

STATE OF NORTH CAROLINA

BEFORE THE NORTH CAROLINA INDUSTRIAL COMMISSION

JULY 19, 2017

PUBLIC HEARING BEFORE THE FULL COMMISSION

REGARDING

PROPOSED RULE AMENDING 04 NCAC 10J .0103

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A P P E A R A N C E S

COMMISSIONERS:

Charlton L. Allen, Chairman
Yolanda K. Stith, Vice-Chairman
Linda Cheatham, Commissioner
Christopher C. Loutit, Commissioner
Tammy R. Nance, Commissioner
Philip A. Baddour, III, Commissioner

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P R O C E E D I N G S

1
2 CHAIRMAN ALLEN: Okay. Good afternoon. We are on
3 the record. Today is July 19, 2017. I am Charlton
4 Allen. I'm Chairman at the North Carolina Industrial
5 Commission. In compliance with the requirements of
6 Chapter 138A-15(e) of the North Carolina State
7 Government Ethics Act, I remind all members of the
8 Commission of their duty to avoid conflicts of
9 interest under Chapter 138A. I also inquire as to
10 whether there is any known conflict of interest to the
11 matter coming before the Commission at this time.
12 Hearing none, we will proceed. This is a North
13 Carolina Industrial Commission public hearing on
14 proposed rulemaking. The purpose of this hearing is
15 to receive comments from the public regarding the
16 amendments to 04 NCAC 10J .0103 proposed for permanent
17 rulemaking by the Commission and published in the
18 *North Carolina Register* on June 15, 2017. We have
19 received only one written comment from the public thus
20 far, but the record will be held open to receive
21 written comments from the public through the close of
22 business on August 14, 2017. At this time, I would
23 like to introduce the other Commissioners. To my
24 right is Vice-Chairman Yolanda Stith, Commissioner
25 Tammy Nance and Commissioner Philip Baddour, and to my

1 left, Commissioner Linda Cheatham and Commissioner
2 Christopher Loutit. Anyone who wishes to speak at
3 this hearing must sign-up to do so with Kendall
4 Bourdon so that we have the correct spelling of your
5 name and can call you in order to speak. If anybody
6 would like to speak and has not yet signed up, please
7 do so now. Once we resume the speaking part of the
8 program, the first speaker will be Kendall Bourdon,
9 the rulemaking coordinator, followed by members of the
10 public in the order that they signed up. Ms. Bourdon,
11 would you please raise your hand so people know who to
12 sign-up with? All right. We will stand at ease for a
13 couple of minutes if anyone wishes to add their name
14 to the list of folks to sign-up. Seeing none, we will
15 proceed.

16 KENDALL BOURDON

17 CHAIRMAN ALLEN: Good afternoon, Ms. Bourdon.
18 Will you please state your name, position and whom you
19 work for?

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

23 CHAIRMAN ALLEN: And do you have prepared exhibits
24 that you would like to place into the record at these
25 proceedings?

1 MS. BOURDON: Yes. I have Exhibit 1, which is a
2 copy of the proposed rule as published in the *North*
3 *Carolina Register* on June 15, 2017. Next, I have
4 Exhibit 2, which is a copy of the Fiscal Note
5 analyzing the regulatory impact of this proposed rule,
6 as marked Exhibit 2. I also submit Exhibit 3 as so
7 marked, which is a copy of the temporary rule as
8 approved by the Rules Review Commission and published
9 in the *North Carolina Register* on January 17, 2017.
10 Additionally, I have Exhibit 4, which is the complete
11 transcript of the Industrial Commission's public
12 hearing held on November 18, 2016, including the
13 complete record of the public comment meeting
14 voluntarily held by the Commission on October 3rd,
15 2016, marked Exhibit 4. Finally, I would like to
16 submit Exhibit 5, which is the collection of written
17 public comments received between October 18th, 2016
18 through November 29, 2016.

19 CHAIRMAN ALLEN: Okay. We'll receive those
20 exhibits.

21 (Exhibit Numbers 1, 2, 3, 4 and 5
22 are identified and admitted into
23 the record.)

24 CHAIRMAN ALLEN: Would you briefly give us some
25 background and list the rule that would be affected by

1 the proposed rule change?

2 MS. BOURDON: Yes. We have one rule for
3 amendment. This rule is found in Title 04 of the
4 Administrative Code, Subchapter 10J. We propose to
5 amend Rule .0103, which is titled "Fees for
6 Institutional Services." The proposed effective date
7 is October 1, 2017. It is submitted to you as Exhibit
8 1. The Industrial Commission proposes to amend the
9 provisions of Rule 04 NCAC 10J .0103 for several
10 reasons. The proposed amendment to paragraph (a) is a
11 clarification regarding the qualifications for
12 reimbursement under paragraphs (c), (d) and (f).
13 Next, there are two primary reasons for the proposed
14 amendments to the provisions related to fees for
15 ambulatory surgical centers: Paragraphs (g) and (h).
16 First, this rule has been the subject of litigation
17 that is ongoing at the time of filing. The provisions
18 of the rule as adopted on April 1st, 2015, that relate
19 to fees for ambulatory surgical centers, specifically
20 paragraphs (g) and (h) and the reference to paragraph
21 or - excuse me - the reference to (h) and paragraph
22 (i), were held to be invalid by Wake County Superior
23 Court Judge Paul Ridgeway in an August 9, 2016
24 Decision. The Decision was predicated on the Court's
25 belief that those provisions of the rule were not

1 adopted in compliance with the Administrative
2 Procedure Act because no Fiscal Note was prepared.
3 The Industrial Commission has appealed that ruling and
4 the matter is pending before the North Carolina Court
5 of Appeals. The August 9, 2016 Decision was stayed by
6 Judge Ridgeway by Order dated September 2nd, 2016.
7 While the Industrial Commission maintains its position
8 that it was not required to complete a Fiscal Note to
9 adopt and/or amend the challenged provisions, the
10 Industrial Commission has now completed a Fiscal
11 Note - see Exhibit 2 - which has been approved by OSVM
12 and seeks to amend the ambulatory surgical center fee
13 provisions of Rule 04 NCAC 10J .0103. Pending the
14 outcome of litigation, the amendments are sought to
15 restore certainty and balance to the fee schedule for
16 stakeholders, including payers and medical providers,
17 as to future medical expenses. Moreover, the
18 Industrial Commission is statutorily obligated to
19 periodically review the schedule of maximum fees
20 charged for medical treatment in workers' compensation
21 cases and make revisions, if necessary. The proposed
22 amendments to Rule 04 NCAC 10J .0103 incorporate
23 feedback from various stakeholders that the addition
24 of a provision setting maximum fees for ambulatory
25 surgical centers for additional procedures covered by

1 the Medicare Outpatient Prospective Payment System
2 would be beneficial to payers, providers and injured
3 workers. The fee schedule reimbursement rate for
4 services provided by ambulatory surgical centers
5 covered by the Medicare ambulatory surgical center
6 payment system will be two hundred percent in keeping
7 with the rate for 2017 and beyond and the rule as
8 adopted on April 1st, 2015. The fee schedule
9 reimbursement rate for additional procedures provided
10 by an ambulatory surgical center that are covered by
11 the Medicare Hospital Outpatient Prospective Payment
12 System will be one hundred and thirty-five percent.
13 The rates were calculated to fall in the estimated
14 median range of workers' compensation fee schedules
15 nationally, as well as within the range of workers'
16 compensation fee schedules and states that base
17 payment to ambulatory surgical centers on a percentage
18 of the Medicare Hospital Outpatient Prospective
19 Payment System and/or the Medicare ambulatory surgical
20 center payment systems. The statutory bases for these
21 changes are the North Carolina - are North Carolina
22 General Statutes 97-25, 97-26, 97-80 and Session Law
23 2013-410. The effects of the August 9, 2016 Decision
24 in Surgical Care Affiliates, LLC, versus North
25 Carolina Industrial Commission led the Commission to

1 engage in temporary rulemaking to put a rule in place
2 as soon as possible; thus, limiting the period of
3 time, subject to a potential retroactive invalidation
4 of the ambulatory surgery center fee schedule
5 provisions, in providing certainty regarding medical
6 costs for 2017 and beyond. The temporary rule is
7 submitted to you as Exhibit 3. Prior to proposing the
8 temporary rule, the Industrial Commission voluntarily
9 held a non-mandatory public comment meeting on October
10 3rd, 2016, and accepted written comments from September
11 2nd, 2016 through October 10th, 2016, in order to allow
12 any person or entity the opportunity to present
13 comments and proposals regarding potential rulemaking
14 options to address the effects of the August 9, 2016
15 Court Decision. The Commission then proposed a
16 temporary rule and, in accordance with the temporary
17 rulemaking procedures of North Carolina General
18 Statute 150B, held a public hearing on November 11th,
19 2016; the record of which is submitted to you as
20 Exhibit 4. Additionally, the Commission accepted
21 written comments from October 18, 2016 through
22 November 29th, 2016, submitted herein as Exhibit 5.
23 Although the temporary rule is also the subject of
24 ongoing litigation currently pending at this time, the
25 Commission is now engaged in permanent rulemaking as a

1 follow-up to the temporary rule. Therefore, the
2 permanent rule is proposed to be effective at the time
3 the temporary rule would have expired. The Commission
4 has followed the permanent rulemaking procedures of
5 the Administrative Procedure Act in proposing these
6 rules. The relevant dates involved include the
7 following: The proposed rule amendment was filed with
8 a Notice of Text to the Office of Administrative
9 Hearings on May 24th, 2017; they were then published in
10 the June 15, 2017 issue of the *North Carolina*
11 *Register*. And on the same date - June 15th - the
12 Commission published a notice of these rules and a
13 link to the Fiscal Note on the Commission's website,
14 as required, and also emailed notice with a link to
15 this proposed rule and Fiscal Note to the Industrial
16 Commission's Listserv. The Listserv is an interested
17 person's Listserv that we are required to maintain for
18 rulemaking purposes. Copies of the rule and Fiscal
19 Note were also provided to the North Carolina League
20 of Municipalities and the North Carolina Association
21 of County Commissioners, as required by statute.

22 CHAIRMAN ALLEN: Okay. Ms. Bourdon, the rule in
23 question is found in Title 04, but it is subject to be
24 transferred to Title 11 due to the Commission's
25 transfer to the Department of Insurance, together with

1 all other Industrial Commission rules, at some date to
2 be determined. Is that correct?

3 MS. BOURDON: Yes, that is correct. Any transfer
4 in the code of the Industrial Commission rules will be
5 subsequent to any currently pending rulemaking. As
6 the Industrial Commission was organized under the
7 Department of Commerce when this rulemaking was
8 proposed and published in the *North Carolina Register*,
9 it will be adopted as 04 NCAC 10J .0103.

10 CHAIRMAN ALLEN: Do any members of the Commission
11 have additional questions for Ms. Bourdon? All right.
12 Thank you, Ms. Bourdon. You may return to your seat.

13 (SPEAKER DISMISSED)

14 CHAIRMAN ALLEN: We will proceed to the next
15 speaker. The first person I have on my list is
16 Mr. David Orskey. And as you are approaching the
17 podium, the names I have on my list are Mr. Orskey,
18 Kelli Collins, Renee Montgomery, Stephanie Gay, Stacey
19 Smith, Bruce Clarke and Ronnie Cook. Is there anyone
20 else who wishes to speak?

21 DAVID WILLIAM ORSKEY

22 CHAIRMAN ALLEN: Mr. Orskey, would you please
23 state your name, tell us who you represent, if any
24 particular organization?

25 MR. ORSKEY: David William Orskey and I represent

1 Holly Springs Surgery Center, as well as Compass
2 Surgical Partners.

3 CHAIRMAN ALLEN: Okay. And you wish to speak in
4 regards to the rule that's up for possible amendment,
5 is that correct, sir?

6 MR. ORSKEY: Yes, sir.

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

9 MR. ORSKEY: Okay. Good afternoon, Commissioners.
10 My name is David Orskey, and I'm here today
11 representing the North Carolina Ambulatory Surgical
12 Center Association and its members. I'm also employed
13 by Compass Surgical Partners as administrator of Holly
14 Springs Surgery Center located in Holly Springs, North
15 Carolina. Compass Surgical Partners operates
16 ambulatory surgery centers, or ASCs, throughout North
17 Carolina. Compass is also a founding member of the
18 North Carolina Ambulatory Surgical Association.
19 Ambulatory surgery centers, or ASCs, add green value
20 to North Carolina's delivery system. ASCs can perform
21 the same types of surgical procedures that are
22 provided in hospital outpatient departments and some
23 procedures that are currently being provided to
24 patients within hospitals. The Association was
25 founded in 2016. Since its inception, the Association

1 has taken a very active role in commenting upon, even
2 challenging certain actions that have been taken by
3 the Commission's connection with the ASC fee schedule
4 for workers' compensation cases. The Association is
5 one of the plaintiffs in the legal action filed
6 earlier this year that resulted in the Wake County
7 Superior Court declaring the Commission's temporary
8 rule invalid. When the temporary rule was being
9 considered by the Commission, the Association voiced
10 its serious concerns directly and through its members.
11 Unfortunately, the proposed permanent rule is
12 identical to the temporary rule. The Association and
13 its members are united in the desire to have the
14 Commission adopt a reasonable, comprehensive fee
15 schedule for ambulatory surgical centers that would
16 provide adequate reimbursement in workers'
17 compensation cases. This will result in better
18 containing medical costs because ambulatory surgery
19 centers are the most cost efficient - effective in an
20 efficient setting for many of the surgical procedures
21 needed by injured workers. The lack of adequate
22 reimbursement results in less access for injured
23 workers. In 2015, which was the first year ambulatory
24 surgical fee schedule was slashed by sixty percent,
25 there was a significant decline in the percentage of

1 surgeries for injured workers and that were performed
2 in ambulatory surgery centers. This resulted in these
3 injured workers receiving their surgeries at a higher
4 cost within a hospital setting. The fee schedule
5 adopted by the Commission should provide sufficient
6 reimbursement to ambulatory surgical centers so that
7 access to the most cost-effective setting is
8 encouraged. The fee schedule should also cover all
9 procedures that can be performed within an ambulatory
10 surgery center. This will also increase access.
11 Unfortunately, the fee schedule being proposed by the
12 Commission does not accomplish either of these goals;
13 instead, the Commission is basing the workers'
14 compensation fee schedule on the Medicare fee
15 schedule. There are significant differences between
16 Medicare patient population and workers' compensation
17 population. The - Medicare permits surgical
18 procedures in ASCs only when discharge would be
19 appropriate before the midnight following the
20 procedure. For non-Medicare patients in North
21 Carolina, ASCs are permitted to keep patients for up
22 to twenty-four hours. This means a non-Medicare
23 patient can stay in the facility overnight provided
24 they are released within a specific timeframe. The
25 ability to keep workers' compensation and commercial

1 patients in an ASC overnight broadens the list of
2 procedures that can be performed safely and effective
3 in an ambulatory surgery center. The Commission's
4 proposed rule ignores all these factors and instead
5 treats injured workers like Medicare patients. As a
6 result, injured workers will be denied access to
7 ambulatory surgery centers, causing delays in services
8 and higher inpatient costs and co-pays for certain
9 procedures. The Association also has serious
10 objections to the approach taken and the assumption
11 made by the Fiscal Note. The Commission has not
12 actually analyzed the change for the - to the fee
13 schedule that is being proposed. The Fiscal Note does
14 not take into account the major reduction in - the
15 reduction being proposed to ASCs from the valid fee
16 schedule; instead, it is using the April 2015 fee
17 schedule, which is - which a Superior Court has
18 already invalidated. The Fiscal Note also does not
19 address the dynamic effects that such reduction will
20 have, and already has had, on injured workers and the
21 cost to the system. The Commission's proposed
22 permanent rule is nearly identical to the prior
23 permanent rule and identical to a temporary rule; both
24 of which were invalidated by the courts. Although the
25 courts did not have the opportunity to review the

1 substance of the rules, these prior failed - on
2 rulemaking efforts gave the Commission the opportunity
3 to reconsider its approach to ASC fee schedule and
4 construct a fee schedule that took into account
5 stakeholders' feedback and that accomplished the
6 statutory requirements. With this proposed permanent
7 rule, the Commission has squandered these
8 opportunities. Through this permanent rulemaking
9 process, the Commission has the opportunity to adopt a
10 fee schedule that actually gives access to injured
11 workers and saves the system money. To do so, the
12 Association - the Association recommends that the
13 Commission adopt a rule consistent with the proposal
14 made by one of the Association's members last fall -
15 Surgical Care Associates [sic]. The Commission should
16 also conduct a proper fiscal analysis. Thank you for
17 your time.

18 CHAIRMAN ALLEN: Do the Commissioners have any
19 questions?

20 VICE-CHAIRMAN STITH: No.

21 CHAIRMAN ALLEN: Mr. Orskey, I have a few
22 questions. You indicated that the Commission's
23 proposed rule treats injured workers like Medicare
24 patients. Help me to understand your logic in that
25 considering the proposed rule in large measure has a

1 reimbursement rate that's two hundred percent of the
2 Medicare rate.

3 MR. ORSKEY: Well, so to the injured workers,
4 depending on what they're being seen for, the rate for
5 that Medicare still may not pay for that facility to
6 be able to see that patient. The rates - depending on
7 the type of injuries the patient is being seen for,
8 the cost that we put forth to see that patient and
9 some of the delays in getting approval for surgery
10 increase the costs.

11 CHAIRMAN ALLEN: Okay. And do you have any
12 studies, reports, documentation or anything of the
13 sort that you can submit to the Commission for its
14 review before the end of the written response period?

15 MR. ORSKEY: I'd like to refer that to our legal
16 team.

17 CHAIRMAN ALLEN: Okay. All right. Any further
18 questions?

19 COMMISSIONER CHEATHAM: I have one.

20 CHAIRMAN ALLEN: Commissioner Cheatham, you're
21 recognized.

22 COMMISSIONER CHEATHAM: Okay. Just to tag off, I
23 guess, one of yours, can you give me an example? I
24 mean you referenced in response to Chair Allen's
25 question about - you know, your comment that this

1 treats injured workers like Medicare patients. Can
2 you give me an example of some type of surgery that
3 you - or procedure that you think would be applicable
4 to that?

5 MR. ORSKEY: More - let's - for example, an
6 orthopedic procedure or, let's say, a spine
7 procedure - the expense of that for Medicare patients
8 may not be cost-effective to - at the rates. For
9 example, if there's implants involved which are -
10 Medicare does not pay for, or which may be very
11 expensive and the center may have to - may not be
12 covered in that - the cost or the expense of the
13 procedure. So having, for example, high-dollar
14 implants may cost more than the reimbursement that we
15 get from Medicare.

16 COMMISSIONER CHEATHAM: So the thrust of your
17 concern would be surgeries that involve implants, is
18 that correct?

19 MR. ORSKEY: That's just - that's just an example
20 of some of the expenses that---

21 COMMISSIONER CHEATHAM: But, for example, if you
22 were going to go in and have an ACL redone and you -
23 sorry.

24 MR. ORSKEY: That's all right.

25 COMMISSIONER CHEATHAM: I lost my train of thought

1 here. And you go to an ASC, and you're reimbursed two
2 hundred percent of the Medicare rate. If a Medicare
3 recipient goes to an ASC and has the same procedure
4 done, they would be reimbursed at a hundred percent,
5 correct?

6 MR. ORSKEY: That's true, but at---

7 COMMISSIONER CHEATHAM: And you're not turning
8 away the Medicare people, is that correct?

9 MR. ORSKEY: It depends on, you know, the cost of
10 surgery. If it's a Medicare patient - like I tried to
11 explain earlier, is that we may not - we may not be
12 able to cover the expense of that because of the
13 reimbursement rates, and some of it's just not - it's
14 not doable because of the low rate.

15 COMMISSIONER CHEATHAM: So you would see yourself
16 moving out of the Medicare market?

17 MR. ORSKEY: No, I think you have to not -
18 definitely not move out of Medicare market because not
19 all things fall into that category. We see - we're a
20 multi-specialty facility, so we see people for
21 multiple specialties, whether it be in orthopedics or
22 urology or ophthalmology. Depending on what the
23 service is, you know, you have different rates of
24 payment for that particular ICD (phonetic) code.

25 VICE-CHAIRMAN STITH: Mr.---

1 CHAIRMAN ALLEN: Mr. Orskey.

2 VICE-CHAIRMAN STITH: Mr. Orskey, would you please
3 tell me, in the situation where you have implants that
4 may not be covered, how do you handle those now? Are
5 they turned away? Are those individuals turned away
6 and forced to go somewhere else for the surgery? How
7 do you make up the difference in costs?

8 MR. ORSKEY: It just depends on - depends on the
9 situation we have. If we have a patient who comes in
10 for a procedure and our reimbursement is for the - now
11 when I speak about reimbursement, I'm only speaking
12 about reimbursement fee for the facility, not the
13 professional fee or anesthesia fee. The - some of the
14 implantees (phonetic) are - for the actual implant
15 itself may be more than we would get paid by the - by
16 the payer, so you - it's almost having to pay the
17 patient to go somewhere else because you can't do the
18 case and cover your expenses for the amount of implant
19 and what the payer may pay if they don't cover
20 implants.

21 COMMISSIONER CHEATHAM: So if you have someone who
22 needs an implant, you say, go to the hospital?

23 MR. ORSKEY: No.

24 COMMISSIONER CHEATHAM: No?

25 MR. ORSKEY: No, it just depends on what the---

1 COMMISSIONER CHEATHAM: You say, come on in and---

2 MR. ORSKEY: It depends on---

3 COMMISSIONER CHEATHAM: ---we'll take less?

4 MR. ORSKEY: ---the - it depends on what the fee
5 rate is for that payer.

6 COMMISSIONER CHEATHAM: Okay. Let's suppose you
7 need an implant and you can't make any money on it.
8 Do you send them someplace else?

9 VICE-CHAIRMAN STITH: Yeah.

10 MR. ORSKEY: If we're - I don't send them anywhere
11 else. It just depends on if it's - you know, often,
12 we will do the case for a breakeven because the
13 patient usually - the patient is there and we can do
14 the case, but that's not, you know---

15 COMMISSIONER CHEATHAM: So do you charge the
16 patient more to make up for---

17 MR. ORSKEY: No, we don't. We don't.

18 COMMISSIONER CHEATHAM: No?

19 MR. ORSKEY: No.

20 COMMISSIONER CHEATHAM: So if it's a - if you're
21 not making money, you're losing money on the case---

22 MR. ORSKEY: Uh-huh.

23 COMMISSIONER CHEATHAM: ---you still perform it?

24 MR. ORSKEY: Depends - it depends on the - you
25 know, we don't want - we're not in the business to

1 lose money---

2 COMMISSIONER CHEATHAM: Right. I understand.

3 MR. ORSKEY: ---so we are - we are a for-profit
4 facility, but if it - if we're going to lose hundreds
5 of thousands of dollars, it may be best to - the
6 patient to go somewhere else. You know, it just
7 depends. And if - you can't stay in business and lose
8 money, and that's what I think the thrust of this is,
9 is that the fee schedule we think should be higher to
10 cover the costs of patients' needs. ASCs are a great
11 cost saver or very efficient as opposed to hospitals.
12 Our infection rates are much lower. We provide an
13 efficient way of services to all of our beneficiaries.

14 CHAIRMAN ALLEN: Mr. Orskey, does your group -
15 your particular group have facilities in other states?

16 MR. ORSKEY: Yes, sir, they do.

17 CHAIRMAN ALLEN: Okay. Do you understand that the
18 rule that has been proposed in North Carolina that's
19 before this Commission now is substantially higher
20 than the national average in workers' compensation
21 cases for ASCs?

22 MR. ORSKEY: I'm not aware of that, sir.

23 COMMISSIONER BADDOUR: I just have---

24 CHAIRMAN ALLEN: Commissioner Baddour.

25 COMMISSIONER BADDOUR: ---one follow-up on what

1 you've been asked. Do you have any stats on the
2 number of Medicare or Medicaid cases that you turn
3 away because you think you're going to lose on them
4 because the reimbursement is not enough for the
5 particular procedure?

6 MR. ORSKEY: I do - personally, sir, I do not.
7 The---

8 COMMISSIONER BADDOUR: Would anyone have the stats
9 on that?

10 MR. ORSKEY: The Association might. Stats on
11 Medicare patients that maybe we turned away because of
12 Medicare costs or fee schedules?

13 COMMISSIONER BADDOUR: And if someone else can
14 address it later, that's fine, but did---

15 MR. ORSKEY: I do not, sir.

16 COMMISSIONER BADDOUR: ---someone have stats?

17 MR. ORSKEY: I do not personally, sir.

18 COMMISSIONER BADDOUR: All right.

19 CHAIRMAN ALLEN: If someone can address that
20 later, that's fine. And as I said earlier, any other
21 stats, data, anything you wish this Commission to
22 consider---

23 MR. ORSKEY: Yes, sir.

24 CHAIRMAN ALLEN: ---please submit it to us. We've
25 down this road before, and, quite frankly, the data

1 that has been presented has been scant. It would be
2 very helpful for us to understand your position to
3 have some documentation to back it up.

4 MR. ORSKEY: Yes, sir.

5 CHAIRMAN ALLEN: And that goes - that goes for all
6 the speakers today. Any other questions? All right.

7 Thank you---

8 MR. ORSKEY: Thank you.

9 CHAIRMAN ALLEN: ---Mr. Orskey.

10 MR. ORSKEY: Yeah.

11 (SPEAKER DISMISSED)

12 CHAIRMAN ALLEN: Next will be Kelli Collins.
13 Ms. Collins, please approach.

14 KELLI COLLINS

15 MS. COLLINS: Good afternoon.

16 CHAIRMAN ALLEN: Good afternoon. Again, would---?

17 MS. COLLINS: Chairman Allen, and Commissioners -
18 I'm sorry.

19 CHAIRMAN ALLEN: I'm sorry. I don't want to
20 interrupt, but if you would please state your name,
21 tell us whom you represent, if any particular
22 organization, and, of course, I take it you're here on
23 the rule that's before us.

24 MS. COLLINS: That's correct.

25 CHAIRMAN ALLEN: Okay.

1 MS. COLLINS: My name is Kelli Collins, and I'm a
2 regional vice-president of operations for Surgical
3 Care Affiliates, and I'm here representing that
4 organization today and the seven ambulatory surgery
5 centers that we have in the state. We offer
6 convenient access to high-quality, cost-effective
7 surgical care, and we have several representatives
8 from our facilities here with us today. SCA opposes
9 the proposed permanent rule for the four following
10 reasons: The proposed rule is not cost-effective and
11 does not meet statutory requirements; the proposed
12 rule fails to take into account the significant
13 feedback that has been provided by stakeholders; the
14 Fiscal Note fails to consider the dynamic impacts of
15 reducing reimbursement for procedures in ambulatory
16 surgery centers and shifting costs to more
17 cost-expensive settings; the proposed rule would hurt
18 injured workers by denying or delaying access to more
19 cost-effective services. Before discussing the
20 reasons in more detail, I want to provide a summary of
21 the Commission's prior versions of the ASC fee
22 schedule and the legal actions and developments that
23 have occurred to date. Historically, the Commission
24 has established separate fee schedules for physicians,
25 hospitals, ambulatory surgery centers and other

1 healthcare providers. Payments to ambulatory surgery
2 centers represent less than six percent of workers'
3 compensation medical payments. In 2013, the General
4 Assembly enacted a provision authorizing the
5 Commission to base the fee schedules for physicians
6 and hospitals on the Medicare methodology and
7 permitted the Commission to bypass the usual
8 requirement of obtaining a Fiscal Note to analyze the
9 financial impact of these changes. The Commission
10 tasked a group of stakeholders to develop and
11 recommend the fee schedules. ASCs were not included
12 in that process. In 2015, the Commission adopted
13 rules that changed the fee schedules for physicians
14 and hospitals, as authorized by the General Assembly,
15 but also changed the fee schedules for ambulatory
16 surgery centers. In 2016, a Superior Court struck
17 down the changes to the ASC fee schedule because the
18 Commission was not authorized to ignore the
19 requirement of a Fiscal Note. The Commission has
20 appealed to the Court of Appeals. The Superior Court
21 Decision has been stayed pending the appeal. When the
22 Court appeals - affirms a Superior Court Decision, the
23 valid fee schedule that was in place prior to April of
24 2015 will be the reimbursement that would be applied
25 retroactively to all workers' compensation procedures

1 performed in ambulatory surgery centers. As the
2 Commission acknowledges in its Fiscal Note, ASCs will
3 be entitled to collect underpayments for services
4 provided since April of 2015. Conservatively, this
5 will require insurance carriers and self-insured
6 employees to pay ambulatory surgery centers over
7 seventy-five million dollars. SCA has engaged in
8 numerous efforts with other stakeholders to negotiate
9 a fair fee schedule moving forward and a resolution to
10 the substantial underpayment caused by the
11 Commission's invalid fee schedule. There's not enough
12 time today to describe all these efforts to reach a
13 compromise. Countless meetings and other
14 communications have occurred. Frankly, the
15 flexibility that SCA now has to compromise on the
16 substantial underpayments that will be owed to
17 ambulatory surgery centers would end once the Court of
18 Appeals rules in favor of the SCA. With this
19 background, I now turn to SCA's first reason for
20 opposing the proposed rule. The proposed rule is not
21 cost-effective and does not meet the statutory
22 requirements. North Carolina law requires that fee
23 schedules adopted by the Commission be adequate to
24 ensure that, number one, injured workers are provided
25 access to care and, number two, that providers are

1 reimbursed reasonable fees for providing those
2 services and, number three, that medical costs are
3 controlled. The Commission's proposed permanent rule
4 does not meet any of those requirements. First, the
5 Commission's proposed permanent rule limits access to
6 care for injured workers. The Commission's proposed
7 permanent rule does not set a fee schedule for all
8 procedures that can be performed in an ambulatory
9 surgery center. By crafting a fee schedule that uses
10 only Medicare fee schedules as its foundation, the
11 proposed rule does not recognize that a wide variety
12 of procedures can be performed safely and
13 cost-effectively on the working age population that
14 are not on the Medicare-approved list. The workers'
15 compensation population is typically younger and
16 healthier than the Medicare population, meaning that
17 there are additional procedures that can be performed
18 safely and effectively with a shorter stay. For
19 example, a working age patient with a spinal injury is
20 commonly treated in an ambulatory surgery setting.
21 The proposed rule will prevent injured workers from
22 accessing these procedures in an ambulatory surgery
23 center because of several of these spinal codes not on
24 the Medicare ASC or HOPD fee schedules. Similarly,
25 total joint replacements are paid by Medicare only in

1 the inpatient setting today. If the Commission
2 adopted a rule that set a reasonable fee schedule for
3 these procedures, these cases could be performed on
4 injured workers in the ambulatory surgery setting.
5 The Commission should be proposing a fee schedule that
6 provides having these procedures performed in the
7 ambulatory surgery center instead of a more costly
8 inpatient setting. Second, the proposed ASC fee
9 schedule does not offer a reasonable reimbursement to
10 ambulatory surgery providers. Inadequate
11 reimbursement discourages ambulatory surgery centers
12 treating as many injured workers. In 2015 alone,
13 after the change, there was an eight percent decline
14 in the number of workers' compensation cases done by
15 an ASC. This shift away from ASC - I'm sorry - from
16 ASCs eliminates the third failing of the proposed
17 rule. It does not control medical costs. For every
18 injured worker treated in a hospital instead of an
19 ambulatory surgery center, a business or carrier can
20 pay double, triple, or even more sometimes for that
21 medical care. The Fiscal Note makes no attempt to
22 capture these direct or indirect costs. Number two,
23 the proposed rule ignores the significant input
24 provided by stakeholders. All of these concerns
25 should sound familiar to the Commissioners who have

1 served on the Commission for some length of time. SCA
2 has raised these concerns at prior public hearings.
3 In the proposed rule, the Commission is not just
4 ignoring the concerns raised by SCA and other
5 ambulatory surgery centers; the Commission is ignoring
6 its own advice. The Commission has previously spoken
7 out in favor of parity between ASCs and the hospital
8 outpatient department, or HOPDs. The only way to
9 ensure injured workers access to high-quality,
10 effective care is to create parity between the ASC and
11 the HOPD medical fee schedules. The Commission
12 continues to make misleading comparisons to other
13 states. In doing so, the Commission is moving counter
14 to the trend of states recognizing the importance and
15 cost savings of ASCs in their workers' compensation
16 systems. These states are creating parity across
17 settings. North Carolina is just widening the gap.
18 If the Commission has further questions regarding the
19 national trends in workers' compensation, Stacey Smith
20 with Liberty Partners is present and available to
21 answer any of those questions. Number three, the
22 Fiscal Note is fatally flawed. The Fiscal Note
23 ignores the fact that April 2015 ASC fee schedule was
24 invalidated because it failed to include a Fiscal
25 Note. Contrary to the Superior Court's ruling, the

1 Commission continues to fail to conduct a fiscal
2 analysis between the valid fee schedule, which is the
3 one in effect prior to April of 2015, and the proposed
4 fee schedule. In doing so, the Commission downplays
5 dramatic cut to reimbursement for ASCs and the
6 negative impact on injured workers' access to care.
7 In fact, the Fiscal Note acknowledges that it fails to
8 consider the behavioral changes to the system of
9 reducing ambulatory surgery reimbursement. The Fiscal
10 Note only considers alternatives using April 2015 as
11 the baseline and also inappropriately relies on 2015
12 data, which includes claims under the invalid fee
13 schedule with the valid fee schedule. SCA intends to
14 provide a more detailed critique to the Fiscal Note in
15 its written comments. In sum, the Commission waited
16 over two years to produce a Fiscal Note, and then
17 produced a document that fails to even discuss the
18 fiscal impact or changes to the ASC reimbursement when
19 treating injured workers. This violates the
20 rulemaking requirements under the Administrative
21 Procedure Act. Number four, the proposed rule would
22 harm injured workers. The negative impact to injured
23 workers is not speculative. It is already occurring.
24 Data collected by WCRI demonstrated that common
25 outpatient surgeries occurred in North Carolina ASCs

1 less frequently than in other states. Additionally,
2 injured workers in North Carolina reported that they
3 had big problems getting the primary provider they
4 wanted. The proposed rule only exacerbates these real
5 problems for injured workers since the Commission
6 unlawfully changed the ASC fee schedule. Under the
7 proposed rule, injured workers will be denied access
8 to care in the ambulatory surgery setting and will be
9 forced to receive treatment in more expensive,
10 inpatient settings where scheduling services often
11 takes longer and results in delays in care. SCA
12 recommends that the Commission revise its permanent
13 rule consistent with the recommendation in SCA's
14 September 2016 proposal, which is consistent with the
15 statutory requirements; accounts for all procedures
16 that can be performed in an ambulatory surgery center
17 and as would have been demonstrated if a more thorough
18 and appropriate Fiscal Note had been done; results in
19 substantial savings to the workers' compensation
20 system in North Carolina. SCA also insists that the
21 Commission conduct a fiscal analysis that actually
22 looks at the impact of the proposed rule as compared
23 to the valid pre-April 2015 fee schedule instead of
24 using an invalid rule as the baseline. Thank you for
25 the opportunity to speak to you today.

1 CHAIRMAN ALLEN: Questions? Okay. I will start
2 with some questions. Ms. Collins, you realize that
3 the Fiscal Note was approved by OSVM, correct?

