RRC STAFF OPINION

PLEASE NOTE: THIS COMMUNICATION IS EITHER 1) ONLY THE RECOMMENDATION OF AN RRC STAFF ATTORNEY AS TO ACTION THAT THE ATTORNEY BELIEVES THE COMMISSION SHOULD TAKE ON THE CITED RULE AT ITS NEXT MEETING, OR 2) AN OPINION OF THAT ATTORNEY AS TO SOME MATTER CONCERNING THAT RULE. THE AGENCY AND MEMBERS OF THE PUBLIC ARE INVITED TO SUBMIT THEIR OWN COMMENTS AND RECOMMENDATIONS (ACCORDING TO RRC RULES) TO THE COMMISSION.

AGENCY: Industrial Commission

RULE CITATION: 04 NCAC 10J, Section .0100

RECOMMENDED ACTION:

X Approve, but note staff's comment

Object, based on:

Lack of statutory authority

Unclear or ambiguous

Unnecessary

Failure to comply with the APA

Extend the period of review

COMMENT:

The Industrial Commission was exempt from rulemaking under Article 2A until the General Assembly repealed that exemption in Session Law 2011-287. The Industrial Commission acted to adopt rules in accordance with that law. In its October, November and December 2012 meetings, the RRC reviewed over 150 rules adopted by the Industrial Commission and ultimately approved them all.

In December 2012, the RRC approved Rule 04 NCAC 10J .0101, General Provisions. This was the only Rule in Subchapter 10J, Fees for Medical Compensation. This Rule did not receive ten letters of objection and was not subject to legislative review; it went into effect January 1, 2013. The RRC approved this Rule again in March 2014 after the agency amended it; the amendment became effective July 1, 2014.

In Session Law 2013-410 (attached), Section 33, the Industrial Commission was directed to base the fee schedules for maximum physician and hospital fees upon the applicable Medicare payment methodologies. The Industrial Commission was also told to periodically review the fee schedule.

The Industrial Commission is now proposing to separate Rule 10J .0101 into three rules, effective April 1, 2015. Rule 10J .0101 would now only include general guidelines for the fee schedule. Rule 10J .0102 sets fees for professional services. Rule 10J .0103 sets the fees for institutional services.

Amanda J. Reeder
Commission Counsel

The Industrial Commission submitted two versions of Rule 04 NCAC 10J .0102 with different effective dates. The version that is proposed to become effective April 1, 2015 is almost a verbatim restatement of Rule 10J .0101, Paragraphs (b) and (c); these Paragraphs are being removed from Rule 10J .0101 in the April 1, 2015 amendment. The second version, proposed to become effective July 1, 2015, sets different rates for professional services. While it is unusual to see two versions of the same Rule submitted for approval at one meeting, staff understands the agency's desire to change the professional fee schedule in July 2015. Staff believes that the agency gave sufficient explanation in its Notice of Text regarding the effective dates. (See attached the pages from the NC Register, which explain the rationale for publishing two versions of the Rule.)

Rule 04 NCAC 10J .0103 sets the fee schedule for institutional services; that schedule is currently contained in Rule 10J .0101, Paragraph (d). Rule 10J .0103 is not a restatement of Paragraph (d), but sets a different rate schedule.

Staff recommends approval of all four rules at the February 2015 meeting.

SESSION LAW 2013-410
HOUSE BILL 92

AN ACT TO MAKE TECHNICAL CORRECTIONS TO THE GENERAL STATUTES AND SESSION LAWS, AS RECOMMENDED BY THE GENERAL STATUTES COMMISSION, AND TO MAKE ADDITIONAL TECHNICAL AND OTHER CHANGES TO THE GENERAL STATUTES AND SESSION LAWS.

The General Assembly of North Carolina enacts:

PART I. TECHNICAL CORRECTIONS RECOMMENDED BY THE GENERAL STATUTES COMMISSION

SECTION 1. The title of Article 9 of Chapter 7A of the General Statutes reads as rewritten:

"Article 9.
District Attorneys and ~~Judicial~~ Prosecutorial Districts."

SECTION 2. G.S. 13-1 reads as rewritten:

"**§ 13-1. Restoration of citizenship.**

Any person convicted of a crime, whereby the rights of citizenship are forfeited, shall have such rights automatically restored upon the occurrence of any one of the following conditions:

(1) The unconditional discharge of an inmate, of a probationer, or of a parolee by the ~~Division of Adult Correction of the Department of Public Safety;~~ agency of the State having jurisdiction of that person or of a defendant under a suspended sentence by the court.
(2) The unconditional pardon of the offender.
(3) The satisfaction by the offender of all conditions of a conditional pardon.
(4) With regard to any person convicted of a crime against the United States, the unconditional discharge of such person by the agency of the United States having jurisdiction of such person, the unconditional pardon of such person or the satisfaction by such person of a conditional pardon.
(5) With regard to any person convicted of a crime in another state, the unconditional discharge of such person by the agency of that state having jurisdiction of such person, the unconditional pardon of such person or the satisfaction by such person of a conditional pardon."

