STATE OF NORTH CAROLINA

BEFORE THE NORTH CAROLINA INDUSTRIAL COMMISSION

DECEMBER 17, 2014

HEARING BEFORE THE FULL COMMISSION

ON

PROPOSED MEDICAL FEE SCHEDULE RULE CHANGES

GRAHAM ERLACHER & ASSOCIATES
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WINSTON-SALEM, NORTH CAROLINA 27103
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A P P E A R A N C E S

COMMISSIONERS:

Andrew T. Heath, Chairman and Chair of Panel

Bernadine S. Ballance

Danny L. McDonald

Linda Cheatham

Charlton L. Allen

Tammy R. Nance

I N D E X

E X H I B I T S

P R O C E E D I N G S

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

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

MEREDITH HENDERSON

MS. HENDERSON: Good afternoon.

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

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

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

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

(Exhibit Number 1 is identified.)

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

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

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

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

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

MS. HENDERSON: Thank you.

(SPEAKER DISMISSED)

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

KIMBERLY ROWLAND

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

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

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

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

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

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

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

CHAIRMAN HEATH: Ms. Rowland---

MS. ROWLAND: Yes?

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

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

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

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

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

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

MS. ROWLAND: Absolutely.

CHAIRMAN HEATH: Okay.

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

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

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

MS. ROWLAND: Yes?

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

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

CHAIRMAN HEATH: At a hundred and ninety-five?

MS. ROWLAND: Yes.

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

MS. ROWLAND: 2 something – yes.

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

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

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

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

that treat your workers – your injured workers.

CHAIRMAN HEATH: Right.

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

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

COMMISSIONER MCDONALD: So what is the answer?

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

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

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

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

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

MS. ROWLAND: Go ahead.

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

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

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

MS. ROWLAND: Uh-huh.

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

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

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

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

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

MS. ROWLAND: We---

CHAIRMAN HEATH: ---what does it represent?

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

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

MS. ROWLAND: Well, we---

CHAIRMAN HEATH: ---any group of radiologists?

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

CHAIRMAN HEATH: Okay. Any other questions?

MS. ROWLAND: Thank you for having me.

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

(SPEAKER DISMISSED)

CHAIRMAN HEATH: Okay. Conor Brockett.

CONOR BROCKETT

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

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

CHAIRMAN HEATH: Thank you.

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

specifically the version taking effect on July 1st of 2015. 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. I'd like to touch first on what we've been talking about so far, which is radiology and the changes that will come under this new rule in July. Under the proposal, the Commission would establish payments for all radiology services at a hundred and ninety-five percent of Medicare. This is the highest percentage that the Commission has been willing, at least in the rule, to apply to professional services in the fee schedule. Also, to talk for a second about the Medicare – using Medicare as the basis, that was a decision that was essentially made for you by the General Assembly, and it was the job of the Commission to go from there and put together a rule that would satisfy the various legislative mandates, the balancing act that you have to achieve so that there is proper access for injured workers, so that the providers are compensated fairly, so on and so forth, and we think you've done that. The Radiological Society and a multi-specialty taskforce that the Medical Society put together looked closely at this

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

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

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

problems. And since publication of the proposed rule, we've identified some other details that could be clearer with the rule, and we plan to share those with you in our written comments which we will submit in the coming weeks. None of the ones – none of what we have seen present any fatal problems, but would only aid in our estimation of the ongoing administration of the fee schedule over time. 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.

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

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

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

CHAIRMAN HEATH: Okay.

MR. BROCKETT: Yes, Your Honor.

CHAIRMAN HEATH: Thank you. Any other questions? All right. Thank you.

MR. BROCKETT: Thank you.

(SPEAKER DISMISSED)

CHAIRMAN HEATH: All right. Thank everyone for participating in this public hearing. Again, the period for public comments will be held open through the close of business on January 16, 2015. If you have any further comments, please send them to Meredith Henderson, as directed in the hearing notice on the *North Carolina Register*. 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 notice (phonetic) submitted by Ms. Henderson as Exhibit 1 previously.

(Exhibit Number 1 is admitted.)

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

(WHEREUPON, THE HEARING WAS ADJOURNED.)

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

STATE OF NORTH CAROLINA

COUNTY OF FORSYTH

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 twenty-five (25) pages prepared under my supervision are a true and accurate transcription of the testimony of this trial which was tape 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 20th day of December 2014.