4 MS. COLLINS: I do.

5 CHAIRMAN ALLEN: Okay. And you mentioned that
6 there are misleading comparisons to other states.

7 MS. COLLINS: Yes.

8 CHAIRMAN ALLEN: Could you help explain what you
9 contend is misleading in those comparisons?

10 MS. COLLINS: I think that we believe that when
11 you compare - and I'll just say South Carolina to
12 North Carolina, it's a different economy; it's a
13 different environment. There are a different number
14 of folks employed, different number of folks needing
15 certain services versus others, so it's really not an
16 apples to apples comparison, so can tend to be
17 misleading.

18 CHAIRMAN ALLEN: So it's your position that any
19 comparison would be misleading, or is there a better
20 state to compare North Carolina to?

21 MS. COLLINS: I don't think you can evaluate
22 workers' compensation across state lines.

23 CHAIRMAN ALLEN: Would it be valid to compare
24 North Carolina to the national average in Medicare
25 reimbursement rates for ASCs in workers' comp?

1 MS. COLLINS: To Medicare reimbursement rates?

2 CHAIRMAN ALLEN: In workers' compensation.

3 MS. COLLINS: I mean I think - I think you're
4 asking the same question in a different way. I just
5 think the environments are entirely different,
6 depending on the state and the requirements and the
7 population.

8 CHAIRMAN ALLEN: I'm not talking about a
9 particular state, but comparison to the national
10 average - would that be appropriate?

11 MS. COLLINS: I would defer to Stacey on that
12 question, actually.

13 CHAIRMAN ALLEN: Okay. And the national average I
14 think is a hundred and forty-seven percent, and our
15 rate is two hundred percent, so that's where I think
16 there's a disconnect when you say that, you know, it's
17 hard to make a comparison. Any other questions?

18 MS. COLLINS: Thank you.

19 CHAIRMAN ALLEN: Thank you, Ms. Collins.

20 (SPEAKER DISMISSED)

21 CHAIRMAN ALLEN: Next will be Ms. Renee
22 Montgomery. Ms. Montgomery, if you would please
23 approach.

24 RENEE MONTGOMERY

25 MS. MONTGOMERY: Now when - I don't wish to make

1 comments. I put my name on there in case there were
2 questions.

3 CHAIRMAN ALLEN: If you would speak up for the
4 benefit of the court reporter.

5 VICE-CHAIRMAN STITH: To the mike, yeah.

6 MS. MONTGOMERY: Okay. Then I don't wish to be
7 heard.

8 CHAIRMAN ALLEN: Yeah - to the microphone, please.

9 MS. MONTGOMERY: Excuse me?

10 CHAIRMAN ALLEN: To the microphone.

11 VICE-CHAIRMAN STITH: To the microphone.

12 MS. MONTGOMERY: Okay. Sure. Yes. I am Renee
13 Montgomery, and I represent Surgical Care Affiliates,
14 and I indicated on the list that if I needed to answer
15 any questions, particularly as it pertained to the
16 litigation, that I would be available and happy to do
17 that. So, unless there are any questions from the
18 Commissioners, I don't - I don't plan to offer any
19 additional comments. If something comes up later, I
20 would just ask to be called back if---

21 CHAIRMAN ALLEN: Very well.

22 MS. MONTGOMERY: ---that's all right.

23 CHAIRMAN ALLEN: Any questions? All right. Thank
24 you, Ms. Montgomery. You may be seated.

25 (SPEAKER DISMISSED)

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CHAIRMAN ALLEN: Next will be Stephanie Gay.

STEPHANIE GAY

CHAIRMAN ALLEN: And, Ms. Gay, as you approach, if you would, please state your name, tell us whom you represent, and I'm going to take a leap of faith that you're here on - in respect to the rule that is under consideration for amendment.

MS. GAY: That is correct. My name is Stephanie Gay. I am with Aegis Administrative Services, which is a third-party administrator, handling workers' compensation claims. If you will indulge me, I have a very long list of the business community that I am here to represent. That would be Capital Associated Industries, Incorporated, the North Carolina Association of County Commissioners, the North Carolina Association of Self-Insurers, the North Carolina Automobile Dealers Association, the North Carolina Chamber, the North Carolina Farm Bureau and affiliated companies, the North Carolina Forestry Association, the North Carolina Home Builders Association, the North Carolina League of Municipalities, the North Carolina Manufacturers Alliance, the North Carolina Retail Merchants Association, the American Insurance Association, Property Casualty Insurers of America Association,

1 Builders Mutual Insurance Company, Dealers Choice
2 Mutual Insurance Company, First Benefits Insurance
3 Mutual, Forestry Mutual, the North Carolina Farm
4 Bureau, The Employers Association, the Employers
5 Coalition of North Carolina and WCI, Incorporated.
6 We're a very large group, obviously, in the builders'
7 community - or in the employment community. I daresay
8 we probably have more claims with this contingency
9 than anybody you will hear from today. Let me just
10 give you a little history, if you will allow me to do
11 so. I, among several people, were involved in the
12 negotiations for a medical fee schedule dating back to
13 2013. It was about a two and a half year process. We
14 negotiated with the North Carolina Medical Society,
15 the Hospital Association and members of the business
16 community. I will take issue as to whether or not the
17 am surg folks were present. SCA may not have been
18 present, but hospitals and physicians owning
19 ambulatory surgical centers were represented at this
20 meeting. Our goal all along was to be fair and
21 reasonable. We had many costs that were not
22 reasonable for doctors. We had many costs on the
23 hospital side, particularly with the implants and the
24 surgeries that were not fair to employers. The goal
25 was to reach a median level. We didn't want to be the

1 lowest state; we did not want to be the highest state.
2 I believe we accomplished that, and that resulted in
3 the 2015 fee schedule that was adopted. As I've
4 listened to the comments from the speakers before me,
5 I would just say I disagree with a few - a few of the
6 comments. I understand that access to medical care is
7 incredibly important. I do not believe that this will
8 prevent access to medical care. People are having
9 surgeries. They're having them at hospitals. They
10 are having them at ambulatory surgical centers. I
11 daresay that the decline of - I heard six percent by
12 one speaker, eight percent by another in surgeries is
13 the direct result of the fact that the WCRI recognized
14 that North Carolina had more surgeries for backs than
15 almost any other state that they look at. I think the
16 decrease is the direct result of the fact that we no
17 longer incentivize doctors to do those kinds of
18 surgeries. Ambulatory surgical centers have not been
19 used for those types of procedures in the past. The
20 wonderful thing about this new rule is that that is
21 going to allow that to happen, provided we as
22 employers who get to direct the medical treatment
23 decide that is a facility that we'd like to have that
24 patient undergo that procedure. I think that the
25 whole idea of controlling costs is great. We have

1 been involved in negotiating, as this was mentioned,
2 with SCA about doing a new proposed fee schedule. We
3 have not come to an agreement yet. I don't think that
4 is a result of a lack of effort or a lack of certainly
5 folks trying. There have been a few issues that have
6 come up along the way, such as the Wilkes case that
7 has maybe sidetracked us a bit, but I will tell you
8 that it became very apparent to me in my discussions
9 directly with SCA and their contingencies that what
10 they really wanted was the ability to be able to do
11 those said procedures that the Medicare ambulatory fee
12 schedule would not allow them to do. And, in fact, I
13 would quote them to say it would be a win-win if they
14 were able to do that because it would give them more
15 procedures that they weren't allowed to do, which
16 obviously generates revenue, and it would also provide
17 us all a cost-saving factor for those of us on the
18 employer side because we could have our patients have
19 those procedures there. Let's be clear about the
20 procedures that we're talking about. We're talking
21 about lumbar/cervical fusions. We're talking about
22 total joint replacements, whether it's knee, elbow or
23 shoulder. We're talking about major procedures that
24 historically have not been done in ambulatory surgical
25 centers in the State of North Carolina. I think this

1 is a new arena for all of us. And, obviously, if this
2 is a place where they can be done and they can truly
3 do things like prevent infections, MRSA, where we tend
4 to have those in hospital settings, I absolutely would
5 love to have it done in those facilities. I think
6 this gives us that opportunity. You have come up with
7 a fee schedule that honors the - I think the spirit
8 with which we negotiated on for two and a half years
9 trying to get to a median level. And now, we are
10 opening the door for them to do these procedures that
11 previously they would not have been reimbursed for and
12 they were sending to the hospitals. I congratulate
13 you, and I thank you, and I - and we, obviously,
14 support that rule.

15 CHAIRMAN ALLEN: Any questions? All right. Thank
16 you, Ms. Gay.

17 MS. GAY: Sure. Thank you.

18 (SPEAKER DISMISSED)

19 CHAIRMAN ALLEN: Next, Stacey Smith.

20 STACEY SMITH

21 CHAIRMAN ALLEN: And, if you would, state your
22 name, tell us whom you represent, if any particular
23 organization. And, of course, I'm assuming you're
24 here in respect to the proposed amendment to the rule.

25 MS. SMITH: I hope so because I've been sitting

1 through a lot of information I wouldn't necessarily
2 want to hear if I wasn't, so good afternoon. Stacey
3 Smith with Liberty Partners Group; I'm here on behalf
4 of Surgical Care Affiliates. I'm sorry. I had put my
5 name down to speak. I don't have any kind of prepared
6 testimony, but I thought maybe to answer some
7 questions or add some clarifications for the record
8 for the previous speakers from both the Association
9 and some of the - a clarification on some of the
10 questions to Ms. Kelli Collins from SCA. I would like
11 to begin with just to your - the last point that you
12 made to Kelli, Chairman Allen, regarding the
13 Department of Labor national fee schedule for DOL
14 cases on workers' comp, and you asked if that
15 average - where that was versus what you would be
16 proposing in North Carolina. I don't know what the
17 rate is for the DOL, but I do have the - what it does
18 pay for, and I think that the main difference when you
19 look at the DOL fee schedule at the national level
20 versus what you are proposing is that it does not
21 cover implants. It is very specific in the fee
22 schedule rule. DOL's website - you can go to it, and
23 it says, what does the facility payment pay for? And
24 it gives a list of items which mirror the ASC fee
25 schedule under Medicare, with a caveat that it gives

1 the same payments - what they don't pay for, and then
2 they don't pay for implants. That's paid separately.
3 So I think the delta and the difference between a
4 hundred - I think he said a hundred and forty-seven
5 percent of Medicare versus what a two hundred percent
6 of ASC - you know, one of the things you can look at
7 is what an implant cost would be, and that can make a
8 very big difference in what the actual payment to the
9 facility when you add that implant, so I would say
10 that that would be the biggest difference between
11 comparing the DOL schedule to what you are proposing.
12 It is apples to oranges, especially when you take into
13 consideration the implant costs. The second item just
14 to bring up is talking about what Stephanie had just
15 brought up about spine and certain procedures that
16 have been done. I think it's - to just correct the
17 record, their total joints, spine codes have been done
18 in North Carolina since 2011. These procedures are
19 safe, and they are to be done in an outpatient setting
20 in ambulatory surgery centers, and commercial payers
21 have been doing so in this market since 2011,
22 especially North Carolina allows for stays in ASCs up
23 to twenty-three hours and fifty-nine minutes, which is
24 allowed under the Medicare rules under Section 416.2
25 for ASCs. So commercial payers, because they want to

1 bring their - you know, their patients out of an
2 inpatient setting, into an outpatient setting, allowed
3 ASCs to do these procedures. So spine, total joint -
4 that has been done in these markets since '11. And
5 then just regarding - there was the discussion on
6 Medicare and implants, so I think what's really
7 important to remember on the Medicare fee schedule,
8 you know, you have the inpatient fee schedule,
9 hospital outpatient - HOPD, as it's referred to in the
10 ASC. Every year, CMS goes through the rulemaking, and
11 they'll take codes off of the inpatient schedule and
12 they'll put them - you know, they'll say, we're moving
13 these codes to be done in an outpatient setting, and
14 they will either move them onto the HOPD schedule or
15 both the HOPD and ASC. And quite often, they will
16 move those codes onto those schedules without any
17 value, without any payment in dollars. There are
18 spine codes right now that CMS, HHS has said, these
19 are, you know, safe to do in an outpatient setting,
20 but we're not going to put any value on them. And
21 then they may go in and reexamine them and put a
22 valuation to them, but they will put them on the
23 approved list. And the risk you run in North
24 Carolina, just looking at an ASC fee schedule, is
25 there are codes since - you know, that there are

1 procedures that have been being done since 2011 in
2 ASCs that are not on the ASC fee schedule, that may
3 not even be on the HOPD fee schedule, and are being
4 done safely in the ASC setting. By moving to that fee
5 schedule, you are immediately limiting access to
6 injured workers to those facilities. And if - because
7 there will be no associated payment to those - to
8 those codes. If you have no associated payment to
9 those codes, there's only - if it's not on the HOPD
10 schedule and you're only on an ASC, you are
11 immediately driving a cost to the system because that
12 they will move into that inpatient setting and the
13 rates are much, much higher because now while you're
14 paying for the procedure, you are paying for days in
15 the hospital, and you are running the risk of all the
16 things that are associated with staying in the
17 hospital for an extended stay. I think Ms. Gay
18 mentioned MRSA and all the other infections that can
19 come along with surgery. So that's just one example
20 that it's not - you know, it's not this easy, magical
21 thing just to take an ASC and put it on an ASC fee
22 schedule on Medicare. The last item I just want to
23 address is the discussion on the WCRI. There's been a
24 lot of talk about the - you know, the thirty-three
25 state median average, you know, in North Carolina of

1 where they want to come, where they're not the low or
2 the high, but, you know, where do we want to sit in
3 this median average? Well, I think it probably would
4 be beneficial because we talk about WCRI a lot for,
5 you know, your staff to pull up the WCRI reports that
6 are cited all the time and maybe pull out the section,
7 you know, of data methods and limitations of the
8 report and where WCRI specifically mentions that they
9 look at these thirty-three states. And these are -
10 this is data from 2013. Their most recent report is
11 from 2013. That data says from 2013. They have
12 states that they asterisk, you know, when you look at
13 the - you know, the median average charts, right, but
14 then you have to read the footnotes of what's included
15 in here, and they have caveats of what states have
16 made changes to their fee schedules. Some have
17 brought down. They had, you know, just bill charges.
18 Connecticut is an example. They moved to - ACSs to a
19 hundred and ninety percent of HOPD. They had some
20 states move their rates up. So that's really
21 important to me - those footnotes. And the biggest
22 footnote in here are there are five or six states
23 where they say one of the largest payers in the
24 system - or the largest workers' comp carrier payers
25 did not submit their data files. They could not put

1 that data into the knee and shoulder. And they
2 actually said, this may lead to possible under and
3 overstatements in the results. So while medians and
4 national averages and, you know, regression analysis
5 is all very important, it's also important to know
6 what the caveats are to that data and the limitations,
7 and WCRI does disclose those limitations, but I think
8 it's important for you all to be informed that there
9 are limitations on this. Just lastly on the averages,
10 you could set your fee schedule at the median or you
11 could go lower. That doesn't necessarily mean injured
12 workers are going to be treated there, and so, you
13 know, by believing that you're going to bring savings
14 to the system by having maybe a little bit lower than
15 these averages or a little - that doesn't
16 necessarily - that may not actually end up within the
17 real world. If those cases are not being seen in
18 those facilities, where do you think those payments
19 are going to materialize because it's not a static
20 market? There is an injured worker who has a - who
21 needs a spine procedure. There's not just one place
22 of site of service that that injured worker could go
23 to; there are three. And so if you have an ASC that
24 is not able to see that because that code is not on
25 their fee schedule or it's being reimbursed at such

1 level that it's not in their - and that they can't do
2 it, it's not a viable procedure, there are two other
3 sites of service that that injured worker could go to
4 that are considerably higher in cost even if you take
5 an ASC fee schedule for here and discount it to HOPD.
6 It's not a static marketplace. If you just had one
7 site of service, that would be probably a correct
8 analysis, but you have three different sites of
9 service that can treat the same injured worker.
10 That's the point. And then just one of the last
11 things on the implant issue is Medicare. When you
12 were having the dialogue on if you have a Medicare
13 patient that has an ACL tear or a shoulder, and then
14 you have an injured worker. So the point - the goal
15 of the Medicare fee schedule on the Medicare system is
16 to treat seniors - older citizens over the age of
17 sixty-five with a different standard. Your statutory
18 duties under workers' comp is to have injured workers
19 have the best care available to them to get them back
20 to work and get them back to work at the - at their
21 ability of which they were pre-injury because it costs
22 this system so much more if they're on any kind of
23 disability and they are not returned, and so when you
24 look at doing a procedure like a shoulder, you may put
25 maybe - there may be an implant for someone who's

1 seventy-five. They may put in an implant, or they may
2 not, but if it is a forty-five-year-old construction
3 worker who needs that shoulder to work, there may be
4 additional implants that are put in to make sure he
5 or - he is able to recover faster and would gain the
6 mobility and the ability that he had prior to his
7 injury because that's the goal, I mean, paying into
8 the workers' comp system for the employers, and that's
9 what the workers would expect if they are injured on
10 the job. So that's a little bit of the caveat
11 difference between a fee schedule that is based for
12 the citizens - you know, people over sixty-five, and
13 then, you know, for an able working population, so I
14 just wanted to add that clarification. So I'll be
15 happy to answer any questions you might have.

16 CHAIRMAN ALLEN: Ms. Smith, you indicated you're
17 with, I think, Liberty Partners. Did I---

18 MS. SMITH: Yeah.

19 CHAIRMAN ALLEN: ---hear that correctly?

20 MS. SMITH: It's a consulting firm.

21 CHAIRMAN ALLEN: It's a consulting firm. Is it a
22 lobbying firm?

23 MS. SMITH: We do lobbying, and we do government
24 relations, advocacy---

25 CHAIRMAN ALLEN: Okay.

1 MS. SMITH: ---all types of consulting.

2 CHAIRMAN ALLEN: Are y'all registered here in
3 North Carolina?

4 MS. SMITH: Not lobbying on behalf of SCA.

5 CHAIRMAN ALLEN: Okay. All right. Do you have
6 any data or anything to substantiate what you have
7 articulated before us today that you're going to want
8 to present?

9 MS. SMITH: Yeah, absolutely. And thank you for
10 giving us that opportunity. We'll be providing our
11 data with our final proposal on - in the August
12 submission.

13 CHAIRMAN ALLEN: And one of the things I think
14 Ms. Collins indicated that in terms of reimbursement
15 if we go back to the prior fee schedule would be along
16 the lines of seventy-five million dollars. A lot of
17 the analysis I've seen indicates that, you know, if we
18 were to adopt various, you know, ideas or proposals
19 that would be more in line with what SCA or the ASCs
20 are requesting, it would be tens of millions of
21 dollars, and, yet, it seems like you're indicating
22 that there would be cost savings. Is there any
23 documentation you can provide that would show what
24 those cost savings are?

25 MS. SMITH: I'm not - I think I understand your

1 question, but just to clarify so that I know that I'm
2 answering it properly, so you stated that Kelli had
3 said sixty to seventy million dollars and that there
4 would be tens of - what are you referring to - on the
5 tens of millions of dollars?

6 CHAIRMAN ALLEN: Tens of millions of dollars if we
7 were to adopt, for instance, a fee schedule that
8 reimbursed ASCs at the outpatient rate on parity with
9 the hospital outpatient rates.

10 MS. SMITH: And that tens of millions - is that
11 that would be savings?

12 CHAIRMAN ALLEN: Costs, not savings.

13 MS. SMITH: I'm not sure---

14 CHAIRMAN ALLEN: And yet, you indicated---

15 MS. SMITH: ---where that cost is---

16 CHAIRMAN ALLEN: ---that there would be a savings.
17 I would be particularly interested in seeing what
18 documentation supports that savings so we can fairly
19 consider all that information.

20 MS. SMITH: Sure. I'm not - I can't - I don't
21 know if I can answer the question on the tens of - the
22 tens of millions savings [sic] because I don't know
23 what's being compared, but I can answer the questions
24 on savings.

25 CHAIRMAN ALLEN: Right.

1 MS. SMITH: Okay. So I can do that. So let's go
2 back to, you know, 2015 - well, 2015, and I think the
3 point that was made - that Kelli made in her testimony
4 on the Fiscal Note is really critical for you all to
5 consider. The Fiscal Note and the subsequent NCCI
6 analysis is all being based upon the invalid fee
7 schedule, which I think is two hundred and ten of ASC
8 this year - which is two hundred and ten percent of
9 ASC with no payment to implants. If the court case is
10 upheld and the appeal - if SCA wins the appeal -
11 upheld - and the stay is lifted, the fee schedule goes
12 back to the valid - you know, it is the valid fee
13 schedule, but now that will have to be paid at those
14 rates, right, so I think it was sixty-seven percent of
15 bill charges. So the major issue I think we all are
16 having with this is that any comparison to what SCA
17 has proposed as a discount to what the hospitals are -
18 so if the hospitals are at - you know, I think the
19 proposal is a - be a ten or twenty percent discount of
20 HOPD - off of the hospitals - that comparison is all
21 being done off of the invalid fee schedule of two
22 hundred and ten percent of ASC. If the Court ruled
23 today and you did the Fiscal Note analysis tomorrow,
24 you would have - you would have to base it off the
25 valid fee schedule at sixty-seven percent of bill

1 charges. If you went to, let's say, a hundred and
2 ninety percent of HOPD for ASCs, you would still have
3 a thirty to forty percent savings off of that old fee
4 schedule because that old fee schedule - the cut from
5 the old fee schedule to where you are right now was
6 around sixty percent. And so when you're - we're at
7 this ASC fee schedule, which we shouldn't be. We are
8 up here, and if we go back to percent of charges, and
9 then we want to go to this discount of HOPD to make
10 sure we are giving workers access to all the
11 procedures that are available to them, that's still a
12 reduction. It's just where the baseline that's being
13 used is improper. There's a savings to the system
14 with every proposal that SCA has put forward. The
15 flaw has been with using the invalid fee schedule as
16 the measure towards the savings.

17 CHAIRMAN ALLEN: So if I understand your answer
18 correctly - and please correct if I'm wrong - if I
19 understand your position, you do not believe it's
20 valid to compare for cost-saving purposes the proposed
21 rule versus the rule that was adopted in 2015. You
22 want to compare it to the prior 2015 rule, correct?

23 MS. SMITH: Say it one more time.

24 CHAIRMAN ALLEN: You do not believe it is valid to
25 compare the proposed rule to the rule that was enacted

1 in 2015. You want to go a step back further and only
2 have a valid comparison to the percent of charges
3 rule.

4 MS. SMITH: That would be the most - that would be
5 the most accurate, right? That's the most accurate.
6 Correct. Right, because right now, the proposed rule
7 is comparing to the invalid fee schedule, what - you
8 know, the 2015 implementation. There's no - there's
9 no real difference. There's a little bit of a bump
10 because of how you treat some codes, so you get within
11 like a million dollars, so it's kind of neutral, but
12 if you compared this proposed rule to the valid fee
13 schedule percent charges, it would show a tremendous -
14 you know, some would say savings; some would say cut.
15 So I think - I think that's a critical factor. I
16 think the goal of - I think even the providers' goal,
17 you all's goal, the carriers, the business community
18 is to provide savings into the system that breeds -
19 you know, that brings efficiencies, but at some point
20 those savings of what you are proposing actually mean
21 cuts, and that will then deter and push those patients
22 somewhere else. So where you see a savings - and
23 we've provided these examples in our other
24 submissions - what you think of as savings actually
25 increases costs because if you have a worker who

1 cannot have that procedure done in an ASC setting and
2 goes to an outpatient - or goes to a hospital, it can
3 be thirty, forty, fifty percent higher, so all the
4 savings that you think you're bringing into the system
5 by putting in this fee schedule - you're really just
6 cutting it for a provider group because you are then
7 increasing your costs in another group of the medical
8 spend.

9 CHAIRMAN ALLEN: Have y'all had an opportunity, or
10 sought an opportunity, to talk to the Rate Bureau or
11 any other entity such as that to see what the impact
12 would be of any particular proposal that y'all have to
13 the rates in this state?

14 MS. SMITH: No. I don't think that's really---

15 CHAIRMAN ALLEN: Because if we're going to look at
16 costs and savings and use those terms interchangeably
17 or whatnot, it would be helpful to know what the
18 impact would be on rates because if it results in
19 ultimately costs going up, that money is going to come
20 from somewhere, isn't it?

21 MS. SMITH: Right. And I understand. This point
22 has been made, and this is what makes it difficult.
23 If the case is upheld - I think this is really
24 critical - the assumptions on whatever workers' comp
25 rates would have been were made under the wrong

1 assumptions. We're ready---

2 CHAIRMAN ALLEN: Of course, the opposite is true
3 if the case is not upheld.

4 MS. SMITH: How is---? I don't understand.

5 CHAIRMAN ALLEN: Well, if the case is not upheld -
6 the first case - there are two cases - the first case,
7 if Judge Ridgeway's Order is overturned, then the
8 prior rule would be for all intents and purposes
9 validated, saving except for the fact that this
10 Commission is undertaking new permanent rulemaking
11 here today.

12 MS. SMITH: Sure.

13 CHAIRMAN ALLEN: And, of course, this would
14 supersede that, and I think it would supersede it in a
15 way that's actually beneficial to the ASC community.
16 I think that's gotten kind of lost in translation, but
17 I think it would be a benefit to the ASC community.
18 So, ultimately, the issue is, what impact does any
19 proposal that's offered by the ASC community have on
20 insurance rates in this state?

21 MS. SMITH: I think you cannot answer that without
22 understanding that if the valid fee schedule - if
23 the - if the rates have to incorporate the valid fee
24 schedule, any proposal coming off the valid fee
25 schedule would be savings to the system. You know,

1 you can't - if the Court - if the Court upholds the
2 Decision, you can't ignore the Decision just because
3 it's an inconvenience. You have to abide by what the
4 law says and what the court order is. And I
5 understand. I mean it's - it could - it - but you
6 can't ignore that---

7 CHAIRMAN ALLEN: And, ma'am, I can---

8 MS. SMITH: ---because there may be some---

9 CHAIRMAN ALLEN: I'm sorry.

10 MS. SMITH: ---adjustments that need to be done in
11 rates so---

12 CHAIRMAN ALLEN: Ma'am, I can assure you---

13 MS. SMITH: Oh, I know you won't---

14 CHAIRMAN ALLEN: ---on behalf of this
15 Commission---

16 MS. SMITH: ---but I'm just saying that's where I
17 think I'm a little confused.

18 CHAIRMAN ALLEN: Well, let me make this perfectly
19 clear. We have no intention to ignore any Decision of
20 the courts.

21 MS. SMITH: Right. I totally understand that, but
22 I would just think it also should be made clear that
23 SCA came to this Commission, came to Chairman Heath in
24 2015 - in December of 2015 with this issue and tried
25 to resolve this first through a declaratory ruling.

1 Then Chairman Heath asked us to put a proposal
2 forward, which we did. And then Chairman Heath left.
3 SCA has tried to bring this to this, you know,
4 attention years ago, and it's just now, you know,
5 stacked up these costs, so I think there's been
6 outreach on multiple occasions to try to work this
7 out, to resolve this without too much time going by
8 because if the appeal is upheld, there will be a lot
9 of money that is owed back to the carrier, to the
10 providers, and that is a disruptor on the system, and
11 SCA has tried to avoid that.

12 CHAIRMAN ALLEN: Any further questions?

13 COMMISSIONER CHEATHAM: I have one---

14 MS. SMITH: Sure.

15 COMMISSIONER CHEATHAM: ---quick question. You
16 mentioned that spine surgery has been done at ASCs
17 since 2011, correct?

18 MS. SMITH: Yes, ma'am.

19 COMMISSIONER CHEATHAM: How is that spine
20 surgery - how are you reimbursed for that?

21 MS. SMITH: Well, I think---

22 COMMISSIONER CHEATHAM: What fee schedule?

23 MS. SMITH: Well, yeah, I would all defer to Kelli
24 but - I mean, they're commercial payers, right?

25 MS. COLLINS: Yeah, our commercial payers

1 reimburse for those procedures in our (inaudible).

2 COMMISSIONER CHEATHAM: So you have no workers'
3 comp---

4 MS. COLLINS: (Inaudible).

5 COMMISSIONER CHEATHAM: ---spine surgeries---

6 CHAIRMAN ALLEN: All right. It would be very---

7 COMMISSIONER CHEATHAM: ---is that correct?

8 CHAIRMAN ALLEN: I'm sorry, Commissioner Cheatham.

9 It would be very helpful for the court reporter if at
10 a bare minimum you repeat the answer you were---

11 MS. SMITH: Okay. That - I---

12 CHAIRMAN ALLEN: ---seeking from the audience so
13 it's transcribed.

14 MS. SMITH: They don't get to have a head shake.
15 So commercial payers, yes; workers' comp---

16 MS. COLLINS: In just some work comp.

17 MS. SMITH: Commercial payers are reimbursing for
18 spinal procedures in some workers' comp.

19 COMMISSIONER CHEATHAM: Some workers' comp spine
20 surgeries are being done in ASCs, correct---

21 MS. SMITH: Correct.

22 COMMISSIONER CHEATHAM: ---since 2011? And how
23 are you being reimbursed for that?

24 MS. SMITH: How are you being reimbursed if
25 they're not---

1 COMMISSIONER CHEATHAM: If it's a workers' comp
2 patient---

3 MS. SMITH: ---on the ASC fee schedule?

4 COMMISSIONER CHEATHAM: ---and he comes into an
5 ASC and he has spine surgery, what reimbursement do
6 you get---

7 MS. COLLINS: I can't---

8 COMMISSIONER CHEATHAM: ---of what fee schedule?

9 MS. COLLINS: I can't tell you that. I can't
10 share our contract rates.

11 MS. SMITH: Yeah. I mean---

12 MS. GAY: They're negotiated rates.

13 MS. SMITH: Yeah, there are negotiated rates, so
14 the fee schedule is just the standard, but then a
15 carrier can - is it a carrier or a provider? Oh,
16 carrier.

17 MS. GAY: A workers' comp carrier or---

18 CHAIRMAN ALLEN: Okay.

19 MS. GAY: ---employer (unintelligible)---

20 MS. SMITH: Can - yeah.

21 MS. GAY: ---has the ability to negotiate any rate
22 of any provider for something that's not
23 accountable---

24 CHAIRMAN ALLEN: All right.

25 MS. GAY: ---on the fee schedule.

1 CHAIRMAN ALLEN: All right.

2 MS. GAY: So that would be how it would be done -
3 how spine surgery could be done at an - at an ASC.

4 CHAIRMAN ALLEN: All right. All right. Again,
5 for the purpose of maintaining a clean record, I
6 really need for everybody to speak into the microphone
7 and---

8 MS. SMITH: You want to come up here, Stephanie?

9 CHAIRMAN ALLEN: If I understand Ms. Collins'
10 comment correct, she said that she could not share
11 that information because it's a contract rate. Is
12 that correct?

13 MS. SMITH: Right. So Stephanie Gay had repeated
14 that it can be a payer or someone - a business
15 provider - a business - someone in the business
16 community can go in and independently negotiate a
17 contract for that procedure to be done in an ASC
18 setting even though it's not on the fee schedule.

19 CHAIRMAN ALLEN: All right.

20 MS. SMITH: Is that right?

21 CHAIRMAN ALLEN: At this point in time, I am going
22 to say we're going to take about a ten-minute recess.
23 We've been going well over an hour now. Ms. Smith, if
24 you have any further comments you would like to make,
25 you'll be more than welcome to do so when we get back

1 from the recess. And then I will open the door up one
2 more time. If anyone wishes to make comments before
3 this Commission, they may sign-up with Ms. Bourdon,
4 and we'll add those names to the list, but we'll
5 take---

6 MS. SMITH: Okay. So thank you very much. Thank
7 you---

8 CHAIRMAN ALLEN: ---about ten minutes.

9 MS. SMITH: ---for your time. I appreciate it.
10 Thank you.

11 (OFF THE RECORD)

12 CHAIRMAN ALLEN: All right. We're back on the
13 record. Ms. Smith, if it's all right with you, could
14 you approach the microphone again? I think there may
15 be at least one follow-up question. And I want to,
16 you know, make it clear, you know, with the - in terms
17 of the Fiscal Note, the baseline was not selected by
18 the Industrial Commission; the baseline was selected
19 by OSVM, and we have to go by what they suggest to us,
20 so I wanted to make that clear, but I also want to ask
21 you about this concern that there are, you know, codes
22 and procedures that ASCs are not being reimbursed for
23 because it is my belief with this proposed rule that's
24 before us, particularly Subparagraph (2), which states
25 that there shall be - "A maximum [...] rate of 135

1 percent shall apply to institutional services
2 performed at an ASC that are eligible for payment by
3 CMS if performed at an outpatient hospital facility,
4 but would not be eligible for payment by CMS if
5 performed at an ASC." We believe that captures those
6 codes. Help me to understand how I am wrong.

7 MS. SMITH: Captures the codes that are on the
8 HOPD schedule that are not on the ASC schedule?

9 CHAIRMAN ALLEN: Right.

10 MS. SMITH: There are - that would be - yes, that
11 would be correct, but I think it's - there are codes
12 that - I think we have to be really careful when you
13 look at these fee schedules, and it's really getting -
14 I mean getting - I am, you know, getting under the
15 hood of the fee schedules, right. So this is a - this
16 is a good segue. And just to add some clarification
17 on - you had a very good question on spine procedures,
18 what were being done in workers' comp. So there's a
19 level-one spine code that is on the ASC fee schedule
20 that is on the Medicare ASC fee schedule, and it has a
21 dollar amount associated with it. That has been done
22 in workers' comp cases, and it is on the ASC fee
23 schedule. There is a level-two spine code that is on
24 the ASC fee schedule that is - that valuation is zero.
25 So what do you do for those level-twos that prior to,

1 you know, going to a Medicare-based fee schedule, you
2 are at a percent of charge, that you could do a level
3 two, you were getting paid for that level-two? Then
4 you convert to a Medicare-based fee schedule with a
5 valuation of zero, so you - you know, zero percent is
6 zero, so you're not getting paid for that code. You
7 can do the level-one and the level-two, which is kind
8 of an add-on, you know, because you'll do one, then
9 you don't have that code, so that---

10 COMMISSIONER CHEATHAM: Can I---?

11 MS. SMITH: ---was a clarification.

12 COMMISSIONER CHEATHAM: Can I you ask a
13 question---

14 MS. SMITH: Sure.

15 COMMISSIONER CHEATHAM: ---for clarification? I
16 thought that I heard that you were in fact doing them
17 off a negotiated rate---

18 VICE-CHAIRMAN STITH: Uh-huh.

19 COMMISSIONER CHEATHAM: ---with the carriers.

20 MR. SMITH: Right. So---

21 COMMISSIONER CHEATHAM: So it really doesn't have
22 anything to do with the fee schedule.

23 MS. SMITH: So I---

24 COMMISSIONER CHEATHAM: It's just whatever your
25 confidential negotiated rate might be.

1 MS. SMITH: So I think on - there may be maybe on
2 a case-by-case basis, which, you know, I - and I don't
3 know what the centers do. And actually, you know, I
4 think NCCI has the data. They could look at, but I
5 think what Kelli was referring to is prior to the '15
6 rule. There may have - there may have been some
7 negotiated rates based on percent of charge that they
8 would negotiate on those rates, but if you go to an
9 ASC-based fee schedule, you're not going to be able
10 to - there's no dollar associated with that code.
11 What are you going to---? Well, you can't negotiate
12 off of nothing if there's no dollar amount associated
13 with that.