SECTION 3.(a) G.S. 14-17(a) reads as rewritten:

"(a) A murder which shall be perpetrated by means of a nuclear, biological, or chemical weapon of mass destruction as defined in G.S. 14-288.21, poison, lying in wait, imprisonment, starving, torture, or by any other kind of willful, deliberate, and premeditated killing, or which shall be committed in the perpetration or attempted perpetration of any arson, rape or a sex offense, robbery, kidnapping, burglary, or other felony committed or attempted with the use of a deadly weapon shall be deemed to be murder in the first degree, a Class A felony, and any person who commits such murder shall be punished with death or imprisonment in the State's prison for life without parole as the court shall determine pursuant to G.S. 15A-2000, except that any such person who was under 18 years of age at the time of the murder shall be punished ~~with imprisonment in the State's prison for life without parole.~~in accordance with Part 2A of Article 81B of Chapter 15A of the General Statutes."

SECTION 3.(b) G.S. 15A-1340.17(c) reads as rewritten:

"(c) Punishments for Each Class of Offense and Prior Record Level; Punishment Chart Described. — The authorized punishment for each class of offense and prior record level is as specified in the chart below. Prior record levels are indicated by the Roman numerals placed

registered mail, certified mail, or in a manner provided by G.S. 1A-1, Rule 4(j)(1)d. The Board may reinstate an expired license upon the showing of good cause for late payment of fees, upon payment of said fees within 60 days after expiration of the license, and upon the further payment of a late penalty of twenty-five dollars ($25.00). After 60 days after the expiration date, the Board may reinstate the license for good cause shown upon application for reinstatement and payment of a late penalty of fifty dollars ($50.00) and the renewal fee. The Board may require all licensees to successfully attend and complete a course or courses of occupational instruction funded, conducted or approved or sponsored by the Board on an annual basis as a condition to any license renewal and evidence of satisfactory attendance and completion of any such course or courses shall be provided the Board by the licensee."

SECTION 32.5.(i) G.S. 93D-12 reads as rewritten:

"**§ 93D-12. License to be displayed at office.**

Every person to whom a license, apprenticeship certificate, or sponsor registration is granted shall display the same in a conspicuous part of his office ~~wherein the fitting and selling of hearing aids is conducted,~~ where the person conducts business as a hearing aid specialist or shall have a copy of such license certificate, or registration on his person and exhibit the same upon request when fitting or selling hearing aids outside of his office."

SECTION 32.5.(j) G.S. 93D-15 reads as rewritten:

"**§ 93D-15. Violation of Chapter.**

Any person who violates any of the provisions of this Chapter and any person who holds himself out to the public as a ~~fitter and seller of hearing aids~~hearing aid specialist without having first obtained a license or apprenticeship registration as provided for herein shall be deemed guilty of a Class 2 misdemeanor."

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. Such fee schedules shall also be periodically reviewed to ensure that they continue to adhere to these standards and applicable fee schedule requirements of Chapter 97. In addition to the statewide fee averages, geographical and community variations in provider costs, and other factors affecting provider costs that the Commission may consider pursuant to G.S. 97-26, the Commission may also consider other payment systems in North Carolina, other states' cost and payment structures for workers' compensation, the impact of changes over time to Medicare fee schedules on payers and providers, and cost issues for providers and payers relating to frequency of service, case mix index, and related issues.

(2) Transition to direct billing. – Pursuant to G.S. 97-26(g) through (g1) and applicable rules, the Commission shall provide for transition to direct claims submission and reimbursement for medical and hospital fees, including an implementation timeline, notice to affected stakeholders, and related compliance issues.

(3) Expedite rule-making process for fee schedule. – The Industrial Commission is exempt from the certification requirements of G.S. 150B-19.1(h) and the fiscal note requirement of G.S. 150B-21.4 in developing the fee schedules required pursuant to this section."

SECTION 33.(b) G.S. 97-26 reads as rewritten:

"**§ 97-26. Fees allowed for medical treatment; malpractice of physician.**

(a) Fee Schedule. – The Commission shall adopt by rule a schedule of maximum fees for medical ~~compensation, except as provided in subsection (b) of this section,~~compensation and shall periodically review the schedule and make revisions.

The fees adopted by the Commission in its schedule shall be adequate to ensure that (i) injured workers are provided the standard of services and care intended by this Chapter, (ii)

providers are reimbursed reasonable fees for providing these services, and (iii) medical costs are adequately contained.

The Commission may consider any and all reimbursement systems and plans in establishing its fee schedule, including, but not limited to, the State Health Plan for Teachers and State Employees (hereinafter, "State Plan"), Blue Cross and Blue Shield, and any other private or governmental plans. The Commission may also consider any and all reimbursement methodologies, including, but not limited to, the use of current procedural terminology ("CPT") codes, diagnostic-related groupings ("DRGs"), per diem rates, capitated payments, and resource-based relative-value system ("RBRVS") payments. The Commission may consider statewide fee averages, geographical and community variations in provider costs, and any other factors affecting provider costs.

(b) Hospital Fees. – Each hospital subject to the provisions of this ~~subsection~~ section shall be reimbursed the amount provided for in this ~~subsection~~ section unless it has agreed under contract with the insurer, managed care organization, employer (or other payor obligated to reimburse for inpatient hospital services rendered under this Chapter) to accept a different amount or reimbursement methodology.

