

**PROPOSAL TO THE NORTH CAROLINA INDUSTRIAL COMMISSION  
TO AMEND PARTIALLY INVALID RULE 04 NCAC 10J .0103**

**September 26, 2016**

To: Kendall Bourdon  
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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.”<sup>1</sup> 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.”<sup>2</sup>

**COST ANALYSIS OF SCA’S REQUESTED AMENDMENT OF THE  
COMMISSION’S PARTIAL INVALIDATED RULE 04 NCAC10J .0103**

At the request of the Commission, the North Carolina Rate Bureau (“NCRB”) and the National Council of Compensation Insurance (“NCCI”) provide a cost analysis for hypothetical ASC fee schedules for workers compensation cases. As stated in the Commission’s Notice of Public Comment Meeting, the purpose of requesting the cost analysis was “to take public comment on and consider rulemaking options to address the effects of the August 9, 2016 court decision invalidating the April 1, 2015 medical fee schedule provisions for ambulatory surgical centers.”

As noted in the August 9, 2016 court decision, the “Commission’s attempted adoption of a new fee schedule for ambulatory surgical center services, but limited solely to those services, as set forth in 04 NCAC 10J. 0103(g) and (h) (also referenced in 04 NCAC 10J. 0103(i)), and the amendment of the Prior Rule, specifically 04 NCAC 10J .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.”<sup>3</sup>

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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<sup>1</sup> North Carolina Industrial Commission, Memorandum Of Law In Support of Motion To Stay, August 17, 2016.

<sup>2</sup> <http://www.ic.nc.gov/ncic/pages/statute/rule407.htm>.

<sup>3</sup> <http://www.ic.nc.gov/080916RidgewayDecision.pdf>.

schedule changes between -0.4% (-\$8.0M) and +1.1% (+\$21.0M).<sup>4</sup> 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.<sup>5</sup>

### **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.<sup>6</sup> 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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<sup>4</sup> 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.

<sup>5</sup> 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."

<sup>6</sup> The NCCI September 19, 2016 analysis also assumes the fee schedule to be effective January 1, 2017.

If the Commission is assuming that a proposed rule changing the fee schedule for ASCs could be adopted as a temporary or emergency rule, the Commission is incorrect. The criteria that set forth when a temporary or emergency rule can be adopted are not applicable. *See* N.C. Gen. Stat. §§ 21.1 and 21.1A. There is no unforeseen threat to the public health, safety, or welfare and the Superior Court Decision concluding that the fee schedule used prior to April 1, 2015 is the valid fee schedule for ASCs does not require that the Commission engage in rulemaking to change the ASC fee schedule.

Respectfully submitted this 26th day of September 2016.



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## REDLINE OF PARTIALLY INVALID RULE

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

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

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

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

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

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

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

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

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

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

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

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

**(g) For those procedures for which CMS has established a Medicare rate, the schedule of maximum reimbursement rates for services provided by ambulatory surgical centers ("ASC") should be the same as the schedule of maximum reimbursement rates for hospital outpatient institutional services as set forth in sub-part (c) above. For those procedures for which CMS has not established a Medicare rate for hospital outpatient institutional services, the maximum allowable amounts for services provided by ASCs shall be 50% of billed charges up to a cap of \$30,000. Charge master increases will be limited to 0% increase for these procedure codes for the first 3 years, or a revenue neutral adjustment will be applied to the percent of charge paid.**

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

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

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

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

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

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

## PROPOSED RULE

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

- (a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services shall be based on the current federal fiscal year's facility-specific Medicare rate established for each institutional facility by the Centers for Medicare & Medicaid Services ("CMS"). "Facility-specific" rate means the all-inclusive amount eligible for payment by Medicare for a claim, excluding pass-through payments.
- (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:
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- (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) 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.
- (i) Charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.
- (j) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping ("DRG") payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.
- (k) For specialty facilities paid outside Medicare's inpatient and outpatient Prospective Payment System, the payment shall be determined using Medicare's payment methodology for those specialized facilities multiplied by the inpatient institutional acute care percentages set out in Paragraphs (b) and (c) of this Rule.