



North Carolina Industrial Commission

Internet Address: <http://www.ic.nc.gov/>

FREQUENTLY ASKED QUESTIONS REGARDING 2015 MEDICAL FEE SCHEDULE CHANGES

GENERAL QUESTIONS

Q: What role does the Commission's Medical Fees Section play in applying the new medical fee schedule?

A: The Commission's Medical Fees Section does the following:

- (1) Reviews medical bills and applies the fee schedule only if there is a dispute between parties about the correct payment amount.
- (2) Reviews and processes medical bills that are not covered by the medical fee schedule where the parties do not have a contract or cannot agree on a payment amount.
- (3) Answers general questions about the Medical Fee Schedule.

Q: How do I contact the Medical Fees Section?

A: Go to <http://www.ic.nc.gov/medfee.html> for contact and other information.

Q: Can a carrier and a health care provider or hospital enter into a contract to use different reimbursement rates or methodologies than the new medical fee schedule rules?

A: Yes. See N.C.G.S. § 97-26(b) and (c).

HOSPITAL FEES

Q: When are the changes to the hospital fee schedule effective?

A: They are effective April 1, 2015, and apply to dates of service on or after April 1, 2015. Note that after the initial rates are applied on April 1, 2015, there are additional rate decreases outlined in Rule 04 NCAC 10J .0103 that will occur on January 1, 2016, and January 1, 2017.

Q: Does the old hospital fee schedule still apply to dates of service prior to April 1, 2015?

A: Yes. That version of the medical fee schedule rule can be accessed at this [link](#). Note that all practices regarding charge neutralization and implants will continue to be applied to hospital charges for dates of service prior to April 1, 2015.

Q: Does the new hospital fee schedule require charge neutralization like the old rule?

A: No. For dates of service on or after April 1, 2015, hospitals and ambulatory surgical centers will no longer need to adjust their total bill charges on each claim to reflect a charge neutralization discount. Therefore, hospitals and ambulatory surgical centers should report their total bill charges on each claim for dates of service on or after April 1, 2015.

Q: Does the new hospital fee schedule require that implant charges be deducted from the total charges like the old rule?

A: No. For dates of service on or after April 1, 2015, hospitals and ambulatory surgical centers will no longer need to list the total implant costs in the FL80 remarks field or attach implant invoices. Therefore, hospitals and ambulatory surgical centers should report their total bill charges on each claim for dates of service on or after April 1, 2015.

Q: How are outlier payment amounts handled under the new hospital fees rule?

A: They are included in the total payment amount to which the fee schedule rate is applied.

Q: The hospital fees rule appears to indicate that outpatient hospital fees will be based on a fiscal year Medicare rate, but Medicare issues calendar year standards for outpatient reimbursement rates with quarterly updates. What is the standard to apply in determining outpatient fees in NC workers' compensation cases?

A: Payers should use Medicare's calendar year facility-specific rates, including all quarterly updates, for determining outpatient institutional reimbursement amounts.

Q: Are there any resources that can assist with determining inpatient hospital reimbursement amounts?

A: (1) MS-DRG grouper applications can be purchased online or through various companies to assist in determining the correct Diagnostic-Related Grouping (DRG) for payment purposes. The Industrial Commission cannot provide recommendations regarding such companies or services.

(2) CMS provides a free PC Pricer tool on its website. Go to <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/index.html> for information and download links for the CMS PC Pricer.

Q: Where can I find online tools or software for Medicare outpatient and ambulatory surgical center pricing?

A: Medicare does not currently provide pricing tools for outpatient and ambulatory surgical center charges. There are several companies that provide such pricing tools or services for a fee. The Industrial Commission cannot provide recommendations regarding such companies or services.

PROFESSIONAL FEES

Q: Is the professional fees rule (Rule 04 NCAC 10J .0102) that comes into effect April 1, 2015, any different from the old fee schedule?

A: No. It merely contains the language from Paragraphs (b) and (c) from the old version of 04 NCAC 10J .0101, with minor rulemaking corrections. The fees established by that rule will only be effective for dates of service prior to July 1, 2015.

Q: When are the changes to the professional fees effective?

A: The professional fees do not change until July 1, 2015. The changes will apply to dates of services on or after July 1, 2015.

Q: How often will the professional fee schedule be updated?

A: The Professional Fee Schedule Table will be updated annually. Starting in 2016, and each year thereafter, the Commission will publish a fee schedule table that will be effective January 1.

Q: Where may I access the revised professional fee schedule?

A: The Commission's professional fee schedule rule and official Professional Fee Schedule Table are available at <http://www.ic.nc.gov/ncic/pages/feesched.asp>.

Q: Where may I access the DME and Clinical Lab fee schedule tables?

A: The Professional Fee Schedule Table, DME Fee Schedule Table, and Clinical Laboratory Fee Schedule Table are being provided together as one large downloadable Excel file for users' convenience. The file is available at <http://www.ic.nc.gov/ncic/pages/feesched.asp>.

Q: Did the Industrial Commission adopt any Medicare payment policies, coverage determinations, or other rules when it established this new fee schedule?

A: No. The Commission only used Medicare Part B allowable amounts to generate the Professional Fee Schedule Table and applied the reimbursement rates in the professional fee schedule rule. The Commission has not incorporated any additional Medicare rules or policies relating to professional services.

Q: Must providers still send invoices to the carriers for durable medical equipment, injectibles, and other supplies?

A: No. As part of the professional fee schedule revisions, the Commission has now established maximum allowed amounts for DME, prosthetics, orthotics, and other medical services and supplies. Therefore, the Commission's previous requirement that providers substantiate their costs for these items and services is no longer in effect. Please refer to the Professional Fee Schedule Table to identify the maximum allowed amount by code.

Q: Do professional fees differ for licensed physician assistants, nurse practitioners, or other non-physician practitioners?

A: No. As long as the provider is practicing within the appropriate scope of practice, services rendered by a physician assistant, nurse practitioner, clinical nurse specialist, certified nurse midwife, certified registered nurse anesthetist, and anesthesiologist assistant are subject to the maximum amounts provided in the Professional Fee Schedule Table.

Please note, however, that the fee schedule establishes different payment rates for anesthesia services provided by anesthesiologists and certified registered nurse anesthetists.