~~Except as otherwise provided herein, payment for medical treatment and services rendered to workers' compensation patients by a hospital shall be a reasonable fee determined by the Commission and adopted by rule. Effective September 16, 2001, through June 30, 2002, the fee shall be the following amount unless the Commission adopts a different fee schedule in accordance with the provisions of this section:~~

~~(1) For inpatient hospital services, the amount that the hospital would have received for those services as of June 30, 2001. The payment shall not be more than a maximum of one hundred percent (100%) of the hospital's itemized charges as shown on the UB-92 claim form nor less than the minimum percentage for payment of inpatient DRG claims that was in effect as of June 30, 2001.~~

~~(2) For outpatient hospital services and any other services that were reimbursed as a discount off of charges under the State Plan as of June 30, 2001, the amount calculated by the Commission as a percentage of the hospital charges for such services. The percentage applicable to each hospital shall be the percentage used by the Commission to determine outpatient rates for each hospital as of June 30, 2001.~~

~~(3) For any other services, a reasonable fee as determined by the Industrial Commission.~~

The explanation of the fee schedule change that is published pursuant to G.S. 150B-21.2(c)(2) shall include a summary of the data and calculations on which the fee schedule rate is based.

A hospital's itemized charges on the UB-92 claim form for workers' compensation services shall be the same as itemized charges for like services for all other payers.

…."

SECTION 36.(a) G.S. 115D-67.2(b) reads as rewritten:

"(b) The Advisory Board shall consist of 14 ~~members:~~members as follows:

(1) The President of Gaston College, who shall serve ex ~~officio;~~officio.

(2) ~~Four~~ Two members who are residents of North Carolina appointed by the ~~North Carolina Manufacturers Association, Inc.;~~National Council of Textile Organizations.

(2a) Two members appointed by the Southern Textile Association, Inc.

(3) Two members appointed by the board of the North Carolina Center for Applied Textile Technology ~~Foundation;~~Foundation.

(4) Two members appointed by the board of trustees of Gaston ~~College;~~College.

(5) Three members appointed by the State Board of Community ~~Colleges;~~Colleges.

(6) One member appointed by the dean of the College of Textiles at North Carolina State ~~University; and~~University.

(7) The Director of the Manufacturing Solutions Center at Catawba Valley Community College who shall serve ex officio as a nonvoting member.

The appointing entities shall attempt to appoint members who are distributed geographically throughout the State; members representing large and small companies; and members from

…."

PART IV. EFFECTIVE DATE

SECTION 48. Except where otherwise provided, this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 26th day of July, 2013.

s/ Philip E. Berger
President Pro Tempore of the Senate

s/ Thom Tillis
Speaker of the House of Representatives

s/ Pat McCrory
Governor

Approved 10:52 a.m. this 23rd day of August, 2013

Note from the Codifier: *The notices published in this Section of the NC Register include the text of proposed rules. The agency must accept comments on the proposed rule(s) for at least 60 days from the publication date, or until the public hearing, or a later date if specified in the notice by the agency. If the agency adopts a rule that differs substantially from a prior published notice, the agency must publish the text of the proposed different rule and accept comment on the proposed different rule for 60 days.*
Statutory reference: G.S. 150B-21.2.

TITLE 04 – DEPARTMENT OF COMMERCE

Notice *is hereby given in accordance with G.S. 150B-21.2 that the NC Industrial Commission intends to adopt the rules cited as 04 NCAC 10J .0102, .0103 and amend the rules cited as 04 NCAC 10J .0101, .0102.*

Link to agency website pursuant to G.S. 150B-19.1(c): *http://www.ic.nc.gov/ProposedNCICMedicalFeeScheduleRules.html*

Proposed Effective Date: *April 1, 2015 – 04 NCAC 10J .0101, .0102, .0103; and July 1, 2015 – 04 NCAC 10J .0102*

Public Hearing:
Date: *December 17, 2014*
Time: *2:00 p.m.*
Location: *Dobbs Building, Room 2173, 430 N. Salisbury Street, Raleigh, NC 27603*

Reason for Proposed Action: *The Industrial Commission has proposed these four rules to fulfill its statutory duty to periodically review the schedule of fees charged for medical treatment in workers' compensation cases and to make revisions if necessary. The revisions reflected in the proposed rules are intended to ensure that injured workers are provided the standard of services and care intended by the Workers' Compensation Act, that health care providers receive reasonable reimbursement for services, and that medical costs are adequately contained. The Industrial Commission was directed in S.L. 2013-410, s. 33.(a) to base its physician and hospital fee schedules on "the applicable Medicare payment methodologies." The proposed rules are intended to carry out this legislative mandate. There are two versions of Rule 04 NCAC 10J .0102 in order to move the physician and hospital fee schedules out of Rule 04 NCAC 10J .0101 and keep the current physician fee schedule in place until July 1, 2015. The April 1, 2015 version of Rule 04 NCAC 10J .0102 is essentially Paragraphs (b) and (c) of the current Rule 04 NCAC 10J .0101. As required by G.S. 97-26(b), the following is a summary of the data and information sources reviewed by the Commission in determining the applicable fee schedule rates for hospitals and ambulatory surgery centers. Rates were calculated to fall in the estimated median range of workers' compensation fee schedules nationally, based on data available from the following studies and data sources:*
(1) NORTH CAROLINA WORKERS COMPENSATION INSURANCE: A WHITE PAPER REVIEWING MEDICAL COSTS AND MEDICAL FEE REGULATIONS, prepared for the National Foundation for Unemployment Compensation and Workers' Compensation; prepared by Philip S. Borba, Ph.D. and Robert K. Briscoe, WCP, Milliman, Inc.; May 23, 2013.
(2) CompScope Medical Benchmarks, 15th Edition, for North Carolina, published by the Workers' Compensation Research Institute, August 2014.
(3) North Carolina Hospital Association/Optum Group Health survey data, June 2013 and July 2014.
(4) Review of states' fee schedule structures, nationally and regionally.