14 COMMISSIONER CHEATHAM: Okay. Then I must have
15 misunderstood the answer because---

16 VICE-CHAIRMAN STITH: Uh-huh.

17 COMMISSIONER CHEATHAM: ---my question was, what
18 are you reimbursed? You said you've been doing spine
19 codes since 2011.

20 MS. SMITH: Correct.

21 COMMISSIONER CHEATHAM: And so if you did a spine
22 code today, what would you be reimbursed? And then I
23 thought I heard, no, that comes off the negotiated
24 rate.

25 MS. SMITH: So there are multiple different spine

1 codes, right - level-one, level-two. I'm sure there's
2 a level-three - I believe three and four. Level-one
3 is on the ASC fee schedule.

4 COMMISSIONER CHEATHAM: Right.

5 MS. SMITH: That was, but---

6 COMMISSIONER CHEATHAM: But I think that---

7 MS. SMITH: ---level-two was not.

8 COMMISSIONER CHEATHAM: But I think what you said
9 and what I wrote down anyway - I could be wrong - that
10 you were talking about spine codes without
11 reimbursement have been being done since 2011.

12 MS. SMITH: Right. But then---

13 COMMISSIONER CHEATHAM: Would you have then
14 applied---

15 MS. SMITH: ---when the fee schedule - the 2015
16 fee schedule is an ASC-based fee schedule. Those
17 codes were not on - those codes are no longer on the
18 fee schedule. Prior to 2015, they were percent of
19 charge, and so---

20 COMMISSIONER CHEATHAM: Right.

21 MS. SMITH: ---they were being - when the 2015 fee
22 schedule went into place, it was an ASC-based fee
23 schedule, and those codes do not have a dollar amount
24 on the ASC fee schedule, so there's no corresponding
25 payment so---

1 COMMISSIONER CHEATHAM: But you're doing it and
2 you're somehow getting paid and you're getting paid---

3 MS. SMITH: Doing the - we're doing the first
4 level, yes, because that is on the - but the first
5 level - but the second level is not on the fee
6 schedule.

7 COMMISSIONER CHEATHAM: So I wrote down
8 incorrectly when I wrote down spine codes without
9 reimbursement, which to me means codes---

10 MS. SMITH: Right.

11 COMMISSIONER CHEATHAM: ---reimbursed codes, since
12 2011. So I wrote that down incorrectly. You are in
13 fact only doing level-ones, which are on the ASC fee
14 schedule, and you were not doing level-twos?

15 MS. SMITH: I can't - I can't speak to the volume
16 or what could be done.

17 COMMISSIONER CHEATHAM: No, no.

18 VICE-CHAIRMAN STITH: But---

19 MS. SMITH: But I think---

20 COMMISSIONER CHEATHAM: I'm asking you what is
21 being done.

22 MS. SMITH: Well, what---

23 VICE-CHAIRMAN STITH: Is there someone in the
24 audience that knows; that can speak to what they're
25 doing?

1 MS. SMITH: Well, I---

2 MS. MURPHY: Yeah. Can you hear me?

3 VICE-CHAIRMAN STITH: No.

4 CHAIRMAN ALLEN: No.

5 VICE-CHAIRMAN STITH: Could you please get to the
6 mike?

7 MS. SMITH: Yeah, yeah, come up here.

8 CHAIRMAN ALLEN: That's all right.

9 (SPEAKER DISMISSED)

10 DEBBIE MURPHY

11 CHAIRMAN ALLEN: And, ma'am, if you would, state
12 your name, whom you represent, if anyone, and---

13 MS. MURPHY: Okay.

14 CHAIRMAN ALLEN: ---I assume you're here about the
15 ASC proposal.

16 MS. MURPHY: Yes. I'm Debbie Murphy. I'm the
17 administrator at Greensboro Specialty Surgical Center
18 in Greensboro, and I'm an SCA employee. So you can do
19 one-level ACDFs Medicare and pretty much cover your
20 implant costs and have a very thin margin.

21 COMMISSIONER CHEATHAM: I'm going to tell you -
22 and I apologize for this, but you're going to have
23 to---

24 MS. MURPHY: Speak up?

25 COMMISSIONER CHEATHAM: No. You're going to have

1 to speak at a little less technical way for me.

2 MS. SMITH: Spine.

3 MS. MURPHY: Yes.

4 COMMISSIONER CHEATHAM: Yeah, use the word
5 "spine."

6 MS. SMITH: Spine.

7 COMMISSIONER CHEATHAM: I got that.

8 MS. MURPHY: Okay. So the issue now is if you
9 have a Medicare patient come into your facility and
10 they need a two-level spine procedure done, that
11 implant is going to cost more than your reimbursement,
12 so that patient is going to likely be moved to the
13 hospital because, like was mentioned earlier, we don't
14 like to operate at a loss. So anything above a
15 two-level spine procedure, ACDF, your margin is going
16 to be thin to none and more than likely based on which
17 vendor you're using for the spine implant because
18 there's multiple vendors as well.

19 COMMISSIONER CHEATHAM: And is that true even if
20 you are reimbursed at two hundred percent of Medicare?

21 MS. MURPHY: That is true.

22 COMMISSIONER CHEATHAM: Is that true if you are
23 reimbursed at a hundred and thirty-five percent over
24 the HOPD rate?

25 MS. SMITH: They do not reimburse for implants

1 with workers' comp. These are implant intensive
2 procedures.

3 MS. MURPHY: And that's what the issue is. Yes.

4 COMMISSIONER CHEATHAM: But today, you - if you
5 have a level-two spine procedure---

6 MS. MURPHY: Uh-huh.

7 COMMISSIONER CHEATHAM: ---you are being
8 reimbursed and - you mean, you're not?

9 VICE-CHAIRMAN STITH: No.

10 MS. MURPHY: We're being reimbursed for the
11 one-level procedure, not for that second level. So by
12 the time - when you do a spine procedure, you're
13 putting in a plate system. The larger the plate, the
14 more levels you have, the more expensive the implant
15 is, so once you move from a one- to a two-level
16 implant, that implant is going to nearly double. When
17 that happens, that puts that procedure out of the ASC
18 environment because you're going to lose money on that
19 case.

20 COMMISSIONER CHEATHAM: So you have not done
21 anything - any injured worker spine procedures above
22 level-one since 2011?

23 MS. MURPHY: That's - most of that is true, but I
24 have done a few. There is a vendor that's a
25 third-party vendor that use - if a doctor will use

1 that vendor, you can perform that procedure and make a
2 slim margin.

3 COMMISSIONER CHEATHAM: Okay.

4 MS. MURPHY: If they use their normal vendor, no,
5 I cannot do them.

6 CHAIRMAN ALLEN: If we adopt the proposed rule
7 with the provision in it that has a maximum
8 reimbursement rate of one hundred and thirty-five
9 percent of the outpatient procedure Medicare rate,
10 would that then capture those level-two?

11 MS. MURPHY: No, because it still doesn't capture
12 the implant.

13 CHAIRMAN ALLEN: Okay. Do you have---?

14 COMMISSIONER CHEATHAM: And how is---?

15 CHAIRMAN ALLEN: Oh. I'm sorry. Do you have any
16 documentation that you can present to this Commission
17 before the end of the period that substantiates that?

18 MS. SMITH: Yes.

19 MS. MURPHY: Yes.

20 CHAIRMAN ALLEN: Please do so.

21 MS. MURPHY: Okay. Thank you.

22 COMMISSIONER CHEATHAM: So the---

23 CHAIRMAN ALLEN: Commissioner Cheatham.

24 COMMISSIONER CHEATHAM: Sorry. So the outpatient
25 hospital rate has no implants on it? I mean is that

1 what you're telling me because I don't understand your
2 answer to his question---

3 MS. MURPHY: So there---

4 COMMISSIONER CHEATHAM: ---about the hundred and
5 thirty-five percent?

6 MS. MURPHY: Because I don't (unintelligible).
7 I'll just go out.

8 MS. SMITH: Yeah, I don't know how---

9 CHAIRMAN ALLEN: All right. Thank you, ma'am.

10 (SPEAKER DISMISSED)

11 MS. SMITH: Yeah, I don't know how - I mean---

12 CHAIRMAN ALLEN: Let the record reflect---

13 MS. SMITH: ---I don't how---

14 CHAIRMAN ALLEN: ---Ms. Smith is now back in---

15 STACEY SMITH

16 MS. SMITH: Yeah, I'm Ms. Stacey Smith. I think
17 maybe we could add some - let us add some
18 clarification or some points that are in our proposal
19 to you about outpatient implants are treated. For ASC
20 implants, it is - there are - it is - there are - it's
21 within the code, but as you see for workers' comp for
22 the Department of Labor, they don't include the
23 implant. That's a separate charge because, again,
24 injured workers have a different need than what the -
25 a Medicare patient population is, but there is a whole

1 section in the rule of Medicare payments of
2 device-intensive procedures, and so that is a
3 separate - there are separate add-on codes for
4 device-intensive procedures. So, you know, it gets
5 into those kinds of details. Again, it's a Medicare
6 population; it's not a workers' comp. And while it's
7 understandable that Medicare is the most standard fee
8 schedule, maybe, you know, across the board, I think
9 even, you know, WCRI and NCCI have caveats that they
10 understand that there are limitations to using it
11 because of what the population that they are
12 addressing. So I think you just have to make
13 adjustments to it.

14 CHAIRMAN ALLEN: Okay. Any further questions?
15 All right. Thank you, Ms. Smith.

16 MS. SMITH: Thank you.

17 (SPEAKER DISMISSED)

18 CHAIRMAN ALLEN: Next is Bruce Clark.

19 BRUCE CLARKE

20 CHAIRMAN ALLEN: And again, if you would, state
21 your name, tell whom you - tell us whom you represent,
22 if any particular organization, and I assume you are
23 here in respect to the proposed amendment to the ASC
24 fee schedule.

25 MR. CLARKE: Yes. And I thank you for asking all

1 your tough questions already. My name is Bruce
2 Clarke. I'm president of Capital Associated
3 Industries here in Raleigh. I'm here representing
4 that list of organizations that Stephanie Gay read out
5 for you earlier that are already in the record. I
6 won't make you listen to that again. Capital
7 Associated Industries and the Employers Coalition of
8 North Carolina, which I'm on the board of - we are
9 employer advocates. We are employers' associations,
10 and we advocate for employers on a wide range of
11 workplace matters, including workers' compensation.
12 And we've always believed - and we believe in this
13 process that led to rulemaking before the Commission -
14 that being a good employer means you're also an
15 advocate of the injured worker. You're going to -
16 you're going to see them every day. You know their
17 families. You're interested in their recovery.
18 You're - you want them to get good healthcare. You
19 want them to have an optimal outcome. You want them
20 to return to productive work, and there's a balance in
21 there of costs and that good outcome as well. The
22 Industrial Commission, I believe, struck the right
23 balance and has struck the right balance all along in
24 this process. Back at that mediation, I was - I was
25 in that mediation. The Commissioner - Chairman of the

1 Commission was there. Drew Heath was there in the
2 room with us. There were about two dozen of us in the
3 room. We were there for two days together. We had a
4 mediator. It was one of the best known mediators in
5 the state named Andy Little; runs a mediation teaching
6 organization, in fact, and we had a rigorous
7 stakeholder process there, and that was at the end of
8 a two and a half year, very open stakeholder
9 discussion process - very, very, very much known in
10 the legislative and government relations community.
11 We think you did the right thing there by taking the
12 result of that mediated settlement and analyzing it
13 and reviewing it and putting your own eyes on it and
14 doing your own verification of it and producing a fee
15 schedule from that. We think you did the right thing
16 for the doctors that were there. There were many
17 doctors at that mediated conference, many specialists.
18 We think you did the right thing for facility-based
19 providers. Many of them were there and their
20 representatives, the Medical Society, as well as the
21 Hospital Association. We think you did the right
22 thing for employees and because I think this fee
23 schedule in its totality increased access to good
24 healthcare, particularly on the physician's side where
25 there were some access issues. We think you got it

1 right in the temporary rulemaking process. We think
2 you're getting it right again in this permanent
3 rulemaking process and we urge you to stay the course
4 and adopt the final rule as you have proposed. It's a
5 very important part of the balance that was reached
6 both among the stakeholders, as well as at the
7 Commission to this point, and that balance brings
8 access to good healthcare for workers and a degree of
9 affordability to the employers that are paying the
10 bill for that care. Unfortunately, the ambulatory
11 surgical centers use legal technicalities to knock
12 down some good public policy here the first couple
13 times around, but we thank you for going through this
14 again, knowing this time you will prevail. And thank
15 you for your hard work, and I'm happy to answer a
16 question if I can.

17 CHAIRMAN ALLEN: All right. Sir, do you know if
18 any of your entities that you represent here today
19 have reviewed the ASC proposal and what potential
20 impact it would have on workers' compensation?

21 MR. CLARKE: I have - I have reviewed the reviews
22 of the proposal. I didn't author them or do original
23 research, but, yes, I have looked at them, and there's
24 a significant cost gap there. If we - if we do what
25 the ASCs, through SCA, have requested and have

1 suggested, it is a significant fiscal impact on
2 employers and on payers.

3 CHAIRMAN ALLEN: Okay. Do you have any idea how
4 much that impact would be?

5 MR. CLARKE: We have submitted that, I believe, to
6 the Commission. We'll be happy to highlight that
7 again in another submission. I don't have that handy
8 with me.

9 CHAIRMAN ALLEN: Okay. And if you do submit
10 anything additional, I would ask that any data, you
11 know, background information, documentation that
12 supports that analysis be submitted as well.

13 MR. CLARKE: Happy to do so by the deadline
14 stated.

15 CHAIRMAN ALLEN: Okay. Thank you, sir.

16 MR. CLARKE: Thank you.

17 (SPEAKER DISMISSED)

18 CHAIRMAN ALLEN: Next, Mr. Ronnie Cook.

19 RONNIE COOK

20 CHAIRMAN ALLEN: Mr. Cook, if you would, state
21 your name, tell us whom you represent, if any
22 particular organization, and I assume you're here in
23 regards to the proposed amendment to the ASC fee
24 schedule rules.

25 MR. COOK: Yes, sir, that is correct. Thank you,

1 Chairman Allen, and members of the Industrial
2 Commission for this opportunity to comment and also
3 for all your good work. My name is Ronnie Cook, and I
4 represent the North Carolina Hospital Association and
5 all its member hospitals and health systems, as well
6 as their affiliated providers and employed physicians.
7 And it's important to note that hospitals do own and
8 operate freestanding ambulatory surgery centers in the
9 state, and, therefore, we would be subject - our
10 members - some of our members would be subject under
11 this proposed rule and proposed amendment. The North
12 Carolina Hospital Association supports the proposed
13 amendment as stated. The proposed amendment is a
14 result of a lot of hard work, a lot of compromise. It
15 maintains incorporate and reimbursement integrity. It
16 provides much needed predictability for the Industrial
17 Commission. It is fair and balanced, and it will
18 result in savings for employers, payers, as well as
19 insured workers. That was really my prepared
20 comments, mainly just to offer our support. I mean we
21 talked at the October meeting, shared a lot of
22 information there, and I refer you back to those
23 comments. You know, we'd also provided written
24 comments, but there were a number of statements today
25 that we feel like we needed to at least address or at

1 least provide our comments on. One had to do with
2 access to care - that the proposed amendment could, or
3 probably would, result in limited access to ambulatory
4 surgery centers. For the life of me, I have trouble
5 understanding that. Obviously, there's a fee
6 schedule. There is a compromise in that fee schedule
7 that allows the ambulatory surgery centers to not only
8 perform the surgeries that are on the Medicare fee
9 schedule, but there is a significant compromise that
10 positively impacts the freestanding ambulatory surgery
11 center by allowing them to perform any procedure
12 that's on the outpatient fee schedule. In addition to
13 that, there is a concept that says if it's not on the
14 fee schedule that you pay - or you can have an
15 individual case-by-case consideration under a
16 reasonable customary and reasonable type amount. So
17 it looks like any possible procedure - a worker would
18 have access to any of the providers under those types
19 of arrangements. Now there was a lot of discussion
20 about the fee schedule not being enough - or not being
21 high enough or maybe not covering costs, and,
22 therefore, they could refer to a hospital. Well, I
23 can tell you that it would be unique and you probably
24 wouldn't be real happy with me if I told you now that
25 we also can be in situations where two hundred percent

1 of Medicare may not cover our costs. And where would
2 we refer to if that was the case? Where would they
3 get care if they did not get care in a hospital?
4 Where would they get it? So that's not an option. So
5 access to care - I can't fathom that it's not. Now it
6 may be that there's a business decision that you
7 decide not to perform that service in your particular
8 facility, but the injured and the employer and the
9 payer has access to care. There is access to care.
10 We also talked about implants and the cost of
11 implants. Obviously, under the Medicare fee schedule
12 and under a lot of fee schedules these days under
13 reimbursement, those implants are rolled up. They are
14 packaged into the bigger price that people pay, into
15 the fee schedule that they pay, so hospitals have the
16 same implant problem that a particular surgery center
17 might have, so we could also have implants that cost
18 more than the reimbursement. And there again, where
19 would we do the surgery if we did not do it there? So
20 that's another - you know, that's an - I mean implants
21 are designed. They're there as an averaging concept.
22 You know, the question is in the whole scheme of
23 things, do you do well under two hundred percent of
24 Medicare?

25 COMMISSIONER BADDOUR: Is that because multiple

1 implants take longer? Is it a time issue? What
2 causes the multiple implants to be more expensive for
3 the center or for the hospital?

4 MR. COOK: Well, I'm not sure if it's - well - I
5 mean what - the implants are expensive.

6 COMMISSIONER BADDOUR: The product itself, but
7 you're talking about the facility costs, right?

8 MR. COOK: Correct. But that's bundled into the
9 fee schedule for the facility. When you pay us our
10 fee schedule - two hundred percent of the rate on
11 Medicare - that implant, or whatever implants are
12 used, are in that cost. We don't get - it's not
13 carved out. It's not excluded. It's not carved out.
14 It's not reimbursed separately. It's part of the
15 bundled price.

16 COMMISSIONER BADDOUR: All right. Well, then---

17 MR. COOK: And so we could have the same problem
18 that was described by the surgery centers.

19 COMMISSIONER BADDOUR: But when it's bundled,
20 then - and excuse my ignorance - then how do you
21 decide how much goes to pay for the device, how much
22 goes to the doctor, how much goes to the - to the
23 facility?

24 MR. COOK: It's all facility.

25 COMMISSIONER BADDOUR: It's all facility?

1 MR. COOK: It's all facility.

2 COMMISSIONER BADDOUR: So you're - but you're not
3 paying the doctor?

4 MR. COOK: We could, but the doctor gets paid
5 under a separate fee schedule.

6 COMMISSIONER BADDOUR: Right. So you're - so you
7 got a bundled price for the device and for the
8 facility?

9 MR. COOK: Yeah. The technical fee - or the
10 facility fee is going to cover the hospital, the
11 plant, the utilities, the staff, all the equipment,
12 the implants, all the supplies used, the OR time, all
13 the equipment in the OR, all the - anything that's
14 related to the hospital---

15 COMMISSIONER BADDOUR: I see.

16 MR. COOK: ---it's going to cover that. And then
17 the doctor's professional time and whatever we may pay
18 him if we employ him---

19 COMMISSIONER BADDOUR: Right.

20 MR. COOK: ---then that cost is offset by them
21 billing under a fee schedule that would be paid under
22 the physician fee schedule.

23 COMMISSIONER BADDOUR: All right. All right.
24 Thank you.

25 MR. COOK: So there's a - there's a - there's

1 two - there's two fees that would come from that. And
2 then the anesthesiologist may bill also under their
3 fee schedule, so there's different mechanisms to get
4 paid. So I do not - you know, I do believe that
5 there's access to care. Another - we've talked a
6 little bit about the fact that the proposed fee
7 schedule or reimbursement rate possibly wasn't high
8 enough and there was alternative amounts offered,
9 which was to maintain the current percent of charge,
10 which wouldn't provide any predictability for the
11 Industrial Commission, or, second, to pay up to the
12 Hospital Outpatient Prospective Payment System, and
13 one of the things I find interesting is that how the
14 surgery centers can ask the Industrial Commission to
15 pay equal to or greater than the hospital fee schedule
16 when in fact they have not been able to achieve that
17 with any other payer that they deal with. They deal
18 with managed care payers. They deal with BlueCross.
19 They deal with Aetna and Cigna and United and MedCost.
20 They deal with Medicaid. They deal with Medicare.
21 They deal with other payers, and I can't - and I would
22 be surprised if they could provide you evidence to
23 show you that they have contracts and reimbursement
24 schedules that are consistently equal to what a
25 hospital is paid. And the reason for that is the same

1 concept of the hierarchy of care that we identified
2 earlier, is that you have physicians and they get paid
3 a lower rate because they don't always have the
4 overhead. Then you go to ambulatory surgery centers,
5 and they get paid a higher rate. They're a facility.
6 They have bricks and mortar and equipment and staff
7 and specialized staff, and they perform a great
8 function. They really do. They're convenient. They
9 do what they do very well, but they also don't keep
10 people beyond twenty-four hours. And if somebody goes
11 bad - if there's a surgery that goes south, where do
12 they go? They're not open twenty-four/seven. They
13 don't serve everybody. They go to the hospital.
14 Hospitals have a lot of different rules, safety rules,
15 other regulations, other requirements. We're open
16 twenty-four/seven. There's a reason that the
17 reimbursement is different. Unfortunately, our costs
18 are more because we have things to deal with that they
19 don't, but our costs are more, and that's why we get
20 reimbursed more, and that's why there's a difference
21 in the fee schedules. So, in conclusion, we still
22 think that there is significant integrity in the
23 reimbursement between the providers, and we think that
24 there's a significant compromise that positively
25 impacts the ability of ASCs to perform pretty much any

1 and all services, all procedures, and we support -
2 again, we support wholeheartedly the proposed
3 amendment. And I'm open for any questions you might
4 have.

5 CHAIRMAN ALLEN: Commissioner Cheatham.

6 COMMISSIONER CHEATHAM: I have one quick question.
7 You mentioned at the opening - at the beginning of
8 your - of your remarks that you represent hospitals
9 which own ASCs in some cases who would be subject to
10 the proposed rule.

11 MR. COOK: Yes, ma'am.

12 COMMISSIONER CHEATHAM: You may have told us this
13 already, but, as I sit here, I can't remember.
14 Roughly, how many ASCs are linked to that category?

15 MR. COOK: That are freestanding?

16 COMMISSIONER CHEATHAM: Uh-huh - that would fall
17 into that description.

18 MR. COOK: There's probably a handful. There's a
19 handful. There's not - there's not - I don't---

20 COMMISSIONER CHEATHAM: Ten - five?

21 MR. COOK: ---know the exact number. It's
22 probably less than five.

23 COMMISSIONER CHEATHAM: Thank you.

24 CHAIRMAN ALLEN: Any further questions?

25 MR. COOK: But even at - you know, when you're -

1 when you're an Association and you represent all
2 members, even if there's only one.

3 VICE-CHAIRMAN STITH: I do.

4 CHAIRMAN ALLEN: Vice---

5 VICE-CHAIRMAN STITH: So the question that was
6 posed earlier: How would you handle - how would your
7 member that is a freestanding ACS [sic] handle the
8 level-two, the level-three and level-four? Would they
9 then in turn refer them to a - to a hospital, or would
10 they provide that level to three or four service?

11 MR. COOK: How would they do that? They're owned
12 by the hospital. The hospital is - the one in
13 particular I can think of is in close proximity. I'm
14 not sure. I mean they - obviously, if it's not on the
15 fee schedule, they could attempt to negotiate the UCR
16 amount---

17 VICE-CHAIRMAN STITH: Uh-huh. Uh-huh.

18 MR. COOK: ---and probably would if they think -
19 they think that that's the most appropriate place to
20 do the service---

21 VICE-CHAIRMAN STITH: Okay.

22 MR. COOK: ---or they may refer it to the hospital
23 if they think that they don't have the ability to do
24 that.

25 VICE-CHAIRMAN STITH: Okay. Thank you.

1 MR. COOK: You know, we talk a lot about - you
2 know, we've talked a lot about the positive attributes
3 of surgery centers, and there's many. There's a ton
4 of them. I'm a big supporter of them. There's a ton
5 of positive attributes, and we talk about all the
6 different surgeries that they can do there, but, you
7 know, there's a reason we don't do all surgeries in
8 certain settings. You know, there's a reason for
9 that, you know, and I think we need to be aware of
10 that, but there's a reason that you do a surgery in an
11 inpatient setting versus an outpatient hospital
12 department versus a surgery center versus a
13 physician's office. There's reasons for those things,
14 and we need to be cognizant of that whether you're
15 forty-five or sixty-five. And the other argument is -
16 I mean you could - I mean you could take their
17 position - the ambulatory surgery position and extend
18 it to physicians because there are physicians doing
19 things in their office that potentially could be done
20 in a surgery center and/or hospital. They very well
21 could be sitting in these seats, arguing the same
22 thing. They very well could, if the argument has - if
23 we accept all the merits of those arguments.

24 CHAIRMAN ALLEN: Any further questions? All
25 right. Great.

1 MR. COOK: Thank you.

2 CHAIRMAN ALLEN: Thank you, Mr. Cook.

3 (SPEAKER DISMISSED)

4 CHAIRMAN ALLEN: Ms. Bourdon, did anyone else
5 sign-up to speak? Okay. If any of the speakers have
6 a summary of their remarks that they would like to
7 enter into the record, please, before leaving today,
8 present those to the court report, Ms. Dollar, who is
9 to my right with the notebook computer in front of
10 her, and those will be entered into the record next in
11 number in sequential order of each speaker's remarks
12 today. And the record will remain open for any
13 submissions that any of the stakeholders or interested
14 parties wish to make. Thank you for participating in
15 the public hearing. That period for written comments
16 and other submissions will be held open through the
17 close of business on August 14, 2017, so if you have
18 any further comments or submissions, please send those
19 to Ms. Bourdon as directed in the hearing notice in
20 the *North Carolina Register* and also on the
21 Commission's website. The written comments and
22 submissions and the comments made at the hearing today
23 will be made part of the public record of these
24 proceedings. We would like to include in the
25 transcript, with this proceeding, the materials

1 submitted by Ms. Bourdon as exhibits. Are there any
2 further matters to come before the public hearing?
3 Okay. Very well. Thank you. We'll go off the
4 record.

5 (WHEREUPON, THE HEARING WAS ADJOURNED.)

6 RECORDED BY MACHINE

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

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1 STATE OF NORTH CAROLINA

2 COUNTY OF GUILFORD

3 C E R T I F I C A T E

4 I, Kelly K. Patterson, Notary Public, in and for the
5 State of North Carolina, County of Guilford, do hereby
6 certify that the foregoing eighty-six (86) pages prepared
7 under my supervision are a true and accurate transcription
8 of the testimony of this trial which was recorded by Graham
9 Erlacher & Associates.

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

13 WITNESS my Hand and Seal on this 26th day of July 2017.

14 My commission expires on December 3, 2018.

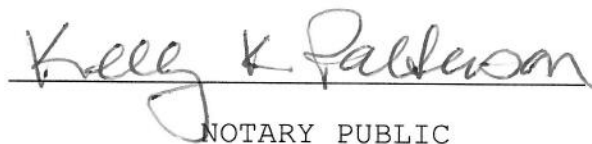
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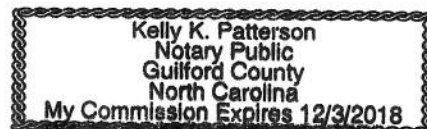
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PROPOSED RULES

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 amend the rule cited as 04 NCAC 10J .0103.

Link to agency website pursuant to G.S. 150B-19.1(c): <http://www.ic.nc.gov/proposed10J0103Notice-61517.pdf>

Proposed Effective Date: October 1, 2017

Public Hearing:

Date: July 19, 2017

Time: 2:30 p.m.

Location: 2149, 2nd Floor, Dobbs Building, 430 North Salisbury Street, Raleigh, NC 27603

Reason for Proposed Action: The Industrial Commission proposes to amend the provisions of Rule 04 NCAC 10J .0103 for several reasons. The proposed amendment to Paragraph (a) is a clarification regarding the qualifications for reimbursement under Paragraphs (c), (d), and (f). Next, there are two primary reasons for the proposed amendments to the provisions related to fees for ambulatory surgical centers, Paragraphs (g) and (h). First, this rule has been the subject of litigation that is ongoing at the time of filing. The provisions of the rule as adopted on April 1, 2015, that relate to fees for ambulatory surgical centers, specifically Paragraphs (g) and (h) and the reference to (h) in Paragraph (i) were held to be invalid by Wake County Superior Court Judge Paul Ridgeway in an August 9, 2016 Decision. The decision was predicated on the court's belief that those provisions of the rule were not adopted in compliance with the Administrative Procedure Act because no fiscal note was prepared. The Industrial Commission has appealed that ruling, and the matter is pending before the North Carolina Court of Appeals. The August 9, 2016 Decision was stayed by Judge Ridgeway by Order dated September 2, 2016. While the Industrial Commission maintains its position that it was not required to complete a fiscal note to adopt and/or amend the challenged provisions, the Industrial Commission has now completed a fiscal note and seeks to amend the ambulatory surgical centers fee provisions of Rule 04 NCAC 10J .0103. Pending the outcome of the litigation, the amendments are sought to restore certainty and balance to the fee schedule for stakeholders, including payers and medical providers, as to future medical expenses. Moreover, the Industrial Commission is statutorily obligated to periodically review the schedule of maximum fees charged for medical treatment in workers' compensation cases and make revisions if necessary. The proposed amendments to Rule 04 NCAC 10J .0103 incorporate feedback from various stakeholders that the addition of a provision setting maximum fees for ambulatory surgical centers,

for additional procedures covered by the Medicare Outpatient Prospective Payment System, would be beneficial to payers, providers, and injured workers.

The fee schedule reimbursement rate for services provided by ambulatory surgical centers covered by the Medicare Ambulatory Surgical Center Payment System will be 200%, in keeping with the rate for 2017 and beyond in the rule as adopted on April 1, 2015. The fee schedule reimbursement rate for additional procedures provided by ambulatory surgical centers that are covered by the Medicare Hospital Outpatient Prospective Payment System will be 135%. The rates were calculated to fall in the estimated median range of workers' compensation fee schedules nationally, as well as within the range of workers' compensation fee schedules in states that base payment to ambulatory surgical centers on a percentage of the Medicare Hospital Outpatient Prospective Payment System and/or the Medicare Ambulatory Surgical Center Payment Systems. The following studies and data sources were reviewed:

- (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.
- (5) CompScope™ Medical Benchmarks for North Carolina, 16th Edition, published by the Workers' Compensation Research Institute, October 2015.
- (6) CompScope™ Medical Benchmarks for North Carolina, 17th Edition, published by the Workers' Compensation Research Institute, October 2016.
- (7) Payments to Ambulatory Surgery Centers, 2nd Edition, published by the Workers' Compensation Research Institute, May 2016.
- (8) Review of medical fee schedules of states that base reimbursement to ambulatory surgical centers on the Medicare Ambulatory Surgical Center Payment System.
- (9) Analysis of Alternatives to the North Carolina Ambulatory Surgical Center Fee Schedule Proposed to Be Effective October 1, 2017, prepared by the National Council on Compensation Insurance, May 2, 2017.
- (10) Analysis of Alternatives to the North Carolina Ambulatory Surgical Center Fee Schedule Proposed to Be Effective January 1, 2017, prepared by the National Council on Compensation Insurance, September 19, 2016.

EXHIBIT

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IC#

RECEIVED 800-857-6888

PROPOSED RULES

(11) *Analysis of Proposed Changes to the North Carolina Medical Fee Schedule, prepared by the National Council on Compensation Insurance, December 4, 2014.*

Comments may be submitted to: *Kendall M. Bourdon, 4340 Mail Service Center, Raleigh, NC 26799-4340; phone (919) 807-2644; email kendall.bourdon@ic.nc.gov*

Comment period ends: *August 14, 2017*

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 (\geq \$1,000,000)
 Approved by OSBM
 No fiscal note required by G.S. 150B-21.4

CHAPTER 10 - INDUSTRIAL COMMISSION

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

**SECTION .0100 – FEES FOR MEDICAL
 COMPENSATION**

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

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

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

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

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

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

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

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

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

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

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

(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the ~~Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective most recently adopted and effective Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment System Systems reimbursement formula and factors factors, including all Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Addenda, as published annually in the Federal Register and on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> ("the Medicare ASC facility-specific amount"). ("the OP/ASC Medicare rule"). An ASC's specific Medicare wage index value as set out in the OP/ASC Medicare rule shall be applied in the calculation of the maximum allowable amount for any institutional service it provides. Reimbursement shall be based on the fully implemented payment amount in Addendum AA, Final ASC Covered Surgical~~

PROPOSED RULES

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.~~
- (1) A maximum reimbursement rate of 200 percent shall apply to institutional services that are eligible for payment by CMS when performed at an ASC.
- (2) A maximum reimbursement rate of 135 percent shall apply to institutional services performed at an ASC that are eligible for payment by CMS if performed at an outpatient hospital facility, but would not be eligible for payment by CMS if performed at an ASC.

(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 10A – DEPARTMENT OF HEALTH AND HUMAN SERVICES

Notice is hereby given in accordance with G.S. 150B-21.2 and G.S. 150B-21.3A(c)(2)g. that the Medical Care Commission intends to readopt with substantive changes the rules cited as 10A NCAC 13J .0901, .1004, .1007, .1107, .1110, .1202, .1402, and .1502.

Link to agency website pursuant to G.S. 150B-19.1(c): <http://www2.ncdhhs.gov/dhsr/ruleactions.html>

Proposed Effective Date: January 1, 2018

Public Hearing:

Date: August 9, 2017

Time: 10:00 a.m.

Location: Dorothea Dix Park, Brown Building, Room 104, 801 Biggs Drive, Raleigh, NC 27603

Reason for Proposed Action: Pursuant to G.S. 150B-21.3A, Periodic Review and Expiration of Existing Rules, all rules are reviewed at least every 10 years or they shall expire. As a result of the periodic review of Subchapter 10A NCAC 13J, The Licensing of Home Care Agencies, eight rules were determined as "Necessary With Substantive Public Interest," thus necessitating readoption. With input from stakeholders, substantial changes have been proposed to these rules to provide clarity and remove ambiguity, address objections from the Rules Review Commission identified in the history notes for five of the rules, and make technical changes and formatting changes. The proposed changes also include updates to the definitions to refer to North Carolina General Statutes definitions.

