

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.