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 notices published in this Section of the NC Register include the text of proposed rules. The agency must accept comments on the proposed rule(s) for at least 60 days from the publication date, or until the public hearing, or a later date if specified in the notice by the agency. If the agency adopts a rule that differs substantially from a prior published notice, the agency must publish the text of the proposed different rule and accept comment on the proposed different rule for 60 days.
Statutory reference: G.S. 150B-21.2.

TITLE 04 – DEPARTMENT OF COMMERCE

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

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

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

Public Hearing:
Date: *December 17, 2014*
Time: *2:00 p.m.*
Location: *Dobbs Building, Room 2173, 430 N. Salisbury Street, Raleigh, NC 27603*

Reason for Proposed Action: *The Industrial Commission has proposed these four rules to fulfill its statutory duty to periodically review the schedule of fees charged for medical treatment in workers' compensation cases and to make revisions if necessary. The revisions reflected in the proposed rules are intended to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act, that health care providers receive reasonable reimbursement for services, and that medical costs are adequately contained. The Industrial Commission was directed in S.L. 2013-410, s. 33.(a) to base its physician and hospital fee schedules on "the applicable Medicare payment methodologies." The proposed rules are intended to carry out this legislative mandate. There are two versions of Rule 04 NCAC 10J .0102 in order to move the physician and hospital fee schedules out of Rule 04 NCAC 10J .0101 and keep the current physician fee schedule in place until July 1, 2015. The April 1, 2015 version of Rule 04 NCAC 10J .0102 is essentially Paragraphs (b) and (c) of the current Rule 04 NCAC 10J .0101. As required by G.S. 97-26(b), the following is a summary of the data and information sources reviewed by the Commission in determining the applicable fee schedule rates for hospitals and ambulatory surgery centers. Rates were calculated to fall in the estimated median range of workers' compensation fee schedules nationally, based on data available from the following studies and data sources:*
(1) NORTH CAROLINA WORKERS COMPENSATION INSURANCE: A WHITE PAPER REVIEWING MEDICAL COSTS AND MEDICAL FEE REGULATIONS, prepared for the National Foundation for Unemployment Compensation and Workers' Compensation; prepared by Philip S. Borba, Ph.D. and Robert K. Briscoe, WCP, Milliman, Inc.; May 23, 2013.
(2) CompScope Medical Benchmarks, 15th Edition, for North Carolina, published by the Workers' Compensation Research Institute, August 2014.
(3) North Carolina Hospital Association/Optum Group Health survey data, June 2013 and July 2014.
(4) Review of states' fee schedule structures, nationally and regionally.

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

Comment period ends: *January 16, 2015*

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

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

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

CHAPTER 10 – INDUSTRIAL COMMISSION

SUBCHAPTER 10J – FEES FOR MEDICAL COMPENSATION

SECTION .0100 – FEES FOR MEDICAL COMPENSATION

04 NCAC 10J .0101 GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(A) Hospital outpatient and ambulatory surgery: The rate in effect as of that date shall be reduced by 15 percent.~~

~~(B) Hospital inpatient: The minimum payment rate in effect as of that date shall be reduced by 10 percent.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Evaluation & management services are 140 percent of the Medicare base amount;

(2) Physical medicine services are 140 percent of the Medicare base amount;

(3) Emergency medicine services are 169 percent of the Medicare base amount;

(4) Neurology services are 153 percent of the Medicare base amount;

(5) Pain management services are 163 percent of the Medicare base amount;

(6) Radiology services are 195 percent of the Medicare base amount;

(7) Major surgery services are 195 percent of the Medicare base amount;

(8) All other professional services are 150 percent of the Medicare base amount.

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

(1) When provided by an anesthesiologist, the allowable amount is three dollars and eighty-eight cents ($3.88) per minute up to and including 60 minutes, and two dollars and five cents ($2.05) per minute beyond 60 minutes.

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

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

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

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

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

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

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

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

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

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

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

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

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

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

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

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

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

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

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

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

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

(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") are based on the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register ("the Medicare ASC facility-specific amount"). Reimbursement shall be based on the fully implemented payment amount as in Addendum AA, Final ASC Covered Surgical Procedures for CY 2014 and Addendum BB Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2014, published in the December 10, 2013 publication of the Federal Register, or its successor.

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

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

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

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

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

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

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

TITLE 13 – DEPARTMENT OF LABOR

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