TEMPORARY RULE

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 .0103

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

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The Industrial Commission was exempt from rulemaking under Article 2A until the General Assembly repealed that exemption in Session Law 2011-287.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, Section 33 (Page 18 of the Tab), 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. Session Law 2013-410 stated that in setting the Medicare methodology for physician and hospital fee schedules, the Industrial Commission was exempt from the certification requirements of G.S. 150B-19.1(h) and the fiscal note requirement of G.S. 150B-21.4.

Amanda J. Reeder
Commission Counsel

In February 2015, the RRC approved rules submitted by the Industrial Commission. Those Rules separated Rule 10J .0101 into three separate rules, effective April 1, 2015. At that time, Rule 10J .0101 was amended to only include general guidelines for the fee schedule. Rule 10J .0102 set fees for professional services. Rule 10J .0103 set the fees for institutional services.

As amended in 2015, Rule 04 NCAC 10J .0103 set the fee schedule for institutional service. Before the adoption of the Rule, that schedule was contained in Rule 10J .0101, Paragraph (d). Rule 10J .0103 was not a restatement of Paragraph (d), but set a different rate schedule. In the agency's Temporary Rulemaking Findings of Need form, the agency states that the reimbursement rate was 67.15% of billed charges prior to April 1, 2015. In the adoption of Rule .0103, effective April 1, 2015, the rate was set to an annually decreasing scale, and would be 200% of the Medicare ASC facility-specific amount beginning January 1, 2017.

In a Wake County Superior Court decision issued August 9, 2016 (Page 5 of the Tab), the Court declared that Paragraphs (g) and (h) of Rule 10J .0103 were invalid, finding that the fiscal note exemption in Session Law 2013-410 did not extend to ambulatory surgical centers. The court found that the amendment of Rule 10J .0101 was also invalid to the extent that it removed the fee schedule for ambulatory surgical centers from that Rule in Subparagraphs (d)(3), (5), and (6).

In response to the August 9, 2016 Order, the agency sought and was awarded a stay while an appeal is pending at the North Carolina Court of Appeals (Pages 14 and 15 of the Tab). In addition, the agency moved to amend the Rule through temporary measures. As stated in the agency's Temporary Rulemaking Findings of Need form, the agency believes that a temporary rule is necessary to ensure continuity of the payments beginning in January 1, 2017 for industry stakeholders, including employers, insurers, and medical providers.

Given that this rulemaking was timely done in response to a court order that invalidated portions of the existing rule, staff recommends approving this Rule amendment as a temporary rule pursuant to G.S. 150B-21.1(a)(5).

TEMPORARY RULE-MAKING FINDINGS OF NEED

[Authority G.S. 150B-21.1]

OAH USE ONLY
VOLUME:
ISSUE:

1. Rule-Making Agency: North Carolina Industrial Commission

2. Rule citation & name: 04 NCAC 10J .0103

3. Action: ☐ Adoption ☒ Amendment ☐ Repeal

4. Was this an Emergency Rule: ☐ Yes ☒ No Effective date:

5. Provide dates for the following actions as applicable:

   a. Proposed Temporary Rule submitted to OAH: October 18, 2016

   b. Proposed Temporary Rule published on the OAH website: October 21, 2016

   c. Public Hearing date: November 18, 2016

   d. Comment Period: October 19, 2016 through November 29, 2016

   e. Notice pursuant to G.S. 150B-21.1(a3)(2): October 18, 2016

   f. Adoption by agency on: December 5, 2016

   g. Proposed effective date of temporary rule [if other than effective date established by G.S. 150B- 21.1(b) and G.S. 150B-21.3]: January 1, 2017

   h. Rule approved by RRC as a permanent rule [See G.S. 150B-21.3(b2)]:

6. Reason for Temporary Action. Attach a copy of any cited law, regulation, or document necessary for the review.

   ☐ A serious and unforeseen threat to the public health, safety or welfare.
   ☐ The effective date of a recent act of the General Assembly or of the U.S. Congress.
   Cite:
   Effective date:
   ☐ A recent change in federal or state budgetary policy.
   Effective date of change:
   ☐ A recent federal regulation.
   Cite:
   Effective date:
   ☒ A recent court order.
   Cite order: *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*, No. 16-CVS-00600 (Wake County Superior Court).
   ☐ State Medical Facilities Plan.
   ☐ Other:

