STATE OF NORTH CAROLINA

BEFORE THE NORTH CAROLINA INDUSTRIAL COMMISSION

NOVEMBER 18, 2016

PUBLIC HEARING BEFORE THE FULL COMMISSION

REGARDING

PROPOSED TEMPORARY RULE AMENDING RULE 04 NCAC 10J .0103

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# A P P E A R A N C E S

COMMISSIONERS:

Charlton L. Allen, Chairman

Bernadine S. Ballance

Linda Cheatham

Christopher C. Loutit

Tammy R. Nance

# I N D E X



# E X H I B I T S

P R O C E E D I N G S

CHAIRMAN ALLEN: Okay. We are on the record. Good afternoon. Today is November 18, 2016. This is a North Carolina Industrial Commission public hearing on proposed rulemaking. I'm Charlton Allen, Chairman of the North Carolina Industrial Commission. In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, I remind all members of the Commission of their duty to avoid conflicts of interest under 138A. I also inquire as to whether there is any known conflict of interest to any matters coming before the Commission at this time. Hearing none, we will proceed. The purpose of this hearing is to receive comments from the public regarding 04 NCAC 10J .0103 proposed for temporary rulemaking by the Commission and submitted for publication on the Office of Administrative Hearings' website on October 18, 2016. We have not yet received comments – written comments from the public, but the record will be held open to receive written comments from the public through the close of business in – on November 29, 2016. At this time, I would like to introduce the other Commissioners. To my right are Commissioners Bernadine Ballance and Christopher Loutit, and to my left are Commissioners Linda

Cheatham and Tammy Nance. Commissioner Daughtridge could not be with us today. At this time, the Commission wishes to thank members of the public and the various stakeholders who attended our public comment meeting on October 3rd, 2016, and gave comments or proposals regarding the rulemaking options considered by the Commissioners. The Commission very much appreciates everyone's time and efforts in that regard. Anyone who wishes to speak at this hearing must sign up to do so with Kendall Bourdon - Ms. Bourdon, would you please raise your hand – so that we have the correct spelling of your name and can call you in order to speak. If anybody would like to speak and has not yet signed up, please do so now. Seeing no movement toward Ms. Bourdon's table, the first speaker will be Kendall Bourdon, the rulemaking coordinator, followed by the members of the public in the order that they have signed up. Ms. Bourdon.

KENDALL BOURDON

CHAIRMAN ALLEN: Ms. Bourdon, will you please state your name, position and with whom you work?

MS. BOURDON: My name is Kendall Bourdon, and I am the rulemaking coordinator for the North Carolina Industrial Commission.

CHAIRMAN ALLEN: And do you have any prepared

exhibits that you would like to place into the record of these proceedings?

MS. BOURDON: I do. I have Exhibit 1, which is a copy of the proposed rule amendment as submitted to the North Carolina Office of Administrative Hearings, Rules Division, for publication on its website on October 18th, 2016. Next, I have Exhibit 2, which is a copy of the Superior Court Decision in the case Surgical Care Affiliates, LLC, versus North Carolina Industrial Commission, No. 16-CVS-0060, Wake County Superior Court. And finally, I would like to submit Exhibit 3, which is a record of the public comment meeting held by the Commission on October 3rd, 2016.

(Exhibit Numbers 1, 2 and 3 are identified.)

CHAIRMAN ALLEN: And would you briefly give us some background and list the rules that would be affected by the proposed rule changes?

MS. BOURDON: Yes. We have one rule for a temporary rulemaking. This rule is found in Title 04 of the Administrative Code, Subchapter 10J. We propose to amend Rule .0103, titled Fees for Institutional Services. This proposed temporary rule would be effective January 1, 2017. This temporary rule is proposed pursuant to North Carolina General

Statute 150B-21.1(a)(5). The effects of the August 9th, 2016 Decision in Surgical Care Affiliates, LLC, versus North Carolina Industrial Commission, which was submitted as Exhibit 2 in this proceeding, necessitate the expedited implementation of this temporary rule. This recent Court Decision invalidated the Industrial Commission's medical fee schedule provisions for ambulatory surgery centers which had taken effect April 1, 2015, based on the Court's interpretation of Session Law 2013-410, Section 33(a), and the application of its fiscal note exemption language. Due to the Court Decision, the medical fee schedule as applied only to ambulatory surgery centers reverts back to the pre-April 1, 2015 provisions which provided for a maximum reimbursement rate of 67.15 percent of billed charges, resulting in an unforeseen retroactive and prospective multi-million dollar increase in costs to the workers' compensation system. Although the August 9, 2016 Decision has been stayed by the Superior Court during the appeal to the North Carolina Court of Appeals, it is the Industrial Commission's statutory obligation to adopt a rule as quickly as possible to restore balance to the workers' compensation system pursuant to North Carolina General Statute 97-26 in the event the Decision is upheld on

appeal. By putting a temporary rule in place as soon as possible, the period of time subject to a potential retroactive invalidation of the ambulatory surgery center fee schedule provisions will be limited to April 1, 2015 to December 31st, 2016, providing certainty regarding medical costs for 2017 and beyond. Prior to proposing the temporary rule, the Industrial Commission voluntarily held a non-mandatory public comment meeting on October 3rd, 2016, and accepted written comments from September 2nd, 2016 through October 10th, 2016, in order to allow any person or entity the opportunity to present comments and proposals regarding potential rulemaking options to address the effects of the August 9th, 2016 Court Decision. The record of that meeting and all proposals and comments received in conjunction with that meeting has been submitted as Exhibit 3 here in this proceeding. The Commission gave thorough consideration to all comments and materials presented in formulating the proposed temporary rule. The proposed temporary rule was submitted to the North Carolina Office of Administrative Hearings, Rules Division, on October 18th, 2016. The rule was published on their website on October 21st, 2016. Simultaneously, notice of the proposed rule was posted

on the Industrial Commission website as required by statute. Also, notice was emailed with a link to this rule to the Commission's Rules Listserv. This is an interested person's Listserv that we are required to maintain.

CHAIRMAN ALLEN: Okay. Do any members of the Commission have questions for Ms. Bourdon? Okay. If not, you may return to your seat.

MS. BOURDON: Thank you.

CHAIRMAN ALLEN: Thank you.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: The first speaker will be Ms. Kelli Collins. Ms. Collins, if you would step up to this table (indicating).

KELLI COLLINS

MS. COLLINS: This looks like something I could really hurt myself on.

CHAIRMAN ALLEN: It's all right. Take your time.

MS. COLLINS: And you were so graceful.

CHAIRMAN ALLEN: Ms. Collins, would you please state your name for the record and tell us whom you represent, if any particular organization?

MS. COLLINS: Yes. My name is Kelli Collins, and I'm the regional vice-president of operations for Surgical Care Affiliates, and that's who I'm

representing today.

CHAIRMAN ALLEN: Okay. And please also identify the specific proposed rule or rules you will be addressing in your remarks.

MS. COLLINS: I'm going to look at my attorney and let him give me those numbers.

UNIDENTIFIED SPEAKER: 04 NCAC 10J .0103.

CHAIRMAN ALLEN: Okay. All right. We'll be happy to hear from you.

MS. COLLINS: Thank you. SCA is proud to operate seven ambulatory facilities – or ASCs in North Carolina. SCA's full response to the temporary rule will be submitted for the record. SCA opposes the Commission's proposed temporary rule for the following reasons: The temporary rule is not cost effective and does not meet North Carolina statutory requirements. The reduction in rates to two hundred percent of Medicare ASC fee schedule would be very harmful to the workers' compensation system. There is no statutory authority for adopting a temporary rule. North Carolina – 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' Comp Act and that providers are reimbursed reasonable fees for

providing these services. The Commission's proposed temporary rule does not meet these requirements since the proposed fee schedule does not include all procedures that can be performed safely in an ambulatory surgery center. By crafting a fee schedule that uses only Medicare as its foundation, the proposed rule does not include a wide variety of procedures that can be performed safely and cost effectively on the working age population. Even with the allowance for usual and customary payment for surgical procedures that are not included in the Medicare ASC fee schedule, there will remain a great uncertainty and likelihood that there will be numerous disputes that will need to be resolved by the Industrial Commission and/or the Courts. This uncertainty of whether and in what amount ASCs will be reimbursed for surgical procedures as not covered by Medicare will create access issues and will increase costs since these procedures will be done in higher cost hospital inpatient settings. Additionally, the proposed temporary rule does not separate reimbursement for implants. The failure to separately reimburse for implants results in even less reimbursement to ambulatory surgery centers and reduces the incentive to provide services involving

high cost implants. In contrast, hospitals will be able to recover higher implant costs by shifting patients to higher cost implant inpatient settings for those surgical procedures. Reducing the fee schedule to two hundred percent of ASC Medicare would also have a greater negative effect on workers' access to surgical care. Given how many injured North Carolinians depend on the community-based surgical care that ASCs provide this represents a real threat to patients in our state. Currently, injured workers are forced to receive treatment in more expensive inpatient settings where scheduling services often takes longer and can result in delays in care. Even the Commission admits this since it has said that this reimbursement disparity would – and I quote, "…potentially diminish the pool of doctors available to treat injured employees and reduce the quality and timeliness of care." The Commission went on to concede – and again, I quote, "That impact will likely be most severely realized on our state's more rural areas where the quality and availability of effective treatment is already a great concern." SCA agrees that the only way to ensure injured workers access to high-quality, effective care is to create a parity between the ASC and the hospital outpatient fee

schedules. Lastly, the Commission's notice of its intent to adopt a temporary rule – the Commission states that the reason is the recent Court Order entered by Wake County Superior Court Judge Paul Ridgeway. However, Judge Ridgeway's Decision does not provide a basis for adopting a temporary rule and bypassing the requirements for permanent rulemaking. North Carolina General Statute allows an agency to adopt a temporary rule only under very limited circumstances. A court can only be the basis for temporary rulemaking if that court order requires the immediate adoption of a rule. There is nothing in Judge Ridgeway's Decision that requires the adoption of a temporary rule. Instead, in setting aside the invalid ASC schedule, Judge Ridgeway's Decision clearly states that the fee schedule adopted in 2013 continues to be effective. SCA recommends that the Commission initiate rulemaking with the proposed fee schedule recommendation in SCA's September proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs and results in substantial savings to the workers' compensation system in North Carolina. We believe that any proposed action taken should give North Carolina's injured workers access to

high-quality, community-based care that they need and deserve. Thank you again for the opportunity.

CHAIRMAN ALLEN: Thank you, Ms. Collins. Commissioners, do you have questions for Ms. Collins?

COMMISSIONER BALLANCE: No.

CHAIRMAN ALLEN: Okay. Thank you so much.

MS. COLLINS: Thank you.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: The next speaker in order will be Mr. Andy Ellen. Mr. Ellen, if you would step forward.

ANDY ELLEN

MR. ELLEN: Thank you, Chairman Allen, and members of the Industrial Commission. I'm Andy Ellen. I'm president and general counsel of the North Carolina Retail Merchants Association, and I'm also the spokesman today for a number of groups, and I think John McMillan appeared for our group last time, but was unavailable to be here, and so I'm John's substitute - not nearly as good as John, but John's substitute today, and I'm here on behalf of the following groups, and I can provide this list as well: Capital Associated Industries, the North Carolina Association of County Commissioners, the North Carolina Association of Self-Insurers, the North Carolina Automobile Dealers Association, the North

Carolina Chamber of Commerce, the North Carolina Farm Bureau and their affiliated companies, the North Carolina Forestry Association, the North Carolina Home Builders Association, the North Carolina League of Municipalities, the North Carolina Manufacturers Alliance, the North Carolina Retail Merchants Association, the American Insurance Association and Property and Casualty Insurers of America Association, Builders Mutual Insurance Company, Dealers Choice Mutual Insurance Company, First Benefits Insurance Mutual, Forestry Mutual, the Employers Coalition and WCI, Incorporated. First, I would like to say thank you. John McMillan appeared before you, and as I think you very adequately described, this process that is before you was the – was the subject of a much negotiated agreement between a number of parties that lasted over three years, and I unfortunately was the one that tried to sort of herd the cats on that, and this is the project that will not end, and I appreciate you taking swift action after Judge Ridgeway's Decision to try and address this issue. We are very much – and I – in referencing the Rule 04 NCAC 10J .0103, specifically Subsection (g), that you have gone in and adopted a fee schedule of two hundred percent of Medicare - and frankly, that was what we

all thought we were doing for all providers at the time we came to that agreement between the hospitals, the physicians, people that we thought had the apparent and actual authority to represent the Orthopedic Association, including the ambulatory surgical centers, as well as the business community and all of the insurance community. And through that three-year process and numerous studies, we thought we were taking care of all the providers and everybody was adequately represented at the table, and so the two hundred percent that you have put in, which was phased in over a three – over a three-step process that you did – we thought that's what we had all done, and we appreciate that you have gone back and trying to rectify that and put clearly in the law what we all thought was the case anyway, so thank you very much for that. I do want to sort of make a couple of statements about Ms. Collins' statement about being, you know, not adequate reimbursement for ambulatory surgical centers. You know, we did a very thorough investigation, hired a consultant to do a study for us, looked at WCRI data, and I think what we found was, you know, in South Carolina the Medical Plus rate was a hundred and forty percent; in Tennessee, it was a hundred and fifty percent. And if you also look at,

you know, I think, the comments that we had back – that John McMillan submitted, we stated that for some procedures – for instance, ASC reimbursement prior to the changes that you made. For a knee arthroscopy, it was thirty-one percent higher than median and forty-nine percent higher than the shoulder arthroscopies procedure prior to what you did, higher than the thirty-three state median. What you have done with the two hundred percent figure is got into that margin of what is a reasonable fee, and again, one that was phased in over three – over three steps to better adequately allow – I think the hospitals referred to at that time as a softer landing so that they could prepare for it, so I appreciate that part of it. I will say – and Ms. Collins referenced the question about procedures that are not allowed to be done in an – in an ambulatory surgical center, and I think you tried to address that in here to allow them to do that, and I think as a provider community – I mean as an employer community, as an insurer community, we very much support them having the ability to do those procedures. Medicare, you know, has not approved that, but you are trying to find a methodology to get there, and I think that's the benefit of everybody, if they have the ability to

compete, but I do think there may be – and Ms. Collins makes one part that I will agree with. You could potentially with a usual and customary charge be creating a little bit of uncertainty in that or some more people coming before you to argue about what the applicable rates are. We would sort of – our – what we would propose on that last section is tweak that a little bit and let them perform those procedures, but use the same type of methodology that they have for outpatient. As I understand it, for outpatient procedures, Medicare pays hospitals a slight higher fee because they have bundled healthcare. They have to serve everybody, and they allow them to make that cost up. Under the current with the usual and customary, you're in a sense could be paying more to an ambulatory surgical center for a procedure Medicare does not let them provide, and so what we would propose – and I don't know what the number is yet – that you pay ambulatory surgical centers a percentage of what you're paying hospitals for those items that are – that hospitals are allowed to provide under Medicare, but currently ambulatory surgical centers are not allowed to provide. So I don't know if that – what that figure is yet. I will point to Surgical Care Affiliates – their September the 20th, 2016

investment report, which I'm glad to provide, where they readily say that they provide forty-five percent savings off of hospital outpatient procedures, and so I think that's a place you could start, which is, you know, fifty-five percent of what you're paying for the hospital on those procedures that Medicare does not cover in an ambulatory surgical center. I'm not saying that's the right number, but certainly a number that we could start and investigate real quickly along with some of the other participants in this discussion, but I think that would solve a couple of things. If you did the two hundred percent as you have proposed and as we, again, very much thank you for doing on the procedures that are covered by Medicare ambulatory surgical centers are allowed to do, and then for those procedures that Medicare does not allow ambulatory surgical centers to perform, let them perform them, come up with a specific rate so that people aren't coming before you arguing that a rate is not adequate. And again, I think you can use the same methodology and do a percentage off of what the hospitals are being paid for those very same services, and I think that would benefit both ambulatory surgical centers – I think it would also benefit the provider community. It would benefit the

workers as well and would provide adequate reimbursement as evidenced by what some of the other states pay, as you're charged with doing by the General Assembly, and what Surgical Care Affiliates have said in their very own documents is a savings off of that. Lastly, I think, if possible, 97-26(c) allows for some negotiation between providers should they wish to do that. I – it was unclear if that's still preserved. We would like to have that ability if a provider or self-insurer or insurer would like to negotiate further with a provider, whether it be a surgical care or - an ambulatory surgical center or whoever it may be - that they can still have that ability to negotiate more. We're not sure quite if that was in here or not, but I would make that last point so – and with, Mr. Chairman, I do not have any other comments, and we will be submitting written comments hopefully in the next week.

CHAIRMAN ALLEN: Okay. All right. Commissioners, do you have any questions for Mr. Ellen? Okay. All right. Thank you, Mr. Ellen.

MR. ELLEN: Thank you, Mr. Chairman; thank you Commissioners.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: Okay. And the next speaker will

be Mr. Ronnie Cook.

RONNIE COOK

CHAIRMAN ALLEN: Mr. Cook, would you please state your name and tell whom you represent, if any particular organization?

MR. COOK: Yes. Thank you. My name is Ronnie Cook, and I represent the North Carolina Hospital Association, all the hospital and health systems in North Carolina, as well as their affiliated employed and physicians.

CHAIRMAN ALLEN: Okay. And please identify the specific proposed rule that you wish to address in your remarks.

MR. COOK: Okay. And I'm here to talk about 04 NCAC 10J .0103, specifically Subsections (g) and (h).

CHAIRMAN ALLEN: Okay. All right. We'll be happy to hear from you, sir.

MR. COOK: Okay. On Subsection (g), which is the maximum reimbursement rate for institutional services provided by an ambulatory surgical center, it's two hundred percent of the Medicare ASC facility specific amount. We are in agreement with that amount. We think it's an appropriate reimbursement amount. It is consistent with the logic that was provided earlier in Andy's comments as he related to the prior

negotiation. Obviously, hospitals get a mark-up – a similar mark-up on Medicare rates. Obviously, when we moved from this section, from our percent of charge-type reimbursement to this more fixed rate related to Medicare – a mark-up on Medicare, that resulted in significant savings related to the payers and to the – and to the individuals involved. Hospitals understood this, realized this and were in acceptance of this, and we were thinking at that point during that negotiation that this applied to all providers. Also, another key point of this is going to the fixed rate versus any sort of percent of charge or any type of unbundling-type logic is you do get the bundled services. You do get a fixed and a very predictable amount of service. All of the services that are billed as part of these codes that are billed to Medicare are rolled up based on status indicators and are paid accordingly, so it is a bundled payment, so there is savings to the carriers, as well as savings to the member, and it's very significant. We are in agreement with that. We think that it would be inappropriate to pay ambulatory surgery centers at a rate higher than you would pay a hospital because, in theory, if you think about the industry standard, there is truly a hierarchy of care, and that hierarchy

of care goes anywhere from licensure all the way up through the type of services rendered, the type of costs, what they can do – the services that those particular facilities can do. For example, you have services that can be provided in a physician office. Then you go up from there to a freestanding ambulatory surgery center, and they obviously can only provide care for up to twenty-four hours. Then you go into a hospital outpatient department, and they can provide care beyond that, but, ultimately, they need to – they deal with higher regulations, higher costs, more intense services, sicker patients in a lot of cases, and therefore – and then you go from that to an inpatient setting. And if you think about the concept at an ambulatory surgery center, obviously, they can provide care to a point, but if something goes bad in that situation, they have to go to a hospital, and the same thing at a hospital outpatient. If something goes south in that particular procedure, then we have the inpatient setting, so there is a hierarchy of care in that and there are higher costs as you go through that hierarchy, and therefore, it makes sense that - and Medicare has recognized this, so it definitely makes sense, and other payers as well – managed care payers, as well as Medicaid - so it makes sense that

there's a comparable relationship between payments, so we believe that the two hundred percent of Medicare for ASC is a valid and appropriate payment. Okay. As we move to Section (h), now Section (h) tries to deal with those services on a particular addendum in the Medicare rule, which is Addendum EE, which is surgical procedures excluded from payment in an ASC for calendar year 2017, but it could be for any calendar year because there will be services. These are codes that Medicare has deemed that is inappropriate to be performed in an ASC for various clinical reasons. We have analyzed those specific codes that would be excluded, especially the ones that had an OPPS – or hospital status indicator, which means they could be done in a hospital outpatient setting. There's two hundred and – two thousand and ninety-six codes on that list. Of those, one thousand, seven hundred and forty-seven are codes which have an outpatient status indicator of C, which means they really should be inpatient only, so these are codes that Medicare feels should be only inpatient. And then, in addition, there's twenty-one codes where Medicare says that there should be no additional payment, so these are codes that they call package codes. They have a status indicator of N, and that means they should be

packaged and paid as part of another service, you know, so what we're talking about then is somewhere in the neighborhood of two or three hundred codes that clinically probably could be performed at an ASC, as well as performed in an outpatient setting. And we're in agreement and see no reason that an ambulatory surgery center would not be eligible to provide those services as well as a hospital outpatient department, which is consistent with Andy's comments. We see no reason that there should not be a difference in that. However, going beyond that, now there could be, I guess, in a few rare, rare cases the potential that someone that's less than sixty-five years old with physician advisement would be able to have some services performed that would be on an inpatient only list for Medicare, so the younger folks may be able to tolerate such a procedure where some folks over Medicare age would not. We do understand that under certain statutes already that there is a UCR-type reimbursement for that, but we think that would be unusual in nature. There would not be that many of those cases. And at that point, we think the UCR, since it is an exception-type basis, may be appropriate, but when you get into Section (h) and we talk about how to reimburse these other procedures, we

do not think it's appropriate to have a UCR-type reimbursement. We think it's a burdensome process, an administratively cost process, and, in addition, it potentially could undermine the fixed payment versus the unbundled payment for charges. It also could result in payment being higher to the ambulatory surgery center versus the hospital which is – it's on the hospital fee schedule, so they would be getting two hundred percent of the Medicare fee schedule, so it's potential that those rates could be higher. We do not think that is appropriate because we do believe that there is a true hierarchy of care and a hierarchy of costs that should be recognized. Therefore, we do believe - again, as what Andy was talking about earlier - that there should be a difference. There should be a difference, and it should relate to the hospital outpatient fee schedule. Again, I've looked up some information today. Obviously, we saw what Andy quoted at that – the percentages that he got out of the – out of the presentations that were made earlier. I've looked at some – an OIG report that was done in 2017. It says that number might be in the neighborhood of sixty-seven percent. I've looked at a MedPAC report. They have differing numbers, and so – but we believe there is a difference. And we – and,

obviously, if you're getting two hundred percent of a Medicare fee schedule for ASC and two – and there's a slightly higher number for hospitals – two hundred percent – we think that that relationship should be maintained for those procedures that are not on the ambulatory surgery fee schedule, but are on the hospital outpatient fee schedule, so there is a difference. There's an ambulatory surgery fee schedule, and they list a lot of procedure codes. There are certain procedure codes that Medicare say they don't think it's appropriate for the ambulatory surgery center to do, but they have said that a hospital outpatient can do those, so those procedure codes – that difference - we're saying is appropriate for the ambulatory surgery center to do those in this setting, but we think that the relationship between the payment should be consistent. So we have a two hundred percent of hospital outpatient now. We have two hundred percent of ASC, so as we move away from the fee schedules, that relationship should stay. That difference, whatever it is, whatever it is, should stay, should be consistent so the ambulatory surgery centers would have an incentive. The payers would have an incentive theoretically to use ambulatory surgery centers if they think it's

appropriate. The payers would have an incentive because payment is fixed. They understand what it's going to be. It's a reduction from what it was, obviously, on a percent of charge basis. So it looks from our point of view that it makes common sense and everybody wins. It's a win-win for everybody in that particular setting. Now one way you could do this – we have thought about a process that if you wanted to, instead of looking at outsider, independent numbers, you could run a relationship between the fee schedules. Obviously, Medicare – when Medicare publishes their fee schedules, they do it by code – by surgical procedure code, and there's a related reimbursement. There's a status indicator that tells whether it's paid for or not, and there's a reimbursement code. And we specifically think that any modification in this area – that the only way we would pay for a service is if it – if the payment code is allowed under Medicare outpatient prospected payments, so there would be caveat with that, but we would compare those two codes for the same services that are on both fee schedules. So, if I have an ASC fee schedule for Medicare and I have a code, I find that corresponding code on the hospital outpatient. If it's a match code and it's reimbursable under both,

then I compare the two fee schedules. That would give me a relationship. I do that for every code that matches. So I take the aggregate of all of that and do a relationship, and whatever that relationship is in aggregate could be applied to these codes where there is a difference, and that would maintain the integrity of what we talked about earlier, that the fee schedules are paid under the same basis. Now I'm available for any questions that you might have.

CHAIRMAN ALLEN: Commissioners, do you have any questions?

COMMISSIONER BALLANCE: Yeah. I'm trying to understand your last point. So you're saying that if a doctor who provides at an ASC the same service that a doctor is providing - or could be – could provide on an outpatient basis there is a reasonable basis for the reimbursement to the ASC to be less than the reimbursement to the outpatient facility. And other than the relationship that you – the fact that the ASC codes are being reimbursed at a lower rate, what is the – your rationale for the reduction in the reimbursement rate for the ASC service?

MR. COOK: Well, it's not really a reduction. What it is is keeping the – because what you have proposed in (g) is two hundred percent of Medicare on

the ASC fee schedule. What hospitals get reimbursed now is two hundred percent of Medicare reimbursement on the outpatient prospected payment fee schedule. There is already an inherent difference, so if I'm on – if I do a service and I'm on either one of those fee schedules, there will be a difference in payment.

COMMISSIONER BALLANCE: That's (unintelligible).

MR. COOK: If you do it at an ASC, it will be a certain rate. If you do it at a hospital, it will be a different rate. It could be the same rate, but I think the way Medicare set those up that it's designed where the ASC would never get paid more than a hospital, so there is a difference now when it's on a fee schedule, so there's already that difference. So what we're – what we're, I guess, proposing is that same logic, that same difference should apply to these other services that theoretically Medicare says that ASC shouldn't do.

COMMISSIONER BALLANCE: Right. And the---

MR. COOK: And so we're saying that same relationship. So if you think it's appropriate that the payments are where they need to be under what you proposed, then what we're saying is you take that same logic and you put it over here for this bundle of codes and services right now that it says an ASC can't

do.

COMMISSIONER BALLANCE: Right.

MR. COOK: Does that make sense?

COMMISSIONER BALLANCE: Well, it – I understand what you're saying, but the basis for the reduction comes from how Medicare values the services within their system of taking lots of factors into consideration. The two hundred percent is two hundred percent. The difference comes from Medicare – the Medicare variable, it would appear. It's – so---

MR. COOK: Well---

COMMISSIONER BALLANCE: ---Medicare says ASCs shouldn't be providing – say, it's a surgery – this type of surgery. It sounds like what you're saying is - ASCs are saying we can – we should and we can. You're agreeing that ASC can---

MR. COOK: Uh-huh.

COMMISSIONER BALLANCE: ---and it's the same thing that would happen at an outpatient facility, but you want to maintain the Medicare lower rate or variable or multiplier, however you do it. You want to maintain Medicare's rationale---

MR. COOK: Uh-huh.

COMMISSIONER BALLANCE: ---even though it's a service that Medicare doesn't recognize as being

performed – capable – or should – Medicare is saying that this is a service that we are not going to reimburse if it's performed at an ASC. Is---?

