August 14, 2017

The Honorable Charlton Allen
Chairman
North Carolina Industrial Commission
4430 Mail Service Center
Raleigh, NC 27699-4340

Dear Chairman Allen:

The undersigned entities ("signatories") respectfully submit the following comments concerning permanent rules proposed by the North Carolina Industrial Commission (Commission) to amend the workers' compensation medical fee schedule, specifically 04 NCAC 10J .0103, with respect to services provided by ambulatory surgery centers (ASCs).

**04 NCAC 10J .0103(g)**

As proposed by the Commission, 04 NCAC 10J .0103(g) would clarify that ASCs are to be reimbursed at a rate of 200% of Medicare for covered procedures. This is consistent with the reimbursement methodology that all stakeholders believed was put in place when the Commission adopted its previous fee schedule on January 16, 2015, and which was subsequently approved by the North Carolina Rules Review Commission on February 19, 2015. Additionally, the same valid reimbursement methodology was proposed and adopted through temporary rule-making by the Commission only to see ASCs file litigation to block this valid reimbursement methodology. The signatories commend the Commission for its perseverance in adopting for a third-time a fee schedule that fairly reimburses ASCs 200% of Medicare and we strongly support the Commission in its proposed amendment of 04 NCAC 10J .0103(g).

To reiterate our previous comments, 200% of Medicare is a fair and reasonable reimbursement methodology that will ensure injured workers receive effective treatment at ASCs while also bringing North Carolina's reimbursement for ASC services in line with other States. Additionally, utilizing a rate of 200% of Medicare for ASCs applies the same Medicare-plus methodology to ASCs that the Commission applies to hospitals for their services.

Prior to the adoption of the current fee schedule, ASC reimbursement in North Carolina for workers' compensation injuries was 31% higher for knee arthroscopy and 49% higher for shoulder arthroscopy than the 33-state median, as reported by the Workers' Compensation Research Institute (WCRI) in *Payments to Ambulatory Surgery Centers, 2nd Edition* (May 2016). Simply put, the ASCs would like to retain this inflated level of reimbursement without providing any valid justification. It is worth noting that Surgical Care Affiliates (SCA) operates ASCs in many of the WCRI study states where ASC reimbursement is significantly lower than the 33-state median, including California, Colorado, Delaware, Michigan, Mississippi, Oklahoma,

Oregon, Pennsylvania, South Carolina, and Texas. Significantly, there are no reported access to care problems in those states. The current fee schedule brings North Carolina ASC reimbursement closer to the 33-state median and should not create any access problems for North Carolina injured workers.

By design, Medicare's rate for hospital outpatient services are generally far more generous than they are for the same service performed at an ACS. Attachment A was prepared by Stephanie Gay, Vice-President of Aegis Administrative Services, who administers workers' compensation claims in several southern states and is very familiar with reimbursement rates for numerous medical providers. Attachment A reflects benchmarking of certain procedure codes to SCA's proposal to utilize a reimbursement methodology of 180% of the Medicare hospital outpatient cost. Using these codes and converting the reimbursement methodology to Medicare plus, it is readily apparent from Attachments A and B that moving to 180% of hospital outpatient charges would result in ASCs receiving 355% of the Medicare ASC rate for the same service. There has been no data provided by the ACSs to demonstrate that they receive (or should be entitled to) this wildly inflationary reimbursement rate in any state or that it is anywhere near the median reimbursement rate paid in other states as determined by WCRI. The effective rate proposed by the ASCs is also dramatically higher than what the Commission has now – for the third time - proposed for procedures performed at ASCs. Even if SCA's proposed reimbursement methodology was reduced to 150% of hospital outpatient charges, it would still translate to approximately 300% of Medicare. We note that the North Carolina Hospital Association, which represents facilities which owns numerous ASCs throughout North Carolina has consistently agreed throughout this process that that the fee schedule constitutes a reasonable reimbursement for services performed at an ASC.

**04 NCAC 10J .0103(h)**

Currently, ASCs are not permitted to provide services to the workers' compensation claimants unless the Centers for Medicare and Medicaid Services (CMS) has deemed them appropriate to be performed by an ASC and established a relevant Medicare reimbursement amount. Part of Medicare's rationale for not allowing such procedures to be performed in an ASC concerns the nature of the procedure and whether it is appropriate to be performed in an outpatient setting, i.e., outside of a hospital. As proposed, 04 NCAC 10J .0103(h) would allow procedures without an established Medicare reimbursement rate for ASCs to be performed by ASCs. The signatories strongly support the Commission's decision to allow ASCs to perform additional outpatient procedures regardless of whether Medicare has established a reimbursement rate as long as the treating physician has approved such decisions and the reimbursement allowed is reasonable. This is due to the fact that workers' compensation claimants are generally far younger than Medicare patients and therefore far less likely to experience complications requiring hospitalization.

The signatories also strongly support the proposed reimbursement methodology whereby ASCs be paid a maximum rate of 135% of the hospital outpatient rate for procedures performed at an ASC that are eligible for payment by CMS if performed at a hospital outpatient facility. This

would address procedures that would not be eligible for payment by CMS if performed at an ASC.

CMS has established a baseline reimbursement for ASCs that is far lower than for hospitals providing the same procedure, in recognition of the cost savings realized by utilizing the ASC setting. As noted on Page 7 of Surgical Care Affiliates' *Investor Presentation* dated September 20, 2016, ASCs provide approximately 45% cost savings compared to hospital outpatient reimbursement. Accordingly, we strongly encourage the Commission to adopt the proposed maximum reimbursement of 135% of hospital outpatient charges for procedures 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. Additionally, payors should retain the authority pursuant to G.S. 97-26(c), to negotiate further discounts with ASCs in these situations.

**CONCLUSION**

The signatories sincerely appreciate and strongly support the Commission's adoption of a general fee schedule for ASCs of 200% of Medicare, as this was the reimbursement methodology that had been negotiated between numerous stakeholders with actual and apparent authority to negotiate -- including those representing orthopedic groups and hospitals which operate many ASCs in North Carolina. 200% of Medicare reimbursement is fair and reasonable and reflects the will of the North Carolina General Assembly to ensure:

*(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. Session Laws 2013-410, s. 33(a).*

In conclusion, we greatly appreciate the Commission's continued efforts to adopt a fair and equitable fee schedule that applies to all medical services provided to workers' compensation claimants, including those performed at ASCs. We recognize that for the better part of four years the Commission has sought to adopt a fee schedule that is consistent with other states only to see SCA seek to utilize legal technicalities and litigation to delay the implementation of a fair fee schedule.

We applaud the Commission's persistence in ensuring that all providers of medical services, including ASCs, are fairly and reasonably reimbursed at a rate that provide injured workers with access to cutting-edge medical care to assist them in their return to work while ensuring that the workers' compensation system funded by public and private payors alike remains affordable.

The Commission's adoption of a Medicare-based fee schedule is one of the primary reasons why workers' compensation premiums fell in North Carolina by 10% in 2016 and 14.4% in 2017 making North Carolina more competitive in job creation and economic development while expanding the availability of medical providers and facilities to ensure excellent care and prompt and successful return to work. The Commission's willingness to proceed with permanent rulemaking despite litigation and challenges to the rulemaking process ensures that this progress will continue. SCA's proposed reimbursement methodology would lead North Carolina in the opposite direction.

Sincerely,

Capital Associated Industries, Inc.
North Carolina Association of County Commissioners
North Carolina Association of Self-Insurers
North Carolina Automobile Dealers Association, Inc.
North Carolina Chamber
North Carolina Farm Bureau and Affiliated Companies
North Carolina Forestry Association
North Carolina Home Builders Association
North Carolina League of Municipalities
North Carolina Manufacturers Alliance
North Carolina Retail Merchants Association
American Insurance Association
Property Casualty Insurers Association of America
Builders Mutual Insurance Company
Dealers Choice Mutual Insurance, Inc.
First Benefits Insurance Mutual, Inc.
Forestry Mutual
The Employers Association, Inc.
Employers Coalition of North Carolina
WCI, Inc.