Explain: The effects of the August 9, 2016 decision in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*, No. 16-CVS-00600 (Wake County Superior Court) necessitate the expedited implementation of this temporary rule. This recent court decision invalidated the Industrial Commission's medical fee schedule provisions for ambulatory surgery centers, which had taken effect April 1, 2015, based on the court's interpretation of Session Law 2013-410, Section 33(a), and the application of its fiscal note exemption language. Due to the court decision, the medical fee schedule, as applied only to ambulatory surgery centers, reverts back to the pre-April 1, 2015 provisions which provided for a maximum reimbursement rate of 67.15% of billed charges, resulting in a potentially retroactive and prospective multi-million dollar increase in costs to the workers' compensation system. Although the August 9, 2016 decision has been stayed by the Superior Court during the appeal to the North Carolina Court of Appeals, it is the Industrial Commission's statutory obligation to adopt a rule as quickly as possible to restore balance to the workers' compensation system pursuant to N.C. Gen. Stat. § 97-26 in the event the decision is upheld on appeal. By putting a temporary rule in place as soon as possible, the period of time subject to a potential retroactive invalidation of the ambulatory surgery center fee schedule provisions will be limited to April 1, 2015 to December 31, 2016, providing certainty regarding medical costs for 2017 and beyond.

7. Why is adherence to notice and hearing requirements contrary to the public interest and the immediate adoption of the rule is required?

The effects of the August 9, 2016 decision in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*, No. 16-CVS-00600 (Wake County Superior Court) necessitate the expedited implementation of this temporary rule. This recent court decision invalidated the Industrial Commission's medical fee schedule provisions for ambulatory surgery centers, which had taken effect April 1, 2015, based on the court's interpretation of Session Law 2013-410, Section 33(a), and the application of its fiscal note exemption language. Due to the court decision, the medical fee schedule, as applied only to ambulatory surgery centers, reverts back to the pre-April 1, 2015 provisions which provided for a maximum reimbursement rate of 67.15% of billed charges, resulting in a potentially retroactive and prospective multi-million dollar increase in costs to the workers' compensation system. Although the August 9, 2016 decision has been stayed by the Superior Court during the appeal to the North Carolina Court of Appeals, it is the Industrial Commission's statutory obligation to adopt a rule as quickly as possible to restore balance to the workers' compensation system pursuant to N.C. Gen. Stat. § 97-26 in the event the decision is upheld on appeal. By putting a temporary rule in place as soon as possible, the period of time subject to a potential retroactive invalidation of the ambulatory surgery center fee schedule provisions will be limited to April 1, 2015 to December 31, 2016, providing certainty for all industry stakeholders, including employers, insurers, and medical providers, regarding medical costs for 2017 and beyond. Although the decision in *Surgical Care Affiliates, LLC v. North Carolina Industrial Commission*, No. 16-CVS-00600 (Wake County Superior Court) did not order the Industrial Commission to engage in temporary rulemaking, it is the Commission's position that the effects of the decision require the immediate adoption of this rule.

8. Rule establishes or increases a fee? (See G.S. 12-3.1)

☐ **Yes**
Agency submitted request for consultation on:
Consultation not required. Cite authority:

☒ **No**

9. Rule-making Coordinator: Kendall M. Bourdon

Phone: (919) 807-2644

E-Mail: kendall.bourdon@ic.nc.gov

Agency contact, if any:

Phone:

E-Mail:

10. Signature of Agency Head*:

*** If this function has been delegated (reassigned) pursuant to G.S. 143B-10(a), submit a copy of the delegation with this form.**

Typed Name: Charlton L. Allen

Title: Chairman

E-Mail: Charlton.Allen@ic.nc.gov

RULES REVIEW COMMISSION USE ONLY	
Action taken: ☐ Date returned to agency:	Submitted for RRC Review:

Wake County Superior Court Decision

STATE OF NORTH CAROLINA	IN THE GENERAL COURT OF JUSTICE
COUNTY OF WAKE	SUPERIOR COURT DIVISION
	16-CVS-00600
SURGICAL CARE AFFILIATES, LLC,	
Petitioner,	
v.	**DECISION**
NORTH CAROLINA INDUSTRIAL COMMISSION,	
Respondent.	