MR. COOK: Yeah, because if you think about it, there's a list of those services on the hospital fee schedule that Medicare says a hospital shouldn't do as an outpatient. It's the same logic. There's a list of services that they set. If Medicare – any time – for example, every year, Medicare looks at the clinical validity of providing services in different settings---

COMMISSIONER BALLANCE: Uh-huh.

MR. COOK: ---and invariably, every year, they add additional services to the ambulatory surgery fee schedule because physicians in the surgery centers are getting better at being able to do those services in that setting and they feel like it's appropriate to do it, even though there's only a twenty-four hour service capability available at ASC, so every time Medicare adds. They added six more services this year in the final rule that just came out. Well, when they add those services, they use that same logic.

COMMISSIONER BALLANCE: Uh-huh.

MR. COOK: It's on the fee schedule now, and it's basically on the same logic, so we're saying that if

Medicare had these services that we're saying it's okay for an ASC to do, even though it's not on their fee schedule - then if Medicare did that, they would use the same logic. They would put it under their – under their fee schedule at the same approach, so we're saying that that's what we should do, and the reason – there is a difference in the hierarchy. They pay – obviously, they pay hospital inpatient more than they pay hospital outpatient. They pay hospital outpatient more than they pay ambulatory surgery centers, and they pay surgery centers far more than they pay physicians, even though in some cases they may be doing similar services, and they do that because there is a far different cost associated with doing that. Obviously, hospitals have more demands and more regulatory burdens. They need – they provide emergency care, safety – their safety-net hospitals, their disaster hospitals. Their patients generally are sicker when they get there because there is a hierarchy of where those services should be performed, and that's why there's a difference in payment because of that, because it actually costs far more. Because when a surgery center - if I – again, like I said before, if I have surgery in a surgery center and something goes bad, they have to send me to the

hospital, and that's a more costly environment, but they have to do that.

COMMISSIONER BALLANCE: Okay.

MR. COOK: Obviously, when they do it over there, there's no intent for that, and, historically, there's a good percentage that you would have that service done there and done well there, and that's probably the appropriate setting.

COMMISSIONER BALLANCE: Is what you are proposing currently happening between the outpatient and the hospital? For example, if Medicare says this service ought to be provided at a hospital, but it is provided in the outpatient setting, is that – well, how is it billed? Is it billed outpatient, or is it billed hospital?

MR. COOK: It's billed hospital outpatient, and it goes against the hospital outpatient fee schedule, and we get two hundred percent of that. So, if there is a procedure – a surgical procedure code that's on our fee schedule, then we would bill it hospital outpatient, and it would be paid at the – at two hundred percent. Now, you know if for some reason there was a decision made that it should be done inpatient, then that's paid at a DRG. That's a total different payment methodology. That's totally

different if someone would say it had to be done inpatient, but if it's billed that way, it would bill hospital outpatient. We would get the mark-up, whatever that particular mark-up percentage is for the time period that we're in, against the Medicare fee schedule, and that's what will happen with the ASC. If an ASC does the – a procedure, whatever it may be, if it's on their fee schedule, they will get two hundred percent of that, but then there's going to be some codes that aren't on their fee schedule, and so one could argue don't let them do that at all. You know, you could---

COMMISSIONER BALLANCE: I understand.

MR. COOK: ---argue that because you don't let hospitals do that necessarily. You could argue that, but we don't think that's totally appropriate for these type of patients that are younger in age. We do think that it would – you know, that there – a lot of advancements have been made and what can be done outpatient, and we're okay to allow that to be done, if you will, or propose that that be done on an outpatient setting.

COMMISSIONER BALLANCE: Okay. Let me---

MR. COOK: We just think there needs to be a relationship in payment, that there---

COMMISSIONER BALLANCE: Let me understand. If Medicare says a particular procedure should be done inpatient and they don't have an outpatient code for it, but that procedure is provided outpatient, it is billed outpatient – the Medicare schedule for outpatient for that instead of inpatient. Is that your understanding?

MR. COOK: I'm not sure I – are you saying if it's – you're saying if a hospital does an inpatient procedure on an outpatient basis?

COMMISSIONER BALLANCE: Right. Is it billed inpatient or outpatient?

MR. COOK: I guess if all the parties, including the physician, were in agreement that it should be done outpatient, even if it's not on that schedule, then I assume under current regulation it would – it would go to UCR, if I understood right – correctly. We would bill it – if everybody says it should be outpatient, we would bill it outpatient if that's what the agreement was with all the parties, and I'm assuming then that the current regulation, which is a UCR payment, would come into play. And the reason you have to do that – and you can't do the relationship between the same logic that we're proposing for outpatient. The outpatient is you can't do the same

concept that I agreed to on outpatient to inpatient because they're paid totally different under Medicare.

COMMISSIONER BALLANCE: I understand.

MR. COOK: They're – there's a DRG payment which is far different than---

COMMISSIONER BALLANCE: I understand.

MR. COOK: ---an APC-type payment, so there's no relationship that you can---

COMMISSIONER BALLANCE: I understand.

MR. COOK: ---develop.

COMMISSIONER BALLANCE: Okay. Thank you.

MR. COOK: It's somewhat complex because you---

COMMISSIONER BALLANCE: Yeah.

MR. COOK: ---have to understand billing. You have to understand care and the way reimbursement is designed and developed. We're just saying that there should be a constant relationship. If it's okay to pay them two hundred percent of the ambulatory fee schedule here on services that are on the fee schedule, then that same logic should occur for those services that aren't on the fee schedule that are still done as an outpatient and payable.

CHAIRMAN ALLEN: Other questions from the Commission?

MR. COOK: Very good.

CHAIRMAN ALLEN: All right. Mr. Cook, I have a question.

MR. COOK: Certainly.

CHAIRMAN ALLEN: I understand the logic of what you're saying and that relationship. Help me to understand, though, the practical aspect of what you're asking the Commission to do in the alternative to what's been proposed regarding these EE codes. How do we get there if we were to adopt whatever it is you're proposing?

MR. COOK: So the logic could be – basically, it would say something that for those codes on that Addendum EE that are not inpatient only-type codes and they are payable under the hospital outpatient OPPS - so, in other words, we have payable codes under outpatient PPS. If those two codes – when they match, then the Commission is proposing to pay X percent of the hospital outpatient prospected payment fee schedule or X percent of two hundred percent of, so what you would do is you would take the outpatient prospected payment fee schedule. You will find the same code over there on that particular schedule, and let's say it's $100, and let's say the percentage relationship – if the OIG schedule is right and it's about sixty-five percent, which seems to be consistent

with some of the numbers floating around, then you – if it's a thousand bucks, you pay six hundred and fifty bucks. It will be an automatic. The payers would know exactly what to do. The ASCs would know exactly what to expect on payment when they did it. Everybody would know. There would be no UCR negotiation, no what does UCR mean, any – it would be a – it would be a slam dunk.

CHAIRMAN ALLEN: All right.

COMMISSIONER CHEATHAM: And whatever that percentage turned out to be, you would propose that that be applied in the aggregate to any---?

MR. COOK: Yeah, for all the codes---

COMMISSIONER CHEATHAM: Okay.

MR. COOK: ---on the two. I mean – I mean you could do it.

COMMISSIONER CHEATHAM: Right.

MR. COOK: You could do it code by code, but that just makes---

COMMISSIONER CHEATHAM: I just wanted to make---

MR. COOK: ---it far more complex.

COMMISSIONER CHEATHAM: No, no, no, I'm not advocating that. No.

MR. COOK: Yeah, yeah - I mean but it's just trying to keep it simple, I guess, is what we're

trying to---

COMMISSIONER CHEATHAM: Right.

MR. COOK: You could do code by code, but that would – that would be difficult for the payers, I think.

CHAIRMAN ALLEN: And the Commission.

MR. COOK: This you would put in regulation that it's sixty-five percent. As long as it's payable on the OPPS schedule, then you're going to pay sixty-five percent, whatever the number is. Now you can – I mean that number potentially could change every year, and you could either lock it in stone and say it's sixty-five percent, whatever it is now it's going to be that way, you know, or you could say you're going to update it annually. That would be another option if you want to complex – make it a little bit complex.

CHAIRMAN ALLEN: Okay. Any other questions? Hearing none---

MR. COOK: Okay.

CHAIRMAN ALLEN: ---thank you, Mr. Cook.

MR. COOK: Thank you.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: If any of the speakers today prepared a summary of your remarks, please provide them to the court reporter at this time. We thank you

for your inputs, and we'll consider all your comments. I want to thank each of you for participating in this public hearing. The period for written comments will be held open through the close of business on November 29, 2016, so if you have further comments, please send them to Ms. Bourdon as directed in the hearing notice on the Commission website and the Office of Administrative Hearings' website. The written comments and the comments made at the hearing today will be made part of the public record of these proceedings. We would like to include in the transcript of this proceeding the materials submitted by Ms. Bourdon as Exhibits 1, 2 and 3.

(Exhibits 1, 2 and 3 are admitted into the record.)

CHAIRMAN ALLEN: And I'm not aware of any materials that have been submitted to the court reporter. Are there any further matters to come before the public hearing? If not, the hearing is adjourned. Thank you. And we will go off the record.

(WHEREUPON, THE HEARING WAS ADJOURNED.)

RECORDED BY MACHINE

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

STATE OF NORTH CAROLINA

COUNTY OF GUILFORD

C E R T I F I C A T E

I, Kelly K. Patterson, Notary Public, in and for the State of North Carolina, County of Guilford, do hereby certify that the foregoing thirty-eight (38) pages prepared under my supervision are a true and accurate transcription of the testimony of this trial which was recorded by Graham Erlacher & Associates.

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

WITNESS my Hand and Seal on this 21st day of November 2016.

My commission expires on December 3, 2018.

Kelly K. Patterson

NOTARY PUBLIC

Kelly K. Patterson
Notary Public
Guilford County
North Carolina
My Commission Expires 12/3/2018

*Note from the Codifier: The OAH website includes notices and the text of proposed temporary rules as required by G.S. 150B-21.1(a1). Prior to the agency adopting the temporary rule, the agency must hold a public hearing no less than five days after the rule and notice have been published and must accept comments for at least 15 business days.*
*For questions, you may contact the Office of Administrative Hearings at 919.431.3000 or email oah.postmaster@oah.nc.gov.*

**TITLE 04 – DEPARTMENT OF COMMERCE**

**Rulemaking Agency:** *North Carolina Industrial Commission*

**Codifier of Rules** ***received for publication the following notice and proposed temporary rule(s) on:*** *October 18, 2016*

**Rule Citations:** *04 NCAC 10J .0103*

**Public Hearing:**
**Date:** *November 18, 2016*
**Time:** *1:00 p.m.*
**Location:** *Room 2149, Utilities Commission Hearing Room, 2nd Floor, Dobbs Building, 430 North Salisbury Street, Raleigh, NC 27603*

**Reason:** *A recent court order, Surgical Care Affiliates, LLC v. North Carolina Industrial Commission, No. 16-CVS-0060 (Wake County Superior Court).*

*The effects of the August 9, 2016 decision in Surgical Care Affiliates, LLC v. North Carolina Industrial Commission, No. 16-CVS-0060 (Wake County Superior Court) necessitate the expedited implementation of this temporary rule. This recent court decision invalidated the Industrial Commission's medical fee schedule provisions for ambulatory surgery centers which had taken effect April 1, 2015, based on the court's interpretation of Session Law 2013-410, Section 33(a), and the application of its fiscal note exemption language. Due to the court decision, the medical fee schedule, as applied only to ambulatory surgery centers, reverts back to the pre-April 1, 2015 provisions which provided for a maximum reimbursement rate of 67.15% of billed charges, resulting in an unforeseen retroactive and prospective multi-million dollar increase in costs to the workers' compensation system. Although the August 9, 2016 decision has been stayed by the Superior Court during the appeal to the North Carolina Court of Appeals, it is the Industrial Commission's statutory obligation to adopt a rule as quickly as possible to restore balance to the workers' compensation system pursuant to N.C. Gen. Stat. § 97-26 in the event the decision is upheld on appeal. By putting a temporary rule in place as soon as possible, the period of time subject to a potential retroactive invalidation of the ambulatory surgery center fee schedule provisions will be limited to April 1, 2015 to December 31, 2016, providing certainty regarding medical costs for 2017 and beyond.*

**Comment Procedures:** *Comments from the public shall be directed to: Kendall M. Bourdon, 4333 Mail Service Center, Raleigh, NC 27699-4333, phone (919) 807-2644, email kendall.bourdon@ic.nc.gov. The comment period begins October 19, 2016 and ends November 29, 2016.*

**CHAPTER 10 - INDUSTRIAL COMMISSION**

**SUBCHAPTER 10J – FEES FOR MEDICAL COMPENSATION**

**SECTION 0100 – FEES FOR MEDICAL COMPENSATION**

**04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES**

(a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services shall be based on the current federal fiscal year's facility-specific Medicare rate established for each institutional facility by the Centers for Medicare & Medicaid Services ("CMS"). "Facility-specific" rate means the all-inclusive amount eligible for payment by Medicare for a claim, excluding pass-through payments. An institutional facility may only be reimbursed for hospital outpatient institutional services pursuant to this Paragraph and Paragraphs (c), (d), and (f) of this Rule if it qualifies for payment by CMS as an outpatient hospital.

(b) The schedule of maximum reimbursement rates for hospital inpatient institutional services is as follows:
- (1) Beginning April 1, 2015, 190 percent of the hospital's Medicare facility-specific amount.
- (2) Beginning January 1, 2016, 180 percent of the hospital's Medicare facility-specific amount.
- (3) Beginning January 1, 2017, 160 percent of the hospital's Medicare facility-specific amount.

(c) The schedule of maximum reimbursement rates for hospital outpatient institutional services is as follows:
- (1) Beginning April 1, 2015, 220 percent of the hospital's Medicare facility-specific amount.
- (2) Beginning January 1, 2016, 210 percent of the hospital's Medicare facility-specific amount.
- (3) Beginning January 1, 2017, 200 percent of the hospital's Medicare facility-specific amount.

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

(e) The schedule of maximum reimbursement rates for inpatient institutional services provided by CAHs is as follows:
- (1) Beginning April 1, 2015, 200 percent of the hospital's Medicare CAH per diem amount.

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

(f) The schedule of maximum reimbursement rates for outpatient institutional services provided by CAHs is as follows:
(1) Beginning April 1, 2015, 230 percent of the hospital's Medicare CAH claims payment amount.
(2) Beginning January 1, 2016, 220 percent of the hospital's Medicare CAH claims payment amount.
(3) Beginning January 1, 2017, 210 percent of the hospital's Medicare CAH claims payment amount.

(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register ("the Medicare ASC facility-specific amount"). Reimbursement shall be based on the fully implemented payment amount in Addendum ~~AA, Final~~ AA (Final ASC Covered Surgical Procedures for CY ~~2015,~~ 2017) and Addendum ~~BB, Final~~ BB (Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for ~~2015,~~ 2017) as published in the Federal Register, or their successors. The maximum reimbursement rate for institutional services provided by ambulatory surgical centers is 200 percent of the Medicare ASC facility-specific amount.

~~(h) The schedule of maximum reimbursement rates for institutional services provided by ambulatory surgical centers is as follows:~~
~~(1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility-specific amount.~~
~~(2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.~~
~~(3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.~~

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

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

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

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

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

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

FILED

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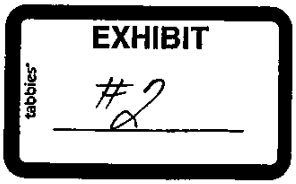
| STATE OF NORTH CAROLINA | IN THE GENERAL COURT OF JUSTICE |
| COUNTY OF WAKE 2016 AUG -9 PM 2:51 | SUPERIOR COURT DIVISION<br>16-CVS-00600 |
| SURGICAL CARE AFFILIATES, LLC, BY | |
| Petitioner, | |
| v. | **DECISION** |
| NORTH CAROLINA INDUSTRIAL COMMISSION, | |
| Respondent. | |

This matter came before the undersigned Superior Court Judge of Wake County upon a Petition for Judicial Review filed by Petitioner Surgical Care Affiliates, LLC ("SCA") pursuant to Article 4 of the North Carolina Administrative Procedure Act ("APA"). Petitioner seeks reversal of the December 14, 2015 Declaratory Ruling entered by Respondent North Carolina Industrial Commission ("the Commission") denying the declaratory relief sought in SCA's October 1, 2015 Request for Declaratory Ruling filed with the Commission.

After review and consideration of the Official Record and the filings and arguments of the parties, this Court has concluded that the Commission's Declaratory Ruling should be reversed.

## THE PARTIES

SCA manages seven ambulatory surgical centers in North Carolina and has an ownership interest in each of these centers through wholly owned subsidiary corporations (hereinafter "SCA Ambulatory Surgical Centers"). (Record page 8, hereinafter "R p __"). The SCA Ambulatory Surgical Centers are located throughout North Carolina and include Blue Ridge Day Surgery Center at 2308 Westfield Court in Raleigh, Wake County, North Carolina. (R p 8).



The Commission is an agency of the State of North Carolina created by the General Assembly and has the responsibility for administering the North Carolina Workers' Compensation Act ("the Act"). N.C. Gen. Stat. § 97-77. Among its responsibilities, the Commission adopts rules setting forth a schedule of maximum fees for medical compensation to be paid to injured employees who are covered by the Act. N.C. Gen. Stat. § 97-26(a). As a State agency, the Commission is subject to the rule-making requirements of Article 2A of the APA. N.C. Gen. Stat. §§ 150B-2(1a), 150B-18.

## SCA'S REQUEST AND THE COMMISSION'S DECLARATORY RULING

On October 1, 2015, SCA filed with the Commission a Request for Declaratory Ruling. (R p 8–25). In SCA's Request, SCA sought a ruling from the Commission declaring invalid those parts of the Commission's rules with an effective date of April 1, 2015 that changed the workers' compensation maximum fee schedule for services provided by ambulatory surgical centers. (R pp 8–25). In its Request for Declaratory Ruling, SCA contended that the Commission failed to adopt a new fee schedule for ambulatory surgical centers in substantial compliance with the rule-making requirements of Article 2A of the APA because the Commission had failed to prepare or obtain the fiscal note and certifications from the Office of State Budget and Management required under N.C. Gen. Stat. §§ 150B-21.2(a) and 150B-21.4(b1). (R pp 9–10). On October 30, 2015, the Commission granted SCA's request for a declaratory ruling and indicated that a ruling on the merits would be issued within 45 days. (R p 6).

On December 14, 2015, the Commission issued its Declaratory Ruling. The Ruling concluded that the Commission had followed the law in adopting a new maximum fee schedule

for ambulatory surgical centers and declined to declare those parts of its rules invalid as requested by SCA in its Request for Declaratory Ruling. (R pp 2–5).

On January 13, 2016, SCA filed a Petition for Judicial Review pursuant to Article 4 of the APA seeking reversal of the Commission's Declaratory Ruling and a decision invalidating those parts of the Commission's rules that changed the ambulatory surgical center fee schedule.

**THE MOTION TO INTERVENE AS AMICI CURIAE**

Ten days prior to the week of the hearing on SCA's Petition for Judicial Review, Greensboro Orthopedics, P.A., OrthoCarolina, P.A., Raleigh Orthopaedic Clinic, P.A., Surgical Center of Greensboro, LLC, Southeastern Orthopaedic Specialists, P.A., Orthopaedic & Hand Specialists, P.A., Cary Orthopaedic and Sports Medicine Specialists, P.A., and Stephen D. Lucey (collectively "the Movants" or "Intervenors") filed a Motion to Intervene as *Amici Curiae*. Along with the Motion, Movants filed a Brief. Attached to Movants' Brief is an Affidavit of Conor Brockett, Associate General Counsel for the North Carolina Medical Society. In response to the Motion to Intervene, Respondent filed an objection to Movants' Motion to Intervene as *Amici Curiae* and a Motion to Strike the Affidavit of Conor Brockett and the attachment to that Affidavit, as well as all references to the Affidavit and exhibit within the body of Movants' brief.

In reaching the decision on the relief requested in SCA's Petition for Judicial Review, the undersigned has disregarded and not considered the Affidavit of Conor Brockett and attached exhibit and has disregarded any references to the Affidavit and exhibit in Movants' Brief. Respondent's Motion to Strike has been granted. The Affidavit of Conor Brockett and exhibit are not part of the record in this case.

In its discretion, this Court has allowed Movants' Motion to Intervene in this judicial review proceeding for the limited purpose of filing the *Amici Curiae Brief* without the Affidavit of Conor Brockett and exhibit.

## STANDARD OF REVIEW

Article 4 of the APA governs judicial review of a declaratory ruling. N.C. Gen. Stat. §§ 150B-43 *et seq.* The Commission's issuance of a Declaratory Ruling upholding the validity of rule provisions challenged by SCA is a decision that is subject to judicial review under Article 4 of the APA. *See* N.C. Gen. Stat. § 150B-4(a1)(2).

In its Petition for Judicial Review, SCA contends that the Commission's Declaratory Ruling is in excess of its statutory authority, made upon unlawful procedure, and affected by other error of law. Because of these errors asserted by the SCA, this Court has applied the *de novo* standard of review to review the Commission's decision as required under N.C. Gen. Stat. § 150B-51(c).

## ANALYSIS

The Commission, pursuant to N.C. Gen. Stat. § 97-26, is required to adopt by rule a schedule of maximum fees for medical compensation. The fees adopted by the Commission in its schedule must be adequate to ensure that (i) injured workers are provided the standard of services and care intended by North Carolina Workers' Compensation Act, (ii) providers are reimbursed reasonable fees for providing services, and (iii) medical costs are adequately contained. N.C. Gen. Stat. § 97-26(a).

Prior to the promulgation of the rules at issue in this case, the Commission, in accordance with the statutory mandate set out in N.C. Gen. Stat. § 97-26, adopted through rule-making procedures its "Fees for Medical Compensation" published at 04 NCAC 10J .0101. This rule

consisted of a "Medical Fee Schedule" and a "Hospital Fee Schedule" (the "Prior Rule"). The "Medical Fee Schedule" of the Prior Rule set maximum amounts that could be paid for "medical, surgical, nursing, dental and rehabilitative services, and medicines, sick travel and other treatment, including medical and surgical supplies, and original artificial members." The "Hospital Fee Schedule" of the Prior Rule set maximum amounts that could be paid for "inpatient hospital fees," "outpatient hospital fees," and "ambulatory surgery fees."

On August 23, 2013, Session Law 2013-410 was enacted into law. Section 33.(a) of Session Law 2013-410 provided the following:

> **SECTION 33.(a)** Industrial Commission Hospital Fee Schedule:
>
> (1) Medicare methodology for physician and hospital fee schedules. – With respect to the schedule of maximum fees for physician and hospital compensation adopted by the Industrial Commission pursuant to G.S. 97-26, those fee schedules shall be based on the applicable Medicare payment methodologies, with such adjustments and exceptions as are necessary and appropriate to ensure that (i) injured workers are provided the standard of services and care intended by Chapter 97 of the General Statutes, (ii) providers are reimbursed reasonable fees for providing these services, and (iii) medical costs are adequately contained. . . .
>
> . . .
>
> (3) Expedite rule-making process for fee schedule. - The Industrial Commission is exempt from the certification requirements of G.S. 150B-19.1(h) and the fiscal note requirement of G.S. 150B-21.4 in developing the fee schedules required pursuant to this section.

Notably, in Session Law 2013-410, Section 33.(a), the General Assembly provided for an expedited rule-making process for the new fee schedules which bypassed the certification and fiscal note requirements that would otherwise be required prior to adoption of a fee schedule. Although the certification requirements of N.C. Gen. Stat. § 150B-19.1(h) became moot when those requirements were repealed by Session Law 2014-112, Section 6(a), there are certification requirements in preparing the fiscal note described in N.C. Gen. Stat. § 150B-21.4(b1).

In response to this Session Law, the Commission undertook a process to modify its fee schedules and ultimately amended 04 NCAC 10J .0101 and adopted two rules: (1) a rule setting fees for "Professional Services," 04 NCAC 10J.0102, which sets fees for physicians and health care providers; and (2) the rule at issue in this matter, 04 NCAC 10J.0103, entitled "**Fees for Institutional Services.**" In adopting the "Fees for Institutional Services" rule, the Commission did not prepare or obtain a fiscal note, relying upon the exemption language set forth in Session Law 2013-410, Section 33.(a)(3). The fee schedule set forth in the new "Fees for Institutional Services" rule includes separate subsections setting forth maximum fees for "**hospital** inpatient institutional services," "**hospital** outpatient institutional services," "critical access **hospital**" inpatient and outpatient services, and "institutional services provided by **ambulatory surgical centers.**"

Petitioner, an owner and operator of ambulatory surgical centers, seeks declaratory relief from this Court on the grounds that the Commission exceeded the statutory authority of Session Law 2013-410, Section 33.(a) by adopting a fee schedule pertaining to ambulatory surgical centers without complying with the fiscal note requirements of N.C. Gen. Stat. §§ 150B-21.2(a) and 150B-21.4. Specifically, Petitioner, joined by Intervenors for the purposes of this Petition, contends that the General Assembly, in Session Law 2013-410, Section 33.(a), mandated only that new schedules of maximum fees for **physicians** and **hospitals** be adopted under an expedited rule-making process, so as to ensure that the maximum fees of **physicians** and **hospitals** be based on the applicable Medicare payment methodologies.

Petitioners and Intervenors contend that they, as **ambulatory surgical centers**, are legally distinct from **hospitals** and that because the General Assembly mandated new fee schedules for physicians and hospitals, and not ambulatory surgical centers, the Commission did

not have statutory authority to adopt new fee schedules relating to ambulatory surgical centers under the expedited rule-making process.

North Carolina law defines a "**hospital**" as:

> any facility which has an organized medical staff and which is designed, used and operated to provide health care, diagnostic and therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered of the supervision and direction of physicians licensed under Chapter 90 of the General Statutes, Article 1, to two or more persons over a period in excess of 24 hours.

N.C. Gen. Stat. § 131E-76(3).

North Carolina law defines an "**ambulatory surgical facility**" as:

> a facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours . . . .

N.C. Gen. Stat. § 131E-146(1); *see also* N.C. Gen. Stat. § 131E-176(1b) and (13) (setting forth separate definitions for hospitals and ambulatory surgical facilities). No further definition of the terms "hospital" or "ambulatory surgical facility" is contained in the statutes pertaining to the authority of the Commission to adopt fee schedules.

The Court finds and concludes that **hospitals** are separate and legally distinct entities from **ambulatory surgical centers.** The Court further finds and concludes that the plain language of the General Assembly, in enacting Session Law 2013-410, Section 33.(a), authorized the Commission to use an expedited rule-making process only in adopting new maximum fees for **physicians** and **hospitals** and that the General Assembly did not authorize the Commission to use an expedited rule-making process in adopting new maximum fees for **ambulatory surgical centers.**

As the North Carolina Supreme Court has stated on numerous occasions, when the language of a statute is clear and unambiguous, courts must give the statute its plain and definite meaning. *State v. Dellinger*, 343 N.C. 93, 95, 468 S.E.2d 218, 220 (1996); *Lemons v. Old Hickory Council, Boy Scouts of America*, 322 N.C. 271, 276, 367 S.E.2d 655, 658 (1988).

