

Regulatory Impact Analysis
Fees for Medical Compensation – 11 NCAC 23J

Agency: North Carolina Industrial Commission
Contact: Dana McGhee – (919-807-2674)
Rules proposed for readoption 11 NCAC 23J .0101-.0103

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

Statutory Authority: G.S. 97-26.1

Necessity for Rule Change

The North Carolina Industrial Commission (“Commission”) proposes to readopt 11 NCAC 23J, Fees for Medical Compensation, with amendments intended to clarify and update the rules. In addition, proposed amendments to 11 NCAC 23J .0101 would establish maximum fees that medical providers can charge for providing medical records under the Worker’s Compensation Act.

North Carolina workers’ compensation attorney stakeholders report that a small subset of providers charge records request fees that are significantly higher than the retrieval, copying costs and administrative effort involved -- especially when multiple parties (employer, carrier, TPA, rehabilitation professional, employee/attorney) each request copies from the same provider. Reports include charges in the hundreds or even thousands of dollars for access to a provider’s records. While most providers charge reasonable amounts, even a small percentage of unusually high-fee cases can materially increase costs for injured workers, attorneys, employers, carriers, and third-party administrators. These high charges create multiple problems:

- They can impede timely access to records needed to resolve disputes.
- They increase claim-handling costs for plaintiff attorneys because plaintiff attorneys front record-related expenses and other costs and are only reimbursed for costs at the end of a case if the injured worker is financially able to reimburse the attorney. Normally, when the injured worker settles or wins his or her case, they are asked to reimburse the attorney for costs, but in cases where the injured worker loses his or her case or does not settle his or her case, the worker typically cannot afford to reimburse the attorney for costs. Ultimately, inflated record fees reduce the net benefit to the injured workers in cases where the worker receives a settlement or an award of monetary benefits.
- They add avoidable costs for employers, carriers, TPAs, and rehabilitation professionals, who require records to manage care authorizations and claim decisions.
- They introduce uncertainty and disputes into the WC process, because parties do not know in advance what a provider might charge.

Under current conditions, North Carolina has no specific regulation governing the fees medical providers may charge for workers’ compensation records requests. This proposed amendment

establishes clear maximums to prevent exorbitant fee practices while preserving providers' ability to recover reasonable, cost-based copying expenses.

Importance of Access to Medical Records in Workers' Compensation Cases

Medical records are central to nearly every aspect of a workers' compensation claim. When an employee is injured and receiving treatment paid for by the employer or carrier, that payor needs access to the treating provider's records to understand diagnoses, track progress, verify the necessity of care, and ensure the treatment is related to the compensable injury. Likewise, when a dispute arises regarding any aspect of the claim -- such as the compensability of the injury, entitlement to benefits, adequacy of medical care, or rating determinations -- the employee's attorney must obtain complete and accurate medical records to present evidence to the Industrial Commission.

Medical records are evidentiary documents in workers' compensation proceedings. In practice, the Commission relies on medical records when reviewing filings, resolving disputes, evaluating permanent impairment ratings, and adjudicating medical treatment authorizations.

Most records today are transmitted electronically, especially by large health systems that use MyChart or similar platforms. Electronic fulfillment typically requires less staff time, fewer supplies, and no postage, making very high fees increasingly difficult to justify. Some small practices may still rely more on paper, and the proposed rule accommodates these providers by allowing cost recovery -- just not excessive charges.

Regulatory Baseline

No explicit cap currently exists in Subchapter 23J on fees that medical providers may charge for searching, handling, copying, or mailing medical records. Although the requirement is not currently in Subchapter 23J, the Commission established in a 1995 memorandum a practice of providing one free copy of medical records to the first requesting party among employers, carriers, third-party administrators, and rehabilitation professionals. The 1995 memorandum also established fees of up to \$0.50 per page for the first 40 pages and \$0.20 per page for each page thereafter, with a minimum charge of \$10 for subsequent requests. Although the memorandum is no longer enforceable by the Commission, it remains the de facto baseline for a likely significant number of medical providers and parties familiar with the workers' compensation system. As a result, it is expected that a significant number of providers already provide a first copy without charge and apply fees similar (albeit lower) to those contemplated by the proposed amendment.