Comments may be submitted to: *Meredith Henderson, 4333 Mail Service Center, Raleigh, NC 27699-4333; phone (919) 807-2575; fax (919) 715-0282; email meredith.henderson@ic.nc.gov*

Comment period ends: *January 16, 2015*

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)**
☒ **No fiscal note required by G.S. 150B-21.4**

*****These rules were exempted from the fiscal note requirement of G.S. 150B-21.4 in S.L. 2013-410, s. 33.(a)(3).**

CHAPTER 10 – INDUSTRIAL COMMISSION

SUBCHAPTER 10J – FEES FOR MEDICAL COMPENSATION

SECTION .0100 – FEES FOR MEDICAL COMPENSATION

04 NCAC 10J .0101 GENERAL PROVISIONS

(a) ~~The Commission adopted and published a Medical Fee Schedule, pursuant to the provisions of G.S. 97-26(a), setting maximum amounts, except for hospital fees pursuant to G.S. 97-26(b), that may be paid for medical, surgical, nursing, dental, and rehabilitative services, and medicines, sick travel, and other treatment, including medical and surgical supplies, original artificial members as may reasonably be necessary at the end of the healing period and the replacement of such artificial members when reasonably necessitated by ordinary use or medical circumstances.~~ Pursuant to G.S. 97-26, the Commission adopts a Medical Fee Schedule composed of maximum amounts, reimbursement rates, and payment guidelines. The amounts and reimbursement rates prescribed in the applicable published Medical Fee Schedule shall govern and apply according to G.S. 97-26(c). The Medical Fee Schedule is available on the Commission's website at http://www.ic.nc.gov/ncic/pages/feesched.asp and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.

~~(b) The Commission's Medical Fee Schedule contains maximum allowed amounts for medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology (CPT) codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems (HCPCS) codes, and jurisdiction specific codes. A listing of the maximum allowable amount for each code is available on the Commission's website at http://www.ic.nc.gov/ncic/pages/feesched.asp and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.~~

~~(c) The following methodology provides the basis for the Commission's Medical Fee Schedule:~~

~~(1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201 99205 and 99211 99215, which are based on 1995 Medicare values multiplied by 2.05.~~

~~(2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.~~

~~(3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.~~

~~(4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.~~

~~(d) The Commission's Hospital Fee Schedule, adopted pursuant to G.S. 97-26(b), provides for payment as follows:~~

~~(1) Inpatient hospital fees: Inpatient services are reimbursed based on a Diagnostic Related Groupings (DRG) methodology. The Hospital Fee Schedule utilizes the 2001 Diagnostic Related Groupings adopted by the State Health Plan. Each DRG amount is based on the amount that the State Health Plan had in effect for the same DRG on June 30, 2001.~~

~~DRG amounts are further subject to the following payment band that establishes maximum and minimum payment amounts:~~

~~(A) The maximum payment is 100 percent of the hospital's itemized charges.~~

~~(B) For hospitals other than critical access hospitals, the minimum payment is 75 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

~~(C) For critical access hospitals, the minimum payment is 77.07 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

~~(2) Outpatient hospital fees: Outpatient services are reimbursed based on the hospital's actual charges as billed on the UB-04 claim form, subject to the following percentage discounts:~~

~~(A) For hospitals other than critical access hospitals, the payment shall be 79 percent of the hospital's billed charges. Effective February 1, 2013, the payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

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

~~(3) Ambulatory surgery fees: Ambulatory surgery center services are reimbursed at 79 percent of billed charges. Effective February 1, 2013, the ambulatory surgery center services are reimbursed at the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

~~(4) Other rates: If a provider has agreed under contract with the insurer or managed care organization to accept a different amount or reimbursement methodology, that amount or methodology establishes the applicable fee.~~

~~(5) Payment levels frozen and reduced pending study of new fee schedule: Effective February 1, 2013, inpatient and outpatient payments for each hospital and the payments for each ambulatory surgery center shall be set at the payment rates in effect for those facilities as of June 30, 2012. Effective April 1, 2013, those rates shall then be reduced as follows:~~

~~(A) Hospital outpatient and ambulatory surgery: The rate in effect as of that date shall be reduced by 15 percent.~~

~~(B) Hospital inpatient: The minimum payment rate in effect as of that date shall be reduced by 10 percent.~~

~~(6) Effective April 1, 2013, implants shall be paid at no greater than invoice cost plus 28 percent.~~

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

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

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

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

~~(i)~~(f) The responsible employer, carrier, managed care organization, or administrator shall pay the ~~statements~~ bills of medical compensation providers to whom the employee has been referred by the treating physician authorized by the insurance carrier for the compensable injury or body part, unless the physician has been requested to obtain authorization for referrals or tests; provided that compliance with the request shall not unreasonably delay the treatment or service to be rendered to the employee.