FILED
2016 AUG -9 PM 2:51
C.S.C.
BY

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

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

THE PARTIES

SCA manages seven ambulatory surgical centers in North Carolina and has an ownership interest in each of these centers through wholly owned subsidiary corporations (hereinafter "SCA Ambulatory Surgical Centers"). (Record page 8, hereinafter "R p __"). The SCA Ambulatory Surgical Centers are located throughout North Carolina and include Blue Ridge Day Surgery Center at 2308 Westfield Court in Raleigh, Wake County, North Carolina. (R p 8).

The Commission is an agency of the State of North Carolina created by the General Assembly and has the responsibility for administering the North Carolina Workers' Compensation Act ("the Act"). N.C. Gen. Stat. § 97-77. Among its responsibilities, the Commission adopts rules setting forth a schedule of maximum fees for medical compensation to be paid to injured employees who are covered by the Act. N.C. Gen. Stat. § 97-26(a). As a State agency, the Commission is subject to the rule-making requirements of Article 2A of the APA. N.C. Gen. Stat. §§ 150B-2(1a), 150B-18.

SCA'S REQUEST AND THE COMMISSION'S DECLARATORY RULING

On October 1, 2015, SCA filed with the Commission a Request for Declaratory Ruling. (R p 8–25). In SCA's Request, SCA sought a ruling from the Commission declaring invalid those parts of the Commission's rules with an effective date of April 1, 2015 that changed the workers' compensation maximum fee schedule for services provided by ambulatory surgical centers. (R pp 8–25). In its Request for Declaratory Ruling, SCA contended that the Commission failed to adopt a new fee schedule for ambulatory surgical centers in substantial compliance with the rule-making requirements of Article 2A of the APA because the Commission had failed to prepare or obtain the fiscal note and certifications from the Office of State Budget and Management required under N.C. Gen. Stat. §§ 150B-21.2(a) and 150B-21.4(b1). (R pp 9–10). On October 30, 2015, the Commission granted SCA's request for a declaratory ruling and indicated that a ruling on the merits would be issued within 45 days. (R p 6).

On December 14, 2015, the Commission issued its Declaratory Ruling. The Ruling concluded that the Commission had followed the law in adopting a new maximum fee schedule

for ambulatory surgical centers and declined to declare those parts of its rules invalid as requested by SCA in its Request for Declaratory Ruling. (R pp 2–5).

On January 13, 2016, SCA filed a Petition for Judicial Review pursuant to Article 4 of the APA seeking reversal of the Commission's Declaratory Ruling and a decision invalidating those parts of the Commission's rules that changed the ambulatory surgical center fee schedule.

THE MOTION TO INTERVENE AS AMICI CURIAE

Ten days prior to the week of the hearing on SCA's Petition for Judicial Review, Greensboro Orthopedics, P.A., OrthoCarolina, P.A., Raleigh Orthopaedic Clinic, P.A., Surgical Center of Greensboro, LLC, Southeastern Orthopaedic Specialists, P.A., Orthopaedic & Hand Specialists, P.A., Cary Orthopaedic and Sports Medicine Specialists, P.A., and Stephen D. Lucey (collectively "the Movants" or "Intervenors") filed a Motion to Intervene as *Amici Curiae*. Along with the Motion, Movants filed a Brief. Attached to Movants' Brief is an Affidavit of Conor Brockett, Associate General Counsel for the North Carolina Medical Society. In response to the Motion to Intervene, Respondent filed an objection to Movants' Motion to Intervene as *Amici Curiae* and a Motion to Strike the Affidavit of Conor Brockett and the attachment to that Affidavit, as well as all references to the Affidavit and exhibit within the body of Movants' brief.

In reaching the decision on the relief requested in SCA's Petition for Judicial Review, the undersigned has disregarded and not considered the Affidavit of Conor Brockett and attached exhibit and has disregarded any references to the Affidavit and exhibit in Movants' Brief. Respondent's Motion to Strike has been granted. The Affidavit of Conor Brockett and exhibit are not part of the record in this case.