Comments may be submitted to: Nadine Pfeiffer, 2701 Mail Service Center, Raleigh, NC 27699-2701; email DHRS.RulesCoordinator@dhhs.nc.gov

Comment period ends: August 14, 2017

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)
- Approved by OSBM
- No fiscal note required by G.S. 150B-21.4
- No fiscal note required by G.S. 150B-21.3A(d)(2)

CHAPTER 13 – NC MEDICAL CARE COMMISSION
SUBCHAPTER 13J – THE LICENSING OF HOME CARE AGENCIES
SECTION .0900 - GENERAL

Fiscal Note
Proposed Permanent Rule Amending Fees for Medical Compensation

Basic Information

Agency: North Carolina Industrial Commission

Agency Contact: Kendall Bourdon, Rulemaking Coordinator
North Carolina Industrial Commission
4340 Mail Service Center
Raleigh, N.C. 27699-4340
(919) 807-2644
Kendall.Bourdon@ic.nc.gov

Rules Proposed for Amendment: Rule 04 NCAC 10J .0103
Fees for Institutional Services
(See proposed rule text in Appendix 1)

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

Impact Summary

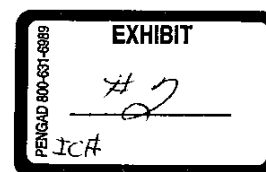
State Government: Yes
Local Government: Yes
Private Sector: Yes
Substantial Economic Impact: Yes

Description of the Proposed Rule

04 NCAC 10J .0103 provides a schedule of maximum reimbursement rates for institutional medical providers participating in the workers' compensation system. This rulemaking amends the rule with respect to the maximum reimbursement rates for ambulatory surgery centers ("ASCs"). The rule sets reimbursement rates at a percentage of the amount the Centers for Medicare and Medicaid Services ("CMS") would pay for services. CMS regularly updates and publishes its fee schedule. The rule, as amended, will provide a maximum reimbursement rate of 200% for institutional services that are eligible for payment by CMS when performed at an ASC. Additionally, for institutional services performed at an ASC that are eligible for payment by CMS if performed at an outpatient hospital facility, but are not eligible for payment by CMS if performed at an ASC, the amended rule sets a maximum reimbursement rate of 135%.

Necessity for the Proposed Rule

The North Carolina Industrial Commission ("the Commission") was directed by Session Law 2013-410 to revise its medical fee schedule. Session Law 2013-410 instructed the Commission to base these revisions on the applicable CMS payment methodologies. Session Law 2013-410



specifically granted the Commission authority for an expedited rulemaking process. This exempted the Commission from the North Carolina Administrative Procedure Act's ("the APA") fiscal note requirement, as set forth in N.C. Gen. Stat. § 150B-21.4, in developing the fee schedule. Subsequently, the permanent rule, effective April 1, 2015, was challenged on the alleged basis that the rule was not adopted in conformance with the permanent rulemaking requirements of the APA. Specifically, the litigation hinges on the lack of a fiscal note and whether the General Assembly's fiscal note exemption in Session Law 2013-410 applies to fee provisions for services performed at ASCs. This litigation is currently pending on appeal to the N.C. Court of Appeals.

The Commission is statutorily mandated to adopt by rule a schedule of maximum fees for medical compensation provided in workers' compensation claims. The fee schedule must be adequate to ensure (1) the proper standard of care for injured workers, (2) reasonable reimbursement to providers, and (3) cost containment for payers. *See* N.C. Gen. Stat. § 97-26. Due to the pending litigation, there is uncertainty for payers and providers regarding both past and prospective medical costs and the potential for imbalance among the three factors underpinning the fee schedule. This amended rule will provide certainty for all industry stakeholders, including employers, insurers, and medical providers, regarding medical costs prospectively.

It will also provide balance in the fee schedule by basing reimbursement to ASCs on the CMS fee schedule, similar to other institutions covered by the rule, at percentage rates that reflect the goals laid out in N.C. Gen. Stat. § 97-26. If the Commission is unable to adopt this rule, one category of institutional medical providers—ASCs—would potentially receive reimbursement based on an old percentage-of-charges method, leading to increased medical costs and/or the routing of surgeries away from ASCs, and preventing the Commission from fulfilling its statutory obligation to keep medical costs balanced and affordable.

Adopting this amended rule will ensure that the Commission remains in compliance with the General Assembly's direction to create Medicare-based compensation systems, while also addressing feedback from the medical provider community regarding certain procedures not covered by the current rule.

Introduction and Background:

The North Carolina Industrial Commission is a statutory creation of the General Assembly tasked with administering the Workers' Compensation Act ("the Act") and adjudicating all cases arising thereunder. Pursuant to N.C. Gen. Stat. § 97-26, the Commission is required to adopt by rule a schedule of maximum fees for medical compensation resulting from the treatment of workers' compensation injuries. In complying with this statutory requirement, the Commission must consider and balance three competing interests. First, the Commission must ensure that injured workers are provided the standard of services and care intended by the Act. Second, any promulgated fee schedule must ensure that providers are reimbursed reasonable fees for providing these services. Finally, the Commission must ensure that medical costs are adequately contained.

On July 25, 2013, the North Carolina General Assembly passed Session Law 2013-410. Section 33.(a) of that Session Law directed the Commission to revise its physician and hospital medical fee schedule. Specifically, with respect to the schedule of maximum fees for physician and

hospital compensation, the Commission was instructed to adopt a fee schedule based on the applicable Medicare payment methodologies. In order to expedite this process, the Session Law also granted the Commission an exemption from the now-repealed certification requirement and the fiscal note requirement as required under the APA.

In order to carry out the General Assembly's mandate set forth in Session Law 2013-410, s. 33.(a), the Commission engaged in rulemaking to adopt new rules and amend existing rules in accordance with the APA. On November 17, 2014, the Commission gave notice of its intention to adopt Rules 04 NCAC 10J .0102 and .0103 and to amend Rules 04 NCAC 10J .0101 and .0102. This notice was published in Volume 29, Issue 10 of the North Carolina Register. Based on the Session Law, specifically with regard to the General Assembly's stated exemptions, the Commission did not obtain a fiscal note. The Commission held a public hearing on December 17, 2014, and accepted written comments on the proposed rules through January 16, 2015. The proposed rules were approved by the Rules Review Commission on February 19, 2015, and entered into the North Carolina Administrative Code on April 1 and July 1, 2015, respectively.

On October 1, 2015, six months after the rule went into effect, the Commission received a Request for Declaratory Ruling challenging the rules' validity based on the lack of a fiscal note as applied to ambulatory surgery centers. The Commission issued its Declaratory Ruling denying the relief requested on December 14, 2015. Following a petition for judicial review of the declaratory ruling, Judge Paul Ridgeway of the Wake County Superior Court ruled in favor of the petitioner, finding that the fiscal note exemption in the Session Law did not apply to rulemaking for ASCs, and therefore, the Commission did not substantially comply with the APA when it amended the fee schedule provisions for ambulatory surgery centers. The impact of the Superior Court Judge's ruling is to invalidate the revised fee schedule provisions that apply to ASCs back to the original effective date of April 1, 2015.

With the invalidation of the ASC-specific provisions of 04 NCAC 10J .0103(g) and (h), the reimbursement rates for ASCs would revert to the provisions in place prior to the effective date of April 1, 2015.

Upon the Commission's Motion to Stay, the August 9, 2016 decision was stayed by the Wake County Superior Court allowing the current 04 NCAC 10J .0103 to remain in effect pending appeal to the North Carolina Court of Appeals. This stay was granted on September 2, 2016. Litigation over this rule is currently pending before the North Carolina Court of Appeals. However, even with the stay, considerable uncertainty remains within the North Carolina workers' compensation system.

At present, under the April 1, 2015 rule, the fee schedule provisions provide a maximum reimbursement rate, for institutional services provided at an ASC, of 200% of the Medicare ASC facility-specific amount. See Appendix 2, 04 NCAC 10J .0103(g) and (h). Because these provisions of the rule are currently in effect by application of the Stay, it is this rule that is evaluated as the baseline for purposes of this fiscal note.

If the Commission takes no rulemaking action, the outcome of the appellate court case leaves two possible outcomes. First, a favorable decision from the Court of Appeals would leave the April 1,

2015 rule in place, resulting in no change from the baseline scenario. The proposed rule amendment differs from the April 1, 2015 permanent rule because it addresses the procedures CMS will reimburse if performed at an outpatient hospital but not if performed at an ASC. Because of the differing demographics for the CMS and workers' compensation populations, the Commission proposes to include fee provisions in the rule that will guide reimbursement for procedures performed at ASCs for which they would not be reimbursed by CMS.

On the other hand, if the Commission takes no rulemaking action and receives an unfavorable decision upholding the invalidation of the current ASC fee provisions, the rule in effect prior to April 1, 2015, would be reinstated. This older fee schedule, which was in place for charges prior to April 1, 2015, was structured to reimburse providers at a percentage of the charges billed by the provider. The former rule language states that ASC services are reimbursed at 67.15% of the billed charges. Additionally, implants are paid at no greater than invoice cost plus 28%.

The second scenario would result in a very disproportionate reimbursement model for one type of institutional provider, cause imbalance in the workers' compensation system, and contradict the Commission's understanding of the General Assembly's intent in its 2013 Session Law, which directs the Commission to transition to a Medicare-based fee schedule model. The effect of this result would be both retroactive and prospective. ASCs would be able to request payment adjustments on all bills dating back to April 1, 2015. ASCs would also be able to control the rate of their compensation going forward because it is based on the billed charges that they set, while all other institutional provider types would continue to be reimbursed at a percentage of the schedule based on CMS payment rates.

In order to limit the period of time subject to retroactive payment adjustments in the event of an invalidation of the current ASC fee provisions and to provide certainty for the insurance community, providers, and employers going forward, the Commission is engaging in permanent rulemaking to amend the challenged April 1, 2015 ASC fee provisions. The Commission maintains its position that it is not required to obtain a fiscal note in order to do permanent rulemaking regarding fees for ASCs. However, this fiscal note has been prepared in light of the August 9, 2016 decision and the pending appeal before the Court of Appeals.

The proposed amendments to 04 NCAC 10J .0103 differ from the April 1, 2015 permanent rule because the Commission received input from various stakeholders indicating the need to set reimbursement rates for ASCs for procedures CMS will reimburse if performed at an outpatient hospital but not if performed at an ASC. Because of the demographics of the population served by CMS, many procedures that could normally be performed in ASCs are required to be performed in outpatient or inpatient hospitals. Because those demographic considerations do not necessarily apply to the workers' compensation population, the Commission proposes to add fee provisions in the rule that will guide reimbursement for certain procedures performed at ASCs for which ASCs would not be reimbursed by CMS.

Impact of the Proposed New Rule

1. Costs to the State through the Commission:
 - Once adopted, the proposed rule amendments may impose some minimal opportunity costs on the State through the Commission. Medical providers and payers are not required to send bills to the Commission for review, but the Commission will assist parties in determining the correct reimbursement. The Commission also has a medical fee dispute resolution procedure. Because the proposed amendments include a change to the current rule, there may be increased requests for assistance or disputes filed until the workers' compensation community becomes familiar with the new rule. However, the Commission believes that the current staff of two in the Medical Fees Section will be able to handle the increased temporary workload, though there may be a temporary unquantifiable increase in response time due to increased workload.
 - To the extent that the Commission is an employer, it could experience workers' compensation claims which would be subject to the new rule. The May 2, 2017 NCCI *Analysis of Alternatives to the North Carolina Ambulatory Surgical Center Fee Schedule* attached as Appendix 3 indicates that the proposed rule amendments would result in a negligible decrease in costs for services furnished at ASCs.

2. Costs to payers, including self-insured employers:
 - The costs to payers captures both private sector insurance carriers and self-insured employers. Approximately 24.2% of workers' compensation costs in North Carolina are paid by self-insured employers, including the State, local government units, and private employers.¹ All of State government, many local government entities, and a minority of private sector employers are self-insured, and thus bear the cost of workers' compensation benefits directly as payers.
 - There could be some initial costs to all payers, including self-insured employers, in implementing the amended rule because it requires the determination of reimbursement for various ASC services using either the CMS ASC fee schedule or the CMS Outpatient Prospective Payment System ("OPPS") fee schedule. The baseline rule does not contain a provision for payment for certain ASC services based on the CMS OPPS fee schedule. Therefore, there could be some initial costs to reprogram any reimbursement-related software and to train employees on the changes in the amended rule. The Commission reached out to the payer community to get a sample of these costs. One carrier that processes its medical bills in-house reported that the costs included 2.5 days for a full-time employee at \$65-\$75 per hour for the initial analysis and one day at \$85 per hour for the programming. The carrier termed this one-time cost of approximately \$2,000 "not significant." The Commission is also aware that

¹ See *Workers' Compensation: Benefits, Coverage, and Costs*, October 2016, National Academy of Social Insurance, Table 8, Workers' Compensation Benefits Paid by Type of Coverage, and State, 2014, page 23, at http://www.nasi.org/sites/default/files/research/NASI_Workers_Comp_Report_2016.pdf.

several major carriers and third-party administrators use third-party medical bill review companies to carry out medical bill reimbursement duties. One such bill review company estimates that it would take 145-150 hours for programming at an hourly rate of \$200. This large nationwide workers' compensation billing review system expects the cost to be approximately \$28,000-\$30,000. With such contrasting input, the Commission is unable to definitively quantify this potential cost uniformly to all payers with any accuracy or consistency.²

3. Costs to the State and the private sector as ambulatory surgery centers:

- The State has limited, indirect exposure through any ASCs owned, controlled, and/or operated by the University of North Carolina. Because the analysis conducted by NCCI (Appendix 3) suggests that total losses to ASCs will be negligible and these centers occupy only a small portion of the ASC market, the proposed rule amendments will result in *de minimis* losses to the State. It is assumed that the State as an ASC will share in a small portion of all costs estimated to impact ASCs.
- In North Carolina, payments for ASC services represent 4.8% of total medical payments in workers' compensation cases, or \$45,700,000, in 2015. See Appendix 3.
- The proposed rule amendments are projected by NCCI to result in an estimated impact to ASC services of -0.1% when compared to the current baseline rule, which totals -\$45,700. According to the Division of Health Service Regulation's May 2017 facility listing for ambulatory surgical facilities licensed by the State, there are 118 licensed ASCs in North Carolina.³ Subtracting the ASCs dedicated to endoscopy, gastroenterology, and OB/GYN services left 43 licensed ASCs likely to provide services in workers' compensation cases. The projected loss amount of -\$45,700 can be divided by 43 ASCs for an average loss of -\$1,063 per ASC from the proposed rule amendments.⁴ It is possible that not all 43 ASCs identified will provide services in workers' compensation cases.
- Adoption of the proposed rule amendments may result in potential future costs or lost profits for ASCs if the August 9, 2016 decision is ultimately upheld in the higher courts, invalidating the current rule. First, the proposed rule amendments, if adopted, would limit the past ASC bills subject to potential recalculation and readjustment to the old

² Because the temporary rule in effect from January 1, 2017, to March 21, 2017 was exactly the same as the proposed rule amendments, payers, including self-insured employers, have already made this adjustment once. Therefore, the cost may be somewhat mitigated as employees have been recently trained and the correct way to reprogram the software has already been determined once.

³ The 118 ASCs listed appeared to be primarily free-standing ASCs not associated with hospitals. The Commission reviewed the Division of Health Service Regulation's May 2017 list of hospitals licensed by the State of North Carolina. The hospital list gives a count of operating rooms, classifying them as inpatient or ambulatory surgery or shared, but it was not possible to tell whether the hospitals had actual ambulatory surgery centers on their campus or attached to the hospital. It appeared that the term ambulatory surgery must also mean outpatient surgery because there were no counts for outpatient surgery operating rooms.

⁴ See footnote 3. The loss amount per ASC would likely be much smaller if hospital-owned ASCs were included in the calculation.

percentage-of-charges fee provisions to those for dates of service between April 1, 2015, and the effective date of the amended rule. Second, ASC reimbursements for dates of service on or after the effective date of the proposed rule would not be subject to the outcome of the pending litigation and would not revert to the percentage-of-charges model. See the Uncertainties and Risk Analysis section below for more detail.

4. Costs to Employees and Injured Workers:

- The proposed amended rule provisions could change the location where injured workers receive certain medical services. The location of care affects the total cost of these medical services, and thus affects the costs borne by employees and injured workers. However, it is not possible to provide an accurate forecast of regulatory-driven changes in patient care settings. In the *NCCI Analysis* (Appendix 3), NCCI calculated the impact of the proposed amended rule provisions using bills for ASC services provided in 2015 (the most current complete year of data available) assuming no change in the number or type of procedures or the place they were performed under the proposed new reimbursement rates. The proposed rule differs from the baseline rule in that it specifies that procedures performed at ASCs for which they could not be reimbursed by CMS will be reimbursed at 135% of the CMS OPPS rate. If the true experience has been that patients were in fact getting these procedures done in other treatment settings in 2015, with this proposed rule amendment to clarify maximum reimbursement rates for procedures without a designated CMS ASC rate, it is possible that there will be a shifting of these procedures to ASCs. Alternatively, if the true experience is that ASCs were performing these procedures but negotiating reimbursement at more than the 135% of the CMS OPPS rate prior to receiving rule clarity, it is possible that ASCs will lose revenue for these procedures. In this case, it is possible that there will be a shifting of these procedures away from ASCs to other care settings.
- Certain ASCs could choose to provide fewer services in workers' compensation cases based on the projected negligible decrease in revenue from the proposed rule amendments to the baseline rule. The Commission cannot predict this potential behavior or quantify its effect with any accuracy.

5. Benefits to the State through the Commission:

- The Commission is an employer under the umbrella of the State's self-insurance program. Each division of the State pays for its workers' compensation losses from its division budget. To the extent that the proposed rule amendments result in a decrease in medical costs and greater certainty regarding ongoing medical costs, the State will receive these benefits through the Commission.

6. Benefits to payers, including self-insured employers:

- Based on the *NCCI Analysis* (Appendix 3), there would be a decrease in costs for ASC services as a result of the proposed rule amendments when compared to the April 1,

2015 baseline. Although the decrease is estimated to be negligible, any decrease in costs is a benefit to payers, including self-insured employers. For payers, this would translate to reduced costs for medical care, as well as more administrative certainty of costs going forward.

- The amended rule will decrease the amount of uncertainty payers, including self-insured employers, have regarding prospective medical costs due to the pending litigation. ASC reimbursements for dates of service on or after the effective date of the proposed rule would not be subject to the outcome of the pending litigation and would not revert to the percentage of charges model. Better certainty will likely create efficiencies because they will be able to set reserves for future benefits more accurately and not have to set aside extra funds for increases in future medical costs in the event that the litigation regarding the April 1, 2015 rule is not resolved in the Commission's favor.

7. Benefits to the State and the private sector as ambulatory surgical centers:

- The proposed rule amendments would bring ASCs several benefits. First, the proposed rule addresses stakeholder concerns brought forward by ASCs that there are certain procedures that can be performed for the workers' compensation population at ASCs that are not paid under the CMS ASC fee schedule. This has been addressed in the proposed rule amendments, which provide that ASCs are to be reimbursed at 135 percent of what Medicare would pay for those procedures pursuant to its outpatient hospital fee schedule.
- Second, the certainty that a new permanent rule will bring to other stakeholders is also a benefit to ASCs.

8. Benefits to Employers:

- For purchasers of workers' compensation insurance policies, these proposed rule amendments could result in a net reduction in premiums through lower medical costs and a lower risk of rate hikes to cover larger retrospective payments to ASCs. If the Commission is not successful on appeal, the ASC reimbursement rates will revert to a percentage-of-charges basis, increasing future workers' compensation costs for employers and payers. ASCs will also be eligible for retrospective payments from employers, at the old percentage of billed charges rate, for procedures performed since April 1, 2015. The potential retrospective payment amount is highly uncertain, estimated to exceed \$10M.
- Completing the rulemaking process again in advance of the appeal decision will avoid the former, much higher ASC reimbursement rates from being reinstated prospectively and limit the amount of time subject to retrospective payments, should the court invalidate the current rule provisions. To the extent that costs to insurers are passed on to employers, employers will benefit from the proposed rule amendments by avoiding the effects of a substantial increase in future medical costs on their premiums. The

future medical benefits cost increases under a percentage-of-charges model are not quantifiable. See the Uncertainties and Risk Analysis section below for more detail.

Alternatives Analysis

Baseline: The baseline rule used for the fiscal impact analysis is the April 1, 2015 version of 04 NCAC 10A.0103. See Appendix 2. Pursuant to that rule, the current reimbursement methodology for services provided by ASCs is 200% of what CMS would pay for the services. As explained above, this provision of the rule was challenged and invalidated, but the August 9, 2016 decision invalidating the rule was stayed pending the Commission's appeal of the decision. Therefore, the rule remains in place at the time of writing.

In considering amending the baseline rule, the Commission requested the analysis of four alternative amendments. The NCCI *Analysis* (Appendix 3) provided a forecast of the fiscal effect of each alternative on the workers' compensation system.

- Alternative 1: This alternative was chosen for the proposed rule amendments because it has a very minimal projected impact of -0.1% on ASC costs, described as a negligible decrease in overall workers' compensation system costs, and it improves on the baseline rule by adding certain procedures included under the CMS OPSS fee rule. This alternative is a good choice because this rulemaking is an effort to put a new permanent rule in place for the reasons explained in Necessity section above, not to make significant changes to costs to payers or providers. This alternative is similar to the baseline rule in that it would allow reimbursement of services provided by ASCs at 200% of what CMS would pay for those services that are deemed payable in the CMS ASC fee schedule. For those services that CMS does not pay ASCs to perform, but does pay outpatient hospitals to perform, ASCs would be reimbursed at 135% of what CMS would pay under its outpatient hospital fee schedule. This second provision involving the CMS outpatient fee schedule was included in response to stakeholder feedback received by the Commission in past public comment proceedings. N.C. Gen. Stat. § 97-26(c) allows for payment of any procedure not covered by the fee schedule either by agreement or at the "usual, customary, and reasonable charge" ("UCR") for the service. Therefore, the payment rules of CMS that relate to the older population they serve do not restrict what procedures ASCs can perform for workers' compensation. However, expanding the number of procedures with fees set by the fee schedule will assist the payer and ASC community by not requiring them to negotiate or determine a UCR charge for procedures not listed in the CMS ASC fee rule.
- Alternative 2: This alternative reflects a potential decrease from 200% to 175% for services paid under the CMS ASC fee schedule, but it reflects the addition of a rate of 135% for those procedures that are performed at an ASC but are paid by CMS under the OPSS fee schedule. Because the Commission was concerned that allowing 135% of the CMS OPSS fee schedule for certain procedures performed at ASCs might inflate medical costs, the Commission requested an analysis of a rule alternative with a slightly lower ASC rate of 175%. This alternative was not selected for proposal because it resulted in a projected -\$2 million change in workers' compensation costs, which would reflect a benefit for payers, but a loss for ASCs.

- Alternative 3: This alternative reflects the request of certain ASCs that all services performed by ASCs in workers' compensation cases be reimbursed at 200% of the CMS OPPS fee schedule. This alternative was not selected for proposal because it reflects a potential +\$12 million increase in costs to the workers' compensation system. While this alternative would provide a benefit to ASCs, it would be a significant cost to payers. Based on the Commission's review of states that allow payment to ASCs under the CMS OPPS fee schedule, such a rule would also be significantly above the average reimbursement rate of 127%.
- Alternative 4: This alternative would allow all services provided at ASCs that are included for payment in the CMS OPPS and ASC fee rules to be reimbursed at 135% of the CMS OPPS fee rule. The procedures allowed by CMS to be performed in ASCs are also included in the CMS OPPS fee rule. The Commission requested an analysis of this rule alternative because there are states that use only the CMS OPPS fee rule as their basis for reimbursement of both ASCs and outpatient hospitals. As stated above, the average rate applied to the CMS OPPS fee schedule for services provided at ASCs is 127%. The result of the analysis indicated a negligible decrease in workers' compensation system costs, with a -1.1% change to ASC-related medical costs. This alternative was not chosen because the -1.1% effect on ASC-related costs was larger than the -0.1% change under the proposed rule amendments, implying a greater loss to ASCs, even if negligible. There are also concerns that basing the fee provisions for ASCs on the CMS OPPS fee rule for all procedures could have unintended consequences if the CMS OPPS fee rule is adjusted in the future for reasons unrelated to ASC services or costs. Such an adjustment could create imbalance in the reimbursement levels between institutional providers in the Commission's fee schedule.

Uncertainties and Risk Analysis

Data Limitations and Behavioral Assumptions

The proposed rule differs from the baseline rule in that it specifies that procedures performed at ASCs for which they could not be reimbursed by CMS will be reimbursed at 135% of the CMS OPPS rate. NCCI's *Analysis* estimated that the proposed changes would result in a -0.1% decline in ASC reimbursements in the year following rule implementation.

NCCI's *Analysis* (Appendix 3) relies on the observed experience in 2015 as the basis for the impact estimates in this fiscal note. NCCI calculated the impact of the proposed amended rule provisions using bills for ASC services provided in 2015 because they are the most current complete year of data available. However, these data limitations are a source of uncertainty.

NCCI is not able to forecast any changes in the number, type, or location of procedures that may have occurred between 2015 and the present day. The maximum reimbursement rate of 67.15% of billed charges was in place for 3 months of 2015; a maximum reimbursement rate of 220% of the CMS ASC rate was in place for the remaining months. In the *Analysis*, NCCI first calculated the expected ASC reimbursements for the procedures completed in 2015, at 200% of the CMS ASC rate (the current fee schedule in effect). Then, NCCI estimated how those reimbursements would change after clarifying the reimbursement rate for certain procedures not reimbursed by CMS at

ASCs. The *Analysis* presents the effect of a price change on the observed procedures in 2015. However, that estimate does not capture any economic or population-driven changes in procedures performed at ASCs that may have occurred in the past two years.

Furthermore, because the analysis applies differing payment methodologies to past procedures, it does not account for any behavioral changes on the part of providers or the insurers and self-insureds regarding the chosen location of patient care for those procedures not reimbursed by CMS at the ASC rate. If the true experience has been that patients were in fact getting these procedures done in other treatment settings in 2015, with this proposed rule amendment to clarify maximum reimbursement rates for procedures without a designated CMS ASC rate, it is possible that there will be a shifting of these procedures to ASCs. Alternatively, if the true experience is that ASCs were performing these procedures but negotiating reimbursement at more than the 135% of the CMS OPPS rate prior to receiving rule clarity, it is possible that ASCs will lose revenue for these procedures. In this case, it is possible that there will be a shifting of these procedures away from ASCs to other care settings. Without experience data, the Commission is not able to quantify a potential shift in patient treatment settings with any accuracy.

If the negligible decrease in costs to payers translates to a minor decrease in profits for ASCs, some ASCs may decide to perform fewer procedures in workers' compensation cases. If more procedures are performed at outpatient or inpatient hospital facilities, there may be an increase in medical costs as CMS generally reimburses outpatient and inpatient hospitals at higher rates than ASCs for the similar services. This difference in CMS payment rates is related to the lower overhead costs experienced by ASCs.⁵

Finally, the Commission cannot predict with confidence this rule's impact on employer behavior or premiums. As detailed by the NCCI analysis, there is minimal difference in cost to the workers' compensation system between the April 1, 2015 rule and the new proposal. The Commission thus cannot predict whether this small difference will result in changes to wages or hiring practices. Nor can the Commission predict whether this small change will place any upward or downward pressure on employer premiums or self-insureds' costs.

Litigation Outcome

Adoption of the new rule does not resolve all uncertainties related to the litigation over the April 1, 2015 rule, which moved the Commission from a percent-of-charges method to a Medicare-based methodology. While the decision of the Wake County Superior Court to stay the August 9, 2016 decision has temporarily preserved the status quo, subsequent litigation may eventually end this stay. The April 1, 2015 rule is in effect until a court ends this stay. If the August 9, 2016 decision is upheld, ASCs may request to be reimbursed under the old percentage of charges method, requiring insurers and self-insured employers to recalculate and compensate these providers retroactively for the difference between what they received under the April 1, 2015

⁵ See *Medicare Program: Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs) Beginning in CY 2008*, 72 FR 42470, 42475, August 2, 2007, at <https://www.federalregister.gov/documents/2007/08/02/07-3490/medicare-program-revised-payment-system-policies-for-services-furnished-in-ambulatory-surgical>; *Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient System*, GAO-07-86, November 30, 2006, at <http://www.gao.gov/products/GAO-07-86>.

rule and the former method based on percentage-of-charges assessed by the provider.⁶ Furthermore, if the court invalidates the current rule, the percentage-of-charges based reimbursement rates would be reinstated for ASCs for any procedures performed from that point forward, barring the adoption of the proposed rule amendments. The Commission is unlikely to know the outcome of this litigation prior to the completion of rulemaking on the proposed rule amendments.

By adopting this rule, Commission can put a firm boundary on the end of this period of uncertainty over retrospective bill calculations and prospective repayment.

- Retrospective reimbursement: By adopting the proposed rules, the Commission will limit the period of time for which employers would be responsible for retrospective payments to ASCs in the event that the August 9, 2016 decision is upheld on appeal. The period under which these charges would have to be recalculated ranges from the adoption of the April 1, 2015 rule until the date the Commission formally adopts and implements a new rule.
 - NCCI analyses conducted in 2014 and 2016 estimated the impact on ASC reimbursements of, first, the change from 67.15% of charges to 220% of the CMS ASC rate, and then the later change from 220% of the CMS rate to 200% of the CMS rate (the baseline rule).⁷ The ASC reimbursement losses presented in the NCCI analyses are not an accurate estimate of the total retrospective payments that employers and payers would be required to make in the event that the August 9, 2016 decision is upheld on appeal. At the time of the analyses, NCCI did not have current claims data or certain knowledge of changes to Medicare payment rates. NCCI is not able to forecast changes in the number or type of claims, or market-driven shifts in patient treatment settings. Therefore, these analyses do not represent the true changes in reimbursements experienced by ASCs. However, they can provide an estimate of the order of magnitude of the potential retrospective payments. Based on the NCCI analyses, the Commission makes a conservative estimate that retrospective payments could exceed \$10M in total.
- Prospective reimbursement: Because the litigation over the April 1, 2015 rule would only apply to payments made between the adoption of the April 1, 2015 rule and its proposed replacement, by adopting these proposed rule amendments the Commission will provide certainty to payers and providers for medical reimbursement rates. This certainty is an inherent goal of the Commission's schedule of fees for medical compensation. However, the potential impacts associated with avoiding a reinstatement of the percentage-of-charges fee schedule cannot be determined due to lack of experience data about future injuries and costs. Further, NCCI indicated that fee schedules that are strictly based on charges rather than a fixed maximum provide a maximum reimbursement rate that changes with inflationary measures that are not subject to regulatory

⁶ Of course, if the August 9, 2016 decision is reversed on appeal, there will be no period for which providers will have to make retroactive payments.

⁷ See Appendix 4 for the December 4, 2014 NCCI analysis and go to www.ic.nc.gov/NCCINCRBAanalysis.pdf for the September 19, 2016 NCCI Analysis.

action. Consequently, a change in rules reflecting a percentage of charges is not measurable at a fixed point in time. As such, NCCI would not estimate a price impact for medical fee schedule changes that are purely based on charges.

Summary of economic impact

Compared to the baseline under the April 1, 2015 rule, payers in the North Carolina workers' compensation system, including both insurers and self-insured employers, stand to benefit from the proposed rule amendments by reducing uncertainty regarding retroactive and prospective medical costs based on the ongoing litigation regarding the April 1, 2015 rule and minor savings on medical costs as they can be projected at this time. If the proposed rule is adopted, ASCs will be limited in the amount of retroactive reimbursement they may receive if the August 9, 2016 decision is upheld. ASCs would also receive a negligible decrease in revenue under the amended rule from its effective date. However, under the amended rule, ASCs will benefit from clarity regarding the reimbursement rates for certain procedures.

APPENDIX 1

Rule 04 NCAC 10J .0103 is proposed for amendment as follows:

04 NCAC 10J.0103 FEES FOR INSTITUTIONAL SERVICES

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

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

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

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

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

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

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

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

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

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

(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the ~~Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective~~ most recently adopted and effective Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment System Systems reimbursement formula and ~~factors~~ factors, including all Hospital Outpatient Prospective Payment and Ambulatory Surgical Center

Payment Systems Addenda, as published annually in the Federal Register and on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> (“the Medicare ASC facility specific amount”). (“the OPPS/ASC Medicare rule”). An ASC’s specific Medicare wage index value as set out in the OPPS/ASC Medicare rule shall be applied in the calculation of the maximum allowable amount for any institutional service it provides. ~~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.~~
- (1) A maximum reimbursement rate of 200 percent shall apply to institutional services that are eligible for payment by CMS when performed at an ASC.
- (2) A maximum reimbursement rate of 135 percent shall apply to institutional services performed at an ASC that are eligible for payment by CMS if performed at an outpatient hospital facility, but would not be eligible for payment by CMS if performed at an ASC.

(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.

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

Eff. April 1, ~~2015~~, 2015;

Amendment Eff. October 1, 2017.

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

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

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

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

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

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

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

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

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

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

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

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

(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.

History Note: Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410; Eff. April 1, 2015.



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

The North Carolina Industrial Commission has requested that NCCI estimate the impact on workers compensation system costs under four reimbursement alternatives for Ambulatory Surgical Center (ASC) services. NCCI estimates that the fee schedule alternatives would result in an overall impact between -0.1% (-\$2.0M¹) and +0.6% (+\$12.0M) on North Carolina workers compensation system costs, if adopted.

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

Maximum Reimbursement for ASC	(A) Estimated Impact on ASC Services	(B) ASC Share of Medical Costs (SY 2015)	(C) Estimated Impact On Medical Costs (A) x (B)	(D) Medical Costs as % of Overall Workers Compensation Benefit Costs (Eff. 10/1/2017)	(E) Estimated Impact on Overall Workers Compensation System Costs (C) x (D)
200% of Medicare ASC Payment Rate with 135% of Medicare Outpatient Prospective Payment System (OPPS)	-0.1%	4.8%	Negligible decrease	48.5%	Negligible decrease
175% of Medicare ASC Payment Rate with 135% of Medicare OPPS	-5.0%		-0.2%		-0.1% (-2.0M)
200% of Medicare OPPS	+27.6%		+1.3%		+0.6% (+12.0M)
135% of Medicare OPPS	-1.1%		-0.1%		Negligible decrease

¹ The estimated dollar impact is the percentage impact(s) displayed multiplied by 2015 written premium of \$1,963M from NAIC Annual Statement data for North Carolina. This figure includes self-insurance, but not the policyholder retained portion of deductible policies, or the adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs. The dollar impact on overall system costs inclusive of self-insurance is estimated to be between -\$2M and \$+12M, where data on self-insurance is approximated using the National Academy of Social Insurance's October 2016 publication "Workers' Compensation: Benefits, Coverages, and Costs, 2014."



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

Summary of Proposed Medical Fee Schedule Changes

The North Carolina Industrial Commission has requested that NCCI estimate the impact on workers compensation system costs from a change to the maximum reimbursement rate of 200% of the 2017 Medicare ASC facility specific amounts as of January 1, 2017. The following fee schedule alternatives for reimbursement for institutional services provided by ASCs, proposed to be effective October 1, 2017 are listed below:

1. Maximum reimbursement rate of 200% of the 2017 Medicare ASC facility specific amount and a maximum reimbursement rate of 135% of the OPPS facility specific amount for institutional services performed at an ASC that are eligible for payment if performed at an outpatient hospital facility, but would not be eligible for payment under Medicare rules if performed at an ASC.
2. Maximum reimbursement rate of 175% of the 2017 Medicare ASC facility specific amount and a maximum reimbursement rate of 135% of the OPPS facility specific amount for institutional services performed at an ASC that are eligible for payment if performed at an outpatient hospital facility, but would not be eligible for payment under Medicare rules if performed at an ASC.
3. Maximum reimbursement rate of 200% of the 2017 Medicare Outpatient facility specific amount
4. Maximum reimbursement rate of 135% of the 2017 Medicare Outpatient facility specific amount

Actuarial Analysis of Proposed Medical Fee Schedule Changes

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

1. Calculate the percentage change in maximum reimbursements
 - a. Compare the prior and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
 - b. Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.
2. Estimate the price level change as a result of the proposed fee schedule
 - a. NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.



