several years, our practice is very pleased to now review and comment on the changes contained in the proposed rules. Overall, physician payment rates in our workers' compensation system are among the worst nationally, and have been for some time. So we appreciate the leadership that the Commission, the North Carolina Medical Society, and other stakeholders have shown to address this problem and put this compromise proposal forward. TOA supports this proposal and encourages the Commission to adopt it permanently.

The changes will impact our practice by:

- Increases in PM and E&M services to 140% Medicare
- Covers additional Overhead and Expenditures due to the additional paperwork required for WC patient.
- Encourages physicians to participate with carriers allowing further specialty care
- Increases in X-ray will lessen impact of MRI & CT reductions
- Reduced administrative burdens associated with DME billing
- Physicians will be able to more confidently involve PAs/NPs in WC patient care

Thank you for the opportunity to comment on this proposal. Please contact me if I may be of further assistance.

Sincerely,



Charles H. Wilson, CEO

Note from the Codifier: The notices published in this Section of the NC Register include the text of proposed rules. The agency must accept comments on the proposed rule(s) for at least 60 days from the publication date, or until the public hearing, or a later date if specified in the notice by the agency. If the agency adopts a rule that differs substantially from a prior published notice, the agency must publish the text of the proposed different rule and accept comment on the proposed different rule for 60 days.

Statutory reference: G.S. 150B-21.2.

TITLE 04 – DEPARTMENT OF COMMERCE

Notice is hereby given in accordance with G.S. 150B-21.2 that the NC Industrial Commission intends to adopt the rules cited as 04 NCAC 10J .0102, .0103 and amend the rules cited as 04 NCAC 10J .0101, .0102.

Link to agency website pursuant to G.S. 150B-19.1(c):
<http://www.ic.nc.gov/ProposedNCICMedicalFeeScheduleRules.html>

Proposed Effective Date: April 1, 2015 – 04 NCAC 10J .0101, .0102, .0103; and July 1, 2015 – 04 NCAC 10J .0102

Public Hearing:

Date: December 17, 2014

Time: 2:00 p.m.

Location: Dobbs Building, Room 2173, 430 N. Salisbury Street, Raleigh, NC 27603

Reason for Proposed Action: The Industrial Commission has proposed these four rules to fulfill its statutory duty to periodically review the schedule of fees charged for medical treatment in workers' compensation cases and to make revisions if necessary. The revisions reflected in the proposed rules are intended to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act, that health care providers receive reasonable reimbursement for services, and that medical costs are adequately contained. The Industrial Commission was directed in S.L. 2013-410, s. 33.(a) to base its physician and hospital fee schedules on "the applicable Medicare payment methodologies." The proposed rules are intended to carry out this legislative mandate. There are two versions of Rule 04 NCAC 10J .0102 in order to move the physician and hospital fee schedules out of Rule 04 NCAC 10J .0101 and keep the current physician fee schedule in place until July 1, 2015. The April 1, 2015 version of Rule 04 NCAC 10J .0102 is essentially Paragraphs (b) and (c) of the current Rule 04 NCAC 10J .0101. As required by G.S. 97-26(b), the following is a summary of the data and information sources reviewed by the Commission in determining the applicable fee schedule rates for hospitals and ambulatory surgery centers. Rates were calculated to fall in the estimated median range of workers' compensation fee schedules nationally, based on data available from the following studies and data sources:

(1) NORTH CAROLINA WORKERS COMPENSATION INSURANCE: A WHITE PAPER REVIEWING MEDICAL COSTS AND MEDICAL FEE REGULATIONS, prepared for the National Foundation for Unemployment Compensation and

Workers' Compensation; prepared by Philip S. Borba, Ph.D. and Robert K. Briscoe, WCP, Milliman, Inc.; May 23, 2013.

(2) CompScope Medical Benchmarks, 15th Edition, for North Carolina, published by the Workers' Compensation Research Institute, August 2014.

(3) North Carolina Hospital Association/Optum Group Health survey data, June 2013 and July 2014.

(4) Review of states' fee schedule structures, nationally and regionally.

Comments may be submitted to: Meredith Henderson, 4333 Mail Service Center, Raleigh, NC 27699-4333; phone (919) 807-2575; fax (919) 715-0282; email meredith.henderson@ic.nc.gov

Comment period ends: January 16, 2015

Procedure for Subjecting a Proposed Rule to Legislative Review: If an objection is not resolved prior to the adoption of the rule, a person may also submit written objections to the Rules Review Commission after the adoption of the Rule. If the Rules Review Commission receives written and signed objections after the adoption of the Rule in accordance with G.S. 150B-21.3(b2) from 10 or more persons clearly requesting review by the legislature and the Rules Review Commission approves the rule, the rule will become effective as provided in G.S. 150B-21.3(b1). The Commission will receive written objections until 5:00 p.m. on the day following the day the Commission approves the rule. The Commission will receive those objections by mail, delivery service, hand delivery, or facsimile transmission. If you have any further questions concerning the submission of objections to the Commission, please call a Commission staff attorney at 919-431-3000.

Fiscal impact (check all that apply).

- ☐ State funds affected
- ☐ Environmental permitting of DOT affected
- ☐ Analysis submitted to Board of Transportation
- ☐ Local funds affected
- ☐ Substantial economic impact (≥\$1,000,000)
- ☒ No fiscal note required by G.S. 150B-21.4

***These rules were exempted from the fiscal note requirement of G.S. 150B-21.4 in S.L. 2013-410, s. 33.(a)(3).

CHAPTER 10 – INDUSTRIAL COMMISSION

SUBCHAPTER 10J – FEES FOR MEDICAL COMPENSATION

SECTION .0100 – FEES FOR MEDICAL
COMPENSATION

04 NCAC 10J .0101 GENERAL PROVISIONS

(a) The Commission adopted and published a Medical Fee Schedule, pursuant to the provisions of G.S. 97-26(a), setting maximum amounts, except for hospital fees pursuant to G.S. 97-26(b), that may be paid for medical, surgical, nursing, dental, and rehabilitative services, and medicines, sick travel, and other treatment, including medical and surgical supplies, original artificial members as may reasonably be necessary at the end of the healing period and the replacement of such artificial members when reasonably necessitated by ordinary use or medical circumstances. Pursuant to G.S. 97-26, the Commission adopts a Medical Fee Schedule composed of maximum amounts, reimbursement rates, and payment guidelines. The amounts and reimbursement rates prescribed in the applicable published Medical Fee Schedule shall govern and apply according to G.S. 97-26(c). The Medical Fee Schedule is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.

(b) The Commission's Medical Fee Schedule contains maximum allowed amounts for medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology (CPT) codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems (HCPCS) codes, and jurisdiction-specific codes. A listing of the maximum allowable amount for each code is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.

(c) The following methodology provides the basis for the Commission's Medical Fee Schedule:

- (1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201-99205 and 99211-99215, which are based on 1995 Medicare values multiplied by 2.05.
- (2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.
- (3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.
- (4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.

(d) The Commission's Hospital Fee Schedule, adopted pursuant to G.S. 97-26(b), provides for payment as follows:

- (1) Inpatient hospital fees: Inpatient services are reimbursed based on a Diagnostic Related Groupings (DRG) methodology. The Hospital Fee Schedule utilizes the 2001 Diagnostic Related Groupings adopted by the State Health

Plan. Each DRG amount is based on the amount that the State Health Plan had in effect for the same DRG on June 30, 2001.

DRG amounts are further subject to the following payment band that establishes maximum and minimum payment amounts:

(A) The maximum payment is 100 percent of the hospital's itemized charges.

(B) For hospitals other than critical access hospitals, the minimum payment is 75 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.

(C) For critical access hospitals, the minimum payment is 77.07 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.

(2) Outpatient hospital fees: Outpatient services are reimbursed based on the hospital's actual charges as billed on the UB-04 claim form, subject to the following percentage discounts:

(A) For hospitals other than critical access hospitals, the payment shall be 79 percent of the hospital's billed charges. Effective February 1, 2013, the payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.

(B) For critical access hospitals, the payment shall be 87 percent of the hospital's billed charges. For purposes of the hospital fee schedule, critical access hospitals are those hospitals designated as such pursuant to federal law (42 CFR 485.601 et seq.). Effective February 1, 2013, the critical access hospital's payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.

(3) Ambulatory surgery fees: Ambulatory surgery center services are reimbursed at 79 percent of billed charges. Effective February 1, 2013, the ambulatory surgery center services are reimbursed at the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.

- (4) ~~Other rates: If a provider has agreed under contract with the insurer or managed care organization to accept a different amount or reimbursement methodology, that amount or methodology establishes the applicable fee.~~
- (5) ~~Payment levels frozen and reduced pending study of new fee schedule: Effective February 1, 2013, inpatient and outpatient payments for each hospital and the payments for each ambulatory surgery center shall be set at the payment rates in effect for those facilities as of June 30, 2012. Effective April 1, 2013, those rates shall then be reduced as follows:~~
- (A) ~~Hospital outpatient and ambulatory surgery: The rate in effect as of that date shall be reduced by 15 percent.~~
- (B) ~~Hospital inpatient: The minimum payment rate in effect as of that date shall be reduced by 10 percent.~~
- (6) ~~Effective April 1, 2013, implants shall be paid at no greater than invoice cost plus 28 percent.~~

(e)(b) Insurers and managed care organizations, or administrators on their behalf, may review and reimburse charges for all medical compensation, including medical, hospital, and dental fees, without submitting the charges to the Commission for review and approval.