Proposed Amendments

11 NCAC 23J .0101 – General Provisions

In addition to clarifying changes, including updating web addresses and rule references, proposed amendments establish maximum fees for searching, handling, copying, and mailing medical records as follows:

- Medical providers shall provide one free copy of medical records to the first requesting party among the following: (A) employers; (B) carriers; (C) third-party administrators; and (D) rehabilitation professionals.
- For paper copies, medical providers can charge each subsequent requesting party a fee of no more than \$0.75 per page for the first 25 pages; \$0.50 per page for pages 26-100; and no more than \$0.25 per page for each page over 100, with a minimum charge of \$10.00.
- For electronic copies, the per page fee structure and minimum charge is the same as for paper copies, but with an additional flat maximum charge of \$200.
- Medical records include all medical bills related to the records, including CMS-1500 and UB-04 medical billing forms, together with any invoices, bills, or account statements that reflect the charge summary and any payments or discounts applied.

Rationale for the Specific Fee Levels

One free copy for the first payor-side request: reduces duplicative charges when multiple payor-side entities in a single workers' compensation matter need the same records (employer, carrier, TPA, rehab professional).

Tiered per-page caps ($\leq \$0.75$ for first 25 pages; $\leq \$0.50$ for pages 26-100; $\leq \$0.25$ thereafter; \$10 minimum) + \$200 flat maximum charge for electronic copies:

- The tiered structure balances cost recovery for providers (labor, supplies, postage) and affordability for requesters in workers' compensation cases, where records can be voluminous. The \$10 minimum recognizes fixed handling costs.
- The tiers align with the broader North Carolina patient access caps under G.S. 90-411, aligning workers' compensation costs with reasonable cost-based norms without exceeding State schedules applied elsewhere.

The change is also consistent with HIPAA's "reasonable, cost-based" fee standard for copying records (labor for copying, supplies, postage) and with federal guidance that prohibits charging for search and retrieval labor.¹ While attorney-initiated requests may follow state schedules rather than HIPAA's patient-access framework, the Commission is expressly empowered under G.S. 97-26.1 to set maximums for workers' compensation matters.

Affected Parties

The proposed amendment affects parties differently depending on their current pricing and record request practices.

Medical Providers

Providers currently charging more than the proposed caps for per-page fees or electronic copies are likely to see reduced revenue, especially for large records requests. Those already pricing within reasonable, cost-based ranges should experience minimal impact. Providers following the 1995 memorandum may be able to charge slightly higher fees for many requests under the proposed tiered schedule. However, providers charging more than the proposed caps would

¹ [How can covered entities calculate the limited fee that can be charged to individuals to provide them with a copy of their PHI? | HHS.gov](#)

experience reduced revenue on affected requests, particularly for very large electronic records requests subject to the \$200 ceiling. For the free-copy requirement, providers who do not currently furnish a first copy at no cost would incur new expenses to comply. The rule is not expected to change the underlying process for retrieving and producing records. However, providers not already following the free copy practice may need to track whether the required copy has been provided and adjust their billing practices accordingly. The extent of any incremental administrative burden is unknown.

Injured Workers & Their Attorneys

Since plaintiff attorneys advance records-retrieval costs, the tiered fee caps can generate meaningful case-level savings that would otherwise indirectly reduce an injured worker's net settlement or increase out-of-pocket litigation expenses in cases with no settlement or monetary award. However, these savings will not be universal. In situations where providers currently charge at or below the proposed caps -- or where large electronic records requests still exceed the capped amounts -- the financial impact for attorneys and injured workers may be limited. As a result, while many cases will benefit from lower recoverable records costs, others may see little change or even modest increases depending on existing provider practices and the size and format of the records requested.

Employers, Carriers, TPAs, Rehabilitation Professionals

Employers affected by the proposed rule include both private sector employers as well as State and local government entities. For employers, carriers, TPAs, and rehabilitation professionals, the requirement to provide at least one free copy per case can reduce duplicative charges, possibly supporting more efficient claims handling. Subsequent requests would be cost-contained under the proposed cap, offering predictable and generally lower expenses compared to uncapped pricing. However, these benefits will vary. Organizations already receiving records at low or no cost -- or those dealing with large, complex electronic files that still approach the capped amounts -- may experience limited or no savings. As a result, while some payors are likely to see reduced administrative costs and faster access to necessary documentation, others may see minimal change depending on current provider practices and the nature of the records requested.

Industrial Commission

No material operational impacts are expected. In the rare cases where the Commission is a defendant and requires records, the free copy provision and capped fees could offer modest cost and efficiency benefits.

11 NCAC 23J .0102 – Fees for Professional Services

The proposed amendments are clarifying changes, including updating web addresses and rule references. No material incremental costs or benefits are expected.

11 NCAC 23J .0103 – Fees for Institutional Services [Effective April 1, 2015]

The proposed amendments are clarifying changes to update a rule reference. No material incremental costs or benefits are expected.

