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
APPEARANCES

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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PROCEEDINGS

CHAIRMAN ALLEN: Okay. Good afternoon. We are on the record. Today is July 19, 2017. I am Charlton Allen. I’m Chairman at the North Carolina Industrial Commission. In compliance with the requirements of Chapter 138A-15(e) of the North Carolina State Government Ethics Act, I remind all members of the Commission of their duty to avoid conflicts of interest under Chapter 138A. I also inquire as to whether there is any known conflict of interest to the matter coming before the Commission at this time. Hearing none, we will proceed. This is a North Carolina Industrial Commission public hearing on proposed rulemaking. The purpose of this hearing is to receive comments from the public regarding the amendments to 04 NCAC 10J .0103 proposed for permanent rulemaking by the Commission and published in the North Carolina Register on June 15, 2017. We have received only one written comment from the public thus far, but the record will be held open to receive written comments from the public through the close of business on August 14, 2017. At this time, I would like to introduce the other Commissioners. To my right is Vice-Chairman Yolanda Stith, Commissioner Tammy Nance and Commissioner Philip Baddour, and to my
left, Commissioner Linda Cheatham and Commissioner Christopher Loutit. Anyone who wishes to speak at this hearing must sign-up to do so with Kendall Bourdon so that we have the correct spelling of your name and can call you in order to speak. If anybody would like to speak and has not yet signed up, please do so now. Once we resume the speaking part of the program, the first speaker will be Kendall Bourdon, the rulemaking coordinator, followed by members of the public in the order that they signed up. Ms. Bourdon, would you please raise your hand so people know who to sign-up with? All right. We will stand at ease for a couple of minutes if anyone wishes to add their name to the list of folks to sign-up. Seeing none, we will proceed.

KENDALL BOURDON

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

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

CHAIRMAN ALLEN: And do you have prepared exhibits that you would like to place into the record at these proceedings?
MS. BOURDON: Yes. I have Exhibit 1, which is a copy of the proposed rule as published in the North Carolina Register on June 15, 2017. Next, I have Exhibit 2, which is a copy of the Fiscal Note analyzing the regulatory impact of this proposed rule, as marked Exhibit 2. I also submit Exhibit 3 as so marked, which is a copy of the temporary rule as approved by the Rules Review Commission and published in the North Carolina Register on January 17, 2017. Additionally, I have Exhibit 4, which is the complete transcript of the Industrial Commission’s public hearing held on November 18, 2016, including the complete record of the public comment meeting voluntarily held by the Commission on October 3rd, 2016, marked Exhibit 4. Finally, I would like to submit Exhibit 5, which is the collection of written public comments received between October 18th, 2016 through November 29, 2016.

CHAIRMAN ALLEN: Okay. We’ll receive those exhibits.

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

CHAIRMAN ALLEN: Would you briefly give us some background and list the rule that would be affected by
the proposed rule change?

MS. BOURDON: Yes. We have one rule for amendment. This rule is found in Title 04 of the Administrative Code, Subchapter 10J. We propose to amend Rule .0103, which is titled “Fees for Institutional Services.” The proposed effective date is October 1, 2017. It is submitted to you as Exhibit 1. 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 1st, 2015, that relate to fees for ambulatory surgical centers, specifically paragraphs (g) and (h) and the reference to 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 2nd, 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 - see Exhibit 2 - which has been approved by OSVM and seeks to amend the ambulatory surgical center fee provisions of Rule 04 NCAC 10J .0103. Pending the outcome of 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 two hundred percent in keeping with the rate for 2017 and beyond and the rule as adopted on April 1st, 2015. The fee schedule reimbursement rate for additional procedures provided by an ambulatory surgical center that are covered by the Medicare Hospital Outpatient Prospective Payment System will be one hundred and thirty-five percent. 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 and 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 statutory bases for these changes are the North Carolina – are North Carolina General Statutes 97-25, 97-26, 97-80 and Session Law 2013-410. The effects of the August 9, 2016 Decision in Surgical Care Affiliates, LLC, versus North Carolina Industrial Commission led the Commission to
engage in temporary rulemaking to put a rule in place as soon as possible; thus, limiting the period of time, subject to a potential retroactive invalidation of the ambulatory surgery center fee schedule provisions, in providing certainty regarding medical costs for 2017 and beyond. The temporary rule is submitted to you as Exhibit 3. Prior to proposing the temporary rule, the Industrial Commission voluntarily held a non-mandatory public comment meeting on October 3rd, 2016, and accepted written comments from September 2nd, 2016 through October 10th, 2016, in order to allow any person or entity the opportunity to present comments and proposals regarding potential rulemaking options to address the effects of the August 9, 2016 Court Decision. The Commission then proposed a temporary rule and, in accordance with the temporary rulemaking procedures of North Carolina General Statute 150B, held a public hearing on November 11th, 2016; the record of which is submitted to you as Exhibit 4. Additionally, the Commission accepted written comments from October 18, 2016 through November 29th, 2016, submitted herein as Exhibit 5. Although the temporary rule is also the subject of ongoing litigation currently pending at this time, the Commission is now engaged in permanent rulemaking as a
follow-up to the temporary rule. Therefore, the permanent rule is proposed to be effective at the time the temporary rule would have expired. The Commission has followed the permanent rulemaking procedures of the Administrative Procedure Act in proposing these rules. The relevant dates involved include the following: The proposed rule amendment was filed with a Notice of Text to the Office of Administrative Hearings on May 24th, 2017; they were then published in the June 15, 2017 issue of the North Carolina Register. And on the same date – June 15th – the Commission published a notice of these rules and a link to the Fiscal Note on the Commission’s website, as required, and also emailed notice with a link to this proposed rule and Fiscal Note to the Industrial Commission’s Listserv. The Listserv is an interested person’s Listserv that we are required to maintain for rulemaking purposes. Copies of the rule and Fiscal Note were also provided to the North Carolina League of Municipalities and the North Carolina Association of County Commissioners, as required by statute.

CHAIRMAN ALLEN: Okay. Ms. Bourdon, the rule in question is found in Title 04, but it is subject to be transferred to Title 11 due to the Commission’s transfer to the Department of Insurance, together with
all other Industrial Commission rules, at some date to be determined. Is that correct?

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

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

(SPEAKER DISMISSED)

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

DAVID WILLIAM ORSKEY

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

MR. ORSKEY: David William Orskey and I represent
CHAIRMAN ALLEN: Okay. And you wish to speak in regards to the rule that’s up for possible amendment, is that correct, sir?

MR. ORSKY: Yes, sir.

CHAIRMAN ALLEN: Okay. All right. We’ll be happy to hear from you.

MR. ORSKY: Okay. Good afternoon, Commissioners. My name is David Orskey, and I’m here today representing the North Carolina Ambulatory Surgical Center Association and its members. I’m also employed by Compass Surgical Partners as administrator of Holly Springs Surgery Center located in Holly Springs, North Carolina. Compass Surgical Partners operates ambulatory surgery centers, or ASCs, throughout North Carolina. Compass is also a founding member of the North Carolina Ambulatory Surgical Association. Ambulatory surgery centers, or ASCs, add green value to North Carolina’s delivery system. ASCs can perform the same types of surgical procedures that are provided in hospital outpatient departments and some procedures that are currently being provided to patients within hospitals. The Association was founded in 2016. Since its inception, the Association
has taken a very active role in commenting upon, even challenging certain actions that have been taken by the Commission’s connection with the ASC fee schedule for workers’ compensation cases. The Association is one of the plaintiffs in the legal action filed earlier this year that resulted in the Wake County Superior Court declaring the Commission’s temporary rule invalid. When the temporary rule was being considered by the Commission, the Association voiced its serious concerns directly and through its members. Unfortunately, the proposed permanent rule is identical to the temporary rule. The Association and its members are united in the desire to have the Commission adopt a reasonable, comprehensive fee schedule for ambulatory surgical centers that would provide adequate reimbursement in workers’ compensation cases. This will result in better containing medical costs because ambulatory surgery centers are the most cost efficient – effective in an efficient setting for many of the surgical procedures needed by injured workers. The lack of adequate reimbursement results in less access for injured workers. In 2015, which was the first year ambulatory surgical fee schedule was slashed by sixty percent, there was a significant decline in the percentage of
surgeries for injured workers and that were performed in ambulatory surgery centers. This resulted in these injured workers receiving their surgeries at a higher cost within a hospital setting. The fee schedule adopted by the Commission should provide sufficient reimbursement to ambulatory surgical centers so that access to the most cost-effective setting is encouraged. The fee schedule should also cover all procedures that can be performed within an ambulatory surgery center. This will also increase access. Unfortunately, the fee schedule being proposed by the Commission does not accomplish either of these goals; instead, the Commission is basing the workers’ compensation fee schedule on the Medicare fee schedule. There are significant differences between Medicare patient population and workers’ compensation population. The Medicare permits surgical procedures in ASCs only when discharge would be appropriate before the midnight following the procedure. For non-Medicare patients in North Carolina, ASCs are permitted to keep patients for up to twenty-four hours. This means a non-Medicare patient can stay in the facility overnight provided they are released within a specific timeframe. The ability to keep workers’ compensation and commercial
patients in an ASC overnight broadens the list of procedures that can be performed safely and effective in an ambulatory surgery center. The Commission’s proposed rule ignores all these factors and instead treats injured workers like Medicare patients. As a result, injured workers will be denied access to ambulatory surgery centers, causing delays in services and higher inpatient costs and co-pays for certain procedures. The Association also has serious objections to the approach taken and the assumption made by the Fiscal Note. The Commission has not actually analyzed the change for the – to the fee schedule that is being proposed. The Fiscal Note does not take into account the major reduction in – the reduction being proposed to ASCs from the valid fee schedule; instead, it is using the April 2015 fee schedule, which is – which a Superior Court has already invalidated. The Fiscal Note also does not address the dynamic effects that such reduction will have, and already has had, on injured workers and the cost to the system. The Commission’s proposed permanent rule is nearly identical to the prior permanent rule and identical to a temporary rule; both of which were invalidated by the courts. Although the courts did not have the opportunity to review the
substance of the rules, these prior failed — on rulemaking efforts gave the Commission the opportunity to reconsider its approach to ASC fee schedule and construct a fee schedule that took into account stakeholders’ feedback and that accomplished the statutory requirements. With this proposed permanent rule, the Commission has squandered these opportunities. Through this permanent rulemaking process, the Commission has the opportunity to adopt a fee schedule that actually gives access to injured workers and saves the system money. To do so, the Association — the Association recommends that the Commission adopt a rule consistent with the proposal made by one of the Association’s members last fall — Surgical Care Associates [sic]. The Commission should also conduct a proper fiscal analysis. Thank you for your time.

CHAIRMAN ALLEN: Do the Commissioners have any questions?

VICE-CHAIRMAN STITH: No.

CHAIRMAN ALLEN: Mr. Orskey, I have a few questions. You indicated that the Commission’s proposed rule treats injured workers like Medicare patients. Help me to understand your logic in that considering the proposed rule in large measure has a
reimbursement rate that’s two hundred percent of the Medicare rate.

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

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

MR. ORSKEY: I’d like to refer that to our legal team.

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

COMMISSIONER CHEATHAM: I have one.

CHAIRMAN ALLEN: Commissioner Cheatham, you’re recognized.

COMMISSIONER CHEATHAM: Okay. Just to tag off, I guess, one of yours, can you give me an example? I mean you referenced in response to Chair Allen’s question about - you know, your comment that this
treats injured workers like Medicare patients. Can you give me an example of some type of surgery that you – or procedure that you think would be applicable to that?

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

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

MR. ORSKEY: That’s just – that’s just an example of some of the expenses that---

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

MR. ORSKEY: That’s all right.

COMMISSIONER CHEATHAM: I lost my train of thought
here. And you go to an ASC, and you’re reimbursed two hundred percent of the Medicare rate. If a Medicare recipient goes to an ASC and has the same procedure done, they would be reimbursed at a hundred percent, correct?

MR. ORSKEY: That’s true, but at---

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

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

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

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

VICE-CHAIRMAN STITH: Mr.---
CHAIRMAN ALLEN: Mr. Orskey.

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

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

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

MR. ORSKEY: No.

COMMISSIONER CHEATHAM: No?

MR. ORSKEY: No, it just depends on what the---
COMMISSIONER CHEATHAM: You say, come on in and---
MR. ORSKEY: It depends on---
COMMISSIONER CHEATHAM: ---we’ll take less?
MR. ORSKEY: ---the – it depends on what the fee
rate is for that payer.
COMMISSIONER CHEATHAM: Okay. Let’s suppose you
need an implant and you can’t make any money on it.
Do you send them someplace else?
VICE-CHAIRMAN STITH: Yeah.
MR. ORSKEY: If we’re - I don’t send them anywhere
else. It just depends on if it’s - you know, often,
we will do the case for a breakeven because the
patient usually - the patient is there and we can do
the case, but that’s not, you know---
COMMISSIONER CHEATHAM: So do you charge the
patient more to make up for---?
MR. ORSKEY: No, we don’t. We don’t.
COMMISSIONER CHEATHAM: No?
MR. ORSKEY: No.
COMMISSIONER CHEATHAM: So if it’s a - if you’re
not making money, you’re losing money on the case---
MR. ORSKEY: Uh-huh.
COMMISSIONER CHEATHAM: ---you still perform it?
MR. ORSKEY: Depends – it depends on the - you
know, we don’t want – we’re not in the business to
lose money---

COMMISSIONER CHEATHAM: Right. I understand.

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

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

MR. ORSKEY: Yes, sir, they do.

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

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

COMMISSIONER BADDOUR: I just have---

CHAIRMAN ALLEN: Commissioner Baddour.

COMMISSIONER BADDOUR: ---one follow-up on what
you’ve been asked. Do you have any stats on the number of Medicare or Medicaid cases that you turn away because you think you’re going to lose on them because the reimbursement is not enough for the particular procedure?

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

The---

COMMISSIONER BADDOUR: Would anyone have the stats on that?

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

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

MR. ORSKEY: I do not, sir.

COMMISSIONER BADDOUR: ---someone have stats?

MR. ORSKEY: I do not personally, sir.

COMMISSIONER BADDOUR: All right.

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

MR. ORSKEY: Yes, sir.

CHAIRMAN ALLEN: ---please submit it to us. We’ve down this road before, and, quite frankly, the data
that has been presented has been scant. It would be very helpful for us to understand your position to have some documentation to back it up.

MR. ORSKEY: Yes, sir.

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

MR. ORSKEY: Thank you.

CHAIRMAN ALLEN: ---Mr. Orskey.

MR. ORSKEY: Yeah.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: Next will be Kelli Collins.

Ms. Collins, please approach.

KELLI COLLINS

MS. COLLINS: Good afternoon.

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

MS. COLLINS: Chairman Allen, and Commissioners - I’m sorry.

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

MS. COLLINS: That’s correct.

CHAIRMAN ALLEN: Okay.
MS. COLLINS: My name is Kelli Collins, and I’m a regional vice-president of operations for Surgical Care Affiliates, and I’m here representing that organization today and the seven ambulatory surgery centers that we have in the state. We offer convenient access to high-quality, cost-effective surgical care, and we have several representatives from our facilities here with us today. SCA opposes the proposed permanent rule for the four following reasons: The proposed rule is not cost-effective and does not meet statutory requirements; the proposed rule fails to take into account the significant feedback that has been provided by stakeholders; the Fiscal Note fails to consider the dynamic impacts of reducing reimbursement for procedures in ambulatory surgery centers and shifting costs to more cost-expensive settings; the proposed rule would hurt injured workers by denying or delaying access to more cost-effective services. Before discussing the reasons in more detail, I want to provide a summary of the Commission’s prior versions of the ASC fee schedule and the legal actions and developments that have occurred to date. Historically, the Commission has established separate fee schedules for physicians, hospitals, ambulatory surgery centers and other
healthcare providers. Payments to ambulatory surgery centers represent less than six percent of workers' compensation medical payments. In 2013, the General Assembly enacted a provision authorizing the Commission to base the fee schedules for physicians and hospitals on the Medicare methodology and permitted the Commission to bypass the usual requirement of obtaining a Fiscal Note to analyze the financial impact of these changes. The Commission tasked a group of stakeholders to develop and recommend the fee schedules. ASCs were not included in that process. In 2015, the Commission adopted rules that changed the fee schedules for physicians and hospitals, as authorized by the General Assembly, but also changed the fee schedules for ambulatory surgery centers. In 2016, a Superior Court struck down the changes to the ASC fee schedule because the Commission was not authorized to ignore the requirement of a Fiscal Note. The Commission has appealed to the Court of Appeals. The Superior Court Decision has been stayed pending the appeal. When the Court appeals - affirms a Superior Court Decision, the valid fee schedule that was in place prior to April of 2015 will be the reimbursement that would be applied retroactively to all workers' compensation procedures.
performed in ambulatory surgery centers. As the Commission acknowledges in its Fiscal Note, ASCs will be entitled to collect underpayments for services provided since April of 2015. Conservatively, this will require insurance carriers and self-insured employees to pay ambulatory surgery centers over seventy-five million dollars. SCA has engaged in numerous efforts with other stakeholders to negotiate a fair fee schedule moving forward and a resolution to the substantial underpayment caused by the Commission’s invalid fee schedule. There’s not enough time today to describe all these efforts to reach a compromise. Countless meetings and other communications have occurred. Frankly, the flexibility that SCA now has to compromise on the substantial underpayments that will be owed to ambulatory surgery centers would end once the Court of Appeals rules in favor of the SCA. With this background, I now turn to SCA’s first reason for opposing the proposed rule. The proposed rule is not cost-effective and does not meet the statutory requirements. North Carolina law requires that fee schedules adopted by the Commission be adequate to ensure that, number one, injured workers are provided access to care and, number two, that providers are
reimbursed reasonable fees for providing those services and, number three, that medical costs are controlled. The Commission’s proposed permanent rule does not meet any of those requirements. First, the Commission’s proposed permanent rule limits access to care for injured workers. The Commission’s proposed permanent rule does not set a fee schedule for all procedures that can be performed in an ambulatory surgery center. By crafting a fee schedule that uses only Medicare fee schedules 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 that are not on the Medicare-approved list. 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. For example, a working age patient with a spinal injury is commonly treated in an ambulatory surgery setting. The proposed rule will prevent injured workers from accessing these procedures in an ambulatory surgery center because of several of these spinal codes not on the Medicare ASC or HOPD fee schedules. Similarly, total joint replacements are paid by Medicare only in
the inpatient setting today. If the Commission adopted a rule that set a reasonable fee schedule for these procedures, these cases could be performed on injured workers in the ambulatory surgery setting. The Commission should be proposing a fee schedule that provides having these procedures performed in the ambulatory surgery center instead of a more costly inpatient setting. Second, the proposed ASC fee schedule does not offer a reasonable reimbursement to ambulatory surgery providers. Inadequate reimbursement discourages ambulatory surgery centers treating as many injured workers. In 2015 alone, after the change, there was an eight percent decline in the number of workers’ compensation cases done by an ASC. This shift away from ASC – I’m sorry – from ASCs eliminates the third failing of the proposed rule. It does not control medical costs. For every injured worker treated in a hospital instead of an ambulatory surgery center, a business or carrier can pay double, triple, or even more sometimes for that medical care. The Fiscal Note makes no attempt to capture these direct or indirect costs. Number two, the proposed rule ignores the significant input provided by stakeholders. All of these concerns should sound familiar to the Commissioners who have
served on the Commission for some length of time. SCA has raised these concerns at prior public hearings. In the proposed rule, the Commission is not just ignoring the concerns raised by SCA and other ambulatory surgery centers; the Commission is ignoring its own advice. The Commission has previously spoken out in favor of parity between ASCs and the hospital outpatient department, or HOPDs. The only way to ensure injured workers access to high-quality, effective care is to create parity between the ASC and the HOPD medical fee schedules. The Commission continues to make misleading comparisons to other states. In doing so, the Commission is moving counter to the trend of states recognizing the importance and cost savings of ASCs in their workers’ compensation systems. These states are creating parity across settings. North Carolina is just widening the gap. If the Commission has further questions regarding the national trends in workers’ compensation, Stacey Smith with Liberty Partners is present and available to answer any of those questions. Number three, the Fiscal Note is fatally flawed. The Fiscal Note ignores the fact that April 2015 ASC fee schedule was invalidated because it failed to include a Fiscal Note. Contrary to the Superior Court’s ruling, the
Commission continues to fail to conduct a fiscal analysis between the valid fee schedule, which is the one in effect prior to April of 2015, and the proposed fee schedule. In doing so, the Commission downplays dramatic cut to reimbursement for ASCs and the negative impact on injured workers’ access to care. In fact, the Fiscal Note acknowledges that it fails to consider the behavioral changes to the system of reducing ambulatory surgery reimbursement. The Fiscal Note only considers alternatives using April 2015 as the baseline and also inappropriately relies on 2015 data, which includes claims under the invalid fee schedule with the valid fee schedule. SCA intends to provide a more detailed critique to the Fiscal Note in its written comments. In sum, the Commission waited over two years to produce a Fiscal Note, and then produced a document that fails to even discuss the fiscal impact or changes to the ASC reimbursement when treating injured workers. This violates the rulemaking requirements under the Administrative Procedure Act. Number four, the proposed rule would harm injured workers. The negative impact to injured workers is not speculative. It is already occurring. Data collected by WCRI demonstrated that common outpatient surgeries occurred in North Carolina ASCs
less frequently than in other states. Additionally, injured workers in North Carolina reported that they had big problems getting the primary provider they wanted. The proposed rule only exacerbates these real problems for injured workers since the Commission unlawfully changed the ASC fee schedule. Under the proposed rule, injured workers will be denied access to care in the ambulatory surgery setting and will be forced to receive treatment in more expensive, inpatient settings where scheduling services often takes longer and results in delays in care. SCA recommends that the Commission revise its permanent rule consistent with the recommendation in SCA’s September 2016 proposal, which is consistent with the statutory requirements; accounts for all procedures that can be performed in an ambulatory surgery center and as would have been demonstrated if a more thorough and appropriate Fiscal Note had been done; results in substantial savings to the workers’ compensation system in North Carolina. SCA also insists that the Commission conduct a fiscal analysis that actually looks at the impact of the proposed rule as compared to the valid pre-April 2015 fee schedule instead of using an invalid rule as the baseline. Thank you for the opportunity to speak to you today.
CHAIRMAN ALLEN: Questions? Okay. I will start with some questions. Ms. Collins, you realize that the Fiscal Note was approved by OSVM, correct?

MS. COLLINS: I do.

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

MS. COLLINS: Yes.

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

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

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

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

CHAIRMAN ALLEN: Would it be valid to compare North Carolina to the national average in Medicare reimbursement rates for ASCs in workers’ comp?
MS. COLLINS: To Medicare reimbursement rates?

CHAIRMAN ALLEN: In workers’ compensation.

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

CHAIRMAN ALLEN: I’m not talking about a particular state, but comparison to the national average – would that be appropriate?

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

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

MS. COLLINS: Thank you.

CHAIRMAN ALLEN: Thank you, Ms. Collins.