The Commission contends that because the term "Hospital Fee Schedule" is used in the heading of Section 33.(a) of Session Law 2013-410, this indicates that ambulatory surgical centers were included in the General Assembly's mandate to change the maximum fee schedules using an expedited rule-making process. The Commission contends that under the prior fee schedules, ambulatory surgical centers were included as one subsection of "Hospital Fee Schedule." However, North Carolina law is clear that captions of a statute cannot control when the text is clear. *Appeal of Forsythe County*, 285 N.C. 64, 71, 203 S.E.2d 51, 55 (1974). Respondent's argument also is contradicted by the fact that the physician fee schedule is included within the fee schedules that the General Assembly mandated be changed and physicians were not included as a subsection of "Hospital Fee Schedule" under the Prior Rule.

Unless otherwise exempted, the fiscal note requirements are part of the mandatory procedure of administrative rule-making. N.C. Gen. Stat. § 150B-21.2. Under N.C. Gen. Stat. § 150B-18, a rule is not valid unless it is adopted in substantial compliance with Article 2A of the APA. The failure of the Commission to comply with the fiscal note requirements in adopting a new fee schedule for ambulatory surgical centers cannot, in this instance, be viewed as substantial compliance with the rule-making requirements of Article 2A of the APA.

Because the Commission was required to comply with the fiscal note requirements in adopting a new fee schedule for ambulatory surgical centers and failed to do so, the Commission

exceeded its statutory authority and employed an unlawful procedure. N.C. Gen. Stat. § 150B-51(c).

Therefore, this Court finds and concludes that the Petitioner is entitled to the declaratory ruling that the Commission's attempted adoption of a new fee schedule for ambulatory surgical center services, but limited solely to those services, as set forth in 04 NCAC 10J. 0103(g) and (h) (also referenced in 04 NCAC 10J. 0103(i)), and the amendment of the Prior Rule 04 NCAC 10J .0101(d)(3), (5), and (6), to the extent that the amendment removed the old fee schedule for ambulatory surgical centers, are invalid and of no effect.

IT IS THEREFORE ORDERED, ADJUDGED, AND DECREED that the relief sought by SCA in its Request for Declaratory Ruling and Petition for Judicial Review is GRANTED and the Declaratory Ruling entered by the Commission is REVERSED.

The Commission's attempted adoption of a new fee schedule for ambulatory surgical center services, but limited solely to those services, as set forth in 04 NCAC 10J. 0103(g) and (h) (also referenced in 04 NCAC 10J. 0103(i)), and the amendment of the Prior Rule, specifically 04 NCAC 10J .0101(d)(3), (5), and (6), to the extent that the amendment removed the old fee schedule for ambulatory surgical centers, are invalid and of no effect.

This the 9 day of August 2016.

The Honorable Paul C. Ridgeway
Superior Court Judge

# North Carolina Industrial Commission

September 2, 2016

## NOTICE OF PUBLIC COMMENT MEETING

The North Carolina Industrial Commission will hold a non-mandatory public comment meeting at 1:00 p.m. on October 3, 2016, in Room 3099, Third Floor, Dobbs Building, 430 North Salisbury Street, Raleigh, NC 27603, to take public comment on and consider rulemaking options to address the effects of the August 9, 2016 court decision invalidating the April 1, 2015 medical fee schedule provisions for ambulatory surgery centers. Please click here to read the August 9, 2016 court decision.

To obtain baseline information for comparison and useful benchmarks, the Commission has requested from the North Carolina Rate Bureau (NCRB) and the National Council on Compensation Insurance (NCCI) cost analyses for the application of the following hypothetical fee schedule rates to charges for institutional services provided by ambulatory surgery centers in workers' compensation cases:

- Maximum reimbursement rate of 200 percent of the Medicare payment amount for institutional services provided by ambulatory surgery centers.
- Maximum reimbursement rate of 200 percent of the Medicare payment amount for institutional services provided by outpatient hospitals.
- Maximum reimbursement rate of 150 percent of the Medicare payment amount for institutional services provided by ambulatory surgery centers.
- Maximum reimbursement rate of 100 percent of the Medicare payment amount for institutional services provided by outpatient hospitals.

The cost analyses will apply the above hypothetical fee schedule rates to the 2016 Medicare payment amounts allowed for institutional services provided by ambulatory surgery centers and the 2016 Medicare payment amounts allowed for hospital outpatient institutional services, respectively. The payment amounts will be determined by using the final rule for the Medicare hospital outpatient prospective payment system and the Medicare ambulatory surgical center payment system for CY 2016, as published in the Federal Register. The period of medical cost data used in the analyses will be from dates of services January 1 to December 31, 2015, and the source of the medical cost data is based on NCCI's Medical Data Call for North Carolina for Service Year 2015.

NCCI and NCRB estimate that they can provide the cost analyses by September 19, 2016. Upon receipt, the Commission will publish the analyses on its website at www.ic.nc.gov/abtrules.html for use by the public in formulating any comments or proposals prior to or following the public comment meeting.



Public Comment Deadlines related to the October 3, 2016 public comment meeting:

1. Any proposals to amend the North Carolina workers' compensation medical fee schedule (Rules 04 NCAC 10J .0101, .0102, and .0103) with an earliest effective date on or about January 1, 2017, to address the effects of the August 9, 2016 court decision must be presented to the Commission no later than September 26, 2016. The proposals will be published on the Commission's website within two business days of the deadline at www.ic.nc.gov/abtrules.html.

   Such proposals shall be in writing, filed with the IC Rulemaking Coordinator Kendall Bourdon at kendall.bourdon@ic.nc.gov, and shall include at a minimum:
   a. The person or entity making the proposal with contact information;
   b. The text of a proposed rule(s) or rule amendment(s), to include any proposed maximum allowable amounts for specific DRG, CPT, or revenue codes;
   c. A detailed explanation of the proposal which shows how the proposed rule(s) or amendment(s) achieves the statutory requirements of ensuring the following:
      i. injured workers are provided the services and standard of care required by the Workers' Compensation Act,
      ii. providers are reimbursed reasonable fees for providing these services, and
      iii. medical costs in workers' compensation claims are adequately contained.

      The explanation should include an analysis of the impact of the proposal on the proponent and the workers' compensation system. The analysis should make use of the baseline comparisons and benchmarks to be provided by NCCI and NCRB, as well as any other well-documented data and information proponent wishes to present to the Commission in support of its proposal; and
   d. Any other written information or data and supporting documentation the proponent wishes the Commission to consider.

2. Any person wishing to address oral comments to the Commission at the public comment meeting on October 3, 2016, shall sign up to do so by 5:00 p.m. on September 30, 2016, by contacting IC Rulemaking Coordinator Kendall Bourdon at (919) 807-2644 or kendall.bourdon@ic.nc.gov. Oral comments addressed to the Commission shall be limited to 10 minutes per speaker.

3. Any person or entity wishing to present written comments and other documentation to the Commission in response to a proposal submitted pursuant to 1. above shall file the comments and corresponding documentation with IC Rulemaking Coordinator Kendall Bourdon at kendall.bourdon@ic.nc.gov no later than October 10, 2016. These responses will be published on the Commission's website within two business days of the deadline at www.ic.nc.gov/abtrules.html.

For additional information or for questions, you may contact Rulemaking Coordinator Kendall Bourdon at (919) 807-2644 or kendall.bourdon@ic.nc.gov or Executive Secretary Meredith Henderson at (919) 807-2575 or meredith.henderson@ic.nc.gov.

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|---|---|
| STATE OF NORTH CAROLINA<br>COUNTY OF WAKE | IN THE GENERAL COURT OF JUSTICE<br>SUPERIOR COURT DIVISION<br>16 CVS 00600 |
| SURGICAL CARE AFFILIATES, LLC,<br>*Petitioner*<br><br>v.<br><br>NORTH CAROLINA INDUSTRIAL COMMISSION,<br>*Respondent* | ORDER ALLOWING STAY |

THIS MATTER comes before the undersigned upon Respondent's Motion to Stay the Final Judgment of the Superior Court pursuant to N.C. Gen. Stat. § 150B-52 and Rule 62 of the North Carolina Rules of Civil Procedure. On August 9, 2016, the Superior Court, by and through the undersigned, issued its final judgment in the above-captioned matter, wherein the Court reversed the Respondent's Declaratory Ruling and granted the relief requested by the Petitioner. Respondent seeks, through its motion, to preserve the *status quo* of the subject matter while pursuing an appeal of the Court's final judgment. The Court has considered the record proper and the arguments of counsel.

For good cause shown, and in the discretion of the Court, the Court finds and concludes that the Motion to Stay should be allowed. Therefore, it is ORDERED that the application and effect of the Court's Final Judgment entered on August 9, 2016 in this matter is STAYED until such time that the Court of Appeals of North Carolina can rule on the matter or until this order is modified by a court of competent jurisdiction.

So ORDERED, this the 2nd day of September, 2016.

Paul C. Ridgeway, Superior Court Judge

## ANALYSIS OF ALTERNATIVES TO THE NORTH CAROLINA AMBULATORY SURGICAL CENTER FEE SCHEDULE PROPOSED TO BE EFFECTIVE JANUARY 1, 2017

**NCCI estimates that the fee schedule alternatives for Ambulatory Surgical Center (ASC) services would result in an overall impact between -0.4% (-$8.0M[1]) and +1.1% (+$21.0M) on North Carolina workers compensation system costs, if adopted.**

**The following table summarizes the alternatives and includes the estimated impacts.**

| Maximum Reimbursement for ASC | (A) Impact on ASC Services | | (B) ASC Share of Medical Costs | (C) Impact On Medical Costs (A) x (B) | | (D) Medical Costs as % of Overall Workers Compensation Benefit Costs in North Carolina | (E) Total Impact on Overall Workers Compensation System Costs in North Carolina (C) x (D) | |
|---|---|---|---|---|---|---|---|---|
| | Lower | Upper | (SY 2015) | Lower | Upper | (Eff. 1/1/2017) | Lower | Upper |
| 150% of Medicare ASC Payment Rate | -17.0% | -12.9% | 4.8% | -0.8% | -0.6% | 48.3% | -0.4% (-$8.0M) | -0.3% (-$6.0M) |
| 200% of Medicare ASC Payment Rate | -9.4% | -4.0% | | -0.5% | -0.2% | | -0.2% (-$4.0M) | -0.1% (-$1.9M) |
| 235% of Medicare ASC Payment Rate | -4.1% | +3.7% | | -0.2% | +0.2% | | -0.1% (-$1.9M) | +0.1% (+$1.9M) |
| 100% of Medicare Outpatient Prospective Payment System (OPPS) | -12.2% | -6.0% | | -0.6% | -0.3% | | -0.3% (-$6.0M) | -0.1% (-$1.9M) |
| 150% of Medicare OPPS | +2.8% | +17.7% | | +0.1% | +0.8% | | 0.0% ($0.0M) | +0.4% (+$8.0M) |
| 200% of Medicare OPPS | +25.2% | +44.9% | | +1.2% | +2.2% | | +0.6% (+$11.0M) | +1.1% (+$21.0M) |

**Summary of Proposed Medical Fee Schedule Changes**

The North Carolina Industrial Commission requested that NCCI estimate the impact on workers compensation system costs for the following fee schedule alternatives for institutional services provided by ASCs, proposed to be effective January 1, 2017:

- Maximum reimbursement rate of 150% of the 2016 Medicare ASC facility specific amount
- Maximum reimbursement rate of 200% of the 2016 Medicare ASC facility specific amount

[1] Overall system costs are based on NAIC Annual Statement data. The estimated dollar impact is the percentage impacts displayed multiplied by 2014 written premium of $1,888M from NAIC Annual Statement data for North Carolina. This figure includes self-insurance but does not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs. The potential range of dollar impacts on overall system costs, excluding self-insurance, is estimated to be between $-6M and $+16M. The data on self-insurance is approximated using the National Academy of Social Insurance's August 2015 publication "Workers' Compensation: Benefits, Coverages, and Costs, 2013."

- Maximum reimbursement rate of 235% of the 2016 Medicare ASC facility specific amount
- Maximum reimbursement rate of 100% of the 2016 Medicare Outpatient facility specific amount
- Maximum reimbursement rate of 150% of the 2016 Medicare Outpatient facility specific amount
- Maximum reimbursement rate of 200% of the 2016 Medicare Outpatient facility specific amount.

**Actuarial Analysis of Proposed Medical Fee Schedule Changes**

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

1. Calculate the percentage change in maximum reimbursements
   a. Compare the prior and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
   b. Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.

2. Estimate the price level change as a result of the proposed fee schedule
   a. NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
      i. In response to a fee schedule decrease, NCCI's research indicates that payments decline by approximately 50% of the fee schedule change.
      ii. In response to a fee schedule increase, NCCI's research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
      The formula used to determine the percent realized for fee schedule increases is 80% x (1.10 + 1.20 x (price departure)).

3. Estimate the share of costs that are subject to the fee schedule
   a. The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.

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

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for North Carolina for Service Year 2015.

- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for North Carolina from the latest two policy years projected to the effective date of the benefit changes.

**Ambulatory Surgical Center Fee Schedule**

In North Carolina, payments for ASC services represent 4.8% of total medical payments. NCCI calculated the percentage change in maximums and the percentage change in reimbursements for ASC services to estimate upper and lower bound impacts due to the proposed fee schedule changes. The estimated upper and lower bounds are calculated as follows:

Estimated Upper Bound Impact

To calculate the percentage change in maximums for ASC services, NCCI calculates the percentage change in maximum allowable reimbursement (MAR) for each procedure code listed on the fee schedule. The overall change in maximums for ASC services is a weighted average of the percentage change in MAR (proposed MAR / prior MAR) by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2015. The prior and proposed maximums are calculated as follows:

Prior MAR

Prior MAR = [Multiplier x 2015 Medicare ASC Payment Rate – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 220%

Proposed MAR – ASC-Based Alternatives

Proposed MAR = [Multiplier x 2016 Medicare ASC Payment Rate – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 150%, 200%, or 235% in three distinct scenarios

Proposed MAR – Hospital Outpatient-Based Alternatives

Proposed MAR = [Multiplier x 2016 Medicare OPPS Payment Rate – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 100%, 150% or 200% in three distinct scenarios

The overall weighted-average percentage change in maximums for each scenario for ASC services is then multiplied by the price realization factor[2]. The estimated impact on ASC costs is

[2] The price realization factor from a fee schedule increase is estimated according to the formula 80% x (1.10 + 1.20 x (price departure)). Due to the volatility observed in the price departure for ASC services, a reliable price departure could not be determined in North Carolina. In such a situation, the price realization factor for a fee schedule increase is assumed to be 80%. The price realization factor for a fee schedule decrease is expected to be 50%.

then multiplied by the percentage of medical costs attributed to ASC payments (4.8%) to arrive at the estimated impact on medical costs. The estimated impact on medical costs is then multiplied by the North Carolina percentage of benefit costs attributed to medical benefits (48.3%) to arrive at the estimated impact on overall workers compensation costs in North Carolina. The estimated impact on ASC services for each upper bound scenario is shown in the chart below.

| Medicare Payment Schedule | Medicare Multiplier | Percentage Change in MAR | Price Realization Factor | Impact on ASC Service |
|---|---|---|---|---|
| ASC | 150% | -25.8% | 50% | -12.9% |
| | 200% | -8.0% | 50% | -4.0% |
| | 235% | +4.6% | 80% | +3.7% |
| Outpatient | 100% | -11.9% | 50% | -6.0% |
| | 150% | +22.1% | 80% | +17.7% |
| | 200% | +56.1% | 80% | +44.9% |

Estimated Lower Bound Impact

To calculate the percentage change in reimbursements for ASC services, NCCI calculates the percentage change in reimbursements for each procedure code listed on the fee schedule. The overall change in reimbursements for ASC services is a weighted average of the percentage change in reimbursements by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2015. The prior and proposed reimbursements are calculated as follows:

Prior Reimbursement

Prior Reimbursement = Current Payments x Trend Factor

This calculation presumes that no Medicare-based fee schedule is currently in effect. The current payments by procedure code are obtained from NCCI's Medical Data Call for North Carolina for Service Year 2015. These payments are adjusted to reflect changes from past price levels to the price levels projected to be in effect on the effective date of the proposed fee schedule (January 1, 2017). The trend factor is based on the most recent available U.S hospital outpatient component of the medical consumer price index (MCPI) as shown below:

| Service Year | Hospital Outpatient MCPI* Change from July of previous year |
|---|---|
| 2013 | 4.8% |
| 2014 | 4.5% |
| 2015 | 3.9% |
| Average | 4.4% |

*Source: Bureau of Labor Statistics

**ANALYSIS OF ALTERNATIVES TO THE NORTH CAROLINA AMBULATORY SURGICAL CENTER FEE SCHEDULE PROPOSED TO BE EFFECTIVE JANUARY 1, 2017**

A trend factor of 1.067 is applied to ASC payments for Service Year 2015 to determine the projected payments at the January 1, 2017 price level. The trend factor is calculated in two steps:

1. Estimate the yearly Hospital Outpatient MCPI, for services years 2015 and beyond, as the arithmetic three-year average of the observed Hospital Outpatient MCPI for 2013-2015. This average is equal to 4.4% (=[4.8% + 4.5% + 3.9%] / 3).
2. Raise the value above to the number of years elapsed from the midpoint of Service Year 2015 to the proposed effective date of the fee schedule, which is 1.5 years.

Therefore, the trend factor from July 1, 2015 to January 1, 2017 is estimated as 1.067 = $1.044^{1.5}$.

Proposed Reimbursement – ASC-Based Alternatives

Proposed Reimbursement = [Multiplier x 2016 Medicare ASC Payment Rate – Multiple Procedure Discounts (if applicable)] x (1+ Price Departure)

Where Multiplier = 150%, 200%, or 235% in three distinct scenarios.
Price Departure is estimated to be -10%.

To estimate the proposed reimbursement effective January 1, 2017, NCCI compares trended payments to discounted fee schedule maximums. In general, NCCI observes that average prices paid are below fee schedule maximums. Based on a combination of actuarial judgment and observations of price departure in states that already have a fee schedule, a price departure of -10% was selected.

Packaged services are those services for which payment is packaged into payment for the associated primary service; therefore, there is no separate APC payment. Packaged services that are currently reimbursed separately are assumed to be included in the reimbursement for the primary service under the proposed fee schedule. Therefore, there is no separate proposed cost associated with packaged services. Payments for packaged services make up 6.3% of ASC costs subject to the fee schedule.

Proposed Reimbursement – Hospital Outpatient-Based Alternatives

Proposed Reimbursement = [Multiplier x 2016 Medicare OPPS Payment Rate – Multiple Procedure Discounts (if applicable)] x (1+ Price Departure)

Where Multiplier = 100%, 150% or 200% in three distinct scenarios.
Price Departure is estimated to be -10%.

The estimated impacts for the lower bound scenarios are calculated in an analogous manner to the estimated impacts for the upper bound scenarios. The estimated impact for each lower bound scenario is shown in the chart below.

## ANALYSIS OF ALTERNATIVES TO THE NORTH CAROLINA AMBULATORY SURGICAL CENTER FEE SCHEDULE PROPOSED TO BE EFFECTIVE JANUARY 1, 2017

| Medicare Payment Schedule | Medicare Multiplier | Percentage Change in Reimbursement | Price Realization Factor | Impact on ASC Service |
|---|---|---|---|---|
| ASC | 150% | -33.9% | 50% | -17.0% |
| | 200% | -18.8% | 50% | -9.4% |
| | 235% | -8.2% | 50% | -4.1% |
| Outpatient | 100% | -24.4% | 50% | -12.2% |
| | 150% | +3.5% | 80% | +2.8% |
| | 200% | +31.5% | 80% | +25.2% |

STATE OF NORTH CAROLINA

BEFORE THE NORTH CAROLINA INDUSTRIAL COMMISSION

OCTOBER 3, 2016

PUBLIC COMMENT MEETING BEFORE THE FULL COMMISSION

REGARDING

PROPOSALS FOR THE MEDICAL FEE SCHEDULE

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

A P P E A R A N C E S

COMMISSIONERS:

Charlton L. Allen, Chairman

Bernadine S. Ballance

Linda Cheatham

Bill Daughtridge, Jr.

Christopher C. Loutit

Tammy R. Nance

I N D E X

P R O C E E D I N G S

CHAIRMAN ALLEN: We are on the record. I'm Charlton Allen. I serve as Chairman of the North Carolina Industrial Commission. With me today are my fellow Commissioners. I'll start on my right - Commissioner Linda Cheatham, and then Commissioner Bill Daughtridge. And then on my left will be Commissioner Ballance - Bernadine Ballance, Commissioner Christopher Loutit and Commissioner Tammy Nance. And we want to thank each of you for being here today. This is a public hearing regarding some issues that have arisen with our Fee Schedule, and we want to thank all the interested parties who have submitted proposals and for your presentations to come today. It's my understanding - and if there are any additions or corrections to this, feel free to let me know - that the first speaker this afternoon will be Kelli Collins, who is the vice-president of operations for Surgical Care Affiliates, and also with Ms. Collins will be Renee Montgomery, who's a lawyer with Parker Poe, and Stacey Smith with Liberty Partners Group, and it's my understanding that Ms. Montgomery and Ms. Smith will be available to answer any questions or supplement that comment period. The second speaker will be John McMillan of

Manning Fulton, and he is representing other stakeholders who have expressed, you know, a proposal to the Commission. And finally, Linwood Jones with the Hospital Association will be speaking as well. As a reminder, any person or entity wishing to present written comments or other documentation to the Commission in response to a proposal or discussion here today should file the comments and corresponding documentation with the Industrial Commission Rulemaking Coordinator Kendall Bourdon. Ms. Bourdon is at - sitting over at the table to my right. These comments and documentation should be submitted no later than October 10th, 2016, and these responses will be published on the Commission's website within two business days of that deadline. If you are making comments, I will ask you to stay for the entirety of the meeting today. This is to help facilitate, if the Commissioners have any questions that arise after a follow-up speaker, that, you know, there's an opportunity to have those questions answered by the appropriate party. As we articulated in the notice of the meeting, the purpose of this meeting is to take public comment on and consider rulemaking options to address the effects of the August 9th, 2016 court Decision by Judge Ridgeway invalidating the April 1,

2015 Medical Fee Schedule provisions for ambulatory surgery centers. By way of a brief history, Surgical Care Affiliates filed a Petition for Declaratory Ruling regarding the Commission's enacted Medical Fee Schedule last fall. The Commission issued its Declaratory Ruling denying the requested relief. SCA filed a Petition for Judicial Review in Wake County Superior Court. Judge Paul Ridgeway ruled the Commission's Medical Fee Schedule to be invalid as applied to ambulatory surgery centers based on a rulemaking procedural issue going back to the language of the General Assembly Session Law instructing this transition to a Medicare-based Fee Schedule. The Judge granted the Commission's Motion for Stay of the Decision pending the outcome of this litigation on appeal. I say all this to ensure that we are all on the same page moving forward. First of all, we are not here to discuss the validity of the current rule or any of the currently pending litigation. It would be improper and inappropriate to discuss the merits of that litigation in today's setting and would defeat the purpose for which we are all gathered here today, so let's be clear. We are here to allow the public to make proposals, presentations and give oral comments and responses on what to do in light of the ruling.

Although the lower court ruling has been stayed, based on the contingency that Judge Ridgeway's Decision could be upheld on appeal, it is the Commission's responsibility to determine what to do in that potential eventuality. We are operating under the assumption that you all received the analysis provided by NCCI. I would like to provide a few comments on that analysis. As we contemplated eliciting proposals in advance of this public comment meeting, we contacted NCCI to ask if they would be willing and able to price out the various proposals that we would receive. They suggested that instead they provide a range of price proposals because that would provide a better set of benchmarks in evaluating proposals received. We understand that there is a lot of noise in these numbers. The Commission is not taking these analyses to be more than a set of benchmarks, fully aware of all the complications and factors behind these numbers. At this point, this is the best data set that we have to work with as 2015 was a transitional year in that the Medicare-based Fee Schedule went into effect on April 1st, 2015, and, of course, 2016 isn't complete, so there is no complete set of data on the Medicare-based Fee Schedule by which to analyze and compare. In addressing the

baseline use in the analysis and consultation with the actuaries and data analysis experts, the two hundred and ten percent of the Medicare ASC Fee Schedule - or fee rate was selected to be the baseline for this analysis. Because of the effect of Judge Ridgeway's Decision is to invalidate the Commission's Fee Schedule as applied to ambulatory surgery centers, meaning that the maximum reimbursement rate for ASCs revert back to the percentage of charges model, a percentage of charges analysis was not requested from NCCI because it is not a stable model or benchmark in that it is not an easily controllable metric because charges can fluctuate. From the Commission's perspective, our approach to the Medical Fee Schedule is as it should be that it requires us to balance three factors: Number one, appropriate care for injured workers; two, adopting a reasonable reimbursement rate and, three, medical cost containment. Those of you who have experience within rulemaking know that it goes much more smoothly if all stakeholders are in some sort of an agreement or can come to an agreement. The Commission recognizes that there are many competing interests involved, and the Commission hopes that this public comment meeting will allow those interests to be aired in the hopes that

the stakeholders can better understand each other's positions and potentially establish some lines of communication that will result in a reasonable compromise. We will take presentations and comments in the order that people signed up to speak, and I just went over that list. Presentations are limited to ten minutes. That does not necessarily include time spent answering questions from the Commissioners. To help facilitate that time period, to my right, Executive Secretary Meredith Henderson will be tracking that time. When each speaker is at the two-minute mark, she will raise her hand with two, and then likewise one minute, and then she will alert you when your time is up, and then we will ask you to immediately conclude your remarks. With that said, I will now yield the floor to Ms. Kelli Collins with Surgical Care Affiliates for time not to exceed ten minutes---

KELLI COLLINS

MS. COLLINS: Thank you.

CHAIRMAN ALLEN: ---and then questions to follow.

MS. COLLINS: Good afternoon.

CHAIRMAN ALLEN: Good afternoon.

