~~(5) Recordkeeping. All loans, lines of credit, or letters of credit, the proceeds of which will be used for a commercial, corporate, business, investment property or venture, or agriculture purpose, shall be separately identified in the records of the credit union and reported as such in financial and statistical reports required by the Administrator in Subpart (b)(2)(C)(iv) of this Rule or the Regional Director of the National Credit Union Administration.~~

(a) Commercial lending and member business loans. State chartered federally insured credit unions shall adhere to the federal regulations prescribed by the National Credit Union Administration relating to commercial lending and member business loan program pursuant to 12 C.F.R. Part 723, and this Rule.

(b) Written loan policies. The Board of Directors shall give notification to the Administrator of Credit Unions prior to initiating a commercial lending and member business loan program and adopt specific commercial lending and member business loan policies and review them at least annually. The Board of Directors shall review its commercial lending and member business loan policies prior to any material change in the credit union's commercial lending and member business loan program or related organizational structure, and in response to any material change in portfolio performance or change in economic conditions. Credit unions with an asset size of two hundred fifty million dollars ($250,000,000) or below shall have commercial lending and member business loan polices submitted to the Administrator of Credit Unions 30 days prior to initiating a commercial lending an d member business loan program.

History Note: Authority G.S. 54-109.12; 54-109.21(25); 54-109.78; 12 C.F.R. Part 741.3; 12 C.F.R. Part 723; 12 C.F.R. Part 741.203;
Eff. January 1, 1988;
Amended Eff. August 1, 1998; March 2, 1992;
Temporary Amendment Eff. January 1, 2017.

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Rule-making Agency: *North Carolina Industrial Commission*

Rule Citation: *04 NCAC 10J .0103*

Effective Date: *January 1, 2017*

Date Approved by the Rules Review Commission: *December 15, 2016*

Reason for Action: *A recent court order. Surgical Care Affiliates, LLC v. North Carolina Industrial Commission, No. 16-CVS-00600 (Wake County Superior Court).*
The effects of the August 9, 2016 decision in Surgical Care Affiliates, LLC v. North Carolina Industrial Commission, No. 16-CVS-00600 (Wake County Superior Court) necessitate the expedited implementation of this temporary rule. This recent court decision invalidated the Industrial Commission's medical fee schedule provisions for ambulatory surgery centers, which had taken effect April 1, 2015, based on the court's interpretation of Session Law 2013-410, Section 33(a), and the application of its fiscal note exemption language. Due to the court decision, the medical fee schedule, as applied only to ambulatory surgery centers, reverts back to the pre-April 1, 2015 provisions which provided for maximum reimbursement rate of 67.15% of billed charges, resulting in a potentially retroactive and prospective multi-million dollar increase in costs to the workers' compensation system. Although the August 9, 2016 decision has been stayed by the Superior Court during the appeal to the North Carolina Court of Appeals, it is the Industrial Commission's statutory obligation to adopt a rule as quickly as possible to restore balance to the workers' compensation system pursuant to N.C. Gen. Stat. § 97-26 in the event the decision is upheld on appeal. By putting a temporary rule in place as soon as possible, the period of time subject to a potential retroactive invalidation of the ambulatory surgery center fee schedule provisions will be limited to April 1, 2015 to December 31, 2016 providing certainty regarding medical costs for 2017 and beyond.

CHAPTER 10 - INDUSTRIAL COMMISSION

SUBCHAPTER 10J – FEES FOR MEDICAL COMPENSATION

SECTION 0100 – FEES FOR MEDICAL COMPENSATION

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. An institutional facility may only be reimbursed for hospital outpatient institutional services pursuant to this Paragraph and Paragraphs (c), (d), and (f) of this Rule if it qualifies for payment by CMS as an outpatient hospital.

(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~~ most recently adopted and effective Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment ~~System~~ Systems reimbursement formula and ~~factors~~ factors, including all ~~OPPS~~ Hospital Outpatient Prospective Payment and ~~ASC~~ Ambulatory Surgical Center Payment Systems Addenda, as published annually ~~or referenced by website~~ in the Federal Register and on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html~~("the Medicare ASC facility-specific amount").~~ ("the OPPS/ASC Medicare rule"). An ASC's specific Medicare wage index value as set out in the OPPS/ASC Medicare rule shall be applied in the calculation of the maximum allowable amount for any institutional service it provides. ~~Reimbursement shall be based on the fully implemented payment amount in Addendum AA, Final AA (Final ASC Covered Surgical Procedures for CY 2015, 2017) and Addendum BB, Final BB (Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2015, 2017) as published in the Federal Register, or their successors. The maximum reimbursement rate for institutional services provided by ambulatory surgical centers is 200 percent of the Medicare ASC facility-specific amount.~~

(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.~~

(1) A maximum reimbursement rate of 200 percent shall apply to institutional services that are eligible for payment by CMS when performed at an ASC.

(2) A maximum reimbursement rate of 135 percent shall apply to institutional services performed at an ASC that are eligible for payment by CMS if performed at an outpatient hospital facility, but would not be eligible for payment by CMS if performed at an ASC.

~~(h) Notwithstanding Paragraph (g) of this Rule, if surgical procedures listed in Addendum EE (Surgical Procedures Excluded from Payment in ASCs for CY 2017) to the most recently adopted and effective Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems as published in the Federal Register, or its successors, are provided at ASCs, they shall be reimbursed with the maximum amount being the usual, customary, and reasonable charge for the service or treatment rendered.~~

(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;
Temporary Amendment Eff. January 1, 2017.