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

- i. In response to a fee schedule decrease, NCCI's research indicates that payments decline by approximately 50% of the fee schedule change.
 - ii. In response to a fee schedule increase, NCCI's research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
The formula used to determine the percent realized for fee schedule increases is $80\% \times (1.10 + 1.20 \times (\text{price departure}))$.
3. Estimate the share of costs that are subject to the fee schedule
- a. The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.

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

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for North Carolina for Service Year 2015.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for North Carolina from the latest two policy years projected to the effective date of the benefit changes.

Ambulatory Surgical Center Fee Schedule

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

Alternatives 1 & 2

To calculate the percentage change in maximums for ASC services, NCCI calculates the percentage change in maximum allowable reimbursement (MAR) for each procedure code listed on the fee schedule. For these alternatives, 2017 Medicare OPPS rates are to be utilized only when an applicable outpatient procedure is performed that is not included in the 2017 Medicare ASC fee schedule. The overall change in maximums for ASC services is a weighted average of the percentage change in MAR (proposed MAR / prior MAR) by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2015. The prior and proposed maximums are calculated as follows:



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

Prior MAR

Prior MAR = [Multiplier x 2017 Medicare Adjusted Base Rate for North Carolina x 2017 Medicare ASC Payment Weight – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 200%

Proposed MAR – ASC or Hospital Outpatient-Based

Proposed MAR = [Multiplier x 2017 Medicare Adjusted Base Rate for North Carolina x 2017 Medicare ASC Payment Weight – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 200% or 175% in the two distinct scenarios or

Proposed MAR = [Multiplier x 2017 Medicare Adjusted Base Rate for North Carolina x 2017 Medicare OPPS Relative Weight – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 135% in the two distinct scenarios

The overall weighted-average percentage change in maximums for each scenario for ASC services is multiplied by the price realization factor² to arrive at the estimated impact on ASC costs. The estimated impact on ASC costs is then multiplied by the percentage of medical costs attributed to ASC payments (4.8%) to arrive at the estimated impact on medical costs. The estimated impact on medical costs is then multiplied by the North Carolina percentage of benefit costs attributed to medical benefits (48.5%) to arrive at the estimated impact on overall workers compensation costs in North Carolina. The estimated impact on ASC services for each alternative is shown in the chart below.

Alternative	Proposed ASC Medicare Multiplier	Proposed OPPS Medicare Multiplier	Percentage Change in MAR	Price Realization Factor	Estimated Impact on ASC Service Costs
1	200%	135%	-0.2%	50%	-0.1%
2	175%	135%	-9.9%	50%	-5.0%

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



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

Alternative 3 & 4

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

Prior MAR

Prior MAR = [Multiplier x 2017 Medicare Adjusted Base Rate for North Carolina x 2017 Medicare ASC Payment Weight – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 200%

Proposed MAR – Hospital Outpatient-Based

Proposed MAR = [Multiplier x 2017 Medicare Adjusted Base Rate for North Carolina x 2017 Medicare OPPTS Relative Weight – Multiple Procedure Discounts (if applicable)]

Where Multiplier = 200% and 135% in the two distinct scenarios

The overall weighted-average percentage change in maximums for each scenario for ASC services is then multiplied by the price realization factor to arrive at the estimated impact on ASC costs. The estimated impact on ASC costs is then multiplied by the percentage of medical costs attributed to ASC payments (4.8%) to arrive at the estimated impact on medical costs. The estimated impact on medical costs is then multiplied by the North Carolina percentage of benefit costs attributed to medical benefits (48.5%) to arrive at the estimated impact on overall workers compensation costs in North Carolina. The estimated impact on ASC services for each alternative is shown in the chart below.

Alternative	Proposed OPPTS Medicare Multiplier	Percentage Change in Reimbursement	Price Realization Factor	Estimated Impact on ASC Service Costs
3	200%	+34.5%	80%	+27.6%
4	135%	-2.2%	50%	-1.1%



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

NCCI estimates that the proposal to adopt a Medicare based fee schedule, effective 4/1/2015, for Hospital Inpatient, Hospital Outpatient, and Ambulatory Surgical Center (ASC) services would result in an impact of -2.9% (-\$39.0M¹) on North Carolina workers compensation system costs.

NCCI estimates that the proposed changes to the fee schedule for professional services, effective 7/1/2015, would result in an impact of +1.4% (+19.0M¹) on North Carolina workers compensation system costs.

NCCI estimates the combined impact of the proposed 2015 changes on North Carolina workers compensation system costs to be -1.5% (-\$20.0M).

Note that the actual rules and fee schedules are not currently available. NCCI will review actual rules when they become available, which may result in a different cost impact. In particular, the 2015 Medicare physician fee schedule was not available at the time of this analysis.

Summary of Proposed Changes

The medical fee schedule changes proposed by the North Carolina Industrial Commission are summarized below.

• **Hospital Outpatient Services**

The provisions underlying the proposed outpatient fee schedule, proposed to be effective 4/1/2015, are as follows:

- o Services performed in acute care hospitals will be based upon 220% of Medicare's hospital outpatient payment rates. Currently, these services are reimbursed at 67.15% of charges.
- o Services performed in critical access hospitals will be based upon 230% of Medicare's hospital outpatient payment rates. Currently, these services are reimbursed at 73.95% of charges.

¹ Overall system costs are based on NAIC Annual Statement data. The estimated dollar impact is the percentage impact displayed multiplied by 2013 written premium of \$1,356M from NAIC Annual Statement data for North Carolina. This figure does not include self-insurance, the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs. The dollar impact on overall system costs inclusive of self-insurance is estimated to be \$-52M for fee schedule changes effective 4/1/2015 and \$+26M for fee schedule changes effective 7/1/2015. The data on self-insurance is approximated using the National Academy of Social Insurance's August 2014 publication "Workers' Compensation: Benefits, Coverages, and Costs, 2012."



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

- **Hospital Inpatient Services**

Currently, hospital inpatient services are reimbursed as a discount of charges and Diagnosis Related Group (DRG) maximum reimbursements. The provisions underlying the proposed inpatient fee schedule, proposed to be effective 4/1/2015, are as follows:

- o Services performed in acute care hospitals will be based upon 190% of the Medicare's hospital inpatient payment rates
- o Services performed in critical access hospitals will be based upon 200% of the Medicare's hospital inpatient base rates

- **ASC Services**

Currently, ASC services are reimbursed at 67.15% of charges. The proposed maximums for ASC services will be based on 190% of Medicare's ASC payment rates.

- **Physician Services**

The maximum reimbursements underlying the current physician fee schedule are established by the North Carolina Industrial Commission. The provisions underlying the proposed physician fee schedule, proposed to be effective 7/1/2015, are as follows:

- o Update the maximum allowable reimbursements (MARs) to be based on the current Medicare Resource Based Relative Value System (RBRVS)
- o Adopt the following multipliers by service category²:

Physician Service Category	Percentage of NC Medicare
Evaluation and Management	140%
Physical Medicine	140%
Emergency Medicine	169%
Neurology	153%
Pain Management	163%
Radiology	195%
Major Surgery	195%
Clinical Laboratory	150%
Other Professional Services	150%

² North Carolina Industrial Commission provided NCCI a list of approximately 200 physician services that were classified in the first seven categories listed in the table above. Clinical Laboratory grouping was based on Clinical Laboratory (CLAB) Fee Schedule published by CMS, while the State Specific Codes grouping was based on the Commission Assigned Codes section of the current physician fee schedule available at <http://www.ic.nc.gov/ncic/pages/feesched.asp>. Following the directive from NC IC, all other physician services with MAR but not listed in any of the aforementioned categories were classified into the Other Professional Services group. To the extent that a more detailed practice category taxonomy is provided to NCCI, the overall weighted-average percentage change in MAR may differ.



ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

- Durable Medical Equipment (DME) and Supplies

The maximum reimbursements underlying the current DME and Supplies fee schedule are established by the North Carolina Industrial Commission. Under the proposal, these services are to be reimbursed at 100% of those rates established for North Carolina in the Centers for Medicaid and Medicare Services' (CMS) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") Fee Schedule.



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

Actuarial Analysis of Proposal

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

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

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

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

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

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for North Carolina for Service Year 2013.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for North Carolina from the latest two policy years projected to the effective date of the benefit changes.



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

Analysis of Proposed Fee Schedule Changes effective 4/1/2015

Hospital Outpatient Fee Schedule

In North Carolina, payments for hospital outpatient services represent 19.3% of total medical payments. To calculate the percentage change in reimbursements for hospital outpatient services, NCCI calculates the percentage change in current reimbursement to proposed reimbursement for each procedure. The overall change in reimbursements for hospital outpatient services is a weighted average of the percentage change in reimbursements by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013. The current and proposed reimbursements are calculated as follows:

Current Reimbursement

For each relevant procedure,

Current Reimbursement = Current Payments x Trend Factor

The current payments by procedure code are obtained from NCCI's Medical Data Call for North Carolina for Service Year 2013. These payments are adjusted to reflect changes from past price levels to the price levels projected to be in effect on the effective date of the hospital outpatient fee schedule. The trend factor is based on the most recent available U.S hospital outpatient component of the medical consumer price index (MCPI) as shown below:

Year	MCPI Change
2011	5.1%
2012	5.0%
2013	4.8%
Average	4.9%

*Source: Bureau of Labor Statistics

A trend factor of 1.087 is applied to hospital outpatient payments for Service Year 2013 to determine the projected payments at the 4/1/2015 price level. This trend factor is calculated in two steps

1. Estimate the yearly Hospital Outpatient MCPI, for service years 2014 and beyond, as the arithmetic three-year average of the observed Hospital Outpatient MCPI for 2011-2013. This average is equal to 4.9% ($=[5.1\% + 5.0\% + 4.8\%] / 3$).



**ANALYSIS OF PROPOSED CHANGES
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2. Raise the value above to the number of years elapsed from the midpoint of service year 2013 (7/1/2013) to the effective date of the fee schedule (4/1/2015), which is 1.75 years.

Therefore, the trend factor from 7/1/2013 to 4/1/2015 is estimated as $1.087 = 1.049^{1.75}$.

Proposed Reimbursement on or after April 1, 2015

For each relevant procedure,

Proposed Reimbursement = [Multiplier * Medicare Payment Rate + Outlier Amount (if applicable) - Multiple Procedure Discounts (if applicable)] x (1 + Price Departure)

Where Multiplier = 220% (for acute care hospitals*)

Price Departure for hospital outpatient services is estimated to be -10%

*Given the relatively small percentage of workers compensation hospital costs attributed to critical access hospitals (these comprise less than 1%) the hospital outpatient analysis is based on MARs for acute care hospitals.

The Medicare Payment Rate is based on the Calendar Year 2015 version of Medicare's Hospital Outpatient Prospective Payment System (OPPS) publication. To estimate the proposed reimbursement effective 4/1/2015, NCCI compares trended payments to discounted fee schedule maximums. In general, NCCI observes that average prices paid are below fee schedule maximums. Based on a combination of actuarial judgment and observations of price departure in states that already have a fee schedule, a price departure of -10% was selected.

The Medicare Hospital Outpatient Prospective Payment System (OPPS) reimbursement rule also contains an additional provision for outlier payments. Under the Medicare OPPS rule, the outlier threshold is met when both of the following rules have been satisfied

1. Trended Charges submitted at the bill level times Cost-to-Charge ratio exceeds 1.75 times the North Carolina Medicare Ambulatory Payment Classification (APC) rate and
2. Trended Charges submitted at the bill level multiplied by the Cost-to-Charge ratio exceeds the North Carolina APC payment rate plus a \$3,100 fixed-dollar threshold.

When this threshold is met, Medicare provides for an outlier reimbursement that is calculated as 50 percent of the amount by which the cost of furnishing the procedure exceeds 1.75 times 220% of the Medicare APC payment rate.



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

The table below displays a hypothetical example of the calculation of the proposed reimbursement on or after 4/1/2015 for an APC of 0203 (Level IV Nerve Injections).

(1)	(2)	(3)	(4)	(5)	(6)
		= (2) x Cost-to-Charge Ratio	(i) 175% x (1) (ii) (1) + \$3,100	= 2.2 x 0.5 x [(3) - 1.75 x (1)]	= (1) + (5)
220% of 2015 NC Medicare APC Payment Rate	Total Trended Charge Submitted at the bill level	Total Costs for OPPS procedure	Proposed Outlier Threshold	Proposed Outlier Payment	Total Proposed MAR
\$2,992	\$ 40,000	\$10,520	Threshold (i): \$5,236 Threshold (ii): \$6,092	\$5,284	\$8,276

The Cost to Charge ratio (CCR) is obtained from Medicare and is calculated as the simple average of the North Carolina Statewide Urban and Rural CCRs ($0.263 = 0.5 \times (0.246 + 0.280)$).

The calculation for the proposed reimbursements also considers multiple procedure discounts. Under the Medicare OPPS reimbursement rule, multiple procedure discounts are allowed for multiple surgical procedures performed during the same operative session. Primary procedures (the procedure with the highest payment rate) would be reimbursed at 100% of the fee schedule amount, and secondary surgical procedures would be reimbursed at 50% of the fee schedule amount.

The overall weighted-average percentage change in reimbursements for hospital outpatient services is -40.7%.

Since the overall reimbursements for hospital outpatient services decreased, NCCI expects that 50% of the decrease will be realized on hospital outpatient price levels. The impact on hospital outpatient payments after the 50% offset is -20.4%.

The above impact on hospital outpatient payments is then multiplied by the percentage of medical costs attributed to hospital outpatient payments in North Carolina (19.3%) to arrive at the impact on medical costs of -3.9%. The resulting impact on medical costs is then multiplied by the percentage of benefit costs attributed to medical costs in North Carolina (49.5%) to arrive at the estimated impact on overall workers compensation costs in North Carolina of -1.9% (-\$26M).



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

Hospital Inpatient

In North Carolina, payments for hospital inpatient services represent (13.2%) of total medical payments. To calculate the percentage change in reimbursements for hospital inpatient services, we calculate the percentage change in current reimbursement to proposed reimbursement for each inpatient hospital bill that is reported with a diagnosis related group (DRG) procedure code. The overall change in reimbursements for hospital inpatient services is a weighted average of the percentage change in reimbursements for each bill weighted by the observed payments by bill as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013. The current and proposed reimbursements are calculated as follows:

Current Reimbursement

For each relevant inpatient hospital bill,

Current Reimbursement = Current Payments x Trend Factor

The current payments are obtained from NCCI's Medical Data Call for North Carolina for Service Year 2013. These payments are adjusted to reflect changes from past price levels to the price levels projected to be in effect on the effective date of the hospital inpatient fee schedule. The trend factor is based on the most recent available U.S hospital inpatient component of the medical consumer price index (MCPI) as shown below:

Year	Hospital Inpatient MCPI Inflation Rate
2011	6.8%
2012	5.2%
2013	4.4%
Average	5.5%

*Source: Bureau of Labor Statistics

A trend factor of 1.098 is applied to hospital inpatient payments for Service Year 2013 to determine the projected payments at the 4/1/2015 price level.

This trend factor is calculated in two steps

1. Estimate the yearly Hospital Inpatient MCPI, for service years 2014 and beyond, as the arithmetic three-year average of the observed Hospital Outpatient MCPI for 2011-2013. This average is equal to 5.5% $(=[6.8\% + 5.2\% + 4.4\%] / 3)$
2. Raise the value above to the number of years elapsed from the midpoint of service year 2013 (7/1/2013) to the effective date of the fee schedule (4/1/2015), which is 1.75 years.

Therefore, the trend factor from 7/1/2013 to 4/1/2015 is estimated as $1.098 = 1.055^{1.75}$.



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

Proposed Reimbursement on or after 4/1/2015

For each relevant inpatient hospital bill,

Proposed Reimbursement = [Multiplier x Medicare Payment Rate + Outlier Amount (if applicable)] x (1 + Price Departure)

Where Multiplier = 190% (for acute care hospitals*)

Price Departure for hospital inpatient services is estimated to be -10%

*Given the relatively small percentage of workers compensation hospital costs attributed to critical access hospitals (these comprise less than 1%) the hospital inpatient analysis is based on MARs for acute care hospitals.

The Medicare Payment Rate is based on Calendar Year 2015 version of Medicare Hospital Inpatient Prospective Payment System (IPPS) publication. To estimate the proposed reimbursement effective 4/1/2015, NCCI compares trended payments to discounted fee schedule maximums. In general, NCCI observes that average prices paid are below fee schedule maximums. Based on a combination of actuarial judgment and observations of price departure in states that already have a fee schedule, a price departure of -10% was selected.

Similar to the OPPS outlier example shown previously, Medicare's Hospital Inpatient Prospective Payment System (IPPS) reimbursement rule also contains an additional provision for outlier payments. Under the Medicare IPPS rule, the outlier threshold is met when the cost for a particular case exceeds a fixed-loss threshold which is comprised of the following components:

- Medicare Severity Diagnosis Related Group (MS-DRG) payment for that case (both operating and capital)
- Any Indirect Medical Education (IME), Disproportionate Share Hospital (DSH) and new technology payments
- A fixed loss amount of \$24,758

Once this threshold is met, the outlier reimbursement is made at 80% of the hospital's costs in excess of the fixed loss threshold for that case.



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

The table below displays a hypothetical example of the calculation of the proposed reimbursement on or after 4/1/2015 for a DRG of 459 (Spinal Fusion Except Cervical with Major Complications and Comorbidities).

(1)	(2)	(3)	(5)	(6)
		= (2) x Cost-to-Charge Ratio	= 1.9 x 0.8 x ((3) - ((1) + \$24,758))	= (1) + (5)
190% of 2015 NC MS-DRG Payment Rate	Total Trended Charge Submitted at the bill level	Total Costs for IPPS procedure	Proposed Outlier Payment	Total Proposed MAR
\$21,770	\$ 190,000	\$68,400	\$33,245	\$55,015

The Cost to Charge ratio (CCR) is obtained from Medicare and is calculated as the simple average of the North Carolina Statewide Urban and Rural CCRs (0.360 = 0.5 x (0.340 + 0.380))

The overall weighted average percentage change in reimbursements for hospital inpatient services is -18.2%. Since the overall reimbursements for hospital inpatient services decreased, NCCI expects that 50% of the decrease would be realized on hospital inpatient price levels. The impact on hospital inpatient payments after the 50% offset is -9.1%.

The above impact on hospital inpatient costs is then multiplied by the percentage of medical costs attributed to hospital inpatient payments (13.2%) to arrive at the impacts on medical costs of -1.2%. The resulting impact on medical costs is then multiplied by the percentage of North Carolina benefit costs attributed to medical costs (49.5%) to arrive at the impact on North Carolina's overall workers compensation system costs of -0.6% (-\$8.0M).

ASC Fee Schedule

In North Carolina, payments for ASC services represent 5.7% of total medical payments. To calculate the percentage change in reimbursements for ASC services, NCCI calculates the percentage change in current reimbursement to proposed reimbursement for each procedure. The overall change in reimbursements for ASC services is a weighted average of the percentage change in reimbursements by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013.

The current and proposed reimbursements are calculated in an analogous manner to the hospital outpatient analysis, except that Medicare has no outlier provision under the ASC fee schedule.

The overall weighted average percentage change in reimbursements for ASC services was estimated to be -29.3%. Since the overall reimbursements for ASC services decreased, NCCI expects that 50% of the decrease will be realized on ASC price levels. The impact on ASC payments after the 50% offset is -14.7%.



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

The above Impact on ASC costs is then multiplied by the percentage of medical costs attributed to ASC payments in North Carolina (5.7%) to arrive at the impact on medical costs of -0.8%. The resulting impact on medical costs is then multiplied by the percentage of benefit costs attributed to medical costs in North Carolina (49.5%) to arrive at the impact on overall workers compensation system costs in North Carolina of -0.4% (-\$5.0M).

Summary of Impacts

The impacts from the changes to the North Carolina Medical Fee Schedules effective 4/1/2015 are summarized below:

	(A) Estimated Impact on Type of Service	(B) Medical Cost Distribution	(C) Estimated Impact On Medical Costs (A) x (B)	(D) Estimated Impact on Overall Costs (C) x (2)
Hospital Inpatient	-9.1%	13.2%	-1.2%	-0.6%
Hospital Outpatient	-20.4%	19.3%	-3.9%	-1.9%
ASC	-14.7%	5.7%	-0.8%	-0.4%
(1) Total Impact on North Carolina Medical Costs			-5.9%	
(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in North Carolina				49.5%
(3) Total Impact on Overall Workers Compensation System Costs in North Carolina = (1) x (2)				-2.9%



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

Analysis of Proposed Fee Schedule Changes effective 7/1/2015

Physician Fee Schedule

In North Carolina, payments for physician services represent 33.5% of total medical payments. To calculate the percentage change in maximum reimbursements for physician services, NCCI calculates the percentage change in maximum reimbursements for each procedure code. The overall change in maximum reimbursements for physician services is a weighted average of the percentage change in MAR (proposed MAR / current MAR) by procedure code weighted by the observed payments by procedure code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013.

The overall weighted-average percentage change in MAR is +10.8%.

The impact by category is shown in the table below.

Physician Practice Category	Cost Distribution	Percentage Change in MAR
Anesthesia	2.9%	+4.1%
Major Surgery	9.0%	-21.7%
Pain Management	1.8%	-25.1%
Radiology	10.0%	-28.1%
Physical Medicine	22.3%	+59.9%
Evaluation and Management	16.3%	+33.5%
Emergency Medicine	2.1%	+35.2%
Clinical Laboratory	1.4%	-11.6%
State Specific Codes	0.2%	0.0%
Other Professional Services	20.4%	-17.6%
Physician Payments with no specific MAR	13.6%	0.0%
Total	100.0%	10.8%

Since the overall average maximum reimbursement for physicians increased, the percentage expected to be realized from the fee schedule increase is estimated according to the formula $80\% \times (1.10 + 1.20 \times (\text{price departure}))$. The observed price departure for physician payments in North Carolina is -9%. The percentage realized is estimated to be 79% ($= 80\% \times (1.10 + 1.20 \times (-0.09))$). The impact on physician payments due to the revised physician fee schedule change is +8.5% ($= +10.8\% \times 0.79$).

The above impact of +8.5% is then multiplied by the North Carolina percentage of medical costs attributed to physician payments (33.5%) to arrive at the impact on medical costs of +2.8%.

Finally, the above impact of +2.8% is then multiplied by the percentage of North Carolina benefit costs attributed to medical benefits (48.1%) to arrive at the estimated impact on North Carolina overall workers compensation costs of +1.3% (+18.0M).



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

Durable Medical Equipment (DME)

In North Carolina, payments for DME represent 2% of total medical payments. DME payments are based on 2015 North Carolina adjusted Medicare rates.

The overall change in maximum reimbursements for DME is a weighted average of the percentage change in MAR (proposed MAR / current MAR) by code weighted by the observed payments by code as reported on NCCI's Medical Data Call, for North Carolina for Service Year 2013. The overall weighted average percentage change in MAR is estimated to be +10.4%.

Since the overall average maximum reimbursement for DME services increased, the percentage expected to be realized from the fee schedule increase is typically estimated to be 80%. The impact on DME payments due to the revised DME fee schedule change is +8.3% (= +10.4% x 0.80).

The above impact of +8.3% is then multiplied by the North Carolina percentage of medical costs attributed to DME payments (2.0%) to arrive at the impact on medical costs of +0.2%.

The above impact is then multiplied by the percentage of North Carolina benefit costs attributed to medical benefits (48.1%) to arrive at the estimated impact on North Carolina overall workers compensation costs of +0.1%(+1.4M).



**ANALYSIS OF PROPOSED CHANGES
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE**

Summary of Impacts

The impacts from the changes to the North Carolina Medical Fee Schedules effective 7/1/2015 are summarized below:

	(A)	(B)	(C)	(D)
	Estimated Impact on Type of Service	Medical Cost Distribution	Estimated Impact On Medical Costs	Estimated Impact on Overall Costs
			(A) x (B)	(C) x (2)
Physician	+8.5%	33.5%	+2.8%	+1.3%
DME	+8.3%	2.0%	+0.2%	+0.1%
(1) Total Impact on North Carolina Medical Costs			+3.0%	
(2) Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in North Carolina				48.1%³
(3) Total Estimated Impact on Overall Workers Compensation System Costs in North Carolina = (1) x (2)				+1.4%

³ The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for North Carolina from the latest two policy years projected to the effective date of the benefit changes, after adjusting for the medical fee changes assumed to become effective April 1, 2015.

TEMPORARY RULES

(5) Recordkeeping. All loans, lines of credit, or letters of credit, the proceeds of which will be used for a commercial, corporate, business, investment property or venture, or agriculture purpose, shall be separately identified in the records of the credit union and reported as such in financial and statistical reports required by the Administrator in Subpart (b)(2)(C)(iv) of this Rule or the Regional Director of the National Credit Union Administration.

(a) Commercial lending and member business loans. State chartered federally insured credit unions shall adhere to the federal regulations prescribed by the National Credit Union Administration relating to commercial lending and member business loan program pursuant to 12 C.F.R. Part 723, and this Rule.

(b) Written loan policies. The Board of Directors shall give notification to the Administrator of Credit Unions prior to initiating a commercial lending and member business loan program and adopt specific commercial lending and member business loan policies and review them at least annually. The Board of Directors shall review its commercial lending and member business loan policies prior to any material change in the credit union's commercial lending and member business loan program or related organizational structure, and in response to any material change in portfolio performance or change in economic conditions. Credit unions with an asset size of two hundred fifty million dollars (\$250,000,000) or below shall have commercial lending and member business loan policies submitted to the Administrator of Credit Unions 30 days prior to initiating a commercial lending and member business loan program.

History Note: Authority G.S. 54-109.12; 54-109.21(25); 54-109.78; 12 C.F.R. Part 741.3; 12 C.F.R. Part 723; 12 C.F.R. Part 741.203; Eff. January 1, 1988; Amended Eff. August 1, 1998; March 2, 1992; Temporary Amendment Eff. January 1, 2017.

Rule-making Agency: North Carolina Industrial Commission

Rule Citation: 04 NCAC 10J .0103

Effective Date: January 1, 2017

Date Approved by the Rules Review Commission: December 15, 2016

Reason for Action: A recent court order. Surgical Care Affiliates, LLC v. North Carolina Industrial Commission, No. 16-CVS-00600 (Wake County Superior Court). The effects of the August 9, 2016 decision in Surgical Care Affiliates, LLC v. North Carolina Industrial Commission, No. 16-CVS-00600 (Wake County Superior Court) necessitate the expedited implementation of this temporary rule. This recent court decision invalidated the Industrial Commission's medical fee schedule provisions for ambulatory surgery centers, which

had taken effect April 1, 2015, based on the court's interpretation of Session Law 2013-410, Section 33(a), and the application of its fiscal note exemption language. Due to the court decision, the medical fee schedule, as applied only to ambulatory surgery centers, reverts back to the pre-April 1, 2015 provisions which provided for maximum reimbursement rate of 67.15% of billed charges, resulting in a potentially retroactive and prospective multi-million dollar increase in costs to the workers' compensation system. Although the August 9, 2016 decision has been stayed by the Superior Court during the appeal to the North Carolina Court of Appeals, it is the Industrial Commission's statutory obligation to adopt a rule as quickly as possible to restore balance to the workers' compensation system pursuant to N.C. Gen. Stat. § 97-26 in the event the decision is upheld on appeal. By putting a temporary rule in place as soon as possible, the period of time subject to a potential retroactive invalidation of the ambulatory surgery center fee schedule provisions will be limited to April 1, 2015 to December 31, 2016 providing certainty regarding medical costs for 2017 and beyond.

CHAPTER 10 - INDUSTRIAL COMMISSION

SUBCHAPTER 10J - FEES FOR MEDICAL COMPENSATION

SECTION 0100 - FEES FOR MEDICAL COMPENSATION

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

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

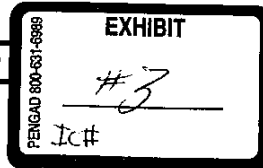
(b) The schedule of maximum reimbursement rates for hospital inpatient institutional services is as follows:

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

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

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

(d) Notwithstanding the Paragraphs (a) through (c) of this Rule, maximum allowable amounts for institutional services provided



TEMPORARY RULES

by critical access hospitals ("CAH"), as certified by CMS, are based on the Medicare inpatient per diem rates and outpatient claims payment amounts allowed by CMS for each CAH facility.

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

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

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

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

(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective most recently adopted and effective Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment System—Systems reimbursement formula and factors—factors, including all OPSS Hospital Outpatient Prospective Payment and ASC Ambulatory Surgical Center Payment Systems Addenda, as published annually or referenced by website in the Federal Register and on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> ("the Medicare ASC facility-specific amount"). ("the OPSS/ASC Medicare rule"). An ASC's specific Medicare wage index value as set out in the OPSS/ASC Medicare rule shall be applied in the calculation of the maximum allowable amount for any institutional service it provides. Reimbursement shall be based on the fully implemented payment amount in Addendum AA, Final AA (Final ASC Covered Surgical Procedures for CY 2015, 2017) and Addendum BB, Final BB (Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2015, 2017) as published in the Federal Register, or their successors. The maximum reimbursement rate for institutional services provided by ambulatory surgical centers is 200 percent of the Medicare ASC facility specific amount.

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

- ~~(1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility specific amount.~~
- ~~(2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility specific amount.~~
- ~~(3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility specific amount.~~
- (1) A maximum reimbursement rate of 200 percent shall apply to institutional services that are eligible for payment by CMS when performed at an ASC.
- (2) A maximum reimbursement rate of 135 percent shall apply to institutional services performed at an ASC that are eligible for payment by CMS if performed at an outpatient hospital facility, but would not be eligible for payment by CMS if performed at an ASC.

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

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

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

Eff. April 1, 2015;

Temporary Amendment Eff. January 1, 2017.

STATE OF NORTH CAROLINA

BEFORE THE NORTH CAROLINA INDUSTRIAL COMMISSION

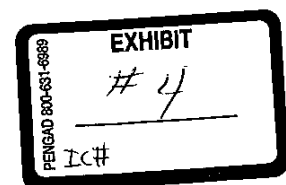
NOVEMBER 18, 2016

PUBLIC HEARING BEFORE THE FULL COMMISSION

REGARDING

PROPOSED TEMPORARY RULE AMENDING RULE 04 NCAC 10J .0103

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



Full Commission Public Hearing, November 18, 2016

A P P E A R A N C E S

COMMISSIONERS:

Charlton L. Allen, Chairman

Bernadine S. Ballance

Linda Cheatham

Christopher C. Loutit

Tammy R. Nance

I N D E X

SPEAKERS:

PAGE

Kendall Bourdon 2

Kelli Collins. 6

Andy Ellen. 11

Ronnie Cook 18

E X H I B I T S

IDENTIFIED ADMITTED

(Bourdon) Exhibit Number 1 3 38

(Bourdon) Exhibit Number 2 3 38

(Bourdon) Exhibit Number 3 3 38

P R O C E E D I N G S

1
2 CHAIRMAN ALLEN: Okay. We are on the record.
3 Good afternoon. Today is November 18, 2016. This is
4 a North Carolina Industrial Commission public hearing
5 on proposed rulemaking. I'm Charlton Allen, Chairman
6 of the North Carolina Industrial Commission. In
7 compliance with the requirements of Chapter 138A-15(e)
8 of the State Government Ethics Act, I remind all
9 members of the Commission of their duty to avoid
10 conflicts of interest under 138A. I also inquire as
11 to whether there is any known conflict of interest to
12 any matters coming before the Commission at this time.
13 Hearing none, we will proceed. The purpose of this
14 hearing is to receive comments from the public
15 regarding 04 NCAC 10J .0103 proposed for temporary
16 rulemaking by the Commission and submitted for
17 publication on the Office of Administrative Hearings'
18 website on October 18, 2016. We have not yet received
19 comments - written comments from the public, but the
20 record will be held open to receive written comments
21 from the public through the close of business in - on
22 November 29, 2016. At this time, I would like to
23 introduce the other Commissioners. To my right are
24 Commissioners Bernadine Ballance and Christopher
25 Loutit, and to my left are Commissioners Linda

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

19 KENDALL BOURDON

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

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

25 CHAIRMAN ALLEN: And do you have any prepared

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

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

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

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

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

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

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

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

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

9 MS. BOURDON: Thank you.

10 CHAIRMAN ALLEN: Thank you.

11 (SPEAKER DISMISSED)

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

15 KELLI COLLINS

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

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

19 MS. COLLINS: And you were so graceful.

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

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

1 representing today.

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

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

7 UNIDENTIFIED SPEAKER: 04 NCAC 10J .0103.

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

10 MS. COLLINS: Thank you. SCA is proud to operate
11 seven ambulatory facilities - or ASCs in North
12 Carolina. SCA's full response to the temporary rule
13 will be submitted for the record. SCA opposes the
14 Commission's proposed temporary rule for the following
15 reasons: The temporary rule is not cost effective and
16 does not meet North Carolina statutory requirements.
17 The reduction in rates to two hundred percent of
18 Medicare ASC fee schedule would be very harmful to the
19 workers' compensation system. There is no statutory
20 authority for adopting a temporary rule. North
21 Carolina - North Carolina law requires that fee
22 schedules adopted by the Commission be adequate to
23 ensure that injured workers are provided the standard
24 of services and care intended by the Workers' Comp Act
25 and that providers are reimbursed reasonable fees for

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

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

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

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

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

5 COMMISSIONER BALLANCE: No.

6 CHAIRMAN ALLEN: Okay. Thank you so much.

7 MS. COLLINS: Thank you.

8 (SPEAKER DISMISSED)

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

11 ANDY ELLEN

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

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

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

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

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

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

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

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

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

24 (SPEAKER DISMISSED)

25 CHAIRMAN ALLEN: Okay. And the next speaker will

1 be Mr. Ronnie Cook.

2 RONNIE COOK

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

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

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

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

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

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

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

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

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

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

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

1 obviously, if you're getting two hundred percent of a
2 Medicare fee schedule for ASC and two - and there's a
3 slightly higher number for hospitals - two hundred
4 percent - we think that that relationship should be
5 maintained for those procedures that are not on the
6 ambulatory surgery fee schedule, but are on the
7 hospital outpatient fee schedule, so there is a
8 difference. There's an ambulatory surgery fee
9 schedule, and they list a lot of procedure codes.
10 There are certain procedure codes that Medicare say
11 they don't think it's appropriate for the ambulatory
12 surgery center to do, but they have said that a
13 hospital outpatient can do those, so those procedure
14 codes - that difference - we're saying is appropriate
15 for the ambulatory surgery center to do those in this
16 setting, but we think that the relationship between
17 the payment should be consistent. So we have a two
18 hundred percent of hospital outpatient now. We have
19 two hundred percent of ASC, so as we move away from
20 the fee schedules, that relationship should stay.
21 That difference, whatever it is, whatever it is,
22 should stay, should be consistent so the ambulatory
23 surgery centers would have an incentive. The payers
24 would have an incentive theoretically to use
25 ambulatory surgery centers if they think it's

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

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

10 CHAIRMAN ALLEN: Commissioners, do you have any
11 questions?

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

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

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

7 COMMISSIONER BALLANCE: That's (unintelligible).

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

19 COMMISSIONER BALLANCE: Right. And the---

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

1 do.