11 NCAC 23J .0103 – Fees for Institutional Services [Effective June 1, 2018]

The proposed amendments are clarifying changes, including updating a web address. No material incremental costs or benefits are expected.

Impact Analysis

The Commission reviewed four datasets from both State and private entities, each listing the total amounts charged for workers' compensation medical record requests and, in some cases, the associated per-page and ancillary fees.

- For datasets that included page counts, the proposed tiered fee structure would result in an overall **per-page cost decrease of about 4 cents**, based on 3,647 total pages and an average request size of approximately 54 pages. This reflects a mix of increases and decreases: some high-page paper records would fall significantly under the new structure, while certain very low-cost electronic requests would rise to meet the allowed -- but not required -- \$10 minimum charge.
- Expressed per request rather than per page, that same page-count data translates to an **average cost decrease of about \$2.13 per records request** under the proposed structure. Like the per-page figure, this reflects a mix of larger decreases on high-page paper records and small increases where very low-cost requests rise to the \$10 minimum.
- In a sample of 8,300 requests (no page counts), **28% were billed exactly \$10**, suggesting that the \$10 minimum is already common in the observed transactions. However, the data do not establish the proportion of providers that use this amount. In observed transactions, **fewer than 1% exceeded \$200**, the proposed maximum charge for electronic copies.
- In a separate single-provider dataset of 1,220 requests, all charges exceeded \$10, but fewer than 0.1% exceeded \$200.

The takeaway: most charges already cluster at the low end, and very high fees are rare. The proposed rule mainly reduces the small number of outlier charges rather than cutting revenue across the board. That being said, the estimated average fee change is based on a limited sample of requests with available page counts and may not reflect the statewide distribution of request sizes, formats, providers, or current fees. The resulting Statewide estimates are illustrative and should not be interpreted as precise forecasts.

To visualize how the proposed fee schedule could change the fee landscape, the Commission compared each reported charge in the page-count datasets against the charge that would result under the proposed tiered structure. Figure 1 shows both distributions side by side.

Figure 1. Distribution of Reported fees vs Proposed fees (total \$ per request)

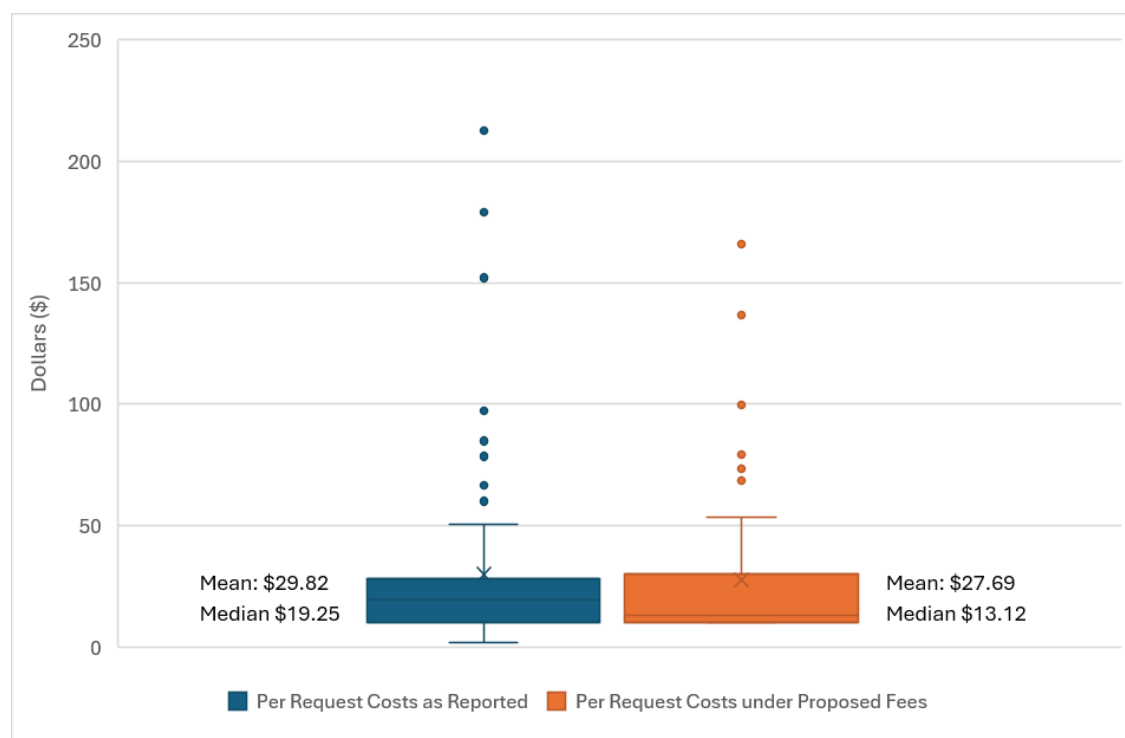


Figure 1 Notes:

- N = 68 records; total pages 3,647; net change -\$0.04 per page.
- The dollar amounts in the chart are the per record request cost, not the per page cost.
- Each box represents the middle 50% of all fees charged -- the range between the 25th and 75th percentiles -- showing where most record-request charges fall.
- The line inside each box marks the median fee.
- The whiskers reflect the spread of the remaining typical values outside the box, while any points extending beyond the whiskers represent unusually high outlier fees.

Using the available data as a reasonable estimation of the current fee landscape, the proposed fee structure would lower both the median and average charges and reduce the influence of high-cost outliers, creating a more compact and predictable range of fees.

Per-request Impact

- Free copy: For estimation purposes, the analysis assumes a **\$10 impact** for each newly required free copy, using the minimum charge observed in the available data as a proxy for the value of the waived fee. This is not a direct estimate of providers' incremental resource costs, which vary by provider and request.
- Fee caps: approximately **\$2.13 in reduced billing per request, on average**. This was calculated by repricing each request in the page-count dataset under the proposed tiers and averaging the difference against the amount actually billed. This amount represents the estimated net change in billed fees per request and is a transfer of value from providers to requestors.

Number of Cases

The Commission relied on the number of cases opened over the past five years to project the possible scale of future impacts.

Table 1. Workers' Compensation Cases Opened, 2021–2025

Year	# WC Cases Opened
2021	60,661
2022	57,616
2023	52,703
2024	48,001
2025	59,921
5-Year Total	278,902
5-Year Average	55,780

Sensitivity Analysis

The table below applies the per-copy costs above to the 5-year average case count from Table 1 at different assumptions about how many records requests each case generates and about what percentage of providers are already providing one free copy. For this analysis, we assumed at least one free copy and one capped request per case. The higher multipliers illustrate how the aggregate figures increase with more transactions. These are meant to be illustrations of the sensitivity of the aggregate impact to the number of records requests per case, not a precise prediction of total costs.

Table 2. Illustrative Five-Year Impact at Varying Transactions per Case (undiscounted)

Transactions per case	Free-copy cost (75% already providing free copy)	Free-copy cost (25% already providing free copy)	Per-page fee cap: Estimated net change in billed fees per request
1 (floor)	~\$0.70M <i>55,780 requests x 0.25 x \$10 per copy x 5yrs</i>	~\$2.09M <i>55,780 requests x 0.75 x \$10 per copy x 5yrs</i>	~\$0.60M <i>\$2.13 per request x 55,780 requests x 5 yrs</i>
3	~\$2.09M <i>167,340 requests x 0.25 x \$10 per copy x 5yrs</i>	~\$6.28M <i>167,340 requests x 0.75 x \$10 per copy x 5yrs</i>	~\$1.78M <i>\$2.13 per request x 167,340 requests x 5 yrs</i>
5	~\$3.49M	~\$10.46M	~\$2.97M <i>\$2.13 per request x</i>

	<i>278,900 requests x 0.25 x \$10 per copy x 5yrs</i>	<i>278,900 requests x 0.75 x \$10 per copy x 5yrs</i>	<i>278,900 requests x 5 yrs</i>
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Table 2 Notes.

- The 25% and 75% columns reflect uncertainty about how many providers already give a free copy.
- Present value (which reduces future dollars to today's value) at 7% discount would lower each figure by roughly 12% over five years.
- Because both the fee cap and the free copy shift dollars between parties rather than consume resources, the **net present value** to the state economy as a whole is **essentially \$0** -- each provider's foregone revenue or cost is matched by an equal saving to the requester; the figures above therefore show the size of that transfer, not a net cost to the economy.

Read together, the data support three conclusions without overstating certainty:

1. The per-transaction effects are small -- about \$10 per free copy and about \$2.13 in reduced billing per capped request (on average).
2. The statewide total depends on how many requests each case has and how many providers already provide one free copy. At the low end (one transaction per case), the 5-year impact is estimated on the order of \$1.3M-\$2.7M; realistic multipliers of three or more would place the aggregate total higher. The Commission does not have a way of knowing how many records requests each case generates or exactly how many providers offer a free copy already; as such, these estimates are presented as ranges to account for the uncertainty.
3. The impact is a transfer of value from the provider to the requester, and the impact is expected to be concentrated in the outlier highest-cost transactions. In the data reviewed, fewer than 1% of requests exceeded the \$200 ceiling and approximately 28% already sit at the \$10 minimum, so the changes are expected to largely redistribute value from a small set of high-fee providers to requesters (and ultimately injured workers).