(SPEAKER DISMISSED)

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

RENEE MONTGOMERY

MS. MONTGOMERY: Now when - I don’t wish to make
comments. I put my name on there in case there were questions.

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

VICE-CHAIRMAN STITH: To the mike, yeah.

MS. MONTGOMERY: Okay. Then I don’t wish to be heard.

CHAIRMAN ALLEN: Yeah – to the microphone, please.

MS. MONTGOMERY: Excuse me?

CHAIRMAN ALLEN: To the microphone.

VICE-CHAIRMAN STITH: To the microphone.

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

CHAIRMAN ALLEN: Very well.

MS. MONTGOMERY: ---that’s all right.

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

(SPEAKER DISMISSED)
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,
Builders Mutual Insurance Company, Dealers Choice Mutual Insurance Company, First Benefits Insurance Mutual, Forestry Mutual, the North Carolina Farm Bureau, The Employers Association, the Employers Coalition of North Carolina and WCI, Incorporated. We’re a very large group, obviously, in the builders’ community – or in the employment community. I daresay we probably have more claims with this contingency than anybody you will hear from today. Let me just give you a little history, if you will allow me to do so. I, among several people, were involved in the negotiations for a medical fee schedule dating back to 2013. It was about a two and a half year process. We negotiated with the North Carolina Medical Society, the Hospital Association and members of the business community. I will take issue as to whether or not the am surg folks were present. SCA may not have been present, but hospitals and physicians owning ambulatory surgical centers were represented at this meeting. Our goal all along was to be fair and reasonable. We had many costs that were not reasonable for doctors. We had many costs on the hospital side, particularly with the implants and the surgeries that were not fair to employers. The goal was to reach a median level. We didn’t want to be the
lowest state; we did not want to be the highest state. I believe we accomplished that, and that resulted in the 2015 fee schedule that was adopted. As I’ve listened to the comments from the speakers before me, I would just say I disagree with a few – a few of the comments. I understand that access to medical care is incredibly important. I do not believe that this will prevent access to medical care. People are having surgeries. They’re having them at hospitals. They are having them at ambulatory surgical centers. I daresay that the decline of – I heard six percent by one speaker, eight percent by another in surgeries is the direct result of the fact that the WCRI recognized that North Carolina had more surgeries for backs than almost any other state that they look at. I think the decrease is the direct result of the fact that we no longer incentivize doctors to do those kinds of surgeries. Ambulatory surgical centers have not been used for those types of procedures in the past. The wonderful thing about this new rule is that that is going to allow that to happen, provided we as employers who get to direct the medical treatment decide that is a facility that we’d like to have that patient undergo that procedure. I think that the whole idea of controlling costs is great. We have
been involved in negotiating, as this was mentioned, with SCA about doing a new proposed fee schedule. We have not come to an agreement yet. I don’t think that is a result of a lack of effort or a lack of certainly folks trying. There have been a few issues that have come up along the way, such as the Wilkes case that has maybe sidetracked us a bit, but I will tell you that it became very apparent to me in my discussions directly with SCA and their contingencies that what they really wanted was the ability to be able to do those said procedures that the Medicare ambulatory fee schedule would not allow them to do. And, in fact, I would quote them to say it would be a win-win if they were able to do that because it would give them more procedures that they weren’t allowed to do, which obviously generates revenue, and it would also provide us all a cost-saving factor for those of us on the employer side because we could have our patients have those procedures there. Let’s be clear about the procedures that we’re talking about. We’re talking about lumbar/cervical fusions. We’re talking about total joint replacements, whether it’s knee, elbow or shoulder. We’re talking about major procedures that historically have not been done in ambulatory surgical centers in the State of North Carolina. I think this
is a new arena for all of us. And, obviously, if this is a place where they can be done and they can truly do things like prevent infections, MRSA, where we tend to have those in hospital settings, I absolutely would love to have it done in those facilities. I think this gives us that opportunity. You have come up with a fee schedule that honors the – I think the spirit with which we negotiated on for two and a half years trying to get to a median level. And now, we are opening the door for them to do these procedures that previously they would not have been reimbursed for and they were sending to the hospitals. I congratulate you, and I thank you, and I - and we, obviously, support that rule.

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

MS. GAY: Sure. Thank you.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: Next, Stacey Smith.

STACEY SMITH

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

MS. SMITH: I hope so because I’ve been sitting
through a lot of information I wouldn’t necessarily
want to hear if I wasn’t, so good afternoon. Stacey
Smith with Liberty Partners Group; I’m here on behalf
of Surgical Care Affiliates. I’m sorry. I had put my
name down to speak. I don’t have any kind of prepared
testimony, but I thought maybe to answer some
questions or add some clarifications for the record
for the previous speakers from both the Association
and some of the - a clarification on some of the
questions to Ms. Kelli Collins from SCA. I would like
to begin with just to your - the last point that you
made to Kelli, Chairman Allen, regarding the
Department of Labor national fee schedule for DOL
cases on workers’ comp, and you asked if that
average - where that was versus what you would be
proposing in North Carolina. I don’t know what the
rate is for the DOL, but I do have the - what it does
pay for, and I think that the main difference when you
look at the DOL fee schedule at the national level
versus what you are proposing is that it does not
cover implants. It is very specific in the fee
schedule rule. DOL’s website - you can go to it, and
it says, what does the facility payment pay for? And
it gives a list of items which mirror the ASC fee
schedule under Medicare, with a caveat that it gives
the same payments – what they don’t pay for, and then they don’t pay for implants. That’s paid separately. So I think the delta and the difference between a hundred – I think he said a hundred and forty-seven percent of Medicare versus what a two hundred percent of ASC – you know, one of the things you can look at is what an implant cost would be, and that can make a very big difference in what the actual payment to the facility when you add that implant, so I would say that that would be the biggest difference between comparing the DOL schedule to what you are proposing. It is apples to oranges, especially when you take into consideration the implant costs. The second item just to bring up is talking about what Stephanie had just brought up about spine and certain procedures that have been done. I think it’s – to just correct the record, their total joints, spine codes have been done in North Carolina since 2011. These procedures are safe, and they are to be done in an outpatient setting in ambulatory surgery centers, and commercial payers have been doing so in this market since 2011, especially North Carolina allows for stays in ASCs up to twenty-three hours and fifty-nine minutes, which is allowed under the Medicare rules under Section 416.2 for ASCs. So commercial payers, because they want to
bring their—you know, their patients out of an inpatient setting, into an outpatient setting, allowed ASCs to do these procedures. So spine, total joint—that has been done in these markets since ’11. And then just regarding—there was the discussion on Medicare and implants, so I think what’s really important to remember on the Medicare fee schedule, you know, you have the inpatient fee schedule, hospital outpatient—HOPD, as it’s referred to in the ASC. Every year, CMS goes through the rulemaking, and they’ll take codes off of the inpatient schedule and they’ll put them—you know, they’ll say, we’re moving these codes to be done in an outpatient setting, and they will either move them onto the HOPD schedule or both the HOPD and ASC. And quite often, they will move those codes onto those schedules without any value, without any payment in dollars. There are spine codes right now that CMS, HHS has said, these are, you know, safe to do in an outpatient setting, but we’re not going to put any value on them. And then they may go in and reexamine them and put a valuation to them, but they will put them on the approved list. And the risk you run in North Carolina, just looking at an ASC fee schedule, is there are codes since—you know, that there are
procedures that have been being done since 2011 in
ASCs that are not on the ASC fee schedule, that may
not even be on the HOPD fee schedule, and are being
done safely in the ASC setting. By moving to that fee
schedule, you are immediately limiting access to
injured workers to those facilities. And if - because
there will be no associated payment to those - to
those codes. If you have no associated payment to
those codes, there's only - if it's not on the HOPD
schedule and you're only on an ASC, you are
immediately driving a cost to the system because that
they will move into that inpatient setting and the
rates are much, much higher because now while you're
paying for the procedure, you are paying for days in
the hospital, and you are running the risk of all the
things that are associated with staying in the
hospital for an extended stay. I think Ms. Gay
mentioned MRSA and all the other infections that can
come along with surgery. So that's just one example
that it's not - you know, it's not this easy, magical
thing just to take an ASC and put it on an ASC fee
schedule on Medicare. The last item I just want to
address is the discussion on the WCRI. There's been a
lot of talk about the - you know, the thirty-three
state median average, you know, in North Carolina of
where they want to come, where they’re not the low or
the high, but, you know, where do we want to sit in
this median average? Well, I think it probably would
be beneficial because we talk about WCRI a lot for,
you know, your staff to pull up the WCRI reports that
are cited all the time and maybe pull out the section,
you know, of data methods and limitations of the
report and where WCRI specifically mentions that they
look at these thirty-three states. And these are –
this is data from 2013. Their most recent report is
from 2013. That data says from 2013. They have
states that they asterisk, you know, when you look at
the - you know, the median average charts, right, but
then you have to read the footnotes of what’s included
in here, and they have caveats of what states have
made changes to their fee schedules. Some have
brought down. They had, you know, just bill charges.
Connecticut is an example. They moved to - ACSs to a
hundred and ninety percent of HOPD. They had some
states move their rates up. So that’s really
important to me - those footnotes. And the biggest
footnote in here are there are five or six states
where they say one of the largest payers in the
system - or the largest workers’ comp carrier payers
did not submit their data files. They could not put
that data into the knee and shoulder. And they actually said, this may lead to possible under and overstatements in the results. So while medians and national averages and, you know, regression analysis is all very important, it’s also important to know what the caveats are to that data and the limitations, and WCRI does disclose those limitations, but I think it’s important for you all to be informed that there are limitations on this. Just lastly on the averages, you could set your fee schedule at the median or you could go lower. That doesn’t necessarily mean injured workers are going to be treated there, and so, you know, by believing that you’re going to bring savings to the system by having maybe a little bit lower than these averages or a little - that doesn’t necessarily - that may not actually end up within the real world. If those cases are not being seen in those facilities, where do you think those payments are going to materialize because it’s not a static market? There is an injured worker who has a - who needs a spine procedure. There’s not just one place of site of service that that injured worker could go to; there are three. And so if you have an ASC that is not able to see that because that code is not on their fee schedule or it’s being reimbursed at such
level that it’s not in their – and that they can’t do it, it’s not a viable procedure, there are two other sites of service that that injured worker could go to that are considerably higher in cost even if you take an ASC fee schedule for here and discount it to HOPD. It’s not a static marketplace. If you just had one site of service, that would be probably a correct analysis, but you have three different sites of service that can treat the same injured worker. That’s the point. And then just one of the last things on the implant issue is Medicare. When you were having the dialogue on if you have a Medicare patient that has an ACL tear or a shoulder, and then you have an injured worker. So the point – the goal of the Medicare fee schedule on the Medicare system is to treat seniors – older citizens over the age of sixty-five with a different standard. Your statutory duties under workers’ comp is to have injured workers have the best care available to them to get them back to work and get them back to work at the – at their ability of which they were pre-injury because it costs this system so much more if they’re on any kind of disability and they are not returned, and so when you look at doing a procedure like a shoulder, you may put maybe – there may be an implant for someone who’s
seventy-five. They may put in an implant, or they may not, but if it is a forty-five-year-old construction worker who needs that shoulder to work, there may be additional implants that are put in to make sure he or she is able to recover faster and would gain the mobility and the ability that he had prior to his injury because that’s the goal, I mean, paying into the workers’ comp system for the employers, and that’s what the workers would expect if they are injured on the job. So that’s a little bit of the caveat difference between a fee schedule that is based for the citizens – you know, people over sixty-five, and then, you know, for an able working population, so I just wanted to add that clarification. So I’ll be happy to answer any questions you might have.

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

MS. SMITH: Yeah.

CHAIRMAN ALLEN: ---hear that correctly?

MS. SMITH: It’s a consulting firm.

CHAIRMAN ALLEN: It’s a consulting firm. Is it a lobbying firm?

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

CHAIRMAN ALLEN: Okay.
MS. SMITH: ---all types of consulting.

CHAIRMAN ALLEN: Are y’all registered here in North Carolina?

MS. SMITH: Not lobbying on behalf of SCA.

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

MS. SMITH: Yeah, absolutely. And thank you for giving us that opportunity. We’ll be providing our data with our final proposal on – in the August submission.

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

MS. SMITH: I’m not – I think I understand your
question, but just to clarify so that I know that I’m answering it properly, so you stated that Kelli had said sixty to seventy million dollars and that there would be tens of – what are you referring to – on the tens of millions of dollars?

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

MS. SMITH: And that tens of millions – is that that would be savings?

CHAIRMAN ALLEN: Costs, not savings.

MS. SMITH: I’m not sure---

CHAIRMAN ALLEN: And yet, you indicated---

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

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

MS. SMITH: Sure. I’m not – I can’t – I don’t know if I can answer the question on the tens of – the tens of millions savings [sic] because I don’t know what’s being compared, but I can answer the questions on savings.

CHAIRMAN ALLEN: Right.
MS. SMITH: Okay. So I can do that. So let’s go back to, you know, 2015 – well, 2015, and I think the point that was made – that Kelli made in her testimony on the Fiscal Note is really critical for you all to consider. The Fiscal Note and the subsequent NCCI analysis is all being based upon the invalid fee schedule, which I think is two hundred and ten percent of ASC this year – which is two hundred and ten percent of ASC with no payment to implants. If the court case is upheld and the appeal – if SCA wins the appeal – upheld – and the stay is lifted, the fee schedule goes back to the valid – you know, it is the valid fee schedule, but now that will have to be paid at those rates, right, so I think it was sixty-seven percent of bill charges. So the major issue I think we all are having with this is that any comparison to what SCA has proposed as a discount to what the hospitals are – so if the hospitals are at – you know, I think the proposal is a – be a ten or twenty percent discount of HOPD – off of the hospitals – that comparison is all being done off of the invalid fee schedule of two hundred and ten percent of ASC. If the Court ruled today and you did the Fiscal Note analysis tomorrow, you would have – you would have to base it off the valid fee schedule at sixty-seven percent of bill
charges. If you went to, let’s say, a hundred and ninety percent of HOPD for ASCs, you would still have a thirty to forty percent savings off of that old fee schedule because that old fee schedule – the cut from the old fee schedule to where you are right now was around sixty percent. And so when you’re – we’re at this ASC fee schedule, which we shouldn’t be. We are up here, and if we go back to percent of charges, and then we want to go to this discount of HOPD to make sure we are giving workers access to all the procedures that are available to them, that’s still a reduction. It’s just where the baseline that’s being used is improper. There’s a savings to the system with every proposal that SCA has put forward. The flaw has been with using the invalid fee schedule as the measure towards the savings.

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

MS. SMITH: Say it one more time.

CHAIRMAN ALLEN: You do not believe it is valid to compare the proposed rule to the rule that was enacted
in 2015. You want to go a step back further and only have a valid comparison to the percent of charges rule.

MS. SMITH: That would be the most - that would be the most accurate, right? That’s the most accurate. Correct. Right, because right now, the proposed rule is comparing to the invalid fee schedule, what - you know, the 2015 implementation. There’s no - there’s no real difference. There’s a little bit of a bump because of how you treat some codes, so you get within like a million dollars, so it’s kind of neutral, but if you compared this proposed rule to the valid fee schedule percent charges, it would show a tremendous - you know, some would say savings; some would say cut. So I think - I think that’s a critical factor. I think the goal of - I think even the providers’ goal, you all’s goal, the carriers, the business community is to provide savings into the system that breeds - you know, that brings efficiencies, but at some point those savings of what you are proposing actually mean cuts, and that will then deter and push those patients somewhere else. So where you see a savings - and we’ve provided these examples in our other submissions - what you think of as savings actually increases costs because if you have a worker who
cannot have that procedure done in an ASC setting and
goes to an outpatient – or goes to a hospital, it can
be thirty, forty, fifty percent higher, so all the
savings that you think you’re bringing into the system
by putting in this fee schedule – you’re really just
cutting it for a provider group because you are then
increasing your costs in another group of the medical
spend.

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

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

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

MS. SMITH: Right. And I understand. This point
has been made, and this is what makes it difficult.
If the case is upheld – I think this is really
critical – the assumptions on whatever workers’ comp
rates would have been were made under the wrong
assumptions. We’re ready---

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

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

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

MS. SMITH: Sure.

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

MS. SMITH: I think you cannot answer that without understanding that if the valid fee schedule – if the – if the rates have to incorporate the valid fee schedule, any proposal coming off the valid fee schedule would be savings to the system. You know,
you can’t - if the Court - if the Court upholds the Decision, you can’t ignore the Decision just because it’s an inconvenience. You have to abide by what the law says and what the court order is. And I understand. I mean it’s - it could - it - but you can’t ignore that---

CHAIRMAN ALLEN: And, ma’am, I can---

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

CHAIRMAN ALLEN: I’m sorry.

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

CHAIRMAN ALLEN: Ma’am, I can assure you---

MS. SMITH: Oh, I know you won’t---

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

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

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

MS. SMITH: Right. I totally understand that, but I would just think it also should be made clear that SCA came to this Commission, came to Chairman Heath in 2015 – in December of 2015 with this issue and tried to resolve this first through a declaratory ruling.
Then Chairman Heath asked us to put a proposal forward, which we did. And then Chairman Heath left. SCA has tried to bring this to this, you know, attention years ago, and it’s just now, you know, stacked up these costs, so I think there’s been outreach on multiple occasions to try to work this out, to resolve this without too much time going by because if the appeal is upheld, there will be a lot of money that is owed back to the carrier, to the providers, and that is a disruptor on the system, and SCA has tried to avoid that.

CHAIRMAN ALLEN: Any further questions?

COMMISSIONER CHEATHAM: I have one---

MS. SMITH: Sure.

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

MS. SMITH: Yes, ma’am.

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

MS. SMITH: Well, I think---

COMMISSIONER CHEATHAM: What fee schedule?

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

MS. COLLINS: Yeah, our commercial payers
reimburse for those procedures in our (inaudible).

COMMISSIONER CHEATHAM: So you have no workers’ comp---

MS. COLLINS: (Inaudible).

COMMISSIONER CHEATHAM: ---spine surgeries---

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

COMMISSIONER CHEATHAM: ---is that correct?

CHAIRMAN ALLEN: I’m sorry, Commissioner Cheatham. It would be very helpful for the court reporter if at a bare minimum you repeat the answer you were---

MS. SMITH: Okay. That – I---

CHAIRMAN ALLEN: ---seeking from the audience so it’s transcribed.

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

MS. COLLINS: In just some work comp.

MS. SMITH: Commercial payers are reimbursing for spinal procedures in some workers’ comp.

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

MS. SMITH: Correct.

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

MS. SMITH: How are you being reimbursed if they’re not---
COMMISSIONER CHEATHAM: If it’s a workers’ comp patient---

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

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

MS. COLLINS: I can’t---

COMMISSIONER CHEATHAM: ---of what fee schedule?

MS. COLLINS: I can’t tell you that. I can’t share our contract rates.

MS. SMITH: Yeah. I mean---

MS. GAY: They’re negotiated rates.

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

MS. GAY: A workers’ comp carrier or---

CHAIRMAN ALLEN: Okay.

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

MS. SMITH: Can – yeah.

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

CHAIRMAN ALLEN: All right.

MS. GAY: ---on the fee schedule.
CHAIRMAN ALLEN: All right.

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

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

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

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

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

CHAIRMAN ALLEN: All right.

MS. SMITH: Is that right?

CHAIRMAN ALLEN: At this point in time, I am going to say we’re going to take about a ten-minute recess. We’ve been going well over an hour now. Ms. Smith, if you have any further comments you would like to make, you’ll be more than welcome to do so when we get back.
from the recess. And then I will open the door up one more time. If anyone wishes to make comments before this Commission, they may sign-up with Ms. Bourdon, and we’ll add those names to the list, but we’ll take---

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

CHAIRMAN ALLEN: ---about ten minutes.

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

(OFF THE RECORD)

CHAIRMAN ALLEN: All right. We’re back on the record. Ms. Smith, if it’s all right with you, could you approach the microphone again? I think there may be at least one follow-up question. And I want to, you know, make it clear, you know, with the – in terms of the Fiscal Note, the baseline was not selected by the Industrial Commission; the baseline was selected by OSVM, and we have to go by what they suggest to us, so I wanted to make that clear, but I also want to ask you about this concern that there are, you know, codes and procedures that ASCs are not being reimbursed for because it is my belief with this proposed rule that’s before us, particularly Subparagraph (2), which states that there shall be - “A maximum [...] 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.” We believe that captures those codes. Help me to understand how I am wrong.

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

CHAIRMAN ALLEN: Right.

MS. SMITH: There are – that would be – yes, that would be correct, but I think it’s – there are codes that – I think we have to be really careful when you look at these fee schedules, and it’s really getting – I mean getting – I am, you know, getting under the hood of the fee schedules, right. So this is a – this is a good segue. And just to add some clarification on – you had a very good question on spine procedures, what were being done in workers’ comp. So there’s a level-one spine code that is on the ASC fee schedule that is on the Medicare ASC fee schedule, and it has a dollar amount associated with it. That has been done in workers’ comp cases, and it is on the ASC fee schedule. There is a level-two spine code that is on the ASC fee schedule that is – that valuation is zero. So what do you do for those level-twos that prior to,
you know, going to a Medicare-based fee schedule, you are at a percent of charge, that you could do a level two, you were getting paid for that level-two? Then you convert to a Medicare-based fee schedule with a valuation of zero, so you - you know, zero percent is zero, so you’re not getting paid for that code. You can do the level-one and the level-two, which is kind of an add-on, you know, because you’ll do one, then you don’t have that code, so that---

COMMISSIONER CHEATHAM: Can I---?

MS. SMITH: ---was a clarification.

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

MS. SMITH: Sure.

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

VICE-CHAIRMAN STITH: Uh-huh.

COMMISSIONER CHEATHAM: ---with the carriers.

MR. SMITH: Right. So---

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

MS. SMITH: So I---

COMMISSIONER CHEATHAM: It’s just whatever your confidential negotiated rate might be.
MS. SMITH: So I think on – there may be maybe on a case-by-case basis, which, you know, I – and I don’t know what the centers do. And actually, you know, I think NCCI has the data. They could look at, but I think what Kelli was referring to is prior to the ’15 rule. There may have – there may have been some negotiated rates based on percent of charge that they would negotiate on those rates, but if you go to an ASC-based fee schedule, you’re not going to be able to – there’s no dollar associated with that code.

What are you going to---? Well, you can’t negotiate off of nothing if there’s no dollar amount associated with that.

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

VICE-CHAIRMAN STITH: Uh-huh.

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

MS. SMITH: Correct.

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

MS. SMITH: So there are multiple different spine
codes, right – level-one, level-two. I’m sure there’s a level-three – I believe three and four. Level-one is on the ASC fee schedule.

COMMISSIONER CHEATHAM: Right.

MS. SMITH: That was, but---

COMMISSIONER CHEATHAM: But I think that---

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

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

MS. SMITH: Right. But then---

COMMISSIONER CHEATHAM: Would you have then applied---?

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

COMMISSIONER CHEATHAM: Right.