MS. COLLINS: Thank you for allowing me the opportunity to speak with you today. My name is Kelli

Collins, and I'm here on behalf of Surgical Care Affiliates, which is proud to operate seven ambulatory surgery centers - or ASCs - in North Carolina. The question before this panel today is two important parts: Process and patients. And I'd like to take the opportunity to address both of those. With respect to process, three years ago, the Commission tasked a stakeholders group with developing a Fee Schedule for ambulatory surgery centers among others, but did not invite the ambulatory surgery centers to participate. This flawed process was itself without basis since the underlying 2013 legislation did not direct that the ASC Fee Schedule had to be changed. The fact was even underscored by the North Carolina Hospital Association which wrote in a memo, "The legislation did not specify that am surge rates would be changed." As a result, SCA had no option but to file a Request for Declaratory Ruling asking that Commission invalidate its new ASC Fee Schedule. The Commission refused to do so. As suggested by Chairman Heath, SCA then filed a Petition for Rulemaking with the Commission, but the Commission denied SCA's Petition. SCA appealed, and Wake County Superior Court Judge Paul Ridgeway ruled this August that the new SCA Fee Schedule is invalid and that the prior Fee

Schedule should remain in place. Since then, the Commission has filed an appeal to reverse Judge Ridgeway's Decision and is proceeding as if the Judge ruling has never been issued. Throughout this regrettable process, SCA has tried in every way to achieve resolution. Even now, we are seeking an amendment to address procedures that are not currently covered in the invalid Fee Schedule and to ensure that reimbursement allows for site of service decisions to be based solely on clinical judgment, quality outcomes and scheduling efficiencies, all for the sole benefit of the injured worker. And that brings me to the second and most important aspect of this issue: Patients. The Commission's invalidated Fee Schedule creates a significant reimbursement disparity between ASCs and hospital outpatient departments for the same services. Given how many injured North Carolinians depend on a community-based surgical care that ASCs provide, that represents a real threat to patients in our state. Currently, injured workers are forced to receive treatment in a more expensive inpatient setting where scheduling services also takes longer and results in delays of care. Even the Commission admits this since it has said the reimbursement disparity would, and I quote, "...potentially diminish

the pool of doctors available to treat injured employees and reduce the quality and timeliness of care." The Commission went on to concede, and again I quote, "That impact will most likely severely be realized in our state's more rural areas where the quality and availability of effective treatment is already a greater concern." SCA agrees that the only way to ensure injured workers across - access to high quality care and effective care is to create parity between the ambulatory surgery and hospital outpatient Fee Schedules. We therefore urge you to adopt the amendment we have proposed, which includes the following: For those procedures for which CMS has established a Medicare rate, the schedule of maximum reimbursement rates for services provided by ASCs would be the same as the maximum reimbursement rates for hospital outpatient institutional services and, two, for those procedures for which CMS has not established has not established a Medicare rate for hospital outpatient institutional services, the maximum allowable amounts for services provided by ASCs would be fifty percent of bill charges up to a cap of $30,000. Charge master increases would be limited to a zero percent increase for these procedures for the first three years or a revenue

neutral adjustment would be applied as a percentage of a charge paid. In its proposal, SCA has shown how the partially invalid rule on fees for institutional services would be amended to set forth this Fee Schedule for ASCs. The amendment would eliminate the confusion that currently exists, lower the cost for surgical treatment and increase access to timely community-based care. Moreover, an independent analysis has determined that this approach will generate overall savings to the workers' comp system in 2017 of 8.8 million dollars. In closing, we believe the proposed action should be taken both to correct serious procedural flaws and, even more important, to give North Carolinians - injured workers access to the high quality community-based care they want and deserve. Thank you again for the opportunity. I would be more than happy to address any questions you may have. I also have with me Renee Montgomery, our legal counsel, and Stacey Smith with Liberty Partners, both of whom are also available to answer questions. And I did want to take a moment to introduce the administrative members of the SCA team that are in attendance: Jenny Graham, Cathy Libel (phonetic), Debbie Murphy, Tom Lowey (phonetic), Cathy Stout and/or - and Corey Hess and Colleen Lochamy.

And I want to thank the rest of the team for attending. And again, thank you for your time today.

CHAIRMAN ALLEN: Good. And you stayed under ten minutes. Thanks.

MS. COLLINS: Yay.

CHAIRMAN ALLEN: I have a few questions---

MS. COLLINS: Okay.

CHAIRMAN ALLEN: ---if that's all right.

MS. COLLINS: That's - of course.

CHAIRMAN ALLEN: We understand that there is noise, as I mentioned - the NCCI analysis - and it's just one way of looking at things. Can you please explain your statement that the NCCI analysis overstate the costs and understates potential savings of a change to the ambulatory surgical care Fee Schedule?

MS. MONTGOMERY: That was actually - if I may, I'm Renee Montgomery.

CHAIRMAN ALLEN: Ms. Montgomery, if you could step up to the microphone and make sure---

MS. MONTGOMERY: I can do that. The - Chairman Allen and Commissioners, again, I'm Renee Montgomery, representing SCA, and I was involved in the Judicial Review matter on behalf of SCA. The - that point has to do with the fact that the National Council on

Compensation Insurance - the cost analysis it did - it assumed that an invalid Fee Schedule was a valid Fee Schedule, and so they used the invalid Fee Schedule as the baseline, and that is the concern. By using the invalid Fee Schedule as the baseline, it overstated the costs involved and the potential savings. It overstated costs, so it actually is just not a valid comparison. To use that as the baseline makes it appear that it will be much more costly than it really will. As we said in our proposal, and I think Ms. Collins eluded to, SCA has done an analysis that shows that the savings with what it is proposing is in excess of eight million dollars, so that's---

CHAIRMAN ALLEN: I don't want to interrupt---

MS. MONTGOMERY: Okay.

CHAIRMAN ALLEN: ---but if this is a good point, have y'all provided that independent analysis?

MS. MONTGOMERY: We have. We have.

CHAIRMAN ALLEN: Okay.

MS. MONTGOMERY: I believe it was set forth in the proposal itself.

MS. COLLINS: It was. Yes.

CHAIRMAN ALLEN: Okay.

MS. MONTGOMERY: And that is what we think that the Commission should take into account in determining

the rule. And I might also while I'm - while I'm up here, we also had a concern, which was also stated in the proposal, regarding the timing of what was asked of the proponents. It was - the proponents were - if there was proposals to be submitted, the proponents were to assume an effective date of January 2017, and we don't think that's a realistic assumption for a new Fee Schedule. Because of the requirements of permanent rulemaking, that will take significantly longer than the two and a half - three months, and I don't think reading the requirements for a temporary rule - that it would meet the - any of the criteria that would need to be met before a temporary rule could be put in place, so that's a second concern we have about the cost analysis that was done, as well as the directions given to the interested parties.

CHAIRMAN ALLEN: All right. I also wanted to ask - it's my understanding - and perhaps y'all can correct me if my understanding is incorrect - that the - for the states that utilize a Medicare-based Fee Schedule for workers' compensation, for ambulatory surgical centers, the nationwide average rate is 146.7 percent, which is substantially lower than the rule that was adopted by this Commission. Do you have any explanation for why the rule that was adopted by North

Carolina that has been argued to be inequitable is substantially higher than the nationwide average?

MS. MONTGOMERY: Okay. Stacey---

MS. SMITH: You want me---? Oh.

MS. MONTGOMERY: Ms. Smith could respond to that. She works with a lot of other states and is very familiar with workers' compensation schedules.

CHAIRMAN ALLEN: Sure.

MS. SMITH: Hi. Thank you, Chairman Allen. Stacey Smith with Liberty Partners. I work with SCA. I appreciate the opportunity. I - and that point was made both in - well, along the way as far as what the averages are on a state-by-state basis. I think looking at that analysis is just a piece of taking a very small segment of Fee Schedules that exist. I think that analysis is based on NCCI data and not all states are NCCI states, so you're getting a snapshot of those. The two most recent states that went to a Fee Schedule were Connecticut and Alaska. Connecticut went to a percent of Medicare, and they had parity between outpatient and ASC, so they are both paid - I believe it's two hundred and ten percent of Medicare HOPD - ASCs and HOPDs. Alaska did the same thing. They went through quite a process in rulemaking. They did not have a Fee Schedule, and so they just issued a

rule where HOPDs and ASCs are paid at the same rate, which is around - they have a - they do something very specific in Alaska, so they use the Medicare as kind of a baseline, and then they add an Alaska-specific regional code to that, and it's a little bit over two hundred and - it's around two hundred and thirty percent of Medicare, so it varies from state to state. And I said - and I would also say that if the analysis will be done - if that analysis is what's going to hold on part of ASCs, I would like to maybe know what the national average is for HOPDs and if the current HOPD Schedule is higher. So I think it's - you know, I think there's also a lot of dynamics as far as each state is very different on workforce issues, as you well know. I mean North Carolina has a thriving economy. Some states may not be as strong. Rates will be different. Workforce issues are different, injuries, your whole classification of the industries, so it's very hard to look at a state-by-state basis when you look at what the rate is.

CHAIRMAN ALLEN: And I understand that, but I was just intrigued and - you know, for instance, South Carolina, one of our neighboring states, utilizes a Medicare ASC payment rate of a hundred and forty percent.

MS. SMITH: Yeah, yeah. And South Carolina went through some real challenges with their Fee Schedule. When they went through changes and reforms, because of the rates that they set and how low the rate was, ASCs exited the market, and then the hospital outpatient departments exited the market as well, and they had to come back into session and fix their Fee Schedule to make some modifications, and that was specific to some other issues, but there are some very unintended consequences when you don't look at the real needs of an injured worker and what can happen. So there are some very specific - Texas is another example where they put in some pretty significant cuts and had to come back and readjust that Schedule because they saw providers moving out of the market, and it ends up costing employers more at the end because they're going to kick it on the indemnity side if they don't - if they don't get their workers back fast enough.

CHAIRMAN ALLEN: Okay. And can you explain the statement that was made that aligning the ASC reimbursement schedule with outpatient allows for site of service to be based purely on clinical judgment, quality outcomes and scheduling efficiencies?

MS. SMITH: Yes.

MS. COLLINS: Yeah, I can actually take that. We

believe that if there's parity across the Fee Schedule, then the physicians can decide where the patient should be cared for, and, you know, obviously, in an ambulatory surgery environment, we think that's a faster access, you know, higher clinical quality situation than we can create in other places.

CHAIRMAN ALLEN: Okay. And do you have any, you know, backup documentation that can be submitted on that?

MS. COLLINS: I don't. I mean I know that in the document it said that the Fee Schedule changes were limiting access and - by making it more difficult for folks to come to the ambulatory surgery center environment, and if we change that and we have parity in the Fee Schedule, obviously, that would open up access to those operating rooms.

CHAIRMAN ALLEN: Okay. And can you explain why the importance is placed on being paid the same as a hospital outpatient facility?

MS. COLLINS: I think we should be paid the same thing for the same services provided and, again, don't want to not be able to provide the care and the access for the injured workers.

CHAIRMAN ALLEN: Okay. Is that disparity that's based upon the Medicare Fee - well, Medicare's rubric

that has a different rate for hospital outpatient versus ASCs?

MS. COLLINS: I'm not sure I understand what you're asking.

MS. SMITH: I think I understand what you're saying. I think what you're saying is the disparity if you go to an ASC versus HOPD and how the Medicare Fee Schedule is a different Fee Schedule.

CHAIRMAN ALLEN: Right.

MS. SMITH: I think what - the states that you are seeing that - you know, Medicare gives you all good baseline because it's kind of a standard measure, right, so every year, you know, you have a certain amount of codes that are covered at a certain rate coming out of CMS, but I think what's important when you - when you look at a Medicare Fee Schedule is it's not intended to be a Fee Schedule for injured workers. A Medicare Fee Schedule is for patients over the age of sixty-five, and they have very different needs, but it does - it can and does create - could create a baseline of measure, but an injured worker is very different than, you know, a sixty-seven-year-old, you know, woman who hurts her knee or needs a procedure done in an ASC. So while it is in - a good baseline - and I understand what the approach is to the point -

to your question, is why parity - why is parity important. And I think the Commission said it best in its statement of law in regards to the case that "If you don't have parity" - and I'm just using the Commission's words - "you will have behavioral patterns take place." You will have employers shifting patients into a lower side of service because that's for - beneficial to them. You may have, you know, then the higher side of service have access issues or there may be a diminishing - you're going to set up tremendous behavioral issues unless there's parity, and which that was confirmed by the Commission. And you want site of service neutrality. You want an injured worker to be able to go where they feel that they want to go and not having those decisions being made based on the finances of the system. Does that help answer that a little bit for you? Is that---?

CHAIRMAN ALLEN: I think so. Okay. I also wanted to ask about one of the aspects of the proposal that was made, was that, you know, fifty percent of bill charges up to a cap of $30,000 for, as I understand it, the codes that there is not a Medicare reimbursement rate for.

MS. COLLINS: So, again, just asking for parity.

And the way that we interpreted the change that happened on April 15th was that there are certain CPT codes or procedures that are assigned to CMS as considered approved for an ambulatory surgery environment and certain ones that are not. So when NCIC adopted the new Fee Schedule and followed Medicare standards, we removed about thirty-seven procedures from our eligible list that we had been able to do prior in our environment, and those are some pretty high acuity cases.

CHAIRMAN ALLEN: Were there any efforts to try to resolve that with the carriers - the insurance carriers or through UCR?

MS. COLLINS: Through our conversations, and then also in our proposal.

CHAIRMAN ALLEN: Okay. But I take it there was no resolution with those.

MS. COLLINS: There was not.

CHAIRMAN ALLEN: Okay. Do you have any idea of what the percentage of the ASC market SCA represents in North Carolina?

MS. COLLINS: I know that - I think they're on record about a hundred and twenty ambulatory surgery centers in this state. I - we are seven of those. One of our facilities is single specialty, and about

fifty percent of the others are single specialty, either GI or I, so pretty significant portion---

CHAIRMAN ALLEN: Okay.

MS. COLLINS: ---of the multispecialty market, I should say.

CHAIRMAN ALLEN: And, also, I noted in the proposal and in prior documentation that there was the assertion the ASCs provide better quality outcomes and improved return-to-work metrics. Do you have any information to substantiate that?

MS. COLLINS: Well, I do, and would be happy to provide that for you.

CHAIRMAN ALLEN: Okay. Very good. Could you describe to us how and why the discrepancy in payments impact the doctors providing care?

MS. COLLINS: I think the doctors are concerned with the cost to their patients and the cost to the employers, and they're going to choose to take these - or would like to have the ability to choose to take these patients to a lower cost environment. And when we can't do things, they're not on the Medicare-approved list, obviously, that pushes those to a higher cost environment, and if we're not paid in a way that allows us to have a margin on our business or to afford to do the volume, then those things are

going to be pushed into the hospital. So the physicians are making - being forced frankly to make those decisions based on finances rather than the best environment of care.

CHAIRMAN ALLEN: Okay. Help me to understand how if we were to adopt a proposal that has parity between the hospital outpatient rate and the ASC rate that that would create a lower cost environment in the ASC.

MS. COLLINS: Do you want to help me with this?

MS. SMITH: So I think - I think the proposal from SCA presents the parity issue between ASCs and HOPDs. I think that you get into cost savings by providing access to care. If you limit access to care to injured workers, you will see, you know, lower return to work and - longer return-to-work statistics, and what you may be saving on the medical benefit side you're going to - you're going to end up seeing on the cash benefit side. You're not going to have workers going back to work as soon as possible and having greater indemnity benefits paid to them. I think for the SCA proposal of a lower cost site really goes to these codes that were - these procedures that were being done in ASCs prior to the implementation of the April 1st Fee Schedule. And what's happening now is that those codes are being done in a much higher cost

setting of a hospital inpatient. So that's where you get the real savings and a lower cost environment, is allowing these procedures to go back into an ASC setting, putting a cap on what can be spent, keeping the control of the costs with reviews and getting them back into the setting where you can save money through those.

CHAIRMAN ALLEN: Okay.

MS. COLLINS: Our return-to-work data will help you - help shed light on that as well.

CHAIRMAN ALLEN: Okay. And who provided the analysis of that return-to-work data?

MS. COLLINS: We have - we do - we measure clinical metrics, and we work with our physicians' offices to determine all - several (unintelligible) measures.

CHAIRMAN ALLEN: So it's an internally-developed document?

MS. COLLINS: It is.

CHAIRMAN ALLEN: Okay. Also, is it truly the case that ASCs won't do these type surgeries anymore?

MS. COLLINS: The thirty-two on the---?

CHAIRMAN ALLEN: Right.

MS. COLLINS: Yeah, we can't. I mean we are not - we're not being reimbursed in a way that allows us to

even cover the cost of implants for those---

CHAIRMAN ALLEN: Okay.

MS. COLLINS: ---procedures.

CHAIRMAN ALLEN: And, if so, how does that diminish the pool of doctors available?

MS. COLLINS: It doesn't diminish the pool of doctors. It diminishes the access.

CHAIRMAN ALLEN: Okay. Okay. So, in effect, this is really an issue about inpatient versus ASC under Medicare.

MS. COLLINS: Part of the issue is that. Yes.

CHAIRMAN ALLEN: Okay. Were ASCs really getting paid the same under the bill charges model as the outpatient facilities?

MS. COLLINS: I don't believe that Schedule was the same either. No.

MS. SMITH: Well, no, the procedure - it was - let me - since those bill charges. I mean ASCs were paid a hundred percent of bill charges in - around 2008. You all made some reforms in 2009, I believe, and---

MS. COLLINS: And it went to sixty-seven percent of bill charges.

MS. SMITH: Wait. It was seventy-nine percent then. Yeah. And then ASC and HOPD were at - both at seventy-nine percent. And then a couple of months

later, there was the fifteen percent reduction to 67, I think, .15 of---

MS. COLLINS: 15.

MS. SMITH: ---bill charges.

CHAIRMAN ALLEN: Okay.

COMMISSIONER CHEATHAM: Even after---

CHAIRMAN ALLEN: Commissioner---

COMMISSIONER CHEATHAM: Even after sixty-seven percent of bill charges, were not outpatient hospital bill charges higher than ASC?

MS. COLLINS: The Fee Schedule for hospitals typically is higher than it is for ambulatory surgery centers, so, yes, because of that.

COMMISSIONER CHEATHAM: So the Fee Schedule today - you'll be getting less than the hospitals?

MS. COLLINS: That's correct.

COMMISSIONER CHEATHAM: The Fee Schedule that you are proposing - you would be getting the same thing?

MS. COLLINS: Correct.

COMMISSIONER CHEATHAM: And how much of an increase would that be?

MS. COLLINS: Do you know? Do you have that math?

MS. SMITH: It's a forty percent - it's a forty percent reduction actually off of the bill charges number.

COMMISSIONER CHEATHAM: But---

MS. COLLINS: From where we were in April---

MS. SMITH: Yeah.

MS. COLLINS: ---of 2015.

MS. SMITH: From the valid Fee Schedule in effect right now, which is 67.15 percent of bill charges, to the SCA proposal is a forty percent reduction in medical costs.

COMMISSIONER CHEATHAM: I'm sorry. I still missed it. Let's back us up two years. Sixty-seven percent is in place. How much were hospital outpatient receiving for - on the whole, on the average for---

MS. SMITH: I don't - I don't think---

COMMISSIONER CHEATHAM: ---same service as - at an ASC?

MS. SMITH: Yeah. I don't think - we can - we can look up that data, but I don't think we can provide that answer to you right now. All we can do is quote a relative basis of what was happening in the ASC space.

COMMISSIONER CHEATHAM: My sense is that back then the fees going to hospitals were a good deal higher than ASCs which in fact recognized the lower cost structure and that that's what you're talking about eliminating. Correct?

MS. COLLINS: Well, what we're - I would - my impression is that the hospitals were reimbursed higher than us at that time. Yes.

COMMISSIONER CHEATHAM: Right. That's mine as well.

MS. COLLINS: Yes. Yes.

COMMISSIONER CHEATHAM: Thank you.

CHAIRMAN ALLEN: All right.

MS. COLLINS: Thank you.

CHAIRMAN ALLEN: Thank you.

MS. COLLINS: Thank you all very much.

CHAIRMAN ALLEN: Next, I'll recognize and yield the floor to John McMillan.

JOHN MCMILLAN

MR. MCMILLAN: Thank you, Mr. Chairman, members of the Commission. I'm John McMillan. I'm speaking this afternoon on behalf of employers, employer associations and insurance carriers, those who pay the workers' compensation benefits to injured workers and their healthcare providers. The list of these entities appears on page five of the written comments submitted to the Commission on September 26th. The medical costs for the North Carolina workers' compensation system have been an issue for decades, and there have been numerous attempts to bring them in

line with other states, states with which North Carolina competes for economic development. Beginning in 2012, the employer and insurer communities began meeting with representatives of the providers in a negotiation process that lasted almost three years. We agreed to and jointly paid for a consultant who assisted with providing relevant information to all of the parties. We engaged a prominent mediator who met with both sides and with Chairman Heath to help develop Fee Schedules that, one, ensured that worker - injured workers are provided the services and standard of care required by the Workers' Compensation Act; two, providers are reimbursed reasonable fees for providing these services and, three, medical costs in workers' compensation claims are adequately contained. Agreements were reached on the revised Fee Schedules. It was a negotiation process in which there was give and take on all sides with the objective being to meet the statutory standards. Proposed rules were promulgated by the Commission and published in the *North Carolina Register*. A public comment period was noticed, a hearing was held, and the rules with the new Fee Schedules were adopted. Under the previous North Carolina Fee Schedule, ambulatory surgery centers' reimbursement for workers' compensation

injuries was thirty-one percent higher for knee arthroscopy and forty-nine percent higher for shoulder arthroscopy than the thirty-three state median reported by the Workers' Compensation Research Institute. Employers and insurers agreed to the mediated settlement in an effort to avoid litigation on these issues. That has been successful except for one group - Surgical Care Affiliates, LLC. They claim that they did not participate in the Fee Schedule discussions or rulemaking process; our position is set out in our written comments, is that they did through their representatives at the Medical Society, but that is a discussion for another day. As you consider the proposed rule for ambulatory surgery centers, we would ask that you consider adopting the Schedule previously adopted through the rulemaking process or, in the alternative, adopt a phased-in Fee Schedule that would provide for reimbursement rates of a hundred and fifty percent of the Medicare ASC facility specific amount when fully implemented. That would put North Carolina in line with our neighboring states of South Carolina, which is one hundred and forty percent, and Tennessee, which is a hundred and fifty percent; closer to the median of the states that use Medicare reimbursement methodology. For our complete statement, please refer

to our written comments previously submitted. And I'll be glad to attempt to respond to any questions you might have.

CHAIRMAN ALLEN: I have often heard that the Fee Schedule as it was adopted - and I think it's an apt analogy - it's like a finely-woven rug and that once you pull one thread out, the rest of it can become unwoven. Is that a fair assessment?

MR. MCMILLAN: I think it is. I don't want to spend a lot of time on who was representing who at these - at this long, drawn-out, three-year process. Linwood Jones is going to speak for the Hospital Association, and the hospitals own ambulatory surgery centers, so they were participating. ASCs were participating through their representatives in the Hospital Association. The Medical Society was actively participating, was a principal participant in all of the discussions. And hiring the consultant in the mediation, an agreement was reached, and it was a landmark agreement, and we came to a resolution based on Medicare Fee Schedule which is in place in most other states and works.

CHAIRMAN ALLEN: And what is the position, if there is a unified position, amongst your groups that you represent on the adoption of a rule provision that

would account for procedures that could be done at ASCs that are not paid for by Medicare?

MR. MCMILLAN: I've asked that question. My understanding is two things: One is the Commission can adopt a Fee for any such procedures that fall into that category, but, second, that virtually all procedures are included in the Medicare Fee Schedule. Where we get into issues is some of these procedures are bundled, and they include all aspects of the procedure, and sometimes some pieces of that are pulled out. I don't think that's a separate procedure as such, and it's - in the Medicare Fee Schedule, it's woven into the - into the overall price. When they pull it out, then they create an issue.

CHAIRMAN ALLEN: And have any of the proposing entities worked out contractual arrangements with ASCs outside the Fee Schedule that you are aware of?

MR. MCMILLAN: I don't know.

CHAIRMAN ALLEN: Okay. Given that we are supposed to balance the three factors that I talked about earlier and the two hundred percent Medicare ASC rate was acceptable for cost containment purposes in 2014, 2015, what is the impetus now to move it further at this time?

MR. MCMILLAN: Well, the two hundred percent was a

negotiated settlement with the give and take, and the one hundred and fifty is more aligned with what the average is. I think you correctly stated that the average is slightly under a hundred and fifty percent - one forty-six - one forty-seven, and our neighboring states of South Carolina and Virginia are one forty and one fifty percent - South Carolina and Tennessee. Virginia is undergoing rulemaking as we speak, and the General Assembly in Virginia instructed the Commission to adopt a Fee Schedule, and they're in the process of doing that, so they - I think they have a meeting within the next two weeks to discuss the Virginia's Fee Schedule.

CHAIRMAN ALLEN: Okay. Are you aware of any states that have switched to a Medicare - percentage of a Medicare-based Fee Schedule that have later gone back and revised the Fee Schedule rate?

MR. MCMILLAN: I'm sure there may be some, but I don't - I don't know that.

CHAIRMAN ALLEN: Okay.

MR. MCMILLAN: I will point out that Surgical Care Affiliates does business in many, many states that are under the thirty-three state average, and there's a list of those in our written comments, but there are a lot of states in which they have facilities that

operate.

CHAIRMAN ALLEN: Are you aware of any state that has---? I'm sorry. Were you about to say something?

MR. MCMILLAN: No. No.

CHAIRMAN ALLEN: Okay. Are you aware of any state that has subsequently adjusted the rate significantly downward as---

MR. MCMILLAN: I'm not.

CHAIRMAN ALLEN: ---one of y'all's proposals---

MR. MCMILLAN: I am not.

CHAIRMAN ALLEN: ---suggested?

MR. MCMILLAN: I am not.

CHAIRMAN ALLEN: Okay. Do you think that our workers' compensation system in North Carolina is structurally similar to that of the other states, such as South Carolina and Tennessee or Virginia?

MR. MCMILLAN: Every state is a little bit different, but when you say substantially similar, I would say that they are substantially similar.

CHAIRMAN ALLEN: Okay. Y'all have any further questions? Okay.

MR. MCMILLAN: Thank you very much.

CHAIRMAN ALLEN: All right. Thank you. Thank you, Mr. McMillan. Mr. Linwood Jones.