2 COMMISSIONER BALLANCE: Right.

3 MR. COOK: Does that make sense?

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

11 MR. COOK: Well---

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

17 MR. COOK: Uh-huh.

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

23 MR. COOK: Uh-huh.

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

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

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

12 COMMISSIONER BALLANCE: Uh-huh.

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

23 COMMISSIONER BALLANCE: Uh-huh.

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

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

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

3 COMMISSIONER BALLANCE: Okay.

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

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

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

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

13 COMMISSIONER BALLANCE: I understand.

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

23 COMMISSIONER BALLANCE: Okay. Let me---

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

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

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

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

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

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

3 COMMISSIONER BALLANCE: I understand.

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

6 COMMISSIONER BALLANCE: I understand.

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

9 COMMISSIONER BALLANCE: I understand.

10 MR. COOK: ---develop.

11 COMMISSIONER BALLANCE: Okay. Thank you.

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

13 COMMISSIONER BALLANCE: Yeah.

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

23 CHAIRMAN ALLEN: Other questions from the
24 Commission?

25 MR. COOK: Very good.

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

3 MR. COOK: Certainly.

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

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

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

9 CHAIRMAN ALLEN: All right.

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

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

14 COMMISSIONER CHEATHAM: Okay.

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

17 COMMISSIONER CHEATHAM: Right.

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

20 COMMISSIONER CHEATHAM: I just wanted to make---

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

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

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

1 trying to---

2 COMMISSIONER CHEATHAM: Right.

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

6 CHAIRMAN ALLEN: And the Commission.

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

17 CHAIRMAN ALLEN: Okay. Any other questions?

18 Hearing none---

19 MR. COOK: Okay.

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

21 MR. COOK: Thank you.

22 (SPEAKER DISMISSED)

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

1 for your inputs, and we'll consider all your comments.
2 I want to thank each of you for participating in this
3 public hearing. The period for written comments will
4 be held open through the close of business on November
5 29, 2016, so if you have further comments, please send
6 them to Ms. Bourdon as directed in the hearing notice
7 on the Commission website and the Office of
8 Administrative Hearings' website. The written
9 comments and the comments made at the hearing today
10 will be made part of the public record of these
11 proceedings. We would like to include in the
12 transcript of this proceeding the materials submitted
13 by Ms. Bourdon as Exhibits 1, 2 and 3.

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

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

21 (WHEREUPON, THE HEARING WAS ADJOURNED.)

22 RECORDED BY MACHINE

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

25

Full Commission Public Hearing, November 18, 2016

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1 STATE OF NORTH CAROLINA

2 COUNTY OF GUILFORD

3 C E R T I F I C A T E

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

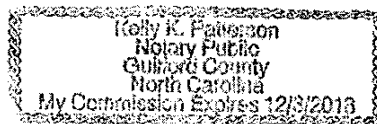
10 I further certify that I have no financial interest in
11 the outcome of this action. Nor am I a relative, employee,
12 attorney or counsel for any of the parties.

13 WITNESS my Hand and Seal on this 21st day of November
14 2016.

15 My commission expires on December 3, 2018.

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Kelly K. Patterson
NOTARY PUBLIC



PROPOSED TEMPORARY RULES

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

TITLE 04 – DEPARTMENT OF COMMERCE

Rulemaking Agency: *North Carolina Industrial Commission*

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

Rule Citations: *04 NCAC 10J.0103*

Public Hearing:

Date: *November 18, 2016*

Time: *1:00 p.m.*

Location: *Room 2149, Utilities Commission Hearing Room, 2nd Floor, Dobbs Building, 430 North Salisbury Street, Raleigh, NC 27603*

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

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

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

CHAPTER 10 - INDUSTRIAL COMMISSION

SUBCHAPTER 10J – FEES FOR MEDICAL COMPENSATION

SECTION 0100 – FEES FOR MEDICAL COMPENSATION

04 NCAC 10J.0103 FEES FOR INSTITUTIONAL SERVICES

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

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

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

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

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

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

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

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



PROPOSED TEMPORARY RULES

- (2) Beginning January 1, 2016, 190 percent of the hospital's Medicare CAH per diem amount.
- (3) Beginning January 1, 2017, 170 percent of the hospital's Medicare CAH per diem amount.
- (f) The schedule of maximum reimbursement rates for outpatient institutional services provided by CAHs is as follows:
- (1) Beginning April 1, 2015, 230 percent of the hospital's Medicare CAH claims payment amount.
- (2) Beginning January 1, 2016, 220 percent of the hospital's Medicare CAH claims payment amount.
- (3) Beginning January 1, 2017, 210 percent of the hospital's Medicare CAH claims payment amount.
- (g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register ("the Medicare ASC facility-specific amount"). Reimbursement shall be based on the fully implemented payment amount in Addendum AA, ~~Final AA~~ (Final ASC Covered Surgical Procedures for CY-2015, 2017) and Addendum BB, ~~Final BB~~ (Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for-2015, 2017) as published in the Federal Register, or their successors. The maximum reimbursement rate for institutional services provided by ambulatory surgical centers is 200 percent of the Medicare ASC facility-specific amount.
- ~~(h) The schedule of maximum reimbursement rates for institutional services provided by ambulatory surgical centers is as follows:~~
- ~~(1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility-specific amount.~~
- ~~(2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.~~
- ~~(3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.~~
- (h) Notwithstanding Paragraph (g) of this Rule, if surgical procedures listed in Addendum EE (Surgical Procedures Excluded from Payment in ASCs for CY 2017) to the most recently adopted and effective Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems as published in the Federal Register, or its successors, are provided at ASCs, they shall be reimbursed with the maximum amount being the usual, customary, and reasonable charge for the service or treatment rendered.
- (i) If the facility-specific Medicare payment includes an outlier payment, the sum of the facility-specific reimbursement amount and the applicable outlier payment amount shall be multiplied by the applicable percentages set out in Paragraphs (b), (c), (e), (f), and ~~(h)~~(g) of this Rule.
- (j) Charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.
- (k) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping ("DRG") payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.
- (l) For specialty facilities paid outside Medicare's inpatient and outpatient Prospective Payment System, the payment shall be determined using Medicare's payment methodology for those specialized facilities multiplied by the inpatient institutional acute care percentages set out in Paragraphs (b) and (c) of this Rule.

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

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

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

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

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

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

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

THE MOTION TO INTERVENE AS AMICI CURIAE

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

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

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

STANDARD OF REVIEW

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

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

ANALYSIS

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

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

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

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

SECTION 33.(a) Industrial Commission Hospital Fee Schedule:

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

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

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

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

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

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

North Carolina law defines a “hospital” as:

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

N.C. Gen. Stat. § 131E-76(3).

North Carolina law defines an “ambulatory surgical facility” as:

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

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

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

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

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

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

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


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

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

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

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

This the 9 day of August 2016.



The Honorable Paul C. Ridgeway
Superior Court Judge

Pat McCrory, Governor
Charlton L. Allen, Chairman



Bernadine S. Ballance, Commissioner
Linda Cheatham, Commissioner
Bill Daughtridge, Jr., Commissioner
Christopher C. Loutit, Commissioner
Tammy R. Nance, Commissioner

North Carolina Industrial Commission

September 2, 2016

NOTICE OF PUBLIC COMMENT MEETING

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

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

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

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

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



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

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

Such proposals shall be in writing, filed with the IC Rulemaking Coordinator Kendall Bourdon at kendall.bourdon@ic.nc.gov, and shall include at a minimum:

- a. The person or entity making the proposal with contact information;
- b. The text of a proposed rule(s) or rule amendment(s), to include any proposed maximum allowable amounts for specific DRG, CPT, or revenue codes;
- c. A detailed explanation of the proposal which shows how the proposed rule(s) or amendment(s) achieves the statutory requirements of ensuring the following:
 - i. injured workers are provided the services and standard of care required by the Workers' Compensation Act,
 - ii. providers are reimbursed reasonable fees for providing these services, and
 - iii. medical costs in workers' compensation claims are adequately contained.

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

- d. Any other written information or data and supporting documentation the proponent wishes the Commission to consider.
2. Any person wishing to address oral comments to the Commission at the public comment meeting on October 3, 2016, shall sign up to do so by 5:00 p.m. on September 30, 2016, by contacting IC Rulemaking Coordinator Kendall Bourdon at (919) 807-2644 or kendall.bourdon@ic.nc.gov. Oral comments addressed to the Commission shall be limited to 10 minutes per speaker.
 3. Any person or entity wishing to present written comments and other documentation to the Commission in response to a proposal submitted pursuant to 1. above shall file the comments and corresponding documentation with IC Rulemaking Coordinator Kendall Bourdon at kendall.bourdon@ic.nc.gov no later than October 10, 2016. These responses will be published on the Commission's website within two business days of the deadline at www.ic.nc.gov/abtrules.html.

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


STATE OF NORTH CAROLINA COUNTY OF WAKE	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION 16 CVS 00600
SURGICAL CARE AFFILIATES, LLC, <i>Petitioner</i>))))))))))
v.))))))))))
NORTH CAROLINA INDUSTRIAL COMMISSION, <i>Respondent</i>))))))))))

ORDER ALLOWING STAY

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

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

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



Paul C. Ridgeway, Superior Court Judge



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

NCCI estimates that the fee schedule alternatives for Ambulatory Surgical Center (ASC) services would result in an overall impact between -0.4% (-\$8.0M¹) and +1.1% (+\$21.0M) on North Carolina workers compensation system costs, if adopted.

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

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

Summary of Proposed Medical Fee Schedule Changes

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

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

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



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

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

Actuarial Analysis of Proposed Medical Fee Schedule Changes

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

1. Calculate the percentage change in maximum reimbursements
 - a. Compare the prior and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
 - b. Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.
2. Estimate the price level change as a result of the proposed fee schedule
 - a. NCCI research by Frank Schmid and Nathan Lord (2013), "The Impact of Physician Fee Schedule Changes in Workers Compensation: Evidence from 31 States", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
 - i. In response to a fee schedule decrease, NCCI's research indicates that payments decline by approximately 50% of the fee schedule change.
 - ii. In response to a fee schedule increase, NCCI's research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
The formula used to determine the percent realized for fee schedule increases is $80\% \times (1.10 + 1.20 \times (\text{price departure}))$.
3. Estimate the share of costs that are subject to the fee schedule
 - a. The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.

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

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



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

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

Ambulatory Surgical Center Fee Schedule

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

Estimated Upper Bound Impact

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

Prior MAR

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

Where Multiplier = 220%

Proposed MAR – ASC-Based Alternatives

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

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

Proposed MAR – Hospital Outpatient-Based Alternatives

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

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

The overall weighted-average percentage change in maximums for each scenario for ASC services is then multiplied by the price realization factor². The estimated impact on ASC costs is

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



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

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

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

Estimated Lower Bound Impact

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

Prior Reimbursement

Prior Reimbursement = Current Payments x Trend Factor

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

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

*Source: Bureau of Labor Statistics



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

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

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

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

Proposed Reimbursement – ASC-Based Alternatives

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

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

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

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

Proposed Reimbursement – Hospital Outpatient-Based Alternatives

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

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

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



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

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

STATE OF NORTH CAROLINA
BEFORE THE NORTH CAROLINA INDUSTRIAL COMMISSION

OCTOBER 3, 2016

PUBLIC COMMENT MEETING BEFORE THE FULL COMMISSION

REGARDING

PROPOSALS FOR THE MEDICAL FEE SCHEDULE

Full Commission Public Hearing, October 3, 2016

A P P E A R A N C E S

COMMISSIONERS:

Charlton L. Allen, Chairman

Bernadine S. Ballance

Linda Cheatham

Bill Daughtridge, Jr.

Christopher C. Loutit

Tammy R. Nance

I N D E X

SPEAKERS:

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Kelli Collins 6

John McMillan 27

Linwood Jones 34

Full Commission Public Hearing, October 3, 2016

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P R O C E E D I N G S

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

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

Full Commission Public Hearing, October 3, 2016

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1 2015 Medical Fee Schedule provisions for ambulatory
2 surgery centers. By way of a brief history, Surgical
3 Care Affiliates filed a Petition for Declaratory
4 Ruling regarding the Commission's enacted Medical Fee
5 Schedule last fall. The Commission issued its
6 Declaratory Ruling denying the requested relief. SCA
7 filed a Petition for Judicial Review in Wake County
8 Superior Court. Judge Paul Ridgeway ruled the
9 Commission's Medical Fee Schedule to be invalid as
10 applied to ambulatory surgery centers based on a
11 rulemaking procedural issue going back to the language
12 of the General Assembly Session Law instructing this
13 transition to a Medicare-based Fee Schedule. The
14 Judge granted the Commission's Motion for Stay of the
15 Decision pending the outcome of this litigation on
16 appeal. I say all this to ensure that we are all on
17 the same page moving forward. First of all, we are
18 not here to discuss the validity of the current rule
19 or any of the currently pending litigation. It would
20 be improper and inappropriate to discuss the merits of
21 that litigation in today's setting and would defeat
22 the purpose for which we are all gathered here today,
23 so let's be clear. We are here to allow the public to
24 make proposals, presentations and give oral comments
25 and responses on what to do in light of the ruling.

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

Full Commission Public Hearing, October 3, 2016

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

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

19 KELLI COLLINS

20 MS. COLLINS: Thank you.
21 CHAIRMAN ALLEN: ---and then questions to follow.
22 MS. COLLINS: Good afternoon.
23 CHAIRMAN ALLEN: Good afternoon.
24 MS. COLLINS: Thank you for allowing me the
25 opportunity to speak with you today. My name is Kelli

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

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

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

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

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

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

5 MS. COLLINS: Yay.

6 CHAIRMAN ALLEN: I have a few questions---

7 MS. COLLINS: Okay.

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

9 MS. COLLINS: That's - of course.

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

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

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

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

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

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

15 MS. MONTGOMERY: Okay.

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

18 MS. MONTGOMERY: We have. We have.

19 CHAIRMAN ALLEN: Okay.

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

22 MS. COLLINS: It was. Yes.

23 CHAIRMAN ALLEN: Okay.

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

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

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

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

3 MS. MONTGOMERY: Okay. Stacey---

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

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

8 CHAIRMAN ALLEN: Sure.

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

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

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

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

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

24 MS. SMITH: Yes.

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

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

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

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

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

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

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

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1 that has a different rate for hospital outpatient
2 versus ASCs?

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

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

9 CHAIRMAN ALLEN: Right.

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

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

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

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

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

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

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

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

18 MS. COLLINS: There was not.

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

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

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

3 CHAIRMAN ALLEN: Okay.

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

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

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

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

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

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

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

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

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

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

8 CHAIRMAN ALLEN: Okay.

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

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

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

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

19 MS. COLLINS: It is.

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

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

23 CHAIRMAN ALLEN: Right.

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

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1 even cover the cost of implants for those---

2 CHAIRMAN ALLEN: Okay.

3 MS. COLLINS: ---procedures.

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

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

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

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

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

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

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

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

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

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

3 MS. COLLINS: 15.

4 MS. SMITH: ---bill charges.

5 CHAIRMAN ALLEN: Okay.

6 COMMISSIONER CHEATHAM: Even after---

7 CHAIRMAN ALLEN: Commissioner---

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

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

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

16 MS. COLLINS: That's correct.

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

19 MS. COLLINS: Correct.

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

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

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

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1 COMMISSIONER CHEATHAM: But---

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

3 MS. SMITH: Yeah.

4 MS. COLLINS: ---of 2015.

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

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

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

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

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

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

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

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

6 MS. COLLINS: Yes. Yes.

7 COMMISSIONER CHEATHAM: Thank you.

8 CHAIRMAN ALLEN: All right.

9 MS. COLLINS: Thank you.

10 CHAIRMAN ALLEN: Thank you.

11 MS. COLLINS: Thank you all very much.

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

14 JOHN MCMILLAN

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

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

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

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

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

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

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

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

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

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

18 MR. MCMILLAN: I don't know.

19 CHAIRMAN ALLEN: Okay. Given that we are supposed
20 to balance the three factors that I talked about
21 earlier and the two hundred percent Medicare ASC rate
22 was acceptable for cost containment purposes in 2014,
23 2015, what is the impetus now to move it further at
24 this time?

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

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

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

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

20 CHAIRMAN ALLEN: Okay.

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

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1 operate.

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

4 MR. MCMILLAN: No. No.

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

8 MR. MCMILLAN: I'm not.

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

10 MR. MCMILLAN: I am not.

11 CHAIRMAN ALLEN: ---suggested?

12 MR. MCMILLAN: I am not.

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

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

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

22 MR. MCMILLAN: Thank you very much.

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

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LINWOOD JONES

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

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

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

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

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

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

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

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

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

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

21 MR. JONES: That's correct.

22 CHAIRMAN ALLEN: Okay.

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

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1 qualify under Medicare to do that.

2 CHAIRMAN ALLEN: Okay.

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

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

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

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

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

8 COMMISSIONER CHEATHAM: I am.

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

17 COMMISSIONER CHEATHAM: Okay.

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

19 COMMISSIONER CHEATHAM: That's enough.

20 MR. JONES: Right.

21 COMMISSIONER CHEATHAM: I just needed an example.

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

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

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

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

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

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

22 MR. JONES: Not that we've heard.

23 CHAIRMAN ALLEN: Okay.

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

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

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

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

9 CHAIRMAN ALLEN: All right. Thank you, sir.

10 MR. JONES: Thank you.

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

17 (OFF THE RECORD)

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

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1 forwarded to us? It's referenced---

2 MS. SMITH: I---

3 CHAIRMAN ALLEN: Yes, please come.

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

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

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

23 CHAIRMAN ALLEN: ---to be produced?

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

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1 with you tomorrow on the timeline.

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

4 MS. SMITH: Sure. Thank you.

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

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

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

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

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

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

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

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

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

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

6 MS. SMITH: Yeah. So it---

7 MS. COLLINS: ---to North Carolina.

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

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

11 CHAIRMAN ALLEN: Okay.

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

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

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

2 COMMISSIONER CHEATHAM: Translated to a multiplier
3 times---

4 MS. SMITH: Multiplier, right, right.

5 COMMISSIONER CHEATHAM: ---the Medicare rate.

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

8 COMMISSIONER CHEATHAM: Could you get it?

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

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

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

14 MS. SMITH: Yeah.

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

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

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

25 COMMISSIONER CHEATHAM: I'm probably less

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1 interested in that than my other question, but okay.

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

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

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

14 COMMISSIONER CHEATHAM: ---magnitude than hospital
15 outpatient?

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

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

22 COMMISSIONER CHEATHAM: Do you know---

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

24 COMMISSIONER CHEATHAM: ---how much less?

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

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

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

16 MS. SMITH: I don't.

17 COMMISSIONER CHEATHAM: No?

18 MS. SMITH: No.

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

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

23 COMMISSIONER CHEATHAM: I agree.

24 MS. SMITH: Right.

25 COMMISSIONER CHEATHAM: I've recently become well

1 aware of that. Thank you.

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

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

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

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

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

10 MS. SMITH: You can answer that?

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

16 COMMISSIONER BALLANCE: Thank you.

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

19 MS. SMITH: Yeah, yeah, yeah.

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

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

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

19 (WHEREUPON, THE HEARING WAS ADJOURNED.)

20 RECORDED BY MACHINE

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

23
24
25

Full Commission Public Hearing, October 3, 2016

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1 STATE OF NORTH CAROLINA

2 COUNTY OF GUILFORD

3 C E R T I F I C A T E

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

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

13 WITNESS my Hand and Seal on this 5th day of October
14 2016.

15 My commission expires on December 3, 2018.

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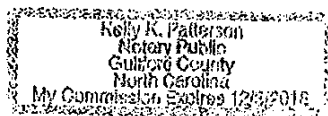
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Kelly K. Patterson
NOTARY PUBLIC

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

September 26, 2016

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

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

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

SCA manages seven ambulatory surgical centers in North Carolina and has an ownership interest in each of these centers through wholly-owned subsidiary corporations (hereinafter "SCA ambulatory surgical centers"). The SCA ambulatory surgical centers are located throughout North Carolina and include Blue Ridge Day Surgery in Raleigh, Charlotte Surgery Center, Fayetteville Ambulatory Surgical Center, Greensboro Specialty Surgery Center, Surgical Center of Greensboro, The Eye Surgery Center of the Carolinas in Southern Pines, and Eastern Regional Surgical Center in Wilson.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

As noted by the Commission, discrepancies in payments between ambulatory surgical centers and hospital outpatient departments would “potentially diminish the pool of doctors available to treat injured employees, and reduce the quality and timeliness of care. That impact will likely be most severely realized in our State’s more rural areas, where the quality and availability of effective treatment is already a greater concern.”¹ SCA agrees with the Commission that the only way to ensure injured workers access to high-quality, effective care is to create parity between the ASC and hospital outpatient fee schedules.

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

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

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

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

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

¹ North Carolina Industrial Commission, Memorandum Of Law In Support of Motion To Stay, August 17, 2016.

² <http://www.ic.nc.gov/ncic/pages/statute/rule407.htm>.

³ <http://www.ic.nc.gov/080916RidgewayDecision.pdf>.

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

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

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

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

OTHER RELEVANT INFORMATION

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

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

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

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

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

Respectfully submitted this 26th day of September 2016.



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REDLINE OF PARTIALLY INVALID RULE

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

- (a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services shall be based on the current federal fiscal year's facility-specific Medicare rate established for each institutional facility by the Centers for Medicare & Medicaid Services ("CMS"). "Facility-specific" rate means the all-inclusive amount eligible for payment by Medicare for a claim, excluding pass-through payments.
- (b) The schedule of maximum reimbursement rates for hospital inpatient institutional services is as follows:
- (1) Beginning April 1, 2015, 190 percent of the hospital's Medicare facility-specific amount.
 - (2) Beginning January 1, 2016, 180 percent of the hospital's Medicare facility-specific amount.
 - (3) Beginning January 1, 2017, 160 percent of the hospital's Medicare facility-specific amount.
- (c) The schedule of maximum reimbursement rates for hospital outpatient institutional services is as follows:
- (1) Beginning April 1, 2015, 220 percent of the hospital's Medicare facility-specific amount.
 - (2) Beginning January 1, 2016, 210 percent of the hospital's Medicare facility-specific amount.
 - (3) Beginning January 1, 2017, 200 percent of the hospital's Medicare facility-specific amount.
- (d) Notwithstanding the Paragraphs (a) through (c) of this Rule, maximum allowable amounts for institutional services provided by critical access hospitals ("CAH"), as certified by CMS, are based on the Medicare inpatient per diem rates and outpatient claims payment amounts allowed by CMS for each CAH facility.
- (e) The schedule of maximum reimbursement rates for inpatient institutional services provided by CAHs is as follows:
- (1) Beginning April 1, 2015, 200 percent of the hospital's Medicare CAH per diem amount.
 - (2) Beginning January 1, 2016, 190 percent of the hospital's Medicare CAH per diem amount.
 - (3) Beginning January 1, 2017, 170 percent of the hospital's Medicare CAH per diem amount.
- (f) The schedule of maximum reimbursement rates for outpatient institutional services provided by CAHs is as follows:
- (1) Beginning April 1, 2015, 230 percent of the hospital's Medicare CAH claims payment amount.
 - (2) Beginning January 1, 2016, 220 percent of the hospital's Medicare CAH claims payment amount.
 - (3) Beginning January 1, 2017, 210 percent of the hospital's Medicare CAH claims payment amount.
- ~~(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register ("the Medicare ASC facility-specific amount"). Reimbursement shall be based on the fully implemented payment amount in Addendum AA, Final ASC Covered Surgical Procedures for CY 2015, and Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2015, as published in the Federal Register, or their successors.~~
- (g) For those procedures for which CMS has established a Medicare rate, the schedule of maximum reimbursement rates for services provided by ambulatory surgical centers ("ASC") should be the same as the schedule of maximum reimbursement rates for hospital outpatient institutional services as set forth in sub-part (c) above. For those procedures for which CMS has not established a Medicare rate for hospital outpatient institutional services, the maximum allowable amounts for services provided by ASCs shall be 50% of billed charges up to a cap of \$30,000. Charge master increases will be limited to 0% increase for these procedure codes for the first 3 years, or a revenue neutral adjustment will be applied to the percent of charge paid.
- ~~(h) The schedule of maximum reimbursement rates for institutional services provided by ambulatory surgical centers is as follows:~~
- ~~(1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility-specific amount.~~
 - ~~(2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.~~
 - ~~(3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.~~
- (h) If the facility-specific Medicare payment includes an outlier payment, the sum of the facility-specific reimbursement amount and the applicable outlier payment amount shall be multiplied by the applicable percentages set out in Paragraphs (b), (c), (e), and (f), and ~~(h)~~ of this Rule.
- (i) Charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.
- (j) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping ("DRG") payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.
- (k) For specialty facilities paid outside Medicare's inpatient and outpatient Prospective Payment System, the payment shall be determined using Medicare's payment methodology for those specialized facilities multiplied by the inpatient institutional acute care percentages set out in Paragraphs (b) and (c) of this Rule.

PROPOSED RULE

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

- (a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services shall be based on the current federal fiscal year's facility-specific Medicare rate established for each institutional facility by the Centers for Medicare & Medicaid Services ("CMS"). "Facility-specific" rate means the all-inclusive amount eligible for payment by Medicare for a claim, excluding pass-through payments.
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- (h) If the facility-specific Medicare payment includes an outlier payment, the sum of the facility-specific reimbursement amount and the applicable outlier payment amount shall be multiplied by the applicable percentages set out in Paragraphs (b), (c), (e), and (f) of this Rule.
- (i) Charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.
- (j) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping ("DRG") payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.
- (k) For specialty facilities paid outside Medicare's inpatient and outpatient Prospective Payment System, the payment shall be determined using Medicare's payment methodology for those specialized facilities multiplied by the inpatient institutional acute care percentages set out in Paragraphs (b) and (c) of this Rule.

September 26, 2016

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

Dear Chairman Allen:

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

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

BASIS FOR PROPOSAL

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

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

Prior to the adoption of the current fee schedule, ASC reimbursement in North Carolina for workers' compensation injuries was 31% higher for knee arthroscopy and 49% higher for shoulder arthroscopy than the 33-state median, as reported by the Workers' Compensation Research Institute (WCRI) in *Payments to Ambulatory Surgery Centers, 2nd Edition* (May 2016). It is worth noting that Surgical Care Affiliates operates ASCs in a number of the WCRI study states where ASC reimbursement is significantly less than the 33-state median, including California, Colorado, Delaware, Michigan, Mississippi, Oklahoma, Oregon, Pennsylvania, South Carolina, and Texas. There are no access to care problems reported in those states. The current fee schedule puts North Carolina ASC reimbursement closer to the 33-state median and should not create any access to care problems for North Carolina injured workers.

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

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

DETAILS OF THE NEGOTIATED RULEMAKING PROCESS

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

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

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

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

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

- 1) The statement on the North Carolina Medical Society's website that the Society's Specialty Society and Meeting Services Department currently manages ten specialty associations in North Carolina, one of which was the North Carolina Orthopedic Society. (See Attachment A)
- 2) The North Carolina Orthopedic Society is housed inside the physical office of the North Carolina Medical Society Headquarters located at 222 North Person Street, Raleigh, NC. (See Attachment B)
- 3) The email address for Alan Skipper the Executive Director of the North Carolina Orthopedic Society is ncoga@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 70 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.

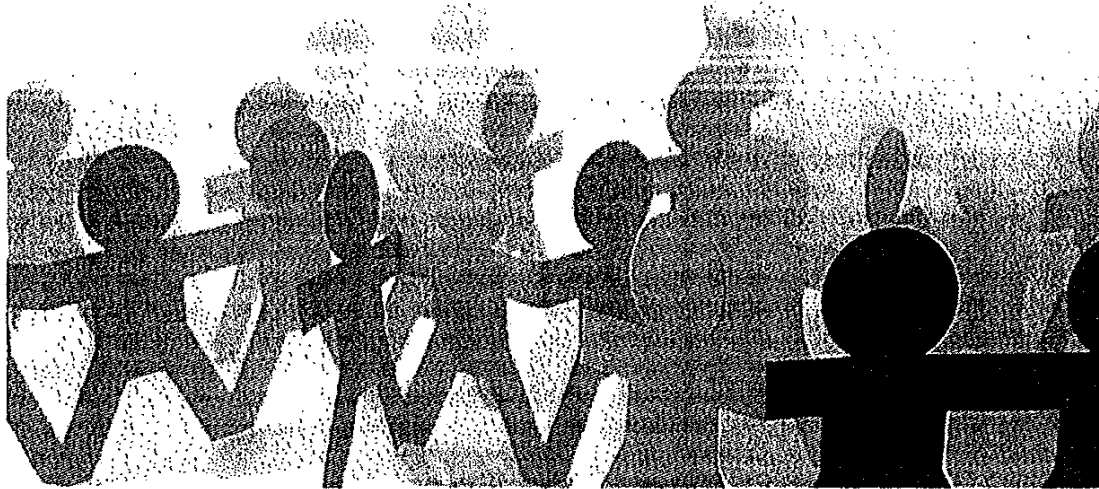
(k) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping (DRG) payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.

(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.

9/26/2018

Partner Organizations | North Carolina Medical Society

Attachment A



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

9/26/2016

North Carolina Orthopaedic Association | North Carolina Medical Society

Attachment B

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North Carolina Orthopaedic Association

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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

9/26/2016

North Carolina Orthopaedic Association | North Carolina Medical Society

Attachment B

- **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 Sklpper, CAE – Raleigh, NC

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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

9/26/2016

North Carolina Orthopaedic Association | North Carolina Medical Society

Attachment B

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.

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- [May 21, 2015](#)
- [Apr. 14, 2015](#)
- [Mar. 5, 2015](#)
- [Jan. 12, 2015](#)
- [Dec. 23, 2014](#)
- [Oct. 8, 2014](#)

Contact Us

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 Fax: (919) 833-2023
 Web: www.ncorthopaedics.org
 Email: ncoa@ncmedsoc.org
 Executive Director: W. Alan Skipper



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North Carolina Orthopaedic Association | North Carolina Medical Society

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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

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Attachment C

January 16, 2015

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

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

Dear Ms. Henderson,

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

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

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

- *Payment Rates.* Paragraph (b) of Rule .0102 establishes basic payment rates for all categories of professional services ranging from 140%-195% of Medicare. We understand that the Commission assigned percentages to each category that, based on the available literature, reflect the national median of payment rates for each category. We anticipate, therefore, that this methodology will also result in North Carolina's professional rates moving to the national median in the aggregate -- a significant improvement that will also more closely reflect today's costs of providing medical care. According to the most recent WCRI analysis, North Carolina now ranks 41st out of the 43 states that have adopted professional fee schedules. Better rates will help to drive more physicians to participate in the workers' compensation system.
- *PAs, NPs, and other providers.* Physicians have cited difficulties when involving physician assistants, nurse practitioners, and other members of their care teams in treating workers' compensation patients. More specifically, medical practices encounter varying requirements from the carrier community about when (if ever) one of these providers may treat patients and be compensated. Paragraph (h) of Rule .0102 effectively clarifies that physicians may rely on other providers so long as scope of practice laws are followed, and that the rates for services

Attachment C

Fee Schedule Rule Comments
 Physician Coalition
 Page 2 of 2

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

9/28/2016

<https://www2.ncmedsoc.org/emailviewonwebpage.aspx?erid=246467&trid=e010ba06-3f9e-4774-87e9-b82e8cee0f68>

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

9/26/2016

<https://www2.ncmedsoc.org/email/viewonwebpage.aspx?erid=246467&trid=e010ba06-3f9e-4774-87e9-b82e8eee0f68>

Attachment D

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

Reprinted with permission from the North Carolina Medical Society.

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

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

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

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

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Advocacy Update: Certificate of Need Reform Effort is Gaining Momentum

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

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



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September 26, 2016

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

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

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

Dear Chairman Allen and Coordinator Bourdon,

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

- The rule was properly adopted following approximately three years of negotiations and hearings in accordance with the North Carolina Administrative Procedures Act;
- Rulemaking negotiations included a jointly funded consultant, a formal mediation, and years of rulemaking hearings involving government, business, insurance, community, and professional/expert feedback;
- The rule was produced by way of thoughtful dialogue, investigation, and objective quantitative analysis that allowed North Carolina to bring some of its medical expenses, including those impacting ambulatory surgery centers, in line with those of surrounding states. States that have adopted of Medicare-based fee schedules for workers'

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

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

- All North Carolina stakeholders, including SCA, were provided ample opportunity to participate in the administrative rule-making process;
- Pursuant to NCCI's *Analysis of Alternatives to the North Carolina Ambulatory Surgical Center Fee Schedule Proposed to be Effective January 1, 2017*, in relation to the fee schedule reflected in the rule, the fee schedule clearly reflects the maximum Ambulatory Surgical Center allowable fees proposed in the current rule remain well above the amount permitted for reimbursement by Medicare beneficiaries;
- Any retroactive amendment sought by SCA would result in irreparable harm to businesses in North Carolina that purchase workers' compensation insurance as required by North Carolina law;
- Any amendment to the rule would adversely affect medical costs incurred by the State of North Carolina, local governments, school boards, and insurers, amongst others.

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

Regards,



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



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North Carolina Hospital Association

September 26, 2016

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

Dear Chairman Allen and Commissioners:

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

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

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

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

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

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September 26, 2016

Page 2

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

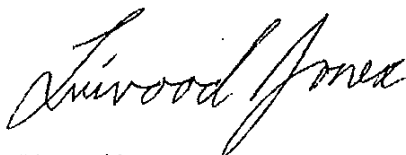
(3) North Carolina Hospital Association/Optum Group Health survey data, June 2013 and July 2014.

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

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

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

Sincerely,



Linwood Jones
General Counsel
North Carolina Hospital Association

cc. Kendall Bourdon
Meredith Henderson

North Carolina Industrial Commission
April 18, 2016

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04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

North Carolina Industrial Commission
April 18, 2016

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2. (2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.
 3. (3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.
- (i) If the facility-specific Medicare payment includes an outlier payment, the sum of the facility-specific reimbursement amount and the applicable outlier payment amount shall be multiplied by the applicable percentages set out in Paragraphs (b), (c), (e), (f), and (h) of this Rule.
- (j) Charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.
- (k) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping ("DRG") payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.
- (l) For specialty facilities paid outside Medicare's inpatient and outpatient Prospective Payment System, the payment shall be determined using Medicare's payment methodology for those specialized facilities multiplied by the inpatient institutional acute care percentages set out in Paragraphs (b) and (c) of this Rule.