(f)(c) A provider of medical compensation shall submit its statement bill for services within 75 days of the rendition of the service, or if treatment is longer, within 30 days after the end of the month during which multiple treatments were provided. However, in cases where liability is initially denied but subsequently admitted or determined by the Commission, the time for submission of medical bills shall run from the time the health care provider received notice of the admission or determination of liability. Within 30 days of receipt of the statement bill, the employer, carrier, or managed care organization, or administrator on its behalf, shall pay or submit the statement to the Commission for approval the bill or send the provider written objections to the statement bill. If an employer, carrier, administrator, or managed care organization disputes a portion of the provider's bill, the employer, carrier, administrator, or managed care organization, shall pay the uncontested portion of the bill and shall resolve disputes regarding the balance of the charges through its contractual arrangement or through the Commission.

(g)(d) Pursuant to G.S. 97-18(i), when the 10 percent addition to the bill is uncontested, payment shall be made to the provider without notifying or seeking approval from the Commission. When the 10 percent addition to the bill is contested, any party may request a hearing by the Commission pursuant to G.S. 97-83 and G.S. 97-84.

(h)(e) When the responsible party seeks an audit of hospital charges, and has paid the hospital charges in full, the payee hospital, upon request, shall provide reasonable access and copies of appropriate records, without charge or fee, to the person(s) chosen by the payor to review and audit the records.

(i)(f) The responsible employer, carrier, managed care organization, or administrator shall pay the statements bills of medical compensation providers to whom the employee has

been referred by the treating physician authorized by the insurance carrier for the compensable injury or body part, unless the physician has been requested to obtain authorization for referrals or tests; provided that compliance with the request shall not unreasonably delay the treatment or service to be rendered to the employee.

(j)(g) Employees are entitled to reimbursement for sick travel when the travel is medically necessary and the mileage is 20 or more miles, round trip, at the business standard mileage rate set by the Internal Revenue Service per mile of travel and the actual cost of tolls paid. Employees are entitled to lodging and meal expenses, at a rate to be established for state employees by the North Carolina Director of Budget, when it is medically necessary that the employee stay overnight at a location away from the employee's usual place of residence. Employees are entitled to reimbursement for the costs of parking or a vehicle for hire, when the costs are medically necessary, at the actual costs of the expenses.

(k)(h) Any employer, carrier or administrator denying a claim in which medical care has previously been authorized is responsible for all costs incurred prior to the date notice of denial is provided to each health care provider to whom authorization has been previously given.

Authority G.S. 97-18(i); 97-25; 97-25.6; 97-26; 97-80(a); 138-6; S.L. 2013-410.

04 NCAC 10J .0102 FEES FOR PROFESSIONAL SERVICES (Proposed Eff. APRIL 1, 2015)

(a) The Commission's Medical Fee Schedule contains maximum allowed amounts for professional medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology ("CPT") codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems ("HCPCS") codes, and jurisdiction-specific codes. A listing of the maximum allowable amount for each code is available in the Medical Fee Schedule on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.

(b) The following methodology provides the basis for the Commission's Medical Fee Schedule:

- (1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201-99205 and 99211-99215, which are based on 1995 Medicare values multiplied by 2.05.
- (2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.
- (3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.
- (4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.

Authority G.S. 97-25; 97-26; 97-80(a).

04 NCAC 10J .0102 FEES FOR PROFESSIONAL SERVICES (Proposed Eff. JULY 1, 2015)

(a) The Commission's Medical Fee Schedule contains maximum allowed amounts for medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology (CPT) codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems (HCPCS) codes, and jurisdiction-specific codes. A listing of the maximum allowable amount for each code is available on the Commission's website at

<http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.

(b) The following methodology provides the basis for the Commission's Medical Fee Schedule:

- (1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201-99205 and 99211-99215, which are based on 1995 Medicare values multiplied by 2.05.
- (2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.
- (3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.

(4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.

(a) Except where otherwise provided, maximum allowable amounts payable to health care providers for professional services are based on the current year's Medicare Part B Fee Schedule for North Carolina as published by the Centers for Medicare & Medicaid Services ("CMS") ("the Medicare base amount"), including subsequent versions and editions.

(b) The schedule of maximum reimbursement rates for professional services is as follows:

- (1) Evaluation & management services are 140 percent of the Medicare base amount;
- (2) Physical medicine services are 140 percent of the Medicare base amount;
- (3) Emergency medicine services are 169 percent of the Medicare base amount;
- (4) Neurology services are 153 percent of the Medicare base amount;
- (5) Pain management services are 163 percent of the Medicare base amount;
- (6) Radiology services are 195 percent of the Medicare base amount;
- (7) Major surgery services are 195 percent of the Medicare base amount;
- (8) All other professional services are 150 percent of the Medicare base amount.

(c) Anesthesia services shall be paid at no more than the following rates:

- (1) When provided by an anesthesiologist, the allowable amount is three dollars and eighty-eight cents (\$3.88) per minute up to and including 60 minutes, and two dollars and five cents (\$2.05) per minute beyond 60 minutes.
- (2) When provided by a certified registered nurse anesthetist, the allowable amount is two dollars and fifty-five cents (\$2.55) per minute up to and including 60 minutes, and one dollar and fifty-five cents (\$1.55) per minute beyond 60 minutes.

(d) The maximum allowable amount for an assistant at surgery is 20 percent of the amount payable for the surgical procedure.

(e) Using the Medicare base amounts and maximum reimbursement rates in the Paragraphs above, the Commission will publish annually an official Professional Fee Schedule Table listing allowable amounts for individual professional services in accordance with this fee schedule. The Professional Fee Schedule Table, including all subsequent versions and editions, is incorporated by reference. The allowable amounts contained in the Professional Fee Schedule Table will take effect January 1 of each year. The Professional Fee Schedule Table is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in Rule 04 NCAC 10A .0101.

(f) Maximum allowable amounts for durable medical equipment and supplies ("DME") provided in the context of professional services are 100 percent of those rates established for North Carolina in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") Fee Schedule published by CMS. The Commission will publish once annually to its website an official DME Fee Schedule Table listing allowable amounts for individual items and services in accordance with this fee schedule. The DME Fee Schedule Table, including all subsequent versions and editions, is incorporated by reference. The allowable amounts contained in the DME Fee Schedule Table will take effect January 1 of each year. The DME Fee Schedule Table is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in Rule 04 NCAC 10A .0101.

(g) Maximum allowable amounts for clinical laboratory services are 150 percent of those rates established for North Carolina in the Clinical Diagnostic Laboratory Fee Schedule published by CMS. The Commission will publish once annually to its website an official Clinical Laboratory Fee Schedule Table listing allowable amounts for individual items and services in accordance with this fee schedule. The Clinical Laboratory Fee Schedule Table, including all subsequent versions and editions, is incorporated by reference. The allowable amounts contained in the Clinical Laboratory Fee Schedule Table will take effect January 1 of each year. The Clinical Laboratory Fee Schedule Table is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at the offices of the Commission as set forth in Rule 04 NCAC 10A .0101.

(h) The following licensed health care providers may provide professional services in workers' compensation cases subject to

physician supervision and other scope of practice requirements and limitations under North Carolina law:

- (1) Certified registered nurse anesthetists;
- (2) Anesthesiologist assistants;
- (3) Nurse practitioners;
- (4) Physician assistants;
- (5) Certified nurse midwives;
- (6) Clinical nurse specialists.

Services rendered by these providers are subject to the schedule of maximum fees for professional services as provided in this Rule.

Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410.

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

(a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services are 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 for a claims payment that Medicare would make, but excludes 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 defined by the 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") are 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 as in Addendum AA, Final ASC Covered Surgical Procedures for CY 2014 and Addendum BB Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2014, published in the December 10, 2013 publication of the Federal Register, or its successor.

(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.

(i) 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), (f), and (h) of this Rule.

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

(k) 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.

(l) 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.

Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410.

TITLE 13 – DEPARTMENT OF LABOR

Notice is hereby given in accordance with G.S. 150B-21.2 that the Department of Labor intends to amend the rules cited as 13 NCAC 13 .0101, .0203, .0205, .0210, .0213, .0303, 13 NCAC 15 .0307, and repeal the rule cited as 13 NCAC 07F .0206.

Beverly Eaves Perdue, Governor
Camela T. Young, Chair



Bernadine S. Ballance, Commissioner
Laura K. Mavretic, Commissioner
Danny L. McDonald, Commissioner
Staci Meyer, Commissioner
Christopher Scott, Commissioner
Dianne C. Sellers, Commissioner

North Carolina Industrial Commission

Order Adopting Revised Inpatient Hospital Billing Band, Outpatient Reimbursement Rate, and Ambulatory Surgical Center Reimbursement Rate for Workers' Compensation Cases

The North Carolina Industrial Commission published a "Public Notice of Rule-Making by the North Carolina Industrial Commission Concerning Amendment of Hospital Fee Schedule for Workers' Compensation Cases" in the *North Carolina Public Register* on December 15, 2008, and on the Industrial Commission's web site continuously from November 20, 2008, through the present.

Pursuant to the Notice, a Public Hearing was held on January 6, 2009, in the North Carolina Industrial Commission Hearing Room, Room 2173 of the Dobbs Building in Raleigh, NC. A representative from the Industrial Commission spoke at the hearing to introduce the proposed changes and submit related exhibits. Two other individuals requested to and did speak at the hearing. Other hearing attendees were invited to speak, but did not choose to do so. Exhibits and written comments were received into the record. The record of the Public Hearing was held open for written comments through midnight on January 14, 2009. Three additional sets of comments were received and have been included in the record.