**Volume by Primary CPT Code**
15 Months Data

| | | Post Fee Schedule | | MCR HOPD | Billed Charges | Implants | AmSurg MC Rate | Current Fee Schedule Fee | MC ASC Fee Sched | MC ASC Fee Sched | MC ASC Fee Sched | MC ASC Fee Sched | MC ASC Fee Sched | MC ASC Fee Sched | MC ASC Fee Sched | % Needed for 180% HOPD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Primary CPT Code | Primary CPT Code Description | Case Count | % Cases | 180% | 67.14% | Implants Billed | | 200% | 205% | 210% | 215% | 220% | 225% | 250% | 300% | |
| 29881 | ARTHRS KNE SURG W/MENISCECTOMY MED/LAT W/SHVG | 199 | 7.14% | $4,138 | $6,441 | Yes | $1,166 | $2,331.16 | 2,389.44 | $2,447.72 | $2,506.00 | $2,564.28 | $2,622.56 | $2,913.95 | $3,496.74 | 355% |
| 64483 | NJX ANES&/STRD W/IMG TFRML EDRL LMBR/SAC 1 LVL | 138 | 4.95% | $1,084 | $1,756 | No | $330 | $660.34 | 676.85 | $693.36 | $709.87 | $726.37 | $742.88 | $825.43 | $990.51 | 328% |
| 29827 | ARTHROSCOPY SHOULDER ROTATOR CUFF REPAIR | 265 | 9.51% | $8,860 | $7,047 | Yes | $2,534 | 5,067.56 | 5,194.25 | $5,320.94 | $5,447.63 | $5,574.32 | $5,701.01 | $6,334.45 | $7,601.34 | 350% |
| 29824 | ARTHROSCOPY SHOULDER DISTAL CLAVICULECTOMY | 90 | 3.23% | $4,138 | $6,972 | Yes | $1,166 | $2,331.16 | 2,389.44 | $2,447.72 | $2,506.00 | $2,564.28 | $2,622.56 | $2,913.95 | $3,496.74 | 355% |
| 64510 | NJX ANES STELLATE GANGLION CRV SYMPATHETIC | 115 | 4.13% | $1,084 | $1,926 | Yes | $330 | $660.34 | 676.85 | $693.36 | $709.87 | $726.37 | $742.88 | $825.43 | $990.51 | 328% |
| 64721 | NEUROPLASTY &/TRANSPOS MEDIAN NRV CARPAL TUNNEL | 115 | 4.13% | $2,653 | $3,462 | Yes | $754 | $1,508.82 | 1,546.54 | $1,584.26 | $1,621.98 | $1,659.70 | $1,697.42 | $1,886.03 | $2,263.23 | 352% |
| 29880 | ARTHRS KNEE W/MENISCECTOMY MED&LAT W/SHAVING | 83 | 2.98% | $4,138 | $5,559 | Yes | $1,166 | $2,331.16 | 2,389.44 | $2,447.72 | $2,506.00 | $2,564.28 | $2,622.56 | $2,913.95 | $3,496.74 | 355% |
| 64493 | NJX DX/THER AGT PVRT FACET JT LMBR/SAC 1 LEVEL | 58 | 2.08% | $1,084 | $1,713 | Yes | $330 | $660.34 | 676.85 | $693.36 | $709.87 | $726.37 | $742.88 | $825.43 | $990.51 | 328% |
| 62311 | NJX DX/THER SBST EPIDURAL/SUBARACH LUMBAR/SACRAL | 52 | 1.87% | $0 | $0 | Yes | $0 | $0.00 | 0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | $0.00 | #DIV/0! |
| 64479 | NJX ANES&/STRD W/IMG TFRML EDRL CRV/THRC 1 LVL | 44 | 1.58% | $1,084 | $1,753 | Yes | $330 | $660.34 | 676.85 | $693.36 | $709.87 | $726.37 | $742.88 | $825.43 | $990.51 | 328% |
| 29823 | ARTHROSCOPY SHOULDER SURG DEBRIDEMENT EXTENSIVE | 23 | 0.83% | $4,138 | $6,802 | Yes | $1,166 | $2,331.16 | 2,389.44 | $2,447.72 | $2,506.00 | $2,564.28 | $2,622.56 | $2,913.95 | $3,496.74 | 355% |
| 64520 | INJECTION ANES LMBR/THRC PARAVERTBRL SYMPATHETIC | 64 | 2.30% | $1,084 | $1,902 | Yes | $330 | $660.34 | 676.85 | $693.36 | $709.87 | $726.37 | $742.88 | $825.43 | $990.51 | 328% |
| 26055 | TENDON SHEATH INCISION | 44 | 1.58% | $2,066 | $1,755 | Yes | $665 | $1,330.18 | 1,363.43 | $1,396.69 | $1,429.94 | $1,463.20 | $1,496.45 | $1,662.73 | $1,995.27 | 311% |
| 64635 | DSTR NROLYTC AGNT PARVERTEB FCT SNGL LMBR/SACRAL | 41 | 1.47% | $2,653 | $2,087 | Yes | $754 | $1,508.82 | 1,546.54 | $1,584.26 | $1,621.98 | $1,659.70 | $1,697.42 | $1,886.03 | $2,263.23 | 352% |
| 20680 | REMOVAL IMPLANT DEEP | 32 | 1.15% | $3,646 | $2,754 | Yes | $986 | $1,972.72 | 2,022.04 | $2,071.36 | $2,120.67 | $2,169.99 | $2,219.31 | $2,465.90 | $2,959.08 | 370% |
| 29888 | ARTHRS AIDED ANT CRUCIATE LIGM RPR/AGMNTJ/RCNSTJ | 53 | 1.90% | $8,860 | $11,087 | Yes | $2,534 | $5,067.56 | 5,194.25 | $5,320.94 | $5,447.63 | $5,574.32 | $5,701.01 | $6,334.45 | $7,601.34 | 350% |
| 29822 | ARTHROSCOPY SHOULDER SURG DEBRIDEMENT LIMITED | 31 | 1.11% | $4,138 | $5,530 | Yes | $1,166 | $2,331.16 | 2,389.44 | $2,447.72 | $2,506.00 | $2,564.28 | $2,622.56 | $2,913.95 | $3,496.74 | 355% |
| 29877 | ARTHRS KNEE DEBRIDEMENT/SHAVING ARTCLR CRTLG | 35 | 1.26% | $4,138 | $8,859 | Yes | $1,166 | $2,331.16 | 2,389.44 | $2,447.72 | $2,506.00 | $2,564.28 | $2,622.56 | $2,913.95 | $3,496.74 | 355% |
| 29806 | ARTHROSCOPY SHOULDER SURGICAL CAPSULORRHAPHY | 20 | 0.72% | $8,860 | $6,462 | Yes | $2,534 | $5,067.56 | 5,194.25 | $5,320.94 | $5,447.63 | $5,574.32 | $5,701.01 | $6,334.45 | $7,601.34 | 350% |
| 23412 | OPEN REPAIR OF ROTATOR CUFF CHRONIC | 21 | 0.75% | $8,860 | $7,308 | Yes | $2,534 | $5,067.56 | 5,194.25 | $5,320.94 | $5,447.63 | $5,574.32 | $5,701.01 | $6,334.45 | $7,601.34 | 350% |
| 26418 | REPAIR EXTENSOR TENDON FINGER W/O GRAFT EACH | 21 | 0.75% | $4,138 | $3,144 | Yes | $1,166 | $2,331.16 | 2,389.44 | $2,447.72 | $2,506.00 | $2,564.28 | $2,622.56 | $2,913.95 | $3,496.74 | 355% |
| 23430 | TENODESIS LONG TENDON BICEPS | 80 | 2.87% | $8,860 | $7,128 | Yes | $2,534 | $5,067.56 | 5,194.25 | $5,320.94 | $5,447.63 | $5,574.32 | $5,701.01 | $6,334.45 | $7,601.34 | 350% |
| 64718 | NEUROPLASTY &/TRANSPOSITION ULNAR NERVE ELBOW | 12 | 0.43% | $2,653 | $3,392 | Yes | $754 | $1,508.82 | 1,546.54 | $1,584.26 | $1,621.98 | $1,659.70 | $1,697.42 | $1,886.03 | $2,263.23 | 352% |
| 29846 | ARTHRS WRST EXC&/RPR TRIANG FIBROCART&/JT DBRDMT | 27 | 0.97% | $4,138 | $3,893 | Yes | $1,166 | $2,331.16 | 2,389.44 | $2,447.72 | $2,506.00 | $2,564.28 | $2,622.56 | $2,913.95 | $3,496.74 | 355% |
| 24342 | RINSJ RPTD BICEPS/TRICEPS TDN DSTL W/WO TDN GRF | 30 | 1.08% | $8,860 | $4,647 | Yes | $2,324 | $4,647.00 | 4,763.18 | $4,879.35 | $4,995.53 | $5,111.70 | $5,227.88 | $5,808.75 | $6,970.50 | 381% |
| 63030 | LAMNOTMY INCL W/DCMPRSN NRV ROOT 1 INTRSPC LUMBR | 33 | 1.18% | $8,860 | $7,234 | Yes | $2,534 | $5,067.56 | 5,194.25 | $5,320.94 | $5,447.63 | $5,574.32 | $5,701.01 | $6,334.45 | $7,601.34 | 350% |
| 25000 | Incision of tendon sheath | 7 | 0.25% | $2,066 | $2,860 | Yes | $665 | $1,330.18 | 1,363.43 | $1,396.69 | $1,429.94 | $1,463.20 | $1,496.45 | $1,662.73 | $1,995.27 | 311% |
| 25260 | RPR TDN/MUSC FLXR F/ARM&/WRST PRIM 1 EA TDN/MU | 1 | 0.04% | $4,138 | $2,547 | Yes | $1,166 | $2,331.16 | 2,389.44 | $2,447.72 | $2,506.00 | $2,564.28 | $2,622.56 | $2,913.95 | $3,496.74 | 355% |
| 25350 | Revision of radius | 2 | 0.07% | $8,860 | $9,523 | Yes | $3,555 | $7,109.34 | 7,287.07 | $7,464.81 | $7,642.54 | $7,820.27 | $7,998.01 | $8,886.68 | $10,664.01 | 249% |
| 29826 | ARTHROSCOPY SHOULDER W/CORACOACRM LIGMNT RELEASE | 27 | 0.97% | $4,138 | $0 | Yes | #VALUE! | Bundled | #VALUE! | #VALUE! | #VALUE! | #VALUE! | #VALUE! | #VALUE! | #VALUE! | #VALUE! |
| 64415 | SINGLE NERVE BLOCK INJECTION ARM NERVE | 4 | 0.14% | $1,084 | $1,949 | Yes | $330 | $660.34 | 676.85 | $693.36 | $709.87 | $726.37 | $742.88 | $825.43 | $990.51 | 328% |
| 64450 | INJECTION ANES OTHER PERIPHERAL NERVE/BRANCH | 2 | 0.07% | $861 | $1,949 | Yes | $50 | $99.48 | 101.97 | $104.45 | $106.94 | $109.43 | $111.92 | $124.35 | $149.22 | 1731% |
| 64479 | NJX ANES&/STRD W/IMG TFRML EDRL CRV/THRC 1 LVL | 44 | 1.58% | $1,084 | $1,753 | Yes | $330 | $660.34 | 676.85 | $693.36 | $709.87 | $726.37 | $742.88 | $825.43 | $990.51 | 328% |
| 64836 | Repair of hand or foot nerve | 2 | 0.07% | $7,045 | $3,331 | Yes | $1,666 | $3,331.00 | 3,414.28 | $3,497.55 | $3,580.83 | $3,664.10 | $3,747.38 | $4,163.75 | $4,996.50 | 423% |
| 64890 | Nerve graft hand/foot </4 cm | 2 | 0.07% | $7,045 | $5,035 | Yes | $2,518 | $5,035.00 | 5,160.88 | $5,286.75 | $5,412.63 | $5,538.50 | $5,664.38 | $6,293.75 | $7,552.50 | 280% |

| Primary CPT Code | Primary CPT Code Description | SCA Proposed Rate 180% HOPD | HOPD Rate No Multiplier | HOPD Rate 135% | HOPD Rate 140% | HOPD Rate 145% | HOPD Rate 150% | Current FS 200% ASC |
|---|---|---|---|---|---|---|---|---|
| 29881 | ARTHRS KNE SURG W/MENISCECTOMY MED/LAT W/SHVG | $ 4,138 | $ 2,298.89 | $3,103.50 | $3,218.44 | $3,333.39 | $3,448.33 | $2,331.16 |
| 64483 | NJX ANES&/STRD W/IMG TFRML EDRL LMBR/SAC 1 LVL | $ 1,084 | $ 602.22 | $ 813.00 | $ 843.11 | $ 873.22 | $ 903.33 | $660.34 |
| 29827 | ARTHROSCOPY SHOULDER ROTATOR CUFF REPAIR | $ 8,860 | $ 4,922.22 | $6,645.00 | $6,891.11 | $7,137.22 | $7,383.33 | 5,067.56 |
| 29824 | ARTHROSCOPY SHOULDER DISTAL CLAVICULECTOMY | $ 4,138 | $ 2,298.89 | $3,103.50 | $3,218.44 | $3,333.39 | $3,448.33 | $2,331.16 |
| 64510 | NJX ANES STELLATE GANGLION CRV SYMPATHETIC | $ 1,084 | $ 602.22 | $ 813.00 | $ 843.11 | $ 873.22 | $ 903.33 | $660.34 |
| 64721 | NEUROPLASTY &/TRANSPOS MEDIAN NRV CARPAL TUNNEL | $ 2,653 | $ 1,473.89 | $1,989.75 | $2,063.44 | $2,137.14 | $2,210.83 | $1,508.82 |
| 29880 | ARTHRS KNEE W/MENISCECTOMY MED&LAT W/SHAVING | $ 4,138 | $ 2,298.89 | $3,103.50 | $3,218.44 | $3,333.39 | $3,448.33 | $2,331.16 |
| 64493 | NJX DX/THER AGT PVRT FACET JT LMBR/SAC 1 LEVEL | $ 1,084 | $ 602.22 | $ 813.00 | $ 843.11 | $ 873.22 | $ 903.33 | $660.34 |
| 62311 | NJX DX/THER SBST EPIDURAL/SUBARACH LUMBAR/SACRAL | $ - | $ - | $ - | $ - | $ - | $ - | $0.00 |
| 64479 | NJX ANES&/STRD W/IMG TFRML EDRL CRV/THRC 1 LVL | $ 1,084 | $ 602.22 | $ 813.00 | $ 843.11 | $ 873.22 | $ 903.33 | $660.34 |
| 29823 | ARTHROSCOPY SHOULDER SURG DEBRIDEMENT EXTENSIVE | $ 4,138 | $ 2,298.89 | $3,103.50 | $3,218.44 | $3,333.39 | $3,448.33 | $2,331.16 |
| 64520 | INJECTION ANES LMBR/THRC PARAVERTBRL SYMPATHETIC | $ 1,084 | $ 602.22 | $ 813.00 | $ 843.11 | $ 873.22 | $ 903.33 | $660.34 |
| 26055 | TENDON SHEATH INCISION | $ 2,066 | $ 1,147.78 | $1,549.50 | $1,606.89 | $1,664.28 | $1,721.67 | $1,330.18 |
| 64635 | DSTR NROLYTC AGNT PARVERTEB FCT SNGL LMBR/SACRAL | $ 2,653 | $ 1,473.89 | $1,989.75 | $2,063.44 | $2,137.14 | $2,210.83 | $1,508.82 |
| 20680 | REMOVAL IMPLANT DEEP | $ 3,646 | $ 2,025.56 | $2,734.50 | $2,835.78 | $2,937.06 | $3,038.33 | $1,972.72 |
| 29888 | ARTHRS AIDED ANT CRUCIATE LIGM RPR/AGMNTJ/RCNSTJ | $ 8,860 | $ 4,922.22 | $6,645.00 | $6,891.11 | $7,137.22 | $7,383.33 | $5,067.56 |
| 29822 | ARTHROSCOPY SHOULDER SURG DEBRIDEMENT LIMITED | $ 4,138 | $ 2,298.89 | $3,103.50 | $3,218.44 | $3,333.39 | $3,448.33 | $2,331.16 |
| 29877 | ARTHRS KNEE DEBRIDEMENT/SHAVING ARTCLR CRTLG | $ 4,138 | $ 2,298.89 | $3,103.50 | $3,218.44 | $3,333.39 | $3,448.33 | $2,331.16 |
| 29806 | ARTHROSCOPY SHOULDER SURGICAL CAPSULORRHAPHY | $ 8,860 | $ 4,922.22 | $6,645.00 | $6,891.11 | $7,137.22 | $7,383.33 | $5,067.56 |
| 23412 | OPEN REPAIR OF ROTATOR CUFF CHRONIC | $ 8,860 | $ 4,922.22 | $6,645.00 | $6,891.11 | $7,137.22 | $7,383.33 | $5,067.56 |
| 26418 | REPAIR EXTENSOR TENDON FINGER W/O GRAFT EACH | $ 4,138 | $ 2,298.89 | $3,103.50 | $3,218.44 | $3,333.39 | $3,448.33 | $2,331.16 |
| 23430 | TENODESIS LONG TENDON BICEPS | $ 8,860 | $ 4,922.22 | $6,645.00 | $6,891.11 | $7,137.22 | $7,383.33 | $5,067.56 |
| 64718 | NEUROPLASTY &/TRANSPOSITION ULNAR NERVE ELBOW | $ 2,653 | $ 1,473.89 | $1,989.75 | $2,063.44 | $2,137.14 | $2,210.83 | $1,508.82 |
| 29846 | ARTHRS WRST EXC&/RPR TRIANG FIBROCART&/JT DBRDMT | $ 4,138 | $ 2,298.89 | $3,103.50 | $3,218.44 | $3,333.39 | $3,448.33 | $2,331.16 |
| 24342 | RINSJ RPTD BICEPS/TRICEPS TDN DSTL W/WO TDN GRF | $ 8,860 | $ 4,922.22 | $6,645.00 | $6,891.11 | $7,137.22 | $7,383.33 | $4,647.00 |
| 63030 | LAMNOTMY INCL W/DCMPRSN NRV ROOT 1 INTRSPC LUMBR | $ 8,860 | $ 4,922.22 | $6,645.00 | $6,891.11 | $7,137.22 | $7,383.33 | $5,067.56 |
| 25000 | Incision of tendon sheath | $ 2,066 | $ 1,147.78 | $1,549.50 | $1,606.89 | $1,664.28 | $1,721.67 | $1,330.18 |
| 25260 | RPR TDN/MUSC FLXR F/ARM&/WRST PRIM 1 EA TDN/MU | $ 4,138 | $ 2,298.89 | $3,103.50 | $3,218.44 | $3,333.39 | $3,448.33 | $2,331.16 |
| 25350 | Revision of radius | $ 8,860 | $ 4,922.22 | $6,645.00 | $6,891.11 | $7,137.22 | $7,383.33 | $7,109.34 |
| 29826 | ARTHROSCOPY SHOULDER W/CORACOACRM LIGMNT RELEASE | $ 4,138 | $ 2,298.89 | $3,103.50 | $3,218.44 | $3,333.39 | $3,448.33 | Bundled |
| 64415 | SINGLE NERVE BLOCK INJECTION ARM NERVE | $ 1,084 | $ 602.22 | $ 813.00 | $ 843.11 | $ 873.22 | $ 903.33 | $660.34 |
| 64450 | INJECTION ANES OTHER PERIPHERAL NERVE/BRANCH | $ 861 | $ 478.33 | $ 645.75 | $ 669.67 | $ 693.58 | $ 717.50 | $99.48 |
| 64479 | NJX ANES&/STRD W/IMG TFRML EDRL CRV/THRC 1 LVL | $ 1,084 | $ 602.22 | $ 813.00 | $ 843.11 | $ 873.22 | $ 903.33 | $660.34 |
| 64836 | Repair of hand or foot nerve | $ 7,045 | $ 3,913.89 | $5,283.75 | $5,479.44 | $5,675.14 | $5,870.83 | $3,331.00 |
| 64890 | Nerve graft hand/foot </4 cm | $ 7,045 | $ 3,913.89 | $5,283.75 | $5,479.44 | $5,675.14 | $5,870.83 | $5,035.00 |