In its discretion, this Court has allowed Movants' Motion to Intervene in this judicial review proceeding for the limited purpose of filing the *Amici Curiae Brief* without the Affidavit of Conor Brockett and exhibit.

STANDARD OF REVIEW

Article 4 of the APA governs judicial review of a declaratory ruling. N.C. Gen. Stat. §§ 150B-43 *et seq*. The Commission's issuance of a Declaratory Ruling upholding the validity of rule provisions challenged by SCA is a decision that is subject to judicial review under Article 4 of the APA. *See* N.C. Gen. Stat. § 150B-4(a1)(2).

In its Petition for Judicial Review, SCA contends that the Commission's Declaratory Ruling is in excess of its statutory authority, made upon unlawful procedure, and affected by other error of law. Because of these errors asserted by the SCA, this Court has applied the *de novo* standard of review to review the Commission's decision as required under N.C. Gen. Stat. § 150B-51(c).

ANALYSIS

The Commission, pursuant to N.C. Gen. Stat. § 97-26, is required to adopt by rule a schedule of maximum fees for medical compensation. The fees adopted by the Commission in its schedule must be adequate to ensure that (i) injured workers are provided the standard of services and care intended by North Carolina Workers' Compensation Act, (ii) providers are reimbursed reasonable fees for providing services, and (iii) medical costs are adequately contained. N.C. Gen. Stat. § 97-26(a).

Prior to the promulgation of the rules at issue in this case, the Commission, in accordance with the statutory mandate set out in N.C. Gen. Stat. § 97-26, adopted through rule-making procedures its "Fees for Medical Compensation" published at 04 NCAC 10J .0101. This rule

consisted of a "Medical Fee Schedule" and a "Hospital Fee Schedule" (the "Prior Rule"). The "Medical Fee Schedule" of the Prior Rule set maximum amounts that could be paid for "medical, surgical, nursing, dental and rehabilitative services, and medicines, sick travel and other treatment, including medical and surgical supplies, and original artificial members." The "Hospital Fee Schedule" of the Prior Rule set maximum amounts that could be paid for "inpatient hospital fees," "outpatient hospital fees," and "ambulatory surgery fees."

On August 23, 2013, Session Law 2013-410 was enacted into law. Section 33.(a) of Session Law 2013-410 provided the following:

> **SECTION 33.(a)** Industrial Commission Hospital Fee Schedule:
>
> (1) Medicare methodology for physician and hospital fee schedules. – With respect to the schedule of maximum fees for physician and hospital compensation adopted by the Industrial Commission pursuant to G.S. 97-26, those fee schedules shall be based on the applicable Medicare payment methodologies, with such adjustments and exceptions as are necessary and appropriate to ensure that (i) injured workers are provided the standard of services and care intended by Chapter 97 of the General Statutes, (ii) providers are reimbursed reasonable fees for providing these services, and (iii) medical costs are adequately contained. . . .
>
> . . .
>
> (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.

Notably, in Session Law 2013-410, Section 33.(a), the General Assembly provided for an expedited rule-making process for the new fee schedules which bypassed the certification and fiscal note requirements that would otherwise be required prior to adoption of a fee schedule. Although the certification requirements of N.C. Gen. Stat. § 150B-19.1(h) became moot when those requirements were repealed by Session Law 2014-112, Section 6(a), there are certification requirements in preparing the fiscal note described in N.C. Gen. Stat. § 150B-21.4(b1).

In response to this Session Law, the Commission undertook a process to modify its fee schedules and ultimately amended 04 NCAC 10J .0101 and adopted two rules: (1) a rule setting fees for "Professional Services," 04 NCAC 10J.0102, which sets fees for physicians and health care providers; and (2) the rule at issue in this matter, 04 NCAC 10J.0103, entitled "**Fees for Institutional Services.**" In adopting the "Fees for Institutional Services" rule, the Commission did not prepare or obtain a fiscal note, relying upon the exemption language set forth in Session Law 2013-410, Section 33.(a)(3). The fee schedule set forth in the new "Fees for Institutional Services" rule includes separate subsections setting forth maximum fees for "**hospital** inpatient institutional services," "**hospital** outpatient institutional services," "critical access **hospital**" inpatient and outpatient services, and "institutional services provided by **ambulatory surgical centers.**"