MS. SMITH: ---they were being – when the 2015 fee schedule went into place, it was an ASC-based fee schedule, and those codes do not have a dollar amount on the ASC fee schedule, so there’s no corresponding payment so---
COMMISSIONER CHEATHAM: But you’re doing it and you’re somehow getting paid and you’re getting paid---

MS. SMITH: Doing the – we’re doing the first level, yes, because that is on the – but the first level – but the second level is not on the fee schedule.

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

MS. SMITH: Right.

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

MS. SMITH: I can’t – I can’t speak to the volume or what could be done.

COMMISSIONER CHEATHAM: No, no.

VICE-CHAIRMAN STITH: But---

MS. SMITH: But I think---

COMMISSIONER CHEATHAM: I’m asking you what is being done.

MS. SMITH: Well, what---

VICE-CHAIRMAN STITH: Is there someone in the audience that knows; that can speak to what they’re doing?
MS. SMITH: Well, I---

MS. MURPHY: Yeah. Can you hear me?

VICE-CHAIRMAN STITH: No.

CHAIRMAN ALLEN: No.

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

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

CHAIRMAN ALLEN: That’s all right.

(SPEAKER DISMISSED)

DEBBIE MURPHY

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

MS. MURPHY: Okay.

CHAIRMAN ALLEN: ---I assume you’re here about the ASC proposal.

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

COMMISSIONER CHEATHAM: I’m going to tell you—and I apologize for this, but you’re going to have to---

MS. MURPHY: Speak up?

COMMISSIONER CHEATHAM: No. You’re going to have
to speak at a little less technical way for me.

MS. SMITH: Spine.

MS. MURPHY: Yes.

COMMISSIONER CHEATHAM: Yeah, use the word “spine.”

MS. SMITH: Spine.

COMMISSIONER CHEATHAM: I got that.

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

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

MS. MURPHY: That is true.

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

MS. SMITH: They do not reimburse for implants
with workers’ comp. These are implant intensive procedures.

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

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

MS. MURPHY: Uh-huh.

COMMISSIONER CHEATHAM: ---you are being reimbursed and – you mean, you’re not?

VICE-CHAIRMAN STITH: No.

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

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

MS. MURPHY: That’s – most of that is true, but I have done a few. There is a vendor that’s a third-party vendor that use – if a doctor will use
that vendor, you can perform that procedure and make a slim margin.

COMMISSIONER CHEATHAM: Okay.

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

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

MS. MURPHY: No, because it still doesn’t capture the implant.

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

COMMISSIONER CHEATHAM: And how is---?

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

MS. SMITH: Yes.

MS. MURPHY: Yes.

CHAIRMAN ALLEN: Please do so.

MS. MURPHY: Okay. Thank you.

COMMISSIONER CHEATHAM: So the---

CHAIRMAN ALLEN: Commissioner Cheatham.

COMMISSIONER CHEATHAM: Sorry. So the outpatient hospital rate has no implants on it? I mean is that
what you’re telling me because I don’t understand your
answer to his question---

MS. MURPHY: So there---

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

MS. MURPHY: Because I don’t (unintelligible).

I’ll just go out.

MS. SMITH: Yeah, I don’t know how---

CHAIRMAN ALLEN: All right. Thank you, ma’am.

(SPEAKER DISMISSED)

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

CHAIRMAN ALLEN: Let the record reflect---

MS. SMITH: ---I don’t how---

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

STACEY SMITH

MS. SMITH: Yeah, I’m Ms. Stacey Smith. I think
maybe we could add some - let us add some
clarification or some points that are in our proposal
to you about outpatient implants are treated. For ASC
implants, it is - there are - it is - there are - it’s
within the code, but as you see for workers’ comp for
the Department of Labor, they don’t include the
implant. That’s a separate charge because, again,
injured workers have a different need than what the -
a Medicare patient population is, but there is a whole
section in the rule of Medicare payments of device-intensive procedures, and so that is a separate - there are separate add-on codes for device-intensive procedures. So, you know, it gets into those kinds of details. Again, it’s a Medicare population; it’s not a workers’ comp. And while it’s understandable that Medicare is the most standard fee schedule, maybe, you know, across the board, I think even, you know, WCRI and NCCI have caveats that they understand that there are limitations to using it because of what the population that they are addressing. So I think you just have to make adjustments to it.

CHAIRMAN ALLEN: Okay. Any further questions?

All right. Thank you, Ms. Smith.

MS. SMITH: Thank you.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: Next is Bruce Clark.

BRUCE CLARKE

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

MR. CLARKE: Yes. And I thank you for asking all
your tough questions already. My name is Bruce Clarke. I’m president of Capital Associated Industries here in Raleigh. I’m here representing that list of organizations that Stephanie Gay read out for you earlier that are already in the record. I won’t make you listen to that again. Capital Associated Industries and the Employers Coalition of North Carolina, which I’m on the board of – we are employer advocates. We are employers’ associations, and we advocate for employers on a wide range of workplace matters, including workers’ compensation. And we’ve always believed – and we believe in this process that led to rulemaking before the Commission – that being a good employer means you’re also an advocate of the injured worker. You’re going to – you’re going to see them every day. You know their families. You’re interested in their recovery. You’re – you want them to get good healthcare. You want them to have an optimal outcome. You want them to return to productive work, and there’s a balance in there of costs and that good outcome as well. The Industrial Commission, I believe, struck the right balance and has struck the right balance all along in this process. Back at that mediation, I was – I was in that mediation. The Commissioner – Chairman of the
Commission was there. Drew Heath was there in the room with us. There were about two dozen of us in the room. We were there for two days together. We had a mediator. It was one of the best known mediators in the state named Andy Little; runs a mediation teaching organization, in fact, and we had a rigorous stakeholder process there, and that was at the end of a two and a half year, very open stakeholder discussion process – very, very, very much known in the legislative and government relations community. We think you did the right thing there by taking the result of that mediated settlement and analyzing it and reviewing it and putting your own eyes on it and doing your own verification of it and producing a fee schedule from that. We think you did the right thing for the doctors that were there. There were many doctors at that mediated conference, many specialists. We think you did the right thing for facility-based providers. Many of them were there and their representatives, the Medical Society, as well as the Hospital Association. We think you did the right thing for employees and because I think this fee schedule in its totality increased access to good healthcare, particularly on the physician’s side where there were some access issues. We think you got it
right in the temporary rulemaking process. We think you’re getting it right again in this permanent rulemaking process and we urge you to stay the course and adopt the final rule as you have proposed. It’s a very important part of the balance that was reached both among the stakeholders, as well as at the Commission to this point, and that balance brings access to good healthcare for workers and a degree of affordability to the employers that are paying the bill for that care. Unfortunately, the ambulatory surgical centers use legal technicalities to knock down some good public policy here the first couple times around, but we thank you for going through this again, knowing this time you will prevail. And thank you for your hard work, and I’m happy to answer a question if I can.

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

MR. CLARKE: I have – I have reviewed the reviews of the proposal. I didn’t author them or do original research, but, yes, I have looked at them, and there’s a significant cost gap there. If we – if we do what the ASCs, through SCA, have requested and have
suggested, it is a significant fiscal impact on employers and on payers.

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

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

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

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

CHAIRMAN ALLEN: Okay. Thank you, sir.

MR. CLARKE: Thank you.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: Next, Mr. Ronnie Cook.

RONNIE COOK

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

MR. COOK: Yes, sir, that is correct. Thank you,
Chairman Allen, and members of the Industrial
Commission for this opportunity to comment and also
for all your good work. My name is Ronnie Cook, and I
represent the North Carolina Hospital Association and
all its member hospitals and health systems, as well
as their affiliated providers and employed physicians.
And it’s important to note that hospitals do own and
operate freestanding ambulatory surgery centers in the
state, and, therefore, we would be subject – our
members – some of our members would be subject under
this proposed rule and proposed amendment. The North
Carolina Hospital Association supports the proposed
amendment as stated. The proposed amendment is a
result of a lot of hard work, a lot of compromise. It
maintains incorporate and reimbursement integrity. It
provides much needed predictability for the Industrial
Commission. It is fair and balanced, and it will
result in savings for employers, payers, as well as
insured workers. That was really my prepared
comments, mainly just to offer our support. I mean we
talked at the October meeting, shared a lot of
information there, and I refer you back to those
comments. You know, we’d also provided written
comments, but there were a number of statements today
that we feel like we needed to at least address or at
least provide our comments on. One had to do with access to care - that the proposed amendment could, or probably would, result in limited access to ambulatory surgery centers. For the life of me, I have trouble understanding that. Obviously, there’s a fee schedule. There is a compromise in that fee schedule that allows the ambulatory surgery centers to not only perform the surgeries that are on the Medicare fee schedule, but there is a significant compromise that positively impacts the freestanding ambulatory surgery center by allowing them to perform any procedure that’s on the outpatient fee schedule. In addition to that, there is a concept that says if it’s not on the fee schedule that you pay - or you can have an individual case-by-case consideration under a reasonable customary and reasonable type amount. So it looks like any possible procedure - a worker would have access to any of the providers under those types of arrangements. Now there was a lot of discussion about the fee schedule not being enough - or not being high enough or maybe not covering costs, and, therefore, they could refer to a hospital. Well, I can tell you that it would be unique and you probably wouldn’t be real happy with me if I told you now that we also can be in situations where two hundred percent
of Medicare may not cover our costs. And where would we refer to if that was the case? Where would they get care if they did not get care in a hospital? Where would they get it? So that’s not an option. So access to care - I can’t fathom that it’s not. Now it may be that there’s a business decision that you decide not to perform that service in your particular facility, but the injured and the employer and the payer has access to care. There is access to care. We also talked about implants and the cost of implants. Obviously, under the Medicare fee schedule and under a lot of fee schedules these days under reimbursement, those implants are rolled up. They are packaged into the bigger price that people pay, into the fee schedule that they pay, so hospitals have the same implant problem that a particular surgery center might have, so we could also have implants that cost more than the reimbursement. And there again, where would we do the surgery if we did not do it there? So that’s another - you know, that’s an - I mean implants are designed. They’re there as an averaging concept. You know, the question is in the whole scheme of things, do you do well under two hundred percent of Medicare?

COMMISSIONER BADDOUR: Is that because multiple
implants take longer? Is it a time issue? What causes the multiple implants to be more expensive for the center or for the hospital?

MR. COOK: Well, I’m not sure if it’s – well – I mean what – the implants are expensive.

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

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

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

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

COMMISSIONER BADDOUR: But when it’s bundled, then – and excuse my ignorance – then how do you decide how much goes to pay for the device, how much goes to the doctor, how much goes to the – to the facility?

MR. COOK: It’s all facility.

COMMISSIONER BADDOUR: It’s all facility?
MR. COOK: It’s all facility.

COMMISSIONER BADDOUR: So you’re – but you’re not paying the doctor?

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

COMMISSIONER BADDOUR: Right. So you’re – so you got a bundled price for the device and for the facility?

MR. COOK: Yeah. The technical fee – or the facility fee is going to cover the hospital, the plant, the utilities, the staff, all the equipment, the implants, all the supplies used, the OR time, all the equipment in the OR, all the – anything that’s related to the hospital---

COMMISSIONER BADDOUR: I see.

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

COMMISSIONER BADDOUR: Right.

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

COMMISSIONER BADDOUR: All right. All right.

Thank you.

MR. COOK: So there’s a – there’s a – there’s
two - there’s two fees that would come from that. And then the anesthesiologist may bill also under their fee schedule, so there’s different mechanisms to get paid. So I do not - you know, I do believe that there’s access to care. Another - we’ve talked a little bit about the fact that the proposed fee schedule or reimbursement rate possibly wasn’t high enough and there was alternative amounts offered, which was to maintain the current percent of charge, which wouldn’t provide any predictability for the Industrial Commission, or, second, to pay up to the Hospital Outpatient Prospective Payment System, and one of the things I find interesting is that how the surgery centers can ask the Industrial Commission to pay equal to or greater than the hospital fee schedule when in fact they have not been able to achieve that with any other payer that they deal with. They deal with managed care payers. They deal with BlueCross. They deal with Aetna and Cigna and United and MedCost. They deal with Medicaid. They deal with Medicare. They deal with other payers, and I can’t - and I would be surprised if they could provide you evidence to show you that they have contracts and reimbursement schedules that are consistently equal to what a hospital is paid. And the reason for that is the same.
concept of the hierarchy of care that we identified earlier, is that you have physicians and they get paid a lower rate because they don’t always have the overhead. Then you go to ambulatory surgery centers, and they get paid a higher rate. They’re a facility. They have bricks and mortar and equipment and staff and specialized staff, and they perform a great function. They really do. They’re convenient. They do what they do very well, but they also don’t keep people beyond twenty-four hours. And if somebody goes bad – if there’s a surgery that goes south, where do they go? They’re not open twenty-four/seven. They don’t serve everybody. They go to the hospital. Hospitals have a lot of different rules, safety rules, other regulations, other requirements. We’re open twenty-four/seven. There’s a reason that the reimbursement is different. Unfortunately, our costs are more because we have things to deal with that they don’t, but our costs are more, and that’s why we get reimbursed more, and that’s why there’s a difference in the fee schedules. So, in conclusion, we still think that there is significant integrity in the reimbursement between the providers, and we think that there’s a significant compromise that positively impacts the ability of ASCs to perform pretty much any
and all services, all procedures, and we support again, we support wholeheartedly the proposed amendment. And I’m open for any questions you might have.

CHAIRMAN ALLEN: Commissioner Cheatham.

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

MR. COOK: Yes, ma’am.

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

MR. COOK: That are freestanding?

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

MR. COOK: There’s probably a handful. There’s a handful. There’s not - there’s not - I don’t---

COMMISSIONER CHEATHAM: Ten - five?

MR. COOK: ---know the exact number. It’s probably less than five.

COMMISSIONER CHEATHAM: Thank you.

CHAIRMAN ALLEN: Any further questions?

MR. COOK: But even at - you know, when you’re -
when you’re an Association and you represent all
members, even if there’s only one.

VICE-CHAIRMAN STITH: I do.

CHAIRMAN ALLEN: Vice---

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

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


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

VICE-CHAIRMAN STITH: Okay.

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

VICE-CHAIRMAN STITH: Okay. Thank you.
MR. COOK: You know, we talk a lot about – you know, we’ve talked a lot about the positive attributes of surgery centers, and there’s many. There’s a ton of them. I’m a big supporter of them. There’s a ton of positive attributes, and we talk about all the different surgeries that they can do there, but, you know, there’s a reason we don’t do all surgeries in certain settings. You know, there’s a reason for that, you know, and I think we need to be aware of that, but there’s a reason that you do a surgery in an inpatient setting versus an outpatient hospital department versus a surgery center versus a physician’s office. There’s reasons for those things, and we need to be cognizant of that whether you’re forty-five or sixty-five. And the other argument is – I mean you could – I mean you could take their position – the ambulatory surgery position and extend it to physicians because there are physicians doing things in their office that potentially could be done in a surgery center and/or hospital. They very well could be sitting in these seats, arguing the same thing. They very well could, if the argument has – if we accept all the merits of those arguments.

CHAIRMAN ALLEN: Any further questions? All right. Great.
MR. COOK: Thank you.

CHAIRMAN ALLEN: Thank you, Mr. Cook.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: Ms. Bourdon, did anyone else sign-up to speak? Okay. If any of the speakers have a summary of their remarks that they would like to enter into the record, please, before leaving today, present those to the court report, Ms. Dollar, who is to my right with the notebook computer in front of her, and those will be entered into the record next in number in sequential order of each speaker’s remarks today. And the record will remain open for any submissions that any of the stakeholders or interested parties wish to make. Thank you for participating in the public hearing. That period for written comments and other submissions will be held open through the close of business on August 14, 2017, so if you have any further comments or submissions, please send those to Ms. Bourdon as directed in the hearing notice in the North Carolina Register and also on the Commission’s website. The written comments and submissions and the comments made at the hearing today will be made part of the public record of these proceedings. We would like to include in the transcript, with this proceeding, the materials
submitted by Ms. Bourdon as exhibits. Are there any further matters to come before the public hearing?
Okay. Very well. Thank you. We’ll go off the record.

(WHEREUPON, THE HEARING WAS ADJOURNED.)

RECORDED BY MACHINE
TRANSCRIBED BY: Lisa D. Dollar, Graham Erlacher and Associates
STATE OF NORTH CAROLINA
COUNTY OF GUILFORD

CERTIFICATE

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

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

WITNESS my Hand and Seal on this 26th day of July 2017.
My commission expires on December 3, 2018.

[Signature]

NOTARY PUBLIC

GRAHAM ERLACHER & ASSOCIATES
3504 VEST MILL ROAD - SUITE 22
WINSTON-SALEM, NORTH CAROLINA 27103
336/708-1152
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-01517.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 for the Medicare Ambulatory Surgical Center Payment Systems. The following studies and data sources were reviewed:

(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.
(8) Review of medical fee schedules of states that base reimbursement to ambulatory surgical centers on the Medicare Ambulatory Surgical Center Payment System.

Comments may be submitted to: Kendall M. Bourdon, 4340 Mail Service Center, Raleigh, NC 27699-4340; 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 (≥$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 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-impacted payment amount in Addendum AA, Final ASC Covered Surgical.
DEPARTMENT
THE
Authority
31:24
Proposed
NCAC
Notice is hereby given in accordance with .I502.
outpatient Prospective
care percentages set out in Paragraphs (b) and (c) of this Rule.
Link to agency website pursuant to G.S. 150B-19.1(c):
PreereElures fur CY
AHeillary Serviees
(k) If the billed charges are less than the maximum allowable
charges.
If the facility-specific Medicare payment includes an outlier
payment, the sum of the facility-specific reimbursement amount
shall be paid pursuant to the applicable fee schedules in
institutional services provided by ambulatory surgical centers is
as follows:

A maximum reimbursement rate of 200 percent shall apply to institutional services that are
eligible for payment by CMS when performed at an ASC.
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.

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.

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

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 andExpiration 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
DHSR.RulesCoordinator@dhs.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

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, and
.1402.

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
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 I)

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:

   o 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.

   o 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:

   o 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. 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.

   o 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

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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:

o 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.

o 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.

o 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.

o 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

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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,
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 OPPS 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 OPPS fee schedule. Because the Commission was concerned that allowing 135% of the CMS OPPS 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.
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 rule.

rule and the former method based on percentage-of-charges assessed by the provider. 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.

  o **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).** 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

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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.

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.
(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 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, 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), (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 (e) of this Rule.

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

(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.
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% (-$2.0M) 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.

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

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.'
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 = \([\text{Multiplier} \times 2017 \text{ Medicare Adjusted Base Rate for North Carolina} \times 2017 \text{ Medicare ASC Payment Weight} - \text{Multiple Procedure Discounts (if applicable)}]\)

Where Multiplier = 200%

Proposed MAR – ASC or Hospital Outpatient-Based

Proposed MAR = \([\text{Multiplier} \times 2017 \text{ Medicare Adjusted Base Rate for North Carolina} \times 2017 \text{ Medicare ASC Payment Weight} - \text{Multiple Procedure Discounts (if applicable)}]\)

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

Proposed MAR = \([\text{Multiplier} \times 2017 \text{ Medicare Adjusted Base Rate for North Carolina} \times 2017 \text{ Medicare OPPS Relative Weight} - \text{Multiple Procedure Discounts (if applicable)}]\)

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 factor\(^2\) 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.

<table>
<thead>
<tr>
<th>Alternative</th>
<th>Proposed ASC Medicare Multiplier</th>
<th>Proposed OPPS Medicare Multiplier</th>
<th>Percentage Change in MAR</th>
<th>Price Realization Factor</th>
<th>Estimated Impact on ASC Service Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>200%</td>
<td>135%</td>
<td>-0.2%</td>
<td>50%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>2</td>
<td>175%</td>
<td>135%</td>
<td>-9.9%</td>
<td>50%</td>
<td>-5.0%</td>
</tr>
</tbody>
</table>

\(^2\) The price realization factor from a fee schedule increase is estimated according to the formula \(0.80 \times (1.10 + 1.20 \times \text{(price departure)})\). 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 OPPS 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.

<table>
<thead>
<tr>
<th>Alternative</th>
<th>Proposed OPPS Medicare Multiplier</th>
<th>Percentage Change in Reimbursement</th>
<th>Price Realization Factor</th>
<th>Estimated Impact on ASC Service Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>200%</td>
<td>+34.5%</td>
<td>80%</td>
<td>+27.6%</td>
</tr>
<tr>
<td>4</td>
<td>135%</td>
<td>-2.2%</td>
<td>50%</td>
<td>-1.1%</td>
</tr>
</tbody>
</table>

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NCCI estimates that the proposal to adopt a Medicare-based fee schedule, effective 4/1/2016, for Hospital Inpatient, Hospital Outpatient, and Ambulatory Surgical Center (ASC) services would result in an impact of -2.9% (-$39.0M) 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% (+$19.0M) 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:

  - Services performed in acute care hospitals will be based upon 220% of Medicare's hospital outpatient payment rates. Currently, these services are reimbursed at 67.16% of charges.

  - Services performed in critical access hospitals will be based upon 230% of Medicare's hospital outpatient payment rates. Currently, these services are reimbursed at 73.33% 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 $1,368M 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 -$32M for fee schedule changes effective 4/1/2016 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:

  1. Services performed in acute care hospitals will be based upon 190% of the Medicare's hospital inpatient payment rates.

  2. 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:

  1. Update the maximum allowable reimbursements (MARs) to be based on the current Medicare Resource Based Relative Value System (RBRVS).

  2. Adopt the following multipliers by service category:

<table>
<thead>
<tr>
<th>Physician Service Category</th>
<th>Percentage of NC Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Management</td>
<td>140%</td>
</tr>
<tr>
<td>Physical Medicine</td>
<td>140%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>159%</td>
</tr>
<tr>
<td>Neurology</td>
<td>153%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>165%</td>
</tr>
<tr>
<td>Radiology</td>
<td>163%</td>
</tr>
<tr>
<td>Major Surgery</td>
<td>155%</td>
</tr>
<tr>
<td>Clinical Laboratory</td>
<td>150%</td>
</tr>
<tr>
<td>Other Professional Services</td>
<td>150%</td>
</tr>
</tbody>
</table>

The North Carolina Industrial Commission (NCIC) 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 (CLAS) 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.nc.gov/ncic/pages/fresched.asp](http://www.nc.gov/ncic/pages/fresched.asp). Following the directive from NCIC, all other physician services with MAR 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 NCIC, 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 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,

\[
\text{Current Reimbursement} = \text{Current Payments} \times \text{Trend Factor}
\]

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:

<table>
<thead>
<tr>
<th>Year</th>
<th>MCPI %</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>5.1%</td>
</tr>
<tr>
<td>2012</td>
<td>5.0%</td>
</tr>
<tr>
<td>2013</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

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
TO THE NORTH CAROLINA MEDICAL FEE SCHEDULE

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,

$$
\text{Proposed Reimbursement} = \text{Multiplier} \times \text{Medicare Payment Rate} + \text{Outlier Amount (if applicable)} - \text{Multiple Procedure Discounts (if applicable)} \times (1 + \text{Price Departure})
$$

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 80 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).