After careful review of the record, the Commission adopts the following:

Beginning July 27, 2009, for service dates on and after that date, the following inpatient hospital billing band and outpatient and ambulatory surgical center reimbursement rates shall come into effect:

- The lower end cap of the DRG band for reimbursement of inpatient hospital bills will be adjusted from 77.07% to 75% of charges for hospitals other than critical access hospitals. (Critical access hospitals are defined by federal law and are the smallest hospitals in the State, located in rural areas.)
- The reimbursement rate for outpatient hospital bills will be adjusted from 95% of charges to 79% of charges for hospitals other than critical access hospitals. For critical access hospitals, the outpatient reimbursement rate will be reduced from 95% to 87% of charges.
- The reimbursement rate for ambulatory surgical centers will be adjusted from 100% of charges to 79% of charges.

The Industrial Commission takes this action pursuant to Sections 97-26(a) & (b) and 97-80(a) of the North Carolina General Statutes.

This the 21 day of January, 2009.

Pamela T. Young
Pamela T. Young
Chair

Bernadine S. Ballance
Bernadine S. Ballance
Commissioner

Danny L. McDonald
Danny L. McDonald
Commissioner

Dianne C. Sellers
Dianne C. Sellers
Commissioner

Laura K. Mavretic
Laura Kranifeld Mavretic
Commissioner

Christopher L. Scott
Christopher L. Scott
Commissioner

(j) No cause of action shall arise and no health care provider shall incur any liability as a result of the release of medical records, reports, or information pursuant to this Article.

(k) For purposes of this section, the term "employer" means the employer, the employer's attorney, and the employer's insurance carrier or third-party administrator; and the term "employee" means the employee, legally appointed guardian, or any attorney representing the employee."

SECTION 3. G.S. 97-26 reads as rewritten:

"§ 97-26. Fees allowed for medical treatment; malpractice of physician.

(a) Fee Schedule. – The Commission shall adopt by rule a schedule of maximum fees for medical compensation, except as provided in subsection (b) of this section, and shall periodically review the schedule and make ~~revisions pursuant to the provisions of this Article.~~revisions.

The fees adopted by the Commission in its schedule shall be adequate to ensure that (i) injured workers are provided the standard of services and care intended by this Chapter, (ii) providers are reimbursed reasonable fees for providing these services, and (iii) medical costs are adequately contained.

~~Prior to adoption of a fee schedule, the Commission shall publish notice of its intent to adopt the schedule in the North Carolina Register and hold a public hearing. The published notice shall include the location, date and time of the public hearing, the proposed effective date of the fee schedule, the period of time during which the Commission will receive written comments on the proposed schedule, and the person to whom comments and questions should be directed. In addition to publication in the North Carolina Register, the notice may be mailed to parties who have requested notice of the fee schedule hearing. The public hearing shall be held no earlier than 15 days after the publication of the notice. The Commission shall receive written comments for at least 30 days or until the date of the public hearing, whichever is later, after which the Commission may adopt the fee schedule.~~

The Commission may consider any and all reimbursement systems and plans in establishing its fee schedule, including, but not limited to, the State Health Plan for Teachers and State Employees (hereinafter, "State Plan"), Blue Cross and Blue Shield, and any other private or governmental plans. The Commission may also consider any and all reimbursement methodologies, including, but not limited to, the use of current procedural terminology ("CPT") codes, diagnostic-related groupings ("DRGs"), per diem rates, capitated payments, and resource-based relative-value system ("RBRVS") payments. The Commission may consider statewide fee averages, geographical and community variations in provider costs, and any other factors affecting provider costs.

~~An appeal from a decision of the Commission establishing a fee schedule, by any party aggrieved thereby, shall be to the North Carolina Court of Appeals. The decision of the Commission shall be affirmed if supported by substantial evidence. For the purposes of the appeal, the Commission is a party.~~

(b) Hospital Fees. – Each hospital subject to the provisions of this subsection shall be reimbursed the amount provided for in this subsection unless it has agreed under contract with the insurer, managed care organization, employer (or other payor obligated to reimburse for inpatient hospital services rendered under this Chapter) to accept a different amount or reimbursement methodology.

Except as otherwise provided herein, payment for medical treatment and services rendered to workers' compensation patients by a hospital shall be a reasonable fee determined by the ~~Commission.~~Commission and adopted by rule. Effective September 16, 2001, through June 30, 2002, the fee shall be the following amount unless the Commission adopts a different fee schedule in accordance with the provisions of this section:

- (1) For inpatient hospital services, the amount that the hospital would have received for those services as of June 30, 2001. The payment shall not be more than a maximum of one hundred percent (100%) of the hospital's itemized charges as shown on the UB-92 claim form or less than the minimum percentage for payment of inpatient DRG claims that was in effect as of June 30, 2001.
- (2) For outpatient hospital services and any other services that were reimbursed as a discount off of charges under the State Plan as of June 30, 2001, the amount calculated by the Commission as a percentage of the hospital charges for such services. The percentage applicable to each hospital shall be

the percentage used by the Commission to determine outpatient rates for each hospital as of June 30, 2001.

- (3) For any other services, a reasonable fee as determined by the Industrial Commission.

~~Notwithstanding any other provisions of law, the Commission's determination of payment rates under this subsection shall:~~

- ~~(1) Comply with the procedures for adoption of a fee schedule established in G.S. 97-26(a);~~
~~(2) Include publication of the proposed payment rate, and a summary of the data and calculations on which the rate is based at least 90 days before the proposed effective date;~~
~~(3) Be subject to the declaratory ruling provisions of G.S. 150B-4; and~~
~~(4) Be deemed to constitute a final permanent rule under Article 2A of Chapter 150B for purposes of judicial review under Article 4 of that Chapter.~~

The explanation of the fee schedule change that is published pursuant to G.S. 150B-21.2(c)(2) shall include a summary of the data and calculations on which the fee schedule rate is based.

A hospital's itemized charges on the UB-92 claim form for workers' compensation services shall be the same as itemized charges for like services for all other payers.

(c) Maximum Reimbursement for Providers Under Subsection (a). – Each health care provider subject to the provisions of subsection (a) of this section shall be reimbursed the amount specified under the fee schedule unless the provider has agreed under contract with the insurer or managed care organization to accept a different amount or reimbursement methodology. In any instance in which neither the fee schedule nor a contractual fee applies, the maximum reimbursement to which a provider under subsection (a) is entitled under this Article is the usual, customary, and reasonable charge for the service or treatment rendered. In no event shall a provider under subsection (a) charge more than its usual fee for the service or treatment rendered.

(d) Information to Commission. – Each health care provider seeking reimbursement for medical compensation under this Article shall provide the Commission information requested by the Commission for the development of fee schedules and the determination of appropriate reimbursement.

(e) When Charges Submitted. – Health care providers shall submit charges to the insurer or managed care organization within 30 days of treatment, within 30 days after the end of the month during which multiple treatments were provided, or within such other reasonable period of time as allowed by the Commission. If an insurer or managed care organization disputes a portion of a health care provider's bill, it shall pay the uncontested portion of the bill and shall resolve disputes regarding the balance of the charges in accordance with this Article or its contractual arrangement.

(f) Repeating Diagnostic Tests. – A health care provider shall not authorize a diagnostic test previously conducted by another provider, unless the health care provider has reasonable grounds to believe a change in patient condition may have occurred or the quality of the prior test is doubted. The Commission may adopt rules establishing reasonable requirements for reports and records to be made available to other health care providers to prevent unnecessary duplication of tests and examinations. A health care provider that violates this subsection shall not be reimbursed for the costs associated with administering or analyzing the test.

(g) Direct Reimbursement. – The Commission may adopt rules to allow insurers and managed care organizations to review and reimburse charges for medical compensation without submitting the charges to the Commission for review and approval.

(g1) Administrative Simplification. – The applicable administrative standards for code sets, identifiers, formats, and electronic transactions to be used in processing electronic medical bills under this Article shall comply with 45 C.F.R. § 162. The Commission shall adopt rules to require electronic medical billing and payment processes, to standardize the necessary medical documentation for billing adjudication, to provide for effective dates and compliance, and for further implementation of this subsection.

(h) Malpractice. – The employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of this section, but the

consequences of any such malpractice shall be deemed part of the injury resulting from the accident, and shall be compensated for as such.

(i) Resolution of Dispute. – The employee or health care provider may apply to the Commission by motion or for a hearing to resolve any dispute regarding the payment of charges for medical compensation in accordance with this Article."

SECTION 4. G.S. 97-26.1 reads as rewritten:

"§ 97-26.1. **Fees for medical records and reports; expert witnesses; ~~witnesses;~~ communications with health care providers.**

The Commission may establish maximum fees for the following when related to a claim under this Article: (i) the searching, handling, copying, and mailing of medical records, (ii) the preparation of medical reports and narratives, ~~and~~ (iii) the presentation of expert testimony in a Commission ~~proceeding-proceeding~~, and (iv) the time spent communicating with the employer or employee pursuant to G.S. 97-25.6(i)."