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LINWOOD JONES

MR. JONES: Thank you, Mr. Chairman, and Commissioners. I'm Linwood Jones, general counsel with the North Carolina Hospital Association. Commissioner Ballance, I know you're getting tired of seeing me here. It's like fifteen years I've been over here talking about Fee Schedules for hospitals. I did - we did file a comment letter last week, and it's - the proposal - at least part of the proposal was the same as Mr. McMillan had stated. Let's, you know, adopt the rule we had in place that was negotiated before, which would have hospitals and am surges at two hundred percent of Medicare beginning in January of next year. That is still our proposal. I'll get to the hundred and fifty percent issue in a minute. There are some areas where we - despite that being our proposal, there are actually some areas we agree with some points SCA has made, but, overall, those don't change our opinion about what we've already negotiated and agreed to and what we think is right here. First of all, we don't like Medicare - being tied to the Medicare Fee Schedule for the very reason they've stated. It was developed for elderly Medicaid - Medicare patients, not for a workers' comp population that's typically younger and has different

needs. So that's - it's - you know, we debated a long time, as John talked about. It took a long time for the Hospital Association to agree to a - to get to the Medicare Fee Schedule system to tie our rates to because it presents several - a number of problems for us; the biggest of which I think - and this is what drove the rates more than anything else - is looking at what the rates were in other states. If we had to agree or disagree on a settlement with the payers based on how much financial impact this had on hospitals, we never would have come to an agreement. It was huge. It was a fifty - sixty - seventy million dollar hit just in the first year, so it was a substantial reduction moving from the sixty-seven percent of charges in the implant carve-out to the - what was two hundred and twenty percent of Medicare and what could be two hundred by next year. Another point on that: Most what hospitals are looking at - and am surges may do the same; physicians, too - they're looking at what the other commercial payers are paying and what is BlueCross paying me, what is United paying me for this business. Those are their benchmarks for what they consider to be an appropriate payment. Medicare at two hundred percent is lower than what hospitals are typically paid on Medicare

outpatient, but, again, if that were the only factor driving this, then we wouldn't have been able to agree to it, but we obviously had to look at the plain numbers of what other states were looking at as far as percentages, and you just don't see many percentages above two hundred percent in the other states that we looked at. So there is some - there is an issue there about using Medicare, but we've sort of agreed to it because it's a transparent system, and, frankly, we couldn't find another system to tie it to. We looked at the State Health Plan. We looked at tying hospitals for workers' comp to their commercial plans, but none of that's transparent to payers; Medicare is. All their rules are published. The rates are published. You know what you're dealing with as a payer, and so a lot of that played a big part in driving what we eventually agreed to and recommended to the Commission. A few other notes - and these are more about comments and questions I've heard as we've been sitting here. There was some reference to a memo we had in - that the Hospital Association had in 2012 or 2013 saying am surge is not in the legislation. That's - I probably wrote that. I don't remember that, but that's probably true. At the time we were dealing with this in the legislature, the focus just

at that time was physicians and hospitals, with the understanding that the Commission had the authority to deal with everybody else without us having to put it in legislation, so that's part of the thinking behind why that wasn't in the legislation. Another point where we are - we're still looking at it - and we put this in our comment letter - is we're still unclear on NCCI's analysis, and that's mostly because we don't know what documentation they used, what factors they looked at. We've had a consultant that does workers' comp Fee Schedules in other states, including Georgia and some of the other southern states, take a look at this. We're not saying it's not valid. We're just saying we don't know some of their assumptions yet, and we'll try and dig into that a little more this week and follow-up with you all by written comment on that. There was some comment about a hundred and forty-six percent national average, a hundred and fifty percent. We had a long discussion about that during the mediation and in the year or two leading up to mediation that while some reports, including WCRI, may show that as the average, you - so I think the ASC said you can't really compare a state to state. Some of these states carve out implants and treat those differently, and that makes a huge difference

comparing one state to another. We heard the same thing in South Carolina that the ASCs did after they passed a rate that low at a hundred and forty percent. I wasn't aware of what happened to the ASCs, but we knew the hospitals were exiting the market, didn't want to take the business anymore, and that did go through litigation there, too, I think, and may have been resolved by adding implants back into the hundred and forty percent. I forgot how it was resolved, but there was an issue with going to a rate that low. There was some discussion about ASC rates versus hospital outpatient rates, and, Commissioner Cheatham, I think you kind of seized on the difference there. A lot of that - it's all driven by Medicare, and the reason there's a difference in Medicare is because of the costs. The hospitals are going to have higher costs. That was true when we were billing charges, too. We're always going to have higher costs because we're bringing in the costs of the ED, operating the facility twenty-four/seven. There are a lot of overhead costs that go into everybody's rates whether it's a workers' comp payer or BlueCross making the payment. So Medicare has that difference there, but there are other reasons for that other than just the overhead. We had our consultant - and we'll follow-up

in more detail on this. We had our consultant look at over three thousand procedures that are done by ASCs and hospitals, and out of those - well, let me back up a minute. Medicare determines - looks at these costs in coming up with what they call a weight, and that weight goes into setting these rates. They set it for hospitals, am surges and probably any other facility that's on some kind of Medicare Fee Schedule. So we had our consultant look at the weights. There were about three thousand of them, and two thousand, nine hundred and fifty-two times the hospital outpatient rate - or weight was higher than the ASC weight. A hundred and twenty-five times it was the other way around. So I think what's driving that is that the procedures may look the same. It may be a knee surgery here and a knee surgery there, but you may have lab, imaging and other services that are working their way into the hospital outpatient procedure that aren't necessarily captured in the ASC procedure, so there's some - there's some cost reason for the difference there by Medicare. The thirty - I heard thirty-two and I heard thirty-seven procedures not covered by Medicare. I'm not - I'm not sure exactly what that is. If - it could be as John said. It's things that Medicare considers you to already be paid

for on the overall procedure rate. I don't know that. I haven't - we haven't looked at what those are. We'd be interested in knowing more about that. Certainly, if it's a full procedure and Medicare is not covering it, it needs to be paid for by workers' comp, but if it's something that's gotten - if it's a procedure that's been bundled up into a rate you're already being paid, that's a different issue that would have to be looked at, I think. I'll stop there. I've tried to tackle the questions I heard, but I don't know if you have more.

CHAIRMAN ALLEN: Do you know what percentage of ASCs are hospital-owned in North Carolina?

MR. JONES: I don't, but we think they're around half, maybe more.

CHAIRMAN ALLEN: And I - and I believe the other Commissioners - heard - and, perhaps, we would learn for the first time at a recent WCRI conference that hospital-based ASCs are billing as outpatient entities. Is that correct?

MR. JONES: That's correct.

CHAIRMAN ALLEN: Okay.

MR. JONES: Well, most of them are. Some of them bill the exact same way an SCA facility would bill. It depends on how they're structured and whether they

qualify under Medicare to do that.

CHAIRMAN ALLEN: Okay.

MR. JONES: So this is all driven by Medicare.

CHAIRMAN ALLEN: Right. Is it equitable for a hospital-owned ASC to be billing at an outpatient rate when an ASC - or for the purpose of this question, an SCA-owned ASC is billing at a reduced rate?

MR. JONES: Well, we think so because the hospital outpatient is capturing additional costs an ASC is not going to have. That's the overhead that's coming in from running the ED and the other facilities. There's also - there may also be - and I'm not familiar with them all, but there are requirements a hospital outpatient facility, even an ASC operating as an outpatient facility, has to meet that an ASC doesn't necessarily have to meet. Now I having said that, Congress has just changed the rule for off-campus hospital outpatient departments to put them on the same billing as an ASC, and that's because the hospital off-campus department doesn't have these ED costs and other things to work into their rate. So they're - Medicare is kind of going the other way. They're bringing the off-campus hospital outpatient rates down towards the ASC rate going forward. They've grandfathered in the existing facilities.

COMMISSIONER CHEATHAM: I just - a quick follow-up. You have mentioned that there are certain requirements of outpatients - outpatient departments that differ from ASCs. Did I understand that correctly?

MR. JONES: I believe that's right. Now I don't - I don't - are you about to ask what they are or---?

COMMISSIONER CHEATHAM: I am.

MR. JONES: Okay. Well, we'll have to follow-up, and I think it's more being tied into the emergency department, having call ensured around the clock, certain clinical requirements of having your medical records tied into the hospitals. Some of that's going to drive costs, and some of the additional costs are just being driven by the overhead from the ED and other---

COMMISSIONER CHEATHAM: Okay.

MR. JONES: ---facilities moving into that rate.

COMMISSIONER CHEATHAM: That's enough.

MR. JONES: Right.

COMMISSIONER CHEATHAM: I just needed an example.

CHAIRMAN ALLEN: The Fee Schedule in 2015 was a substantial reduction for all medical facilities. How has that gone?

MR. JONES: It didn't go well when I informed my

members about it, but they've - as far as I know, they've learned to live with it. The payment issues we were anticipating have not been as bad as we expected because no one else - BlueCross, no one else uses Medicare as their fee payment system, and so the concerns were, were the payers ever going to be able to tap into the Medicare system and figure out the payments. And there have been some issues with it, but I think most of the larger payers have it figured out.

CHAIRMAN ALLEN: Do you have any information regarding how it has affected patient care in any way or changed site of service selection?

MR. JONES: We wouldn't know about any change between hospital outpatient and am surge. I don't think it has created access problems, at least not among our members that we know of.

CHAIRMAN ALLEN: Yeah. Are there any hospitals that you're aware of that are refusing or choosing not to take workers' compensation patients due to the reduction in fees?

MR. JONES: Not that we've heard.

CHAIRMAN ALLEN: Okay.

COMMISSIONER CHEATHAM: And I presume all hospitals are continuing to take Medicare patients?

MR. JONES: They all - out of all of them that I know take Medicare.

COMMISSIONER CHEATHAM: Just as they - I mean, there's no denial of access to care there that you know of?

MR. JONES: Right. It's - that's a much bigger volume, and that's part of the reason they will continue taking it at lower rates. Yeah.

CHAIRMAN ALLEN: All right. Thank you, sir.

MR. JONES: Thank you.

CHAIRMAN ALLEN: We would like to take about a ten-minute recess, see if there are any follow-up questions for the other participants. So we'll go off the record, and everyone will stand at ease for about ten minutes, so we'll get back on the record about two ten.

(OFF THE RECORD)

CHAIRMAN ALLEN: All right. We're back on the record. Before we go into any additional questions, it's my understanding no other persons have signed up to speak. Is that consistent with everybody's views here? All right. There are a few additional questions, and, first of all, this is directed at SCA. The independent analysis - we do not seem to have received that here at the Commission. Can that be

forwarded to us? It's referenced---

MS. SMITH: I---

CHAIRMAN ALLEN: Yes, please come.

MS. SMITH: Yeah. Sorry. I think what we provided was the broad range numbers, so how the analysis was conducted is we took the NCCI modeling, you know, because they take the percentage of what ASCs are within the Medical Fee Schedule, what the savings or costs would be; then they apply the discount based on the outliers, so fifty percent discount on reduction, eighty percent increase based on a Fee Schedule increase. We used that methodology and gave you the high top line numbers, but we'll be more than happy to provide the more granular data, and I think that will help, and maybe even getting NCCI involved and using some of the data from the ASC community that they can provide to NCCI and using that data to provide - I think that may give you all a better baseline.

CHAIRMAN ALLEN: Yes, if you would provide that data. What's a reasonable timeframe for that---

MS. SMITH: I'll have to check with---

CHAIRMAN ALLEN: ---to be produced?

MS. SMITH: I'll have to check with SCA and I think some of the other providers, but we'll get back

with you tomorrow on the timeline.

CHAIRMAN ALLEN: Very well. If you could let Kendall Bourdon know that information, please.

MS. SMITH: Sure. Thank you.

CHAIRMAN ALLEN: Okay. And, also, are y'all aware of any circumstance where an SCA has stopped providing care to injured workers in states that have a lower than two hundred percent rate?

MS. SMITH: Yeah, that's a great question as well, Chairman Allen. I think what we would like to be able to provide - and I think some analysis that should be conducted prior to moving into a new schedule is when you look at these averages - what, the hundred and thirty, the hundred and forty percent ASC - is what happened in those states to patients getting care on ASCs' markets. For instance, in Texas, when Texas did some pretty significant cuts, both on the HOPD and ASC Fee Schedule, ASC stopped seeing patients, so there were some real negative consequences, and so I know there are some deadlines coming up on the 10th, but maybe it's something we should do a deeper dive in to see what happened and how injured workers' access to care and ASCs were impacted when those rates went to a certain level. I think that's an important analysis because we can talk about a hundred and thirty, a

hundred and fifty, a hundred and seventy; the real question is when you move to that rate, what does it do to access? And I think the only way you can do that is to go back in some of these states and look at some historical context. There was some data that was provided in Hawaii. Texas referred - used this data in their - when they went through these Fee Schedule changes where you saw some real changes in the quality of providers when the Fee Schedule was reduced. You ended up - you may have some providers out there providing the care, but they're not necessarily the quality of care, and you're not getting the clinical outcomes, but Hawaii did do some pretty extensive research on that, and we'll be more than happy to provide that to the Commission for you to look at.

CHAIRMAN ALLEN: Yes, if you would, and also provide the data from other states to the degree that y'all have that. That would be very helpful.

MS. SMITH: Just a caveat on that. It is very, very difficult to get workers' comp data because the carriers hold it and NCCI holds it, and so maybe the Commission can help assist in that matter as far as finding - getting us some access to the Medical Fee Schedule component of the whole workers' comp spend historically and what portion of that was ASCs. Maybe

we can - it's just very, very difficult. It's a very opaque data system - data set.

CHAIRMAN ALLEN: Okay. I understand. If you could, walk us through the site of service selection process and how parity between hospital outpatients' and ASC rates is so important in that. So, you know, we're - we don't operate in the environment where y'all are coming from, obviously, so it's hard for us to understand. We'd like to have y'all have the opportunity to explain that.

MS. COLLINS: Yeah. I mean I think I understand what you're saying, and it's a good question. I think that where we're coming from is that, again, we think that we should be paid in our environment the same as the care that's provided in other environments. And as far as how that limits determination of where care is administered, I think a physician is going to choose to go to the most convenient place that he can go, and I think, for example, if he has the ability to come to an ambulatory surgery center, that ambulatory surgery center is not reimbursed at a level that allows the costs of that care to be covered, those cases are going to go to the hospital. They're going to go to the hospital environment, and that's the part that we could control if we were paid equitably.

CHAIRMAN ALLEN: And is there any documentation showing the asserted delay in care that is alleged because of the differential in rates?

MS. COLLINS: I don't know that there's anything specific---

MS. SMITH: Yeah. So it---

MS. COLLINS: ---to North Carolina.

MS. SMITH: Yeah. And we can - this all goes back to data sets. I think a broader question is that we - the ability for this sector - or for providers to get data to give you the answers that you're asking is so limited because of who holds that data set, but we can - we'll do our best to try to find you some answers on - I know that SCA has some internal return-to-work statistics, care statistics. I do just want to touch on one point that was brought up during the earlier discussion, and that's just some questions about HOPDs, hospital outpatient, hospital-owned ASCs, you know, SCA ASCs, other ASCs. An ASC is a licensed legal entity, and if a hospital owns an ASC, they own a Medicare-certified ASC, and if they are billing at HOPD rates, they are - they basically are committing Medicare fraud. They have to bill at the ASC Fee Schedule rate. Now a hospital can have an outpatient center, and it can be - if they want to call it

ambulatory surgery center, that's fine, but it's - if it's not a licensed Medicare-certified ASC, it is an HOPD and they're billing at the higher rate, so I think it's real - and physicians cannot have ownership in HOPDs. The hospitals can have ownership in ASCs, so there's - they are very distinct legal entities, and there's no squishiness on how you bill because it is set up by - an ASC is a Medicare-certified facility and the licensing is such, so I just wanted to provide that clarity.

CHAIRMAN ALLEN: Okay.

COMMISSIONER CHEATHAM: I've got a couple of questions. Sorry. I want to go back to a statement that I believe maybe Ms. Smith made that - you know, we talked about the different percentages as multipliers and the real question being what does that do to access. I'm really interested in what does that do to revenues. When you were at the sixty-seven percent level, what multiplier of a Medicare rate would it have taken to break even?

MS. SMITH: I don't think - I don't have that historical data, and I think it varies from ASC to ASC. I think it depends on the provider. So I think - is - so your question is as far as what would a - what would that revenue rate have been translated

to an ASC Schedule, right, and that's what you---?

COMMISSIONER CHEATHAM: Translated to a multiplier times---

MS. SMITH: Multiplier, right, right.

COMMISSIONER CHEATHAM: ---the Medicare rate.

MS. SMITH: Right. And we don't - I don't have that data with me, but we can - but we---

COMMISSIONER CHEATHAM: Could you get it?

MS. SMITH: I think we can try. Yeah.

COMMISSIONER CHEATHAM: I'd be very excited. That would be great.

MS. COLLINS: And please understand that our goal is not to break even at that rate.

MS. SMITH: Yeah.

MS. COLLINS: That's not our goal, even remotely.

COMMISSIONER CHEATHAM: Right. I understand that, but I think that would be helpful and---

MS. SMITH: Well, I - what I can provide for you is the analysis that we did based on going to a two hundred - to going to a parity with the HOPD based on bill charges to the two hundred percent of Medicare HOPD starting in '17, and that would be a forty percent reduction in savings to the workers' comp system.

COMMISSIONER CHEATHAM: I'm probably less

interested in that than my other question, but okay.

MS. SMITH: But I think it's almost relatable, but I think - so we can back out that data for you because if we can - if we can show savings based on a Medicare Fee Schedule from bill charges, then we can probably provide what that rate may have been. Now, given that the codes have changed, the payment underlying Medicare codes have changed from year to year because of CMS's annual adjustments to the Fee Schedule every calendar year.

COMMISSIONER CHEATHAM: Do you generally agree that your overheads at ASCs are less to some---

MS. SMITH: Oh, I can't---

COMMISSIONER CHEATHAM: ---magnitude than hospital outpatient?

MS. COLLINS: I'm sorry. I was talking to (inaudible).

MS. SMITH: Oh. I - no, she asked if the overhead is less in an ASC than a hospital. I think - I think that is a generally discussed - that is a general assumption, yeah, but I---

COMMISSIONER CHEATHAM: Do you know---

MS. SMITH: ---don't think that's---

COMMISSIONER CHEATHAM: ---how much less?

MS. SMITH: ---relevant to the workers' comp

system because I don't - I don't think the employer should be subsidizing a - you know, should they be subsidizing a hospital emergency room? So, you know, I think you have to look at it in the context of care to workers, right, and getting injured workers back, and there's always all these other issues of uninsured patients and, you know, the overhead that hospitals do have because they are, you know, Charity Care, and they are those emergency room providers, but I think in the context of a workers' comp system we have to talk at - what is at heart is getting injured workers back on the job as quickly as possible, which saves employers money.

COMMISSIONER CHEATHAM: So do you have any idea what the difference in overhead percentage might be?

MS. SMITH: I don't.

COMMISSIONER CHEATHAM: No?

MS. SMITH: No.

COMMISSIONER CHEATHAM: Have you had any access to care issues for just Medicare patients at all?

MS. SMITH: Well, Medicare is a totally different patient population.

COMMISSIONER CHEATHAM: I agree.

MS. SMITH: Right.

COMMISSIONER CHEATHAM: I've recently become well

aware of that. Thank you.

MS. SMITH: I just - I - it's just a different - I think it's a different patient population. There are - there are---

COMMISSIONER CHEATHAM: But there are no access to care issues for Medicare in the ASCs?

MS. SMITH: I can't answer specifically to ASCs, but I can answer on a more broadly point. I think if you just moved into Medicare, what you are - you will find is that there are a lot of providers that don't take Medicare, and it is a problem that policymakers contemplate all the time, is - you know, with the spend in the Medicare Program and making sure reimbursement is sufficient in guaranteeing access and what we have seen specifically in the Medicare Program - and we can provide that data to you - is providers leaving the Medicare system because it doesn't reimburse high enough. You see it in cardiology. You see it in general practitioners. You see it across the board in the provider spectrum that they are withdrawing from the Medicare system because it doesn't reimburse at a higher - a high enough level to cover their costs, so we'll be more than happy to provide that data - how many providers are leaving the general Medicare system because of low reimbursement.

And Washington is actually taking this into consideration. They're moving to all these alternative payment models and, you know, bundled payments and - because they know - they're trying to address this.

COMMISSIONER BALLANCE: Are ambulatory surgical centers more likely than, say, hospitals or hospital outpatient facilities to be located in rural, underserved areas?

MS. SMITH: You can answer that?

MS. COLLINS: No, not typically. We're seeing actually more and more of those models; obviously, very restricted in a CON state, as you all know. Typically, they're located within about a three-mile radius of a hospital.

COMMISSIONER BALLANCE: Thank you.

MS. COLLINS: And we do take care of Medicare patients. I want to make sure you know that.

MS. SMITH: Yeah, yeah, yeah.

CHAIRMAN ALLEN: And I have a follow-up to Commissioner Ballance's question. Does SCA have any facilities that are in a rural or underserved area?

MS. COLLINS: Well, I'm going to offend one of my facilities that's represented here, but, yes, we do. We have - in Wilson, North Carolina.

CHAIRMAN ALLEN: Wilson. Okay. No further questions, so we will go off the record momentarily. I want to thank everybody for being here today and the comments that we've received and the material that has been provided to date and will be provided after today's date. It has been especially helpful, and, you know, the Commission will take it under consideration, and, you know, if you're going to be submitting any additional comments, as I stated before, be sure to check in with Kendall Bourdon to do that. Also, we have a rulemaking list serve that Kendall helps maintain. I would suggest that you sign-up for that as well to be apprised of any rulemaking developments, you know, whether in regards to this or any other things, including E-filing. We have some rules that are upcoming with that. So, with all that said, thank you all for being here and thanks for coming. We'll go off the record.

(WHEREUPON, THE HEARING WAS ADJOURNED.)

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STATE OF NORTH CAROLINA

COUNTY OF GUILFORD

C E R T I F I C A T E

I, Kelly K. Patterson, Notary Public, in and for the State of North Carolina, County of Guilford, do hereby certify that the foregoing fifty-six (56) pages prepared under my supervision are a true and accurate transcription of the testimony of this trial which was recorded by Graham Erlacher & Associates.

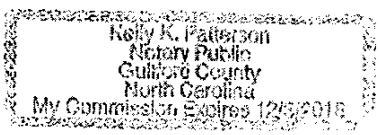
I further certify that I have no financial interest in the outcome of this action. Nor am I a relative, employee, attorney or counsel for any of the parties.

WITNESS my Hand and Seal on this 5th day of October 2016.

My commission expires on December 3, 2018.

Kelly K. Patterson

NOTARY PUBLIC



**PROPOSAL TO THE NORTH CAROLINA INDUSTRIAL COMMISSION TO AMEND PARTIALLY INVALID RULE 04 NCAC 10J .0103**

**September 26, 2016**

To: Kendall Bourdon
IC Rulemaking Coordinator
North Carolina Industrial Commission
Delivered via email to kendall.bourdon@ic.nc.gov

Pursuant to the North Carolina Industrial Commission's September 2, 2016 Notice of Public Comment Meeting, Surgical Care Affiliates, LLC ("SCA") respectfully submits the following proposal, which addresses fees for institutional services in Workers' Compensation cases. This proposed amendment addresses the maximum allowable amounts for services provided by ambulatory surgical centers ("ASCs") in Workers' Compensation cases under North Carolina's Workers' Compensation Act.

As an initial matter, the Commission's attempted adoption of a new fee schedule for ambulatory surgical center services as set forth in 04 NCAC 10J. 0103(g) and (h) (also referenced in 04 NCAC 10J. 0103(i)), and the amendment of the Prior Rule, specifically 04 NCAC 10J .0101(d)(3), (5), and (6) has already been declared invalid and rendered ineffective by the Wake County Superior Court's August 9, 2016 Order in *Surgical Care Affiliates, LLC v. N.C. Industrial Commission* (16 CVS 00600). The Commission has proceeded with its request for proposed amendments as if this judicial decision was not made. Similarly, the cost analysis requested by the Commission wrongly compares new ASC fee schedules to the ASC fee schedule that has been declared invalid. As a result, NCCI improperly overstates the costs and understates the potential savings of a change to the ASC fee schedule.

SCA manages seven ambulatory surgical centers 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 Day 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.

## SCA'S REQUESTED AMENDMENT OF THE COMMISSION'S PARTIALLY INVALIDATED RULE 04 NCAC 10J .0103

The Commission's partially invalidated Rule 04 NCAC 10J .0103 addresses fees for institutional services under North Carolina's Workers' Compensation Act and includes a schedule of maximum reimbursement rates for some of the services provided by ASCs. The schedule set forth in this regulation only addresses surgical procedures

that are covered under the Medicare program and does not include surgical procedures that can be and are performed in ASCs but are not covered under Medicare.

The amendment proposed by SCA addresses procedures that are not currently covered in this regulation and changes the schedule of maximum reimbursement rates for ASCs to align with the reimbursement rates set for hospital outpatient departments. This alignment of reimbursement schedules allows for site-of-service decisions to be based solely on clinical judgment, quality outcomes, and scheduling efficiency—all for the sole benefit of the injured worker.

For those services that are covered under Medicare, the invalid fee schedule contains reimbursement that is inadequate and that would create a significant disparity between ASCs and hospital outpatient departments for the same services. As previously recognized by the Commission, the disparity in reimbursement could cause changes to referral patterns and where services are utilized.

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

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

*See* Attachment (redline of revised 04 NCAC 10J .0103).

SCA's proposed amendment to the regulation serves to align payments for ambulatory surgical procedures with the Medicare fee schedule while at the same time acknowledging that Medicare has not created an allowance for certain procedures that are routinely and safely provided to non-Medicare patients in the ASC setting. As such, SCA is proposing a rate for these services that is consistent with the resources and time involved in providing such procedures. In order to limit the uncertainty of the insurers' exposure on reimbursement, charge master increases will be limited to 0% increase for

these procedure codes for the first 3 years, or a revenue neutral adjustment will be applied to the percent of charge paid.

The amendment of 04 NCAC 10J.0103 is needed for two reasons:

First, the ASC Medicare fee schedule does not cover all procedures that were being performed prior to the enactment of the invalid fee schedule on April 1, 2015 and that can be performed in ambulatory surgical centers. Currently, injured workers are receiving these surgical services in the more expensive inpatient hospital setting. Receiving these services in an inpatient hospital setting often takes longer to schedule than scheduling the same procedure in an ambulatory surgical center, resulting in delays to injured workers from receiving needed surgical services. The failure to address all surgical procedures in the fee schedule has also resulted in confusion and a failure by some carriers to provide any reimbursement to the SCA ambulatory surgical centers for procedures it has traditionally provided to injured workers because they are not covered under the ASC Medicare fee schedule.

Second, the reduction in rate for ambulatory surgical services in the invalid fee schedule contained in the current version of 04 NCAC 10J .0103 is insufficient to meet the requirements set forth in N.C. Gen. Stat. § 97-26(a). Ambulatory surgical centers are currently not being reimbursed equitable fees, and injured workers are not being provided services consistent with the timing or standard of care intended by the Workers' Compensation Act. Further, because SCA and other free standing ambulatory surgical centers were not involved in the process of developing new fee schedules that are set forth in the regulation, the Commission did not have any information that would have been useful in determining reimbursement for ambulatory surgical centers, which would include the administrative burdens related to scheduling, approval, claims processing and collections, the additional expenses related to caring for traumatic injuries in a timely manner, and the financial risk related to delayed payment due to litigation that is carried by a provider when caring for injured workers. Importantly, injured workers treated by ambulatory surgical centers have significantly better quality outcomes and improved return-to-work metrics. These benefits are not considered in the September 19, 2016 cost analysis.

The amendment being proposed by SCA would have a positive effect on the procedures of the Commission because it will eliminate the confusion that currently exists whereby some insurance carriers have determined that some procedures currently being performed at ambulatory surgical centers are not covered in the current invalid fee schedule based on ASC Medicare rates.

Additionally, the proposed fee schedule for ambulatory surgical centers will have the added positive effect of lowering the costs for some surgical procedures that are currently provided in a hospital inpatient setting by ensuring that those procedures can be reimbursed in ambulatory surgical centers at a lower cost. This proposed regulation has also been drafted to allow the State, on an ongoing yearly basis, to manage only one fee schedule across all outpatient surgical settings, including ASCs and hospital outpatient departments.

As noted by the Commission, discrepancies in payments between ambulatory surgical centers and hospital outpatient departments would "potentially diminish the pool of doctors available to treat injured employees, and reduce the quality and timeliness of care. 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."[1] 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 hospital outpatient fee schedules.

Lastly, there is precedence in North Carolina that ASCs and hospital outpatient were reimbursed in a similar manner. As noted in the Commission's prior Rule, compensation effective January 1, 2013 for ambulatory surgical centers and hospital outpatient departments was set at 79% of billed charges and, effective April 1, 2013, payments to "Hospital outpatient and ambulatory surgery . . . shall be reduced by 15 percent."[2]

## COST ANALYSIS OF SCA'S REQUESTED AMENDMENT OF THE COMMISSION'S PARTIAL INVALIDATED RULE 04 NCAC10J .0103

At the request of the Commission, the North Carolina Rate Bureau ("NCRB") and the National Council of Compensation Insurance ("NCCI") provide a cost analysis for hypothetical ASC fee schedules for workers compensation cases. As stated in the Commission's Notice of Public Comment Meeting, the purpose of requesting the cost analysis was "to take public comment on and consider rulemaking options to address the effects of the August 9, 2016 court decision invalidating the April 1, 2015 medical fee schedule provisions for ambulatory surgical centers."