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Trended Charge</td>
<td>Total Cost for OPPS procedure</td>
<td>Proposed Outlier Threshold</td>
<td>Proposed Outlier Payment</td>
<td>Total Proposed MAR</td>
</tr>
<tr>
<td></td>
<td>Submitted at the bill level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$2,992</td>
<td>$40,000</td>
<td>$10,520</td>
<td>Threshold (1): $5,236</td>
<td>$5,284</td>
<td>$8,276</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Threshold (3): $8,092</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 x (0.246 + 0.260)).

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 -3.5%. 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:

<table>
<thead>
<tr>
<th>Year</th>
<th>MCPI Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>6.8%</td>
</tr>
<tr>
<td>2012</td>
<td>5.2%</td>
</tr>
<tr>
<td>2013</td>
<td>4.4%</td>
</tr>
<tr>
<td>2014</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

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 5.6% (=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 MABs 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.
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).

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
<th>(6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of 2015 NC MS-DRG Payment Rate</td>
<td>Total Treated Charge Submitted at the bill level</td>
<td>Total Costs for IPPS procedure</td>
<td>Proposed Outlier Payment</td>
<td>Total Proposed MAR</td>
<td></td>
</tr>
<tr>
<td>$21,770</td>
<td>$190,000</td>
<td>$56,400</td>
<td>$33,245</td>
<td>$55,015</td>
<td></td>
</tr>
</tbody>
</table>

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 impact 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 (49.6%) 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 analytes, 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 (6.7%) 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:

<table>
<thead>
<tr>
<th>Estimated Impact on Type of Service</th>
<th>Medical Cost Distribution</th>
<th>Estimated Impact On Medical Costs</th>
<th>Estimated Impact on Overall Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
<td>(D)</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>-9.1%</td>
<td>13.2%</td>
<td>-1.2%</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>-20.4%</td>
<td>19.3%</td>
<td>-3.9%</td>
</tr>
<tr>
<td>ASC</td>
<td>-14.7%</td>
<td>5.7%</td>
<td>-0.8%</td>
</tr>
</tbody>
</table>

(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) = -2.3%

Prepared on 12/4/2014
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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.

<table>
<thead>
<tr>
<th>Physician Practice Category</th>
<th>Cost Distribution</th>
<th>Percentage Change in MAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>2.9%</td>
<td>+4.1%</td>
</tr>
<tr>
<td>Major Surgery</td>
<td>9.9%</td>
<td>-21.7%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>1.8%</td>
<td>-25.1%</td>
</tr>
<tr>
<td>Radiology</td>
<td>10.0%</td>
<td>-28.1%</td>
</tr>
<tr>
<td>Physical Medicine</td>
<td>22.3%</td>
<td>+99.9%</td>
</tr>
<tr>
<td>Evaluation and Management</td>
<td>10.3%</td>
<td>+33.6%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>2.1%</td>
<td>+36.2%</td>
</tr>
<tr>
<td>Clinical Laboratory</td>
<td>1.4%</td>
<td>-11.6%</td>
</tr>
<tr>
<td>State Specific Codes</td>
<td>0.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other Professional Services</td>
<td>20.4%</td>
<td>-17.6%</td>
</tr>
<tr>
<td>Physician Payments with no specific MAR</td>
<td>13.9%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>10.8%</td>
</tr>
</tbody>
</table>

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% x (1.10 + 1.20 x (price departure)). The observed price departure for physician payments in North Carolina is -9%. The percentage realized is estimated to be 79% (= 80% x (1.10 + 1.20 x (-0.09))). The impact on physician payments due to the revised physician fee schedule change is +8.5% (= +10.8% x 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.

<table>
<thead>
<tr>
<th></th>
<th>(A) Estimated Impact on Type of Service</th>
<th>(B) Medical Cost Distribution</th>
<th>(C) Estimated Impact on Medical Costs</th>
<th>(D) Estimated Impact on Overall Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>+8.5%</td>
<td>33.5%</td>
<td>+2.8%</td>
<td>+1.3%</td>
</tr>
<tr>
<td>DME</td>
<td>+8.3%</td>
<td>2.0%</td>
<td>+0.2%</td>
<td>+0.1%</td>
</tr>
</tbody>
</table>

(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) Total Estimated Impact on Overall Workers Compensation System Costs in North Carolina = (1) x (2): +1.4%

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3 The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for North Carolina from the last 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.
(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.

Eff. January 1, 1988;
Amended Eff. August 1, 1998; March 2, 1992;

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.


(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.

(c) 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.

(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.

(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 Center Payment Systems Addendum as published in the Federal Register and on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulatorySurgicalCenterPaymentSystemsAddenda, as published annually or referenced by website in the Federal Register and on the CMS website.

(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.
4. A maximum reimbursement rate of 200 percent shall apply to institutional services that are eligible for payment by CMS when performed at an ASC.
5. 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) Notwithstanding Paragraph (g) of this Rule, if surgical procedures listed in Addendum FF (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 do not apply to institutional services provided by ambulatory surgical centers, they shall be reimbursed with the maximum amount being the usual, customary, and reasonable charge for the service or treatment rendered.

(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) The schedule of maximum reimbursement rates for institutional services 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.

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

C O M M I S S I O N E R S:
Charlton L. Allen, Chairman
Bernadine S. Ballance
Linda Cheatham
Christopher C. Loutit
Tammy R. Nance

I N D E X

S P E A K E R S:  
Kendall Bourdon .......................... 2
Kelli Collins .................................. 6
Andy Ellen .................................. 11
Ronnie Cook .................................. 18

E X H I B I T S

(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

CHAIRMAN ALLEN: Okay. We are on the record.

Good afternoon. Today is November 18, 2016. This is a North Carolina Industrial Commission public hearing on proposed rulemaking. I'm Charlton Allen, Chairman of the North Carolina Industrial Commission. In compliance with the requirements of Chapter 138A-15(e) of the State Government Ethics Act, I remind all members of the Commission of their duty to avoid conflicts of interest under 138A. I also inquire as to whether there is any known conflict of interest to any matters coming before the Commission at this time. Hearing none, we will proceed. The purpose of this hearing is to receive comments from the public regarding 04 NCAC 10J .0103 proposed for temporary rulemaking by the Commission and submitted for publication on the Office of Administrative Hearings' website on October 18, 2016. We have not yet received comments - written comments from the public, but the record will be held open to receive written comments from the public through the close of business in - on November 29, 2016. At this time, I would like to introduce the other Commissioners. To my right are Commissioners Bernadine Ballance and Christopher Loutit, and to my left are Commissioners Linda
Cheatham and Tammy Nance. Commissioner Daughtridge could not be with us today. At this time, the Commission wishes to thank members of the public and the various stakeholders who attended our public comment meeting on October 3rd, 2016, and gave comments or proposals regarding the rulemaking options considered by the Commissioners. The Commission very much appreciates everyone's time and efforts in that regard. Anyone who wishes to speak at this hearing must sign up to do so with Kendall Bourdon - Ms. Bourdon, would you please raise your hand - so that we have the correct spelling of your name and can call you in order to speak. If anybody would like to speak and has not yet signed up, please do so now. Seeing no movement toward Ms. Bourdon's table, the first speaker will be Kendall Bourdon, the rulemaking coordinator, followed by the members of the public in the order that they have signed up. Ms. Bourdon.

KENDALL BOURDON

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

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

CHAIRMAN ALLEN: And do you have any prepared
exhibits that you would like to place into the record
of these proceedings?

    MS. BOURDON: I do. I have Exhibit 1, which is a
copy of the proposed rule amendment as submitted to
the North Carolina Office of Administrative Hearings,
Rules Division, for publication on its website on
October 18th, 2016. Next, I have Exhibit 2, which is a
copy of the Superior Court Decision in the case
Surgical Care Affiliates, LLC, versus North Carolina
Industrial Commission, No. 16-CVS-0050, Wake County
Superior Court. And finally, I would like to submit
Exhibit 3, which is a record of the public comment
meeting held by the Commission on October 3rd, 2016.
(Exhibit Numbers 1, 2 and 3 are
identified.)

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

    MS. BOURDON: Yes. We have one rule for a
temporary rulemaking. This rule is found in Title 04
of the Administrative Code, Subchapter 10J. We
propose to amend Rule .0103, titled Fees for
Institutional Services. This proposed temporary rule
would be effective January 1, 2017. This temporary
rule is proposed pursuant to North Carolina General
Statute 150B-21.1(a)(5). The effects of the August 9th, 2016 Decision in Surgical Care Affiliates, LLC, versus North Carolina Industrial Commission, which was submitted as Exhibit 2 in this proceeding, 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 percent 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 North Carolina General Statute 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 31st, 2016, providing certainty regarding medical costs for 2017 and beyond.

Prior to proposing the temporary rule, the Industrial Commission voluntarily held a non-mandatory public comment meeting on October 3rd, 2016, and accepted written comments from September 2nd, 2016 through October 10th, 2016, in order to allow any person or entity the opportunity to present comments and proposals regarding potential rulemaking options to address the effects of the August 9th, 2016 Court Decision. The record of that meeting and all proposals and comments received in conjunction with that meeting has been submitted as Exhibit 3 here in this proceeding. The Commission gave thorough consideration to all comments and materials presented in formulating the proposed temporary rule. The proposed temporary rule was submitted to the North Carolina Office of Administrative Hearings, Rules Division, on October 18th, 2016. The rule was published on their website on October 21st, 2016.
on the Industrial Commission website as required by statute. Also, notice was emailed with a link to this rule to the Commission’s Rules Listserv. This is an interested person’s Listserv that we are required to maintain.

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

MS. BOURDON: Thank you.

CHAIRMAN ALLEN: Thank you.

(SPEAKER DISMISSED)

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

KELLI COLLINS

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

CHAIRMAN ALLEN: It’s all right. Take your time.

MS. COLLINS: And you were so graceful.

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

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

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

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

UNIDENTIFIED SPEAKER: 04 NCAC 10J .0103.

CHAIRMAN ALLEN: Okay. All right. We’ll be happy to hear from you.

MS. COLLINS: Thank you. SCA is proud to operate seven ambulatory facilities - or ASCs in North Carolina. SCA’s full response to the temporary rule will be submitted for the record. 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 two hundred percent 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 - 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’ Comp Act and that providers are reimbursed reasonable fees for
providing these services. The Commission’s proposed temporary rule does not meet these requirements since the proposed fee schedule does not include all procedures that can be performed safely in an ambulatory surgery center. By crafting a fee schedule that uses only Medicare as its foundation, the proposed rule does not include a wide variety of procedures that can be performed safely and cost effectively on the working age population. Even with the allowance for usual and customary payment for surgical procedures that are not included in the Medicare ASC fee schedule, there will remain a great uncertainty and likelihood that there will be numerous disputes that will need to be resolved by the Industrial Commission and/or the Courts. This uncertainty of whether and in what amount ASCs will be reimbursed for surgical procedures as not covered by Medicare will create access issues and will increase costs since these procedures will be done in higher cost hospital inpatient settings. Additionally, the proposed temporary rule does not separate reimbursement for implants. The failure to separately reimburse for implants results in even less reimbursement to ambulatory surgery centers and reduces the incentive to provide services involving
high cost implants. In contrast, hospitals will be able to recover higher implant costs by shifting patients to higher cost implant inpatient settings for those surgical procedures. Reducing the fee schedule to two hundred percent of ASC Medicare would also have a greater negative effect on workers' access to surgical care. Given how many injured North Carolinians depend on the community-based surgical care that ASCs provide this represents a real threat to patients in our state. Currently, injured workers are forced to receive treatment in more expensive inpatient settings where scheduling services often takes longer and can result in delays in care. Even the Commission admits this since it has said that this reimbursement disparity would - and I quote, "...potentially diminish the pool of doctors available to treat injured employees and reduce the quality and timeliness of care." The Commission went on to concede - and again, I quote, "That impact will likely be most severely realized on our state's more rural areas where the quality and availability of effective treatment is already a great concern." SCA agrees that the only way to ensure injured workers access to high-quality, effective care is to create a parity between the ASC and the hospital outpatient fee.
schedules. Lastly, 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. However, Judge Ridgeway’s Decision does not provide a basis for adopting a temporary rule and bypassing the requirements for permanent rulemaking. North Carolina General Statute allows an agency to adopt a temporary rule only under very limited circumstances. A court can only be the basis for temporary rulemaking if that court order requires the immediate adoption of a rule. There is nothing in Judge Ridgeway’s Decision that requires the adoption of a temporary rule. Instead, in setting aside the invalid ASC schedule, Judge Ridgeway’s Decision clearly states that the fee schedule adopted in 2013 continues to be effective. SCA recommends that the Commission initiate 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. We believe that any proposed action taken should give North Carolina’s injured workers access to
high-quality, community-based care that they need and
deserve. Thank you again for the opportunity.

CHAIRMAN ALLEN: Thank you, Ms. Collins.

Commissioners, do you have questions for Ms. Collins?

COMMISSIONER BALLANCE: No.

CHAIRMAN ALLEN: Okay. Thank you so much.

MS. COLLINS: Thank you.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: The next speaker in order will be

Mr. Andy Ellen. Mr. Ellen, if you would step forward.

ANDY ELLEN

MR. ELLEN: Thank you, Chairman Allen, and members

of the Industrial Commission. I’m Andy Ellen. I’m

president and general counsel of the North Carolina

Retail Merchants Association, and I’m also the

spokesman today for a number of groups, and I think

John McMillan appeared for our group last time, but

was unavailable to be here, and so I’m John’s

substitute - not nearly as good as John, but John’s

substitute today, and I’m here on behalf of the

following groups, and I can provide this list as well:

Capital Associated Industries, the North Carolina

Association of County Commissioners, the North

Carolina Association of Self-Insurers, the North

Carolina Automobile Dealers Association, the North
Carolina Chamber of Commerce, the North Carolina Farm
Bureau and their 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 and
Property and Casualty Insurers of America Association,
Builders Mutual Insurance Company, Dealers Choice
Mutual Insurance Company, First Benefits Insurance
Mutual, Forestry Mutual, the Employers Coalition and
WCI, Incorporated. First, I would like to say thank
you. John McMillan appeared before you, and as I
think you very adequately described, this process that
is before you was the - was the subject of a much
negotiated agreement between a number of parties that
lasted over three years, and I unfortunately was the
one that tried to sort of herd the cats on that, and
this is the project that will not end, and I
appreciate you taking swift action after Judge
Ridgeway’s Decision to try and address this issue. We
are very much - and I - in referencing the Rule 04
NCAC 10J .0103, specifically Subsection (g), that you
have gone in and adopted a fee schedule of two hundred
percent of Medicare - and frankly, that was what we
all thought we were doing for all providers at the
time we came to that agreement between the hospitals,
the physicians, people that we thought had the
apparent and actual authority to represent the
Orthopedic Association, including the ambulatory
surgical centers, as well as the business community
and all of the insurance community. And through that
three-year process and numerous studies, we thought we
were taking care of all the providers and everybody
was adequately represented at the table, and so the
two hundred percent that you have put in, which was
phased in over a three - over a three-step process
that you did - we thought that’s what we had all done,
and we appreciate that you have gone back and trying
to rectify that and put clearly in the law what we all
thought was the case anyway, so thank you very much
for that. I do want to sort of make a couple of
statements about Ms. Collins’ statement about being,
you know, not adequate reimbursement for ambulatory
surgical centers. You know, we did a very thorough
investigation, hired a consultant to do a study for
us, looked at WCRI data, and I think what we found
was, you know, in South Carolina the Medical Plus rate
was a hundred and forty percent; in Tennessee, it was
a hundred and fifty percent. And if you also look at,
you know, I think, the comments that we had back -
that John McMillan submitted, we stated that for some
procedures - for instance, ASC reimbursement prior to
the changes that you made. For a knee arthroscopy, it
was thirty-one percent higher than median and
forty-nine percent higher than the shoulder
arthroscopies procedure prior to what you did, higher
than the thirty-three state median. What you have
done with the two hundred percent figure is got into
that margin of what is a reasonable fee, and again,
one that was phased in over three - over three steps
to better adequately allow - I think the hospitals
referred to at that time as a softer landing so that
they could prepare for it, so I appreciate that part
of it. I will say - and Ms. Collins referenced the
question about procedures that are not allowed to be
done in an - in an ambulatory surgical center, and I
think you tried to address that in here to allow them
to do that, and I think as a provider community - I
mean as an employer community, as an insurer
community, we very much support them having the
ability to do those procedures. Medicare, you know,
has not approved that, but you are trying to find a
methodology to get there, and I think that’s the
benefit of everybody, if they have the ability to
compete, but I do think there may be - and Ms. Collins
makes one part that I will agree with. You could
potentially with a usual and customary charge be
creating a little bit of uncertainty in that or some
more people coming before you to argue about what the
applicable rates are. We would sort of - our - what
we would propose on that last section is tweak that a
little bit and let them perform those procedures, but
use the same type of methodology that they have for
outpatient. As I understand it, for outpatient
procedures, Medicare pays hospitals a slight higher
fee because they have bundled healthcare. They have
to serve everybody, and they allow them to make that
cost up. Under the current with the usual and
customary, you’re in a sense could be paying more to
an ambulatory surgical center for a procedure Medicare
does not let them provide, and so what we would
propose - and I don’t know what the number is yet -
that you pay ambulatory surgical centers a percentage
of what you’re paying hospitals for those items that
are - that hospitals are allowed to provide under
Medicare, but currently ambulatory surgical centers
are not allowed to provide. So I don’t know if that -
what that figure is yet. I will point to Surgical
Care Affiliates - their September the 20th, 2016
investment report, which I’m glad to provide, where they readily say that they provide forty-five percent savings off of hospital outpatient procedures, and so I think that’s a place you could start, which is, you know, fifty-five percent of what you’re paying for the hospital on those procedures that Medicare does not cover in an ambulatory surgical center. I’m not saying that’s the right number, but certainly a number that we could start and investigate real quickly along with some of the other participants in this discussion, but I think that would solve a couple of things. If you did the two hundred percent as you have proposed and as we, again, very much thank you for doing on the procedures that are covered by Medicare ambulatory surgical centers are allowed to do, and then for those procedures that Medicare does not allow ambulatory surgical centers to perform, let them perform them, come up with a specific rate so that people aren’t coming before you arguing that a rate is not adequate. And again, I think you can use the same methodology and do a percentage off of what the hospitals are being paid for those very same services, and I think that would benefit both ambulatory surgical centers - I think it would also benefit the provider community. It would benefit the
workers as well and would provide adequate reimbursement as evidenced by what some of the other states pay, as you’re charged with doing by the General Assembly, and what Surgical Care Affiliates have said in their very own documents is a savings off of that. Lastly, I think, if possible, 97-26(c) allows for some negotiation between providers should they wish to do that. I - it was unclear if that’s still preserved. We would like to have that ability if a provider or self-insurer or insurer would like to negotiate further with a provider, whether it be a surgical care or - an ambulatory surgical center or whoever it may be - that they can still have that ability to negotiate more. We’re not sure quite if that was in here or not, but I would make that last point so - and with, Mr. Chairman, I do not have any other comments, and we will be submitting written comments hopefully in the next week.

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

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

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: Okay. And the next speaker will
be Mr. Ronnie Cook.

RONNIE COOK

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

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

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

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

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

MR. COOK: Okay. On Subsection (g), which is the
maximum reimbursement rate for institutional services
provided by an ambulatory surgical center, it’s two
hundred percent of the Medicare ASC facility specific
amount. We are in agreement with that amount. We
think it’s an appropriate reimbursement amount. It is
consistent with the logic that was provided earlier in
Andy’s comments as he related to the prior
negotiation. Obviously, hospitals get a mark-up - a similar mark-up on Medicare rates. Obviously, when we moved from this section, from our percent of charge-type reimbursement to this more fixed rate related to Medicare - a mark-up on Medicare, that resulted in significant savings related to the payers and to the - and to the individuals involved. Hospitals understood this, realized this and were in acceptance of this, and we were thinking at that point during that negotiation that this applied to all providers. Also, another key point of this is going to the fixed rate versus any sort of percent of charge or any type of unbundling-type logic is you do get the bundled services. You do get a fixed and a very predictable amount of service. All of the services that are billed as part of these codes that are billed to Medicare are rolled up based on status indicators and are paid accordingly, so it is a bundled payment, so there is savings to the carriers, as well as savings to the member, and it's very significant. We are in agreement with that. We think that it would be inappropriate to pay ambulatory surgery centers at a rate higher than you would pay a hospital because, in theory, if you think about the industry standard, there is truly a hierarchy of care, and that hierarchy
of care goes anywhere from licensure all the way up through the type of services rendered, the type of costs, what they can do - the services that those particular facilities can do. For example, you have services that can be provided in a physician office. Then you go up from there to a freestanding ambulatory surgery center, and they obviously can only provide care for up to twenty-four hours. Then you go into a hospital outpatient department, and they can provide care beyond that, but, ultimately, they need to - they deal with higher regulations, higher costs, more intense services, sicker patients in a lot of cases, and therefore - and then you go from that to an inpatient setting. And if you think about the concept at an ambulatory surgery center, obviously, they can provide care to a point, but if something goes bad in that situation, they have to go to a hospital, and the same thing at a hospital outpatient. If something goes south in that particular procedure, then we have the inpatient setting, so there is a hierarchy of care in that and there are higher costs as you go through that hierarchy, and therefore, it makes sense that - and Medicare has recognized this, so it definitely makes sense, and other payers as well - managed care payers, as well as Medicaid - so it makes sense that
there's a comparable relationship between payments, so we believe that the two hundred percent of Medicare for ASC is a valid and appropriate payment. Okay. As we move to Section (h), now Section (h) tries to deal with those services on a particular addendum in the Medicare rule, which is Addendum EE, which is surgical procedures excluded from payment in an ASC for calendar year 2017, but it could be for any calendar year because there will be services. These are codes that Medicare has deemed that is inappropriate to be performed in an ASC for various clinical reasons. We have analyzed those specific codes that would be excluded, especially the ones that had an OPPS - or hospital status indicator, which means they could be done in a hospital outpatient setting. There's two hundred and - two thousand and ninety-six codes on that list. Of those, one thousand, seven hundred and forty-seven are codes which have an outpatient status indicator of C, which means they really should be inpatient only, so these are codes that Medicare feels should be only inpatient. And then, in addition, there's twenty-one codes where Medicare says that there should be no additional payment, so these are codes that they call package codes. They have a status indicator of N, and that means they should be
packaged and paid as part of another service, you
know, so what we’re talking about then is somewhere in
the neighborhood of two or three hundred codes that
clinically probably could be performed at an ASC, as
well as performed in an outpatient setting. And we’re
in agreement and see no reason that an ambulatory
surgery center would not be eligible to provide those
services as well as a hospital outpatient department,
which is consistent with Andy’s comments. We see no
reason that there should not be a difference in that.
However, going beyond that, now there could be, I
guess, in a few rare, rare cases the potential that
someone that’s less than sixty-five years old with
physician advisement would be able to have some
services performed that would be on an inpatient only
list for Medicare, so the younger folks may be able to
tolerate such a procedure where some folks over
Medicare age would not. We do understand that under
certain statutes already that there is a UCR-type
reimbursement for that, but we think that would be
unusual in nature. There would not be that many of
those cases. And at that point, we think the UCR,
since it is an exception-type basis, may be
appropriate, but when you get into Section (h) and we
talk about how to reimburse these other procedures, we
do not think it's appropriate to have a UCR-type reimbursement. We think it's a burdensome process, an administratively cost process, and, in addition, it potentially could undermine the fixed payment versus the unbundled payment for charges. It also could result in payment being higher to the ambulatory surgery center versus the hospital which is - it's on the hospital fee schedule, so they would be getting two hundred percent of the Medicare fee schedule, so it's potential that those rates could be higher. We do not think that is appropriate because we do believe that there is a true hierarchy of care and a hierarchy of costs that should be recognized. Therefore, we do believe - again, as what Andy was talking about earlier - that there should be a difference. There should be a difference, and it should relate to the hospital outpatient fee schedule. Again, I've looked up some information today. Obviously, we saw what Andy quoted at that - the percentages that he got out of the - out of the presentations that were made earlier. I've looked at some - an OIG report that was done in 2017. It says that number might be in the neighborhood of sixty-seven percent. I've looked at a MedPAC report. They have differing numbers, and so - but we believe there is a difference. And we - and,
obviously, if you’re getting two hundred percent of a Medicare fee schedule for ASC and two - and there’s a slightly higher number for hospitals - two hundred percent - we think that that relationship should be maintained for those procedures that are not on the ambulatory surgery fee schedule, but are on the hospital outpatient fee schedule, so there is a difference. There’s an ambulatory surgery fee schedule, and they list a lot of procedure codes. There are certain procedure codes that Medicare say they don’t think it’s appropriate for the ambulatory surgery center to do, but they have said that a hospital outpatient can do those, so those procedure codes - that difference - we’re saying is appropriate for the ambulatory surgery center to do those in this setting, but we think that the relationship between the payment should be consistent. So we have a two hundred percent of hospital outpatient now. We have two hundred percent of ASC, so as we move away from the fee schedules, that relationship should stay. That difference, whatever it is, whatever it is, should stay, should be consistent so the ambulatory surgery centers would have an incentive. The payers would have an incentive theoretically to use ambulatory surgery centers if they think it’s
appropriate. The payers would have an incentive
because payment is fixed. They understand what it’s
going to be. It’s a reduction from what it was,
obviously, on a percent of charge basis. So it looks
from our point of view that it makes common sense and
everybody wins. It’s a win-win for everybody in that
particular setting. Now one way you could do this -
we have thought about a process that if you wanted to,
instead of looking at outsider, independent numbers,
you could run a relationship between the fee
schedules. Obviously, Medicare - when Medicare
publishes their fee schedules, they do it by code - by
surgical procedure code, and there’s a related
reimbursement. There’s a status indicator that tells
whether it’s paid for or not, and there’s a
reimbursement code. And we specifically think that
any modification in this area - that the only way we
would pay for a service is if it - if the payment code
is allowed under Medicare outpatient prospected
payments, so there would be caveat with that, but we
would compare those two codes for the same services
that are on both fee schedules. So, if I have an ASC
fee schedule for Medicare and I have a code, I find
that corresponding code on the hospital outpatient.
If it’s a match code and it’s reimbursable under both,
then I compare the two fee schedules. That would give me a relationship. I do that for every code that matches. So I take the aggregate of all of that and do a relationship, and whatever that relationship is in aggregate could be applied to these codes where there is a difference, and that would maintain the integrity of what we talked about earlier, that the fee schedules are paid under the same basis. Now I'm available for any questions that you might have.