SECTION 5. G.S. 97-27(b) reads as rewritten:

"(b) In any case arising under this Article in which the employee is dissatisfied with the percentage of permanent disability as provided by G.S. 97-31 and determined by the authorized health care provider, the employee is entitled to have another examination solely on the percentage of permanent disability provided by a duly qualified physician of the employee's choosing who is licensed to practice in North Carolina, or licensed in another state if agreed to by the parties or ordered by the Commission, and designated by the employee. That physician shall be paid by the employer in the same manner as health care providers designated by the employer or the Industrial Commission are paid. The Industrial Commission must either disregard or give less weight to the opinions of the duly qualified physician chosen by the employee pursuant to this subsection on issues outside the scope of the G.S. 97-27(b) examination. No fact that is communicated to or otherwise learned by any physician who attended or examined the employee, or who was present at any examination, shall be privileged with respect to a claim before the Industrial Commission. Provided, however, that all travel expenses incurred in obtaining the examination shall be paid by the employee."

SECTION 6. G.S. 97-29(b) reads as rewritten:

"(b) When a claim is compensable pursuant to G.S. 97-18(b), paid without prejudice pursuant to G.S. 97-18(d), agreed by the parties pursuant to G.S. 97-82, or when a claim has been deemed compensable following a hearing pursuant to G.S. 97-84, an employee proves by a preponderance of the evidence that the employee is unable to earn the same wages the employee had earned before the injury, either in the same or other employment, the employee qualifies for temporary total disability subject to the limitations noted herein. The employee shall not be entitled to compensation pursuant to this subsection greater than 500 weeks from the date of first disability unless the employee qualifies for extended compensation under subsection (c) of this section."

SECTION 7. G.S. 97-32.2(a) reads as rewritten:

"(a) In a compensable claim, the employer may engage vocational rehabilitation services at any point during a claim, regardless of whether the employee has reached maximum medical improvement to include, among other services, a one-time assessment of the employee's vocational ~~potential-potential~~, except vocational rehabilitation services may not be required if the employee is receiving benefits pursuant to G.S. 97-29(c) or G.S. 97-29(d). If the employee (i) has not returned to work or (ii) has returned to work earning less than seventy-five percent (75%) of the employee's average weekly wages and is receiving benefits pursuant to G.S. 97-30, the employee may request vocational rehabilitation services, including education and retraining in the North Carolina community college or university systems so long as the education and retraining are reasonably likely to substantially increase the employee's wage-earning capacity following completion of the education or retraining program. Provided, however, the seventy-five percent (75%) threshold is for the purposes of qualification for vocational rehabilitation benefits only and shall not impact a decision as to whether a job is suitable per G.S. 97-2(22). The expense of vocational rehabilitation services provided pursuant to this section shall be borne by the employer in the same manner as medical compensation."

SECTION 8.(a) Creation and Membership. – The Joint Legislative Committee on Workers' Compensation Insurance Coverage Compliance and Fraud Prevention and Detection (Committee) is created. The Committee shall consist of eight members to be appointed as follows:

SUBCHAPTER 10J – FEES FOR MEDICAL COMPENSATION

SECTION .0100 – FEES FOR MEDICAL COMPENSATION

04 NCAC 10J .0101 FEES FOR MEDICAL COMPENSATION (EFFECTIVE UNTIL JUNE 30, 2014)

(a) The Commission has adopted and published a Medical Fee Schedule, pursuant to the provisions of G.S. 97-26(a), setting maximum amounts, except for hospital fees pursuant to G.S. 97-26(b), that may be paid for medical, surgical, nursing, dental, and rehabilitative services, and medicines, sick travel, and other treatment, including medical and surgical supplies, original artificial members as may reasonably be necessary at the end of the healing period and the replacement of such artificial members when reasonably necessitated by ordinary use or medical circumstances. The amounts prescribed in the applicable published Fee Schedule shall govern and apply according to G.S. 97-26(c).

(b) The Commission's Medical Fee Schedule contains maximum allowed amounts for medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology (CPT) codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems (HCPCS) codes, and jurisdiction-specific codes. A listing of the maximum allowable amount for each code is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.asp> and in hardcopy at 430 N. Salisbury Street, Raleigh, North Carolina.

(c) The following methodology provides the basis for the Commission's Medical Fee Schedule:

- (1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201-99205 and 99211-99215, which are based on 1995 Medicare values multiplied by 2.05.
- (2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.
- (3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.
- (4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.

(d) The Commission's Hospital Fee Schedule, adopted pursuant to G.S. 97-26(b), provides for payment as follows:

- (1) Inpatient hospital fees: Inpatient services are reimbursed based on a Diagnostic Related Groupings (DRG) methodology. The Hospital Fee Schedule utilizes the 2001 Diagnostic Related Groupings adopted by the State Health Plan. Each DRG amount is based on the amount that the State Health Plan had in effect for the same DRG on June 30, 2001.

DRG amounts are further subject to the following payment band that establishes maximum and minimum payment amounts:

- (A) The maximum payment is 100 percent of the hospital's itemized charges.
 - (B) For hospitals other than critical access hospitals, the minimum payment is 75 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
 - (C) For critical access hospitals, the minimum payment is 77.07 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
- (2) Outpatient hospital fees: Outpatient services are reimbursed based on the hospital's actual charges as billed on the UB-04 claim form, subject to the following percentage discounts:
 - (A) For hospitals other than critical access hospitals, the payment shall be 79 percent of the hospital's billed charges. Effective February 1, 2013, the payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
 - (B) For critical access hospitals, the payment shall be 87 percent of the hospital's billed charges. For purposes of the hospital fee schedule, critical access hospitals are those hospitals designated as such pursuant to federal law (42 CFR 485.601 et seq.). Effective February 1, 2013, the critical access hospital's payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
 - (3) Ambulatory surgery fees: Ambulatory surgery center services are reimbursed at 79 percent of billed charges. Effective February 1, 2013, the ambulatory surgery center services are reimbursed at the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.

- (4) Other rates: If a provider has agreed under contract with the insurer or managed care organization to accept a different amount or reimbursement methodology, that amount or methodology establishes the applicable fee.
 - (5) Payment levels frozen and reduced pending study of new fee schedule: Effective February 1, 2013, inpatient and outpatient payments for each hospital and the payments for each ambulatory surgery center shall be set at the payment rates in effect for those facilities as of June 30, 2012. Effective April 1, 2013, those rates shall then be reduced as follows:
 - (A) Hospital outpatient and ambulatory surgery: The rate in effect as of that date shall be reduced by 15 percent.
 - (B) Hospital inpatient: The minimum payment rate in effect as of that date shall be reduced by 10 percent.
 - (6) Effective April 1, 2013, implants shall be paid at no greater than invoice cost plus 28 percent.
- (e) A provider of medical compensation shall submit its statement for services within 75 days of the rendition of the service, or if treatment is longer, within 30 days after the end of the month during which multiple treatments were provided. However, in cases where liability is initially denied but subsequently admitted or determined by the Commission, the time for submission of medical bills shall run from the time the health care provider received notice of the admission or determination of liability. Within 30 days of receipt of the statement, the employer, carrier, or managed care organization, or administrator on its behalf, shall pay or submit the statement to the Commission for approval or send the provider written objections to the statement. If an employer, carrier, administrator, or managed care organization disputes a portion of the provider's bill, the employer, carrier, administrator, or managed care organization, shall pay the uncontested portion of the bill and shall resolve disputes regarding the balance of the charges through its contractual arrangement or through the Commission.
- (f) Pursuant to G.S. 97-18(i), when the 10 percent addition to the bill is uncontested, payment shall be made to the provider without notifying or seeking approval from the Commission. When the 10 percent addition to the bill is contested, any party may request a hearing by the Commission pursuant to G.S. 97-83 and G.S. 97-84.
- (g) When the responsible party seeks an audit of hospital charges, and has paid the hospital charges in full, the payee hospital, upon request, shall provide reasonable access and copies of appropriate records, without charge or fee, to the person(s) chosen by the payor to review and audit the records.
- (h) The responsible employer, carrier, managed care organization, or administrator shall pay the statements of medical compensation providers to whom the employee has been referred by the treating physician authorized by the insurance carrier for the compensable injury or body part, unless the physician has been requested to obtain authorization for referrals or tests; provided that compliance with the request shall not unreasonably delay the treatment or service to be rendered to the employee.
- (i) Employees are entitled to reimbursement for sick travel when the travel is medically necessary and the mileage is 20 or more miles, round trip, at the business standard mileage rate set by the Internal Revenue Service per mile of travel and the actual cost of tolls paid. Employees are entitled to lodging and meal expenses, at a rate to be established for state employees by the North Carolina Director of Budget, when it is medically necessary that the employee stay overnight at a location away from the employee's usual place of residence. Employees are entitled to reimbursement for the costs of parking or a vehicle for hire, when the costs are medically necessary, at the actual costs of the expenses.
- (j) Any employer, carrier or administrator denying a claim in which medical care has previously been authorized is responsible for all costs incurred prior to the date notice of denial is provided to each health care provider to whom authorization has been previously given.

History Note: Authority G.S. 97-18(i); 97-25; 97-25.6; 97-26; 97-80(a); 138-6;
 Eff. January 1, 1990;
 Amended Eff. January 1, 2013; June 1, 2000.

04 NCAC 10J .0101 FEES FOR MEDICAL COMPENSATION (EFFECTIVE JULY 1, 2014)

(a) The Commission adopted and published a Medical Fee Schedule, pursuant to the provisions of G.S. 97-26(a), setting maximum amounts, except for hospital fees pursuant to G.S. 97-26(b), that may be paid for medical, surgical, nursing, dental, and rehabilitative services, and medicines, sick travel, and other treatment, including medical and surgical supplies, original artificial members as may reasonably be necessary at the end of the healing period and the replacement of such artificial members when reasonably necessitated by ordinary use or medical circumstances. The amounts prescribed in the applicable published Fee Schedule shall govern and apply according to G.S. 97-26(c).