As noted in the August 9, 2016 court decision, the "Commission's attempted adoption of a new fee schedule for ambulatory surgical center services, but limited solely to those services, as set forth in 04 NCAC 10J. 0103(g) and (h) (also referenced in 04 NCAC 10J. 0103(i)), and the amendment of the Prior Rule, specifically 04 NCAC 10J .010l(d)(3), (5), and (6), to the extent that the amendment removed the old fee schedule for ambulatory surgical centers, are invalid and of no effect."[3]

As detailed in the NCRB's and NCCI's "ANALYSIS OF ALTERNATIVES TO THE NORTH CAROLINA AMBULATORY SURGICAL CENTER FEE SCHEDULE PROPOSED TO BE EFFECTIVE JANUARY 1, 2017," the estimated overall impact of six different ASC fee schedule scenarios estimates the overall impact of the proposed fee

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[1] North Carolina Industrial Commission, Memorandum Of Law In Support of Motion To Stay, August 17, 2016.
[2] http://www.ic.nc.gov/ncic/pages/statute/rule407.htm.
[3] http://www.ic.nc.gov/080916RidgewayDecision.pdf.

schedule changes between -0.4% (-$8.0M) and +1.1% (+$21.0M).[4] However, SCA objects to the findings in NCCI's analysis.

Specifically, NCCI improperly uses the invalid ASC fee schedule as the baseline for calculating the cost or saving related to the proposed changes. The ASC fee schedule required by the August 9, 2016 court decision reimburses providers at 67.15% of billed charges. The NCCI analysis uses the invalid ASC fee schedule reimbursement of 210% of Medicare ASC rates as the baseline for the proposed fee schedule changes. Therefore, NCCI's analysis using the invalid fee schedule understates the total impact on the overall workers compensation system when adopting a ASC fee schedule that reimburses ASC at a lower rate than the current fee schedule reimbursement of 67.15%.

SCA conducted independent analysis using internal data and NCCI's methodology to evaluate the impact of SCA's proposed fee schedule change from the current ASC fee schedule reimbursement rate of 67.15% of billed charges to the 2017 Service Year reimbursement rate of 200% of HOPD Medicare. The analysis concluded that the resulting overall savings in 2017 to the overall workers comp system would be $8.8M (-0.5%). The NCCI report using the invalid fee schedule suggests an overall workers comp system cost increase by $21M (1.1%).

SCA also questions why the September 9, 2016 NCCI analysis uses written premiums including the self-insurance market when the past two reports NCCI presented analyzing fee schedule changes did not include the self-insurance market written premium data. By including the self-insurance market written premiums, the dollar cost associated with a fee schedule increase are overstated and dollar savings are understated when there is a fee schedule reduction relative to analysis that did not include the self-insurance market written premium data.[5]

## OTHER RELEVANT INFORMATION

The Commission's Notice of Public Comment Meeting indicates that proposals should assume an effective date as early as January 1, 2017, which is not feasible.[6] The process of promulgating a permanent rule takes significantly longer than three months. *See* N.C. Gen. Stat. § 150B-21.2. Before a rule becomes effective, the Commission is required to prepare or obtain a fiscal note, publish the proposed rule and fiscal note, accept public comments on the proposed rule and fiscal note for at least 60 days, and then submit the proposed rule to the Rules Review Commission for its review and approval.

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[4] The NCIC requested four different scenarios. NCCI included two additional fee schedule scenarios. No explanation was provided by the NCIC or NCCI on why additional payment scenarios were included.

[5] The September 19, 2016 NCCI study reports: "This figure includes self-insurance." The NCCI March 29, 2016 and December 4, 2014 studies state: "This figure does not include self-insurance."

[6] The NCCI September 19, 2016 analysis also assumes the fee schedule to be effective January 1, 2017.

If the Commission is assuming that a proposed rule changing the fee schedule for ASCs could be adopted as a temporary or emergency rule, the Commission is incorrect. The criteria that set forth when a temporary or emergency rule can be adopted are not applicable. *See* N.C. Gen. Stat. §§ 21.1 and 21.1A. There is no unforeseen threat to the public health, safety, or welfare and the Superior Court Decision concluding that the fee schedule used prior to April 1, 2015 is the valid fee schedule for ASCs does not require that the Commission engage in rulemaking to change the ASC fee schedule.

Respectfully submitted this 26th day of September 2016.

K. Collins

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## REDLINE OF PARTIALLY INVALID RULE

**04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES**

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

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

(1) Beginning April 1, 2015, 190 percent of the hospital's Medicare facility-specific amount.

(2) Beginning January 1, 2016, 180 percent of the hospital's Medicare facility-specific amount.

(3) Beginning January 1, 2017, 160 percent of the hospital's Medicare facility-specific amount.

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

(1) Beginning April 1, 2015, 220 percent of the hospital's Medicare facility-specific amount.

(2) Beginning January 1, 2016, 210 percent of the hospital's Medicare facility-specific amount.

(3) Beginning January 1, 2017, 200 percent of the hospital's Medicare facility-specific amount.

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

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

(1) Beginning April 1, 2015, 200 percent of the hospital's Medicare CAH per diem amount.

(2) Beginning January 1, 2016, 190 percent of the hospital's Medicare CAH per diem amount.

(3) Beginning January 1, 2017, 170 percent of the hospital's Medicare CAH per diem amount.

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

(1) Beginning April 1, 2015, 230 percent of the hospital's Medicare CAH claims payment amount.

(2) Beginning January 1, 2016, 220 percent of the hospital's Medicare CAH claims payment amount.

(3) Beginning January 1, 2017, 210 percent of the hospital's Medicare CAH claims payment amount.

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

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

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

~~(1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility-specific amount.~~

~~(2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.~~

~~(3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.~~

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

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

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

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

## PROPOSED RULE

**04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES**

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

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

(1) Beginning April 1, 2015, 190 percent of the hospital's Medicare facility-specific amount.

(2) Beginning January 1, 2016, 180 percent of the hospital's Medicare facility-specific amount.

(3) Beginning January 1, 2017, 160 percent of the hospital's Medicare facility-specific amount.

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

(1) Beginning April 1, 2015, 220 percent of the hospital's Medicare facility-specific amount.

(2) Beginning January 1, 2016, 210 percent of the hospital's Medicare facility-specific amount.

(3) Beginning January 1, 2017, 200 percent of the hospital's Medicare facility-specific amount.

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

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

(1) Beginning April 1, 2015, 200 percent of the hospital's Medicare CAH per diem amount.

(2) Beginning January 1, 2016, 190 percent of the hospital's Medicare CAH per diem amount.

(3) Beginning January 1, 2017, 170 percent of the hospital's Medicare CAH per diem amount.

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

(1) Beginning April 1, 2015, 230 percent of the hospital's Medicare CAH claims payment amount.

(2) Beginning January 1, 2016, 220 percent of the hospital's Medicare CAH claims payment amount.

(3) Beginning January 1, 2017, 210 percent of the hospital's Medicare CAH claims payment amount.

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

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

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

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

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

September 26, 2016

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

Dear Chairman Allen:

The undersigned entities respectfully submit the following proposal to amend the North Carolina workers' compensation medical fee schedule (04 NCAC 10J .0101, .0102 and .0103) with respect to services provided by ambulatory surgery centers (ASCs). This proposal is intended to address the effects of the August 9, 2016 order issued by Wake County Superior Court Judge Paul Ridgeway in *Surgical Care Affiliates, L.L.C. v. North Carolina Industrial Commission*, in the event that the order is upheld by the appellate process.

This proposal seeks to not only address the fee schedule for ASC services set forth in 04 NCAC 10J .0103(g), (h) and (i) and 04 NCAC 10J .0101(d)(3), (5) and (6), as referenced in Judge Ridgeway's order, but also to prevent similar efforts by other medical provider groups to nullify the current fee schedule as it pertains to their services. Please note that the proposal amending 04 NCAC 10J .0101 is exactly the same as the one published in the North Carolina Register on November 17, 2014, while the proposal amending 04 NCAC 10J .0103 recodifies the sections previously adopted by the Commission but brought into question by Judge Ridgeway's order. Based on the data provided below, we also encourage the Commission to consider reducing the fee schedule for ASC services to 150% of Medicare, which would bring North Carolina's fee schedule more in-line with other states that utilize a Medicare based reimbursement model.

**BASIS FOR PROPOSAL**

As stated above, the proposal recommended in this document would maintain the fee schedule for hospitals, physicians, ASCs and all other health care providers that serve workers' compensation patients as approved by the Commission on January 16, 2015 and by the North Carolina Rules Review Commission on February 19, 2015.

Following the 2011 passage of legislation (HB 709) which addressed indemnity benefits, it became necessary to address the issue of rising medical costs in the workers' compensation system. Prior to the Commission's adoption of a fee schedule tied to Medicare's reimbursement for workers' compensation services, the costs of medical procedures in North Carolina were far higher than those in neighboring states and other states with which North Carolina competes for economic development.

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). It is worth noting that Surgical Care Affiliates operates ASCs in a number of the WCRI study states where ASC reimbursement is significantly less than the 33-state median, including California, Colorado, Delaware, Michigan, Mississippi, Oklahoma, Oregon, Pennsylvania, South Carolina, and Texas. There are no access to care problems reported in those states. The current fee schedule puts North Carolina ASC reimbursement closer to the 33-state median and should not create any access to care problems for North Carolina injured workers.

Maintaining the same adopted multipliers to the Medicare ASC facility-specific reimbursement amount allows North Carolina ASCs to effectively market their services as a value proposition for payers compared to outpatient hospital reimbursement rates. As noted in SCA *Investor Presentation* (September 20, 2016), ASCs provide approximately 45% savings compared to hospital outpatient reimbursement. North Carolina businesses should not be deprived of this value proposition touted by Surgical Care Affiliates.

While the undersigned entities have proposed that the Commission adopt the same fee schedule for ASC facilities that was adopted by the Commission, we also encourage the Commission to consider further reducing the fee schedule for ASCs in order to bring North Carolina more in-line with other States that utilize a Medicare-based fee schedule for ASCs. The current ASC fee schedule places North Carolina in the higher end of states that utilize Medicare's reimbursement methodology. If the Commission wishes to consider amending the multiplier applicable to the Medicare ASC facility-specific reimbursement methodology, we recommend that the multiplier be reduced in order to bring North Carolina closer to the median for states that utilize Medicare's reimbursement methodology. Neighboring states South Carolina (140%) and Tennessee (150%) utilize significantly lower multipliers than North Carolina (currently 210%). Consequently, the Commission should strongly consider adopting 150% as the multiplier to the Medicare ASC facility-specific reimbursement amount. This amendment would put North Carolina closer to the median of states that utilize Medicare reimbursement methodology, and make North Carolina more competitive with neighboring states while saving North Carolina businesses $6-8 million annually according to the NCCI, *Analysis of Alternatives to the North Carolina Ambulatory Surgical Center Fee Schedule Proposed to Be Effective January 1, 2017.*

**DETAILS OF THE NEGOTIATED RULEMAKING PROCESS**

The Commission's adoption of a workers' compensation medical fee schedule was the culmination of a lengthy negotiation process that began in 2012 and lasted more than two years. On one side of this negotiation were representatives of the employer and insurer communities, and on the other side were representatives of facilities and physicians. Both sides had a common goal of ensuring that payment for medical services was fair and ensured access to care for injured workers so they could be treated and successfully returned to employment.

This negotiation process included the selection of a consultant – the Foundation for Unemployment Compensation and Workers' Compensation Study - jointly agreed to and paid

for by all parties, including the American Insurance Association, Capital Associated Industries, North Carolina Hospital Association, North Carolina Medical Society, North Carolina Chamber, North Carolina Home Builders Association, North Carolina Retail Merchants Association and the Property Casualty Insurers Association of America. After numerous informal negotiation sessions, these parties jointly agreed to and paid for Andy Little, one of North Carolina's foremost mediators, to conduct a formal two-day mediation. In addition to these parties, representatives from the North Carolina Advocates for Justice and the North Carolina Association of Defense Attorneys attended these mediations, as did Drew Heath, Chairman of the North Carolina Industrial Commission. Again, the intent of the parties was to reach an agreement on the facility and provider fee schedules that would avoid protracted litigation or opposition from affected parties. While rates for services provided by hospitals and certain physician groups such as radiologists were reduced in attempt to bring North Carolina's medical fee schedules in-line with median averages for other states, other physician groups such as family physicians saw their rates increase to similarly adjust to median averages for other states. Additionally, the rate reductions were stair-stepped over a fifteen month period to mitigate their impact.

Contrary to the affidavit of Conor Brockett of the North Carolina Medical Society put forth by a number of orthopedic groups in *Surgical Care Affiliates, L.L.C. v. North Carolina Industrial Commission*, there was never an attempt to exclude certain types of providers, either Surgical Care Affiliates or any other ASC or orthopedic group. We do acknowledge that, during the final mediation with Andy Little, both sides were asked to limit the number of participants for the sake of efficiency. All parties were instructed to meet with their respective interest groups and arrive at the mediations with the authority to come to a resolution on the fee schedules.

Additionally, there was a general feeling by the parties during all of the negotiations that the North Carolina Medical Society had apparent, if not actual authority, to represent the practice of orthopedic medicine. This was evidenced by:

1) The statement on the North Carolina Medical Society's website that the Society's Specialty Society and Meeting Services Department currently manages ten specialty associations in North Carolina, one of which was the North Carolina Orthopedic Society. (See Attachment A)

2) The North Carolina Orthopedic Society is housed inside the physical office of the North Carolina Medical Society Headquarters located at 222 North Person Street, Raleigh, NC. (See Attachment B)

3) The email address for Alan Skipper the Executive Director of the North Carolina Orthopedic Society is ncoa@ncmedsoc.org. (See Attachment B)

4) The letter of support submitted by the North Carolina Medical Society dated January 16, 2015 lists twelve entities that applaud the efforts of the Commission and encourages the Commission to adopt the fee schedule as proposed. The North Carolina Orthopedic Society is listed as one of the twelve signatory entities. (See Attachment C)

5) The North Carolina Orthopedic Association Electronic Newsletter dated March 5, 2015 trumpets the fee schedule approved by the Commission stating "The North Carolina Orthopedic Association (NCOA) and the North Carolina Medical Society (NCMS) are excited to report that the N.C. Industrial Commission has confirmed that North Carolina's workers' compensation fee schedule has been updated for the first time in nearly 20 years." The newsletter also alludes to the involvement of the North Carolina Orthopedic Association when it states "This outcome is the result of many years of advocacy by the NCMS on this issue along with many specialties' efforts and a lot of work by NCMS Associate General Counsel Conor Brockett, who guided the successful strategy to completion. Richard Bruch, MD, NCOA Executive Committee Member and Councilor to the AAOS, was a member of the NCMS Task Force dedicated to this issue" and that "The NCOA joined the NCMS in a comment letter last month supporting the proposed rules." (See Attachment D)

Additionally, at the Public Hearing conducted by the North Carolina Industrial Commission on December 17, 2014 concerning Proposed Medical Fee Schedule Rule Changes, Mr. Brockett made the following statements of support for the fee schedule as proposed:

*I think the overall message that I want to communicate, and one I hope you'll remember, is that the physician community is squarely behind this proposal and hopes that you will see it through to adoption.* (Transcript from North Carolina Industrial Commission concerning Proposed Medical Fee Schedule Rule Changes, December 17, 2014, Page 19)

*What we have here, though, is a product of compromise – considerable compromise. The proposed rule involves some pain. It involves some gain for all of the stakeholders who are directly affected by this. It's up and down, so it's not really a perfect solution for anybody or for everybody, but I think it's the result of a healthy process so far, and ultimately, our view is it will make the system stronger in the end and going forward. So I'll just close by thanking each of you for the opportunity to share the physician perspective today. We look forward to participating in the process as it continues. Thank you.* (Transcript from North Carolina Industrial Commission concerning Proposed Medical Fee Schedule Rule Changes, December 17, 2014, Page 23).

**CONCLUSION**

The arguments by Surgical Care Affiliates requesting an increase in the ASC fee schedule ring hollow. Surgical Care Affiliates failed to submit written comments to the Commission, failed to appear before the Commission at its Public Hearing, failed to appear before the North Carolina Rules Review Commission, and failed to submit ten (10) letters of objection with the North Carolina Rules Review Commission that would have subjected the fee schedule to legislative review. Surgical Care Affiliates' arguments that the fee schedule is inequitable are simply stale.

Similarly, the arguments by orthopedic medicine groups requesting an increase in the ASC fee schedule should also be rejected, in light of the fact that the North Carolina Medical Society negotiated on their behalf with apparent and actual authority, and also because the North Carolina Orthopedic Association was a signatory on a letter submitted to the Commission in support of the ASC fee schedule.

At a minimum, we recommend that the Commission readopt the ASC fee schedule as previously (and unanimously) approved on January 15, 2015 with the support of numerous interest groups. In the alternative, the Commission should reduce reimbursement for ASC services to 150% of Medicare to bring it in-line with other states that utilize a Medicare base reimbursement methodology for ASC services.

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 and Casualty Insurers of America Association
Builders Mutual Insurance Company
Dealers Choice Mutual Insurance Company, Inc.
First Benefits Insurance Mutual, Inc.
Forestry Mutual
North Carolina Farm Bureau
The Employers Association, Inc.
Employers Coalition of North Carolina
WCI, Inc.

**SECTION .0100 – FEES FOR MEDICAL COMPENSATION 04 NCAC 10J .0101 GENERAL PROVISIONS**

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

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

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

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

~~(2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.~~

~~(3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.~~

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

~~(d) The Commission's Hospital Fee Schedule, adopted pursuant to G.S. 97-26(b), provides for payment as follows: (1) Inpatient hospital fees: Inpatient services are reimbursed based on a Diagnostic Related Groupings (DRG) methodology. The Hospital Fee Schedule utilizes the 2001 Diagnostic Related Groupings adopted by the State Health Plan. Each DRG amount is based on the amount that the State Health Plan had in effect for the same DRG on June 30, 2001. DRG amounts are further subject to the following payment band that establishes maximum and minimum payment amounts:~~

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

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

~~(C) For critical access hospitals, the minimum payment is 77.07 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount~~

~~provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

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

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

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

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

~~(4) Other rates: If a provider has agreed under contract with the insurer or managed care organization to accept a different amount or reimbursement methodology, that amount or methodology establishes the applicable fee.~~

~~(5) Payment levels frozen and reduced pending study of new fee schedule: Effective February 1, 2013, inpatient and outpatient payments for each hospital and the payments for each ambulatory surgery center shall be set at the payment rates in effect for those facilities as of June 30, 2012. Effective April 1, 2013, those rates shall then be reduced as follows: (A) Hospital outpatient and ambulatory surgery: The rate in effect as of that date shall be reduced by 15 percent. (B) Hospital inpatient: The minimum payment rate in effect as of that date shall be reduced by 10 percent.~~

~~(6) Effective April 1, 2013, implants shall be paid at no greater than invoice cost plus 28 percent.~~

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

~~(f)~~ (c) A provider of medical compensation shall submit its ~~statement~~ bill for services within 75 days of the rendition of the service, or if treatment is longer, within 30 days after the end of the month during which multiple treatments were provided. However, in cases where liability is initially denied but subsequently admitted or determined by the Commission, the time for submission of medical bills shall run from the time the health care provider received notice of the admission or determination of liability. Within 30 days of receipt of the ~~statement,~~ bill, the employer, carrier, or managed care organization, or administrator on its behalf, shall pay ~~or submit the statement to the Commission for approval~~ the bill or send the provider written objections to the ~~statement.~~ bill. If an employer, carrier, administrator, or managed care organization disputes a portion of the provider's bill, the employer, carrier, administrator, or managed care organization, shall pay the uncontested portion of the bill and shall resolve disputes regarding the balance of the charges through its contractual arrangement or through the Commission. ~~(g)~~ (d) Pursuant to G.S. 97-18(i), when the 10 percent addition to the bill is uncontested, payment shall be made to the provider without notifying or seeking approval from the Commission. When the 10 percent addition to the bill is contested, any party may request a hearing by the Commission pursuant to G.S. 97- 83 and G.S. 97-84.

~~(h)~~(e) When the responsible party seeks an audit of hospital charges, and has paid the hospital charges in full, the payee hospital, upon request, shall provide reasonable access and copies of appropriate records, without charge or fee, to the person(s) chosen by the payor to review and audit the records. ~~(i)~~(f) The responsible employer, carrier, managed care organization, or administrator shall pay the ~~statements bills~~ of medical compensation providers to whom the employee has been referred by the treating physician authorized by the insurance carrier for the compensable injury or body part, unless the physician has been requested to obtain authorization for referrals or tests; provided that compliance with the request shall not unreasonably delay the treatment or service to be rendered to the employee. ~~(j)~~ (g) Employees are entitled to reimbursement for sick travel when the travel is medically necessary and the mileage is 20 or more miles, round trip, at the business standard mileage rate set by the Internal Revenue Service per mile of travel and the actual cost of tolls paid. Employees are entitled to lodging and meal expenses, at a rate to be established for state employees by the North Carolina Director of Budget, when it is medically necessary that the employee stay overnight at a location away from the employee's usual place of residence. Employees are entitled to reimbursement for the costs of parking or a vehicle for hire, when the costs are medically necessary, at the actual costs of the expenses.
~~(k)~~ (h) Any employer, carrier or administrator denying a claim in which medical care has previously been authorized is responsible for all costs incurred prior to the date notice of denial is provided to each health care provider to whom authorization has been previously given.

**.0103 FEES FOR INSTITUTIONAL SERVICES**

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

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

(1) Beginning April 1, 2015, 190 percent of the hospitals Medicare facility-specific amount.

(2) Beginning January 1, 2016, 180 percent of the hospitals Medicare facility-specific amount.

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

(1) Beginning April 1, 2015, 220 percent of the hospitals Medicare facility-specific amount.

(2) Beginning January 1, 2016, 210 percent of the hospitals Medicare facility-specific amount.

(3) Beginning January 1, 2017, 200 percent of the hospitals Medicare facility-specific amount.

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

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

(1) Beginning April 1, 2015, 200 percent of the hospitals Medicare CAH per diem amount.

(2) Beginning January 1, 2016, 190 percent of the hospitals Medicare CAH per diem amount.

(3) Beginning January 1, 2017, 170 percent of the hospitals Medicare CAH per diem amount.

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

(1) Beginning April 1, 2015, 230 percent of the hospitals Medicare CAH claims payment amount.

(2) Beginning January 1, 2016, 220 percent of the hospitals Medicare CAH claims payment amount.

(3) Beginning January 1, 2017, 210 percent of the hospitals Medicare CAH claims payment amount.

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

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

(1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility-specific amount.

(2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.

(3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.

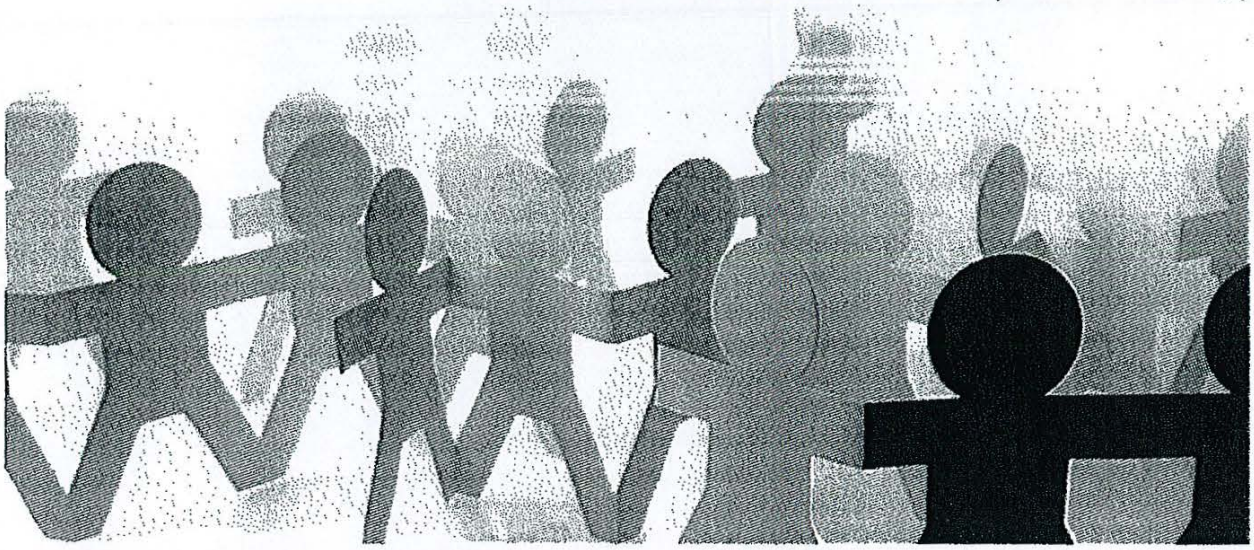
(i) If the facility-specific Medicare payment includes an outlier payment, the sum of the facility-specific reimbursement amount and the applicable outlier payment amount shall be multiplied by the applicable percentages set out in Paragraphs (b), (c), (e), (f), and (h) of this Rule.

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

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

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

Attachment A



## Organizations Affiliated with the NCMS

- CMS Foundation
- CMS Alliance
- CMS Sections
- unty Medical Societies
- ecialty Societies

The North Carolina Medical Society's Specialty Society and Meeting Services Department currently manages ten specialty associations in North Carolina. They are:

1. Carolinas Chapter of the American Association of Clinical Endocrinologists
2. NC Chapter, American College of Physicians
3. North Carolina Dermatology Association
4. North Carolina Neurological Society
5. North Carolina Obstetrical and Gynecological Society
6. North Carolina Orthopaedic Association
7. North Carolina Society of Otolaryngology and Head & Neck Surgery
8. North Carolina Society of Eye Physicians and Surgeons
9. North Carolina Society of Pathologists
10. North Carolina Spine Society

- NCMS Foundation
- NCMS PAC
- Sections
- Specialty Societies

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# North Carolina Medical Society

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# North Carolina Orthopaedic Association

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The mission of the NC Orthopaedic Asociation (NCOA) is to advance the science and practice of orthopaedic surgery through education and advocacy on behalf of patients and practitioners, with emphasis on overall quality orthopaedic health care for the state of North Carolina.

For more information on the NCOA, visit www.ncorthopaedics.org.

## 2016 NCOA Annual Meeting

- **Dates:** October 7-9, 2016
- **Location:** The Pinehurst Resort, Village of Pinehurst, NC
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- Add this event to your calendar.
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For more information on this event, please contact Nancy Lowe, nlowe@ncmedsoc.org, (919) 833-3836 ext. 111.

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**Vice President:** Richard C. "Chad" Mather, III, MD – Durham, NC

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**Councilor to AAOS:** Frank V. Aluisio, MD – Greensboro, NC

**Councilor to AAOS:** Richard Bruch, MD – Durham, NC

**Councilor to AAOS:** Edward G. Lilly, III, MD – Hendersonville, NC

**Executive Director:** W. Alan Skipper, CAE – Raleigh, NC

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- Return your completed Membership Application form along with payment to NCOA; or
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For membership questions, please contact NCOA member services at (800) 722-1350 or ncortho@ncmedsoc.org.

## Support NCOA PAC

NCOA PAC, the non-partisan political committee of the North Carolina Orthopaedic Association (NCOA), relies on voluntary contributions from members like you to back candidates for public office who support the NCOA position on issues affecting orthopaedic practice and patient care in North Carolina. Donate online or download a form to support your PAC.