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

August 14, 2017

The Honorable Charlton Allen, Chairman
North Carolina Industrial Commission
430 N Salisbury St.
Raleigh, NC 27603

Dear Honorable Charlton Allen, Chairman:

Pursuant to the North Carolina Industrial Commission's ("Commission") July 19, 2017 Notice of Public Comment Meeting, the North Carolina Hospital Association ("NCHA") respectfully submits the following information to supplement and further elaborate on the comments that we made during the hearing:

The Industrial Commission has proposed a permanent rule entitled Rule 04 NCAC 10J.0103 Fees for Institutional Services that was published in the *North Carolina Register* on June 15, 2017. The proposed effective date is October 1, 2017. NCHA supports the proposed permanent rule as stated. The proposed permanent rule is a result of a lot of work, a great deal of compromise, and it maintains and incorporates reimbursement integrity. It is fair and balanced and will result in savings for employers, payers, as well as the insured workers.

Specifically, we support that the maximum reimbursement rate for institutional services provided by Ambulatory Surgical Centers (ASCs) should be 200 percent of the Medicare ASC facility-specific amount. We also support that ASCs should be allowed to perform the same procedures as set forth on the Medicare Outpatient Prospective Payment System (HOPPS) list, provided that these procedures are 1) clinically appropriate for the ASC setting, 2) payable to the ASC only if payment is allowed under Medicare's status indicators found for the same code in Addendum B of the HOPPS, and 3) reimbursed at the bundled rate of 135% of the HOPPS rate. This approach will provide fair and reasonable reimbursement for services rendered by ASCs, is consistent with the reimbursement approach used for hospital outpatient services, will protect employers and insurers from the risks associated with the percentage of charge reimbursement methodology by moving to a prospective payments system, and will result in substantial savings for employers and insurers when compared to previous reimbursement methodology.

Thank you for the opportunity to comment. Please feel free to contact me if you have any additional questions.

Sincerely,

Ronnie Cook

Ronald G. Cook
Finance and Managed Care Consultant
North Carolina Hospital Association
(919) 677-4225
rcook@ncha.org

cc: Kendall Bourdon

NCASCA
NORTH CAROLINA AMBULATORY
SURGICAL CENTER ASSOCIATION

**TO: NORTH CAROLINA INDUSTRIAL COMMISSION**

On behalf of the North Carolina Ambulatory Surgical Center Association ("the Association"), please accept this letter in opposition to the proposed permanent rule, 04 NCAC 10J .0103, proposed by the North Carolina Industrial Commission.

The Association represents the overwhelming majority of freestanding ambulatory surgical centers ("ASCs") in North Carolina. ASCs provide great value to North Carolina's health care delivery system broadly and specifically in performing surgical procedures to injured workers through the Workers' Compensation system. ASCs can perform the same types of surgical procedures that are provided in hospital outpatient departments and some procedures that are currently being provided to patients on an inpatient basis in hospitals. Unfortunately, the proposed permanent rule does not recognize the myriad ways that ASCs can serve injured workers and does not properly reimburse ASCs for the procedures they perform.

The Association was formed in 2016. Since its inception, the Association has taken a very active role in commenting upon and even challenging certain actions that have been taken by the Commission in connection with the ASC fee schedule for workers' compensation cases. The Association is one of the plaintiffs in the legal action filed earlier this year that resulted in the Wake County Superior Court declaring the Commission's temporary rule invalid. When the temporary rule was being considered by the Commission, the Association voiced its serious concerns directly and through its members. Unfortunately, the proposed permanent rule currently being considered is identical to the temporary rule.

The Association and its members are united in our desire to have the Commission adopt a reasonable and comprehensive fee schedule for ambulatory surgical centers that will provide adequate reimbursement for workers' compensation cases. This will result in better containing medical costs because ambulatory surgical centers are the most cost-effective, efficient setting for many of the surgical procedures needed by injured workers.

The lack of adequate reimbursement results in less access for injured workers. In 2015, which was the first year the ambulatory surgical fee schedule was slashed by 60 percent by the fee schedule the Superior Court has declared invalid the available data show a significant decline in the percentage of surgeries for injured workers in that were performed in ASCs. Theses injured workers did not vanish; they simply received these surgeries in a higher-cost hospital setting.

The fee schedule adopted by the Commission should provide sufficient reimbursement to ambulatory surgical centers so that access to the most cost-effective setting is encouraged. The fee schedule should also cover all procedures that can be performed in an ambulatory surgical center. This will also increases access. The fee schedule being proposed by the Commission does not accomplish either of these goals.

Instead, the Commission is basing the workers' compensation fee schedule on the Medicare fee schedules. As recognized by national experts on workers' compensation, there are significant differences between the Medicare patient population and workers' compensation patient population. Medicare permits surgical procedures in ASCs only when discharge would be appropriate before the midnight following the procedure. For non-Medicare patients in North Carolina, ASCs are permitted to keep patients for up to 24 hours. This means a non-Medicare patient can stay in the facility overnight, provided they are released within the specified timeframe. The ability to keep workers' compensation and commercial patients in an ASC overnight broadens the list of procedures that can be performed safely and effectively in the ASC setting.

The Commission's proposed rule ignores all of these factors. Instead, the Commission's proposed permanent rule treats injured workers as if they are Medicare patients by preventing them from receiving many surgical procedures that are routinely and safely performed in an ASC setting. As a result, injured workers will be denied access to ASCs for these procedures, causing delays in services and higher inpatient costs and copays for certain procedures.

The Association also has serious objections to the approach taken and the assumptions made in the fiscal note. The Commission has not actually analyzed

the change to the rule that is being proposed. The fiscal note does not take into account the major reduction being proposed to ASCs from the valid fee schedule. Instead, it is using as the baseline the April 2015 fee schedule, which a Superior Court has already invalidated. By comparing the proposed rule change to the invalid rule, the Commission is not actually analyzing the significance of the reduction in reimbursement, the impact on stakeholders, and the impact on the system as a whole.

For example, the fiscal note also does not address the dynamic effects that such a reduction will have—and already has had—on injured workers and the cost to the system. In failing to consider these effects, the Commission has failed to meet its statutory obligations under the rulemaking process.

The Commission's proposed permanent rule is nearly identical to a prior permanent rule and identical to a temporary rule—both of which were invalidated by the courts. Although the courts did not have the opportunity to review the substance of the rules, these prior failed rulemaking efforts gave the Commission the opportunity to reconsider its approach to the ASC fee schedule and construct a fee schedule that took into account stakeholder feedback and that accomplished the statutory requirements. With this proposed permanent rule, the Commission has squandered these opportunities.

Through this permanent rulemaking process, the Commission has the opportunity to adopt a fee schedule that actually gives access to injured workers and saves the system money. To do so, the Association recommends that the Commission adopt a rule consistent with the proposal made by one of the Association's members last fall, Surgical Care Affiliates. The Commission should also conduct a proper fiscal analysis.

Finally, the Association is disappointed that the Commission has chosen to schedule a hearing to approve the permanent rule less than 48 hours after written comments are submitted. Given this short turnaround, the Commission is failing to consider the comments as required by the Administrative Procedure Act.

For the reasons set forth above, the Association opposes the proposed permanent rule, 04 NCAC 10J .0103, as proposed by the North Carolina Industrial Commission.

This the 14th day of August 2017.

Peter Lohrengel
North Carolina Ambulatory Surgical Center
Association

**SURGICAL CARE AFFILIATES' COMMENTS IN RESPONSE TO THE NORTH CAROLINA INDUSTRIAL COMMISSION'S NOTICE OF PROPOSED PERMANENT RULEMAKING FOR WORKERS' COMPENSATION MEDICAL FEE SCHEDULE, 04 NCAC 10J .0103**

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

Pursuant to the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, Surgical Care Affiliates, LLC ("SCA") respectfully submits the following comments in response to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases. SCA also submits the attached report entitled "Economic Effects of Proposed Changes to the North Carolina Workers' Compensation Fee Schedules for Ambulatory Surgery Centers" prepared by Avalon Health Economics (hereinafter "the Avalon Report").

When finalizing its preparation of these written comments, SCA received a Notice of Hearing from the Commission that the Commission intended to approve the proposed permanent rule on Wednesday, August 16, 2017, at 2:30 pm—less than 48 hours after written comments are due to be submitted. SCA objects to the unnecessarily hurried scheduling of this hearing. The Commission cannot seriously expect to consider the myriad comments that we anticipate it will receive with only one business day in-between when the comments are

due and when the hearing will occur. The Commission is failing to meet its obligations under the Administrative Procedure Act to consider written comments in its rulemaking process.

As discussed below, the Commission has also failed to prepare a fiscal note in accordance with the Administrative Procedure Act. SCA has commissioned a more thorough fiscal study by Avalon Health Economics (attached). The Commission should carefully consider this report, these written comments, and all written comments before it meets to decide whether to approve the proposed rule. SCA recommends that the Commission revise the proposed rule and prepare a fiscal note that complies with the Administrative Procedure Act's requirements.

## I. INTRODUCTION

SCA manages seven ASCs in North Carolina and has an ownership interest in each of these centers through wholly-owned subsidiary corporations (hereinafter "SCA ambulatory surgical centers"). The SCA ambulatory surgical centers are located throughout North Carolina and include Blue Ridge Surgery in Raleigh, Charlotte Surgery Center, Fayetteville Ambulatory Surgical Center, Greensboro Specialty Surgery Center, Surgical Center of Greensboro, The Eye Surgery Center of the Carolinas in Southern Pines, and Eastern Regional Surgical Center in Wilson. As stated in the Avalon Report, SCA represents roughly half of all workers' compensation surgical procedures performed in ASCs.

SCA opposes the proposed permanent rule and has determined that the Commission has failed to comply with the rulemaking requirements of the Administrative Procedure Act. Before discussing these reasons in more detail, SCA would like to address questions raised during the July 19, 2017 public hearing and provide a summary of the Commission's prior versions of the ASC fee schedule and the legal actions and developments that have occurred to date.

SCA's written comments are thus divided into the following sections: (1) clarifications to questions raised by the Commission at the

July 19, 2017 public hearing; (2) background of rulemaking and legal challenges to date; (3) reasons why the proposed permanent rulemaking violates the requirements of the Administrative Procedure Act; (4) additional reasons why SCA opposes the substance of the proposed permanent rulemaking; and (5) SCA's recommendations for the Commission to take to provide stability to the workers' compensation system and meet its statutory obligations.

## II. RESPONSES TO QUESTIONS AT JULY 19, 2017 HEARING

In reviewing the transcript of the July 19, 2017 hearing, it appears that there were certain questions raised by the Commission that may not have sufficiently been answered or where there may remain confusion.

**Treatment of Injured Workers as Medicare Patients:** Chairman Allen asked a representative of the North Carolina Ambulatory Surgical Center Association about how injured workers are treated like Medicare patients when the proposed ASC fee schedule is twice that of Medicare patients. SCA's objection to the reliance on the Medicare fee schedule is that it excludes procedures that can be safely performed at an ASC setting on non-Medicare patients. Although the proposed permanent rulemaking permits reimbursement for certain procedures on the Medicare hospital outpatient fee schedule, there are still many procedures that can be performed on injured workers (and are performed when they are covered by other insurance) that are not contemplated in the proposed permanent rule. Even when carriers negotiate with ASCs to render procedures not on the fee schedule, it drives up the cost to the system and makes it less likely that patients will receive these procedures at ASCs. These non-covered procedures are further described below and in the Avalon Report.