(b) The Commission's Medical Fee Schedule contains maximum allowed amounts for medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology (CPT) codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems (HCPCS) codes, and jurisdiction-specific codes. A listing of the maximum allowable amount for each code is available on the Commission's website at <http://www.ic.nc.gov/ncic/pages/feesched.aspx> and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.

(c) The following methodology provides the basis for the Commission's Medical Fee Schedule:

- (1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201-99205 and 99211-99215, which are based on 1995 Medicare values multiplied by 2.05.
- (2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.
- (3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.
- (4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.

(d) The Commission's Hospital Fee Schedule, adopted pursuant to G.S. 97-26(b), provides for payment as follows:

- (1) Inpatient hospital fees: Inpatient services are reimbursed based on a Diagnostic Related Groupings (DRG) methodology. The Hospital Fee Schedule utilizes the 2001 Diagnostic Related Groupings adopted by the State Health Plan. Each DRG amount is based on the amount that the State Health Plan had in effect for the same DRG on June 30, 2001.

DRG amounts are further subject to the following payment band that establishes maximum and minimum payment amounts:

- (A) The maximum payment is 100 percent of the hospital's itemized charges.
 - (B) For hospitals other than critical access hospitals, the minimum payment is 75 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
 - (C) For critical access hospitals, the minimum payment is 77.07 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
- (2) Outpatient hospital fees: Outpatient services are reimbursed based on the hospital's actual charges as billed on the UB-04 claim form, subject to the following percentage discounts:
 - (A) For hospitals other than critical access hospitals, the payment shall be 79 percent of the hospital's billed charges. Effective February 1, 2013, the payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
 - (B) For critical access hospitals, the payment shall be 87 percent of the hospital's billed charges. For purposes of the hospital fee schedule, critical access hospitals are those hospitals designated as such pursuant to federal law (42 CFR 485.601 et seq.). Effective February 1, 2013, the critical access hospital's payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
 - (3) Ambulatory surgery fees: Ambulatory surgery center services are reimbursed at 79 percent of billed charges. Effective February 1, 2013, the ambulatory surgery center services are reimbursed at the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
 - (4) Other rates: If a provider has agreed under contract with the insurer or managed care organization to accept a different amount or reimbursement methodology, that amount or methodology establishes the applicable fee.
 - (5) Payment levels frozen and reduced pending study of new fee schedule: Effective February 1, 2013, inpatient and outpatient payments for each hospital and the payments for each ambulatory surgery center shall be set at the payment rates in effect for those facilities as of June 30, 2012. Effective April 1, 2013, those rates shall then be reduced as follows:
 - (A) Hospital outpatient and ambulatory surgery: The rate in effect as of that date shall be reduced by 15 percent.
 - (B) Hospital inpatient: The minimum payment rate in effect as of that date shall be reduced by 10 percent.
 - (6) Effective April 1, 2013, implants shall be paid at no greater than invoice cost plus 28 percent.

(e) Insurers and managed care organizations, or administrators on their behalf, may review and reimburse charges for all medical compensation, including medical, hospital, and dental fees, without submitting the charges to the Commission for review and approval.

(f) A provider of medical compensation shall submit its statement for services within 75 days of the rendition of the service, or if treatment is longer, within 30 days after the end of the month during which multiple treatments were provided. However, in cases where liability is initially denied but subsequently admitted or determined by the Commission, the time for submission of medical bills shall run from the time the health care provider received notice of the admission or determination of liability. Within 30 days of receipt of the statement, the employer, carrier, or managed care organization, or administrator on its behalf, shall pay or submit the statement to the Commission for approval or send the provider written objections to the statement. If an employer, carrier, administrator, or managed care organization disputes a portion of the provider's bill, the employer, carrier, administrator, or managed care organization, shall pay the uncontested portion of the bill and shall resolve disputes regarding the balance of the charges through its contractual arrangement or through the Commission.

(g) Pursuant to G.S. 97-18(i), when the 10 percent addition to the bill is uncontested, payment shall be made to the provider without notifying or seeking approval from the Commission. When the 10 percent addition to the bill is contested, any party may request a hearing by the Commission pursuant to G.S. 9783 and G.S. 97-84.

(h) When the responsible party seeks an audit of hospital charges, and has paid the hospital charges in full, the payee hospital, upon request, shall provide reasonable access and copies of appropriate records, without charge or fee, to the person(s) chosen by the payor to review and audit the records.

(i) The responsible employer, carrier, managed care organization, or administrator shall pay the statements of medical compensation providers to whom the employee has been referred by the treating physician authorized by the insurance carrier for the compensable injury or body part, unless the physician has been requested to obtain authorization for referrals or tests; provided that compliance with the request shall not unreasonably delay the treatment or service to be rendered to the employee.

(j) Employees are entitled to reimbursement for sick travel when the travel is medically necessary and the mileage is 20 or more miles, round trip, at the business standard mileage rate set by the Internal Revenue Service per mile of travel and the actual cost of tolls paid. Employees are entitled to lodging and meal expenses, at a rate to be established for state employees by the North Carolina Director of Budget, when it is medically necessary that the employee stay overnight at a location away from the employee's usual place of residence. Employees are entitled to reimbursement for the costs of parking or a vehicle for hire, when the costs are medically necessary, at the actual costs of the expenses.

(k) Any employer, carrier or administrator denying a claim in which medical care has previously been authorized is responsible for all costs incurred prior to the date notice of denial is provided to each health care provider to whom authorization has been previously given.

*History Note: Authority G.S. 97-18(i); 97-25; 97-25.6; 97-26; 97-80(a); 138-6;
Eff. January 1, 1990;
Amended Eff. July 1, 2014; January 1, 2013; June 1, 2000.*

REVIEW OF STATES THAT USE PERCENTAGE OF MEDICARE PAYMENT AMOUNTS FOR WC FEE SCHEDULE

Average fee rate for states that use CMS ASC amounts for ASCs: **146.7%**

Average fee rate for states that use CMS OP amounts for ASCs: **127.5%**

State	Base	Rate	Citation
SC	Medicare ASC payment rate	140%	http://www.wcc.sc.gov/Documents/What%27s%20New/Committees/Surgical%20Implant%20Advisory%20Committee/2013%2004%2015%20Commission%20Approves%20Implant%20Adv%20Recommendation%20Notice.pdf
TN	ASC and OP use OPPS Medicare payment rates	150%	Tenn. Comp. R. & Regs. R. 0800-02-18-.07
MD	ASC Medicare payment rate	125%	COMAR 14.09.08.03
CO	ASC and OP use OPPS Medicare payment rates	ASCs receive 85%; OPs receive 170%	7 CCR 1101-3, Exhibit #4
CA	ASC and OP use Medicare OP payment rates	ASCs receive 80% OPs receive 120%	Title 8, California Code of Regulations, §§9789.30(aa).
TX	Medicare ASC payment rate	235%	28 Tex. Admin. Code § 134.402
MI	ASC Medicare payment rate if free-standing ASC (ASCs owned by hospital paid based on charges and hospital-specific ratios)	130%	Mich. Admin. Code R 418.10923b and R 418.101023
PA	ASC Medicare payment rate	113%	34 Pa. Code § 127.125
CT	ASC and OP use OPPS Medicare payment rates	ASCs receive 195%; OPs receive 210%	Memorandum 2015-12 http://wcc.state.ct.us/memos/2015/2015-12.htm
DC	All medical providers based on Medicare schedule	All providers receive 113% of Medicare	D.C. Code § 32-1507(a-1) (5)
IN	ASC Medicare payment rate	200%	IC 22-3-6-1(k)(2)

NM	ASC Medicare base payment rate	130%	http://www.workerscomp.state.nm.us/pdf/NewMexicoPFS2016.pdf
WV	ASC Medicare payment rate	135%	http://www.wvinsurance.gov/Portals/0/pdf/med_rates_and_plans/Ambulatory%20Surgical%20Center%20Methodology%20July%201,%202013.pdf



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

NCCI estimates that the proposal to adopt a Medicare based fee schedule, effective 4/1/2015, for Hospital Inpatient, Hospital Outpatient, and Ambulatory Surgical Center (ASC) services would result in an impact of -2.9% (-\$39.0M¹) on North Carolina workers compensation system costs.

NCCI estimates that the proposed changes to the fee schedule for professional services, effective 7/1/2015, would result in an impact of +1.4% (+19.0M¹) on North Carolina workers compensation system costs.

NCCI estimates the combined impact of the proposed 2015 changes on North Carolina workers compensation system costs to be -1.5% (-\$20.0M).

Note that the actual rules and fee schedules are not currently available. NCCI will review actual rules when they become available, which may result in a different cost impact. In particular, the 2015 Medicare physician fee schedule was not available at the time of this analysis.

Summary of Proposed Changes

The medical fee schedule changes proposed by the North Carolina Industrial Commission are summarized below.

- Hospital Outpatient Services

The provisions underlying the proposed outpatient fee schedule, proposed to be effective 4/1/2015, are as follows:

- Services performed in acute care hospitals will be based upon 220% of Medicare's hospital outpatient payment rates. Currently, these services are reimbursed at 67.15% of charges.
- Services performed in critical access hospitals will be based upon 230% of Medicare's hospital outpatient payment rates. Currently, these services are reimbursed at 73.95% of charges.