## NCOA News

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- Arp. 27, 2016
- Mar. 4, 2016
- Nov. 20, 2015
- Aug. 20, 2015
- July 20, 2015
- May 21, 2015
- Apr. 14, 2015
- Mar. 5, 2015
- Jan. 12, 2015
- Dec. 23, 2014
- Oct. 8, 2014

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Executive Director: W. Alan Skipper

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The North Carolina Medical Society

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Attachment C

January 16, 2015

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

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

Dear Ms. Henderson,

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

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

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

- *Payment Rates.* Paragraph (b) of Rule .0102 establishes basic payment rates for all categories of professional services ranging from 140%-195% of Medicare. We understand that the Commission assigned percentages to each category that, based on the available literature, reflect the national median of payment rates for each category. We anticipate, therefore, that this methodology will also result in North Carolina's professional rates moving to the national median in the aggregate – a significant improvement that will also more closely reflect today's costs of providing medical care. According to the most recent WCRI analysis, North Carolina now ranks 41st out of the 43 states that have adopted professional fee schedules. Better rates will help to drive more physicians to participate in the workers' compensation system.

- *PAs, NPs, and other providers.* Physicians have cited difficulties when involving physician assistants, nurse practitioners, and other members of their care teams in treating workers' compensation patients. More specifically, medical practices encounter varying requirements from the carrier community about when (if ever) one of these providers may treat patients and be compensated. Paragraph (h) of Rule .0102 effectively clarifies that physicians may rely on other providers so long as scope of practice laws are followed, and that the rates for services

Attachment C



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

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

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

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

Sincerely,

North Carolina Medical Society

The NCMS Workers' Comp Fee Schedule Task Force

North Carolina Chapter, American College of Physicians

North Carolina College of Emergency Physicians

North Carolina Medical Group Management Association

North Carolina Neurological Society

North Carolina Orthopaedic Association

North Carolina Psychiatric Association

North Carolina Radiological Society

North Carolina Society of Anesthesiology

North Carolina Society of Otolaryngology and Head & Neck Surgery

North Carolina Society of Pathologists

SouthEastern Atlantic College of Occupational & Environmental Medicine

Attachment D

North Carolina Orthopaedic Association

NCOA

March 5, 2015 | view this message as a webpage

## In this edition:



## Medicaid Cut: Take Action

In 2013, the NC General Assembly included a 3% "withhold" for all Medicaid services with the intention of using that money as the foundation of a shared-savings program. After difficulty developing the program, the "withhold" was redrafted as a cut the following year with an effective date of January 1, 2014. That cut has not been implemented due to delays in NCTracks.

Doctors treating Medicaid patients now face a requirement to pay back 3% of everything they have been paid by Medicaid for the last 14 months. Every day that passes increases this financial and administrative burden. We know this money has already been spent on staff salaries, office overhead, and other basic requirements of serving the Medicaid population.

Call or email your representative/senator and tell them how much you will have to send back to Medicaid, and what it will mean to you and your practice. Tell your legislator that you cannot afford a massive recoupment at the same time as you are being asked to transform the entire way we deliver health care to the Medicaid population.

**Take Action Now ==>** and share this alert with your colleagues.

NOTE: Primary care physicians who received enhanced Medicaid payment rates in accordance with the ACA will not be subject to the 3% reduction in 2014. However, those

same PCPs will be subject to the reduced rates and a recoupment of payments made for January and February 2015 dates of service.

*Reprinted with permission from the North Carolina Medical Society.*

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## Significantly Revised Workers' Comp Fee Schedule Achieves Final Approval--First Update in 20 Years!

The North Carolina Orthopaedic Association (NCOA) and the North Carolina Medical Society (NCMS) are excited to report that the N.C. Industrial Commission has confirmed that North Carolina's workers' compensation fee schedule has been updated for the first time in nearly 20 years. The new rates will take on effect July 1, 2015. The N.C. Rules Review Commission on Thursday, Feb. 19, 2015, approved administrative rules which provide the fee schedule update. "The new fee schedule means huge progress for our state's injured workers, the physicians who treat them, and our workers' compensation system as a whole," said **NCMS President Robert E. Schaaf, MD, FACR** in a statement released by the NCMS on Feb. 23, 2015.

This outcome is the result of many years of advocacy by the NCMS on this issue along with many specialties' efforts and a lot of work by NCMS Associate General Counsel Conor Brockett, who guided the successful strategy to completion. **Richard Bruch, MD, NCOA Executive Committee Member and Councilor to the AAOS**, was a member of the NCMS Task Force dedicated to this issue. The update was required by legislation calling for the Industrial Commission to link workers' compensation rates to Medicare rates and policies. One of the forces that propelled this action is the difficulty that workers currently experience when seeking care resulting from on-the-job injuries. The proposed rules were published in the North Carolina Register in November 2014 and a public hearing was held in December. The NCOA joined the NCMS in a comment letter last month supporting the proposed rules.

"The new Industrial Commission Medical Fee Schedule incorporates long needed revisions that will protect injured workers' access to healthcare while significantly reducing the overall cost of the workers' compensation system by establishing fair and reasonable fees for medical treatment," said Chairman Andrew T. Heath, in a press release.

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## Advocacy Update: Certificate of Need Reform Effort is Gaining Momentum

A casualty of the recent winter weather, the Orthopaedic White Coat Wednesday, originally scheduled for Feb. 25, was expected to draw a dozen physicians to Raleigh. The event, however, was cancelled due to the inclement weather and hazardous road conditions. Please watch for a new date to be announced soon.

NCOA lobbyist Connie Wilson reports that CON bills may be introduced in both chambers as early as this week. The political-legislative climate for CON reform in the NC General

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September 26, 2016

Charlton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Kendall Bourdon, Rulemaking Coordinator
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

**RE: Fees for Institutional Services (04 NCAC 10J .0103) (*eff.* Apr. 1, 2015)**

Dear Chairman Allen and Coordinator Bourdon,

Please accept this correspondence on behalf of the National Association of Mutual Insurance Companies (NAMIC)[1] to communicate our strong support of the North Carolina Industrial Commission's (NCIC) passage of 04 NCAC 10J .0103 (*eff.* April 1, 2015) (rule) and communicate our strong opposition to Surgical Care Affiliates, LLC's (SCA) position in *Surgical Care Affiliates, LLC v. NC Industrial Commission* based on the foregoing:

- The rule was properly adopted following approximately three years of negotiations and hearings in accordance with the North Carolina Administrative Procedures Act;

- Rulemaking negotiations included a jointly funded consultant, a formal mediation, and years of rulemaking hearings involving government, business, insurance, community, and professional/expert feedback;

- The rule was produced by way of thoughtful dialogue, investigation, and objective quantitative analysis that allowed North Carolina to bring some of its medical expenses, including those impacting ambulatory surgery centers, in line with those of surrounding states. States that have adopted of Medicare-based fee schedules for workers'

[1] NAMIC is the largest property/casualty insurance trade association in the United States, with more than 1,400 member companies representing 39 percent of the total U.S. market. NAMIC supports a diverse spectrum of regional and local mutual insurance companies as well as many of the largest insurers in the world. NAMIC member companies in the United States and Canada serve more than 170 million policyholders and write more than $230 billion in annual premiums. Our members account for 54 percent of homeowners, 43 percent of automobile, and 32 percent of the business insurance markets in the United States. Through our advocacy programs we promote public policy solutions that benefit NAMIC member companies and the policyholders they serve and foster greater understanding and recognition of the unique alignment of interests between management and policyholders of mutual companies.

compensation include Connecticut, Delaware, Georgia, Kansas, Mississippi, North Dakota, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, and West Virginia;

- All North Carolina stakeholders, including SCA, were provided ample opportunity to participate in the administrative rule-making process;

- Pursuant to NCCI's *Analysis of Alternatives to the North Carolina Ambulatory Surgical Center Fee Schedule Proposed to be Effective January 1, 2017,* in relation to the fee schedule reflected in the rule, the fee schedule clearly reflects the maximum Ambulatory Surgical Center allowable fees proposed in the current rule remain well above the amount permitted for reimbursement by Medicare beneficiaries;

- Any retroactive amendment sought by SCA would result in irreparable harm to businesses in North Carolina that purchase workers' compensation insurance as required by North Carolina law;

- Any amendment to the rule would adversely affect medical costs incurred by the State of North Carolina, local governments, school boards, and insurers, amongst others.

Thank you greatly for your time and consideration related to the above.

Regards,

Liz L. Reynolds, CPCU, API, IOM
Director – State Affairs
Southeast Region

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North Carolina Hospital Association

September 26, 2016

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

Dear Chairman Allen and Commissioners:

The North Carolina Hospital Association (NCHA) recommends to the Commission, as it considers a new rule for ambulatory surgical facilities, that the ambulatory surgical fee schedule should follow the language, percentages and schedule previously adopted by the Commission in Rule 04 NCAC 10J .0103 (see attached). For 2017 and beyond, that rule had provided for 200% of the applicable Medicare rate for ambulatory surgical centers, with the applicable am-surg fee schedule determined pursuant to subsection (g).

As the Commission is aware, the language of this Rule and the fee schedule amounts were developed over a nearly 3-year period after studies of fee schedules in other states; impact analyses by providers, employers and insurers; and consideration of related issues. The impact of moving to 200% of Medicare was a substantial reduction for hospitals and ambulatory surgery facilities, thus leading to the phase-in of the reductions over the 2015 to 2017 period.

NCHA does not support a lower percentage than 200% for hospital outpatient and ambulatory surgery centers. Medicare's outpatient payments are low in comparison to costs, thus requiring a 2x multiplier to provide adequate reimbursement. Even at 200%, the workers' compensation fee schedule rates are lower than what commercial managed care plans pay hospitals for the same services. The rates were set at that level in order to balance adequate reimbursement with the Commission's duty to control medical costs. Rates lower than 200% will likely create an access problem, as facilities providing services to workers' compensation patients cannot sustain lower levels of payment and would need to consider discontinuing providing costlier services or procedures to injured workers. Ensuring an adequate rate is therefore critical in enabling the Commission to meet the third prong of its duty in developing a fee schedule: ensuring that injured workers are provided the services and standard of care required by the Workers' Compensation Act.

NCHA and others have previously provided the Commission with data and studies used in the development of the fee schedule that was recommended to and adopted by the Commission in 2014. Those studies included the following:

> (1) NORTH CAROLINA WORKERS COMPENSATION INSURANCE: A WHITE PAPER REVIEWING MEDICAL COSTS AND MEDICAL FEE REGULATIONS, prepared for the National Foundation for Unemployment Compensation and Workers' Compensation; prepared by Philip S. Borba, Ph.D. and Robert K. Briscoe, WCP, Milliman, Inc.; May 23, 2013.

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

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

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

We have reviewed the NCCI/NCRB data, and it is unclear on a number of its assumptions and methodologies, which can significantly impact its findings. NCHA is continuing to review the data with our consultant.

If you have any questions, please feel free to contact me.

Sincerely,

Linwood Jones

Linwood Jones
General Counsel
North Carolina Hospital Association

cc. Kendall Bourdon
Meredith Henderson

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

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

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

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

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

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

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

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

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

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

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

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

1. (1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility-specific amount.

2. (2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.

3. (3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.

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

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

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

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


*Triangle Orthopaedic Associates, P.A. affiliate organization*

October 3, 2016

Charlton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Dear Chairman Allen and Commissioners:

Thank you for the opportunity to present comments in response to possible rulemaking options for the maximum allowable amounts for services provided by ambulatory surgical centers ("ASCs") in Workers' Compensation cases under North Carolina's Workers' Compensation Act. Please accept this letter in support of the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

Triangle Orthopaedics Surgery Center (TOSC) is an accredited, two Operating Room, single specialty, orthopaedic ASC located at 7921 ACC Blvd. in Raleigh. TOSC was awarded one of three demonstration project CONs to develop a physician owned ASC as outlined in the State Health Coordinating Council's 2010 State Medical Facilities Plan. Since opening in 2013, Triangle Orthopaedics Surgery Center has served over 7000 patients. It is the mission of TOSC and its physician owners to provide access to safe, high quality outpatient surgical care in a cost effective manner, allowing physicians and patients active involvement in directing the care that is delivered to all members of our community.

In April 2015, the Industrial Commission established new Workers' Compensation fee schedules for hospitals, physicians, and ASCs. However, in promulgating regulations to establish a new fee schedule for ASCs, the Industrial Commission failed to follow the required process set forth in the Administrative Procedure Act. Consequently, the fee schedule was ruled invalid on August 9, 2016 by Wake County Superior Court Judge Paul Ridgeway.

In response to the Court's order invalidating the April 1, 2015 fee schedule for ASCs, the Commission has requested proposals to amend Rule 04 NCAC 10J .0101, .0102, and .0103.

Triangle Orthopaedics Surgery Center is in full support of SCA's proposal to align reimbursement rates for ASCs with the reimbursement rates set for hospital outpatient departments. We fully agree that alignment of reimbursement schedules allows for site-of-service decisions to be based solely on clinical judgment, quality outcomes, and scheduling efficiency.

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Triangle Orthopaedics Surgery Center

*Triangle Orthopaedic Associates, P.A. affiliate organization*

In addition, we fully support SCA's proposal to cover procedures that were being conducted in ASCs prior to the enactment of the invalid fee schedule on April 1, 2015. Excluding the procedures that were previously performed at ASCs will result in an access problem for injured workers, which would violate the statutory requirements of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

Finally, we strongly oppose the three proposals submitted by insurance carriers, third-party administrators, and the North Carolina Hospital Association. The three proposals all recommend a significantly reduced fee schedule for ASCs, which would limit injured workers' access to timely care.

Thank you for your consideration. If you have any questions, please feel free to contact me at (919)596-8524.

Sincerely,

Christine Washick RN, CASC
Administrator
Triangle Orthopaedics Surgery Center, LLC

cc: Kendall Bourdon
Meredith Henderson

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North Carolina Hospital Association

October 10, 2016

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

Dear Chairman Allen and Commissioners:

Thank you for the opportunity for NCHA to comment on the am-surg fee schedule at the October 3rd public hearing. We are providing the following information to supplement and further elaborate on a few issues that were discussed at the hearing.

NCHA recommends that the Commission adopt the same rule that it had adopted earlier for payment of ambulatory surgery rates. NCHA does not support a rate lower than 200% of Medicare for hospital outpatient or am surg rates for reasons noted at the hearing and in our previous comment letter.

**Hospital outpatient rates versus am-surg rates**

There was quite a bit of discussion at the hearing on the difference between hospital outpatient rates and am-surg rates. Under the Medicare fee schedules, hospital outpatient rates are on average higher than those for am-surg centers. NCHA does not support tying am-surg rates to the hospital outpatient fee schedule for several reasons:

- If Medicare is going to be used as the basis for the fee schedule, then Medicare's fee schedules (with the 2x multiplier for workers' compensation) need to be adhered to, without changing the payment differentials between various providers. The Medicare fee schedules have been actuarially developed by CMS, and as discussed below, there are reasons for the differences in reimbursement levels between hospital outpatient and am-surg facilities under those fee schedules.

- Hospital outpatient services are costlier than am-surg services for several reasons. Hospitals incur substantial costs relating to keeping an emergency room open 24/7 and maintaining service lines that are needed by the community but unprofitable. ASCs are also typically able to schedule surgery during normal business hours, whereas hospitals have less predictive scheduling, which results in higher costs. Hospitals also provide charity care to the indigent and are reimbursed below cost for serving Medicaid recipients.

- In addition, as noted in the attached memorandum from Optum, Medicare uses relative weights as one of the factors in determining payment rates for hospital outpatient facilities and ASCs. Relative weights establish how costly any one service is in relation to any other service. Optum examined the relative weights of 3,077 procedures performed by hospital outpatient departments and ASCs. Of those, the hospital outpatient relative weights were higher than ASC relative

weights 2,952 times. The ASC relative weights were higher only 125 times. The relative weight is higher for hospital outpatient because the hospital payment generally includes additional bundled services – such as clinic, emergency department, radiology, MRIs, CTs, laboratory and other services – that are often not performed in an ASC-setting. As noted by Optum, adopting the hospital outpatient relative weights for ASCs would mean paying ASCs for services they often do not – and cannot – perform.

- Hospital outpatient departments must meet the provider-based requirements under federal regulations (42 CFR § 413.65(d) and Transmittal A-03-030). Those requirements include the following:
  - The outpatient department operates under the same license as the hospital.
  - The outpatient department has integrated clinical services with the hospital. This includes requirements that the hospital maintain the same monitoring and oversight of the outpatient facility as it does for any other hospital department. The hospital medical staff committees are responsible for overseeing medical activities and quality assurance at the outpatient department.
  - The hospital and outpatient department have a unified retrieval system for medical records.
  - Patients of the outpatient department have full access to all services of the hospital.
  - The hospital and its outpatient department are fully financially integrated.
  - The hospital outpatient department must comply with hospital rules such as anti-dumping, nondiscrimination, and health and safety rules.
  - Additional rules apply when the outpatient department is located off the hospital campus.

**NCCI Analysis**

NCHA asked Optum to review NCCI's analysis. Optum's comments and questions on the analysis are included in the attached memo. Optum noted that without more explanation of the analysis, "it is difficult to determine whether the models reflect what may happen should any of the various methodologies or percentages be adopted. Generally, models staying within ASC-PPS system are most likely to have some reliability, but cross-system comparisons of ASC-PPS and OPPS need an explanation of discounts and bundles to determine reliability."

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

Sincerely,

Linwood Jones

Linwood Jones
General Counsel

9200 Worthington Rd
Suite 300
Westerville, OH 43082
www.optum.com

Oct. 6, 2016

To: Linwood Jones

From: Eric Anderson
Managing Consultant
Reimbursement Analytics

Re: Discussion of NCIC-requested analysis and SCA Response

At the request of the North Carolina Hospital Association, Optum was asked to perform a technical review of a workers' compensation Ambulatory Surgical Center (ASC) analysis provided to the North Carolina Industrial Commission as well as a response from Surgical Care Associates (SGA).

As background, Optum has provided assistance to more than a dozen states in developing and implementing facility (hospital and ASC) workers' compensation payment methodologies.

## Discussion of analysis for Industrial Commission

Modeling changes in reimbursement methodologies can be extremely difficult, particularly for facility outpatient payments. While Medicare's hospital outpatient prospective payment system (OPPS) and the ambulatory surgery center system (ASC-PPS) are similar, they also differ in significant ways. How those differences are accounted for in the modeling process can make a considerable difference in the results.

The only completely accurate method is to have claim-level detail (all items on the claim), with a sufficient number of claims, and to process those claims through commercially available pricing software with different payment models selected. It appears this option was unavailable. Lacking that, an analyst is confronted with making assumptions in reconciling disparities between OPPS and ASC-PPS.

The reimbursement models provided to NCIC have insufficient documentation how differences between OPPS and ASC-PPS were accounted for. These unanswered questions preclude definitive conclusions on the reliability of cross-system comparisons between ASC-PPS and OPPS.

The following bold-face items are from the analysis with an examination of how different assumptions may produce differing results.

***Page 2: Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code***

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The documentation does not detail how many claims, services, or providers were present in the data. Also missing is explanation of what detail level was used. If a low claim volume is used, there is an increased likelihood of variability between the model and the eventual real-world implementation. If summarized volumes instead of actual claims were analyzed, then certain steps are required to account for the impact of discounts and bundles.

The lack of volume information and use of summarized information does not negate the analysis, but low and/or summarized volumes potentially diminish reliability.

***Page 2: ... "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.***

The physician study cited concludes when a decrease in maximum reimbursement for physician services occurs, only 50% of the decline is realized. Conversely, when an increase in maximum reimbursement for physician services occurs, only 80% of the increase is realized. This physician study becomes the basis for implementing a "price realization factor" which adjusts the impact of any reimbursement methodology changes. Declines are reduced by half; increases are set at 80%.

The referenced study specifically did not consider hospital or ambulatory surgical center transactions. On Page 5, the study noted: *"The data set excludes transactions associated with medical services provided by hospitals and ambulatory surgical centers, but includes transactions related to services delivered by physicians (the provider type) at these places of service.*

OPPS and ASC-PPS are facility fee schedules. Unlike physicians, hospitals and ASCs generally have less flexibility in charging different prices to different payers as physicians might.

Because of payer networks and other factors, the full impact of any methodology change is unlikely to occur. However, applying estimates from physician study to a facility methodology merits further explanation as to its appropriateness.

Using a physician price realization factor may understate the lower boundary by as much as 50% (the reduction may be more than expected) and also underestimate the upper boundary by 20% (the increase may be more than expected).

***Page 3 "Prior MAR"***

There are several questions relating to the MAR calculations.

1. The Prior MAR calculation uses the 2015 ASC-PPS schedule while the proposed MAR calculations use the 2016 ASC-PPS schedule. Although Medicare makes

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adjustments to achieve the same results year-over-year, workers' compensation utilization differs from Medicare's. As the result, weight changes for workers' compensation services might not be neutral and could represent an increase or decrease. This can be tested using North Carolina workers' compensation volumes to determine whether Medicare weight changes impact reimbursement. The documentation does not explain whether this was done. If it was not done, some reimbursement impact may be driven by changes in Medicare's weighting, not changes in reimbursement methodology or percentages.

2. The Proposed MAR – ASC-Based Alternatives does not state whether wage indexes were considered when modeling payments. Because they are not mentioned, presumably they were not. However, if wage indexes were considered they may have created another inadvertent issue. Core Based Statistical Areas (CBSAs) were revamped as the result of the 2010 census. These resulted in changes to CBSA compositions. That, in turn, brought about wage index changes with most occurring between 2014-16. If wage indexing was done, then payment changes as any CBSA changes ought to be been noted in the modeling.

3. The Proposed MAR – Hospital-Based Alternatives lacks a pertinent discussion. While ASC-PPS and OPPS are similar, they differ in discounting and bundling. Because hospitals provide a broader range of services than ASCs, hospital bundles are often larger and more comprehensive. There is no discussion how the disparities between the two systems were reconciled. A reasonable presumption might be that the analysis used the multiple procedure discount flag from ASC-PPS, but strictly speaking that is not following OPPS payment rules. Without clarity on discounting and bundling, the analysis of MAR—Hospital-Based Alternatives should be regarded with some skepticism.

**Summary**

The modeling produced one seemingly unlikely result. One model estimated what happens if payments increased from 220% of ASC-PPS (using 2015 weights) to 235% of ASC-PPS (using 2016 weights). The lower boundary calculation projected overall ASC payments might drop 4.1% or a $1.9 million.

An increase in payment results in less expenditure seems an unlikely result. Although there are ways this might be achieved, an explanation as to how the model creates this counterintuitive result would be helpful. Without further explanation, it is difficult to determine whether the models reflect what may happen should any of the various methodologies or percentages be adopted. Generally, models staying within ASC-PPS system are most likely to have some reliability, but cross-system comparisons of ASC-PPS and OPPS need an explanation of discounts and bundles to determine reliability.

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## Discussion of Surgical Care Associates response

Surgical Care Associates LLC (SCA) offered a response to the payment modeling presented to the Industrial Commission. While the SCA response covers details beyond a technical analysis, the hospital association asked that Optum review the technical components of SCA's response. The bold-face text is from the SCA response.

***Page 2: For those services that are covered under Medicare, the invalid fee schedule contains reimbursement that is inadequate and that would create a significant disparity between ASCs and hospital outpatient departments for the same services.***

The disparity is created by the adoption of a Medicare-based system.

***Page 2: (g) For those procedures for which CMS has established a Medicare rate, the schedule of maximum reimbursement rates for services provided by ambulatory surgical centers ("ASC") should be the same as the schedule of maximum reimbursement rates for hospital outpatient institutional services as set forth in sub-part (c) above.***

This sentence and further discussion equates payments for services in hospital outpatient departments (HOPD) with services provided in ambulatory surgical centers.

There are two components to Medicare's payment policy:

- A relative weight which establishes how costly any one service is in relation to any other service.
- A conversion factor which accounts for differences among hospitals and among ASCs. For outpatient, the only adjustment to the conversion factor is the wage index that adjusts for geographical salary differences.

SCA's suggestion does not say but presumably wishes adoption of both the hospital relative weights as well as hospital conversion factors. Of these two, relative weights present a more complex issue. Medicare's comprehensive and consolidated bundling payment methodology is different between ASCs and hospital outpatient.

In general, what may appear to be equivalent services may not be because Medicare's bundling system includes services beyond just the HCPCS code itself. In other words, while the HCPCS codes for ASCs and hospitals may be the same, the payment often includes a different range of services bundled in the payment.

The chart below illustrates. It shows the difference in relative weights for some common workers' compensation procedures performed in hospital outpatient departments and ASCs.

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| Comparison of Relative Weights, April 2016 OPPS and ASC-PPS (Addendum AA/Addendum B) | | | | |
|---|---|---|---|---|
| HCPCS Code | Short Descriptor | ASC Weight | OPPS Weight | Status Indicator |
| 29806 | Shoulder arthroscopy/surgery | 56.2787 | 67.4027 | J1 |
| 29807 | Shoulder arthroscopy/surgery | 56.2787 | 67.4027 | J1 |
| 29827 | Arthroscop rotator cuff repr | 56.2787 | 67.4027 | J1 |
| 29828 | Arthroscopy biceps tenodesis | 56.2787 | 67.4027 | J1 |
| 29855 | Tibial arthroscopy/surgery | 79.9669 | 95.8165 | J1 |
| 29856 | Tibial arthroscopy/surgery | 79.9669 | 95.8165 | J1 |
| 29862 | Hip arthro w/debridement | 56.2787 | 67.4027 | J1 |
| 29866 | Autgrft implnt knee w/scope | 56.2787 | 67.4027 | J1 |
| 29885 | Knee arthroscopy/surgery | 56.2787 | 67.4027 | J1 |
| 29888 | Knee arthroscopy/surgery | 79.9669 | 95.8165 | J1 |
| 29899 | Ankle arthroscopy/surgery | 79.9669 | 95.8165 | J1 |

The OPPS (hospital outpatient) relative weight is higher than the ASC-PPS weight because the hospital payment usually includes additional bundled services – typically clinic, emergency department, radiology, MRIs, CTs, laboratory and other services – that are often not performed in an ASC-setting.

In the April 2016 Medicare update, OPPS relative weights are higher than ASC relative weights 2,952 times. Conversely, ASC relative weights were higher 125 times.

Because of their nature, ASCs do not perform many of the services included in hospital outpatient bundles. Adopting the OPPS relative weights for ASCs would mean paying ASCs for services they often do not – and cannot – perform.

***Page 3: The amendment being proposed by SCA would have a positive effect on the procedures of the Commission because it will eliminate the confusion that currently exists whereby some insurance carriers have determined that some procedures currently being performed at ambulatory surgical centers are not covered in the current invalid fee schedule based on ASC Medicare rates.***

While the proposed change may or may not eliminate some confusion that currently exists, it would create another type of confusion in determining how to apply a different set of bundling rules – notably the comprehensive status indicator, J1 – that apply in OPPS but is not present in ASC-PPS.

Medicare's J1 status indicator in hospital outpatient has no comparable methodology in ASC-PPS. In general, if a code with a J1 status indicator appears on a claim, that is paid and

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nothing else. There are complex rules relating to payment when two or more HCPCS codes with J1 status indicators appear on a claim. Medicare is greatly expanding HCPCS codes covered by the J1 status indicator. For 2017, more than 2,500, mostly surgical, HCPCS codes will have a J1 status indicator.