Alternatives Analysis

In developing this rule, the Commission considered the following alternatives to the proposed tiered fee schedule. Each was evaluated against the objectives of (1) preventing excessive records request fees, (2) preserving cost-based recovery for providers, and (3) providing predictable, enforceable standards for all parties.

1. (Status Quo)

Under this alternative, the Commission would leave records request fees unregulated for worker's comp cases, relying on the informal 1995 memorandum as the de facto baseline.

The status quo perpetuates the problem the rule is intended to solve and for this reason, this alternative was rejected. Without an enforceable cap, the small subset of providers charging fees in the hundreds or thousands of dollars would continue to do so, impeding timely access to records, inflating claim-handling costs, and reducing injured workers' net recoveries. The 1995 memorandum is no longer enforceable, addresses only paper records, and does not reflect the

shift to electronic fulfillment. Continued reliance on it leaves parties without any predictable, binding standard.

2. Adopt a Single Flat Per-Request Fee Cap

Under this alternative, the Commission would set one single flat maximum fee regardless of page count or format (paper or electronic) in place of the proposed tiered structure.

This alternative was rejected because a single flat cap would require a trade-off between limiting charges for large requests and allowing cost recovery for smaller or more labor-intensive paper productions. A low cap could constrain recovery for large productions, while a higher cap could permit charges that are disproportionate to the size of routine requests. The Commission selected the tiered structure to vary allowable fees with request size while limiting charges for electronic copies.

Conclusion

In addition to minor clarifying changes, the proposed amendments to 11 NCAC 23J establish maximum fees for medical records requests in North Carolina workers' compensation cases and require a free copy for the first eligible payor-side requestor. Stakeholder reports and the available transaction data indicate that some requestors face very high and unpredictable charges, although the available data do not establish the prevalence of these practices across all providers Statewide.

The proposed tiered fee schedule is intended to limit excessive charges while allowing providers to recover fees for producing records. The free-copy requirement and fee caps is expected to reduce costs for eligible requestors, in particular in cases where providers are currently charging higher fees or not allowing for one free copy. Other transactions may experience little change or higher charges, depending on current pricing and how the minimum fee is implemented.

The estimated financial impact is relatively small on a per-transaction basis but may be material in the aggregate because of the volume of workers' compensation cases and records requests statewide. Providers already pricing within cost-based ranges will see little or no change. Providers currently charging above the proposed caps may experience reduced revenue, while providers that do not already provide the required free copy may forgo revenue on that transaction. Other providers may experience little change, and some may be able to charge higher fees for certain requests under the proposed fee schedule. The overall impact will depend on current pricing, existing free-copy practices, and the number, size, and format of records requests.

Assuming one records transaction per case opened, the estimated Statewide financial impact is approximately \$1.3 million to \$2.7 million over five years, or about \$1.1 million to \$2.4 million when expressed in 2026 dollars (discounted at 7%). These estimates are illustrative rather than precise forecasts, given uncertainty about the number of records requests per case, existing free-copy practices, and the representativeness of the available data. Cases involving multiple records

requests could result in substantially larger aggregate effects. The fee changes primarily redistribute payments between providers and requestors, although the free-copy requirement may also affect providers' administrative costs.

Overall, the proposed rule is intended to improve predictability in records request fees, limit unusually high charges, and preserve opportunities for providers to recover reasonable copying costs. The extent of the resulting savings and other impacts will depend on how the rule applies to individual requests and on existing provider and requestor practices.

1 **SUBCHAPTER 23J – FEES FOR MEDICAL COMPENSATION**

2
3 **SECTION 0100 – FEES FOR MEDICAL COMPENSATION**

4
5 **11 NCAC 23J .0101 GENERAL PROVISIONS**

6 (a) Pursuant to G.S. 97-26, the Commission adopts a Medical Fee Schedule composed of maximum amounts,
7 reimbursement rates, and payment guidelines, as set out in the rules of this Subchapter. The amounts and
8 reimbursement rates prescribed in the applicable published Medical Fee Schedule shall govern and apply according
9 to G.S. 97-26(c).