¹ Overall system costs are based on NAIC Annual Statement data. The estimated dollar impact is the percentage impact displayed multiplied by 2013 written premium of \$1,356M from NAIC Annual Statement data for North Carolina. This figure does not include self-insurance, the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs. The dollar impact on overall system costs inclusive of self-insurance is estimated to be \$-52M for fee schedule changes effective 4/1/2015 and \$+25M for fee schedule changes effective 7/1/2015. The data on self-insurance is approximated using the National Academy of Social Insurance's August 2014 publication "Workers' Compensation: Benefits, Coverages, and Costs, 2012."



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

- **Hospital Inpatient Services**

Currently, hospital inpatient services are reimbursed as a discount of charges and Diagnosis Related Group (DRG) maximum reimbursements. The provisions underlying the proposed inpatient fee schedule, proposed to be effective 4/1/2015, are as follows:

- Services performed in acute care hospitals will be based upon 190% of the Medicare's hospital inpatient payment rates
- Services performed in critical access hospitals will be based upon 200% of the Medicare's hospital inpatient base rates

- **ASC Services**

Currently, ASC services are reimbursed at 67.15% of charges. The proposed maximums for ASC services will be based on 190% of Medicare's ASC payment rates.

- **Physician Services**

The maximum reimbursements underlying the current physician fee schedule are established by the North Carolina Industrial Commission. The provisions underlying the proposed physician fee schedule, proposed to be effective 7/1/2015, are as follows:

- Update the maximum allowable reimbursements (MARs) to be based on the current Medicare Resource Based Relative Value System (RBRVS)
- Adopt the following multipliers by service category²:

Physician Service Category	Percentage of NC Medicare
Evaluation and Management	140%
Physical Medicine	140%
Emergency Medicine	169%
Neurology	153%
Pain Management	163%
Radiology	195%
Major Surgery	195%
Clinical Laboratory	150%
Other Professional Services	150%

² North Carolina Industrial Commission provided NCCI a list of approximately 200 physician services that were classified in the first seven categories listed in the table above. Clinical Laboratory grouping was based on Clinical Laboratory (CLAB) Fee Schedule published by CMS, while the State Specific Codes grouping was based on the Commission Assigned Codes section of the current physician fee schedule available at <http://www.ic.nc.gov/ncic/pages/feesched.asp>. Following the directive from NC IC, all other physician services with MAR but not listed in any of the aforementioned categories were classified into the Other Professional Services group. To the extent that a more detailed practice category taxonomy is provided to NCCI, the overall weighted-average percentage change in MAR may differ.



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

- **Durable Medical Equipment (DME) and Supplies**

The maximum reimbursements underlying the current DME and Supplies fee schedule are established by the North Carolina Industrial Commission. Under the proposal, these services are to be reimbursed at 100% of those rates established for North Carolina in the Centers for Medicaid and Medicare Services' (CMS) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") Fee Schedule.



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

Actuarial Analysis of Proposal

NCCI's methodology to evaluate the impact of medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
 - a. Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
 - b. Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.
2. Estimate the price level change as a result of the proposed fee schedule
 - a. NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
 - i. In response to a fee schedule decrease, NCCI's research indicates that payments decline by approximately 50% of the fee schedule change.
 - ii. In response to a fee schedule increase, NCCI's research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).

The formula used to determine the percent realized for fee schedule increases is $80\% \times (1.10 + 1.20 \times (\text{price departure}))$.
3. Determine the share of costs that are subject to the fee schedule
 - a. The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for North Carolina for Service Year 2013.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for North Carolina from the latest two policy years projected to the effective date of the benefit changes.



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

Analysis of Proposed Fee Schedule Changes effective 4/1/2015

Hospital Outpatient Fee Schedule

In North Carolina, payments for hospital outpatient services represent 19.3% of total medical payments. To calculate the percentage change in reimbursements for hospital outpatient services, NCCI calculates the percentage change in current reimbursement to proposed reimbursement for each procedure. The overall change in reimbursements for hospital outpatient services is a weighted average of the percentage change in reimbursements by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013. The current and proposed reimbursements are calculated as follows:

Current Reimbursement

For each relevant procedure,

Current Reimbursement = Current Payments x Trend Factor

The current payments by procedure code are obtained from NCCI's Medical Data Call for North Carolina for Service Year 2013. These payments are adjusted to reflect changes from past price levels to the price levels projected to be in effect on the effective date of the hospital outpatient fee schedule. The trend factor is based on the most recent available U.S hospital outpatient component of the medical consumer price index (MCPI) as shown below:

Service Year	Hospital Outpatient MCPI Change from July of previous year
2011	5.1%
2012	5.0%
2013	4.8%
Average	4.9%

*Source: Bureau of Labor Statistics

A trend factor of 1.087 is applied to hospital outpatient payments for Service Year 2013 to determine the projected payments at the 4/1/2015 price level. This trend factor is calculated in two steps

1. Estimate the yearly Hospital Outpatient MCPI, for service years 2014 and beyond, as the arithmetic three-year average of the observed Hospital Outpatient MCPI for 2011-2013. This average is equal to 4.9% $(=[5.1\% + 5.0\% + 4.8\%] / 3)$.



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

2. Raise the value above to the number of years elapsed from the midpoint of service year 2013 (7/1/2013) to the effective date of the fee schedule (4/1/2015), which is 1.75 years.

Therefore, the trend factor from 7/1/2013 to 4/1/2015 is estimated as $1.087 = 1.049^{1.75}$.

Proposed Reimbursement on or after April 1, 2015

For each relevant procedure,

Proposed Reimbursement = [Multiplier * Medicare Payment Rate + Outlier Amount (if applicable) – Multiple Procedure Discounts (if applicable)] x (1+ Price Departure)

Where Multiplier = 220% (for acute care hospitals*)

Price Departure for hospital outpatient services is estimated to be -10%

*Given the relatively small percentage of workers compensation hospital costs attributed to critical access hospitals (these comprise less than 1%) the hospital outpatient analysis is based on MARs for acute care hospitals.

The Medicare Payment Rate is based on the Calendar Year 2015 version of Medicare's Hospital Outpatient Prospective Payment System (OPPS) publication. To estimate the proposed reimbursement effective 4/1/2015, NCCI compares trended payments to discounted fee schedule maximums. In general, NCCI observes that average prices paid are below fee schedule maximums. Based on a combination of actuarial judgment and observations of price departure in states that already have a fee schedule, a price departure of -10% was selected.

The Medicare Hospital Outpatient Prospective Payment System (OPPS) reimbursement rule also contains an additional provision for outlier payments. Under the Medicare OPPS rule, the outlier threshold is met when both of the following rules have been satisfied

1. Trended Charges submitted at the bill level times Cost-to-Charge ratio exceeds 1.75 times the North Carolina Medicare Ambulatory Payment Classification (APC) rate and
2. Trended Charges submitted at the bill level multiplied by the Cost-to-Charge ratio exceeds the North Carolina APC payment rate plus a \$3,100 fixed-dollar threshold.

When this threshold is met, Medicare provides for an outlier reimbursement that is calculated as 50 percent of the amount by which the cost of furnishing the procedure exceeds 1.75 times 220% of the Medicare APC payment rate.



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

The table below displays a **hypothetical example** of the calculation of the proposed reimbursement on or after 4/1/2015 for an APC of 0203 (Level IV Nerve Injections).

(1)	(2)	(3)	(4)	(5)	(6)
		= (2) x Cost-to-Charge Ratio	(i) 175% x (1) (ii) (1) + \$3,100	= 2.2 x 0.5 x [(3) - 1.75 x (1)]	= (1) + (5)
220% of 2015 NC Medicare APC Payment Rate	Total Trended Charge Submitted at the bill level	Total Costs for OPPS procedure	Proposed Outlier Threshold	Proposed Outlier Payment	Total Proposed MAR
\$2,992	\$ 40,000	\$10,520	Threshold (i): \$5,236 Threshold (ii): \$6,092	\$5,284	\$8,276

The Cost to Charge ratio (CCR) is obtained from Medicare and is calculated as the simple average of the North Carolina Statewide Urban and Rural CCRs ($0.263 = 0.5 \times (0.246 + 0.280)$).

The calculation for the proposed reimbursements also considers multiple procedure discounts. Under the Medicare OPPS reimbursement rule, multiple procedure discounts are allowed for multiple surgical procedures performed during the same operative session. Primary procedures (the procedure with the highest payment rate) would be reimbursed at 100% of the fee schedule amount, and secondary surgical procedures would be reimbursed at 50% of the fee schedule amount.

The overall weighted-average percentage change in reimbursements for hospital outpatient services is -40.7%.

Since the overall reimbursements for hospital outpatient services decreased, NCCI expects that 50% of the decrease will be realized on hospital outpatient price levels. The impact on hospital outpatient payments after the 50% offset is -20.4%.

The above impact on hospital outpatient payments is then multiplied by the percentage of medical costs attributed to hospital outpatient payments in North Carolina (19.3%) to arrive at the impact on medical costs of -3.9%. The resulting impact on medical costs is then multiplied by the percentage of benefit costs attributed to medical costs in North Carolina (49.5%) to arrive at the estimated impact on overall workers compensation costs in North Carolina of -1.9% (-\$26M).