Beyond the bundling issue, there are also differences in how OPPS and ASC-PPS handle wage index adjustments and which wage indexes would apply. Additional rules would need to be developed to handle these disparities.

***Page 4: As noted by the Commission, discrepancies in payments between ambulatory surgical centers and hospital outpatient departments would "potentially diminish the pool of doctors available to treat injured employees, and reduce the quality and timeliness of care.***

Presumably the quoted material accurately reflects the commission's statement.

That notwithstanding, it begs the question of how a discrepancy in facility payment affects the pool of doctors. For most hospitals and some ASCs, workers' compensation is a relatively small portion of their patient volume.

Hospitals make decisions based on their overall patient volume as do some, perhaps most, ASCs. Clearly, a discrepancy in physician payment could impact the availability of physicians, but the contention on facility payments is less clear.

***Page 5: Specifically, NCCI improperly uses the invalid ASC fee schedule as the baseline for calculating the cost or saving related to the proposed changes. The ASC fee schedule required by the August 9, 2016 court decision reimburses providers at 67.15% of billed charges. The NCCI analysis uses the invalid ASC fee schedule reimbursement of 210% of Medicare ASC rates as the baseline for the proposed fee schedule changes. Therefore, NCCI's analysis using the invalid fee schedule understates the total impact on the overall workers compensation system when adopting a ASC fee schedule that reimburses ASC at a lower rate than the current fee schedule reimbursement of 67.15%.***

Our analysis generally agrees with this point. It was unclear from the documentation whether there was an adjustment for the time period. Our reading of the methodology was that 220% of Medicare was used as the basis for the previous MAR calculation.

***Page 5: SCA conducted independent analysis using internal data and NCCI's methodology to evaluate the impact of SCA's proposed fee schedule change from the current ASC fee schedule reimbursement rate of 67.15% of billed charges to the 2017 Service Year reimbursement rate of 200% of HOPD Medicare. The analysis concluded that the resulting overall savings in 2017 to the overall workers comp system would be $8.8M (-0.5%).***

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The description of the SCA analysis does not state whether it used the hospital conversion factor, whether it made wage index adjustments, whether it used the hospital relative weights or how it handled hospital bundled payments. As with the analysis for the Industrial Commission discussed earlier, without this information it is difficult to determine whether SCA's analysis reliably models the impact to changes in payments.

Parker Poe

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October 10, 2016

**Via Hand Delivery**

Charlton L. Allen, Chairman
Rincon Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Re:

Dear Chairman Allen and Commissioners:

On behalf of Surgical Care Affiliates, LLC ("SCA"), we are submitting SCA's comments in response to proposals submitted to the North Carolina Industrial Commission addressing fees for ambulatory surgical center services in workers' compensation cases. We also are submitting a number of letters supporting the proposal that was submitted by SCA and opposing the three other proposals that were submitted to the Industrial Commission.

Thank you for the opportunity to provide these comments.

Sincerely,

Renee J. Montgomery

RJM:rms

cc: Kendall Bourdon (via e-mail)
Meredith Henderson (via e-mail)

**SURGICAL CARE AFFILIATES' COMMENTS
IN RESPONSE TO PROPOSALS SUBMITTED
TO THE NORTH CAROLINA INDUSTRIAL COMMISSION**

**October 10, 2016**

To: Kendall Bourdon
IC Rulemaking Coordinator
North Carolina Industrial Commission
Delivered via email to kendall.bourdon@ic.nc.gov

Pursuant to the North Carolina Industrial Commission's ("Commission") September 2, 2016 Notice of Public Comment Meeting, Surgical Care Affiliates, LLC ("SCA") respectfully submits the following comments in response to the proposals submitted to the Commission addressing fees for ambulatory surgical center services in workers' compensation cases.

SCA manages seven ambulatory surgical centers 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 Day 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.

SCA and the ASCs in North Carolina that support SCA's proposal submitted to the Industrial Commission on September 26, 2016 represent the majority of ASCs in North Carolina that provide surgical services to injured workers covered by the Workers' Compensation Act.

## THE OTHER THREE PROPOSALS ARE NOT COST EFFECTIVE AND DO NOT MEET NORTH CAROLINA STATUTORY 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 other three proposals do not meet these requirements.

The other three proposals do not address all procedures that can be performed in ambulatory surgery centers. By crafting a fee schedule that uses only Medicare as its foundation, the other proposals do 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 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 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 time frame.[4] The ability to keep workers' compensation and commercial patients in the facility overnight broadens the list of procedures that can be performed safely and effectively in the ASC setting.

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.

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 case in its inpatient setting. The result is a much higher cost to the system of an inpatient stay and procedure. Allowing an ASC to perform cases not on the Medicare ASC list provides an alternative setting for these procedures, and allows the injured worker's doctor to make the decision for his or her patient about the best site of service for these procedures.

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 of 2015 when the invalid fee schedule began being used. SCA's Workers' Compensation cases declined by 4.2% between April 1, 2015-March 31, 2016. An NCCI analysis of volume recently obtained by SCA shows a decline in volume of Workers' Compensation cases by all North Carolina ASCs in 2015 of 8.2%.[5]

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

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[1] NCCI, Effectiveness of Workers Compensation Fee Schedules - A Closer Look, February 11, 2009

[2] 42 C.F.R. §416.166 (b).

[3] G.S. §131E-176 (1)(b).

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

[5] NCCI data includes one quarter of payment not under the invalid fee schedule.

Additionally, the unintended consequences of the cost to the system that would be caused by accepting the other three proposals were not considered in the NCCI analysis. Patients are commonly seen much more quickly in the ASC setting than they can be accommodated in the hospital. None of the costs of this system that result from an injured worker having a delay in access to services were included in the NCCI analysis. Additionally, the costs of having services performed in the more expensive inpatient environment as a result of procedures not contemplated in the outpatient methodology were also considered in NCCI's analysis.

Also, as SCA set forth in its proposal, the cost analysis requested by the Commission wrongly compares new ASC fee schedules to the ASC fee schedule that has been declared invalid.

## THE OTHER THREE PROPOSALS ARE OUT OF STEP WITH TRENDS IN MEDICARE REIMBURSEMENT

The other three proposals fail to recognize recent federal Medicare payment policy reforms. In 2015, Congress passed the Bipartisan Budget Act of 2015 (Pub. L. 114-74). The legislation contained a provision that changed the reimbursement methodology for new off-campus hospital outpatient departments. Specifically, Section 603 "would codify the Centers for Medicare & Medicaid Services (CMS) definition of provider-based (PBD) off-campus hospital outpatient departments (HOPDs) as those locations that are not on the main campus of a hospital and are located more 250 yards from the main campus. The section defines a "new" PBD HOPD as an entity that executed a CMS provider agreement [after the date of enactment]. Any PBD HOPD executing a provider agreement after the date of enactment would not be eligible for reimbursements from CMS' Outpatient Prospective Payment System (PPS). New PBD HOPDs, as defined by this section, would be eligible for reimbursements from either the Ambulatory Surgical Center (ASC PPS) or the Medicare Physician Fee Schedule (PFS)."[6] Congress has recognized that ASCs and HOPDs should have parity in their reimbursement by Medicare.

The workers' compensation system should not be responsible for hospital overhead. It has been argued that hospitals have an infrastructure and overhead that necessitates payment for workers compensation cases at higher rates than ASCs. Payment should be equivalent between the two 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 hospital outpatient fee schedule. In 2014, the Medical Services Review Committee in Alaska was directed to create a medical fee schedule

[6] U.S. House Committee on Ways and Means, Bipartisan Budget Act of 2015 Section-by-Section Summary, http://docs.house.gov/meetings/RU/RU00/CPRT-114-RU00-D001.pdf

based on Medicare-based conversion factors. The new schedule became effective December 1, 2015. The Medical Services Review Committee determined that hospital outpatient department and ambulatory surgical centers should be reimbursed as a percent of the Medicare hospital outpatient fee schedule.[7] Similarly, effective April 1, 2015, the Connecticut Workers' Compensation Commission established a medical fee schedule for ASCs based on the Medicare hospital outpatient fee schedule.[8]

## SCA's PROPOSAL WILL SAVE THE SYSTEM MONEY

The analysis done by SCA shows that there will be significant savings in adopting the proposal that SCA has submitted. In crafting this analysis, SCA reviewed historical case volume performed at our seven facilities. Cost comparisons were conducted on payments for these procedures under the former methodology of 67.15% of billed charges for procedure codes versus the same procedures paid at the 2017 Service Year reimbursement rate of 200% of hospital outpatient department Medicare rates. SCA estimated a 40% reduction in payments. Using NCCI's methodology to estimate the impact of the fee schedule reforms, the analysis concluded that the resulting overall savings in 2017 to the overall workers' compensation system would be $8.8M (-0.5%).

As noted by the Commission, 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. 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."[9] 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 hospital outpatient medical fee schedules.

## THE REDUCTION IN RATES TO 150% OF THE MEDICARE ASC FEE SCHEDULE PROPOSED WOULD BE VERY HARMFUL TO THE SYSTEM

Reducing the fee schedule to 150% of ASC Medicare as suggested by one proponent would have an even greater negative affect on workers access to surgical care. As noted by NCCI: "The Medicare fee schedule is very useful as a starting point for the design of WC medical fee schedules, but has notable shortcomings for WC, including too little emphasis on return to function and too little sensitivity to cost differences among states."[10] WCRI noted that "if workers' compensation fee schedule rates are higher than Medicare, this does not necessarily mean that the workers' compensation rates are high enough to avoid access-to-care issues for injured workers. The latter limitation arises because providers' decisions about which patients to see are influenced in part by reimbursement rates from alternative payors.

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[7] HB316, Chapter 63 SLA 14.
[8] CT Public Act 14-167.
[9] North Carolina Industrial Commission, Memorandum of Law In Support of Motion To Stay, August 17, 2016.
[10] NCCI, Effectiveness of Workers Compensation Fee Schedules - A Closer Look, February 11, 2009.

If workers' compensation pays higher than Medicare but lower than commercial insurers, there still might be legitimate concerns about access.[11]

In Texas, following drastic cuts in the fee schedule, the number of physicians willing to treat all work-related injuries dramatically declined from 2002 to 2004. Specifically, "[t]hree quarters (77%) of orthopedic surgeons in Texas now limit workers compensation cases, dramatically up from (29%) two years ago. Similar declines in access have occurred for general surgeons and other surgical specialists.[12]

Hawaii experienced similar access issues when its workers' compensation fee schedule reimbursements were inadequate. As noted in a comprehensive review conducted by the state:

> While the impact of the change in the medical fee schedule may not have reached overwhelming proportions, it appears to have affected the treatment of injuries in workers' compensation cases. Health care providers are struggling with a duty to heal, while juggling fiscal responsibilities that will afford them to stay in business to continue to practice medicine. This trend of turning away workers' compensation patients should be given attention before it becomes critical. The medical fee schedule definitely appears to have had a negative impact on an injured employee's access to specialty care and diminished access to more experienced health care providers.[13]

Workers' compensation medical cost variation is not solely driven by the medical fee schedule. As noted by the National Academy of Social Insurance, "the tremendous interstate variation in the share of total benefits going to medical care reflects between-state differences in: average weekly wages; the nature and severity of work-related injuries; the quantity and prices of medical services provided to injured workers; and the dollar value of cash benefits (driven by factors such as benefit replacement rates, maximum and minimum weekly benefits, the waiting period, and duration of TTD benefits). If, therefore, changes to the workers' compensation law in a given state reduce the dollar value of cash benefits, but medical benefits are stable, the share of benefits accounted for by medical care increases."[14] Additional factors such as strong employment growth also increase medical benefits since more employed workers will be covered under workers compensation.

A significant reduction in ASC rates will benefit the carriers at the expense of providers and employers. Well before the workers compensation fee schedule reforms enacted in 2013, the workers' compensation carriers realized a sharp increase in profits. As reported by the National Association of Insurance Commissioners, underwriting profits and profits on insurance transactions have increased sharply since 2005.

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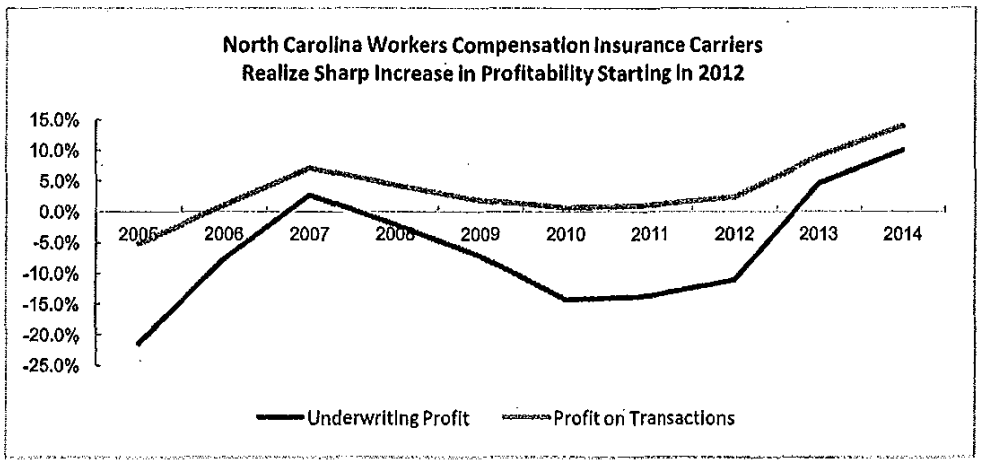
[11] WCRI, Designing Workers' Compensation Medical Fee Schedules, June 2012.
[12] Texas Medical Association, Workers' Compensation Special Report – 2004 Survey of Texas Physicians."
[13] The Medical Fee Schedule Under the Workers' Compensation Law, Legislative Reference Bureau State Capitol, Honolulu, Hawaii
[14] National Academy of Social Insurance, Workers' Compensation: Benefits, Coverage, and Costs, 2014

| | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|
| Underwriting Profit | -21.4% | -7.7% | 2.7% | -2.1% | -7.2% | -14.3% | -13.7% | -11.1% |
| Profit on Transactions | -5.2% | 1.0% | 7.1% | 4.3% | 1.9% | 0.7% | 1.0% | 2.4% |




## CONCLUSION

For the reasons set forth above, the Commission should adopt SCA's proposed fee schedule and reject the fee schedules proposed by the other three proponents. SCA's proposed fee schedule is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Respectfully submitted this 10th day of October 2016.

K. Collins

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CHARLOTTE SURGERY CENTER
*an affiliate of* ***SCA***

October 6, 2016

Charlton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Dear Chairman Allen and Commissioners:

Thank you for the opportunity to present comments in response to possible rulemaking options for the maximum allowable amounts for services provided by ambulatory surgical centers ("ASCs") in Workers' Compensation cases under North Carolina's Workers' Compensation Act. Please accept this letter in support of the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

Charlotte Surgery Center is a multi-specialty ambulatory surgery center affiliated with Surgical Care Affiliates. We have been serving Mecklenburg County cost effectively for over 30 years, and have performed 7,000 Worker's Comp cases since 2009.

We are currently working with self-insured employers to move Worker's Comp cases from the higher cost hospital setting to Charlotte Surgery Center, particularly from surrounding markets where there is not an ASC option. The savings opportunity versus inpatient hospital rates is significant. Should the cuts to Worker's Comp rates drive ASC's to exit the market, as has happened in other states, leaving only the inpatient hospitals to serve the Worker's Comp patients, a significant financial burden would be placed on both the insurers and the self-insured employers they represent.

In April 2015, the Industrial Commission established new Workers' Compensation fee schedules for hospitals, physicians, and ASCs. However, in promulgating regulations to establish a new fee schedule for ASCs, the Industrial Commission failed to follow the required process set forth in the Administrative Procedure Act. Consequently, the fee schedule was ruled invalid on August 9, 2016 by Wake County Superior Court Judge Paul Ridgeway.

In response to the Court's order invalidating the April 1, 2015 fee schedule for ASCs, the Commission has requested proposals to amend Rule 04 NCAC 10J .0101, .0102, and .0103.

Charlotte Surgery Center is in full support of SCA's proposal to align reimbursement rates for ASCs with the reimbursement rates set for hospital outpatient departments. We fully agree

that alignment of reimbursement schedules allows for site-of-service decisions to be based solely on clinical judgment, quality outcomes, and scheduling efficiency. We also believe that the 40% cost savings of $8.8 million, versus the currently valid fee schedule of 67% of billed charges, accomplishes the cost saving goals of the Commission while protecting the aforementioned clinical goals.

In addition, we fully support SCA's proposal to cover procedures that were being conducted in ASCs prior to the enactment of the invalid fee schedule on April 1, 2015. Excluding the procedures that were previously performed at ASCs will result in an access problem for injured workers, which would violate the statutory requirements of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

Finally, we strongly oppose the three proposals submitted by insurance carriers, third-party administrators, and the North Carolina Hospital Association. The three proposals all recommend a significantly reduced fee schedule for ASCs, which would limit injured workers' access to timely care.

Thank you for your consideration. If you have any questions, please feel free to contact me at 704-617-7324.

Sincerely,

Thomas J. Lally
C.E.O.

cc: Kendall Bourdon
Meredith Henderson

October 10, 2016

Charlton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Dear Chairman Allen and Commissioners:

Thank you for the opportunity to present comments in response to possible rulemaking options for the maximum allowable amounts for services provided by ambulatory surgical centers ("ASCs") in Workers' Compensation cases under North Carolina's Workers' Compensation Act. Please accept this letter in support of the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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In addition, we fully support SCA's proposal to cover procedures that were being conducted in ASCs prior to the enactment of the invalid fee schedule on April 1, 2015. Excluding the procedures that were previously performed at ASCs has resulted and will continue to result in an access problem for injured workers, which violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

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Thank you for your consideration.

Sincerely,

S-RO.

SEAN RAMBO
PRESIDENT/COO, COMPASS SURGICAL PARTNERS

cc: Kendall Bourdon
Meredith Henderson

FAYETTEVILLE AMBULATORY SURGERY CENTER
an affiliate of SCA

October 10, 2016

Charlton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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Sincerely,

Debbie Long,
Business Office Manager

cc: Kendall Bourdon
Meredith Henderson

# BLUE RIDGE SURGERY CENTER

an affiliate of SCA

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Sincerely,

Kathy Geiss, Administrator

cc: Kendall Bourdon
Meredith Henderson

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

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Sincerely,

Sean M. McNally, CEO
Raleigh Orthopaedic Clinic

cc: Kendall Bourdon
Meredith Henderson

EASTERN REGIONAL SURGICAL CENTER

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Thank you for your consideration.

Sincerely,

Robert Satterfield, MD
Orthopaedic Surgeon

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,

Douglas Freels, MD
Orthopaedic Surgeon

cc: Kendall Bourdon
Meredith Henderson

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EASTERN REGIONAL SURGICAL CENTER

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Sincerely,

B. Todd Smith, MD
Orthopaedic Surgeon

cc: Kendall Bourden
Meredith Henderson


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Lew Martin, MD
Orthopaedic Surgeon

cc: Kendall Bourdon
Meredith Henderson

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Adam Thorp, MD
Orthopaedic Surgeon

cc: Kendall Bourdon
Meredith Henderson

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EASTERN REGIONAL SURGICAL CENTER

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Sincerely,

Zizette Gabriel, MD
Anesthesiologist / Pain Management

cc: Kendall Bourdon
Meredith Henderson


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In addition, we fully support SCA's proposal to cover procedures that were being conducted in ASCs prior to the enactment of the invalid fee schedule on April 1, 2015. Excluding the procedures that were previously performed at ASCs has resulted and will continue to result in an access problem for injured workers, which violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

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It is also very significant that the other three proposals do not address all procedures that were being conducted in ambulatory surgery centers prior to the enactment of the invalid fee schedule on April 1, 2015. By limiting injured workers access to care for all procedures that have been historically performed in the ASC setting, workers will be forced to receive care in the higher-cost inpatient hospital setting.

The other three proposals are not cost effective and so do not meet statutory requirement of the North Carolina Workers Compensation Act. 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 three other proposals do not meet these requirements.

Lastly, the analysis conducted by NCCI does not take into consideration the shift of injured workers from the ASC setting to the more-costly hospital inpatient setting, therefore, under-estimating the cost to the workers' compensation system.

Thank you for your consideration.

Sincerely,

Ann DuPree Orr

Ann DuPree Orr, RN BSN CNOR
Administrator – Team Carolinas

cc: Kendall Bourdon
Meredith Henderson

# BLUE RIDGE SURGERY CENTER

an affiliate of SCA

October 3, 2016

Charlton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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Thank you for your consideration. If you have any questions, please feel free to contact me at (919)-781-4311.

Sincerely,

Hons Rohm

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,

Robert S Alphin MD

Dr. Alphin, M.D. Medical Director

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,

Larnessa Greene

cc: Kendall Bourdon
Meredith Henderson

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an affiliate of SCA

Thank you for your consideration. If you have any questions, please feel free to contact me at (919)-781-4311.

Sincerely,

Becky Ballard

Becky Ballard

cc: Kendall Bourdon
Meredith Henderson

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*an affiliate of* SCA

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Sincerely,

Grace Smith

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,

Sabrina Robinson

Sabrina Robinson

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,

Colleen Lochamy

Colleen Lochamy

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,

parrish dickens

Parrish Dickens

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,

Danny Thomerson

cc: Kendall Bourdon
Meredith Henderson

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Thank you for your consideration. If you have any questions, please feel free to contact me at (919)-781-4311.

Sincerely,

Cassandra Clark

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,

Kathy Leibl, Administrator

cc: Kendall Bourdon
Meredith Henderson

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Thank you for your consideration. If you have any questions, please feel free to contact me at (919)-781-4311.

Sincerely,

Tiffany Sweeney

cc: Kendall Bourdon
Meredith Henderson

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October 3, 2016

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430 N. Salisbury Street
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Gyto Alexis

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,

Kendra Johnson

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,

Revenue and Special Operations Director

cc: Kendall Bourdon
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William K. Andersen, MD, FAAOS

cc: Kendall Bourdon
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Sincerely,

cc: Kendall Bourdon
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GREENSBORO SPECIALTY SURGICAL CENTER
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Debbie Murphy, Administrator

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# Triad Foot Center

*Partnering for exceptional care.*

NORMAN S REGAL, DPM, FACFAS

M TODD HYATT, DPM, FACFAS

MATTHEW R WAGONER, DPM

GREGORY A MAYER, DPM

RICHARD C BUCHMAN, DPM, FACFAS

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Greensboro NC 27410

BURLINGTON OFFICE
1680 Westbrook Ave
Burlington NC 27215

ASHEBORO OFFICE
220-B Foust Street
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Norman S Regal, DPM, FACFAS

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L. Frank Cashwell, Jr., M.D.
Edward M. Hollander, M.D.
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Meredith Henderson

The Hand Center of Greensboro

ORTHOPAEDIC &
HAND SPECIALISTS, PA

Gary R. Kuzma, M.D.
Matthew A. Weingold, M.D.
Sam Pelligra, M.D.
Kevin R. Kuzma, M.D.
Robert Dasnoit, PA-C
Katherine Hilliard, OTR/L CHT
Terri Rowland, OTR/L CHT
Carol Kinneman, PT, ATC
Lynne Inman, RN

Surgery Of The Hand,
Shoulder & Upper Extremity
Fractures
Microsurgery
Electrodiagnostic Testing
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Hand & Arm Rehabilitation

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Of Orthopaedic Surgery

Diplomate, American Board
Of Physical Medicine &
Rehabilitation

American Society For
Reconstructive Microsurgery

Fellows American Academy
Of Orthopaedic Surgeons

Fellow American
College Of Surgeons

Certified By American Board
Of Orthopaedic Surgery:
Additional Qualifications In
Surgery Of The Hand

Members: American Society
For Surgery Of The Hand

Orthopaedic
And Hand Specialists, PA
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Greensboro, NC 27405
Phone: 336-375-1007
FAX: 336-375-9615

October 10, 2016

Charlton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Dear Chairman Allen and Commissioners:

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We are in full support of SCA's proposal to align reimbursement rates for ASCs with the reimbursement rates set for hospital outpatient departments. We fully agree that alignment of reimbursement schedules allows for site-of-service decisions to be based solely on clinical judgment, quality outcomes, and scheduling efficiency.

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TO: Charlton L. Allen, Chairman
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Thank you for your consideration.

Sincerely,

cc: Kendall Bourdon
Meredith Henderson

SURGICAL CENTER OF GREENSBORO
an affiliate of SCA

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Sincerely,

Jennifer P. Graham

cc: Kendall Bourdon
Meredith Henderson

**ORTHOPAEDICS**
James P. Aplington, M.D., F.A.A.O.S., F.A.C.S.
Ronald A. Gioffre, M.D., F.A.A.O.S., F.A.C.S.
R. Andrew Collins, M.D., F.A.A.O.S.
Jeffrey C. Beane, M.D., F.A.A.O.S.
Kevin M. Supple, M.D., F.A.A.O.S., C.A.Q.S.M.
Frank V. Aluisio, M.D., F.A.A.O.S.
William M. Gramig, III, M.D., F.A.A.O.S., C.A.Q.S.H.
Paul A. Bednarz, M.D., F.A.A.O.S.
Steven R. Norris, M.D., F.A.A.O.S., C.A.Q.S.H.
Matthew D. Olin, M.D., F.A.A.O.S
Fred W. Ortmann, IV, M.D., F.A.A.O.S.
Dahari D. Brooks, M.D., F.A.A.O.S.
John D. Hewitt, M.D., F.A.A.O.S.

**PHYSICAL MEDICINE & REHABILITATION**
Richard D. Ramos, M.D., F.A.A.P.M.R.

**FAMILY PRACTICE / SPORTS MEDICINE**
Adam Scott Kendall, M.D., A.B.F.M.
CAQ Sports Medicine

**RETIRED PHYSICIANS**
Samuel A. Sue, Jr., M.D., F.A.A.O.S., F.A.C.S. (Ret. 2002)
Philips J. Carter, M.D., F.A.A.O.S., F.A.C.S. (Ret. 2004)
Thomas L. Presson, M.D., F.A.A.O.S., A.O.F.A.S. (Ret. 2001)

**ADMINISTRATION**
John S. Nosek, M.P.A., C.M.P.E.
Executive Director

GREENSBORO ORTHOPAEDICS
DOCTORS FOR AN ACTIVE LIFE

- Sports Medicine
- Occupational Medicine
- Low Back Pain
- Arthroscopic Surgery
- Total Joint Replacement
- Back, Hand, Foot & Ankle Surgery
- MRI Center
- Rehabilitation Center
- Physical Medicine and Rehabilitation
- Fellows American Academy of Orthopaedic Surgeons
- Diplomatés American Board of Orthopaedic Surgery

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Sincerely,

Steven R. Norris

cc: Kendall Bourdon
Meredith Henderson

GUILFORD ORTHOPAEDIC AND SPORTS MEDICINE CENTER

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Physical Therapy Appointments: 336.275.3405
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John L. Graves, M.D., FAAOS
Jesse W. Chandler, M.D.
Mark L. Dumonski, M.D.
David A. Thompson, M.D., FAAOS
Dominic W. McKinley, M.D.
Hao Wang, M.D.
Raymond Kargo, MSPT
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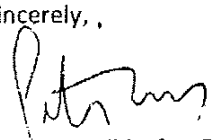

Peter G. Dalldorf, MD

cc: Kendall Bourdon
Meredith Henderson

Southeastern Orthopaedic Specialists

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Greensboro, NC 27415

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W. Dan Caffrey, MD
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