**Inadequacy of Medicare Fee Schedule for Certain Procedures:** In response to questions by Commissioner Cheatham, the North Carolina Ambulatory Surgical Center Association representative stated that Medicare reimbursement for certain procedures does not even cover the costs of implants let alone the other costs to the ASC facility. This does not mean that ASCs do not treat

Medicare patients. They do so in large numbers. But there are certain procedures that simply cannot be performed at an ASC given the Medicare reimbursement, unless the facility is willing to do so at a financial loss.

The Commission specifically asked for statistics on the number of Medicare patients that are turned away due to the inadequacy of reimbursement. Although this is a fair request, it is difficult one to answer. The reason is that facilities do not typically "turn away" patients. Instead, when a procedure is reimbursed at well below cost, those procedures are typically not scheduled in an ASC facility. This is no different than the way a hospital would treat a procedure that is reimbursed at below cost in an outpatient setting. It would be shifted to an inpatient setting where the reimbursement is higher. Since April 1, 2015, North Carolina has conducted an unwitting experiment by implementing an invalid fee schedule for ASCs. The result has been that utilization of ASCs has already declined. *See* Avalon Report. The proposed rule change will thus be expected to have a similarly profound effect. The Commission fails to consider this shift in its fiscal analysis.

**Performance of procedures not on workers' compensation ASC fee schedule:** During the presentation of SCA's Kelli Collins, there was an extensive discussion about procedures not on the existing or proposed ASC fee schedule. Several members in the audience attempted to provide clarity, but it appears from the transcript there may still have been some confusion. ASCs have continued to provide procedures not on the workers' compensation ASC fee schedule for patients that are reimbursed by commercial insurance, not under the Workers' Compensation Act. When SCA was referencing patients who were receiving total joint replacements since April 2015, it was referring to these types of patients.

**Comparisons to other states:** SCA does not oppose the concept of comparing fee schedules to other states in principle. Experiences in other states can be helpful to North Carolina in developing a workers' compensation system that encourages access to care and controls costs. However, SCA's objections are two-fold. First, the Commission's relies on reports from the insurance carriers' trade association, which only

state what the fee schedules are, not what impact those fee schedules have on utilization and overall medical costs. Second, these reports contain incomplete data and have so many caveats to make them almost useless.

**Lack of data:** The Commissioners expressed several times frustration with the lack of data to inform its regulatory actions. SCA shares in this frustration. SCA actually commissioned the attached Avalon Report in order to address some of the Commission's concerns. The Avalon Report is admittedly limited by the fact that SCA only has access to certain data.

That is why SCA recommends that the Commission conduct a complete fiscal analysis based upon data that the Commission already has access to or can request from other stakeholders. It is only with this data that the Commission will be able to make an informed decision and actually comply with its statutory obligations. Otherwise, it is blindly throwing darts.

## III. BACKGROUND ON PRIOR RULEMAKING AND ONGOING LEGAL CHALLENGES

Historically, the Commission has established separate fee schedules for physicians, hospitals, ASCs, and other health care providers. Payments to ASCs represent less than 6% of workers' compensation medical payments.

In 2013, the General Assembly enacted a provision authorizing the Commission to base the fee schedules for physicians and hospitals on the Medicare methodology and permitted the Commission to by-pass the usual requirement of obtaining a fiscal note to analyze the financial impact of these changes. The Commission tasked a group of stakeholders to develop and recommend the fee schedules. ASCs were not included in that process.

In 2015, the Commission adopted rules that changed the fee schedules for physicians and hospitals (as authorized by the General Assembly) but also changed the fee schedule for ASCs.

In 2016, a Superior Court struck down the changes to the ASC fee schedule because the Commission was not authorized to ignore the requirement of a fiscal note. The Commission has appealed to the Court of Appeals. The Superior Court decision has been stayed pending the appeal.

When the Court Appeals affirms the Superior Court decision, the valid fee schedule that was in place prior to April 2015 will be the reimbursement that will be applied retroactively to all workers' compensation procedures performed in ASCs. As the Commission acknowledges in its fiscal note, ASCs will be entitled to collect underpayments for services provided since April 2015. Conservatively, this will require insurance carriers and self-insured employers to pay ASCs over $75 million.

SCA has engaged in numerous efforts with other stakeholders to negotiate a fair fee schedule moving forward and a resolution to the substantial underpayment caused by the Commission's invalid fee schedule. SCA has engaged in numerous meetings and other communications in order to resolve the disputes and provide certainty for all stakeholders. Although there remains an opportunity for resolution, the proposed permanent rule does not provide certainty to the system. The window is closing as the flexibility that stakeholders have to compromise on the substantial underpayments that will be owed to ASCs will end once the Court of Appeals rules in favor of SCA.

## IV. REASONS WHY THE COMMISSION IS VIOLATING THE ADMINISTRATIVE PROCEDURE ACT

As the Commission acknowledges, the Administrative Procedure Act requires a fiscal and regulatory impact analysis for the proposed permanent rule. *See* N.C. Gen. Stat. § 150B-21.4. In developing a fiscal note, the agency must analyze the substantial economic impact by doing the following:

> (1) Determine and identify the appropriate time frame of the analysis.

> (2) Assess the baseline conditions against which the proposed rule is to be measured.
>
> (3) Describe the persons who would be subject to the proposed rule and the type of expenditures these persons would be required to make.
>
> (4) Estimate any additional costs that would be created by implementation of the proposed rule by measuring the incremental difference between the baseline and the future condition expected after implementation of the rule. The analysis should include direct costs as well as opportunity costs. Cost estimates must be monetized to the greatest extent possible. Where costs are not monetized, they must be listed and described.

*Id.* § 150B-21.4(b1). The fiscal note developed by the Commission fails to meet any of these requirements. The Commission uses the wrong timeframe by comparing the proposed rule to a rule that has been invalidated. In so doing, the Commission uses the wrong baseline. Because the Commission uses the wrong baseline, it underestimates the costs that will be borne by certain providers and the injured workers that would otherwise be served by ASC facilities. *See* Avalon Report.

The Commission's fiscal note is not only flawed; it is flawed in bad faith. The Commission ignores the fact that the April 2015 ASC fee schedule was invalidated because the Commission failed to include a fiscal note. Contrary to the Superior Court's ruling, the Commission continues to fail to conduct a fiscal analysis between the valid fee schedule (the one in effect prior to April 2015) and the proposed fee schedule. In so doing, the Commission downplays the dramatic cut to reimbursement for ASCs and the negative impact on injured workers' access to care. The Avalon Report estimates the significant economic impact that the proposed rule change will have.

Moreover, the Commission acknowledges that the fiscal note fails to consider the behavioral changes to the system of reducing ASC reimbursement. *See* Avalon Report. This error is particularly

egregious because the Commission recognizes that changing reimbursement will affect where injured workers receive surgery and therefore the amount of reimbursement paid by insurance carriers and self-insured employers. Still, the Commission neglects to factor how reducing the ASC fee schedule will shift utilization to higher-cost settings. In fact, the invalid fee schedule has already done so, but the Commission simply ignores this data that has been created by the experiment of continuing to enforce an invalid rule.

Finally, the fiscal note only considers alternatives using the invalid fee schedule as the baseline and also inappropriately relies upon 2015 data, which includes claims under the invalid fee schedule and the valid fee schedule. The reliance upon this data is erroneous and in bad faith.

The Commission waited over two years to produce a fiscal note and then produced a document that fails to even discuss the fiscal impact of the changes to ASC reimbursement when treating injured workers. This violates the rulemaking requirements under the Administrative Procedure Act.

## V. REASONS WHY SCA OPPOSES THE SUBSTANCE OF THE PROPOSED PERMANENT RULE

Even if the fiscal note had been developed in accordance with the Administrative Procedure Act, SCA opposes the rule on substantive grounds. The proposed permanent rule should be rejected for the following four reasons:

1. The proposed rule does not meet the Commission's statutory obligations;
2. The proposed rule ignores feedback from stakeholders;
3. The proposed rule is harmful to injured workers; and
4. The proposed rule drives up costs for insurers and employers.

## A. The Proposed Rule Does Not Meet the Commission's Statutory Obligations.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that (1) injured workers are provided access to care, (2) that providers are reimbursed reasonable fees for providing these services, and (3) that medical costs are controlled. The Commission's proposed permanent rule does not meet any of these requirements.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The Commission also is required to ensure that medical costs are adequately contained. N.C. Gen. Stat. § 97-26(a). The Commission's proposed permanent rule does not meet these requirements.

First, the Commission's proposed permanent rule limits access to care for injured workers. The Commission's proposed permanent rule does not set a fee schedule for all procedures that can be performed in ASCs. By crafting a fee schedule that uses only Medicare fee schedules as its foundation, the proposed rule does not recognize that a wide variety of procedures can be performed safely and cost-effectively on the working-age population.

The workers' compensation population is typically younger and healthier than the Medicare population, meaning that there are additional procedures that can be performed safely and effectively with a shorter stay. For example, working-age patients with spinal injuries are commonly treated in an ASC setting, but the proposed rule will prevent injured workers from accessing these procedures in an ASC setting because several of these spinal codes are not on the Medicare ASC or Hospital Outpatient Department ("HOPD") fee schedules. Similarly, total joint replacements are paid by Medicare only in the inpatient setting today. If the Commission adopted a rule that set a

reasonable fee schedule for these procedures, these cases could be performed on injured workers in the ASC setting. The Commission should be proposing a fee schedule that promotes having these procedures performed in ASCs instead of in a more costly inpatient setting.

Second, the proposed ASC fee schedule does not offer a reasonable reimbursement to ASC providers. Inadequate reimbursement discourages ASCs from treating as many injured workers. In 2015 alone, there was an 8% decline in the number of workers' compensation cases done by ASCs. *See* Avalon Report.

This shift away from ASCs illuminates the third failing of the proposed rule—it does not control medical costs. For every injured worker treated in a hospital instead of an ASC, a business or the carrier can pay double, triple, or more for their medical care. As discussed in Section IV, the fiscal note makes no attempt to capture these direct or indirect costs.

By crafting a fee schedule that uses only the Medicare fee schedule as its foundation, the proposed rule does not recognize that a wide variety of procedures can be performed safely and cost-effectively on the working-age population. The workers' compensation population is typically younger and healthier than the Medicare population, meaning that there are additional procedures that can be performed safely and effectively with a shorter stay. As noted by the National Council on Compensation Insurance ("NCCI"): "WC claimants have very different demographics, medical conditions, and priorities than retirees. It would be a mistake to blindly rely on Medicare rates as perfect measures of resources appropriate to treat work-related injuries."[1]

Additionally, for Medicare patients nationwide, covered surgical procedures include "surgical procedures . . . for which standard medical practice dictates that the beneficiary would not typically be expected to

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[1] NCCI, *Effectiveness of Workers Compensation Fee Schedules - A Closer Look* (Feb. 11, 2009).

require active medical monitoring and care at midnight following the procedure."[2] For non-Medicare patients in North Carolina, ASCs are permitted to keep patients for up to 24 hours.[3] This means a non-Medicare patient can stay in the facility overnight, provided they are released within the specified timeframe.[4] The ability to keep workers' compensation and commercial patients in an ASC overnight broadens the list of procedures that can be performed safely and effectively in the ASC setting.

The ASC fee schedule proposed by the Commission fails to take all of these factors into consideration.

### B. The Proposed Rule Ignores the Significant Input Provided by Stakeholders.

All of these concerns should sound familiar to the Commissioners who have served on the Commission for some length. SCA raised these concerns at prior public hearings and in previous submissions.

In the proposed permanent rule, the Commission is not just ignoring the concerns raised by SCA and other ASCs. The Commission is ignoring its own advice. The Commission has previously spoken out in favor of parity between ASCs and HOPDs. The Commission has stated in public court filings that discrepancies in payments between ASCs and HOPDs would "potentially diminish the pool of doctors available to treat injured employees, and reduce the quality and timeliness of care." The Commission further warned: "That impact will likely be most severely realized in our State's more rural areas, where the quality and availability of effective treatment is already a greater concern."[5]

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[2] 42 C.F.R. § 416.166(b).

[3] N.C. Gen. Stat. § 131E-176(1b).

[4] Federal regulations allow for stays up to 24 hours in ASCs. *See* 42 C.F.R. § 416.2.

[5] N.C. Indus Comm'n's Mem. of L. in Support of Mot. to Stay, *Surgical Care Affiliates, LLC v. N.C. Indus. Comm'n*, No. 16-CVS-0060 (Wake Cty. Super. Ct. Aug. 17, 2016).

SCA agrees with the Commission that the only way to ensure injured workers access to high-quality, effective care is to create parity between the ASC and HOPD medical fee schedules.

The Commission continues to make misleading comparisons to other states. In so doing, the Commission is moving counter to the trend of states recognizing the importance and cost savings of ASCs in their workers' compensation systems. These States are creating parity across settings. North Carolina is widening the gap.