Triangle Orthopaedics Surgery Center

Triangle Orthopaedic Associates, P.A. affiliate organization

October 3, 2016

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

Dear Chairman Allen and Commissioners:

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

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

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

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

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

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Triangle Orthopaedics Surgery Center

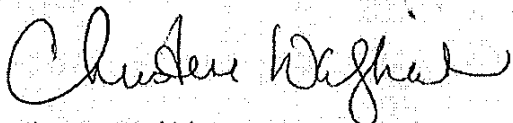
Triangle Orthopaedic Associates, P.A. affiliate organization

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

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

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

Sincerely,



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

cc: Kendall Bourdon
Meredith Henderson



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North Carolina Hospital Association

October 10, 2016

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

Dear Chairman Allen and Commissioners:

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

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

Hospital outpatient rates versus am-surg rates

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

- If Medicare is going to be used as the basis for the fee schedule, then Medicare's fee schedules (with the 2x multiplier for workers' compensation) need to be adhered to, without changing the payment differentials between various providers. The Medicare fee schedules have been actuarially developed by CMS, and as discussed below, there are reasons for the differences in reimbursement levels between hospital outpatient and am-surg facilities under those fee schedules.
- Hospital outpatient services are costlier than am-surg services for several reasons. Hospitals incur substantial costs relating to keeping an emergency room open 24/7 and maintaining service lines that are needed by the community but unprofitable. ASCs are also typically able to schedule surgery during normal business hours, whereas hospitals have less predictive scheduling, which results in higher costs. Hospitals also provide charity care to the indigent and are reimbursed below cost for serving Medicaid recipients.
- In addition, as noted in the attached memorandum from Optum, Medicare uses relative weights as one of the factors in determining payment rates for hospital outpatient facilities and ASCs. Relative weights establish how costly any one service is in relation to any other service. Optum examined the relative weights of 3,077 procedures performed by hospital outpatient departments and ASCs. Of those, the hospital outpatient relative weights were higher than ASC relative

North Carolina Industrial Commission
October 10, 2016

Page 2

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

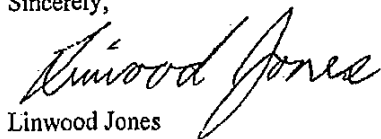
- Hospital outpatient departments must meet the provider-based requirements under federal regulations (42 CFR § 413.65(d) and Transmittal A-03-030). Those requirements include the following:
 - The outpatient department operates under the same license as the hospital.
 - The outpatient department has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

NCCI Analysis

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

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

Sincerely,



Linwood Jones
General Counsel



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Oct. 6, 2016

To: Linwood Jones

From: Eric Anderson
 Managing Consultant
 Reimbursement Analytics

Re: Discussion of NCIC-requested analysis and SCA Response

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

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

Discussion of analysis for Industrial Commission

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

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

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

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

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



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

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

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

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

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

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

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

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

Page 3 "Prior MAR"

There are several questions relating to the MAR calculations.

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



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

2. The Proposed MAR – ASC-Based Alternatives does not state whether wage indexes were considered when modeling payments. Because they are not mentioned, presumably they were not. However, if wage indexes were considered they may have created another inadvertent issue. Core Based Statistical Areas (CBSAs) were revamped as the result of the 2010 census. These resulted in changes to CBSA compositions. That, in turn, brought about wage index changes with most occurring between 2014-16. If wage indexing was done, then payment changes as any CBSA changes ought to be noted in the modeling.
3. The Proposed MAR – Hospital-Based Alternatives lacks a pertinent discussion. While ASC-PPS and OPPS are similar, they differ in discounting and bundling. Because hospitals provide a broader range of services than ASCs, hospital bundles are often larger and more comprehensive. There is no discussion how the disparities between the two systems were reconciled. A reasonable presumption might be that the analysis used the multiple procedure discount flag from ASC-PPS, but strictly speaking that is not following OPPS payment rules. Without clarity on discounting and bundling, the analysis of MAR—Hospital-Based Alternatives should be regarded with some skepticism.

Summary

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

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



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Discussion of Surgical Care Associates response

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

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

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

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

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

There are two components to Medicare's payment policy:

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

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

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

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



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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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



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



Renee J. Montgomery
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Atlanta, GA
Charleston, SC
Charlotte, NC
Columbia, SC
Greenville, SC
Raleigh, NC
Spartanburg, SC

October 10, 2016

Via Hand Delivery

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

Re:

Dear Chairman Allen and Commissioners:

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

Thank you for the opportunity to provide these comments.

Sincerely,



Renee J. Montgomery

RJM:rms

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

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

October 10, 2016

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

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

SCA manages seven ambulatory surgical centers in North Carolina and has an ownership interest in each of these centers through wholly-owned subsidiary corporations (hereinafter "SCA ambulatory surgical centers"). The SCA ambulatory surgical centers are located throughout North Carolina and include Blue Ridge Day Surgery in Raleigh, Charlotte Surgery Center, Fayetteville Ambulatory Surgical Center, Greensboro Specialty Surgery Center, Surgical Center of Greensboro, The Eye Surgery Center of the Carolinas in Southern Pines, and Eastern Regional Surgical Center in Wilson.

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

**THE OTHER THREE PROPOSALS ARE NOT COST EFFECTIVE AND DO NOT
MEET NORTH CAROLINA STATUTORY REQUIREMENTS**

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The other three proposals do not meet these requirements.

The other three proposals do not address all procedures that can be performed in ambulatory surgery centers. By crafting a fee schedule that uses only Medicare as its foundation, the other proposals do not recognize that a wide variety of procedures can be performed safely and cost-effectively on the working-age population. The workers' compensation population is typically younger and healthier than the Medicare population, meaning that there are additional procedures that can be performed safely and effectively with a shorter stay. As noted by NCCI "WC claimants have very different demographics, medical conditions, and priorities than retirees.

It would be a mistake to blindly rely on Medicare rates as perfect measures of resources appropriate to treat work-related injuries.”¹

Additionally, for Medicare patients nationwide, covered surgical procedures include “surgical procedures . . . for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.”² For non-Medicare patients in North Carolina, ASCs are permitted to keep patients for up to 24 hours.³ This means a non-Medicare patient can stay in the facility overnight, provided they are released within the specified time frame.⁴ The ability to keep workers’ compensation and commercial patients in the facility overnight broadens the list of procedures that can be performed safely and effectively in the ASC setting.

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

When confronted with an injured worker who needs a procedure not paid for under Medicare’s HOPD payment methodology, a hospital can choose to perform the case in its inpatient setting. The result is a much higher cost to the system of an inpatient stay and procedure. Allowing an ASC to perform cases not on the Medicare ASC list provides an alternative setting for these procedures, and allows the injured worker’s doctor to make the decision for his or her patient about the best site of service for these procedures.

The impact of not having a fee schedule that includes all procedures can be shown by the drop in Workers’ Compensation cases performed in ASCs since April of 2015 when the invalid fee schedule began being used. SCA’s Workers’ Compensation cases declined by 4.2% between April 1, 2015-March 31, 2016. An NCCI analysis of volume recently obtained by SCA shows a decline in volume of Workers’ Compensation cases by all North Carolina ASCs in 2015 of 8.2%.⁵

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

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

² 42 C.F.R. §416.166 (b).

³ G.S. §131E-176 (1)(b).

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

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

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

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

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

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

The workers' compensation system should not be responsible for hospital overhead. It has been argued that hospitals have an infrastructure and overhead that necessitates payment for workers compensation cases at higher rates than ASCs. Payment should be equivalent between the two settings for equivalent procedures. When an injured worker requiring surgery visits an ASC, he or she receives the same care as he or she would in a hospital environment. For these cases, the direct costs are equivalent – implant and supply costs, nursing staff, anesthesia costs, etc. Payment for surgery for the same patient, receiving the same treatment – in many cases even performed by the same surgeon – should not be differentiated based on factors and costs unrelated to the workers' compensation system and should be the same regardless of location.

Other states are recognizing the importance of addressing the two sites using the same methodology in setting their medical fee schedules. Alaska and Connecticut, two of the most recent states that enacted legislation related to workers' compensation medical fee schedule reforms specific to ambulatory surgical centers, used the hospital outpatient fee schedule. In 2014, the Medical Services Review Committee in Alaska was directed to create a medical fee schedule

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

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

SCA's PROPOSAL WILL SAVE THE SYSTEM MONEY

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

As noted by the Commission, discrepancies in payments between ASCs and HOPDs would "potentially diminish the pool of doctors available to treat injured employees, and reduce the quality and timeliness of care. That impact will likely be most severely realized in our State's more rural areas, where the quality and availability of effective treatment is already a greater concern."⁹ SCA agrees with the Commission that the only way to ensure injured workers access to high-quality, effective care is to create parity between the ASC and hospital outpatient medical fee schedules.

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

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

⁷ HB316, Chapter 63 SLA 14.

⁸ CT Public Act 14-167.

⁹ North Carolina Industrial Commission, Memorandum of Law In Support of Motion To Stay, August 17, 2016.

¹⁰ NCCI, Effectiveness of Workers Compensation Fee Schedules - A Closer Look, February 11, 2009.

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

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

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

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

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

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

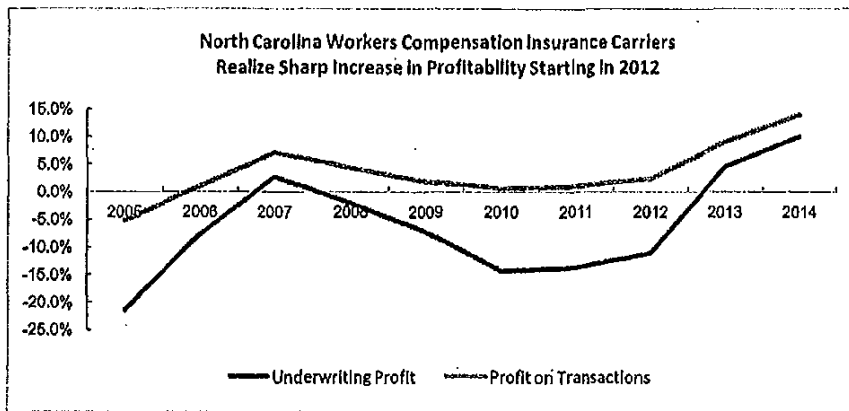
¹¹ WCRI, Designing Workers' Compensation Medical Fee Schedules, June 2012.

¹² Texas Medical Association, Workers' Compensation Special Report – 2004 Survey of Texas Physicians."

¹³ The Medical Fee Schedule Under the Workers' Compensation Law, Legislative Reference Bureau State Capitol, Honolulu, Hawaii

¹⁴ National Academy of Social Insurance, Workers' Compensation: Benefits, Coverage, and Costs, 2014

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



CONCLUSION

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

Respectfully submitted this 10th day of October 2016.

K. Collins

Kelli Collins, Vice President Operations
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CHARLOTTE SURGERY CENTER
an affiliate of SCA

October 6, 2016

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

Dear Chairman Allen and Commissioners:

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

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

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

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

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

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

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

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

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

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

Sincerely,



Thomas J. Lally
C.E.O.

cc: Kendall Bourdon
Meredith Henderson

October 10, 2016

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

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We strongly oppose the three proposals submitted by insurance carriers, third-party administrators, and the North Carolina Hospital Association. The three proposals all recommend a significantly reduced fee schedule for ASCs, which would limit injured workers' access to timely care and also fail to meet the statutory requirement that ASCs receive reasonable fees.


It is also very significant that the other three proposals do not address all procedures that were being conducted in ambulatory surgery centers prior to the enactment of the Invalid fee schedule on April 1, 2015. By limiting Injured workers access to care for all procedures that have been historically performed in the ASC setting, workers will be forced to receive care in the higher-cost Inpatient hospital setting.

The other three proposals are not cost effective and so do not meet statutory requirement of the North Carolina Workers Compensation Act. North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that Injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The three other proposals do not meet these requirements.

Lastly, the analysis conducted by NCCI does not take into consideration the shift of Injured workers from the ASC setting to the more-costly hospital inpatient setting, therefore, underestimating the cost to the workers' compensation system.

Thank you for your consideration.

Sincerely,



SEAN RAMBO
PRESIDENT/COO, COMPASS SURGICAL PARTNERS

cc: Kendall Bourdon
Meredith Henderson

FAYETTEVILLE AMBULATORY SURGERY CENTER
An affiliate of **SCA**

October 10, 2016

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

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Thank you for your consideration.

Sincerely,


Debbie Long,
Business Office Manager

cc: Kendall Bourdon
Meredith Henderson

BLUE RIDGE SURGERY CENTER

an affiliate of **SCA**

October 10, 2016

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

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BLUE RIDGE SURGERY CENTER

an affiliate of **SCA**

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Thank you for your consideration.

Sincerely,

Kathy Baird, Administrator

cc: Kendall Bourdon
Meredith Henderson

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October 10, 2016

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

Dear Chairman Allen and Commissioners:

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

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

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

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

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The other three proposals are not cost effective and so do not meet statutory requirement of the North Carolina Workers Compensation Act. North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The three other proposals do not meet these requirements.

Lastly, the analysis conducted by NCCI does not take into consideration the shift of injured workers from the ASC setting to the more-costly hospital inpatient setting, therefore, underestimating the cost to the workers' compensation system.

Thank you for your consideration.

Sincerely,



Sean M. McNally, CEO
Raleigh Orthopaedic Clinic

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,



Robert Satterfield, MD
Orthopaedic Surgeon

cc: Kendall Bourdon
Meredith Henderson

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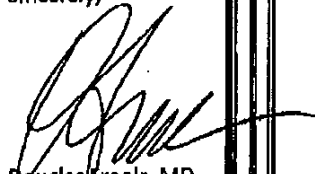
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Douglas Freels, MD
Orthopaedic Surgeon

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,



B. Todd Smith, MD
Orthopaedic Surgeon

cc: Kendall Bourdon
Meredith Henderson

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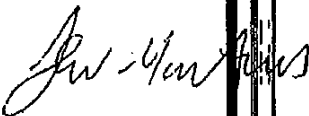
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Sincerely,



Lew Martin, MD
Orthopaedic Surgeon

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,



Adam Thorp, MD
Orthopaedic Surgeon

cc: Kendall Bourdon
Meredith Henderson

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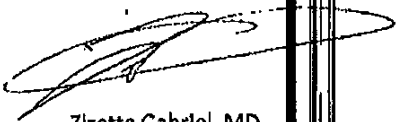
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Zizette Gabriel, MD
Anesthesiologist / Pain Management

cc: Kendall Bourdon
Meredith Henderson

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Ann DuPree Orr, RN BSN CNOR
Administrator -- Team Carolinas

cc: Kendall Bourdon
Meredith Henderson

BLUE RIDGE SURGERY CENTER

an affiliate of SCA

October 3, 2016

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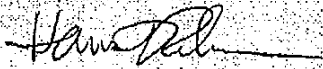
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BLUE RIDGE SURGERY CENTER

an affiliate of SCA

Thank you for your consideration. If you have any questions, please feel free to contact me at (919)-781-4311.

Sincerely,



Hons Rohm

cc: Kendall Bourdon
Meredith Henderson

BLUE RIDGE SURGERY CENTERan affiliate of **SCA**

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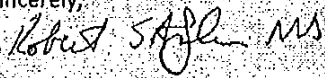
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BLUE RIDGE SURGERY CENTER

an affiliate of 

Thank you for your consideration. If you have any questions, please feel free to contact me at (919)-781-4311.

Sincerely,



Dr. Alphin, M.D. Medical Director

cc: Kendall Bourdon
Meredith Henderson

BLUE RIDGE SURGERY CENTER

an affiliate of **SCA**

October 3, 2016

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

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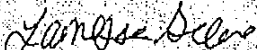
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Sincerely,


Larnessa Greene

cc: Kendall Bourdon
Meredith Henderson

BLUE RIDGE SURGERY CENTER

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Sincerely,



Becky Ballard

cc: Kendall Bourdon
Meredith Henderson

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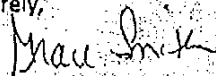
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Sincerely,



Grace Smith

cc: Kendall Bourdon
Meredith Henderson

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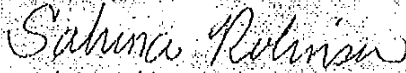
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Sincerely,



Sabrina Robinson

cc: Kendall Bourdon
Meredith Henderson

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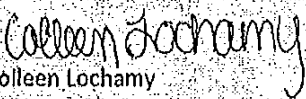
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BLUE RIDGE SURGERY CENTER

an affiliate of 

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Sincerely,


Colleen Lochamy

cc: Kendall Bourdon
Meredith Henderson

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BLUE RIDGE SURGERY CENTER

an affiliate of 

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Sincerely,

Parrish Dickens

Parrish Dickens

cc: Kendall Bourdon
Meredith Henderson

BLUE RIDGE SURGERY CENTER

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October 3, 2016

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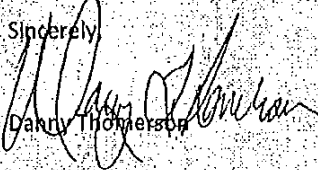
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an affiliate of **SCA**

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Sincerely,



Danny Thompson

cc: Kendall Bourdon
Meredith Henderson

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Sincerely,



Cassandra Clark

cc: Kendall Bourdon
Meredith Henderson

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North Carolina Industrial Commission
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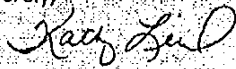
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Sincerely,



Kathy Leibl, Administrator

cc: Kendall Bourdon
Meredith Henderson

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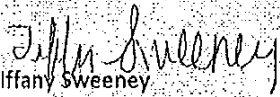
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Sincerely,


Tiffany Sweeney

cc: Kendall Bourdon
Meredith Henderson

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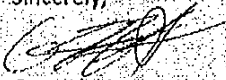
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Sincerely,



Gyto Alexis

cc: Kendall Bourdon
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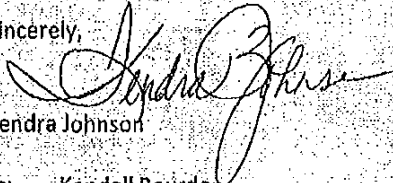
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BLUE RIDGE SURGERY CENTER

an affiliate of SCA

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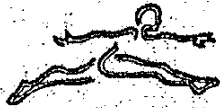
Sincerely,



Kendra Johnson

cc: Kendall Bourdon
Meredith Henderson

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October 3, 2016

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

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Sincerely,

Michelle L. Kuhn
 Revenue and Special Operations Director

cc: Kendall Bourdon
Meredith Henderson

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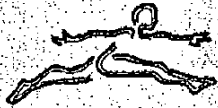
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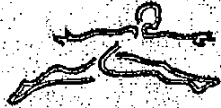
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Sincerely,

WILLIAM K. ANDERSEN, MD, FFAAOS

cc: Kendall Bourdon
Meredith Henderson

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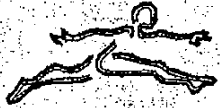
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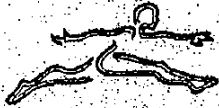
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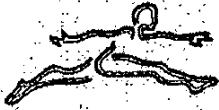
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Christie Giacyle, etc

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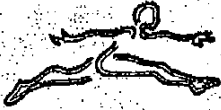
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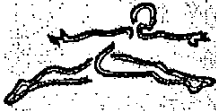
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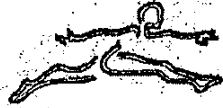
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Sincerely,

cc: Kendall Bourdon
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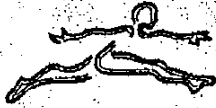
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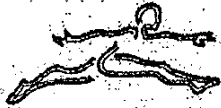
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Administrative Director

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GREENSBORO SPECIALTY SURGICAL CENTER
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Pellee Murphy, Administrator

cc: Kendall Bourdon
Meredith Henderson



Triad Foot Center

Partnering for exceptional care.

NORMAN S. REGAL, DPM, FACAS

M. TODD HYATT, DPM, FACAS

MATTHEW R. WAGNER, DPM

GREGORY A. MAVER, DPM

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Brassfield Professional Center
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Greensboro NC 27410

BI-RENTON OFFICE

1680 Westbrook Ave
Burlington NC 27215

ASHEBORO OFFICE

220-B Foust Street
Asheboro NC 27203

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Sincerely,



Christine L. McCuen, MD

cc: Kendall Bourdon
Meredith Henderson



October 10, 2016

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

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HAND SPECIALISTS, PA

Gary R. Kuzma, M.D.
Matthew A. Weingold, M.D.
Sam Felliga, M.D.
Kevin R. Kuzma, M.D.
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Terri Rowland, OTR/L CHT
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Greensboro, NC 27405

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October 10, 2016

Page 2

TO: Charlton L. Allen, Chairman
North Carolina Industrial Commission

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cc: Kendall Bourdon
Meredith Henderson

SURGICAL CENTER OF GREENSBORO
an affiliate of **SCA**

October 10, 2016

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Raleigh, NC 27603

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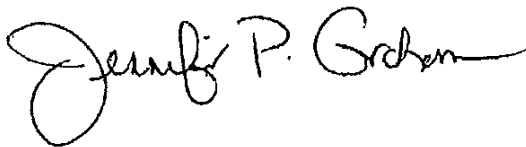
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Sincerely,

A handwritten signature in black ink that reads "Jennifer P. Groden". The signature is written in a cursive style with a large, looping initial "J".

cc: Kendall Bourdon
Meredith Henderson

ORTHOPAEDICS

James P. Aplington, M.D., F.A.A.O.S., F.A.C.S.
 Ronald A. Gioffre, M.D., F.A.A.O.S., F.A.C.S.
 R. Andrew Collins, M.D., F.A.A.O.S.
 Jeffrey C. Beane, M.D., F.A.A.O.S.
 Kevin M. Supple, M.D., F.A.A.O.S., C.A.Q.S.M.
 Frank V. Aluisio, M.D., F.A.A.O.S.
 William M. Gramig, III, M.D., F.A.A.O.S., C.A.Q.S.H.
 Paul A. Bednarz, M.D., F.A.A.O.S.
 Steven R. Norris, M.D., F.A.A.O.S., C.A.Q.S.H.
 Matthew D. Olin, M.D., F.A.A.O.S.
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FAMILY PRACTICE / SPORTS MEDICINE

Adam Scott Kendall, M.D., A.B.F.M.
 CAQ Sports Medicine

RETIRED PHYSICIANS

Samuel A. Sue, Jr., M.D., F.A.A.O.S., F.A.C.S. (Ret. 2002)
 Phillips J. Carter, M.D., F.A.A.O.S., F.A.C.S. (Ret. 2004)
 Thomas L. Presson, M.D., F.A.A.O.S., A.O.F.A.S. (Ret. 2001)

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- Diplomates American Board of Orthopaedic Surgery

October 10, 2016

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

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Signature Place Office: 3200 Northline Avenue, Suite 200 • Greensboro, N.C. 27408-7602 • 336-545-5000 • Fax 336-545-5020

Mailing Address: PO Box 38008 • Greensboro, N.C. 27438-8008 ;

Web Site: www.greensboroorthopaedic.com

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Meredith Henderson



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 Frank J. Rowan, M.D., F.A.A.C.S.
 Peter G. Daildorf, M.D., F.A.A.C.S.
 John L. Graves, M.D., F.A.A.C.S.
 Jesse W. Chindler, M.D.
 Mark L. Dumonski, M.D.
 David A. Thompson, M.D., F.A.A.C.S.
 Dominic W. McKinley, M.D.
 Hao Wang, M.D.
 Raymond Kargo, M.D.
 Melissa Strickland, Administrator

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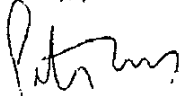
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Thank you for your consideration.

Sincerely, ,



Peter G. Dalldorf, MD

cc: Kendall Bourdon
Meredith Henderson



P.O. Box 14924
Greensboro, NC 27415

**Gulford Orthopaedic and
Sports Medicine Center**

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Justin W. Chandler, MD
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Dominic W. McKinley, MD

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Joshua Landau, MD
Anna Voytek, MD
James S. Kramer, MD
T. Ryan Draper, DO

Piedmont Orthopedics

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Marcus V. Duda, MD
G. Scott Dean, MD
Christopher Y. Blackman, MD
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Michael J. Hilts, MD

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Orthopaedics Center**

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Peter W. Whitfield, MD
W. Dan Caffrey, MD
Stephen D. Lucey, MD
John D. Hewitt, MD
Anna Voytek, MD
Shaifli Devashwar, MD
Rebecca S. Bassett, MD

October 10, 2016

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North Carolina Industrial Commission
430 N. Salisbury Street
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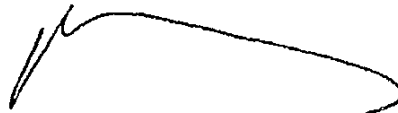
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cc: Kendall Bourdon
Meredith Henderson



North Carolina Hospital Association

Serving North Carolina's Hospitals & Health Systems

November 28, 2016

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

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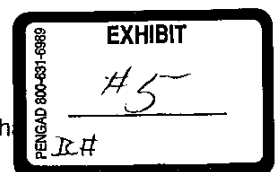
Pursuant to the North Carolina Industrial Commission's ("Commission") November 18, 2015 Notice of Public Comment Meeting, the North Carolina Hospital Association ("NCHA") respectfully submits the following information to supplement and further elaborate on the comments that we made during the hearing:

The Industrial Commission has proposed a temporary rule entitled Rule 04 NCAC 10J.0103 Fees for Institutional Services that was submitted to the North Carolina Office of Administrative Hearings. The temporary rule is pursuant to N. C. General Statute § 150B-21.1(a)(5). The effects of the August 9, 2016 decision in Surgical Care Affiliates, LLC v. North Carolina Industrial Commission, No. 16-CVS-0060 (Wake County) necessitate the expedited implementation of the temporary rule. Specifically, NCHA will be commenting on Paragraphs g and h as set forth in the proposed temporary rule and offering a detailed reimbursement proposal to address the issues related to Paragraph h.

Fees for Institutional Services Provided Ambulatory Surgical Centers – Paragraph G

NCHA agrees that the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASCs") should 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 System reimbursement formula and factors as published annually in the Federal Register. We also support the Commission's decision to adopt the same rule that it had adopted earlier for the payment of services rendered in an ASC. Specifically, we support that the maximum reimbursement rate for institutional services provided by ASCs should be 200 percent of the Medicare ASC facility-specific amount. This approach will provide fair and reasonable reimbursement for services rendered by ASCs, is consistent with the reimbursement approach used for hospital outpatient services, will protect employers and insurers from the risks associated with a percentage of charge reimbursement methodology by moving to a prospective payments system, and will result in substantial savings for employers and insurers when compared to the previous reimbursement methodology.

As indicated in previous comment letters, NCHA does not support a rate lower than 200% of the applicable Medicare fee schedule for outpatient services rendered by hospitals and free-standing ambulatory surgery centers. Medicare payments for outpatient services are low when compared to the costs of providing those services, thus, a 2x multiplier is needed to provide adequate reimbursement and ensure appropriate access to care. Rates lower than 200% of the applicable Medicare fee schedule will likely create access problems. It is imperative that the Commission provide adequate reimbursement rates to providers to ensure that injured workers receive the services and standard of care required by the Workers' Compensation Act.





North Carolina Hospital Association

Serving North Carolina's Hospitals & Health Systems

During the November 18, 2016 public hearing, there were some comments questioning why Medicare rates for outpatient services rendered in a hospital are higher than rates for services rendered by an ambulatory surgery center. The Centers for Medicare and Medicaid Services (CMS) has acknowledged that hospitals have greater costs complying with a more comprehensive scope of licensing, accreditation and other regulatory requirements than other providers and thus, when services are furnished in a hospital setting, total Medicare payments (made to the hospital and the professional combined) typically exceeds the Medicare payment made for the same service at other provider settings. CMS recognized that hospitals incur higher overhead costs because they maintain the capability to furnish services 24 hours a day and 7 days per week, furnish services to higher acuity patients than those who receive services in other provider settings, and have additional legal obligations such as complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). Other justifications supporting the differences in payment are presented below:

Patients who are too sick for physician offices or too medically complex for ASCs are treated in the hospital outpatient department (HOPD). Physicians refer more complex patients to HOPDs for safety reasons, as hospitals are better equipped to handle complications and emergencies. As such, compared to other provider settings, HOPDs treat patients who are suffering from more severe chronic conditions and generally have higher prior utilization of hospitals and emergency departments.

Unlike physician offices and ASCs, hospitals play a unique and critical role in the communities they serve by providing a wide range of acute-care and diagnostic services, supporting public health needs, and offering many other services that promote the health and well-being of the community. By contrast, many physicians and ASCs serve a limited number of Medicaid and charity care patients. In addition, hospitals provide emergency standby services such as:

24/7 Access to Care: Providing health care services, including specialized resources, 24 hours a day, seven days a week (24/7), 365 days a year.

The Safety Net: Caring for all patients who seek emergency care regardless of ability to pay.

Disaster Readiness and Response: Ensuring that staff and facilities are prepared to care for victims of large-scale accidents, natural disasters, epidemics and terrorist actions.

The added costs of operating hospital services are substantial. There are additional costs for infrastructure, Joint Commission requirements, life-safety codes and other regulatory requirements, not to mention the additional overhead cost of being prepared to meet the community's needs on a 24/7 basis. While these expenses increase the cost in hospital settings, they also ensure that safety and quality of the services delivered and 24/7 access.

Fees for Institutional Services Provided Ambulatory Surgical Centers – Paragraph H

The language proposed by the Industrial Commission as set forth in 04 NCAC 10J.0103.h is presented below:

Paragraph h - Notwithstanding Paragraph (g) of this rule, if surgical procedures listed in



North Carolina Hospital Association

Serving North Carolina's Hospitals & Health Systems

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

NCHA does not support the provisions set forth in Paragraph h as presented which appear to allow ASCs to perform other surgical procedures not included on the Covered List of ASC Surgical Procedures for CY 2017 and receive usual, customary, and reasonable charges for these surgical procedures. We do not believe that ASCs should be allowed to perform surgical procedures that are not appropriate for hospital outpatient settings and receive reimbursement that could potentially be far greater than the reimbursement amounts received by hospitals. In addition, we do not feel it is appropriate that ASC reimbursement for these procedures would not include the bundling logic applied to hospitals outpatient procedures through the Medicare APC fee schedule. We believe that there is a true hierarchy related to the appropriate setting for most surgical procedures (e.g., physician office, ASC with limited 24 hour capabilities, hospital outpatient with inpatient support, and hospital inpatient). We are willing to support that ASCs can perform the same procedures as set forth on the Medicare Hospital Outpatient Prospective Payment System (HOPPS) (HOPPS) list, although many of these procedures are currently excluded from the Covered List of ASC Surgical Procedures, provided that these procedures are 1) clinically appropriate for the ASC setting, 2) are payable to an ASC only if payment is allowed under Medicare's status indicators found for the same code in Addendum B of the HOPPS, and 3) reimbursed at a bundled rate comparable to 200% of the ASC fee schedule.

During the November 18, 2016 public hearing, NCHA presented a detailed, common sense approach to developing an appropriate fee schedule, which would be comparable to 200% of the Medicare ASC fee schedule, for those procedures which are payable under the Medicare HOPPS fee schedule but are not currently listed on the Covered List of ASC Surgical Procedures for CY 2017. We suggested that Medicare rates for the covered list of ASC Surgical Procedures be compared to the Medicare rates for the covered list of hospital outpatient surgical procedures to ascertain the percentage relationship between the two fee schedules. This percentage comparison could be calculated on a code specific basis or in aggregate. We recommend that the percentage comparison be calculated in aggregate in order to simply the claim processing/payment process for payers. The resultant percentage (s) would then be applied to 200% of the Medicare HOPPS fee schedule of each applicable surgical code not included on the ASC Covered List to determine the maximum reimbursable ASC rate. This approach would result in ASCs receiving a consistent reimbursement rate at approximately 200% of Medicare ASC fee schedule and would protect payers from having to negotiate unbundled UCR amounts that could in essence be higher than what they are paying hospitals for the same outpatient surgery.

NCHA asked Optum to prepare an assessment comparing the Medicare payments and relative weights for hospitals and ASC from the 2017 final rule in an effort to calculate the aggregate percentage recommended above. Optum excluded all the items that are bundled under the Medicare fee schedules for hospitals and ASCs. In addition, Optum did not include the supplemental ASC services list which primarily includes radiology codes. Optum's comparative assessment is attached as Exhibit I. Based on Optum's assessment, NCHA recommends that the Commission use 55.42% in developing an appropriate ASC fee schedule for those procedures that are payable under the HOPPS fee schedule but are not currently included on the Covered List of ASC Surgical Procedures for CY 2017. NCHA recommends that the resultant ASC fee schedule be developed as follows:



North Carolina Hospital Association

Serving North Carolina's Hospitals & Health Systems

(HOPPS Procedure Payment Rate times 55.42%) times 200% = ASC Payment Rate which should be adjusted by the ASC's specific Medicare wage index

This same calculation can be achieved by multiplying the HOPPS Procedure Payment Rate by 110.84% and then adjusting the results by the ASC's specific Medicare wage index.

An example of this calculation is presented below:

HOPPS Procedure Payment Rate - \$100

ASC Procedure Payment Rate – ((\$100 times 55.42%) times 200%) = \$100.84 or 110.84% of HOPPS Procedure Payment Rate

During the November 18, 2016 public hearing, the Commissioners asked for suggested language that could be used to reflect this recommended approach. NCHA recommends that the Commission adopt the following language for paragraph h:

h) Notwithstanding Paragraph (g) of this Rule, if surgical procedures listed in Addendum EE (Surgical Procedures Excluded from Payment in ASCs for CY 2017) to the most recently adopted and effective Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems as published in the Federal Register, or its successors, are provided at ASCs, they shall be reimbursed with a maximum reimbursement rate of 110.84% of the Medicare Hospital Outpatient Prospective Payment System for the procedure rendered adjusted by the ASC's specific Medicare wage index provided that the procedure is clinically appropriate for the ASC setting and payment is allowed under Medicare's status indicators found for the same code in Addendum B of the Medicare Hospital Outpatient Prospective Payment System.

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

Sincerely,

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

cc. Kendall Bourdon
 Meredith Henderson
 Linwood Jones

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

November 29, 2016

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

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

Dear Chairman Allen & Commissioners:

Pursuant to the North Carolina Industrial Commission's ("Commission") October 18, 2016 Notice of Temporary Rulemaking for Workers' Compensation Medical Fee Schedule amending 04 NCAC 10J .0103, Surgical Care Affiliates, LLC ("SCA") respectfully submits the following comments in response to the proposed temporary rule published by the Commission addressing fees for ambulatory surgical center ("ASC") services in workers' compensation cases.

SCA manages seven ASCs in North Carolina and has an ownership interest in each of these centers through wholly-owned subsidiary corporations (hereinafter "SCA ambulatory surgical centers"). The SCA ambulatory surgical centers are located throughout North Carolina and include Blue Ridge Day Surgery in Raleigh, Charlotte Surgery Center, Fayetteville Ambulatory Surgical Center, Greensboro Specialty Surgery Center, Surgical Center of Greensboro, The Eye Surgery Center of the Carolinas in Southern Pines, and Eastern Regional Surgical Center in Wilson.

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

SCA opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

**THE COMMISSION’S PROPOSED TEMPORARY RULE IS NOT COST EFFECTIVE
AND DOES NOT MEET NORTH CAROLINA STATUTORY REQUIREMENTS**

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

The Proposed Fee Schedule Does Not Cover All ASC Procedures

The Commission’s proposed temporary rule does not set a fee schedule for all procedures that can be performed in ASCs. Instead, for those surgical procedures that are not included in the Medicare ASC fee schedule, the proposed temporary rule states that those procedures are required to be reimbursed “with the maximum amount being the usual, customary and reasonable charge.” Workers’ Compensation Research Institute (“WCRI”) recently reported that “[t]he administration of the usual, customary, and reasonable charges as a basis for reimbursement rates requires substantial resources on the part of the state agencies, both for development of a sufficient and accurate database of charges or fees in the local communities and for timely updates to the database to capture changes in the prevailing charges or reimbursements and in the utilization of new procedures.”¹ Relying upon a usual, customary, and reasonable (“UCR”) methodology will create great uncertainty and a likelihood that there will be numerous disputes that will need to be resolved by the Commission and the courts.

At a public hearing held on November 18, 2016, speakers representing the North Carolina Hospital Association and a group of business and trade associations also commented that the use of UCR to determine the amount that will be paid to ASCs for surgical procedures not covered by the Medicare ASC fee schedule was problematic. Reference was made to the numerous disputes that would arise that would need to be resolved by the Industrial Commission and the substantial resources that would be necessary.