CHAIRMAN ALLEN: Commissioners, do you have any questions?

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

MR. COOK: Well, it's not really a reduction. What it is is keeping the - because what you have proposed in (g) is two hundred percent of Medicare on
the ASC fee schedule. What hospitals get reimbursed now is two hundred percent of Medicare reimbursement on the outpatient prospected payment fee schedule. There is already an inherent difference, so if I’m on - if I do a service and I’m on either one of those fee schedules, there will be a difference in payment.

COMMISSIONER BALLANCE: That’s (unintelligible).

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

COMMISSIONER BALLANCE: Right. And the---

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

COMMISSIONER BALLANCE: Right.

MR. COOK: Does that make sense?

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

MR. COOK: Well---

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

MR. COOK: Uh-huh.

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

MR. COOK: Uh-huh.

COMMISSIONER BALLANCE: ---even though it's a service that Medicare doesn't recognize as being
performed - capable - or should - Medicare is saying that this is a service that we are not going to reimburse if it’s performed at an ASC. Is---?

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

COMMISSIONER BALLANCE: Uh-huh.

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

COMMISSIONER BALLANCE: Uh-huh.

MR. COOK: It’s on the fee schedule now, and it’s basically on the same logic, so we’re saying that if
Medicare had these services that we’re saying it’s okay for an ASC to do, even though it’s not on their fee schedule - then if Medicare did that, they would use the same logic. They would put it under their - under their fee schedule at the same approach, so we’re saying that that’s what we should do, and the reason - there is a difference in the hierarchy. They pay - obviously, they pay hospital inpatient more than they pay hospital outpatient. They pay hospital outpatient more than they pay ambulatory surgery centers, and they pay surgery centers far more than they pay physicians, even though in some cases they may be doing similar services, and they do that because there is a far different cost associated with doing that. Obviously, hospitals have more demands and more regulatory burdens. They need - they provide emergency care, safety - their safety-net hospitals, their disaster hospitals. Their patients generally are sicker when they get there because there is a hierarchy of where those services should be performed, and that’s why there’s a difference in payment because of that, because it actually costs far more. Because when a surgery center - if I - again, like I said before, if I have surgery in a surgery center and something goes bad, they have to send me to the
hospital, and that's a more costly environment, but
they have to do that.

COMMISSIONER BALLANCE: Okay.

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

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

MR. COOK: It's billed hospital outpatient, and it
goes against the hospital outpatient fee schedule, and
we get two hundred percent of that. So, if there is a
procedure - a surgical procedure code that's on our
fee schedule, then we would bill it hospital
outpatient, and it would be paid at the - at two
hundred percent. Now, you know if for some reason
there was a decision made that it should be done
inpatient, then that's paid at a DRG. That's a total
different payment methodology. That's totally
different if someone would say it had to be done
inpatient, but if it’s billed that way, it would bill
hospital outpatient. We would get the mark-up,
whatever that particular mark-up percentage is for the
time period that we’re in, against the Medicare fee
schedule, and that’s what will happen with the ASC.
If an ASC does the - a procedure, whatever it may be,
if it’s on their fee schedule, they will get two
hundred percent of that, but then there’s going to be
some codes that aren’t on their fee schedule, and so
one could argue don’t let them do that at all. You
know, you could---

COMMISSIONER BALLANCE: I understand.

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

COMMISSIONER BALLANCE: Okay. Let me---

MR. COOK: We just think there needs to be a
relationship in payment, that there---
COMMISSIONER BALLANCE: Let me understand. If Medicare says a particular procedure should be done inpatient and they don’t have an outpatient code for it, but that procedure is provided outpatient, it is billed outpatient - the Medicare schedule for outpatient for that instead of inpatient. Is that your understanding?

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

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

MR. COOK: I guess if all the parties, including the physician, were in agreement that it should be done outpatient, even if it’s not on that schedule, then I assume under current regulation it would - it would go to UCR, if I understood right - correctly. We would bill it - if everybody says it should be outpatient, we would bill it outpatient if that’s what the agreement was with all the parties, and I’m assuming then that the current regulation, which is a UCR payment, would come into play. And the reason you have to do that - and you can’t do the relationship between the same logic that we’re proposing for outpatient. The outpatient is you can’t do the same
concept that I agreed to on outpatient to inpatient
because they're paid totally different under Medicare.

COMMISSIONER BALLANCE: I understand.

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

COMMISSIONER BALLANCE: I understand.

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

COMMISSIONER BALLANCE: I understand.

MR. COOK: ---develop.

COMMISSIONER BALLANCE: Okay. Thank you.

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

COMMISSIONER BALLANCE: Yeah.

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

CHAIRMAN ALLEN: Other questions from the
Commission?

MR. COOK: Very good.
CHAIRMAN ALLEN: All right. Mr. Cook, I have a question.

MR. COOK: Certainly.

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

MR. COOK: So the logic could be – basically, it would say something that for those codes on that Addendum EE that are not inpatient only-type codes and they are payable under the hospital outpatient OPPS – so, in other words, we have payable codes under outpatient PPS. If those two codes – when they match, then the Commission is proposing to pay X percent of the hospital outpatient prospected payment fee schedule or X percent of two hundred percent of, so what you would do is you would take the outpatient prospected payment fee schedule. You will find the same code over there on that particular schedule, and let’s say it’s $100, and let’s say the percentage relationship – if the OIG schedule is right and it’s about sixty-five percent, which seems to be consistent...
with some of the numbers floating around, then you -
if it's a thousand bucks, you pay six hundred and
fifty bucks. It will be an automatic. The payers
would know exactly what to do. The ASCs would know
exactly what to expect on payment when they did it.
Everybody would know. There would be no UCR
negotiation, no what does UCR mean, any - it would be
a - it would be a slam dunk.

CHAIRMAN ALLEN: All right.

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

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

COMMISSIONER CHEATHAM: Okay.

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

COMMISSIONER CHEATHAM: Right.

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

COMMISSIONER CHEATHAM: I just wanted to make---

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

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

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

COMMISSIONER CHEATHAM: Right.

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

CHAIRMAN ALLEN: And the Commission.

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

CHAIRMAN ALLEN: Okay. Any other questions?

Hearing none---

MR. COOK: Okay.

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

MR. COOK: Thank you.

(SPEAKER DISMISSED)

CHAIRMAN ALLEN: If any of the speakers today prepared a summary of your remarks, please provide them to the court reporter at this time. We thank you
for your inputs, and we'll consider all your comments.

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

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

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

(WHEREUPON, THE HEARING WAS ADJOURNED.)

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COUNTY OF GUILFORD

CERTIFICATE

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

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

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

My commission expires on December 3, 2018.

Kelly K. Patterson
Notary Public
Guilford County
North Carolina

My Commission Expires 12/3/2018
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(a). 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 919.731.3000 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 these temporary rules 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 Mall Service Center, Raleigh, NC 27609-4333, phone (919) 807-2044, 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 (b), (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, 180 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.

(i) 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-2016; 2017) and Addendum BB, Final-BB (Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2014; 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.

(i) 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.

(j) 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), (e), (f), and (g) of this Rule.

(k) Notwithstanding Paragraph (k) of this Rule, charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.

(l) 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.

(m) 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.
This matter came before the undersigned Superior Court Judge of Wake County upon a Petition for Judicial Review filed by Petitioner Surgical Care Affiliates, LLC ("SCA") pursuant to Article 4 of the North Carolina Administrative Procedure Act ("APA"). Petitioner seeks reversal of the December 14, 2015 Declaratory Ruling entered by Respondent North Carolina Industrial Commission ("the Commission") denying the declaratory relief sought in SCA's October 1, 2015 Request for Declaratory Ruling filed with the Commission.

After review and consideration of the Official Record and the filings and arguments of the parties, this Court has concluded that the Commission's Declaratory Ruling should be reversed.

THE PARTIES

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"). (Record page 8, hereinafter "R p 8"). The SCA Ambulatory Surgical Centers are located throughout North Carolina and include Blue Ridge Day Surgery Center at 2308 Westfield Court in Raleigh, Wake County, North Carolina. (R p 8).
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.

(2) 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 Intervenors 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 Intervenors 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 under 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.


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(c).

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 4 day of August 2016.

The Honorable Paul C. Ridgeway
Superior Court Judge
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

Surgical Care Affiliates, LLC, )
PETITIONER )

v. )

North Carolina Industrial Commission, )
RESPONDENT )

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% (-$8.0M) 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.

<table>
<thead>
<tr>
<th>Maximum Reimbursement for ASC</th>
<th>Impact on ASC Services</th>
<th>ASC Share of Medical Costs</th>
<th>Impact On Medical Costs</th>
<th>Medical Costs as % of Overall Workers Compensation Benefit Costs in North Carolina (Eff. 1/1/2017)</th>
<th>Total Impact on Overall Workers Compensation System Costs in North Carolina</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A)</td>
<td>(B)</td>
<td>(C)</td>
<td>(D)</td>
<td>(E)</td>
<td></td>
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<tr>
<td>Lower</td>
<td>Upper</td>
<td>Lower</td>
<td>Upper</td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>150% of Medicare ASC Payment Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-17.0%</td>
<td>-12.8%</td>
<td>-0.8%</td>
<td>-0.6%</td>
<td>-0.4%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>200% of Medicare ASC Payment Rate</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>-9.4%</td>
<td>-6.0%</td>
<td>-0.5%</td>
<td>-0.2%</td>
<td>-0.2%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>235% of Medicare ASC Payment Rate</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>-4.1%</td>
<td>+3.7%</td>
<td>-0.2%</td>
<td>+0.2%</td>
<td>-0.1%</td>
<td>+0.1%</td>
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<tr>
<td>100% of Medicare Outpatient Prospective Payment System (OPPS)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-12.2%</td>
<td>-6.0%</td>
<td>-0.6%</td>
<td>-0.3%</td>
<td>-0.3%</td>
<td>-0.1%</td>
</tr>
<tr>
<td>150% of Medicare OPPS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+2.8%</td>
<td>+17.7%</td>
<td>+0.1%</td>
<td>+0.6%</td>
<td>0.0%</td>
<td>+0.4%</td>
</tr>
<tr>
<td>200% of Medicare OPPS</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>+25.2%</td>
<td>+44.9%</td>
<td>+1.2%</td>
<td>+2.2%</td>
<td>+0.8%</td>
<td>+1.1%</td>
</tr>
</tbody>
</table>

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:

- Maximum reimbursement rate of 150% of the 2016 Medicare ASC facility specific amount
- 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 $1,688M 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

- Maximum reimbursement rate of 235% of the 2016 Medicare ASC facility specific amount
- Maximum reimbursement rate of 100% of the 2016 Medicare Outpatient facility specific amount
- Maximum reimbursement rate of 150% of the 2016 Medicare Outpatient facility specific amount
- 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 = \[\text{Multiplier} \times 2015 \text{ Medicare ASC Payment Rate} - \text{Multiple Procedure Discounts (if applicable)}\]

Where Multiplier = 220%

Proposed MAR – ASC-Based Alternatives

Proposed MAR = \[\text{Multiplier} \times 2016 \text{ Medicare ASC Payment Rate} - \text{Multiple Procedure Discounts (if applicable)}\]

Where Multiplier = 150%, 200%, or 235% in three distinct scenarios

Proposed MAR – Hospital Outpatient-Based Alternatives

Proposed MAR = \[\text{Multiplier} \times 2016 \text{ OPPS Payment Rate} - \text{Multiple Procedure Discounts (if applicable)}\]

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 factor\(^2\). 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%.
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.

<table>
<thead>
<tr>
<th>Medicare Payment Schedule</th>
<th>Medicare Multiplier</th>
<th>Percentage Change in MAR</th>
<th>Price Realization Factor</th>
<th>Impact on ASC Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC</td>
<td>150%</td>
<td>-25.8%</td>
<td>50%</td>
<td>-12.9%</td>
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<td>-6.0%</td>
<td>50%</td>
<td>-4.0%</td>
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<td>Outpatient</td>
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</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Year</th>
<th>Change in Price Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>4.8%</td>
</tr>
<tr>
<td>2014</td>
<td>4.5%</td>
</tr>
<tr>
<td>2013</td>
<td>3.9%</td>
</tr>
<tr>
<td>2012</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

*Source: Bureau of Labor Statistics*
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% (=\(\frac{4.8\% + 4.5\% + 3.9\%}{3}\)).
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 = \([\text{Multiplier} \times 2016\;\text{Medicare ASC Payment Rate} - \text{Multiple Procedure Discounts (if applicable)}] \times (1 + \text{Price Departure})\)

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 = \([\text{Multiplier} \times 2016\;\text{Medicare OPPS Payment Rate} - \text{Multiple Procedure Discounts (if applicable)}] \times (1 + \text{Price Departure})\)

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

<table>
<thead>
<tr>
<th>Medicare Payment Schedule</th>
<th>Medicare Multiplier</th>
<th>Percentage Change in Reimbursement</th>
<th>Price Realization Factor</th>
<th>Impact on ASC Service</th>
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<td>235%</td>
<td>-8.2%</td>
<td>50%</td>
<td>-4.1%</td>
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<tr>
<td>Outpatient</td>
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<td>200%</td>
<td>+31.5%</td>
<td>80%</td>
<td>+25.2%</td>
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</tbody>
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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

SPARKERS: PAGE
Kelli Collins .................................................. 6
John McMillan .............................................. 27
Linwood Jones .............................................. 34
FULL COMMISSION 

PROCEEDINGS

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
Manning Fulton, and he is representing other stakeholders who have expressed, you know, a proposal to the Commission. And finally, Linwood Jones with the Hospital Association will be speaking as well. As a reminder, any person or entity wishing to present written comments or other documentation to the Commission in response to a proposal or discussion here today should file the comments and corresponding documentation with the Industrial Commission Rulemaking Coordinator Kendall Bourdon. Ms. Bourdon is at - sitting over at the table to my right. These comments and documentation should be submitted no later than October 10th, 2016, and these responses will be published on the Commission's website within two business days of that deadline. If you are making comments, I will ask you to stay for the entirety of the meeting today. This is to help facilitate, if the Commissioners have any questions that arise after a follow-up speaker, that, you know, there's an opportunity to have those questions answered by the appropriate party. As we articulated in the notice of the meeting, the purpose of this meeting is to take public comment on and consider rulemaking options to address the effects of the August 9th, 2016 court Decision by Judge Ridgeway invalidating the April 1,
2015 Medical Fee Schedule provisions for ambulatory surgery centers. By way of a brief history, Surgical Care Affiliates filed a Petition for Declaratory Ruling regarding the Commission’s enacted Medical Fee Schedule last fall. The Commission issued its Declaratory Ruling denying the requested relief. SCA filed a Petition for Judicial Review in Wake County Superior Court. Judge Paul Ridgeway ruled the Commission’s Medical Fee Schedule to be invalid as applied to ambulatory surgery centers based on a rulemaking procedural issue going back to the language of the General Assembly Session Law instructing this transition to a Medicare-based Fee Schedule. The Judge granted the Commission’s Motion for Stay of the Decision pending the outcome of this litigation on appeal. I say all this to ensure that we are all on the same page moving forward. First of all, we are not here to discuss the validity of the current rule or any of the currently pending litigation. It would be improper and inappropriate to discuss the merits of that litigation in today’s setting and would defeat the purpose for which we are all gathered here today, so let’s be clear. We are here to allow the public to make proposals, presentations and give oral comments and responses on what to do in light of the ruling.
Although the lower court ruling has been stayed, based on the contingency that Judge Ridgeway's Decision could be upheld on appeal, it is the Commission's responsibility to determine what to do in that potential eventuality. We are operating under the assumption that you all received the analysis provided by NCCI. I would like to provide a few comments on that analysis. As we contemplated eliciting proposals in advance of this public comment meeting, we contacted NCCI to ask if they would be willing and able to price out the various proposals that we would receive. They suggested that instead they provide a range of price proposals because that would provide a better set of benchmarks in evaluating proposals received. We understand that there is a lot of noise in these numbers. The Commission is not taking these analyses to be more than a set of benchmarks, fully aware of all the complications and factors behind these numbers. At this point, this is the best data set that we have to work with as 2015 was a transitional year in that the Medicare-based Fee Schedule went into effect on April 1st, 2015, and, of course, 2016 isn't complete, so there is no complete set of data on the Medicare-based Fee Schedule by which to analyze and compare. In addressing the
baseline use in the analysis and consultation with the actuaries and data analysis experts, the two hundred and ten percent of the Medicare ASC Fee Schedule - or fee rate was selected to be the baseline for this analysis. Because of the effect of Judge Ridgeway's Decision is to invalidate the Commission's Fee Schedule as applied to ambulatory surgery centers, meaning that the maximum reimbursement rate for ASCs revert back to the percentage of charges model, a percentage of charges analysis was not requested from NCCI because it is not a stable model or benchmark in that it is not an easily controllable metric because charges can fluctuate. From the Commission's perspective, our approach to the Medical Fee Schedule is as it should be that it requires us to balance three factors: Number one, appropriate care for injured workers; two, adopting a reasonable reimbursement rate and, three, medical cost containment. Those of you who have experience within rulemaking know that it goes much more smoothly if all stakeholders are in some sort of an agreement or can come to an agreement. The Commission recognizes that there are many competing interests involved, and the Commission hopes that this public comment meeting will allow those interests to be aired in the hopes that
the stakeholders can better understand each other’s positions and potentially establish some lines of communication that will result in a reasonable compromise. We will take presentations and comments in the order that people signed up to speak, and I just went over that list. Presentations are limited to ten minutes. That does not necessarily include time spent answering questions from the Commissioners. To help facilitate that time period, to my right, Executive Secretary Meredith Henderson will be tracking that time. When each speaker is at the two-minute mark, she will raise her hand with two, and then likewise one minute, and then she will alert you when your time is up, and then we will ask you to immediately conclude your remarks. With that said, I will now yield the floor to Ms. Kelli Collins with Surgical Care Affiliates for time not to exceed ten minutes---

KELLI COLLINS

MS. COLLINS: Thank you.

CHAIRMAN ALLEN: ---and then questions to follow.

MS. COLLINS: Good afternoon.

CHAIRMAN ALLEN: Good afternoon.