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

Hospital Inpatient

In North Carolina, payments for hospital inpatient services represent (13.2%) of total medical payments. To calculate the percentage change in reimbursements for hospital inpatient services, we calculate the percentage change in current reimbursement to proposed reimbursement for each inpatient hospital bill that is reported with a diagnosis related group (DRG) procedure code. The overall change in reimbursements for hospital inpatient services is a weighted average of the percentage change in reimbursements for each bill weighted by the observed payments by bill as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013. The current and proposed reimbursements are calculated as follows:

Current Reimbursement

For each relevant inpatient hospital bill,

$$\text{Current Reimbursement} = \text{Current Payments} \times \text{Trend Factor}$$

The current payments are obtained from NCCI's Medical Data Call for North Carolina for Service Year 2013. These payments are adjusted to reflect changes from past price levels to the price levels projected to be in effect on the effective date of the hospital inpatient fee schedule. The trend factor is based on the most recent available U.S hospital inpatient component of the medical consumer price index (MCPI) as shown below:

Service Year	Hospital Inpatient MCPI Change from July of previous year
2011	6.8%
2012	5.2%
2013	4.4%
Average	5.5%

*Source: Bureau of Labor Statistics

A trend factor of 1.098 is applied to hospital inpatient payments for Service Year 2013 to determine the projected payments at the 4/1/2015 price level.

This trend factor is calculated in two steps

1. Estimate the yearly Hospital Inpatient MCPI, for service years 2014 and beyond, as the arithmetic three-year average of the observed Hospital Outpatient MCPI for 2011-2013. This average is equal to 5.5% ($= [6.8\% + 5.2\% + 4.4\%] / 3$)
2. Raise the value above to the number of years elapsed from the midpoint of service year 2013 (7/1/2013) to the effective date of the fee schedule (4/1/2015), which is 1.75 years.

Therefore, the trend factor from 7/1/2013 to 4/1/2015 is estimated as $1.098 = 1.055^{1.75}$.



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

Proposed Reimbursement on or after 4/1/2015

For each relevant inpatient hospital bill,

Proposed Reimbursement = [Multiplier x Medicare Payment Rate + Outlier Amount (if applicable)] x (1 + Price Departure)

Where Multiplier = 190% (for acute care hospitals*)

Price Departure for hospital inpatient services is estimated to be -10%

*Given the relatively small percentage of workers compensation hospital costs attributed to critical access hospitals (these comprise less than 1%) the hospital inpatient analysis is based on MARs for acute care hospitals.

The Medicare Payment Rate is based on Calendar Year 2015 version of Medicare Hospital Inpatient Prospective Payment System (IPPS) publication. To estimate the proposed reimbursement effective 4/1/2015, NCCI compares trended payments to discounted fee schedule maximums. In general, NCCI observes that average prices paid are below fee schedule maximums. Based on a combination of actuarial judgment and observations of price departure in states that already have a fee schedule, a price departure of -10% was selected.

Similar to the OPPI outlier example shown previously, Medicare's Hospital Inpatient Prospective Payment System (IPPS) reimbursement rule also contains an additional provision for outlier payments. Under the Medicare IPPS rule, the outlier threshold is met when the cost for a particular case exceeds a fixed-loss threshold which is comprised of the following components:

- Medicare Severity Diagnosis Related Group (MS-DRG) payment for that case (both operating and capital)
- Any Indirect Medical Education (IME), Disproportionate Share Hospital (DSH) and new technology payments
- A fixed loss amount of \$24,758

Once this threshold is met, the outlier reimbursement is made at 80% of the hospital's costs in excess of the fixed loss threshold for that case.



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

The table below displays a hypothetical example of the calculation of the proposed reimbursement on or after 4/1/2015 for a DRG of 459 (Spinal Fusion Except Cervical with Major Complications and Comorbidities).

(1)	(2)	(3)	(5)	(6)
		= (2) x Cost-to-Charge Ratio	= $1.9 \times 0.8 \times \{(3) - [(1) + \$24,758]\}$	= (1) + (5)
190% of 2015 NC MS-DRG Payment Rate	Total Trended Charge Submitted at the bill level	Total Costs for IPPS procedure	Proposed Outlier Payment	Total Proposed MAR
\$21,770	\$ 190,000	\$68,400	\$33,245	\$55,015

The Cost to Charge ratio (CCR) is obtained from Medicare and is calculated as the simple average of the North Carolina Statewide Urban and Rural CCRs ($0.360 = 0.5 \times (0.340 + 0.380)$)

The overall weighted average percentage change in reimbursements for hospital inpatient services is -18.2%. Since the overall reimbursements for hospital inpatient services decreased, NCCI expects that 50% of the decrease would be realized on hospital inpatient price levels. The impact on hospital inpatient payments after the 50% offset is -9.1%.

The above impact on hospital inpatient costs is then multiplied by the percentage of medical costs attributed to hospital inpatient payments (13.2%) to arrive at the impacts on medical costs of -1.2%. The resulting impact on medical costs is then multiplied by the percentage of North Carolina benefit costs attributed to medical costs (49.5%) to arrive at the impact on North Carolina's overall workers compensation system costs of -0.6% (-\$8.0M).

ASC Fee Schedule

In North Carolina, payments for ASC services represent 5.7% of total medical payments. To calculate the percentage change in reimbursements for ASC services, NCCI calculates the percentage change in current reimbursement to proposed reimbursement for each procedure. The overall change in reimbursements for ASC services is a weighted average of the percentage change in reimbursements by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013.

The current and proposed reimbursements are calculated in an analogous manner to the hospital outpatient analysis, except that Medicare has no outlier provision under the ASC fee schedule.

The overall weighted average percentage change in reimbursements for ASC services was estimated to be -29.3%. Since the overall reimbursements for ASC services decreased, NCCI expects that 50% of the decrease will be realized on ASC price levels. The impact on ASC payments after the 50% offset is -14.7%.



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

The above impact on ASC costs is then multiplied by the percentage of medical costs attributed to ASC payments in North Carolina (5.7%) to arrive at the impact on medical costs of -0.8%. The resulting impact on medical costs is then multiplied by the percentage of benefit costs attributed to medical costs in North Carolina (49.5%) to arrive at the impact on overall workers compensation system costs in North Carolina of -0.4% (-\$5.0M).

Summary of Impacts

The impacts from the changes to the North Carolina Medical Fee Schedules effective 4/1/2015 are summarized below:

	(A) Estimated Impact on Type of Service	(B) Medical Cost Distribution	(C) Estimated Impact On Medical Costs (A) x (B)	(D) Estimated Impact on Overall Costs (C) x (2)
Hospital Inpatient	-9.1%	13.2%	-1.2%	-0.6%
Hospital Outpatient	-20.4%	19.3%	-3.9%	-1.9%
ASC	-14.7%	5.7%	-0.8%	-0.4%
(1) Total Impact on North Carolina Medical Costs			-5.9%	
(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in North Carolina				49.5%
(3) Total Impact on Overall Workers Compensation System Costs in North Carolina = (1) x (2)				-2.9%



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

Analysis of Proposed Fee Schedule Changes effective 7/1/2015

Physician Fee Schedule

In North Carolina, payments for physician services represent 33.5% of total medical payments. To calculate the percentage change in maximum reimbursements for physician services, NCCI calculates the percentage change in maximum reimbursements for each procedure code. The overall change in maximum reimbursements for physician services is a weighted average of the percentage change in MAR (proposed MAR / current MAR) by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013.

The overall weighted-average percentage change in MAR is +10.8%.

The impact by category is shown in the table below.

Physician Practice Category	Cost Distribution	Percentage Change in MAR
Anesthesia	2.9%	+4.1%
Major Surgery	9.0%	-21.7%
Pain Management	1.8%	-25.1%
Radiology	10.0%	-28.1%
Physical Medicine	22.3%	+59.9%
Evaluation and Management	16.3%	+33.5%
Emergency Medicine	2.1%	+35.2%
Clinical Laboratory	1.4%	-11.6%
State Specific Codes	0.2%	0.0%
Other Professional Services	20.4%	-17.6%
Physician Payments with no specific MAR	13.6%	0.0%
Total	100.0%	10.8%

Since the overall average maximum reimbursement for physicians increased, the percentage expected to be realized from the fee schedule increase is estimated according to the formula $80\% \times (1.10 + 1.20 \times (\text{price departure}))$. The observed price departure for physician payments in North Carolina is -9%. The percentage realized is estimated to be 79% ($= 80\% \times (1.10 + 1.20 \times (-0.09))$). The impact on physician payments due to the revised physician fee schedule change is +8.5% ($= +10.8\% \times 0.79$).

The above impact of +8.5% is then multiplied by the North Carolina percentage of medical costs attributed to physician payments (33.5%) to arrive at the impact on medical costs of +2.8%.

Finally, the above impact of +2.8% is then multiplied by the percentage of North Carolina benefit costs attributed to medical benefits (48.1%) to arrive at the estimated impact on North Carolina overall workers compensation costs of +1.3% (+18.0M).



ANALYSIS OF PROPOSED CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

Durable Medical Equipment (DME)

In North Carolina, payments for DME represent 2% of total medical payments. DME payments are based on 2015 North Carolina adjusted Medicare rates.

The overall change in maximum reimbursements for DME is a weighted average of the percentage change in MAR (proposed MAR / current MAR) by code weighted by the observed payments by code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013. The overall weighted average percentage change in MAR is estimated to be +10.4%.

Since the overall average maximum reimbursement for DME services increased, the percentage expected to be realized from the fee schedule increase is typically estimated to be 80%. The impact on DME payments due to the revised DME fee schedule change is +8.3% ($= +10.4\% \times 0.80$).

The above impact of +8.3% is then multiplied by the North Carolina percentage of medical costs attributed to DME payments (2.0%) to arrive at the impact on medical costs of +0.2%.