This uncertainty of whether and in what amount ASCs will be reimbursed for surgical procedures not covered by Medicare will create access issues and will result in payers (including self-insured employers) having to pay for these procedures at a higher hospital inpatient charge.

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

¹ WCRI, *Designing Workers’ Compensation Medical Fee Schedules* (2016).

rely on Medicare rates as perfect measures of resources appropriate to treat work-related injuries.”²

Additionally, for Medicare patients nationwide, covered surgical procedures include “surgical procedures . . . for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.”³ For non-Medicare patients in North Carolina, ASCs are permitted to keep patients for up to 24 hours.⁴ This means a non-Medicare patient can stay in the facility overnight, provided they are released within the specified timeframe.⁵ The ability to keep workers’ compensation and commercial patients in an ASC overnight broadens the list of procedures that can be performed safely and effectively in the ASC setting.

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

The Failure to Propose a Fee Schedule Covering All Surgical Procedures Results in Greater Costs to the System

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

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

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

Workers’ compensation patients can be prioritized in an ASC setting and are often seen more quickly than they are in a hospital setting. This, combined with the ASC industry’s low infection rates and high quality of care, allows for a rapid return to work, resulting in savings to

² NCCI, *Effectiveness of Workers Compensation Fee Schedules - A Closer Look* (Feb. 11, 2009).

³ 42 C.F.R. § 416.166(b).

⁴ N.C. Gen. Stat. § 131E-176(1b).

⁵ Federal regulations allow for stays up to 24 hours in ASCs. See 42 C.F.R. § 416.2.

the system for short-term disability expenses beyond the savings proposed under the fee schedule.

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

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

SCA's Proposed Fee Schedule Meets the Requirements of the Workers' Compensation Act

SCA's proposed ASC fee schedule submitted to the Commission on September 26, 2016 would align payments for ambulatory surgical procedures with the Medicare HOPD fee schedule while at the same time acknowledging that Medicare has not created an allowance for certain procedures that are routinely and safely provided to non-Medicare patients in the ASC setting. As such, SCA proposed a rate for these services that is consistent with the resources and time involved in providing such procedures. In order to limit the uncertainty of the system's exposure on reimbursement, charge master increases would be limited to 0% increase for these procedure codes for the first 3 years, or a revenue neutral adjustment will be applied to the percent of charge paid. SCA's proposal will provide the standard of services and care intended by the Workers' Compensation Act, will reimburse ASCs reasonable fees for providing services, and will ensure that medical costs are adequately contained. *See* N.C. Gen. Stat. § 97-26(a).

In contrast to the fee schedule proposed by SCA, which covers all procedures that can be safely performed in ASC, a representative of the North Carolina Hospital Association suggested at the public hearing that those surgical procedures not covered under the Medicare ASC fee schedule be reimbursed at some percentage of the hospital outpatient ("HOPD") Medicare fee schedule. Although this methodology makes sense for those procedures that are on the HOPD Medicare fee schedule and is actually consistent with SCA's prior proposal, the Hospital Association's proposal would not address the procedures not on the Medicare HOPD fee schedule. That is because certain procedures, such as total joint replacements, are increasingly being done in ASCs but are not covered under the HOPD Medicare fee schedule.

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

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

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

Other states are recognizing the importance of addressing the two sites using the same methodology in setting their medical fee schedules. Alaska and Connecticut, two of the most recent states that enacted legislation related to workers' compensation medical fee schedule reforms specific to ambulatory surgical centers, used the HOPD fee schedule. In 2014, the Medical Services Review Committee in Alaska was directed to create a medical fee schedule based on Medicare-based conversion factors. The new schedule became effective December 1, 2015. The Medical Services Review Committee determined that HOPDs and ASCs should be reimbursed as a percent of the Medicare HOPD fee schedule.⁷ Similarly, effective April 1, 2015, the Connecticut Workers' Compensation Commission established a medical fee schedule for ASCs based on the Medicare HOPD fee schedule.⁸

As noted by the Commission, discrepancies in payments between ASCs and HOPDs would "potentially diminish the pool of doctors available to treat injured employees, and reduce the quality and timeliness of care." The Commission further warned: "That impact will likely be most severely realized in our State's more rural areas, where the quality and availability of effective treatment is already a greater concern."⁹ SCA agrees with the Commission that the only way to ensure injured workers access to high-quality, effective care is to create parity between the ASC and HOPD medical fee schedules.

⁷ H.B. 316, Chapter 63 SLA 14 (Alaska 2014).

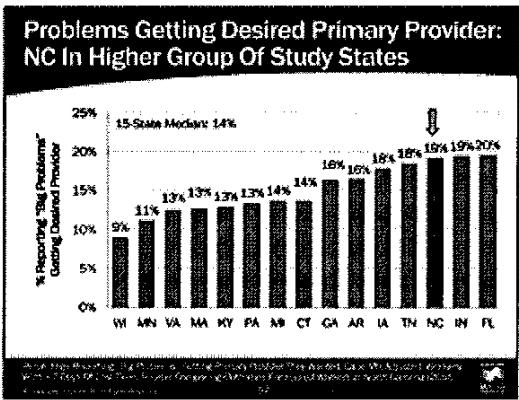
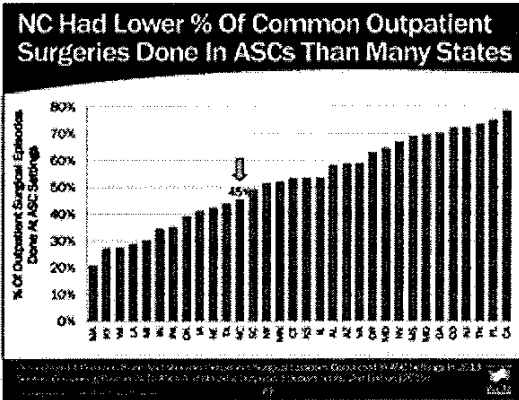
⁸ S.B. 61, Public Act No. 14-167 (Conn. 2014).

⁹ N.C. Indus. Comm'n's Mem. of L. in Support of Mot. to Stay, *Surgical Care Affiliates, LLC v. N.C. Indus. Comm'n*, No. 16-CVS-0060 (Wake Cty. Super. Ct. Aug. 17, 2016).

THE REDUCTION IN RATES TO 200% OF THE MEDICARE ASC FEE SCHEDULE PROPOSED WOULD BE VERY HARMFUL TO THE SYSTEM

Reducing the fee schedule to 200% of ASC Medicare would have an even greater negative affect on workers’ access to surgical care. As noted by NCCI: “The Medicare fee schedule is very useful as a starting point for the design of WC medical fee schedules, but has notable shortcomings for WC, including too little emphasis on return to function and too little sensitivity to cost differences among states.”¹⁰ WCRI noted that “[i]f workers’ compensation fee schedule rates are higher than Medicare, this does not necessarily mean that the workers’ compensation rates are high enough to avoid access-to-care issues for injured workers. The latter limitation arises because providers’ decisions about which patients to see are influenced in part by reimbursement rates from alternative payers. If workers’ compensation pays higher than Medicare but lower than commercial insurers, there still might be legitimate concerns about access.”¹¹

Data collected by WCRI demonstrated that common outpatient surgeries done in North Carolina ASCs was 45% lower than in most states.¹² Additionally, NC injured workers reported that they had “big problems getting the primary provider that they wanted.”¹³ Significantly reducing the payments to ASCs for treating injured workers could exacerbate injured workers’ access to surgical care in ASCs.



In Texas, following drastic cuts in the fee schedule, the number of physicians willing to treat all work-related injuries dramatically declined from 2002 to 2004. Specifically, “[t]hree quarters (77%) of orthopedic surgeons in Texas now limit workers compensation cases, dramatically up from (29%) two years ago. Similar declines in access have occurred for general surgeons and other surgical specialists.”¹⁴

¹⁰ NCCI, *Effectiveness of Workers Compensation Fee Schedules - A Closer Look* (2009).
¹¹ WCRI, *Designing Workers’ Compensation Medical Fee Schedules* (June 2012).
¹² WCRI, *Compscope™ Medical Benchmarks for North Carolina, 17th ed.* (Oct. 2016).
¹³ *Id.*
¹⁴ Texas Medical Association, *Workers’ Compensation Special Report – 2004 Survey of Texas Physicians*.

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

While the impact of the change in the medical fee schedule may not have reached overwhelming proportions, it appears to have affected the treatment of injuries in workers' compensation cases. Health care providers are struggling with a duty to heal, while juggling fiscal responsibilities that will afford them to stay in business to continue to practice medicine. This trend of turning away workers' compensation patients should be given attention before it becomes critical. The medical fee schedule definitely appears to have had a negative impact on an injured employee's access to specialty care and diminished access to more experienced health care providers.¹⁵

Workers' compensation medical cost variation is not solely driven by the medical fee schedule. As noted by the National Academy of Social Insurance:

the tremendous interstate variation in the share of total benefits going to medical care reflects between-state differences in: average weekly wages; the nature and severity of work-related injuries; the quantity and prices of medical services provided to injured workers; and the dollar value of cash benefits (driven by factors such as benefit replacement rates, maximum and minimum weekly benefits, the waiting period, and duration of TTD benefits). If, therefore, changes to the workers' compensation law in a given state reduce the dollar value of cash benefits, but medical benefits are stable, the share of benefits accounted for by medical care increases.¹⁶

Additional factors such as strong employment growth also increase medical benefits since more employed workers will be covered under workers' compensation.

THE INDUSTRIAL COMMISSION DOES NOT HAVE STATUTORY AUTHORITY TO ADOPT A TEMPORARY RULE

In the Commission's notice of its intent to adopt a temporary rule, the Commission states that the reason is the recent court order entered by Wake County Superior Court Judge Paul Ridgeway in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*. However, Judge Ridgeway's decision does not provide a basis for adopting a temporary rule and bypassing the requirements for permanent rulemaking set forth in the Administrative Procedure Act.

¹⁵ Hawaii Legislative Reference Bureau State Capitol, *The Medical Fee Schedule Under the Workers' Compensation Law*.

¹⁶ National Academy of Social Insurance, *Workers' Compensation: Benefits, Coverage, and Costs* (2014).

N.C. Gen. Stat. § 150B-12.1 allows an agency to adopt a temporary rule only under very limited circumstances. A court order can only be the basis for temporary rulemaking if that court order requires the immediate adoption of a rule. That is simply not the case. There is nothing in Judge Ridgeway's decision that requires the adoption of a temporary rule. Instead, in setting aside the invalid ASC fee schedule, Judge Ridgeway's decision clearly states that the fee schedule adopted in 2013 continues to be effective.

CONCLUSION

For the reasons set forth above, SCA opposes the proposed temporary rule. SCA recommends that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Respectfully submitted this 29th day of November 2016.



Kelli Collins, Vice President Operations
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(336) 202-6681 mobile
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November 28, 2016

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

Dear Chairman Allen & Commissioners:

Thank you for the opportunity to present comments in response to the North Carolina Industrial Commission's (Commission) Notice of Temporary Rulemaking for Workers' Compensation Medical Fee Schedule 04 NCAC 10J .0103. Please accept this letter in opposition to the Commission's October 18, 2016 notice of proposed temporary rule to amend 04 NCAC 10J .0103.

Matthews Surgery Center, LLC supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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

Matthews Surgery Center, LLC opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid fee schedule on April 1, 2015.

The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

Under the ASC fee schedule that became effective in 2013, implants are reimbursed at no greater than invoice cost plus 28%. The proposed temporary rule does not separately reimburse for implants. The failure to separately reimburse for implants results in even lower reimbursement to ASCs and creates an unreasonable risk for providing services involving high-cost implants. In contrast, hospitals are able to recover higher implant costs by shifting patients to the higher-cost inpatient setting for those surgical procedures.

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

The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

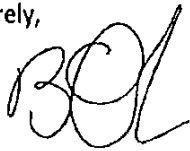
Lastly, the Commission has no basis for promulgating a temporary rule. The Commission states that the reason is the recent court order entered by Wake County Superior Court Judge Paul Ridgeway in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*. Judge Ridgeway's Decision does not require the adoption of a temporary rule and the bypass of the requirements for permanent rulemaking set forth in the Administrative Procedure Act. An agency may adopt a temporary rule only under very limited circumstances. A court order can only be the basis for temporary rulemaking if that court order requires the immediate adoption of a rule. That is simply not the case. There is nothing in Judge Ridgeway's Decision that requires the adoption of a temporary rule. Judge Ridgeway's Decision clearly states that the fee schedule adopted in 2013 continues to be effective.

For the reasons set forth above, Matthews Surgery Center, LLC opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016 proposal, which is

consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,



BENGT COTTEN MD
CEO ORTHOCENTERS OF NORTH CAROLINA

cc: Kendall Bourdon
Meredith Henderson

November 28, 2016

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

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Mallard Creek Surgery Center supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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

Mallard Creek Surgery Center opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid fee schedule on April 1, 2015.

The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

Under the ASC fee schedule that became effective in 2013, implants are reimbursed at no greater than invoice cost plus 28%. The proposed temporary rule does not separately reimburse for implants. The failure to separately reimburse for implants results in even lower reimbursement to ASCs and creates an unreasonable risk for providing services involving high-cost implants. In contrast, hospitals are able to recover higher implant costs by shifting patients to the higher-cost inpatient setting for those surgical procedures.

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

The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

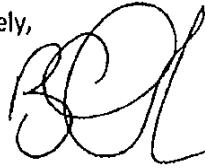
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For the reasons set forth above, Mallard Creek Surgery Center opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016 proposal, which is

consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

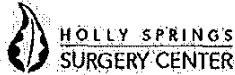
Thank you for your consideration.

Sincerely,



KENDALL BOURDON
CEO OF NORTH CAROLINA

cc: Kendall Bourdon
Meredith Henderson



November 28, 2016

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

Dear Chairman Allen & Commissioners:

Thank you for the opportunity to present comments in response to the North Carolina Industrial Commission's (Commission) Notice of Temporary Rulemaking for Workers' Compensation Medical Fee Schedule 04 NCAC 10J .0103. Please accept this letter in opposition to the Commission's October 18, 2016 notice of proposed temporary rule to amend 04 NCAC 10J .0103.

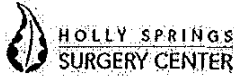
Holly Springs Surgery Center, LLC supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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

Holly Springs Surgery Center, LLC opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid fee schedule on April 1, 2015.



The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

Under the ASC fee schedule that became effective in 2013, implants are reimbursed at no greater than invoice cost plus 28%. The proposed temporary rule does not separately reimburse for implants. The failure to separately reimburse for implants results in even lower reimbursement to ASCs and creates an unreasonable risk for providing services involving high-cost implants. In contrast, hospitals are able to recover higher implant costs by shifting patients to the higher-cost inpatient setting for those surgical procedures.

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

The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

Lastly, the Commission has no basis for promulgating a temporary rule. The Commission states that the reason is the recent court order entered by Wake County Superior Court Judge Paul Ridgeway in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*. Judge Ridgeway's Decision does not require the adoption of a temporary rule and the bypass of the requirements for permanent rulemaking set forth in the Administrative Procedure Act. An agency may adopt a temporary rule only under very limited circumstances. A court order can only be the basis for temporary rulemaking if that court order requires the immediate adoption of a rule. That is simply not the case. There is nothing in Judge Ridgeway's Decision that requires the adoption of a temporary rule. Judge Ridgeway's Decision clearly states that the fee schedule adopted in 2013 continues to be effective.

For the reasons set forth above, Holly Springs Surgery Center, LLC opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016 proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be



performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "D. Orskey", is written over the typed name.

David Orskey
Administrator

cc: Kendall Bourdon
Meredith Henderson

BLUE RIDGE SURGERY CENTER

an affiliate of **SCA**

November 28, 2016

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

Dear Chairman Allen & Commissioners:

Thank you for the opportunity to present comments in response to the North Carolina Industrial Commission's (Commission) Notice of Temporary Rulemaking for Workers' Compensation Medical Fee Schedule 04 NCAC 10J .0103. Please accept this letter in opposition to the Commission's October 18, 2016 notice of proposed temporary rule to amend 04 NCAC 10J .0103.

Blue Ridge Surgery Center supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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

Blue Ridge Surgery Center opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid fee schedule on April 1, 2015.

BLUE RIDGE SURGERY CENTER

an affiliate of **SCA**

The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

Under the ASC fee schedule that became effective in 2013, implants are reimbursed at no greater than invoice cost plus 28%. The proposed temporary rule does not separately reimburse for implants. The failure to separately reimburse for implants results in even lower reimbursement to ASCs and creates an unreasonable risk for providing services involving high-cost implants. In contrast, hospitals are able to recover higher implant costs by shifting patients to the higher-cost inpatient setting for those surgical procedures.

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

The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

Lastly, the Commission has no basis for promulgating a temporary rule. The Commission states that the reason is the recent court order entered by Wake County Superior Court Judge Paul Ridgeway in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*. Judge Ridgeway's Decision does not require the adoption of a temporary rule and the bypass of the requirements for permanent rulemaking set forth in the Administrative Procedure Act. An agency may adopt a temporary rule only under very limited circumstances. A court order can only be the basis for temporary rulemaking if that court order requires the immediate adoption of a rule. That is simply not the case. There is nothing in Judge Ridgeway's Decision that requires the adoption of a temporary rule. Judge Ridgeway's Decision clearly states that the fee schedule adopted in 2013 continues to be effective.

BLUE RIDGE SURGERY CENTER
an affiliate of **SCA**

For the reasons set forth above, Blue Ridge Surgery Center opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the

proposed fee schedule recommendation in SCA's September 26, 2016 proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,

Mae Smith, RN

cc: Kendall Bourdon
Meredith Henderson

November 28, 2016

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

Dear Chairman Allen & Commissioners:

Thank you for the opportunity to present comments in response to the North Carolina Industrial Commission's (Commission) Notice of Temporary Rulemaking for Workers' Compensation Medical Fee Schedule 04 NCAC 10J .0103. Please accept this letter in opposition to the Commission's October 18, 2016 notice of proposed temporary rule to amend 04 NCAC 10J .0103.

Surgery Partners, Inc., which operates Wilmington SurgCare in Wilmington, North Carolina and Orthopaedic Surgery Center of Asheville in Asheville, North Carolina, supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ASCs.

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

Surgery Partners, Inc. opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid fee schedule on April 1, 2015.

The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

Under the ASC fee schedule that became effective in 2013, implants are reimbursed at no greater than invoice cost plus 28%. The proposed temporary rule does not separately reimburse for implants. The failure to separately reimburse for implants results in even lower reimbursement to ASCs and creates an unreasonable risk for providing services involving high-cost implants. In contrast, hospitals are able to recover higher implant costs by shifting patients to the higher-cost inpatient setting for those surgical procedures.

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

The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

Lastly, the Commission has no basis for promulgating a temporary rule. The Commission states that the reason is the recent court order entered by Wake County Superior Court Judge Paul Ridgeway in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*. Judge Ridgeway's Decision does not require the adoption of a temporary rule and the bypass of the requirements for permanent rulemaking set forth in the Administrative Procedure Act. An agency may adopt a temporary rule only under very limited circumstances. A court order can only be the basis for temporary rulemaking if that court order requires the immediate adoption of a rule. That is simply not the case. There is nothing in Judge Ridgeway's Decision that requires the adoption of a temporary rule. Judge Ridgeway's Decision clearly states that the fee schedule adopted in 2013 continues to be effective.

For the reasons set forth above, Surgery Partners, Inc. opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016 proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "Linda Simmons". The signature is fluid and cursive, with a large loop at the beginning and a long tail that curves back towards the end.

Linda Simmons
Regional Vice President
Surgery Partners, Inc.
331 Springwater Chase
Newnan, GA 30265
lsimmons@surgerypartners.com

cc: Kendall Bourdon
Meredith Henderson



Creating High Value Partnerships

November 28, 2016

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

Dear Chairman Allen & Commissioners:

Thank you for the opportunity to present comments in response to the North Carolina Industrial Commission's (Commission) Notice of Temporary Rulemaking for Workers' Compensation Medical Fee Schedule 04 NCAC 10J .0103. Please accept this letter in opposition to the Commission's October 18, 2016 notice of proposed temporary rule to amend 04 NCAC 10J .0103.

Compass Surgical Partners, LLC supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared Invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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

Compass Surgical Partners, LLC opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid fee schedule on April 1, 2015.



The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

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

The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

Lastly, the Commission has no basis for promulgating a temporary rule. The Commission states that the reason is the recent court order entered by Wake County Superior Court Judge Paul Ridgeway in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*. Judge Ridgeway's Decision does not require the adoption of a temporary rule and the bypass of the requirements for permanent rulemaking set forth in the Administrative Procedure Act. An agency may adopt a temporary rule only under very limited circumstances. A court order can only be the basis for temporary rulemaking if that court order requires the immediate adoption of a rule. That is simply not the case. There is nothing in Judge Ridgeway's Decision that requires the adoption of a temporary rule. Judge Ridgeway's Decision clearly states that the fee schedule adopted in 2013 continues to be effective.



For the reasons set forth above, Compass Surgical Partners, LLC opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016 proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read "D.S. Hill", written over a light blue horizontal line.

DJ Hill
Co-Founder & Chief Executive Officer

cc: Kendall Bourdon
Meredith Henderson



November 28, 2016

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

Dear Chairman Allen & Commissioners:

Thank you for the opportunity to present comments in response to the North Carolina Industrial Commission's (Commission) Notice of Temporary Rulemaking for Workers' Compensation Medical Fee Schedule 04 NCAC 10J .0103. Please accept this letter in opposition to the Commission's October 18, 2016 notice of proposed temporary rule to amend 04 NCAC 10J .0103.

Capital City Surgery Center, LLC supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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

Capital City Surgery Center, LLC opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing

23 Sunnybrook Road
Raleigh, NC 27610
capitalcitysurgery.com



these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid fee schedule on April 1, 2015.

The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

Under the ASC fee schedule that became effective in 2013, implants are reimbursed at no greater than invoice cost plus 28%. The proposed temporary rule does not separately reimburse for implants. The failure to separately reimburse for implants results in even lower reimbursement to ASCs and creates an unreasonable risk for providing services involving high-cost implants. In contrast, hospitals are able to recover higher implant costs by shifting patients to the higher-cost inpatient setting for those surgical procedures.

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

The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

Lastly, the Commission has no basis for promulgating a temporary rule. The Commission states that the reason is the recent court order entered by Wake County Superior Court Judge Paul Ridgeway in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*. Judge Ridgeway's Decision does not require the adoption of a temporary rule and the bypass of the requirements for permanent rulemaking set forth in the Administrative Procedure

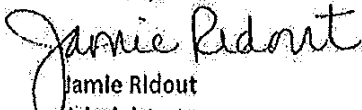


Act. An agency may adopt a temporary rule only under very limited circumstances. A court order can only be the basis for temporary rulemaking if that court order requires the immediate adoption of a rule. That is simply not the case. There is nothing in Judge Ridgeway's Decision that requires the adoption of a temporary rule. Judge Ridgeway's Decision clearly states that the fee schedule adopted in 2013 continues to be effective.

For the reasons set forth above, Capital City Surgery Center, LLC opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016 proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,


Jamie Ridout
Administrator

cc: Kendall Bourdon
Meredith Henderson

FAYETTEVILLE AMBULATORY SURGERY CENTER
an affiliate of **SCA**

November 28, 2016

North Carolina Industrial Commission
430 N. Sallsbury Street
Raleigh, NC 27603

Dear Chairman Allen & Commissioners:

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Fayetteville Ambulatory Surgery Center supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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

Fayetteville Ambulatory Surgery Center opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid fee schedule on April 1, 2015.

FAYETTEVILLE AMBULATORY SURGERY CENTER
an affiliate of **SCA**

The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

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The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

Lastly, the Commission has no basis for promulgating a temporary rule. The Commission states that the reason is the recent court order entered by Wake County Superior Court Judge Paul Ridgeway in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*. Judge Ridgeway's Decision does not require the adoption of a temporary rule and the bypass of the requirements for permanent rulemaking set forth in the Administrative Procedure Act. An agency may adopt a temporary rule only under very limited circumstances. A court order can only be the basis for temporary rulemaking if that court order requires the immediate adoption of a rule. That is simply not the case. There is nothing in Judge Ridgeway's Decision that requires the adoption of a temporary rule. Judge Ridgeway's Decision clearly states that the fee schedule adopted in 2013 continues to be effective.

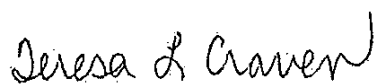
For the reasons set forth above, Fayetteville Ambulatory Surgery Center opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016

FAYETTEVILLE AMBULATORY SURGERY CENTER
an affiliate of **SCA**

proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,



Teresa L. Craven, RN
Administrator
Fayetteville Ambulatory Surgery Center

cc: Kendall Bourdon
Meredith Henderson

November 28, 2016

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

Dear Chairman Allen & Commissioners:

Thank you for the opportunity to present comments in response to the North Carolina Industrial Commission's (Commission) Notice of Temporary Rulemaking for Workers' Compensation Medical Fee Schedule 04 NCAC 10J .0103. Please accept this letter in opposition to the Commission's October 18, 2016 notice of proposed temporary rule to amend 04 NCAC 10J .0103.

The Eye Surgery Center of the Carolinas supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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

The Eye Surgery Center of the Carolinas opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid fee schedule on April 1, 2015.

The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

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The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

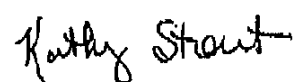
Lastly, the Commission has no basis for promulgating a temporary rule. The Commission states that the reason is the recent court order entered by Wake County Superior Court Judge Paul Ridgeway in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*. Judge Ridgeway's Decision does not require the adoption of a temporary rule and the bypass of the requirements for permanent rulemaking set forth in the Administrative Procedure Act. An agency may adopt a temporary rule only under very limited circumstances. A court order can only be the basis for temporary rulemaking if that court order requires the immediate adoption of a rule. That is simply not the case. There is nothing in Judge Ridgeway's Decision that requires the adoption of a temporary rule. Judge Ridgeway's Decision clearly states that the fee schedule adopted in 2013 continues to be effective.

For the reasons set forth above, The Eye Surgery Center of the Carolinas opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016

proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,

A handwritten signature in black ink that reads "Kathy Stout". The signature is written in a cursive, slightly slanted style.

Kathy Stout RN, Administrator
The Eye Surgery Center of the Carolinas

cc: Kendall Bourdon
Meredith Henderson

GREENSBORO SPECIALTY SURGICAL CENTER
an affiliate of **SCA**

November 28, 2016

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

Dear Chairman Allen & Commissioners:

Thank you for the opportunity to present comments in response to the North Carolina Industrial Commission's (Commission) Notice of Temporary Rulemaking for Workers' Compensation Medical Fee Schedule 04 NCAC 10J .0103. Please accept this letter in opposition to the Commission's October 18, 2016 notice of proposed temporary rule to amend 04 NCAC 10J .0103.

Greensboro Specialty Surgical Centers supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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

Greensboro Specialty Surgical Center opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing

GREENSBORO SPECIALTY SURGICAL CENTER
an affiliate of **SCA**

these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid fee schedule on April 1, 2015.

The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

Under the ASC fee schedule that became effective in 2013, implants are reimbursed at no greater than invoice cost plus 28%. The proposed temporary rule does not separately reimburse for implants. The failure to separately reimburse for implants results in even lower reimbursement to ASCs and creates an unreasonable risk for providing services involving high-cost implants. In contrast, hospitals are able to recover higher implant costs by shifting patients to the higher-cost inpatient setting for those surgical procedures.

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

The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

Lastly, the Commission has no basis for promulgating a temporary rule. The Commission states that the reason is the recent court order entered by Wake County Superior Court Judge Paul Ridgeway in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*. Judge Ridgeway's Decision does not require the adoption of a temporary rule and the bypass of the requirements for permanent rulemaking set forth in the Administrative Procedure Act. An agency may adopt a temporary rule only under very limited circumstances. A court order can only be the basis for temporary rulemaking if that court order requires the immediate adoption of a rule. That is simply not the case. There is nothing in Judge

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Ridgeway's Decision that requires the adoption of a temporary rule. Judge Ridgeway's Decision clearly states that the fee schedule adopted in 2013 continues to be effective.

For the reasons set forth above, Greensboro Specialty Surgical Center opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016 proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,

A handwritten signature in cursive script that reads "Deeie Murray". The signature is written in black ink and is positioned above the typed name and contact information.

cc: Kendall Bourdon
Meredith Henderson

SURGICAL CENTER OF GREENSBORO
an affiliate of **SCA**

November 28, 2016

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

Dear Chairman Allen & Commissioners:

Thank you for the opportunity to present comments in response to the North Carolina Industrial Commission's (Commission) Notice of Temporary Rulemaking for Workers' Compensation Medical Fee Schedule 04 NCAC 10J .0103. Please accept this letter in opposition to the Commission's October 18, 2016 notice of proposed temporary rule to amend 04 NCAC 10J .0103.

Surgical Center of Greensboro / Orthopaedic Surgical Center supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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

Surgical Center of Greensboro / Orthopaedic Surgical Center opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
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SURGICAL CENTER OF GREENSBORO

Affiliate of SCA

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The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

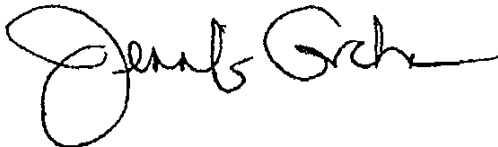
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SURGICAL CENTER OF GREENSBORO
an affiliate of SCA

For the reasons set forth above, Surgical Center of Greensboro / Orthopaedic Surgical Center opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016 proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,



Jennifer Graham
RNFA, CASC, CNOR | Administrator
Surgical Center of Greensboro / Orthopaedic Surgical Center |
www.surgicalcenterofgreensboro.com
1211 Virginia Street / 1101 Carolina Street Greensboro NC 27401

cc: Kendall Bourdon
Meredith Henderson



**EASTERN REGIONAL
SURGICAL CENTER** 

November 28, 2016

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

Dear Chairman Allen & Commissioners:

Thank you for the opportunity to present comments in response to the North Carolina Industrial Commission's (Commission) Notice of Temporary Rulemaking for Workers' Compensation Medical Fee Schedule 04 NCAC 10J .0103. Please accept this letter in opposition to the Commission's October 18, 2016 notice of proposed temporary rule to amend 04 NCAC 10J .0103.

Eastern Regional Surgical Center supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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

Eastern Regional Surgical Center opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid fee schedule on April 1, 2015.

The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for Injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring Injured workers are provided the services and standard of care required by the Workers' Compensation Act.

Under the ASC fee schedule that became effective in 2013, implants are reimbursed at no greater than invoice cost plus 28%. The proposed temporary rule does not separately reimburse for implants. The failure to separately reimburse for implants results in even lower reimbursement to ASCs and creates an unreasonable risk for providing services involving high-cost implants. In contrast, hospitals are able to recover higher Implant costs by shifting patients to the higher-cost inpatient setting for those surgical procedures.

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

The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

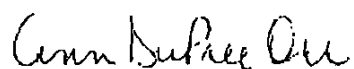
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For the reasons set forth above, Eastern Regional Surgical Center opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016 proposal, which is

consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,

A handwritten signature in cursive script that reads "Ann DuPree Orr".

Ann DuPree Orr RN BSN CNOR
Administrator

cc: Kendall Bourdon
Meredith Henderson

CHARLOTTE SURGERY CENTER

an affiliate of **SCA**

November 28, 2016

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

Dear Chairman Allen & Commissioners:

Thank you for the opportunity to present comments in response to the North Carolina Industrial Commission's (Commission) Notice of Temporary Rulemaking for Workers' Compensation Medical Fee Schedule 04 NCAC 10J .0103. Please accept this letter in opposition to the Commission's October 18, 2016 notice of proposed temporary rule to amend 04 NCAC 10J .0103.

The Charlotte Surgery Center supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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

The Charlotte Surgery Center opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid fee schedule on April 1, 2015.

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The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

Under the ASC fee schedule that became effective in 2013, implants are reimbursed at no greater than invoice cost plus 28%. The proposed temporary rule does not separately reimburse for implants. The failure to separately reimburse for implants results in even lower reimbursement to ASCs and creates an unreasonable risk for providing services involving high-cost implants. In contrast, hospitals are able to recover higher implant costs by shifting patients to the higher-cost inpatient setting for those surgical procedures.

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

The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

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an affiliate of **SCA**

For the reasons set forth above, The Charlotte Surgery Center opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016 proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,



Thomas J. Lally, CEO
Administrator

cc: Kendall Bourdon
Meredith Henderson

CARY ORTHOPAEDICS



& spine specialists

www.caryortho.com

Douglas L. Gollehon, M.D.

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Douglas J. Martini, M.D.

William K. Andersen, M.D.

Derek L. Reinke, M.D.

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Gary L. Smoot, M.D.

Christopher Lin, M.D.

Nicole P. Bullock, M.D.

Paul G. Singh, M.D.

Nael Shanti, M.D.

November 28, 2016

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

Dear Chairman Allen & Commissioners:

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Cary Orthopaedics supports the proposal submitted by Surgical Care Affiliates, LLC ("SCA") on September 26, 2016 to amend the previously declared invalid Rule 04 NCAC 10J .0103 specific to the fee schedule under North Carolina's Workers' Compensation Act for services provided by ambulatory surgical centers (ASCs).

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Cary Orthopaedics opposes the Commission's Proposed Temporary Rule for the following reasons:

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fee schedule on April 1, 2015.

The proposed temporary rule reduces the fee schedule to 200% of ASC Medicare and excludes procedures that are otherwise performed at ASCs. This has restricted and will continue to restrict access for injured workers to receive surgical care in ASCs operating in North Carolina. Limiting access to ASCs violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

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For the reasons set forth above, Cary Orthopaedics opposes the proposed temporary rule. We recommend that the Commission initiate permanent rulemaking with the proposed fee schedule recommendation in SCA's September 26, 2016 proposal, which is consistent with North Carolina statutory requirements, accounts for all procedures that can be performed in ASCs, and results in substantial savings to the Workers' Compensation system in North Carolina.

Thank you for your consideration.

Sincerely,



Kendall Bourdon
admin Director

cc: Kendall Bourdon
Meredith Henderson

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November 28, 2016

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

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Sincerely,

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November 28, 2016

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

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Cary Orthopaedics opposes the Commission's Proposed Temporary Rule for the following reasons:

- The temporary rule is not cost effective and does not meet North Carolina statutory requirements.
- The reduction in rates to 200% of Medicare ASC fee schedule would be very harmful to the workers' compensation system.
- There is no statutory authority for adopting a temporary rule.

North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act and that providers are reimbursed reasonable fees for providing these services. The Commission's proposed rule does not address all procedures that were being conducted in ambulatory surgery centers prior to the implementation of the invalid

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Under the ASC fee schedule that became effective in 2013, implants are reimbursed at no greater than invoice cost plus 28%. The proposed temporary rule does not separately reimburse for implants. The failure to separately reimburse for implants results in even lower reimbursement to ASCs and creates an unreasonable risk for providing services involving high-cost implants. In contrast, hospitals are able to recover higher implant costs by shifting patients to the higher-cost inpatient setting for those surgical procedures.

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

The proposed rule's reliance on a usual, customary, and reasonable ("UCR") methodology for addressing these types of procedures does not address the gap that the Medicare ASC fee schedule creates. All of the stakeholders who presented at the November 18, 2016 public hearing agreed that the UCR methodology would create more uncertainty to the system and increase the number of fee disputes that would have to be resolved by the Commission.

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