MS. COLLINS: Thank you for allowing me the opportunity to speak with you today. My name is Kelli
Collins, and I'm here on behalf of Surgical Care Affiliates, which is proud to operate seven ambulatory surgery centers - or ASCs - in North Carolina. The question before this panel today is two important parts: Process and patients. And I'd like to take the opportunity to address both of those. With respect to process, three years ago, the Commission tasked a stakeholders group with developing a Fee Schedule for ambulatory surgery centers among others, but did not invite the ambulatory surgery centers to participate. This flawed process was itself without basis since the underlying 2013 legislation did not direct that the ASC Fee Schedule had to be changed. The fact was even underscored by the North Carolina Hospital Association which wrote in a memo, "The legislation did not specify that ambulance rates would be changed." As a result, SCA had no option but to file a Request for Declaratory Ruling asking that Commission invalidate its new ASC Fee Schedule. The Commission refused to do so. As suggested by Chairman Heath, SCA then filed a Petition for Rulemaking with the Commission, but the Commission denied SCA’s Petition. SCA appealed, and Wake County Superior Court Judge Paul Ridgeway ruled this August that the new SCA Fee Schedule is invalid and that the prior Fee
Schedule should remain in place. Since then, the Commission has filed an appeal to reverse Judge Ridgeway’s Decision and is proceeding as if the Judge ruling has never been issued. Throughout this regrettable process, SCA has tried in every way to achieve resolution. Even now, we are seeking an amendment to address procedures that are not currently covered in the invalid Fee Schedule and to ensure that reimbursement allows for site of service decisions to be based solely on clinical judgment, quality outcomes and scheduling efficiencies, all for the sole benefit of the injured worker. And that brings me to the second and most important aspect of this issue: Patients. The Commission’s invalidated Fee Schedule creates a significant reimbursement disparity between ASCs and hospital outpatient departments for the same services. Given how many injured North Carolinians depend on a community-based surgical care that ASCs provide, that represents a real threat to patients in our state. Currently, injured workers are forced to receive treatment in a more expensive inpatient setting where scheduling services also takes longer and results in delays of care. Even the Commission admits this since it has said the reimbursement disparity would, and I quote, “...potentially diminish
the pool of doctors available to treat injured employees and reduce the quality and timeliness of care." The Commission went on to concede, and again I quote, "That impact will most likely severely be realized in our state's more rural areas where the quality and availability of effective treatment is already a greater concern." SCA agrees that the only way to ensure injured workers across - access to high quality care and effective care is to create parity between the ambulatory surgery and hospital outpatient Fee Schedules. We therefore urge you to adopt the amendment we have proposed, which includes the following: For those procedures for which CMS has established a Medicare rate, the schedule of maximum reimbursement rates for services provided by ASCs would be the same as the maximum reimbursement rates for hospital outpatient institutional services and, two, for those procedures for which CMS has not established has not established a Medicare rate for hospital outpatient institutional services, the maximum allowable amounts for services provided by ASCs would be fifty percent of bill charges up to a cap of $30,000. Charge master increases would be limited to a zero percent increase for these procedures for the first three years or a revenue
neutral adjustment would be applied as a percentage of a charge paid. In its proposal, SCA has shown how the partially invalid rule on fees for institutional services would be amended to set forth this Fee Schedule for ASCs. The amendment would eliminate the confusion that currently exists, lower the cost for surgical treatment and increase access to timely community-based care. Moreover, an independent analysis has determined that this approach will generate overall savings to the workers' comp system in 2017 of $8.8 million dollars. In closing, we believe the proposed action should be taken both to correct serious procedural flaws and, even more important, to give North Carolinians - injured workers access to the high quality community-based care they want and deserve. Thank you again for the opportunity. I would be more than happy to address any questions you may have. I also have with me Renee Montgomery, our legal counsel, and Stacey Smith with Liberty Partners, both of whom are also available to answer questions. And I did want to take a moment to introduce the administrative members of the SCA team that are in attendance: Jenny Graham, Cathy Libel (phonetic), Debbie Murphy, Tom Lowey (phonetic), Cathy Stout and/or - and Corey Hess and Colleen Lochamy.
And I want to thank the rest of the team for attending. And again, thank you for your time today.

CHAIRMAN ALLEN: Good. And you stayed under ten minutes. Thanks.

MS. COLLINS: Yay.

CHAIRMAN ALLEN: I have a few questions---

MS. COLLINS: Okay.

CHAIRMAN ALLEN: ---if that's all right.

MS. COLLINS: That's - of course.

CHAIRMAN ALLEN: We understand that there is noise, as I mentioned - the NCCI analysis - and it's just one way of looking at things. Can you please explain your statement that the NCCI analysis overstate the costs and understates potential savings of a change to the ambulatory surgical care Fee Schedule?

MS. MONTGOMERY: That was actually - if I may, I'm Renee Montgomery.

CHAIRMAN ALLEN: Ms. Montgomery, if you could step up to the microphone and make sure---

MS. MONTGOMERY: I can do that. The - Chairman Allen and Commissioners, again, I'm Renee Montgomery, representing SCA, and I was involved in the Judicial Review matter on behalf of SCA. The - that point has to do with the fact that the National Council on
Compensation Insurance - the cost analysis it did - it assumed that an invalid Fee Schedule was a valid Fee Schedule, and so they used the invalid Fee Schedule as the baseline, and that is the concern. By using the invalid Fee Schedule as the baseline, it overstated the costs involved and the potential savings. It overstated costs, so it actually is just not a valid comparison. To use that as the baseline makes it appear that it will be much more costly than it really will. As we said in our proposal, and I think Ms. Collins eluded to, SCA has done an analysis that shows that the savings with what it is proposing is in excess of eight million dollars, so that's---

CHAIRMAN ALLEN: I don't want to interrupt---

MS. MONTGOMERY: Okay.

CHAIRMAN ALLEN: ---but if this is a good point, have y'all provided that independent analysis?

MS. MONTGOMERY: We have. We have.

CHAIRMAN ALLEN: Okay.

MS. MONTGOMERY: I believe it was set forth in the proposal itself.

MS. COLLINS: It was. Yes.

CHAIRMAN ALLEN: Okay.

MS. MONTGOMERY: And that is what we think that the Commission should take into account in determining
the rule. And I might also while I'm - while I'm up
here, we also had a concern, which was also stated in
the proposal, regarding the timing of what was asked
of the proponents. It was - the proponents were - if
there was proposals to be submitted, the proponents
were to assume an effective date of January 2017, and
we don't think that's a realistic assumption for a new
Fee Schedule. Because of the requirements of
permanent rulemaking, that will take significantly
longer than the two and a half - three months, and I
don't think reading the requirements for a temporary
rule - that it would meet the - any of the criteria
that would need to be met before a temporary rule
could be put in place, so that's a second concern we
have about the cost analysis that was done, as well as
the directions given to the interested parties.

CHAIRMAN ALLEN: All right. I also wanted to
ask - it's my understanding - and perhaps y'all can
correct me if my understanding is incorrect - that
the - for the states that utilize a Medicare-based Fee
Schedule for workers' compensation, for ambulatory
surgical centers, the nationwide average rate is 146.7
percent, which is substantially lower than the rule
that was adopted by this Commission. Do you have any
explanation for why the rule that was adopted by North
Carolina that has been argued to be inequitable is substantially higher than the nationwide average?

MS. MONTGOMERY: Okay. Stacey---

MS. SMITH: You want me---? Oh.

MS. MONTGOMERY: Ms. Smith could respond to that.

She works with a lot of other states and is very familiar with workers' compensation schedules.

CHAIRMAN ALLEN: Sure.

MS. SMITH: Hi. Thank you, Chairman Allen.

Stacey Smith with Liberty Partners. I work with SCA. I appreciate the opportunity. I - and that point was made both in - well, along the way as far as what the averages are on a state-by-state basis. I think looking at that analysis is just a piece of taking a very small segment of Fee Schedules that exist. I think that analysis is based on NCCI data and not all states are NCCI states, so you’re getting a snapshot of those. The two most recent states that went to a Fee Schedule were Connecticut and Alaska. Connecticut went to a percent of Medicare, and they had parity between outpatient and ASC, so they are both paid - I believe it's two hundred and ten percent of Medicare HOPD - ASCs and HOPDs. Alaska did the same thing. They went through quite a process in rulemaking. They did not have a Fee Schedule, and so they just issued a
rule where HOPDs and ASCs are paid at the same rate, which is around — they have a — they do something very specific in Alaska, so they use the Medicare as kind of a baseline, and then they add an Alaska-specific regional code to that, and it's a little bit over two hundred and — it's around two hundred and thirty percent of Medicare, so it varies from state to state. And I said — and I would also say that if the analysis will be done — if that analysis is what's going to hold on part of ASCs, I would like to maybe know what the national average is for HOPDs and if the current HOPD Schedule is higher. So I think it's — you know, I think there's also a lot of dynamics as far as each state is very different on workforce issues, as you well know. I mean North Carolina has a thriving economy. Some states may not be as strong. Rates will be different. Workforce issues are different, injuries, your whole classification of the industries, so it's very hard to look at a state-by-state basis when you look at what the rate is.

CHAIRMAN ALLEN: And I understand that, but I was just intrigued and — you know, for instance, South Carolina, one of our neighboring states, utilizes a Medicare ASC payment rate of a hundred and forty percent.
MS. SMITH: Yeah, yeah. And South Carolina went through some real challenges with their Fee Schedule. When they went through changes and reforms, because of the rates that they set and how low the rate was, ASCs exited the market, and then the hospital outpatient departments exited the market as well, and they had to come back into session and fix their Fee Schedule to make some modifications, and that was specific to some other issues, but there are some very unintended consequences when you don't look at the real needs of an injured worker and what can happen. So there are some very specific — Texas is another example where they put in some pretty significant cuts and had to come back and readjust that Schedule because they saw providers moving out of the market, and it ends up costing employers more at the end because they're going to kick it on the indemnity side if they don't — if they don't get their workers back fast enough.

CHAIRMAN ALLEN: Okay. And can you explain the statement that was made that aligning the ASC reimbursement schedule with outpatient allows for site of service to be based purely on clinical judgment, quality outcomes and scheduling efficiencies?

MS. SMITH: Yes.

MS. COLLINS: Yeah, I can actually take that. We
believe that if there's parity across the Fee
Schedule, then the physicians can decide where the
patient should be cared for, and, you know, obviously,
in an ambulatory surgery environment, we think that's
a faster access, you know, higher clinical quality
situation than we can create in other places.

CHAIRMAN ALLEN: Okay. And do you have any, you
know, backup documentation that can be submitted on
that?

MS. COLLINS: I don't. I mean I know that in the
document it said that the Fee Schedule changes were
limiting access and - by making it more difficult for
folks to come to the ambulatory surgery center
environment, and if we change that and we have parity
in the Fee Schedule, obviously, that would open up
access to those operating rooms.

CHAIRMAN ALLEN: Okay. And can you explain why
the importance is placed on being paid the same as a
hospital outpatient facility?

MS. COLLINS: I think we should be paid the same
thing for the same services provided and, again, don't
want to not be able to provide the care and the access
for the injured workers.

CHAIRMAN ALLEN: Okay. Is that disparity that's
based upon the Medicare Fee - well, Medicare's rubric
that has a different rate for hospital outpatient
versus ASCs?

MS. COLLINS: I'm not sure I understand what
you're asking.

MS. SMITH: I think I understand what you're
saying. I think what you're saying is the disparity
if you go to an ASC versus HOPD and how the Medicare
Fee Schedule is a different Fee Schedule.

CHAIRMAN ALLEN: Right.

MS. SMITH: I think what - the states that you are
seeing that - you know, Medicare gives you all good
baseline because it's kind of a standard measure,
right, so every year, you know, you have a certain
amount of codes that are covered at a certain rate
coming out of CMS, but I think what's important when
you - when you look at a Medicare Fee Schedule is it's
not intended to be a Fee Schedule for injured workers.
A Medicare Fee Schedule is for patients over the age
of sixty-five, and they have very different needs, but
it does - it can and does create - could create a
baseline of measure, but an injured worker is very
different than, you know, a sixty-seven-year-old, you
know, woman who hurts her knee or needs a procedure
done in an ASC. So while it is in - a good baseline -
and I understand what the approach is to the point -
to your question, is why parity - why is parity important. And I think the Commission said it best in its statement of law in regards to the case that "If you don't have parity" - and I'm just using the Commission's words - "you will have behavioral patterns take place." You will have employers shifting patients into a lower side of service because that's for - beneficial to them. You may have, you know, then the higher side of service have access issues or there may be a diminishing - you're going to set up tremendous behavioral issues unless there's parity, and which that was confirmed by the Commission. And you want site of service neutrality. You want an injured worker to be able to go where they feel that they want to go and not having those decisions being made based on the finances of the system. Does that help answer that a little bit for you? Is that---?

CHAIRMAN ALLEN: I think so. Okay. I also wanted to ask about one of the aspects of the proposal that was made, was that, you know, fifty percent of bill charges up to a cap of $30,000 for, as I understand it, the codes that there is not a Medicare reimbursement rate for.

MS. COLLINS: So, again, just asking for parity.
And the way that we interpreted the change that happened on April 15\textsuperscript{th} was that there are certain CPT codes or procedures that are assigned to CMS as considered approved for an ambulatory surgery environment and certain ones that are not. So when NCIC adopted the new Fee Schedule and followed Medicare standards, we removed about thirty-seven procedures from our eligible list that we had been able to do prior in our environment, and those are some pretty high acuity cases.

CHAIRMAN ALLEN: Were there any efforts to try to resolve that with the carriers - the insurance carriers or through UCR?

MS. COLLINS: Through our conversations, and then also in our proposal.

CHAIRMAN ALLEN: Okay. But I take it there was no resolution with those.

MS. COLLINS: There was not.

CHAIRMAN ALLEN: Okay. Do you have any idea of what the percentage of the ASC market SCA represents in North Carolina?

MS. COLLINS: I know that - I think they're on record about a hundred and twenty ambulatory surgery centers in this state. I - we are seven of those.

One of our facilities is single specialty, and about
fifty percent of the others are single specialty, either GI or I, so pretty significant portion---

CHAIRMAN ALLEN: Okay.

MS. COLLINS: ---of the multispecialty market, I should say.

CHAIRMAN ALLEN: And, also, I noted in the proposal and in prior documentation that there was the assertion the ASCs provide better quality outcomes and improved return-to-work metrics. Do you have any information to substantiate that?

MS. COLLINS: Well, I do, and would be happy to provide that for you.

CHAIRMAN ALLEN: Okay. Very good. Could you describe to us how and why the discrepancy in payments impact the doctors providing care?

MS. COLLINS: I think the doctors are concerned with the cost to their patients and the cost to the employers, and they're going to choose to take these - or would like to have the ability to choose to take these patients to a lower cost environment. And when we can't do things, they're not on the Medicare-approved list, obviously, that pushes those to a higher cost environment, and if we're not paid in a way that allows us to have a margin on our business or to afford to do the volume, then those things are
Full Commission Public Hearing, October 3, 2016

going to be pushed into the hospital. So the physicians are making - being forced frankly to make those decisions based on finances rather than the best environment of care.

CHAIRMAN ALLEN: Okay. Help me to understand how if we were to adopt a proposal that has parity between the hospital outpatient rate and the ASC rate that that would create a lower cost environment in the ASC.

MS. COLLINS: Do you want to help me with this?

MS. SMITH: So I think - I think the proposal from SCA presents the parity issue between ASCs and HOPDs. I think that you get into cost savings by providing access to care. If you limit access to care to injured workers, you will see, you know, lower return to work and - longer return-to-work statistics, and what you may be saving on the medical benefit side you’re going to - you’re going to end up seeing on the cash benefit side. You’re not going to have workers going back to work as soon as possible and having greater indemnity benefits paid to them. I think for the SCA proposal of a lower cost site really goes to these codes that were - these procedures that were being done in ASCs prior to the implementation of the April 1st Fee Schedule. And what’s happening now is that those codes are being done in a much higher cost
setting of a hospital inpatient. So that’s where you get the real savings and a lower cost environment, is allowing these procedures to go back into an ASC setting, putting a cap on what can be spent, keeping the control of the costs with reviews and getting them back into the setting where you can save money through those.

CHAIRMAN ALLEN: Okay.

MS. COLLINS: Our return-to-work data will help you - help shed light on that as well.

CHAIRMAN ALLEN: Okay. And who provided the analysis of that return-to-work data?

MS. COLLINS: We have - we do - we measure clinical metrics, and we work with our physicians’ offices to determine all - several (unintelligible) measures.

CHAIRMAN ALLEN: So it’s an internally-developed document?

MS. COLLINS: It is.

CHAIRMAN ALLEN: Okay. Also, is it truly the case that ASCs won’t do these type surgeries anymore?

MS. COLLINS: The thirty-two on the---?

CHAIRMAN ALLEN: Right.

MS. COLLINS: Yeah, we can’t. I mean we are not - we’re not being reimbursed in a way that allows us to
even cover the cost of implants for those---

CHAIRMAN ALLEN: Okay.

MS. COLLINS: --procedures.

CHAIRMAN ALLEN: And, if so, how does that diminish the pool of doctors available?

MS. COLLINS: It doesn't diminish the pool of doctors. It diminishes the access.

CHAIRMAN ALLEN: Okay. Okay. So, in effect, this is really an issue about inpatient versus ASC under Medicare.

MS. COLLINS: Part of the issue is that. Yes.

CHAIRMAN ALLEN: Okay. Were ASCs really getting paid the same under the bill charges model as the outpatient facilities?

MS. COLLINS: I don't believe that Schedule was the same either. No.

MS. SMITH: Well, no, the procedure - it was - let me - since those bill charges. I mean ASCs were paid a hundred percent of bill charges in - around 2008. You all made some reforms in 2009, I believe, and--

MS. COLLINS: And it went to sixty-seven percent of bill charges.

MS. SMITH: Wait. It was seventy-nine percent then. Yeah. And then ASC and HOPD were at - both at seventy-nine percent. And then a couple of months
later, there was the fifteen percent reduction to 67, I think, .15 of---

MS. COLLINS: 15.

MS. SMITH: ---bill charges.

CHAIRMAN ALLEN: Okay.

COMMISSIONER CHEATHAM: Even after---

CHAIRMAN ALLEN: Commissioner---

COMMISSIONER CHEATHAM: Even after sixty-seven percent of bill charges, were not outpatient hospital

bill charges higher than ASC?

MS. COLLINS: The Fee Schedule for hospitals
typically is higher than it is for ambulatory surgery

centers, so, yes, because of that.

COMMISSIONER CHEATHAM: So the Fee Schedule
today - you'll be getting less than the hospitals?

MS. COLLINS: That's correct.

COMMISSIONER CHATHAM: The Fee Schedule that you
are proposing - you would be getting the same thing?

MS. COLLINS: Correct.

COMMISSIONER CHEATHAM: And how much of an
increase would that be?

MS. COLLINS: Do you know? Do you have that math?

MS. SMITH: It's a forty percent - it's a forty
percent reduction actually off of the bill charges

number.
COMMISSIONER CHEATHAM: But---

MS. COLLINS: From where we were in April---

MS. SMITH: Yeah.


MS. SMITH: From the valid Fee Schedule in effect right now, which is 67.15 percent of bill charges, to the SCA proposal is a forty percent reduction in medical costs.

COMMISSIONER CHEATHAM: I'm sorry. I still missed it. Let's back us up two years. Sixty-seven percent is in place. How much were hospital outpatient receiving for - on the whole, on the average for---

MS. SMITH: I don't - I don't think---

COMMISSIONER CHEATHAM: ---same service as - at an ASC?

MS. SMITH: Yeah. I don't think - we can - we can look up that data, but I don't think we can provide that answer to you right now. All we can do is quote a relative basis of what was happening in the ASC space.

COMMISSIONER CHEATHAM: My sense is that back then the fees going to hospitals were a good deal higher than ASCs which in fact recognized the lower cost structure and that that's what you're talking about eliminating. Correct?
MS. COLLINS: Well, what we're - I would - my impression is that the hospitals were reimbursed higher than us at that time. Yes.

COMMISSIONER CHEATHAM: Right. That's mine as well.

MS. COLLINS: Yes. Yes.

COMMISSIONER CHEATHAM: Thank you.

CHAIRMAN ALLEN: All right.

MS. COLLINS: Thank you.

CHAIRMAN ALLEN: Thank you.

MS. COLLINS: Thank you all very much.

CHAIRMAN ALLEN: Next, I'll recognize and yield the floor to John McMillan.

JOHN MCMILLAN

MR. MCMILLAN: Thank you, Mr. Chairman, members of the Commission. I'm John McMillan. I'm speaking this afternoon on behalf of employers, employer associations and insurance carriers, those who pay the workers' compensation benefits to injured workers and their healthcare providers. The list of these entities appears on page five of the written comments submitted to the Commission on September 26th. The medical costs for the North Carolina workers' compensation system have been an issue for decades, and there have been numerous attempts to bring them in
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line with other states, states with which North Carolina competes for economic development. Beginning in 2012, the employer and insurer communities began meeting with representatives of the providers in a negotiation process that lasted almost three years. We agreed to and jointly paid for a consultant who assisted with providing relevant information to all of the parties. We engaged a prominent mediator who met with both sides and with Chairman Heath to help develop Fee Schedules that, one, ensured that worker-injured workers are provided the services and standard of care required by the Workers' Compensation Act; two, providers are reimbursed reasonable fees for providing these services and, three, medical costs in workers' compensation claims are adequately contained. Agreements were reached on the revised Fee Schedules. It was a negotiation process in which there was give and take on all sides with the objective being to meet the statutory standards. Proposed rules were promulgated by the Commission and published in the North Carolina Register. A public comment period was noticed, a hearing was held, and the rules with the new Fee Schedules were adopted. Under the previous North Carolina Fee Schedule, ambulatory surgery centers' reimbursement for workers' compensation
injuries was thirty-one percent higher for knee arthroscopy and forty-nine percent higher for shoulder arthroscopy than the thirty-three state median reported by the Workers' Compensation Research Institute. Employers and insurers agreed to the mediated settlement in an effort to avoid litigation on these issues. That has been successful except for one group – Surgical Care Affiliates, LLC. They claim that they did not participate in the Fee Schedule discussions or rulemaking process; our position is set out in our written comments, is that they did through their representatives at the Medical Society, but that is a discussion for another day. As you consider the proposed rule for ambulatory surgery centers, we would ask that you consider adopting the Schedule previously adopted through the rulemaking process or, in the alternative, adopt a phased-in Fee Schedule that would provide for reimbursement rates of a hundred and fifty percent of the Medicare ASC facility specific amount when fully implemented. That would put North Carolina in line with our neighboring states of South Carolina, which is one hundred and forty percent, and Tennessee, which is a hundred and fifty percent; closer to the median of the states that use Medicare reimbursement methodology. For our complete statement, please refer
to our written comments previously submitted. And I'll be glad to attempt to respond to any questions you might have.

CHAIRMAN ALLEN: I have often heard that the Fee Schedule as it was adopted - and I think it's an apt analogy - it's like a finely-woven rug and that once you pull one thread out, the rest of it can become unwoven. Is that a fair assessment?

MR. MCMILLAN: I think it is. I don't want to spend a lot of time on who was representing who at these - at this long, drawn-out, three-year process. Linwood Jones is going to speak for the Hospital Association, and the hospitals own ambulatory surgery centers, so they were participating. ASCs were participating through their representatives in the Hospital Association. The Medical Society was actively participating, was a principal participant in all of the discussions. And hiring the consultant in the mediation, an agreement was reached, and it was a landmark agreement, and we came to a resolution based on Medicare Fee Schedule which is in place in most other states and works.

CHAIRMAN ALLEN: And what is the position, if there is a unified position, amongst your groups that you represent on the adoption of a rule provision that
would account for procedures that could be done at
ASCs that are not paid for by Medicare?

MR. MCMILLAN: I've asked that question. My
understanding is two things: One is the Commission
can adopt a Fee for any such procedures that fall into
that category, but, second, that virtually all
procedures are included in the Medicare Fee
Schedule. Where we get into issues is some of these procedures
are bundled, and they include all aspects of the
procedure, and sometimes some pieces of that are
pulled out. I don't think that's a separate procedure
as such, and it's - in the Medicare Fee Schedule, it's
woven into the - into the overall price. When they
pull it out, then they create an issue.

CHAIRMAN ALLEN: And have any of the proposing
entities worked out contractual arrangements with ASCs
outside the Fee Schedule that you are aware of?

MR. MCMILLAN: I don't know.

CHAIRMAN ALLEN: Okay. Given that we are supposed
to balance the three factors that I talked about
earlier and the two hundred percent Medicare ASC rate
was acceptable for cost containment purposes in 2014,
2015, what is the impetus now to move it further at
this time?