~~(j)~~(g) Employees are entitled to reimbursement for sick travel when the travel is medically necessary and the mileage is 20 or more miles, round trip, at the business standard mileage rate set by the Internal Revenue Service per mile of travel and the actual cost of tolls paid. Employees are entitled to lodging and meal expenses, at a rate to be established for state employees by the North Carolina Director of Budget, when it is medically necessary that the employee stay overnight at a location away from the employee's usual place of residence. Employees are entitled to reimbursement for the costs of parking or a vehicle for hire, when the costs are medically necessary, at the actual costs of the expenses.

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

Authority G.S. 97-18(i); 97-25; 97-25.6; 97-26; 97-80(a); 138-6; S.L. 2013-410.

04 NCAC 10J .0102 FEES FOR PROFESSIONAL SERVICES (Proposed Eff. APRIL 1, 2015)

(a) The Commission's Medical Fee Schedule contains maximum allowed amounts for professional medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology ("CPT") codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems ("HCPCS") codes, and jurisdiction-specific codes. A listing of the maximum allowable amount for each code is available in the Medical Fee Schedule on the Commission's website at http://www.ic.nc.gov/ncic/pages/feesched.asp and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.

(b) The following methodology provides the basis for the Commission's Medical Fee Schedule:

(1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201-99205 and 99211-99215, which are based on 1995 Medicare values multiplied by 2.05.

(2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.

(3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.

(4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.

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

04 NCAC 10J .0102 FEES FOR PROFESSIONAL SERVICES (Proposed Eff. JULY 1, 2015)

~~(a) The Commission's Medical Fee Schedule contains maximum allowed amounts for medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology (CPT) codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems (HCPCS) codes, and jurisdiction specific codes. A listing of the maximum allowable amount for each code is available on the Commission's website at http://www.ic.nc.gov/ncic/pages/feesched.asp and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.~~

~~(b) The following methodology provides the basis for the Commission's Medical Fee Schedule:~~

~~(1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201 99205 and 99211 99215, which are based on 1995 Medicare values multiplied by 2.05.~~

~~(2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.~~

~~(3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.~~

~~(4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.~~

(a) Except where otherwise provided, maximum allowable amounts payable to health care providers for professional services are based on the current year's Medicare Part B Fee Schedule for North Carolina as published by the Centers for Medicare & Medicaid Services ("CMS") ("the Medicare base amount"), including subsequent versions and editions.

(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;

(8) All other professional services are 150 percent of the Medicare base amount.

(c) Anesthesia services shall be paid at no more than the following rates:

(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.

(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 the Paragraphs above, the Commission will publish annually an official Professional Fee Schedule Table listing allowable amounts for individual professional services in accordance with this fee schedule. The Professional Fee Schedule Table, including all subsequent versions and editions, is incorporated by reference. The allowable amounts contained in the Professional Fee Schedule Table will take effect January 1 of each year. The Professional Fee Schedule Table 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 Rule 04 NCAC 10A .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 Commission will publish once annually to its website an official DME Fee Schedule Table listing allowable amounts for individual items and services in accordance with this fee schedule. The DME Fee Schedule Table, including all subsequent versions and editions, is incorporated by reference. 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 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 Rule 04 NCAC 10A .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 Commission will publish once annually to its website an official Clinical Laboratory Fee Schedule Table listing allowable amounts for individual items and services in accordance with this fee schedule. The Clinical Laboratory Fee Schedule Table, including all subsequent versions and editions, is incorporated by reference. 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 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 Rule 04 NCAC 10A .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;
(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.

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

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

(a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services are 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 for a claims payment that Medicare would make, but excludes 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 defined by the 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") are 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 as in Addendum AA, Final ASC Covered Surgical Procedures for CY 2014 and Addendum BB Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2014, published in the December 10, 2013 publication of the Federal Register, or its successor.

(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.

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

TITLE 13 – DEPARTMENT OF LABOR

***Notice** is hereby given in accordance with G.S. 150B-21.2 that the Department of Labor intends to amend the rules cited as 13 NCAC 13 .0101, .0203, .0205, .0210, .0213, .0303, 13 NCAC 15 .0307, and repeal the rule cited as 13 NCAC 07F .0206.*

REQUEST FOR TECHNICAL CHANGE

AGENCY: Industrial Commission

RULE CITATION: 04 NCAC 10J .0101

DEADLINE FOR RECEIPT: Friday, February 6, 2015

***NOTE WELL:* This request when viewed on computer extends several pages. Please be sure you have reached the end of the document.**

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

In Paragraph (a), I think you mean to state the Medical Fee Schedule is set forth in Rules .0102 and .0103 of the Section. If that is your intent, make it clear in the Rule. If that is not what you mean, then I do not see any authority for the Industrial Commission to set the fee schedule outside of rulemaking. G.S. 97-26(a) states:

> (a) Fee Schedule.--The Commission shall adopt by rule a schedule of maximum fees for medical compensation and shall periodically review the schedule and make revisions.
>
> The fees adopted by the Commission in its schedule shall be adequate to ensure that (i) injured workers are provided the standard of services and care intended by this Chapter, (ii) providers are reimbursed reasonable fees for providing these services, and (iii) medical costs are adequately contained.