### C. The Proposed Rule Would Harm Injured Workers.

The negative impact to injured workers is not speculative. It is already occurring. Data collected by Workers' Compensation Research Institute demonstrated that common outpatient surgeries occurred in North Carolina ASCs less frequently than in other states. Additionally, injured workers in North Carolina reported that they had "big problems getting the primary provider that they wanted."

The proposed rule only exacerbates these real problems for injured workers since the Commission unlawfully changed the ASC fee schedule. Under the proposed rule, injured workers will be denied access to care in the ASC setting and will be forced to receive treatment in more expensive inpatient settings, where scheduling services often takes longer and results in delays in care.

### D. The Failure to Propose a Fee Schedule Covering All Surgical Procedures Results in Greater Costs.

The failure to include all procedures that can be safely performed on an outpatient basis results in a significant cost to the system. Particularly impactful in the context of workers' compensation injuries are a number of spine codes, many of which are not covered under the Medicare ASC fee schedule but are commonly performed in the ASC setting on working-age patients. Total joint replacements (knee, hip, and shoulder) also are paid by Medicare only in the inpatient setting and these cases are routinely performed on patients – especially young

and otherwise healthy patients like many injured workers – in the ASC setting.

To meet the goals of the Workers' Compensation Act, the Commission should be proposing a fee schedule that promotes having these procedures performed in ASCs instead of in a more costly inpatient setting. The proposed fee schedule will continue to encourage hospitals to provide these surgical procedures in the highest cost setting.

When confronted with an injured worker who needs a procedure not paid for under Medicare's HOPD payment methodology, a hospital can choose to perform the procedure in its inpatient setting. The result is a much higher cost to the system for an inpatient stay and for the procedure. Providing certainty in the reimbursement to ASCs for procedures like total joint replacements that are not on the Medicare ASC list would allow the injured worker's doctor to make the decision for the patient about the best site of service for these procedures.

Workers' compensation patients can be prioritized in an ASC setting and are often seen more quickly than they are in a hospital setting. This, combined with the ASC industry's low infection rates and high quality of care, allows for a rapid return to work, resulting in savings to the system for short-term disability expenses beyond the savings proposed under the fee schedule.

The impact of not having a fee schedule that includes all procedures can be shown by the drop in workers' compensation cases performed in ASCs since April 2015 when the invalid fee schedule began being used. SCA's Workers' Compensation cases declined by 4.2% between April 1, 2015 and March 31, 2016. An NCCI analysis of case volume recently obtained by SCA shows a decline in volume of workers' compensation cases by all North Carolina ASCs in 2015 of 8.2%.[6]

[6] NCCI data include three months of payment not under the invalid fee schedule.

The workers' compensation system benefits when ASCs are able to shift higher acuity cases out of the inpatient environment into a lower cost, outpatient setting. Even though the proposed rule allows for payment for codes that do not have a payment assigned within Medicare fee schedule, without a predictable, reasonable rate for these procedures identified in advance of the case, ASCs cannot determine if they are able to cover the costs of taking on the case and open themselves up to tremendous risk for high cost procedures. The result will likely be that ASCs will refuse to take most of the procedures that are not on the Medicare fee schedule. Therefore, the same procedures will cost more for insurance carriers and self-insured employers.

## VI. RECOMMENDATIONS

SCA recommends that the Commission revise its permanent rule consistent with the recommendation in SCA's September 2016 proposal, which is consistent with the statutory requirements, accounts for all procedures that can be performed in ASCs, and—as would have been demonstrated if a more thorough and appropriate fiscal note had been done—results in substantial savings to the workers' compensation system in North Carolina. SCA also insists that the Commission conduct a fiscal analysis that actually looks at the impact of the proposed rule as compared to the valid, pre-April 2015 fee schedule instead of using an invalid rule as the baseline.

SCA's proposed ASC fee schedule submitted to the Commission on September 26, 2016 would align payments for ambulatory surgical procedures with the Medicare HOPD fee schedule while at the same time acknowledging that Medicare has not created an allowance for certain procedures that are routinely and safely provided to non-Medicare patients in the ASC setting. As such, SCA proposed a rate for these services that is consistent with the resources and time involved in providing such procedures. In order to limit the uncertainty of the system's exposure on reimbursement, charge master increases would be limited to 0% increase for these procedure codes for the first 3 years, or a revenue neutral adjustment will be applied to the percent of charge paid. SCA's proposal will provide the standard of services and care

intended by the Workers' Compensation Act, will reimburse ASCs reasonable fees for providing services, and will ensure that medical costs are adequately contained. *See* N.C. Gen. Stat. § 97-26(a).

SCA's proposed fee schedule provides sufficient reimbursement so that ASCs can recover the cost of the implants involved in some surgical procedures. The proposed temporary rule does not adequately reimburse ASCs so that these costs can be recovered and also does not separately reimburse for implants. Under the ASC fee schedule that became effective in 2013, ASCs were being paid for implants at no greater than invoice cost plus 28%. The failure to separately reimburse for implants results in even less reimbursement to ASCs and reduces the incentive to provide services involving high-cost implants. In contrast, hospitals are able to recover higher implant costs by shifting patients to the higher-cost inpatient setting for those surgical procedures.

Payment for treating injured workers should be equivalent between the two outpatient settings for equivalent procedures. When an injured worker requiring surgery visits an ASC, he or she receives the same care as he or she would in a hospital environment. For these cases, the direct costs are equivalent – implant and supply costs, nursing staff, anesthesia costs, etc. Payment for surgery for the same patient, receiving the same treatment – in many cases even performed by the same surgeon – should not be differentiated based on factors and costs unrelated to the workers' compensation system and should be the same regardless of location.

Other states are recognizing the importance of addressing the two sites using the same methodology in setting their medical fee schedules. Alaska and Connecticut, two of the most recent states that enacted legislation related to workers' compensation medical fee schedule reforms specific to ambulatory surgical centers, used the HOPD fee schedule. In 2014, the Medical Services Review Committee in Alaska was directed to create a medical fee schedule based on Medicare-based conversion factors. The new schedule became effective December 1, 2015. The Medical Services Review Committee determined that

HOPDs and ASCs should be reimbursed as a percent of the Medicare HOPD fee schedule.[7] Similarly, effective April 1, 2015, the Connecticut Workers' Compensation Commission established a medical fee schedule for ASCs based on the Medicare HOPD fee schedule.[8]

If the Commission used the correct baseline, it would see that SCA's proposal would actually decrease medical costs to the workers' compensation system.

## CONCLUSION

For the reasons set forth above, SCA opposes the proposed permanent rule. SCA recommends that the Commission develop a fiscal note that meets the requirements of the Administrative Procedure Act and revise the permanent rule to reflect the lessons learned from a valid fiscal note and to ensure adequate access to surgical services for North Carolina's injured workers.

Respectfully submitted this 14th day of August 2017.

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[7] H.B. 316, Chapter 63 SLA 14 (Alaska 2014).
[8] S.B. 61, Public Act No. 14-167 (Conn. 2014).

AVALON HEALTH ECONOMICS

# Economic Effects of Proposed Changes to the North Carolina Workers' Compensation Fee Schedule for Ambulatory Surgery Centers

REPORT

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1. OBJECTIVES

1.1. Surgical Care Affiliates, LLC ("SCA") has asked Avalon Health Economics ("AHE") to conduct a study to review and calculate the effects of a North Carolina Industrial Commission ("NCIC") workers' compensation (WC) proposed rule change in fee schedules for ambulatory surgery centers (ASCs) as compared to the pre-April 2015 valid fee schedule.

1.2. In this report, we address the following issues. First, we conduct a brief overview of the literature pertaining to the effects of changes in payment mechanisms and payment levels on access to care and quality of care. Second, we recalculate the estimates produced by NCIC in their fiscal impact analysis of the rule, and show that the previous (pre-April 2015) fee schedule follows the North Carolina mandate that fee schedule adopted by the commission must be adequate to ensure that: (1) injured workers are provided the standard of services and care intended by North Carolina Workers' Compensation Act; (2) providers are reimbursed reasonable fees for providing services; and (3) medical costs are adequately contained in accordance with N.C Gen. Stat. §97-26(a). Third, we conclude that the proposed rule change is unlikely to realize savings and will actually cost the system more.

2. BENEFITS OF ASCs

2.1. Since their inception in the 1970s, ASCs have offered a less resource-intensive setting for safely performing a wide range of surgical procedures. As technological advances made it possible to perform many surgeries outside of the expensive inpatient hospital setting, ASCs have been an integral part of the migration of services from the expensive, resource-intensive inpatient setting to the more efficient and consumer-oriented outpatient setting.[1] Currently, ASCs perform more than 40% of colonoscopies, 30% of arthroscopies, and 60% of cataract surgeries.[2]

2.2. The annual Medicare update factor for ASC payment schedules is based on the consumer price index for all urban customers (CPI-U), which is linked to changes in cost of consumer goods. In contrast, HOPD payments are adjusted annually based on the hospital market basket, which measurer changes in medical costs. The cost of providing healthcare has increased more quickly than consumer prices, increasing the reimbursement gap between ASCs and HOPDs. ASCs are currently only reimbursed at 49% of HOPD reimbursement, and these payment differentials have resulted in substantial savings to payers.[3] In addition, the presence of ASCs in the market increases

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[1] Refer to A. M. Suskind et al., "Understanding the Diffusion of Ambulatory Surgery Centers," *SURGICAL INNOVATION* 22, no. 3 (2015); J. Wolfson, G. Walker, and P. J. Levin, "Freestanding Ambulatory Surgery: Cost-Containment Winner?," *Healthc Financ Manage* 47, no. 7 (1993).

[2] L. Koenig and Q. Gu, "Growth of Ambulatory Surgical Centers, Surgery Volume, and Savings to Medicare," *American Journal of Gastroenterology* 108, no. 1 (2013).

[3] Brent Fulton, PhD and Sue Kim, PhD, "Medicare Cost Savings Tied to Ambulatory Surgery Centers," (Ambulatory Surgery Center Association).

levels of competition, and market-level competition is associated with greater efficiency and quality.[4] According to MedPAC's analysis, if ASC payment rates were set equal to the Outpatient Prospective Payment System (OPPS) payment rates for even 89 of the 3,400 possible procedures, Medicare spending and beneficiary cost sharing would have been $1.2 billion lower.[5]

2.3. As of 2013, for WC cases, seven (7) states have established parity between HOPD and ASC fee schedules.[6] These states are Georgia, Massachusetts, Mississippi, Nevada, New York, Oklahoma, and Tennessee.

2.4. The advantages and benefits of ASCs can be grouped into three categories: (1) ASCs provide alternatives to more expensive settings, including inpatient and HOPD settings; (2) ASCs provide competition in regional health care markets, and that competition has been shown to improve the efficiency of hospitals in the same market; and (3) ASCs provide a very high quality of care, at least comparable and in many cases better than their HOPD and inpatient hospital counterparts. The remainder of this section of the report briefly reviews and discusses each of these ASC attributes and cites relevant evidence

2.5. *Costs and Efficiency.* The Medicare Payment Advisory Commission (MedPAC) recently reported that the Medicare program saved an estimated $7 billion from 2007 to 2011 because care was provided at an ASC instead of an HOPD.[7] The cost savings associated with ASCs is in part attributable to the overall less intensive resource use associated with outpatient settings in general,[8] but in addition there is a relatively large volume of research documenting the cost and efficiency benefits of ASCs specifically. There are two primary sources for the savings. First and foremost, ASCs are paid less than their hospital and HOPD counterparts for performing the exact same services. Second, ASCs are also more technically efficient. Munnich and Parente (2014), for example, found that procedures performed in ASCs took approximately 32 minutes less to perform compared to their HOPD counterparts, a 25% difference relative to the mean

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[4] See generally FTC-DOJ, "Improving Health Care: A Dose of Competition," (Washington, D.C.: U.S. Federal Trade Commission & U.S. Department of Justice, 2004); Kathleen Carey, "Ambulatory Surgery Centers and Prices in Hospital Outpatient Departments," *Medical Care Research and Review* 74, no. 2 (2017).

[5] "Report to the Congress: Medicare Payment Policy," (Medicare Payment Advisory Commission, 2017).

[6] Bogdan Savych, "Comparing Payments to Ambulatory Surgery Centers and Hospital Outpatient Departments, 2nd Edition," (Cambridge, Massachusetts: Workers Compensation Research Institute, 2016).

[7] "Report to the Congress: Medicare Payment Policy."

[8] For example, refer to Michael Aynardi et al., "Outpatient Surgery as a Means of Cost Reduction in Total Hip Arthroplasty: A Case-Control Study," *HSS Journal* 10, no. 3 (2014); Dennis C. Crawford et al., "Clinical and Cost Implications of Inpatient Versus Outpatient Orthopedic Surgeries: A Systematic Review of the Published Literature," *Orthopedic reviews* 7, no. 4 (2015).

procedure time.[9] Other studies focusing on specific procedures or therapeutic areas have also found substantial savings associated with providing care in ASC settings relative to HOPD and hospital inpatient settings.[10] It is also important to emphasize that overall growth in the number of ASCs has not contributed to higher health care expenditures.[11]

2.6. *Competitive Effects.* The fiscal note prepared by NCIC makes no attempt to calculate the savings to the system caused by shifting surgical procedures from HOPDs to ASCs. Moreover, in North Carolina, available data from April 2015 to the present shows that the implementation of the invalid fee schedule caused the shift of surgical procedures from the ASC setting to the HOPD setting.