MR. MCMILLAN: Well, the two hundred percent was a
negotiated settlement with the give and take, and the one hundred and fifty is more aligned with what the average is. I think you correctly stated that the average is slightly under a hundred and fifty percent - one forty-six - one forty-seven, and our neighboring states of South Carolina and Virginia are one forty and one fifty percent - South Carolina and Tennessee. Virginia is undergoing rulemaking as we speak, and the General Assembly in Virginia instructed the Commission to adopt a Fee Schedule, and they're in the process of doing that, so they - I think they have a meeting within the next two weeks to discuss the Virginia's Fee Schedule.

CHAIRMAN ALLEN: Okay. Are you aware of any states that have switched to a Medicare - percentage of a Medicare-based Fee Schedule that have later gone back and revised the Fee Schedule rate?

MR. MCMILLAN: I'm sure there may be some, but I don't - I don't know that.

CHAIRMAN ALLEN: Okay.

MR. MCMILLAN: I will point out that Surgical Care Affiliates does business in many, many states that are under the thirty-three state average, and there's a list of those in our written comments, but there are a lot of states in which they have facilities that
CHAIRMAN ALLEN: Are you aware of any state that has---? I’m sorry. Were you about to say something?

MR. MCMILLAN: No. No.

CHAIRMAN ALLEN: Okay. Are you aware of any state that has subsequently adjusted the rate significantly downward as---

MR. MCMILLAN: I’m not.

CHAIRMAN ALLEN: ---one of y’all’s proposals---

MR. MCMILLAN: I am not.

CHAIRMAN ALLEN: ---suggested?

MR. MCMILLAN: I am not.

CHAIRMAN ALLEN: Okay. Do you think that our workers’ compensation system in North Carolina is structurally similar to that of the other states, such as South Carolina and Tennessee or Virginia?

MR. MCMILLAN: Every state is a little bit different, but when you say substantially similar, I would say that they are substantially similar.

CHAIRMAN ALLEN: Okay. Y’all have any further questions? Okay.

MR. MCMILLAN: Thank you very much.

CHAIRMAN ALLEN: All right. Thank you. Thank you, Mr. McMillan. Mr. 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 am surges at two hundred percent of 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' comp population that's typically younger and has different
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needs. So that’s - it’s - you know, we debated a long
time, as John talked about. It took a long time for
the Hospital Association to agree to a – to get to the
Medicare Fee Schedule system to tie our rates to
because it presents several – a number of problems for
us; the biggest of which I think - and this is what
drove the rates more than anything else - is looking
at what the rates were in other states. If we had to
agree or disagree on a settlement with the payers
based on how much financial impact this had on
hospitals, we never would have come to an agreement.
It was huge. It was a fifty - sixty - seventy million
dollar hit just in the first year, so it was a
substantial reduction moving from the sixty-seven
percent of charges in the implant carve-out to the -
what was two hundred and twenty percent of Medicare
and what could be two hundred by next year. Another
point on that: Most what hospitals are looking at -
and am surges may do the same; physicians, too –
they’re looking at what the other commercial payers
are paying and what is BlueCross paying me, what is
United paying me for this business. Those are their
benchmarks for what they consider to be an appropriate
payment. Medicare at two hundred percent is lower
than what hospitals are typically paid on Medicare
outpatient, but, again, if that were the only factor driving this, then we wouldn't have been able to agree to it, but we obviously had to look at the plain numbers of what other states were looking at as far as percentages, and you just don't see many percentages above two hundred percent in the other states that we looked at. So there is some - there is an issue there about using Medicare, but we've sort of agreed to it because it's a transparent system, and, frankly, we couldn't find another system to tie it to. We looked at the State Health Plan. We looked at tying hospitals for workers' comp to their commercial plans, but none of that's transparent to payers; Medicare is. All their rules are published. The rates are published. You know what you're dealing with as a payer, and so a lot of that played a big part in driving what we eventually agreed to and recommended to the Commission. A few other notes - and these are more about comments and questions I've heard as we've been sitting here. There was some reference to a memo we had in - that the Hospital Association had in 2012 or 2013 saying an surge is not in the legislation. That's - I probably wrote that. I don't remember that, but that's probably true. At the time we were dealing with this in the legislature, the focus just
at that time was physicians and hospitals, with the
understanding that the Commission had the authority to
deal with everybody else without us having to put it
in legislation, so that’s part of the thinking behind
why that wasn’t in the legislation. Another point
where we are - we’re still looking at it - and we put
this in our comment letter - is we’re still unclear on
NCCI’s analysis, and that’s mostly because we don’t
know what documentation they used, what factors they
looked at. We’ve had a consultant that does workers’
comp Fee Schedules in other states, including Georgia
and some of the other southern states, take a look at
this. We’re not saying it’s not valid. We’re just
saying we don’t know some of their assumptions yet,
and we’ll try and dig into that a little more this
week and follow-up with you all by written comment on
that. There was some comment about a hundred and
forty-six percent national average, a hundred and
fifty percent. We had a long discussion about that
during the mediation and in the year or two leading up
to mediation that while some reports, including WCRI,
may show that as the average, you - so I think the ASC
said you can’t really compare a state to state. Some
of these states carve out implants and treat those
differently, and that makes a huge difference
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comparing one state to another. We heard the same thing in South Carolina that the ASCs did after they passed a rate that low at a hundred and forty percent. I wasn't aware of what happened to the ASCs, but we knew the hospitals were exiting the market, didn't want to take the business anymore, and that did go through litigation there, too, I think, and may have been resolved by adding implants back into the hundred and forty percent. I forgot how it was resolved, but there was an issue with going to a rate that low.

There was some discussion about ASC rates versus hospital outpatient rates, and, Commissioner Cheatham, I think you kind of seized on the difference there. A lot of that - it's all driven by Medicare, and the reason there's a difference in Medicare is because of the costs. The hospitals are going to have higher costs. That was true when we were billing charges, too. We're always going to have higher costs because we're bringing in the costs of the ED, operating the facility twenty-four/seven. There are a lot of overhead costs that go into everybody's rates whether it's a workers' comp payer or BlueCross making the payment. So Medicare has that difference there, but there are other reasons for that other than just the overhead. We had our consultant - and we'll follow-up
in more detail on this. We had our consultant look at over three thousand procedures that are done by ASCs and hospitals, and out of those—well, let me back up a minute. Medicare determines—looks at these costs in coming up with what they call a weight, and that weight goes into setting these rates. They set it for hospitals, ambulances and probably any other facility that's on some kind of Medicare Fee Schedule. So we had our consultant look at the weights. There were about three thousand of them, and two thousand, nine hundred and fifty-two times the hospital outpatient rate—or weight was higher than the ASC weight. A hundred and twenty-five times it was the other way around. So I think what's driving that is that the procedures may look the same. It may be a knee surgery here and a knee surgery there, but you may have lab, imaging and other services that are working their way into the hospital outpatient procedure that aren't necessarily captured in the ASC procedure, so there's some—there's some cost reason for the difference there by Medicare. The thirty—I heard thirty-two and I heard thirty-seven procedures not covered by Medicare. I'm not—I'm not sure exactly what that is. If—it could be as John said. It's things that Medicare considers you to already be paid
for on the overall procedure rate. I don’t know that. I haven’t - we haven’t looked at what those are. We’d be interested in knowing more about that. Certainly, if it’s a full procedure and Medicare is not covering it, it needs to be paid for by workers’ comp, but if it’s something that’s gotten - if it’s a procedure that’s been bundled up into a rate you’re already being paid, that’s a different issue that would have to be looked at, I think. I’ll stop there. I’ve tried to tackle the questions I heard, but I don’t know if you have more.

CHAIRMAN ALLEN: Do you know what percentage of ASCs are hospital-owned in North Carolina?

MR. JONES: I don’t, but we think they’re around half, maybe more.

CHAIRMAN ALLEN: And I - and I believe the other Commissioners - heard - and, perhaps, we would learn for the first time at a recent WCRI conference that hospital-based ASCs are billing as outpatient entities. Is that correct?

MR. JONES: That’s correct.

CHAIRMAN ALLEN: Okay.

MR. JONES: Well, most of them are. Some of them bill the exact same way an SCA facility would bill. It depends on how they’re structured and whether they
qualify under Medicare to do that.

CHAIRMAN ALLEN: Okay.

MR. JONES: So this is all driven by Medicare.

CHAIRMAN ALLEN: Right. Is it equitable for a hospital-owned ASC to be billing at an outpatient rate when an ASC - or for the purpose of this question, an SCA-owned ASC is billing at a reduced rate?

MR. JONES: Well, we think so because the hospital outpatient is capturing additional costs an ASC is not going to have. That’s the overhead that’s coming in from running the ED and the other facilities. There’s also - there may also be - and I’m not familiar with them all, but there are requirements a hospital outpatient facility, even an ASC operating as an outpatient facility, has to meet that an ASC doesn’t necessarily have to meet. Now I having said that, Congress has just changed the rule for off-campus hospital outpatient departments to put them on the same billing as an ASC, and that’s because the hospital off-campus department doesn’t have these ED costs and other things to work into their rate. So they’re - Medicare is kind of going the other way. They’re bringing the off-campus hospital outpatient rates down towards the ASC rate going forward. They’ve grandfathered in the existing facilities.
COMMISSIONER CHEATHAM: I just - a quick follow-up. You have mentioned that there are certain requirements of outpatients - outpatient departments that differ from ASCs. Did I understand that correctly?

MR. JONES: I believe that's right. Now I don't - I don't - are you about to ask what they are or---?

COMMISSIONER CHEATHAM: I am.

MR. JONES: Okay. Well, we'll have to follow-up, and I think it's more being tied into the emergency department, having call ensured around the clock, certain clinical requirements of having your medical records tied into the hospitals. Some of that's going to drive costs, and some of the additional costs are just being driven by the overhead from the ED and other---

COMMISSIONER CHEATHAM: Okay.

MR. JONES: ---facilities moving into that rate.

COMMISSIONER CHEATHAM: That's enough.

MR. JONES: Right.

COMMISSIONER CHEATHAM: I just needed an example.

CHAIRMAN ALLEN: The Fee Schedule in 2015 was a substantial reduction for all medical facilities. How has that gone?

MR. JONES: It didn't go well when I informed my
members about it, but they've - as far as I know, they've learned to live with it. The payment issues we were anticipating have not been as bad as we expected because no one else - BlueCross, no one else uses Medicare as their fee payment system, and so the concerns were, were the payers ever going to be able to tap into the Medicare system and figure out the payments. And there have been some issues with it, but I think most of the larger payers have it figured out.

CHAIRMAN ALLEN: Do you have any information regarding how it has affected patient care in any way or changed site of service selection?

MR. JONES: We wouldn't know about any change between hospital outpatient and am surge. I don't think it has created access problems, at least not among our members that we know of.

CHAIRMAN ALLEN: Yeah. Are there any hospitals that you're aware of that are refusing or choosing not to take workers' compensation patients due to the reduction in fees?

MR. JONES: Not that we've heard.

CHAIRMAN ALLEN: Okay.

COMMISSIONER CHEATHAM: And I presume all hospitals are continuing to take Medicare patients?
Mr. Jones: They all - out of all of them that I know take Medicare.

Commissioner Cheatham: Just as they - I mean, there's no denial of access to care there that you know of?

Mr. Jones: Right. It's - that's a much bigger volume, and that's part of the reason they will continue taking it at lower rates. Yeah.

Chairman Allen: All right. Thank you, sir.

Mr. Jones: Thank you.

Chairman Allen: We would like to take about a ten-minute recess, see if there are any follow-up questions for the other participants. So we'll go off the record, and everyone will stand at ease for about ten minutes, so we'll get back on the record about two ten.

(OFF THE RECORD)

Chairman Allen: All right. We're back on the record. Before we go into any additional questions, it's my understanding no other persons have signed up to speak. Is that consistent with everybody's views here? All right. There are a few additional questions, and, first of all, this is directed at SCA. The independent analysis - we do not seem to have received that here at the Commission. Can that be...
forwarded to us? It's referenced--

MS. SMITH: I---

CHAIRMAN ALLEN: Yes, please come.

MS. SMITH: Yeah. Sorry. I think what we provided was the broad range numbers, so how the analysis was conducted is we took the NCCI modeling, you know, because they take the percentage of what ASCs are within the Medical Fee Schedule, what the savings or costs would be; then they apply the discount based on the outliers, so fifty percent discount on reduction, eighty percent increase based on a Fee Schedule increase. We used that methodology and gave you the high top line numbers, but we'll be more than happy to provide the more granular data, and I think that will help, and maybe even getting NCCI involved and using some of the data from the ASC community that they can provide to NCCI and using that data to provide - I think that may give you all a better baseline.

CHAIRMAN ALLEN: Yes, if you would provide that data. What's a reasonable timeframe for that---

MS. SMITH: I'll have to check with---

CHAIRMAN ALLEN: ---to be produced?

MS. SMITH: I'll have to check with SCA and I think some of the other providers, but we'll get back
with you tomorrow on the timeline.

CHAIRMAN ALLEN: Very well. If you could let Kendall Bourdon know that information, please.

MS. SMITH: Sure. Thank you.

CHAIRMAN ALLEN: Okay. And, also, are y'all aware of any circumstance where an SCA has stopped providing care to injured workers in states that have a lower than two hundred percent rate?

MS. SMITH: Yeah, that's a great question as well, Chairman Allen. I think what we would like to be able to provide - and I think some analysis that should be conducted prior to moving into a new schedule is when you look at these averages - what, the hundred and thirty, the hundred and forty percent ASC - is what happened in those states to patients getting care on ASCs' markets. For instance, in Texas, when Texas did some pretty significant cuts, both on the HOPD and ASC Fee Schedule, ASC stopped seeing patients, so there were some real negative consequences, and so I know there are some deadlines coming up on the 10th, but maybe it's something we should do a deeper dive in to see what happened and how injured workers' access to care and ASCs were impacted when those rates went to a certain level. I think that's an important analysis because we can talk about a hundred and thirty, a
hundred and fifty, a hundred and seventy; the real
question is when you move to that rate, what does it
do to access? And I think the only way you can do
that is to go back in some of these states and look at
some historical context. There was some data that was
provided in Hawaii. Texas referred - used this data
in their - when they went through these Fee Schedule
changes where you saw some real changes in the quality
of providers when the Fee Schedule was reduced. You
ended up - you may have some providers out there
providing the care, but they’re not necessarily the
quality of care, and you’re not getting the clinical
outcomes, but Hawaii did do some pretty extensive
research on that, and we’ll be more than happy to
provide that to the Commission for you to look at.

CHAIRMAN ALLEN: Yes, if you would, and also
provide the data from other states to the degree that
y’all have that. That would be very helpful.

MS. SMITH: Just a caveat on that. It is very,
very difficult to get workers’ comp data because the
carriers hold it and NCCI holds it, and so maybe the
Commission can help assist in that matter as far as
finding - getting us some access to the Medical Fee
Schedule component of the whole workers’ comp spend
historically and what portion of that was ASCs. Maybe
we can - it's just very, very difficult. It's a very opaque data system - data set.

CHAIRMAN ALLEN: Okay. I understand. If you could, walk us through the site of service selection process and how parity between hospital outpatients' and ASC rates is so important in that. So, you know, we're - we don't operate in the environment where y'all are coming from, obviously, so it's hard for us to understand. We'd like to have y'all have the opportunity to explain that.

MS. COLLINS: Yeah. I mean I think I understand what you're saying, and it's a good question. I think that where we're coming from is that, again, we think that we should be paid in our environment the same as the care that's provided in other environments. And as far as how that limits determination of where care is administered, I think a physician is going to choose to go to the most convenient place that he can go, and I think, for example, if he has the ability to come to an ambulatory surgery center, that ambulatory surgery center is not reimbursed at a level that allows the costs of that care to be covered, those cases are going to go to the hospital. They're going to go to the hospital environment, and that's the part that we could control if we were paid equitably.
CHAIRMAN ALLEN: And is there any documentation showing the asserted delay in care that is alleged because of the differential in rates?

MS. COLLINS: I don’t know that there’s anything specific—

MS. SMITH: Yeah. So it---

MS. COLLINS: ---to North Carolina.

MS. SMITH: Yeah. And we can - this all goes back to data sets. I think a broader question is that we - the ability for this sector - or for providers to get data to give you the answers that you’re asking is so limited because of who holds that data set, but we can - we’ll do our best to try to find you some answers on - I know that SCA has some internal return-to-work statistics, care statistics. I do just want to touch on one point that was brought up during the earlier discussion, and that’s just some questions about HOPDs, hospital outpatient, hospital-owned ASCs, you know, SCA ASCs, other ASCs. An ASC is a licensed legal entity, and if a hospital owns an ASC, they own a Medicare-certified ASC, and if they are billing at HOPD rates, they are - they basically are committing Medicare fraud. They have to bill at the ASC Fee Schedule rate. Now a hospital can have an outpatient center, and it can be - if they want to call it
ambulatory surgery center, that’s fine, but it’s - if
it’s not a licensed Medicare-certified ASC, it is an
HOPD and they’re billing at the higher rate, so I
think it’s real - and physicians cannot have ownership
in HOPDs. The hospitals can have ownership in ASCs,
so there’s - they are very distinct legal entities,
and there’s no squishiness on how you bill because it
is set up by - an ASC is a Medicare-certified facility
and the licensing is such, so I just wanted to provide
that clarity.

CHAIRMAN ALLEN: Okay.

COMMISSIONER CHEATHAM: I’ve got a couple of
questions. Sorry. I want to go back to a statement
that I believe maybe Ms. Smith made that - you know,
we talked about the different percentages as
multipliers and the real question being what does that
do to access. I’m really interested in what does that
do to revenues. When you were at the sixty-seven
percent level, what multiplier of a Medicare rate
would it have taken to break even?

MS. SMITH: I don’t think - I don’t have that
historical data, and I think it varies from ASC to
ASC. I think it depends on the provider. So I
think - is - so your question is as far as what would
a - what would that revenue rate have been translated
to an ASC Schedule, right, and that's what you---?

COMMISSIONER CHEATHAM: Translated to a multiplier times---

MS. SMITH: Multiplier, right, right.

COMMISSIONER CHEATHAM: --the Medicare rate.

MS. SMITH: Right. And we don't - I don't have that data with me, but we can - but we---

COMMISSIONER CHEATHAM: Could you get it?

MS. SMITH: I think we can try. Yeah.

COMMISSIONER CHEATHAM: I'd be very excited. That would be great.

MS. COLLINS: And please understand that our goal is not to break even at that rate.

MS. SMITH: Yeah.

MS. COLLINS: That's not our goal, even remotely.

COMMISSIONER CHEATHAM: Right. I understand that, but I think that would be helpful and---

MS. SMITH: Well, I - what I can provide for you is the analysis that we did based on going to a two hundred - to going to a parity with the HOPD based on bill charges to the two hundred percent of Medicare HOPD starting in '17, and that would be a forty percent reduction in savings to the workers' comp system.

COMMISSIONER CHEATHAM: I'm probably less
interested in that than my other question, but okay.

MS. SMITH: But I think it’s almost relatable, but I think - so we can back out that data for you because if we can - if we can show savings based on a Medicare Fee Schedule from bill charges, then we can probably provide what that rate may have been. Now, given that the codes have changed, the payment underlying Medicare codes have changed from year to year because of CMS’s annual adjustments to the Fee Schedule every calendar year.

COMMISSIONER CHEATHAM: Do you generally agree that your overheads at ASCs are less to some---

MS. SMITH: Oh, I can’t---

COMMISSIONER CHEATHAM: ---magnitude than hospital outpatient?

MS. COLLINS: I’m sorry. I was talking to (inaudible).

MS. SMITH: Oh. I - no, she asked if the overhead is less in an ASC than a hospital. I think - I think that is a generally discussed - that is a general assumption, yeah, but I---

COMMISSIONER CHEATHAM: Do you know---

MS. SMITH: ---don’t think that’s---

COMMISSIONER CHEATHAM: ---how much less?

MS. SMITH: ---relevant to the workers’ comp
system because I don’t — I don’t think the employer should be subsidizing a — you know, should they be subsidizing a hospital emergency room? So, you know, I think you have to look at it in the context of care to workers, right, and getting injured workers back, and there’s always all these other issues of uninsured patients and, you know, the overhead that hospitals do have because they are, you know, Charity Care, and they are those emergency room providers, but I think in the context of a workers’ comp system we have to talk at — what is at heart is getting injured workers back on the job as quickly as possible, which saves employers money.

COMMISSIONER CHEATHAM: So do you have any idea what the difference in overhead percentage might be?

MS. SMITH: I don’t.

COMMISSIONER CHEATHAM: No?

MS. SMITH: No.

COMMISSIONER CHEATHAM: Have you had any access to care issues for just Medicare patients at all?

MS. SMITH: Well, Medicare is a totally different patient population.

COMMISSIONER CHEATHAM: I agree.

MS. SMITH: Right.

COMMISSIONER CHEATHAM: I’ve recently become well
aware of that. Thank you.

MS. SMITH: I just - I - it's just a different - I think it's a different patient population. There are - there are---

COMMISSIONER CHEATHAM: But there are no access to care issues for Medicare in the ASCs?

MS. SMITH: I can't answer specifically to ASCs, but I can answer on a more broadly point. I think if you just moved into Medicare, what you are - you will find is that there are a lot of providers that don't take Medicare, and it is a problem that policymakers contemplate all the time, is - you know, with the spend in the Medicare Program and making sure reimbursement is sufficient in guaranteeing access and what we have seen specifically in the Medicare Program - and we can provide that data to you - is providers leaving the Medicare system because it doesn't reimburse high enough. You see it in cardiology. You see it in general practitioners. You see it across the board in the provider spectrum that they are withdrawing from the Medicare system because it doesn't reimburse at a higher - a high enough level to cover their costs, so we'll be more than happy to provide that data - how many providers are leaving the general Medicare system because of low reimbursement.
And Washington is actually taking this into consideration. They’re moving to all these alternative payment models and, you know, bundled payments and - because they know - they’re trying to address this.

COMMISSIONER BALLANCE: Are ambulatory surgical centers more likely than, say, hospitals or hospital outpatient facilities to be located in rural, underserved areas?

MS. SMITH: You can answer that?

MS. COLLINS: No, not typically. We’re seeing actually more and more of those models; obviously, very restricted in a CON state, as you all know. Typically, they’re located within about a three-mile radius of a hospital.

COMMISSIONER BALLANCE: Thank you.

MS. COLLINS: And we do take care of Medicare patients. I want to make sure you know that.

MS. SMITH: Yeah, yeah, yeah.

CHAIRMAN ALLEN: And I have a follow-up to Commissioner Ballance’s question. Does SCA have any facilities that are in a rural or underserved area?

MS. COLLINS: Well, I’m going to offend one of my facilities that’s represented here, but, yes, we do. We have - in Wilson, North Carolina.
CHAIRMAN ALLEN: Wilson. Okay. No further questions, so we will go off the record momentarily. I want to thank everybody for being here today and the comments that we’ve received and the material that has been provided to date and will be provided after today’s date. It has been especially helpful, and, you know, the Commission will take it under consideration, and, you know, if you’re going to be submitting any additional comments, as I stated before, be sure to check in with Kendall Bourdon to do that. Also, we have a rulemaking list serve that Kendall helps maintain. I would suggest that you sign-up for that as well to be apprised of any rulemaking developments, you know, whether in regards to this or any other things, including E-filing. We have some rules that are upcoming with that. So, with all that said, thank you all for being here and thanks for coming. We’ll go off the record.