You reference the agency url throughout these Rules. I suggest you create a separate Paragraph (b) in this Rule to state that the Medical Fee Schedule referred to throughout the Section is available at the url. This will allow you to avoid repeating the same url throughout these Rules.

In (a), line 15, what is the purpose of the language "according to G.S. 97-26(c)"? It appears unnecessary to me, but I understand if the agency believes it is needed.

On Page 3, Paragraph (c), line 13, delete the comma after "organization"

On line 14, I take it the resolution through the Commission is through a hearing conducted pursuant to other Rules and G.S. 97-25? And your regulated public knows this?

I think Paragraph (d) would make more sense written "When the 10 percent addition to the bill pursuant to G.S. 97-18(i) is uncontested, payment shall be made..."

Amanda J. Reeder
Commission Counsel
Date submitted to agency: January 26, 2015

In Paragraph (e), what is "reasonable access"? And is there any specific way to make this request?

I think Paragraph (f) needs to be more than one sentence in order to be clear.

Also in Paragraph (f), line 23, requested by whom?

In Paragraph (g), on line 26, what is "sick travel"?

On line 28, insert an "any" before "tolls."

Also in (g), I know you are relying upon G.S. 138-6 language, but where does one get the IRS and NC rates? On line 28, state "at ~~a~~ the rate ~~to be~~ established..."

In Paragraph (h), line 33, insert a comma after "carrier"

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: January 26, 2015

Rule 04 NCAC 10J .0101 is amended as published in 29:10 NCR 1193 as follows:

SUBCHAPTER 10J – FEES FOR MEDICAL COMPENSATION

SECTION 0100 – FEES FOR MEDICAL COMPENSATION

04 NCAC 10J .0101 GENERAL PROVISIONS

(a) ~~The Commission adopted and published a Medical Fee Schedule, pursuant to the provisions of G.S. 97-26(a), setting maximum amounts, except for hospital fees pursuant to G.S. 97-26(b), that may be paid for medical, surgical, nursing, dental, and rehabilitative services, and medicines, sick travel, and other treatment, including medical and surgical supplies, original artificial members as may reasonably be necessary at the end of the healing period and the replacement of such artificial members when reasonably necessitated by ordinary use or medical circumstances.~~ Pursuant to G.S. 97-26, the Commission adopts a Medical Fee Schedule composed of maximum amounts, reimbursement rates, and payment guidelines. The amounts and reimbursement rates prescribed in the applicable published Medical Fee Schedule shall govern and apply according to G.S. 97-26(c). The Medical Fee Schedule is available on the Commission's website at http://www.ic.nc.gov/ncic/pages/feesched.asp and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.

~~(b) The Commission's Medical Fee Schedule contains maximum allowed amounts for medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology (CPT) codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems (HCPCS) codes, and jurisdiction specific codes. A listing of the maximum allowable amount for each code is available on the Commission's website at http://www.ic.nc.gov/ncic/pages/feesched.asp and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.~~

~~(c) The following methodology provides the basis for the Commission's Medical Fee Schedule:~~

~~(1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201 99205 and 99211 99215, which are based on 1995 Medicare values multiplied by 2.05.~~

~~(2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.~~

~~(3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.~~

~~(4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.~~

~~(d) The Commission's Hospital Fee Schedule, adopted pursuant to G.S. 97-26(b), provides for payment as follows:~~

~~(1) Inpatient hospital fees: Inpatient services are reimbursed based on a Diagnostic Related Groupings (DRG) methodology. The Hospital Fee Schedule utilizes the 2001 Diagnostic Related Groupings adopted by the State Health Plan. Each DRG amount is based on the amount that the State Health Plan had in effect for the same DRG on June 30, 2001.~~

~~DRG amounts are further subject to the following payment band that establishes maximum and minimum payment amounts:~~

~~(A) The maximum payment is 100 percent of the hospital's itemized charges.~~

~~(B) For hospitals other than critical access hospitals, the minimum payment is 75 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

~~(C) For critical access hospitals, the minimum payment is 77.07 percent of the hospital's itemized charges. Effective February 1, 2013, the minimum payment rate is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

~~(2) Outpatient hospital fees: Outpatient services are reimbursed based on the hospital's actual charges as billed on the UB-04 claim form, subject to the following percentage discounts:~~

~~(A) For hospitals other than critical access hospitals, the payment shall be 79 percent of the hospital's billed charges. Effective February 1, 2013, the payment is the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

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

~~(3) Ambulatory surgery fees: Ambulatory surgery center services are reimbursed at 79 percent of billed charges. Effective February 1, 2013, the ambulatory surgery center services are reimbursed at the amount provided for under Subparagraph (5) below, subject to adjustment on April 1, 2013 as provided therein.~~

~~(4) Other rates: If a provider has agreed under contract with the insurer or managed care organization to accept a different amount or reimbursement methodology, that amount or methodology establishes the applicable fee.~~