2.7. *Quality of Care.* There is ample evidence showing that the care and services provided in ASC settings are at least comparable and often of higher quality than the same services provided in HOPDs and the inpatient hospital. Most of the studies of ASC quality focus on a particular procedure or therapeutic area, but all studies generally and consistently show that ASCs provide a level of quality that is at least as high as their HOPD and inpatient hospital counterparts, and in many cases better.[12] For example, a recent study by Koenig et al. compared mortality and admissions in HOPDs and ASCs for the 10 most common procedures provided in both settings, and found that there were no statistically significant increases in 30-day mortality and 30-day hospital admissions in areas with ASCs.[13]

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[9] E. L. Munnich and S. T. Parente, "Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up," *HEALTH AFFAIRS* 33, no. 5 (2014).

[10] See, for example, C. Nguyen et al., "The Effect of Moving Carpal Tunnel Releases out of Hospitals on Reducing United States Health Care Charges," *J Hand Surg Am* 40, no. 8 (2015); A. M. Suskind et al., "Ambulatory Surgery Centers and Outpatient Urologic Surgery among Medicare Beneficiaries," *Urology* 84, no. 1 (2014).

[11] See generally "Report to the Congress: Medicare Payment Policy."; Koenig and Gu.

[12] See generally "Report to the Congress: Medicare Payment Policy."; T. J. Brolin et al., "Neer Award 2016: Outpatient Total Shoulder Arthroplasty in an Ambulatory Surgery Center Is a Safe Alternative to Inpatient Total Shoulder Arthroplasty in a Hospital: A Matched Cohort Study," *J Shoulder Elbow Surg* 26, no. 2 (2017); K. R. Chin et al., "Lateral Lumbar Interbody Fusion in Ambulatory Surgery Centers: Patient Selection and Outcome Measures Compared with an Inhospital Cohort," *Spine (Phila Pa 1976)* 41, no. 8 (2016); J. Grisel and E. Arjmand, "Comparing Quality at an Ambulatory Surgery Center and a Hospital-Based Facility: Preliminary Findings," *Otolaryngol Head Neck Surg* 141, no. 6 (2009); G. R. Klein et al., "Same Day Total Hip Arthroplasty Performed at an Ambulatory Surgical Center: 90-Day Complication Rate on 549 Patients," *J Arthroplasty* 32, no. 4 (2017); Koenig and Gu; M. J. McGirt et al., "Quality Analysis of Anterior Cervical Discectomy and Fusion in the Outpatient Versus Inpatient Setting: Analysis of 7288 Patients from the Nsqip Database," *Neurosurg Focus* 39, no. 6 (2015); Robert L. Ohsfeldt et al., "Outcomes of Surgeries Performed in Physician Offices Compared with Ambulatory Surgery Centers and Hospital Outpatient Departments in Florida," *Health Services Insights* 10 (2017); I. M. Paquette, D. Smink, and S. R. Finlayson, "Outpatient Cholecystectomy at Hospitals Versus Freestanding Ambulatory Surgical Centers," *J Am Coll Surg* 206, no. 2 (2008); B. W. Parcells et al., "Total Joint Arthroplasty in a Stand-Alone Ambulatory Surgical Center: Short-Term Outcomes," *Orthopedics* 39, no. 4 (2016).

[13] Koenig and Gu.

2.8. Additional benefits of ASCs include convenient locations and shorter wait times for appointments, allowing easier access to care. The shorter wait times also decrease the time that an injured worker has to be out of work. Encouraging utilization of ASCs, therefore, has the benefit of decreasing non-medical payments in the workers' compensation system. The NCIC fiscal note made no attempt to capture this additional cost of slashing the ASC fee schedule so significantly.

3. PAYMENT LEVELS & ACCESS

3.1. The evidence put forth in the preceding section clearly demonstrates that access to ASCs can lead to savings and enhanced quality of care. However, efforts to restrict payments to ASCs, as the proposed rule change does, have been shown to negatively impact access. Any negative impact on access will prevent patients and payers from benefitting from the cost, efficiency, and quality benefits of ASCs. The conceptual and empirical foundation of the "payment-access" relationship is well established, as several studies have found a clear association between payment levels and access to care.[14] Brunt and Jensen (2013), for example, found that in areas where Medicare payments are more generous, physicians are more likely to accept new Medicare patients.[15] The study also found the converse to be true; in areas where payment levels were less generous, physicians were less likely to accept new Medicare patients. Similarly, Clemens and Gottlieb (2014) found that a 2% increase in Medicare payment rates leads to a 3% increase in care provision.[16]

3.2. These same dynamics are relevant to ASCs. A study by Plotzke and Courtemanche (2011) that procedural margins (i.e., profitability) is associated with a 1.2-1.4 percentage point increase in the probability that a surgery is performed in an ASC.[17] This finding is very important because it makes the connection between payment levels and access to less-expensive treatment settings, which in turn has direct implications for payer expenditures. The logic pathway is as follows. We know from the earlier cited literature that ASCs are more efficient than their hospital-based counterparts. Profitability is a function of payment rates and costs. If ASCs have lower costs, than a decrease in payment rates will result in further reductions in already low procedural margins. As this occurs, an ASC may become less willing to treat the patient associated with the lower procedural margin, and that patient may then be treated instead in a costlier

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[14] For a general discussion, see Chapin White, "A Comparison of Two Approaches to Increasing Access to Care: Expanding Coverage Versus Increasing Physician Fees," *Health Services Research* 47, no. 3pt1 (2012).

[15] Christopher S. Brunt and Gail A. Jensen, "Medicare Payment Generosity and Access to Care," *Journal of Regulatory Economics* 44, no. 2 (2013).

[16] Jeffrey Clemens and Joshua D. Gottlieb, "Do Physicians' Financial Incentives Affect Medical Treatment and Patient Health?," *The American Economic Review* 104, no. 4 (2014).

[17] M. R. Plotzke and C. Courtemanche, "Does Procedure Profitability Impact Whether an Outpatient Surgery Is Performed at an Ambulatory Surgery Center or Hospital?," *Health Econ* 20, no. 7 (2011).

hospital-based setting. The net result is that whatever program savings were sought in the lowering of payment rates are erased by the "reverse migration" of patients back to more expensive settings.[18]

3.3. These counterproductive trends can be observed in North Carolina in the wake of the April 2015 ASC fee schedule, which has been invalidated. Between April 1, 2015 and March 31, 2016, SCA surgery centers (which represent over half of the WC payments) saw a 4.2% reduction in WC cases attributable to reduction in reimbursement. Across North Carolina, there was an 8.2% decline in WC cases performed in ASCs in 2015.[19] According to a Workers' Compensation Research Institute (WCRI) study, access to care was a problem even prior to the fee schedule reduction. This study compared WC outcomes and access to care in 15 states.[20] As of 2013 (prior to the NCIC's attempt to tie ASC reimbursement to a percentage of the Medicare ASC fee schedule), North Carolina reimbursement was within 3% of the median among the 33 states studied, and medical costs per claim in North Carolina was comparable to other study states.[21] WCRI found 17% of North Carolina workers reported difficulty getting the services they needed, and 19% workers reported significant problems getting care from their desired primary care provider.

4. LIMITATIONS OF MEDICARE RATES

4.1. There are several important limitations to applying Medicare rates to the WC population. First and foremost, the current ASC fee schedule does not account for the fact that the working-age WC demographics differ significantly from the over-65 Medicare demographics. The vast majority of Medicare patients are over the age of 65, but the majority of injured workers are aged 35-65.[22,23] Furthermore, ASCs primarily treat patients who are at lower risk for complications because they are less medically complex than HOPDs and have significantly lower risk scores on the CMS-hierarchical condition category (CMS-HCC).[24] NCCI acknowledged that due to the different demographics of WC patients, "it would be a mistake to blindly rely on Medicare rates as perfect measures of resources appropriate to treat work-related injuries."[25]

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[18] For example, see generally Melissa Szabad, Melesa Freerks, and Meggan Bushee, "Reverse Migration?: A Trend of Asc Conversion to Hopd," (McGuire Woods 2013).

[19] Kelli Collins, "Surgical Care Affiliates' Comments in Response to Proposals Submitted to the North Carolina Industrial Commission," (Surgical Care Affiliates2016).

[20] Bogdan Savych and Vennela Thumula, "Comparing Outcomes for Injured Workers in North Carolina," (Cambridge, Massachusetts: Workers Compensation Research Institute, 2016).

[21] Bogdan Savych, "Payments to Ambulatory Surgery Centers, 2nd Edition," (Cambridge, Massachusetts: Workers Compensation Research Institute, 2016).

[22] "2016 Cms Statistics," (US Department of Health and Human Services2016).

[23] John Robertson and Dan Corro, "Demographic Factors to Consider: Calculating Lifetime Awards on Workers Compensation " (National Council on Compensation Insurance, 2005).

[24] "Report to the Congress: Medicare Payment Policy."

[25] Barry Lipton et al., "Effectiveness of Wc Fee Schedules: A Closer Look," (National Council on

4.2. Second, the current Medicare ASC fee schedule does not reimburse for certain procedures that may be performed safely in an ASC setting. An example of this total shoulder arthroplasty (TSA), for which there is increasing evidence of safety and efficacy in ASC settings. For example, Brolin et al. (2017) found that there were no differences in outcomes for TSA patient treated in ASCs compared to hospital-based settings.[26] The NCIC's inclusion of a provision permitting ASCs to perform procedures on the Medicare HOPD fee schedule would not address this because procedures such as total joint replacement can be safely performed in an ASC setting but are neither on the Medicare ASC nor the Medicare HOPD fee schedule.

5. EFFECTS OF MEDICARE RATES

5.1. In addition to the limitations on access and net increases in expenditures associated with lowering WC payment rates to ASCs, there are important direct effects on ASC revenues. We conducted an analysis of SCA ASCs in North Carolina to determine the loss in revenue associated with the April 2015 change in WC payment rates. Those changes substantially lowered ASC reimbursement for WC patients for all procedures. We conducted two simulation analyses of the effects of the reimbursement changes on North Carolina's ASC industry. The first model was designed to calculate the decline in revenue for North Carolina's ASCs based on the assumption that the decline in revenue is equal to the difference, from April 1, 2015 to present, between the pre-rule fee structure (i.e., 67.15% of billed charges) and the post-rule structure (i.e., between 200% and 220% of the Medicare ASC fee schedule). The second simulation model takes into account the proposed 200% of Medicare HOPD fee schedule, and calculates the estimated savings to the North Carolina WC program under that proposed payment scheme.

5.2. The results of the first simulation analysis are shown in **Table 1**. The invalid rule change was effective April 1, 2015, which means the first quarter (Q1) of 2015 reflects the existing WC reimbursement scheme and Q2-Q4 of 2015 reflects the "percent of Medicare" rule change. In Q2–Q4 of 2015, NC surgery centers are estimated to have lost $24,910,541 attributable to the invalid rule change. In the full year 2016, the decline is estimated to have been $37,726,112. In 2017, the decline is projected to be $35,623,136. The total decline from April 2015 through (projected) 2017 is $98,259,789.

**Table 1.**
North Carolina ASC reimbursement Schemes, Payment Totals, and Estimated Decline Attributed to WC Payment Rule Change, 2015-2017 (a)

| Year | ASC WC reimbursement | ASC Revenue (Pre-Rule) | ASC Revenue (Post-Rule) | ASC Revenue Decline |
|---|---|---|---|---|

Compensation Insurance, Inc., 2009).

[26] Brolin et al.

| | | | | |
|---|---|---|---|---|
| 2015 (b) | 67.15% (e) | $14,608,520 | N/A | N/A |
| 2015 (c) | 220.00% (f) | $43,951,987 | $19,041,446 | $24,910,541 |
| 2016 | 210.00% (f) | $65,348,540 | $27,622,428 | $37,726,112 |
| 2017 (d) | 200.00% (f) | $61,783,713 | $26,160,577 | $35,623,136 |
| Total (g) | | | | $98,259,789 |

*Notes*: (a) Data was obtained from 7 Ambulatory Surgery Centers in the state of North Carolina who are affiliated with Surgical Care Affiliates (SCA) and extrapolated to represent all ASC's in North Carolina using annual SCA market share percentages (53.6% in 2015 and 43.1% in 2016 and 2017); (b) Data is pre-April 1, 2015 invalid rule implantation; (c) Data is post-April 1, 2015 invalid rule implantation; (d) Data was available through July of 2017 and extrapolated to December 2017; (e) expressed as a percent of billed charges; (f) expressed as a percent of geographically-adjusted Medicare ASC payment rates; (g) total decline from April 2015 rule through December 2017.