10 (b) The Medical Fee Schedule is available on the Commission's website at [https://www.ic.nc.gov/divisions-](https://www.ic.nc.gov/divisions-contacts/medical-fees-section/fee-schedule-disclaimer)
11 [contacts/medical-fees-section/fee-schedule-disclaimer.](https://www.ic.nc.gov/divisions-contacts/medical-fees-section/fee-schedule-disclaimer) ~~<http://www.ic.nc.gov/ncic/pages/feesched.asp> and in~~
12 ~~hardcopy at the offices of the Commission as set forth in 11 NCAC 23A .0101.~~

13 (c) Insurers and managed care organizations, or administrators on their behalf, may review and reimburse charges for
14 all medical compensation, including medical, hospital, and dental fees, without submitting the charges to the
15 Commission for review and approval.

16 (d) A provider of medical compensation shall submit its bill for services within 75 days of the rendition of the service,
17 or if treatment is longer, within 30 days after the end of the month during which multiple treatments were provided.
18 However, in cases where liability is initially denied but subsequently admitted or determined by the Commission, the
19 time for submission of medical bills shall run from the time the health care provider received notice of the admission
20 or determination of liability. Within 30 days of receipt of the bill, the employer, carrier, or managed care organization
21 or administrator on its behalf, shall pay the bill or send the provider written objections to the bill. If an employer,
22 carrier, administrator, or managed care organization disputes a portion of the provider's bill, the employer, carrier,
23 administrator, or managed care organization, shall pay the uncontested portion of the bill and shall resolve disputes
24 regarding the balance of the charges through its contractual arrangement or through the Commission.

25 (e) When the 10 percent addition to the bill pursuant to G.S. 97-18(i) is uncontested, payment shall be made to the
26 provider without notifying or seeking approval from the Commission. When the 10 percent addition to the bill is
27 contested, any party may request a hearing by the Commission pursuant to G.S. 97-83 and G.S. 97-84.

28 (f) When the responsible party seeks an audit of hospital charges, and has paid the hospital charges in full, the payee
29 hospital, upon request, shall provide access to and copies of ~~appropriate~~related records, without charge or fee, to the
30 ~~person(s)~~persons chosen by the payor to review and audit the records.

31 (g) The responsible employer, carrier, managed care organization, or administrator shall pay the bills of medical
32 compensation providers to whom the employee has been referred by the treating physician authorized by the insurance
33 carrier for the compensable injury or body part, unless it has requested that the physician obtain authorization for
34 referrals or tests. Compliance with the request shall not unreasonably delay the treatment or service to be rendered to
35 the employee.

36 (h) Employees are entitled to reimbursement for travel expenses when the travel is medically necessary and the
37 mileage is 20 or more miles, round trip, at the business standard mileage rate set by the Internal Revenue Service per

1 mile of travel and the actual cost of any tolls paid. Employees are entitled to lodging and meal expenses, at the rate
2 established for state employees by the North Carolina Director of Budget, when it is medically necessary that the
3 employee stay overnight at a location away from the employee's usual place of residence. Employees are entitled to
4 reimbursement for the costs of parking or a vehicle for hire, when the costs are medically necessary, at the actual costs
5 of the expenses. The current reimbursement rates referenced in this Paragraph are contained in the Form 25T, Itemized
6 Statement of Charges for Travel, as set forth in 11 NCAC 23L .0113, which shall be used to claim travel expenses.

7 (i) Any employer, carrier, or administrator denying a claim in which medical care has previously been authorized is
8 responsible for all costs incurred prior to the date that notice of denial is provided to each health care provider to whom
9 authorization has been previously given.

10 (j) The maximum fees for searching, handling, copying, and mailing records are set as follows:

11 (1) Medical providers shall provide one free copy of medical records, whether paper or electronic, to
12 the first requesting party among the following:

13 (A) employers;

14 (B) carriers;

15 (C) third party administrators; and

16 (D) rehabilitation professionals.

17 (2) For all subsequent requesting parties, medical providers shall inform the subsequent requesting
18 party that the medical provider previously supplied the records at no charge to one of the requesting
19 parties listed in Subparagraph (1) of this Paragraph, identify the party to whom the records were
20 previously provided, and charge each subsequent requesting party as follows:

21 (A) For paper copies of medical records, a fee of no more than seventy-five cents (\$.75) per
22 page for the first 25 pages, fifty cents (\$.50) per page for pages 26 through 100, and twenty-
23 five cents (\$.25) per page for each page in excess of 100 pages, with a minimum charge of
24 ten dollars (\$10.00); and

25 (B) For electronic copies of medical records, a fee of no more than seventy-five cents (\$.75)
26 per page for the first 25 pages, fifty cents (\$.50) per page for pages 26 through 100, and
27 twenty-five cents (\$.25) per page for each page in excess of 100 pages, with a minimum
28 charge of ten dollars (\$10.00) and a maximum charge of two hundred dollars (\$200.00).