~~(5) Payment levels frozen and reduced pending study of new fee schedule: Effective February 1, 2013, inpatient and outpatient payments for each hospital and the payments for each ambulatory surgery center shall be set at the payment rates in effect for those facilities as of June 30, 2012. Effective April 1, 2013, those rates shall then be reduced as follows:~~

~~(A) Hospital outpatient and ambulatory surgery: The rate in effect as of that date shall be reduced by 15 percent.~~

~~(B) Hospital inpatient: The minimum payment rate in effect as of that date shall be reduced by 10 percent.~~

~~(6) Effective April 1, 2013, implants shall be paid at no greater than invoice cost plus 28 percent.~~

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

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

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

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

~~(i)~~(f) The responsible employer, carrier, managed care organization, or administrator shall pay the ~~statements~~ bills of medical compensation providers to whom the employee has been referred by the treating physician authorized by the insurance carrier for the compensable injury or body part, unless the physician has been requested to obtain authorization for referrals or tests; provided that compliance with the request shall not unreasonably delay the treatment or service to be rendered to the employee.

~~(j)~~(g) Employees are entitled to reimbursement for sick travel when the travel is medically necessary and the mileage is 20 or more miles, round trip, at the business standard mileage rate set by the Internal Revenue Service per mile of travel and the actual cost of tolls paid. Employees are entitled to lodging and meal expenses, at a rate to be established for state employees by the North Carolina Director of Budget, when it is medically necessary that the employee stay overnight at a location away from the employee's usual place of residence. Employees are entitled to reimbursement for the costs of parking or a vehicle for hire, when the costs are medically necessary, at the actual costs of the expenses.

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

History Note: *Authority G.S. 97-18(i); 97-25; 97-25.6; 97-26; 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.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Industrial Commission

RULE CITATION: 04 NCAC 10J .0102, Eff. April 1, 2015

DEADLINE FOR RECEIPT: Friday, February 6, 2015

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

In Paragraph (a), line 5, I suggest saying "sets the" rather than "contains"; however, that is just a suggestion.

On line 8, what are "jurisdiction specific codes"?

End (b)(1) through (3) with a semicolon, and insert an "and" after the semicolon in (b)(3).

In (b)(2), what is "physical medicine"? I take it your regulated public knows?

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: January 26, 2015

Rule 04 NCAC 10J .0102 is adopted as published in 29:10 NCR 1194 as follows:

04 NCAC 10J .0102 FEES FOR PROFESSIONAL SERVICES

(a) The Commission's Medical Fee Schedule contains maximum allowed amounts for professional medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology ("CPT") codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems ("HCPCS") codes, and jurisdiction-specific codes. A listing of the maximum allowable amount for each code is available in the Medical Fee Schedule 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 Rule 04 NCAC 10A .0101.

(b) The following methodology provides the basis for the Commission's Medical Fee Schedule:

(1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201-99205 and 99211-99215, which are based on 1995 Medicare values multiplied by 2.05.

(2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.

(3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.

(4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.

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

REQUEST FOR TECHNICAL CHANGE

AGENCY: Industrial Commission

RULE CITATION: 04 NCAC 10J .0102, Eff. July 1, 2015

DEADLINE FOR RECEIPT: Friday, February 6, 2015

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

Please insert Page Numbers in the Rule.

In Paragraph (a), line 19, just so I understand, do you mean except as otherwise provided in this Rule or through a contract?

Also throughout this Rule, you say "maximum allowable amount" and the payment will be less than that if agreed by contract or if the cost is actually less, per G.S. 97-26?

On line 20, replace "are" with "shall be" before "based on the current year's"

For clarity, please rearrange lines 20 and 21 to state "... Medicare Part B Fee Schedule for North Carolina ("the Medicare base amount"), as published by the Centers for Medicare & Medicaid Services ("CMS"), including..."

In Paragraphs (a), (f), and (g), in order to properly incorporate this material by reference, you need to say where it can be found in an external source. I suggest giving the CMS website. See G.S. 150B-21.6.

In (b)(2), what is "physical medicine"? I take it your regulated public knows?

Please begin (b)(1) though (8) with lowercase letters. End (b)(7) with an "and"

In (c), you state the services shall be "paid at no more than" but in (b), (d), (f) and (g), you state "the schedule of maximum reimbursement..." Why is the language in (c) different?

I believe (c)(1) and (2) are a list, and should begin with lowercase letters, (c)(1) should end with a semicolon and "and"

On Page 2, line 3, replace "will" with "shall"

On lines 5 and 6, G.S. 150B-21.6 does not allow agencies to incorporate their own materials by reference. Further, this Rule is setting the Professional Fee Schedule, correct? If not, then what

Amanda J. Reeder
Commission Counsel
Date submitted to agency: January 26, 2015

is the Industrial Commission's authority to set the schedule outside of rulemaking? I recommend deleting this sentence.

On line 6, replace "will" with "shall"

In (f), line 12, you state ("DMEPOS") but later in the Paragraph, you state "DME" (lines 13, 14 and 15). Assuming this is the same thing, the language should be consistent. If it isn't, what is "DME"?