5.3. The decrement estimates shown in Table 1 are underestimates because they do not account for three potentially important factors. First, as discussed above, in the first year post-April 2015 rule change SCA saw its WC procedure volume decrease. While this decrease is factored into the Q2-Q4 2015 and calendar year 2016 estimates shown on Table 1, the volume change associated with a full-year 2017 is not yet known. Second, there are a number of procedures that are not represented on the Medicare ASC schedule, which can result in significant cost to the system because of the volume shift into more expensive HOPD or inpatient settings. Third, the indirect effects of the payment reduction on access to care and the likely "reverse migration" to more expensive treatment settings will continue to further erode utilization of ASCs in North Carolina's WC system. This will direct care away from settings that have been proven to be efficient, high quality, and consumer-focused. These types of shifts and migration between ASCs and other, more costly settings are a very important effect of any change in payment schemes, and should have either been assessed by the NCIC as part of its earlier analyses or at least proposed as a near-term implementation study.

5.4. In the fiscal note drafted by the NCIC ("Proposed Permanent Rule Amending Fees for Medical Compensation"), the Commission estimated the effects of a court decision reinstating the pre-April 2015 WC fee schedule (i.e., 67.15% of billed charges). Under this scenario, the Commission relies on a 2017 NCCI analysis to estimate the shortfall to North Carolina ASCs (not limited to SCA facilities). The NCCI report uses claims data from 2015 applied to a simulation model for all of North Carolina's ASCs as a whole. The model starts with assumptions about statewide ASC share of WC medical costs and overall WC benefit costs. Thus, the model can at best offer only a very rough approximation of the actual shortfall associated with any particular ASC. Not surprisingly, the methodology grossly underestimates the effects on North Carolina ASCs, estimating the net impact of the invalid April 2015 change in fee schedule to be between $2 million and $12 million. Again, we estimate the statewide ASC WC payment decrement to be just under $100 million.

5.5. In the second simulation model, we re-calculate the costs and savings estimates from NCCI's 2016 analysis, which calculated the impact of several different fee schedule alternatives. The NCCI analysis was performed using the incorrect baseline of 210% of Medicare ASC rates. This incorrect baseline was declared invalid; instead, the impact analysis should have been performed using the fee schedule that reimbursed ASCs at 67.15% of billed charges, which was the prevailing payment scheme prior to the invalid rule. The incorrect financial impact analysis estimated that SCA's proposed fee schedule (i.e., 200% of ASC HOPD) would result in overall costs to the workers' compensation system. When the financial impact analysis is performed with the correct baseline, SCA's proposal will result in savings to the workers' compensation system.

5.6. According to NCCI's incorrect analysis, there would be a 1.3% increase in medical costs if a 200% HOPD reimbursement rate was implemented. When this proposed fee schedule is compared with the correct baseline, it results in a 0.9% *decrease* in medical costs. Based on these estimates, in estimating the impact of the SCA proposed 200% HOPD, use of the incorrect baseline results in added costs of $12 million, whereas using the correct baseline results in savings of $8.3 million.

## 6. CONCLUSIONS

6.1. Although the NCIC frames the proposed rule change as an effort to control WC program expenditures, the above-reviewed literature and our own analysis show that the proposed rule change (altering the ASC fee schedule from 67.15% of billed charges to 200% of Medicare ASC fee schedule) is likely to lead to increased costs over time. Decreases in payment have been shown to reduce access to care. Ambulatory surgery centers provide low-cost, high quality care, and any policy that directs patients away from them and back to the costlier hospital-based facilities will raise WC program expenditures over time. In the vast majority of cases, the lowest-cost, most efficient provider option will always be the ASC, and any policy that directly or indirectly discourages their use will lead to increased expenditures.

6.2. The retroactive shortfall estimates calculated by the NCIC (based on the NCCI report) appear to be a gross underestimate of the actual ASC decrement in North Carolina post April 2015 ruling. The NCIC estimates a shortfall of only $2 million to $12 million, whereas our calculations based on actual claims data are more than eight times the high end of that range.

## 7. REFERENCES


"2016 Cms Statistics." US Department of Health and Human Services, 2016.

Aynardi, Michael, Zachary Post, Alvin Ong, Fabio Orozco, and Dean C. Sukin. "Outpatient Surgery as a Means of Cost Reduction in Total Hip Arthroplasty: A Case-Control Study." *HSS Journal* 10, no. 3 (2014): 252-55.

Brolin, T. J., R. P. Mulligan, F. M. Azar, and T. W. Throckmorton. "Neer Award 2016: Outpatient Total Shoulder Arthroplasty in an Ambulatory Surgery Center Is a Safe Alternative to Inpatient Total Shoulder Arthroplasty in a Hospital: A Matched Cohort Study." [In eng]. *J Shoulder Elbow Surg* 26, no. 2 (Feb 2017): 204-08.

Brunt, Christopher S., and Gail A. Jensen. "Medicare Payment Generosity and Access to Care." *Journal of Regulatory Economics* 44, no. 2 (2013): 215-36.

Carey, K., J. F. Burgess, Jr., and G. J. Young. "Hospital Competition and Financial Performance: The Effects of Ambulatory Surgery Centers." [In eng]. *Health Econ* 20, no. 5 (May 2011): 571-81.

Carey, Kathleen. "Ambulatory Surgery Centers and Prices in Hospital Outpatient Departments." *Medical Care Research and Review* 74, no. 2 (2017): 236-48.

Chin, K. R., F. J. Pencle, A. V. Coombs, M. D. Brown, K. J. Conklin, A. M. O'Neill, M. J. McGarry, J. A. Seale, and E. A. Hothem. "Lateral Lumbar Interbody Fusion in Ambulatory Surgery Centers: Patient Selection and Outcome Measures Compared with an Inhospital Cohort." [In eng]. *Spine (Phila Pa 1976)* 41, no. 8 (Apr 2016): 686-92.

Clemens, Jeffrey, and Joshua D. Gottlieb. "Do Physicians' Financial Incentives Affect Medical Treatment and Patient Health?". *The American Economic Review* 104, no. 4 (2014): 1320-49.

Collins, Kelli. "Surgical Care Affiliates' Comments in Response to Proposals Submitted to the North Carolina Industrial Commission." Surgical Care Affiliates, 2016.

Crawford, Dennis C., Chuan Silvia Li, Sheila Sprague, and Mohit Bhandari. "Clinical and Cost Implications of Inpatient Versus Outpatient Orthopedic Surgeries: A Systematic Review of the Published Literature." *Orthopedic reviews* 7, no. 4 (2015): 6177-77.

FTC-DOJ. "Improving Health Care: A Dose of Competition." Washington, D.C.: U.S. Federal Trade Commission & U.S. Department of Justice, 2004.

Fulton, Brent, PhD, and Sue Kim, PhD. "Medicare Cost Savings Tied to Ambulatory Surgery Centers." Ambulatory Surgery Center Association.

Grisel, J., and E. Arjmand. "Comparing Quality at an Ambulatory Surgery Center and a Hospital-Based Facility: Preliminary Findings." [In eng]. *Otolaryngol Head Neck Surg* 141, no. 6 (Dec 2009): 701-9.

Housman, M., and M. Al-Amin. "Dynamics of Ambulatory Surgery Centers and Hospitals Market Entry." [In eng]. *Health Serv Manage Res* 26, no. 2-3 (Aug 2013): 54-64.

Klein, G. R., J. M. Posner, H. B. Levine, and M. A. Hartzband. "Same Day Total Hip

Arthroplasty Performed at an Ambulatory Surgical Center: 90-Day Complication Rate on 549 Patients." [In eng]. *J Arthroplasty* 32, no. 4 (Apr 2017): 1103-06.

Koenig, L., and Q. Gu. "Growth of Ambulatory Surgical Centers, Surgery Volume, and Savings to Medicare." *American Journal of Gastroenterology* 108, no. 1 (2013): 10-15.

Lipton, Barry, Dan Corro, Natasha Moore, and John Robertson. "Effectiveness of Wc Fee Schedules: A Closer Look." National Council on Compensation Insurance, Inc., 2009.

McGirt, M. J., S. S. Godil, A. L. Asher, S. L. Parker, and C. J. Devin. "Quality Analysis of Anterior Cervical Discectomy and Fusion in the Outpatient Versus Inpatient Setting: Analysis of 7288 Patients from the Nsqip Database." [In eng]. *Neurosurg Focus* 39, no. 6 (Dec 2015): E9.

Munnich, E. L., and S. T. Parente. "Procedures Take Less Time at Ambulatory Surgery Centers, Keeping Costs Down and Ability to Meet Demand Up." *HEALTH AFFAIRS* 33, no. 5 (2014): 764-69.

Nguyen, C., A. Milstein, T. Hernandez-Boussard, and C. M. Curtin. "The Effect of Moving Carpal Tunnel Releases out of Hospitals on Reducing United States Health Care Charges." [In eng]. *J Hand Surg Am* 40, no. 8 (Aug 2015): 1657-62.

Ohsfeldt, Robert L., Pengxiang Li, John E. Schneider, Ivana Stojanovic, and Cara M. Scheibling. "Outcomes of Surgeries Performed in Physician Offices Compared with Ambulatory Surgery Centers and Hospital Outpatient Departments in Florida." *Health Services Insights* 10 (2017).

Paquette, I. M., D. Smink, and S. R. Finlayson. "Outpatient Cholecystectomy at Hospitals Versus Freestanding Ambulatory Surgical Centers." [In eng]. *J Am Coll Surg* 206, no. 2 (Feb 2008): 301-5.

Parcells, B. W., D. Giacobbe, D. Macknet, A. Smith, M. Schottenfeld, D. A. Harwood, and S. Kayiaros. "Total Joint Arthroplasty in a Stand-Alone Ambulatory Surgical Center: Short-Term Outcomes." [In eng]. *Orthopedics* 39, no. 4 (Jul 01 2016): 223-8.

Plotzke, M. R., and C. Courtemanche. "Does Procedure Profitability Impact Whether an Outpatient Surgery Is Performed at an Ambulatory Surgery Center or Hospital?" [In eng]. *Health Econ* 20, no. 7 (Jul 2011): 817-30.

"Report to the Congress: Medicare Payment Policy." 131-54: Medicare Payment Advisory Commission, 2017.

Robertson, John, and Dan Corro. "Demographic Factors to Consider: Calculating Lifetime Awards on Workers Compensation ", 1-4: National Council on Compensation Insurance, 2005.

Savych, Bogdan. "Comparing Payments to Ambulatory Surgery Centers and Hospital Outpatient Departments, 2nd Edition." Cambridge, Massachusetts: Workers Compensation Research Institute, 2016.

———. "Payments to Ambulatory Surgery Centers, 2nd Edition." Cambridge, Massachusetts: Workers Compensation Research Institute, 2016.

Savych, Bogdan, and Vennela Thumula. "Comparing Outcomes for Injured Workers in North

Carolina." Cambridge, Massachusetts: Workers Compensation Research Institute, 2016.

Suskind, A. M., R. L. Dunn, Y. Zhang, J. M. Hollingsworth, and B. K. Hollenbeck. "Ambulatory Surgery Centers and Outpatient Urologic Surgery among Medicare Beneficiaries." [In eng]. *Urology* 84, no. 1 (Jul 2014): 57-61.

Suskind, A. M., Y. Zhang, R. L. Dunn, J. M. Hollingsworth, S. A. Strope, and B. K. Hollenbeck. "Understanding the Diffusion of Ambulatory Surgery Centers." *SURGICAL INNOVATION* 22, no. 3 (2015): 257-65.

Szabad, Melissa, Melesa Freerks, and Meggan Bushee. "Reverse Migration?: A Trend of Asc Conversion to Hopd." McGuire Woods 2013.

White, Chapin. "A Comparison of Two Approaches to Increasing Access to Care: Expanding Coverage Versus Increasing Physician Fees." *Health Services Research* 47, no. 3pt1 (2012): 963-83.

Wolfson, J., G. Walker, and P. J. Levin. "Freestanding Ambulatory Surgery: Cost-Containment Winner?" [In eng]. *Healthc Financ Manage* 47, no. 7 (Jul 1993): 26-30, 32.

# SURGICAL CENTER OF GREENSBORO

An affiliate of SCA

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, Surgical Center of Greensboro, LLC & the Orthopaedic Surgical Center offers this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

Surgical Center of Greensboro, LLC & the Orthopaedic Surgical Center are located in Greensboro (Guilford County) and are multi-specialty ambulatory surgical centers ("ASC"). Surgical Center of Greensboro, LLC & the Orthopaedic Surgical Center currently provide surgical procedures to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs like ours for the services we provided injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at our facility. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

As a member of the North Carolina Ambulatory Surgical Center Association, we support and echo the comments being submitted by the Association.

We ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Jennifer Graham
RNFA, CASC, CNOR | CEO
Surgical Center of Greensboro / Orthopaedic Surgical Center |
www.surgicalcenterofgreensboro.com
1211 Virginia Street / 1101 Carolina Street Greensboro NC 27401
(336)272-0012 ext. 5281(o) | (336)207-1308(c) | (336)544-2150(f)
jennifer.graham@scasurgery.com

FAYETTEVILLE AMBULATORY SURGERY CENTER
an affiliate of SCA

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, Fayetteville Ambulatory Surgery Center offers this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

Fayetteville Ambulatory Surgery Center is located in Fayetteville (Cumberland County) and is a multi-specialty ambulatory surgical center ("ASC"). Fayetteville Ambulatory Surgery Center currently provides surgical procedures to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs like ours for the services we provided injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at our facility. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

As a member of the North Carolina Ambulatory Surgical Center Association, we support and echo the comments being submitted by the Association.

We ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Teresa L Craven

1781 Metromedical Drive | Fayetteville, NC 28304 | 910.323.1647 | Fax 910.323.4142 | www.fayettevilleasc.com

# THE EYE SURGERY CENTER OF THE CAROLINAS

an affiliate of SCA

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, The Eye Surgery Center of the Carolinas offers this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

The Eye Surgery Center of the Carolinas is located in Southern Pines (Moore County) and is a comprehensive ophthalmology ambulatory surgical center ("ASC"). The Eye Surgery Center of the Carolinas currently provides surgical procedures to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs like ours for the services we provided injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at our facility. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

As a member of the North Carolina Ambulatory Surgical Center Association, we support and echo the comments being submitted by the Association.

We ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Kathy Stout RN, CEO

Kathy Stout RN, CEO

# CHARLOTTE SURGERY CENTER

*an affiliate of* ***SCA***

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, Charlotte Surgery Center offers this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

Charlotte Surgery Center is located in Charlotte (Mecklenburg County) and is a multi-specialty ambulatory surgical center ("ASC"). Charlotte Surgery Center currently provides surgical procedures to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs like ours for the services we provided injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at our facility. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

As a member of the North Carolina Ambulatory Surgical Center Association, we support and echo the comments being submitted by the Association.

We ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

C.E.O.
Mobile: 704-617-7324
Email: thomas.lally@scasurgery.com

# BLUE RIDGE SURGERY CENTER

an affiliate of SCA

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, Blue Ridge Surgery Center offers this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

Blue Ridge Surgery Center is located in Raleigh (Wake County) and is a multi-specialty ambulatory surgical center ("ASC"). Blue Ridge Surgery Center currently provides surgical procedures to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs like ours for the services we provided injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at our facility. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

As a member of the North Carolina Ambulatory Surgical Center Association, we support and echo the comments being submitted by the Association.

We ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Kathy Gill, CEO

2308 Wesvill Court | Raleigh, NC 27607 | 919.781.4311 | Fax 919.781.0625 | www.blueridgesurgerycenter.com

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

From: Charles Hord, M.D.
14017 Island Drive
Huntersville, NC 28078

Date: August 14, 2017

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, I offer this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

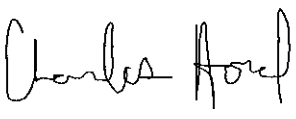
I am an anesthesiologist practicing in Charlotte, Mecklenburg County, currently providing services to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not fairly reimburse ASCs for the services provided to injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at ASCs. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

I support and the comments submitted by the North Carolina Ambulatory Surgical Center Association, and ask that the Commission complete a addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,



Charles Hord, M.D.

Mallard Creek
SURGERY CENTER
9848 North Tryon St. ■ Charlotte, NC 28262 ■ 704.548.5200

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, University Surgery Center (dba Mallard Creek Surgery Center) offers this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

Mallard Creek Surgery Center is located in Charlotte, Mecklenburg County, and is a single-specialty orthopedic ambulatory surgical center ("ASC"). Mallard Creek Surgery Center currently provides surgical procedures to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs like ours for the services we provided injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at our facility. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

As a member of the North Carolina Ambulatory Surgical Center Association, we support and echo the comments being submitted by the Association.

We ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Matthew Kersten, MS, MBA
Director, Facility Relations
matthew.kersten@orthocarolina.com

Greenman
EYE ASSOCIATES

2801 Randolph Road, Suite 200, Charlotte, NC 28211
704-375-2101 • Fax: 704-375-2107 • www.greenmaneyeassociates.com

August 14, 2017

To: North Carolina Industrial Commission

430 N. Salisbury Street

Raleigh, NC 27603

Via: Kendall Bourdon

IC Rulemaking Coordinator

Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, I offer this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

I am an ophthalmologist practicing in Charlotte, Mecklenburg County, currently providing surgical services to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs for the services provided to injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at ASCs. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

I support and echo the comments submitted by the North Carolina Ambulatory Surgical Center Association, and ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Herbert E. Greenman, M.D

MAXWELL GREENMAN, M.D. *Adult* 6- *Pediatric Ophthalmology* · *Laser Vision Correction* = *Cataract* 6- *Glaucoma Surgery* · *Eye Lid* 6- *Muscle Surgery*
DAVID GREENMAN, M.D. *Vitreo-Retinal Diseases* » *Macular Degeneration* » *Diabetic Retinopathy* 6- *Uveitis* = *Consultative Ophthalmology*
HERB GREENMAN, M.D. *Laser Vision Correction* » *Cataract* 6- *Glaucoma Surgery* · *Diabetic* 6- *Macular Degeneration. Plastic Surgery* 6- *Strabismus*

# CHRISTENBURY EYE CENTER

*Jonathan D. Christenbury, M.D., F.A.C.S*
*Medical Director*

*Nicole C Rist, OD*

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, I offer this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

I am an ophthalmologist practicing in Charlotte, Mecklenburg County, currently providing surgical services to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs for the services provided to injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at ASCs. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

I support and echo the comments submitted by the North Carolina Ambulatory Surgical Center Association, and ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Jonathan D. Christenbury, M.D.

Jonathan Christenbury

8/14/2017
Date

*3621 Randolph Road*
*Suite 100*
*Charlotte, NC 28211*
*704-332-9365*
*877-702-2020*
*Fax 704-364-7384*

*www.christenbury.com*

William A. Branner III, M.D.
Brandon C. Whiteside, M.D.
Boyd K. Vaziri, M.D.

CHARLOTTE OPHTHALMOLOGY
Center for Sight & Center for Facial Plastic Surgery

Charlotte
4335 Colwick Road
Charlotte, NC 28211
(704) 364-7400
FAX: (704) 364-9830

Lake Norman
16610 Birkdale Commons Parkway
Huntersville, NC 28078
(704) 895-8200
FAX: (704) 655-8399

www.eyesoncharlotte.com

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, I offer this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

I am an eye surgeon practicing in Charlotte, Mecklenburg County, currently providing surgical services to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs for the services provided to injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at ASCs. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

I support and echo the comments submitted by the North Carolina Ambulatory Surgical Center Association, and ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

William A. Branner, M.D.

EASTERN REGIONAL SURGICAL CENTER

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, Eastern Regional Surgical Center offers this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

Eastern Regional Surgical Center is located in Wilson (Wilson County) and is a multi-specialty ambulatory surgical center ("ASC"). Eastern Regional Surgical Center currently provides surgical procedures to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs like ours for the services we provided injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at our facility. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

As a member of the North Carolina Ambulatory Surgical Center Association, we support and echo the comments being submitted by the Association.

We ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Ann DuPree Orr

Ann DuPree Orr RN, BSN, CNOR
Administrator

1709 Medical Park Drive • Wilson, NC 27893 • [252] 237.5649 • Fax [252] 237.4977

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, Greensboro Specialty Surgical Center offers this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

Greensboro Specialty Surgical Center is located in Greensboro (Guilford County) and is a multi-specialty ambulatory surgical center ("ASC"). Greensboro Specialty Surgical Center currently provides surgical procedures to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs like ours for the services we provided injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at our facility. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

As a member of the North Carolina Ambulatory Surgical Center Association, we support and echo the comments being submitted by the Association.

We ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Dennis Murphy

Sports Medicine & Joint Replacement of GREENSBORO
STEVE LUCEY, M.D.

An affiliate of Wake Forest Baptist Health

200 W. Wendover Avenue
Greensboro, NC 27401
p 336.333.6443
f 336.333.6441

148 Pointe South Drive
Randleman, NC 27137
p 336.799.4433
f 336.799.4436

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, Orthopedic Surgery Center on Carolina Street offers this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

Orthopedic Surgery Center on Carolina Street is located in Greensboro, NC in Guilford County and is a multi-specialty ambulatory surgical center ("ASC"). Orthopedic Surgery Center on Carolina Street currently provides surgical procedures to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs like ours for the services we provided injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at our facility. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

As a member of the North Carolina Ambulatory Surgical Center Association, we support and echo the comments being submitted by the Association.

We ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Stephen D. Lucey, MD

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, I offer this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

I am an orthopedic surgeon practicing in Charlotte, Mecklenburg County, currently providing surgical services to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs for the services provided to injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at ASCs. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

I support and echo the comments submitted by the North Carolina Ambulatory Surgical Center Association, and ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Virginia F. Casey, M.D.

OrthoCarolina

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen and Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, I offer this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

I am an orthopedic surgeon practicing in Charlotte, Mecklenburg County, currently providing surgical services to injured workers under North Carolina's Workers' Compensation system. The proposed permanent rule does not appropriately reimburse ASCs for the services provided to injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at ASCs. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison. I support and echo the comments submitted by the North Carolina Ambulatory Surgical Center Association, and ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Donald F. D'Alessandro, M.D.
***Sports Medicine***
***Shoulder and Elbow Surgery***
***Arthroscopic and Reconstructive Knee Surgery***

**Sports Medicine Center**
**1915 Randolph Road, Charlotte, NC 28207**
**Phone 704-323-3000 Fax 704-323-3537**

**James E. Fleischli, MD**
*Fellowship Director*
*OrthoCarolina - Sports Medicine*
*Shoulder and Elbow Surgery*

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, I offer this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

I am an orthopedic surgeon practicing in Charlotte, Mecklenburg County, currently providing surgical services to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs for the services provided to injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at ASCs. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

I support and echo the comments submitted by the North Carolina Ambulatory Surgical Center Association, and ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

*James E. Fleischli, MD*

James E. Fleischli, M.D.

Practice Address: 1915 Randolph Road, 1st Floor, Charlotte, NC 28207
Phone: 704 323-2776 Fax: 704 323-3537

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, I offer this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

I am an orthopedic surgeon practicing in Charlotte, Mecklenburg County, currently providing surgical services to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs for the services provided to injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at ASCs. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

I support and echo the comments submitted by the North Carolina Ambulatory Surgical Center Association, and ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Michael D. Paloski, D.O.

**R. Glenn Gaston, M.D.**
Hand and Upper Extremity
Orthopaedic Surgery

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, I offer this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

I am an orthopedic surgeon practicing in Charlotte, Mecklenburg County, currently providing surgical services to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs for the services provided to injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at ASCs. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

I support and echo the comments submitted by the North Carolina Ambulatory Surgical Center Association, and ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

R. Glenn Gaston, M.D.

OrthoCarolina Hand Center
1915 Randolph Road, Charlotte, NC 28207
Phone 704-323-2426

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

Dear Chairman Allen & Commissioners:

As permitted in the North Carolina Industrial Commission's ("Commission") June 15, 2017 Notice of Proposed Permanent Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, I offer this letter in opposition to the proposed permanent rule published by the Commission addressing the fee schedule for ambulatory surgical center ("ASC") services in workers' compensation cases.

I am an orthopedic surgeon practicing in Charlotte, Mecklenburg County, currently providing surgical services to injured workers under North Carolina's Workers' Compensation system.

The proposed permanent rule does not appropriately reimburse ASCs for the services provided to injured workers. The new fee schedule also does not include many surgical procedures that could safely be performed at ASCs. The result will be that injured workers will have to go to hospital settings for these procedures, delaying access to care and driving up costs to businesses.

The Commission's fiscal note fails to account for these impacts and also uses the wrong baseline for comparison.

I support and echo the comments submitted by the North Carolina Ambulatory Surgical Center Association, and ask that the Commission complete a fiscal note that addresses our concerns and revise the proposed permanent rule accordingly.

Sincerely,

Robert B. McBride, Jr., M.D.

**Mitchell**
6220 Greenwich Drive
San Diego, California 92122
858.368.7000 | 800.238.9111
mitchell.com

## From Mitchell International – Workers' Compensation Solutions

This communication provides Mitchell's comments on rules proposed by the North Carolina Industrial Commission as a proposed draft rulemaking.

**Comments on Draft Rules:**
Rule 04 NCAC 10J .0103

**Comment 1:**
We need clear guidance in the regulation and on North Carolina website (FAQs) as to the effective dates of this proposed rule if adopted and previous ASC reimbursement beginning 4/1/2015.

August 14, 2017

To: North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Via: Kendall Bourdon
IC Rulemaking Coordinator
Delivered via email to kendall.bourdon@ic.nc.gov

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Sincerely,

J. Kent Ellington, M.D.

**Roy A. Majors, M.D.**

Sports Medicine
Knee & Shoulder Surgery
Arthroscopy

August 14, 2017

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R A Majors MD

Roy A. Majors, M.D.

*Carroll P. Jones, M.D.*
*Orthopedic Foot and Ankle Surgeon*
*OrthoCarolina Foot & Ankle Institute*

August 14, 2017

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Raleigh, NC 27603

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Carroll P. Jones, M.D.

*OrthoCarolina Foot and Ankle Institute 2001 Vail Avenue Suite 200 B Charlotte, North Carolina 28207*
*Telephone: 704 323-3060 Fax: 704 323-3935*