The above impact is then multiplied by the percentage of North Carolina benefit costs attributed to medical benefits (48.1%) to arrive at the estimated impact on North Carolina overall workers compensation costs of +0.1% (+1.4M).



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

Summary of Impacts

The impacts from the changes to the North Carolina Medical Fee Schedules effective 7/1/2015 are summarized below:

	(A) Estimated Impact on Type of Service	(B) Medical Cost Distribution	(C) Estimated Impact On Medical Costs (A) x (B)	(D) Estimated Impact on Overall Costs (C) x (2)
Physician	+8.5%	33.5%	+2.8%	+1.3%
DME	+8.3%	2.0%	+0.2%	+0.1%
(1) Total Impact on North Carolina Medical Costs			+3.0%	
(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in North Carolina				48.1% ³
(3) Total Estimated Impact on Overall Workers Compensation System Costs in North Carolina = (1) x (2)				+1.4%

³ The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for North Carolina from the latest two policy years projected to the effective date of the benefit changes, after adjusting for the medical fee changes assumed to become effective April 1, 2015.



ANALYSIS OF HYPOTHETICAL CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE PROPOSED TO BE EFFECTIVE OCTOBER 1, 2016

NCCI estimates that the proposed hypothetical scenarios involving an update to the North Carolina Ambulatory Surgical Center fee schedule, both proposed to be effective October 1, 2016, would have the following impacts on workers compensation system costs in North Carolina:

	Estimated Overall Impact	Estimated Overall Premium Impact ¹
Hypothetical Scenario 1	+1.5%	+\$21M
Hypothetical Scenario 2	+1.7%	+\$24M

Summary of Proposed Medical Fee Schedule Changes

Beginning January 1, 2016, the schedule of maximum reimbursement rates for institutional services provided by Ambulatory Surgical Centers (ASC) in North Carolina is 210% of Medicare ASC facility specific amounts.

The North Carolina Industrial Commission requested NCCI to estimate the cost impact on workers compensation system costs for the following two hypothetical scenarios, both proposed to be effective October 1, 2016.

1. The schedule of maximum reimbursement rates for institutional services provided by ASC is changed from 210% of Calendar Year (CY) 2016 Medicare ASC facility specific amounts to 210% of CY 2016 Medicare Outpatient facility specific amounts.
2. The schedule of maximum reimbursement rates for institutional services provided by ASC is changed from 210% of CY 2016 Medicare ASC facility specific amounts to 220% of CY 2016 Medicare Outpatient facility specific amounts

Actuarial Analysis of Proposed Medical Fee Schedule Changes

NCCI's methodology to evaluate the impact of medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements

¹ Overall system costs are based on NAIC Annual Statement data. The estimated dollar impact is the percentage impacts displayed multiplied by 2014 written premium of \$1,431M from NAIC Annual Statement data for North Carolina. This figure does not include self-insurance, the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs. The dollar impact on overall system costs inclusive of self-insurance is estimated to be \$+28M and \$+32M for hypothetical scenarios I and II, respectively. The data on self-insurance is approximated using the National Academy of Social Insurance's August 2015 publication "Workers' Compensation: Benefits, Coverages, and Costs, 2013."



ANALYSIS OF HYPOTHETICAL CHANGES TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE PROPOSED TO BE EFFECTIVE OCTOBER 1, 2016

- a. Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
 - b. Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.
2. Estimate the price level change as a result of the proposed fee schedule
- a. NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
 - i. In response to a fee schedule decrease, NCCI's research indicates that payments decline by approximately 50% of the fee schedule change.
 - ii. In response to a fee schedule increase, NCCI's research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
The formula used to determine the percent realized for fee schedule increases is $80\% \times (1.10 + 1.20 \times (\text{price departure}))$.
3. Estimate the share of costs that are subject to the fee schedule
- a. The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for North Carolina for Service Year 2014.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for North Carolina from the latest two policy years projected to the proposed effective date of the benefit changes.

Hypothetical Scenario 1:

In North Carolina, payments for ASC services represent 6.1% of total medical payments. To calculate the percentage change in maximums for ASC services, NCCI calculates the percentage change in maximum allowable reimbursement (MAR) for each procedure code. The overall change in maximums for ASC services is a weighted average of the percentage change in MAR (proposed MAR / current MAR) by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2014. The current and proposed MARs are calculated as follows:

Current MAR = $[210\% \times \text{CY 2016 Medicare } \underline{\text{ASC}} \text{ Payment Rate}]$

Proposed MAR = $[210\% \times \text{CY 2016 Medicare } \underline{\text{Outpatient}} \text{ Payment Rate}]$



**ANALYSIS OF HYPOTHETICAL CHANGES TO THE NORTH CAROLINA MEDICAL FEE
SCHEDULE PROPOSED TO BE EFFECTIVE OCTOBER 1, 2016**

The overall weighted-average percentage change in maximum reimbursement for ASC services is estimated to be +62.8%. Since the overall reimbursements for ASC services increased, NCCI expects that 80%² of the increase would be realized on ASC price levels. The estimated impact on ASC payments after applying the price realization factor of 80% is +50.2%.

The above impact on ASC costs is then multiplied by the percentage of medical costs attributed to ASC payments in North Carolina (6.1%) to arrive at the +3.1% estimated impact on medical costs. The resulting impact on medical costs is then multiplied by the percentage of North Carolina benefit costs attributed to medical benefits (48.6%) to arrive at the estimated impact on North Carolina overall workers compensation costs of +1.5% (+\$21M).

The estimated impact from the Hypothetical Scenario 1 involving the change to the North Carolina ASC fee schedule, proposed to be effective October 1, 2016, is summarized in Table 1.

Hypothetical Scenario 2:

The estimated impact for Hypothetical Scenario 2 is calculated in an analogous manner to Hypothetical Scenario 1; however, the current and proposed MARs are calculated as follows:

Current MAR = [210% x CY 2016 Medicare ASC Payment Rate]

Proposed MAR = [220% x CY 2016 Medicare Outpatient Payment Rate]

The overall weighted-average percentage change in maximum reimbursement for ASC services is estimated to be +69.1%. Since the overall reimbursements for ASC services increased, NCCI expects that 80% of the increase would be realized on ASC price levels. The estimated impact on ASC payments after applying the price realization factor of 80% is +55.3%.

The above impact on ASC costs is then multiplied by the percentage of medical costs attributed to ASC payments in North Carolina (6.1%) to arrive at the +3.4% estimated impact on medical costs. The resulting impact on medical costs is then multiplied by the percentage of North Carolina benefit costs attributed to medical benefits (48.6%) to arrive at the estimated impact on North Carolina overall workers compensation costs of +1.7% (+\$24M).

The estimated impact from the Hypothetical Scenario 2 involving the changes to the North Carolina ASC fee schedule, proposed to be effective October 1, 2016, is summarized in Table 2.

² NCCI was unable to reliably estimate a price departure for ASC services. Thus, the price realization factor was assumed to be 80%.



**ANALYSIS OF HYPOTHETICAL CHANGES TO THE NORTH CAROLINA MEDICAL FEE
SCHEDULE PROPOSED TO BE EFFECTIVE OCTOBER 1, 2016**

Table 1

Summary of Estimated Impacts Due to Changes Outlined in Hypothetical Scenario 1

	(A) Estimated Impact on Type of Service	(B) Share of Medical Costs	(C) Estimated Impact On Medical Costs (A) x (B)	(D) Estimated Impact on Overall Costs (C) x (2)
ASC	+50.2%	6.1%	+3.1%	+1.5%
(1) Total Estimated Impact on North Carolina Medical Costs			+3.1%	
(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in North Carolina				48.6%
(3) Total Estimated Impact on North Carolina's Overall Workers Compensation System Costs = (1) x (2)				+1.5%

Table 2

Summary of Estimated Impacts Due to Changes Outlined in Hypothetical Scenario 2

	(A) Estimated Impact on Type of Service	(B) Share of Medical Costs	(C) Estimated Impact On Medical Costs (A) x (B)	(D) Estimated Impact on Overall Costs (C) x (2)
ASC	+55.3%	6.1%	+3.4%	+1.7%
(1) Total Estimated Impact on North Carolina Medical Costs			+3.4%	
(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in North Carolina				48.6%
(3) Total Estimated Impact on North Carolina's Overall Workers Compensation System Costs = (1) x (2)				+1.7%



**ANALYSIS OF HYPOTHETICAL CHANGES TO THE NORTH CAROLINA MEDICAL FEE
SCHEDULE PROPOSED TO BE EFFECTIVE OCTOBER 1, 2016**

Additional Considerations:

When comparing Medicare's ASC payment rates to Medicare's Outpatient payment rates, please note the following:

1. Medicare's hospital outpatient conversion factor is approximately 70% higher than the ASC conversion factor
2. Given the same type of service, Medicare's hospital outpatient relative weight is higher than the ASC relative weight

Table 3 illustrates the difference between Medicare's ASC and Outpatient payment rates for CPT³ code 29827 (arthroscopic rotator cuff repair) due to differences in conversion factors and relative weights. The conversion factors and relative weights were published by the Centers for Medicare and Medicaid Services (CMS) on January 1, 2016.

Table 3

Comparison of Medicare's Payment Rates for ASC and Outpatient services for CPT code 29827 (arthroscopic rotator cuff repair)

Service	(A) Conversion Factor	(B) Relative Weight	(A) x (B) Medicare Payment Rate
ASC	44.2	56.3	\$2,488.46
Outpatient	73.7	67.4	\$4,967.38

³ Current Procedural Terminology as maintained by the American Medical Association.