Also on line 12, delete "once" and on line 13, replace "to" with "on"

In (g), line 20, delete "once" and on line 21, replace "to" with "on"

Please begin (h)(1) through (6) with lowercase letters, unless you are referring to proper nouns.

Please insert an "and" at the end of (h)(5).

On line 36, "Rule" must be capitalized.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: January 26, 2015

Rule 04 NCAC 10J .0102 is amended as published in 29:10 NCR 1195 as follows:

04 NCAC 10J .0102 FEES FOR PROFESSIONAL SERVICES

~~(a) The Commission's Medical Fee Schedule contains maximum allowed amounts for medical services provided pursuant to Chapter 97 of the General Statutes. The Medical Fee Schedule utilizes 1995 through the present, Current Procedural Terminology (CPT) codes adopted by the American Medical Association, Healthcare Common Procedure Coding Systems (HCPCS) codes, and jurisdiction-specific codes. A listing of the maximum allowable amount for each code is available on the Commission's website at http://www.ic.nc.gov/ncic/pages/feesched.asp and in hardcopy at the offices of the Commission as set forth in 04 NCAC 10A .0101.~~

~~(b) The following methodology provides the basis for the Commission's Medical Fee Schedule:~~

~~(1) CPT codes for General Medicine are based on 1995 North Carolina Medicare values multiplied by 1.58, except for CPT codes 99201-99205 and 99211-99215, which are based on 1995 Medicare values multiplied by 2.05.~~

~~(2) CPT codes for Physical Medicine are based on 1995 North Carolina Medicare values multiplied by 1.36.~~

~~(3) CPT codes for Radiology are based on 1995 North Carolina Medicare values multiplied by 1.96.~~

~~(4) CPT codes for Surgery are based on 1995 North Carolina Medicare values multiplied by 2.06.~~

(a) Except where otherwise provided, maximum allowable amounts payable to health care providers for professional services are based on the current year's Medicare Part B Fee Schedule for North Carolina as published by the Centers for Medicare & Medicaid Services ("CMS") ("the Medicare base amount"), including subsequent versions and editions.

(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;

(8) All other professional services are 150 percent of the Medicare base amount.

(c) Anesthesia services shall be paid at no more than the following rates:

(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.

(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 the Paragraphs above, the Commission will publish annually an official Professional Fee Schedule Table listing allowable amounts for individual professional services in accordance with this fee schedule. The Professional Fee Schedule Table, including all subsequent versions and editions, is incorporated by reference. The allowable amounts contained in the Professional Fee Schedule Table will take effect January 1 of each year. The Professional Fee Schedule Table 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 Rule 04 NCAC 10A .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 Commission will publish once annually to its website an official DME Fee Schedule Table listing allowable amounts for individual items and services in accordance with this fee schedule. The DME Fee Schedule Table, including all subsequent versions and editions, is incorporated by reference. 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 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 Rule 04 NCAC 10A .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 Commission will publish once annually to its website an official Clinical Laboratory Fee Schedule Table listing allowable amounts for individual items and services in accordance with this fee schedule. The Clinical Laboratory Fee Schedule Table, including all subsequent versions and editions, is incorporated by reference. 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 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 Rule 04 NCAC 10A .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;

(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.

REQUEST FOR TECHNICAL CHANGE

AGENCY: Industrial Commission

RULE CITATION: 04 NCAC 10J .0103

DEADLINE FOR RECEIPT: Friday, February 6, 2015

The Rules Review Commission staff has completed its review of this rule prior to the Commission's next meeting. The Commission has not yet reviewed this rule and therefore there has not been a determination as to whether the rule will be approved. You may call this office to inquire concerning the staff recommendation.

In reviewing these rules, the staff determined that the following technical changes need to be made:

In Paragraph (a), line 5, replace "are" with "shall be"

Also in Paragraph (a), line 7, I believe "all inclusive" should be hyphenated.

On line 8, what do you mean by "would make"? Do you mean "eligible for a Medicare payment"?

I think (b)(1) through (3), (c)(1) through (3), (e)(1) through (3) and (f)(1) through (3) need to be sentences ending with periods.

Is the purpose of publishing the new rates and dates intended to give providers notice now, rather than through future rulemaking?

In Paragraph (d), where can one find the CMS definition?

In Paragraph (g), line 29, replace "are" with "shall be"

I don't understand the second sentence in (g). Is this for 2015?

On line 33, delete "as" before "in Addendum AA"

On Page 2, Paragraph (j), line 4, I take it your regulated public knows what an "outlier payment" is?

In Paragraph (k), why do you have "("DRG")" Is this because the term is so common, your regulated public will know the acronym better? I ask because you don't use DRG anywhere else in the Rule language.

Please retype the rule accordingly and resubmit it to our office at 1711 New Hope Church Road, Raleigh, North Carolina 27609.

Amanda J. Reeder
Commission Counsel
Date submitted to agency: January 26, 2015

Rule 04 NCAC 10J .0103 is adopted as published in 29:10 NCR 1196 as follows:

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

(a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services are 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 for a claims payment that Medicare would make, but excludes 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 defined by the 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") are 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 as in Addendum AA, Final ASC Covered Surgical Procedures for CY 2014 and Addendum BB Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2014, published in the December 10, 2013 publication of the Federal Register, or its successor.

(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.