29 (k) For purposes of Paragraph (j) of this Rule, medical records shall include all medical bills related to the records.
30 The medical bills shall include copies of any CMS-1500 or UB-04 medical billing forms completed by the medical
31 provider in addition to any invoices, bills, or account statements that reflect the charge summary and any payments or
32 discounts already applied.

33 (l) Paragraphs (j) and (k) of this Rule do not apply to medical documentation required to support a medical bill for
34 payment. The medical reports and records necessary for an employer, carrier, or third-party administrator to adjudicate
35 a medical bill for payment shall be provided at no cost with the medical bill or after the presentation of the medical
36 bill if requested by the payor to support the bill.

History Note: Authority G.S. 97-18(i); 97-25; 97-25.6; 97-26; 97-26.1; 97-80(a); 138-6; S.L. 2013-410; Eff. January 1, 1990; Amended Eff. April 1, 2015; July 1, 2014; January 1, 2013; June 1, 2000; Recodified from 04 NCAC 10J .0101 Eff. June 1, 2018.

11 NCAC 23J .0102 FEES FOR PROFESSIONAL SERVICES

(a) Except as otherwise provided in this Rule, maximum allowable amounts payable to health care providers for professional services shall be based on the current year's Medicare Part B Fee Schedule for North Carolina ("the Medicare base amount"), as published by the Centers for Medicare & Medicaid Services ("CMS") or its administrative contractor, including subsequent versions and editions. The Medicare Part B Fee Schedule for North Carolina can be found at <https://www.cms.gov/medicare/payment/fee-schedules/physician> ~~<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>~~.

(b) The schedule of maximum reimbursement rates for professional services is as follows:

- (1) evaluation & management services are 140 percent of the Medicare base amount;
- (2) physical medicine services are 140 percent of the Medicare base amount;
- (3) emergency medicine services are 169 percent of the Medicare base amount;
- (4) neurology services are 153 percent of the Medicare base amount;
- (5) pain management services are 163 percent of the Medicare base amount;
- (6) radiology services are 195 percent of the Medicare base amount;
- (7) major surgery services are 195 percent of the Medicare base amount; and
- (8) all other professional services are 150 percent of the Medicare base amount.

(c) The schedule of maximum reimbursement rates for anesthesia services is as follows:

- (1) when provided by an anesthesiologist, the allowable amount is three dollars and eighty-eight cents (\$3.88) per minute up to and including 60 minutes, and two dollars and five cents (\$2.05) per minute beyond 60 minutes; and
- (2) when provided by a certified registered nurse anesthetist, the allowable amount is two dollars and fifty-five cents (\$2.55) per minute up to and including 60 minutes, and one dollar and fifty-five cents (\$1.55) per minute beyond 60 minutes.

(d) The maximum allowable amount for an assistant at surgery is 20 percent of the amount payable for the surgical procedure.

(e) Using the Medicare base amounts and maximum reimbursement rates in Paragraphs (a) through (d) of this Rule the Commission shall publish annually an official Professional Fee Schedule Table listing allowable amounts for individual professional services in accordance with this fee schedule. The allowable amounts contained in the Professional Fee Schedule Table shall take effect January 1 of each year. The Professional Fee Schedule Table is available as set forth in Rule .0101(b) of this ~~Section~~ ~~Section and in hardcopy at the offices of the Commission as set forth in Rule 11 NCAC 23A .0101.~~

(f) Maximum allowable amounts for durable medical equipment and supplies ("DME") provided in the context of professional services are 100 percent of those rates established for North Carolina in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") Fee Schedule published by CMS. The DMEPOS can be found at <https://www.cms.gov/medicare/payment/fee-schedules/dmepos> ~~<http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html>~~. The Commission will publish annually on its website an official DME Fee Schedule Table listing allowable amounts for individual items and services in accordance with this fee schedule. The allowable amounts contained in the DME Fee Schedule Table will take effect January 1 of each year. The DME Fee Schedule Table is available as set forth in Rule .0101(b) of this ~~Section. Section and in hardcopy at the offices of the Commission as set forth in Rule 11 NCAC 23A .0101.~~

