

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.

(3) Beginning January 1, 2017, 160 percent of the hospitals 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 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.

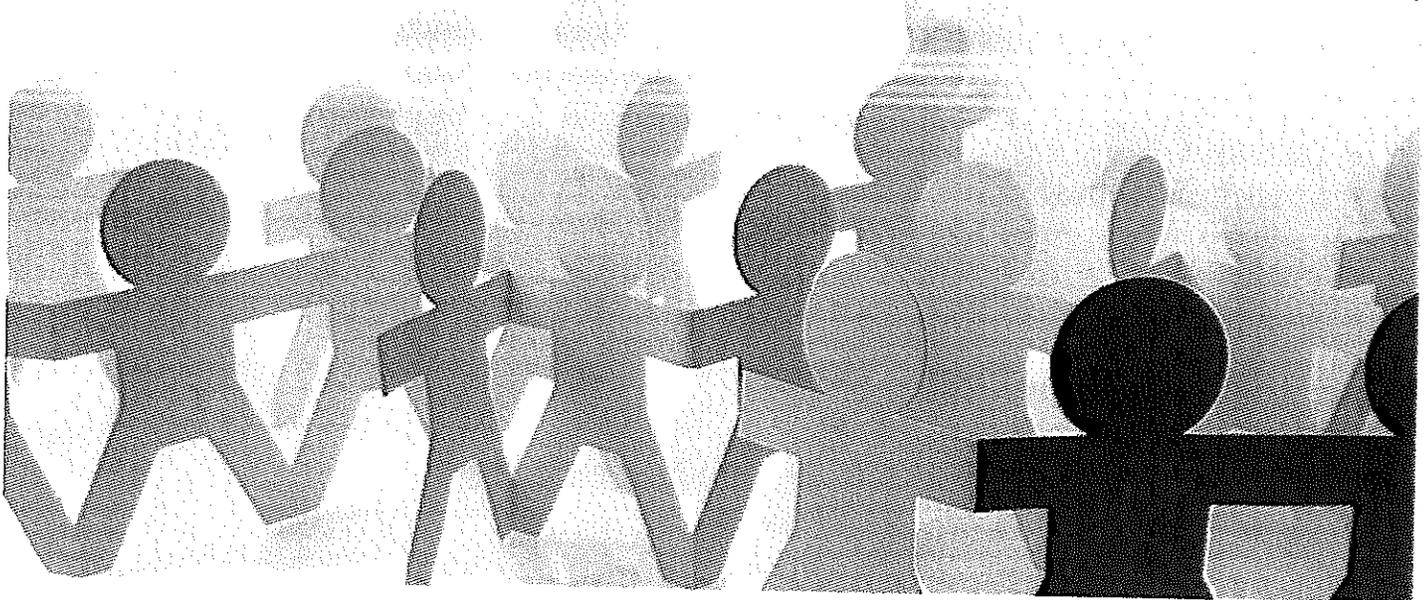
(3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.

(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.



Organizations Affiliated with the NCMS

CMS Foundation

CMS Alliance

CMS Sections

County Medical Societies

Specialty 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](#)

- [Log In](#)
- [Contact](#)

[Log In](#) | [Contact](#) | [Join NCMS](#)

search



North Carolina Medical Society

[Join NCMS](#)

☰ [Menu](#)

- [Home](#)
- [News »](#)
- [Membership »](#)
- [Advocacy »](#)
- [Practice Help »](#)
- [Physician Resources »](#)
- [About NCMS »](#)
- [Specialty Societies](#)
- [Sections](#)
- [NCMS PAC](#)
- [NCMS Foundation](#)

North Carolina Orthopaedic Association

[Back to All Specialty Society Listings](#)

The mission of the NC Orthopaedic Association (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
- **Accommodations:** Call the Pinehurst Resort at 800-487-4653 to reserve a room now!
- Add this event to your calendar.
- **Sponsorship & Exhibiting Opportunities:** Download the Exhibitor Prospectus.



For more information on this event, please contact Nancy Lowe, nlowe@ncmedsoc.org, (919) 833-3836 ext. 111.

Leadership

President: Matthew D. Olin, MD – Greensboro, NC

President Elect: Peter G. Mangone, MD – Asheville, NC

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

Secretary-Treasurer: Shawn B. Hocker, MD – Wilmington, NC

Recording Secretary: Jessica A. Woodcock, MD – New Bern, NC

Historian: Charles H. Classen, Jr., MD – Kinston, NC

Immediate Past President: Julian M. "Mack" Aldridge, III, MD – Durham, NC

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

Join Today!

Become a part of the NCOA!

- Return your completed Membership Application form along with payment to NCOA; or
- Join online at www.ncmedsoc.org/join.

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

- [July 26, 2016](#)
- [Apr. 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](#)

Contact Us

North Carolina Orthopaedic Association
PO Box 27167
222 North Person Street
Raleigh, NC 27611
Phone: (919) 833-3836
Fax: (919) 833-2023
Web: www.ncorthopaedics.org
Email: ncoa@ncmedsoc.org
Executive Director: W. Alan Skipper



About NCMS

- [About NCMS](#)
- [Board of Directors](#)
 - [Contact the Board](#)
- [NCMS Staff](#)
- [NCMS Member Directory](#)
- [Accomplishments](#)
- [NCMS Committees](#)

- [Location & Directions](#)
- [Partner Organizations](#)

The North Carolina Medical Society

Physical Address:

222 N. Person Street

Raleigh, NC 27601

[Get Directions](#)

Phone:

1.919.833.3836

1.800.722.1350 (NC only)

1.919.833.2023 FAX

Mailing Address:

PO Box 27167

Raleigh, NC 27611

The NCMS is a
proud partner
with
[Medical Mutual.](#)

-  [Follow Us On Facebook](#)
-  [Follow Us On Twitter](#)
-  [Subscribe to our Blog](#)

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

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

March 5, 2015 | [view this message as a webpage](#)

In this edition:

- [URGENT: Take Action Now to Stop 3% Medicaid Cut](#)
- [Significantly Revised Workers' Comp Fee Schedule Achieves Final Approval--First Update in 20 Years!](#)
- [Advocacy Update: Certificate of Need Reform Effort is Gaining Momentum](#)
- [The New BCBSNC "Estimate Health Care Costs" Website Provides Cost Estimates for Various Procedures. But How Accurate is the Data?](#)
- [NCMS Responds To Proposed ACO Program Changes](#)
- [NC Doctors' Day 2015](#)
- [2015 NCOA Annual Meeting, Oct. 9-11](#)

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 recoument of payments made for January and February 2015 dates of service.

Reprinted with permission from the North Carolina Medical Society.

[Top of page](#)

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.

[Top of page](#)

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