(WHEREUPON, THE HEARING WAS ADJOURNED.)

RECORDED BY MACHINE

TRANSCRIBED BY: Lisa D. Dollar, Graham Erlacher and Associates
Full Commission Public Hearing, October 3, 2016

STATE OF NORTH CAROLINA
COUNTY OF GUILFORD

CERTIFICATE

I, Kelly K. Patterson, Notary Public, in and for the State of North Carolina, County of Guilford, do hereby certify that the foregoing fifty-six (56) pages prepared under my supervision are a true and accurate transcription of the testimony of this trial which was recorded by Graham Erlacher & Associates.

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

WITNESS my Hand and Seal on this 5th day of October 2016.

My commission expires on December 3, 2018.

[Signature]

NOTARY PUBLIC

GRAHAM ERLACHER & ASSOCIATES
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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.” 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.”

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(j)), 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.”

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

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1 North Carolina Industrial Commission, Memorandum Of Law In Support of Motion To Stay, August 17, 2016.
schedule changes between -0.4% (-$8.0M) and +1.1% (+$21.0M). 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.

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. 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.

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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.

[Signature]

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REDLINE OF PARTIALLY INVALID RULE

04 NGAC 101.0103 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.

(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 (e) 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 rate as certified by CMS, 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 IV to Final ASC Covered Services Interchange Reports 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) 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 (e) 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.

(i) 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 (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.

(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

84 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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   (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 ("CAHs"), 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.

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

(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) 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.

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(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 in line with other states that utilize a Medicare-based fee schedule for ASCs. The current ASC fee schedule places North Carolina in the higher end of states that utilize Medicare's reimbursement methodology. If the Commission wishes to consider amending the multiplier applicable to the Medicare ASC facility-specific reimbursement methodology, we recommend that the multiplier be reduced in order to bring North Carolina closer to the median for states that utilize Medicare's reimbursement methodology. Neighboring states South Carolina (140%) and Tennessee (150%) utilize significantly lower multipliers than North Carolina (currently 210%). Consequently, the Commission should strongly consider adopting 150% as the multiplier to the Medicare ASC facility-specific reimbursement amount. This amendment would put North Carolina closer to the median of states that utilize Medicare reimbursement methodology, and make North Carolina more competitive with neighboring states while saving North Carolina businesses $6-8 million annually according to the NCCI, Analysis of Alternatives to the North Carolina Ambulatory Surgical Center Fee Schedule Proposed to Be Effective January 1, 2017.

DETAILS OF THE NEGOTIATED RULEMAKING PROCESS

The Commission's adoption of a workers' compensation medical fee schedule was the culmination of a lengthy negotiation process that began in 2012 and lasted more than two years. On one side of this negotiation were representatives of the employer and insurer communities, and on the other side were representatives of facilities and physicians. Both sides had a common goal of ensuring that payment for medical services was fair and ensured access to care for injured workers so they could be treated and successfully returned to employment.

This negotiation process included the selection of a consultant – the Foundation for Unemployment Compensation and Workers' Compensation Study - jointly agreed to and paid...
for by all parties, including the American Insurance Association, Capital Associated Industries,
North Carolina Hospital Association, North Carolina Medical Society, North Carolina Chamber,
North Carolina Home Builders Association, North Carolina Retail Merchants Association and
the Property Casualty Insurers Association of America. After numerous informal negotiation
sessions, these parties jointly agreed to and paid for Andy Little, one of North Carolina's
foremost mediators, to conduct a formal two-day mediation. In addition to these parties,
representatives from the North Carolina Advocates for Justice and the North Carolina
Association of Defense Attorneys attended these mediations, as did Drew Heath, Chairman of
the North Carolina Industrial Commission. Again, the intent of the parties was to reach an
agreement on the facility and provider fee schedules that would avoid protracted litigation or
opposition from affected parties. While rates for services provided by hospitals and certain
physician groups such as radiologists were reduced in attempt to bring North Carolina's medical
fee schedules in-line with median averages for other states, other physician groups such as
family physicians saw their rates increase to similarly adjust to median averages for other states.
Additionally, the rate reductions were stair-stepped over a fifteen month period to mitigate their
impact.

Contrary to the affidavit of Conor Brockett of the North Carolina Medical Society put forth by a
number of orthopedic groups in Surgical Care Affiliates, L.L.C. v. North Carolina Industrial
Commission, there was never an attempt to exclude certain types of providers, either Surgical
Care Affiliates or any other ASC or orthopedic group. We do acknowledge that, during the final
mediation with Andy Little, both sides were asked to limit the number of participants for the
sake of efficiency. All parties were instructed to meet with their respective interest groups and
arrive at the mediations with the authority to come to a resolution on the fee schedules.

Additionally, there was a general feeling by the parties during all of the negotiations that the
North Carolina Medical Society had apparent, if not actual authority, to represent the practice of
orthopedic medicine. This was evidenced by:

1) The statement on the North Carolina Medical Society’s website that the Society’s
Specialty Society and Meeting Services Department currently manages ten specialty
associations in North Carolina, one of which was the North Carolina Orthopedic Society.
(See Attachment A)

2) The North Carolina Orthopedic Society is housed inside the physical office of the North
Carolina Medical Society Headquarters located at 222 North Person Street, Raleigh, NC.
(See Attachment B)

3) The email address for Alan Skipper the Executive Director of the North Carolina
Orthopedic Society is ncoa@ncmedsoc.org. (See Attachment B)

4) The letter of support submitted by the North Carolina Medical Society dated January 16,
2015 lists twelve entities that applaud the efforts of the Commission and encourages the
Commission to adopt the fee schedule as proposed. The North Carolina Orthopedic
Society is listed as one of the twelve signatory entities. (See Attachment C)
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 10A .0101

GENERAL PROVISIONS

(a) The Commission adopted and published a Medical Fee Schedule, pursuant to the provisions of G.S. 97-26(e), 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.


(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 1.56, 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 1.06.
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.
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, 2012, the payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.
   (B) For critical access hospitals, the payment shall be 87 percent of the hospital's billed charges. For purposes of the hospital fee schedule, critical access hospitals are those hospitals designated as such pursuant to federal law (42 CFR 485.601 et seq.). Effective February 1, 2013, the critical access hospital's payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.

(3) Ambulatory surgery fees: Ambulatory surgery center services are reimbursed at 79 percent of billed charges. Effective February 1, 2012, 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 payment 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, these 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.

(6)(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.

(4)(a) 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. (6)(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.
(b)(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. (b)(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. (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. (h) (i) 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), (f), and (h) of this Rule.

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

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

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

<table>
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<th>CMS Foundation</th>
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<td>CMS Alliance</td>
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<td>CMS Sections</td>
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<td>County Medical Societies</td>
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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

http://www.ncmedsoc.org/about-ncms/partner-organizations/
North Carolina Orthopaedic Association

North Carolina 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
North Carolina Orthopaedic Association | North Carolina Medical Society

- 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.

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Executive Director: W. Alan Skipper, CAE – Raleigh, NC

Join Today!

Become a part of the NCOA!

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

For membership questions, please contact NCOA member services at (800) 722-1350 or ncortho@ncmedsoc.org.

Support NCOA PAC
NCOA PAC, the non-partisan political committee of the North Carolina Orthopaedic Association (NCOA), relies on voluntary contributions from members like you to back candidates for public office who support the NCOA position on issues affecting orthopaedic practice and patient care in North Carolina. Donate online or download a form to support your PAC.

NCOA News

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* Mar. 4, 2016
* Nov. 20, 2015
* Aug. 20, 2015
* July 20, 2015
* May 21, 2015
* Apr. 15, 2015
* Mar. 5, 2015
* Jan. 12, 2015
* Dec. 23, 2014
* Oct. 9, 2014

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Email: ncoa@ncmedsoc.org
Executive Director: W. Alan Skipper

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January 16, 2015

Ms. Meredith Henderson
Executive Secretary
North Carolina Industrial Commission
4333 Mall 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
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
Medicaid Cut: Take Action

In 2013, the NC General Assembly included a 3% “withhold” for all Medicaid services with the intention of using that money as the foundation of a shared-savings program. After difficulty developing the program, the “withhold” was redrafted as a cut the following year with an effective date of January 1, 2014. That cut has not been implemented due to delays in NCTracks.

Doctors treating Medicaid patients now face a requirement to pay back 3% of everything they have been paid by Medicaid for the last 14 months. Every day that passes increases this financial and administrative burden. We know this money has already been spent on staff salaries, office overhead, and other basic requirements of serving the Medicaid population.

Call or email your representative/senator and tell them how much you will have to send back to Medicaid, and what it will mean to you and your practice. Tell your legislator that you cannot afford a massive recoupment at the same time as you are being asked to transform the entire way we deliver health care to the Medicaid population.

Take Action Now ==> and share this alert with your colleagues.

NOTE: Primary care physicians who received enhanced Medicaid payment rates in accordance with the ACA will not be subject to the 3% reduction in 2014. However, those
same PCPs will be subject to the reduced rates and a recoupment of payments made for January and February 2015 dates of service.

Reprinted with permission from the North Carolina Medical Society.

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 Councillor 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.

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
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) 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 Medicare-based fee schedules for workers' health care services.

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
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 10F .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:

North Carolina Industrial Commission
September 26, 2016


(3) North Carolina Hospital Association/Opum Group Health survey data, June 2013 and July 2014.

(4) Review of states’ fee schedule structures, nationally and regionally.

We have reviewed the NCCI/NORB 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
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, 200 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.

(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, 230 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, 180 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.
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.
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 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.

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.

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.
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 Washlick RN, CASC
Administrator
Triangle Orthopaedics Surgery Center, LLC

cc: Kendall Bourdon
    Meredith Henderson
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 amb-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 amb surg rates for reasons noted at the hearing and in our previous comment letter.

Hospital outpatient rates versus amb-surg rates

There was quite a bit of discussion at the hearing on the difference between hospital outpatient rates and amb surg rates. Under the Medicare fee schedules, hospital outpatient rates are on average higher than those for amb surg centers. NCHA does not support tying amb-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 amb surg facilities under those fee schedules.

• Hospital outpatient services are costlier than amb 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
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 OPPS 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
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
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 understated 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
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.
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:

- A relative weight which establishes how costly any one service is in relation to any other service.
- 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.
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.

**Table:**

<table>
<thead>
<tr>
<th>AHCPCS Code</th>
<th>Short Description</th>
<th>ASC Weight</th>
<th>OPPS Weight</th>
<th>Status Note</th>
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<tbody>
<tr>
<td>29806</td>
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<td>55.2787</td>
<td>67.4027</td>
<td>J1</td>
</tr>
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<td>J1</td>
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<tr>
<td>29827</td>
<td>Arthroscopic rotator cuff repair</td>
<td>56.2787</td>
<td>67.4027</td>
<td>J1</td>
</tr>
<tr>
<td>29838</td>
<td>Arthroscopy biceps tendon repair</td>
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<td>79.9699</td>
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<td>Ankle arthroscopy/surgery</td>
<td>79.9699</td>
<td>95.8165</td>
<td>J1</td>
</tr>
</tbody>
</table>

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...
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 OPPS 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%).
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.
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,

[Signature]

Renee J. Montgomery

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 new 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).” 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.

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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. 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.

**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.” 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.” WCR1 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.

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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.
If workers' compensation pays higher than Medicare but lower than commercial insurers, there still might be legitimate concerns about access.\textsuperscript{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, "three 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."\textsuperscript{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.\textsuperscript{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."\textsuperscript{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.

\textsuperscript{11}WCRI, Designing Workers' Compensation Medical Fee Schedules, June 2012.
\textsuperscript{12}Texas Medical Association, Workers' Compensation Special Report - 2004 Survey of Texas Physicians.
\textsuperscript{13}The Medical Fee Schedule Under the Workers' Compensation Law, Legislative Reference Bureau State Capitol, Honolulu, Hawaii
\textsuperscript{14}National Academy of Social Insurance, Workers' Compensation: Benefits, Coverage, and Costs, 2014
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.

Kelli Collins, Vice President Operations
Surgical Care Affiliates, LLC
3820 North Elm Street #102
Greensboro, NC 27455
(336) 854-1663 office
(336) 202-6681 mobile
(866) 367-3168 fax
kelli.collins@seasurgery.com
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
October 10, 2016

Charleston 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
O~ober 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,

Kathy Sneed, Administrator

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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Thank you for your consideration.

Sincerely,

Sean M. McNally, CEO
Raleigh Orthopaedic Clinic

cc: Kendall Bourdon
Meredith Henderson
October 10, 2016

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North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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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, 2019. 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,

Robert Satterfield, MD
Orthopaedic Surgeon

cc: Kendall Bourdock
Meredith Henderson
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 25, 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.

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 has resulted and will continue to result in an access problem for injured workers, which violates the statutory requirement of ensuring injured workers are provided the services and standard of care required by the Workers' Compensation Act.

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.
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Thank you for your consideration.

Sincerely,

[Signature]

Douglas Reels, MD
Orthopaedic Surgeon

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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Thank you for your consideration.

Sincerely,

B. Todd Smith, MD
Orthopaedic Surgeon

cc: Kendall Bourdon
Meredithe Henderson
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).

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Thank you for your consideration.

Sincerely,

Lew Martin, MD
Orthopaedic Surgeon

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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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.

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Thank you for your consideration.

Sincerely,

Adam Thorp, MD
Orthopaedic Surgeon

cc: Kendall Bourdon
    Meredith Henderson
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 28, 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.

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Thank you for your consideration.

Sincerely,

Zizette Gabriel, MD
Anesthesiologist / Pain Management

cc: Kendall Bourdon
    Meredith Henderson
October 10, 2016

Charlton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Dear Chairman Allen and Commissioners:

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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,

Ann DuPree Orr, RN
Administrator – Team Carolinas

cc: Kendall Bourdon

Meredith Hancock
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 10I. .0103 specific to the fee schedule under North Carolina’s Workers’ Compensation Act for services provided by ambulatory surgical centers (ASCs).

Blue Ridge Surgery Center is an Affiliate of SCA. We are located in Raleigh NC, and provide quality care to over 9k patients per year over the past 31 years serving the 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 Ridgaway.

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Blue Ridge 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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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.

October 3, 2016
Charlton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603
Thank you for your consideration. If you have any questions, please feel free to contact me at (919)-781-4311.

Sincerely,

Hans Rohm

cc:  Kendall Bourdon
     Meredith Henderson
BLUE RIDGE SURGERY CENTER

October 3, 2016

Charlton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Dear Chairman Allen and Commissioners:

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Thank you for your consideration. If you have any questions, please feel free to contact me at (919)-781-4311.

Sincerely,

Robert S. Alphin, M.D.
Medical Director

cc: Kendall Bourdon
    Meredith Henderson
October 3, 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. If you have any questions, please feel free to contact me at (919) 731-4311.

Sincerely,

Larnessa Greene

cc: Kendall Bourdon
    Meredith Henderson
October 3, 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. If you have any questions, please feel free to contact me at (919)-781-4311.

Sincerely,

Becky Ballard

cc: Kendall Bourdon
    Meredith Henderson
October 3, 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. If you have any questions, please feel free to contact me at (919)-781-4311.

Sincerely,

Grace Smith

cc: Kendall Bourdon
    Meredith Henderson
October 3, 2016

Chariton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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Thank you for your consideration. If you have any questions, please feel free to contact me at (919)-781-4311.

Sincerely,

Sabrina Robinson

cc:  Kendall Bourdon
     Meredith Henderson
October 3, 2016

Charlton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Dear Chairman Allen and Commissioners:

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Sincerely,

Colleen Lochamy

cc: Kendall Bourdon
    Meredith Henderson
October 3, 2016

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North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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Sincerely,

Parrish Dickens

cc: Kendall Bourdon
    Meredith Henderson
October 3, 2016

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North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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Sincerely,

[Signature]

cc: Kendall Bourdon
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October 3, 2016

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Sincerely,

Cassandra Clark

cc: Kendall Bourdon
    Meredith Henderson
October 3, 2016

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North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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Sincerely,

Kathy Leibl, Administrator

cc: Kendall Bourdon
Meredith Henderson
October 3, 2016

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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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Sincerely,

Tiffani Sweeney

cc: Kendall Bourdon
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October 3, 2016

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Sincerely,

Gyto Alexis

cc: Kendall Bourdon
    Meredith Henderson
October 8, 2016

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430 N. Salisbury Street
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Sincerely,

Kendra Johnson

cc: Kendall Bourdon
    Meredith Henderson
October 3, 2016

Charlton L. Allen, Chairman
North Carolina Industrial Commission
480 N. Salisbury Street
Raleigh, NC 27603

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Thank you for your consideration. If you have any questions, please feel free to contact me at (919) 467-4992.

Sincerely, 

Michael J. Khan
Revenue and Special Operations Director

cc: Kendall Bourdon
Meredith Henderson
October 3, 2016

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North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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Sincerely,

[Signature]

[Name]

[Title]

cc: Kendall Bourdon
Meredith Henderson
October 3, 2016

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North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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Thank you for your consideration. If you have any questions, please feel free to contact me at our office at (919) 467-4092.

Sincerely,

[Signature]

cc: Kendall Bourdon
Meredith Henderson
October 3, 2016

Charlton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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Sincerely,

[Signature]

cc: Kendall Bourdon
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October 3, 2016

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430 N. Salisbury Street  
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CARY ORTHOPAEDICS
& spine specialists

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Thank you for your consideration. If you have any questions, please feel free to contact me at our office at (919) 467-4992.

Sincerely,

Kendall Bourdon
Meredith Henderson
October 3, 2016

Chariton L. Allen, Chairman
North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

Dear Chairman Allen and Commissioners:

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[Signature]

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[Name]
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Dermody, L. Fletchiga, M.D.
Brian T. Smith, M.D.
Douglas J. Martin, M.D.
William K. Anderson, M.D.
Derek L. Fultz, M.D.
Jared K. Day, M.D.
Raymond J. Carroll, M.D.
Russell R. Ayers, M.D.
Donald M. Eshoka, M.D.
Sue Ann Haines, M.D.
Scott S. Smith, M.D.
Gary L. Smoot, M.D.
Christopher Lee, M.D.
Whitney H. Dobbs, M.D.
Paul G. Bough, M.D.
Neal Sherrill, M.D.

Specializing in Orthopaedic Surgery, Sports Medicine and Spine Care

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Sincerely,

[Signature]

Administrative Director

cc: Kendall Bourdon
Meredith Henderson
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Thank you for your consideration.

Sincerely,

Delil Murphy, Administrator

cc: Kendall Bourdon
Meredith Henderson
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Norman S Regal, DPM, FACFAS

cc: Kendall Bourdon
    Meredith Henderson
October 10, 2015

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[Signature]

Christine L. McGuire, MD

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    Meredith Henderson
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October 10, 2016

TO: Charlton L. Allen, Chairman  
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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.

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 has resulted and will continue to result in an access problem for injured workers, which violates the statutory requirement of ensuring...
injured workers are provided the services and standard of care required by the Workers’ Compensation Act.

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,

[Signature]

cc: Kendall Bourdon
Meredith Henderson
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 101 .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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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.

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Thank you for your consideration.

Sincerely,

Peter G. Dalldorf, MD

cc: Kendall Bourdon
    Meredith Henderson
October 10, 2016

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North Carolina Industrial Commission
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Raleigh, NC 27603

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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, under-estimating the cost to the workers' compensation system.

Thank you for your consideration.

Sincerely,

cc: Kendall Bernard
Meredith Henderson
The Honorable Charlton Allen, Chairman  
North Carolina Industrial Commission  
430 N Salisbury St.  
Raleigh, NC 27603

Dear Chairman Allen and Commissioners:

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 101.0103 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 that 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.
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 exceed 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
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) 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 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:
(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
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 changes 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." 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.\textsuperscript{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.”\textsuperscript{3} For non-Medicare patients in North Carolina, ASCs are permitted to keep patients for up to 24 hours.\textsuperscript{4} This means a non-Medicare patient can stay in the facility overnight, provided they are released within the specified timeframe.\textsuperscript{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

\textsuperscript{2} NCCI, *Effectiveness of Workers Compensation Fee Schedules - A Closer Look* (Feb. 11, 2009).
\textsuperscript{3} 42 C.F.R. § 416.166(b).
\textsuperscript{4} N.C. Gen. Stat. § 131E-176(1b).
\textsuperscript{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.

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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. Similarly, effective April 1, 2015, the Connecticut Workers' Compensation Commission established a medical fee schedule for ASCs based on the Medicare HOPD fee schedule.

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." 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.

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7 H.B. 316, Chapter 63 SLA 14 (Alaska 2014).
8 S.B. 61, Public Act No. 14-167 (Conn. 2014).
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

11 WCRI, Designing Workers' Compensation Medical Fee Schedules (June 2012).
13 Id.
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.\(^\text{15}\)

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.\(^\text{16}\)

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.*

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
Surgical Care Affiliates, LLC
3820 North Elm Street #102
Greensboro, NC 27455
(336) 854-1663 office
(336) 202-6681 mobile
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kelli.collins@scasurgery.com
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 — 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,

[Signature]

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.

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.

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, 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,

[Signature]

cc: Kendall Bourdon  CEO (CEO of North Carolina)
Meredith Henderson
November 28, 2016

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.

600 Village Walk Drive, Holly Springs, NC 27540   P-919-762-3040
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,

David Orskey
Administrator

c: 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.

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.
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, 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,

[Signature]

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,

Linda Simmons
Regional Vice President
Surgery Partners, Inc.
331 Springwater Chase
Newnan, GA 30265
lsimmons@surgerypartners.com

cc: Kendall Boudon
    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.

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,

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
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.
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
Meredit Henderson

23 Sunnybrook Road
Raleigh, NC 27610
capitolsurgyc.com
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.

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.
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, 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

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

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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.

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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,

Kathy Stout RN, Administrator
The Eye Surgery Center of the Carolinas

cc: Kendall Bourdon
    Meredith Henderson
November 28, 2016

North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27613

Dear Chairman Allen & Commissioners:

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Greensboro Specialty 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.

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
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, 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,

[Signature]

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.

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.
- 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, 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,

[Signature]

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
November 28, 2016

North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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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 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,

Ann DuPree Orr
RN  BSN  CNOR
Administrator

cc: Kendall Bourdon
    Meredith Henderson
November 28, 2016

North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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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.
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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,

[Signature]

Thomas J. Tally, CEO
Administrator

cc: Kendall Bourdon
Meredith Henderson
November 28, 2016

North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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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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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,

[Signature]

cc: Kendall Bourdon
    Meredith Henderson
November 28, 2016

North Carolina Industrial Commission
430 N. Salisbury Street
Raleigh, NC 27603

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• 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
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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,

Michelle L. Hunter

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.

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).

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.

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.
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Douglas L. Gollehon, M.D.

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Meredith Henderson

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Meredith Henderson
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