(g) Maximum allowable amounts for clinical laboratory services are 150 percent of those rates established for North Carolina in the Clinical Diagnostic Laboratory Fee Schedule published by CMS. The CMS Clinical Laboratory Fee Schedule can be found at <https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule-clfs> ~~<http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/clinlab.html>~~. The Commission will publish annually on its website an official Clinical Laboratory Fee Schedule Table listing allowable amounts for individual items and services in accordance with this fee schedule. The allowable amounts contained in the Clinical Laboratory Fee Schedule Table will take effect January 1 of each year. The Clinical Laboratory Fee Schedule Table is available as set forth in Rule .0101(b) of this ~~Section. Section and in hardcopy at the offices of the Commission as set forth in Rule 11 NCAC 23A .0101.~~

(h) The following licensed health care providers may provide professional services in workers' compensation cases subject to physician supervision and other scope of practice requirements and limitations under North Carolina law:

- (1) certified registered nurse anesthetists;
- (2) anesthesiologist assistants;
- (3) nurse practitioners;
- (4) physician assistants;
- (5) certified nurse midwives; and
- (6) clinical nurse specialists.

Services rendered by these providers are subject to the schedule of maximum fees for professional services as provided in this Rule.

*History Note: Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410;
Eff. April 1, 2015;
Amended Eff. July 1, 2015;
Recodified from 04 NCAC 10J .0102 Eff. June 1, 2018.*

11 NCAC 23J .0103 FEES FOR INSTITUTIONAL SERVICES [EFFECTIVE APRIL 1, 2015]

(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

1 facility by the Centers for Medicare & Medicaid Services ("CMS"). "Facility-specific" rate means the all-inclusive
2 amount eligible for payment by Medicare for a claim, excluding pass-through payments.

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

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

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

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

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

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

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

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

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

23 (g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services
24 provided by ambulatory surgical centers ("ASC") shall be based on the Medicare ASC reimbursement amount
25 determined by applying the most recently adopted and effective Medicare Payment System Policies for Services
26 Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and
27 factors as published annually in the Federal Register ("the Medicare ASC facility-specific amount"). Reimbursement
28 shall be based on the fully implemented payment amount in Addendum AA, Final ASC Covered Surgical Procedures
29 for CY 2015, and Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for
30 2015, as published in the Federal Register, or their successors.

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

- 33 (1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility-specific amount.
- 34 (2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.
- 35 (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 ~~(e)~~(e) of this Rule.

*History Note: Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410;
Eff. April 1, 2015;
Recodified from 04 NCAC 10J .0103 Eff. June 1, 2018.*

11 NCAC 23J .0103 FEES FOR INSTITUTIONAL SERVICES [EFFECTIVE JUNE 1, 2018]

(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 most recently adopted and effective Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems 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/payment/prospective-payment-systems/hospital-outpatient> and <https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc> <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html> ("the OPPOS/ASC Medicare rule"). An ASC's specific Medicare wage index value as set out in the OPPOS/ASC Medicare rule shall be applied in the calculation of the maximum allowable amount for any institutional service it provides.
- (h) The schedule of maximum reimbursement rates for institutional services provided by ambulatory surgical centers is as follows:
- (1) A maximum reimbursement rate of 200 percent shall apply to institutional services that are eligible for payment by CMS when performed at an ASC.
- (2) A maximum reimbursement rate of 135 percent shall apply to institutional services performed at an ASC that are eligible for payment by CMS if performed at an outpatient hospital facility, but would not be eligible for payment by CMS if performed at an ASC.
- (i) If the facility-specific Medicare payment includes an outlier payment, the sum of the facility-specific reimbursement amount and the applicable outlier payment amount shall be multiplied by the applicable percentages set out in Paragraphs (b), (c), (e), (f), and (h) of this Rule.
- (j) Charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.
- (k) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping ("DRG") payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.
- (l) For specialty facilities paid outside Medicare's inpatient and outpatient Prospective Payment System, the payment shall be determined using Medicare's payment methodology for those specialized facilities multiplied by the inpatient institutional acute care percentages set out in Paragraphs (b) and (c) of this Rule.

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

1 *Temporary Amendment Eff. January 1, 2017;*
2 *Temporary Rule invalidated by Order of Judge G. Bryan Collins, Jr. in North Carolina Ambulatory*
3 *Center Association, et al. v. North Carolina Industrial Commission, No. 17-CVS-00144 (Wake*
4 *County Superior Court);*
5 *Recodified from 04 NCAC 10J .0103 Eff. June 1, 2018;*
6 *Amended Eff. June 1, 2018.*