Petitioner, an owner and operator of ambulatory surgical centers, seeks declaratory relief from this Court on the grounds that the Commission exceeded the statutory authority of Session Law 2013-410, Section 33.(a) by adopting a fee schedule pertaining to ambulatory surgical centers without complying with the fiscal note requirements of N.C. Gen. Stat. §§ 150B-21.2(a) and 150B-21.4. Specifically, Petitioner, joined by Intervenors for the purposes of this Petition, contends that the General Assembly, in Session Law 2013-410, Section 33.(a), mandated only that new schedules of maximum fees for **physicians** and **hospitals** be adopted under an expedited rule-making process, so as to ensure that the maximum fees of **physicians** and **hospitals** be based on the applicable Medicare payment methodologies.

Petitioners and Intervenors contend that they, as **ambulatory surgical centers**, are legally distinct from **hospitals** and that because the General Assembly mandated new fee schedules for physicians and hospitals, and not ambulatory surgical centers, the Commission did

not have statutory authority to adopt new fee schedules relating to ambulatory surgical centers under the expedited rule-making process.

North Carolina law defines a "**hospital**" as:

> any facility which has an organized medical staff and which is designed, used and operated to provide health care, diagnostic and therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered of the supervision and direction of physicians licensed under Chapter 90 of the General Statutes, Article 1, to two or more persons over a period in excess of 24 hours.

N.C. Gen. Stat. § 131E-76(3).

North Carolina law defines an "**ambulatory surgical facility**" as:

> a facility designed for the provision of a specialty ambulatory surgical program or a multispecialty ambulatory surgical program. An ambulatory surgical facility serves patients who require local, regional or general anesthesia and a period of post-operative observation. An ambulatory surgical facility may only admit patients for a period of less than 24 hours . . . .

N.C. Gen. Stat. § 131E-146(1); *see also* N.C. Gen. Stat. § 131E-176(1b) and (13) (setting forth separate definitions for hospitals and ambulatory surgical facilities). No further definition of the terms "hospital" or "ambulatory surgical facility" is contained in the statutes pertaining to the authority of the Commission to adopt fee schedules.

The Court finds and concludes that **hospitals** are separate and legally distinct entities from **ambulatory surgical centers**. The Court further finds and concludes that the plain language of the General Assembly, in enacting Session Law 2013-410, Section 33.(a), authorized the Commission to use an expedited rule-making process only in adopting new maximum fees for **physicians** and **hospitals** and that the General Assembly did not authorize the Commission to use an expedited rule-making process in adopting new maximum fees for **ambulatory surgical centers**.

As the North Carolina Supreme Court has stated on numerous occasions, when the language of a statute is clear and unambiguous, courts must give the statute its plain and definite meaning. *State v. Dellinger*, 343 N.C. 93, 95, 468 S.E.2d 218, 220 (1996); *Lemons v. Old Hickory Council, Boy Scouts of America*, 322 N.C. 271, 276, 367 S.E.2d 655, 658 (1988).

The Commission contends that because the term "Hospital Fee Schedule" is used in the heading of Section 33.(a) of Session Law 2013-410, this indicates that ambulatory surgical centers were included in the General Assembly's mandate to change the maximum fee schedules using an expedited rule-making process. The Commission contends that under the prior fee schedules, ambulatory surgical centers were included as one subsection of "Hospital Fee Schedule." However, North Carolina law is clear that captions of a statute cannot control when the text is clear. *Appeal of Forsythe County*, 285 N.C. 64, 71, 203 S.E.2d 51, 55 (1974). Respondent's argument also is contradicted by the fact that the physician fee schedule is included within the fee schedules that the General Assembly mandated be changed and physicians were not included as a subsection of "Hospital Fee Schedule" under the Prior Rule.

Unless otherwise exempted, the fiscal note requirements are part of the mandatory procedure of administrative rule-making. N.C. Gen. Stat. § 150B-21.2. Under N.C. Gen. Stat. § 150B-18, a rule is not valid unless it is adopted in substantial compliance with Article 2A of the APA. The failure of the Commission to comply with the fiscal note requirements in adopting a new fee schedule for ambulatory surgical centers cannot, in this instance, be viewed as substantial compliance with the rule-making requirements of Article 2A of the APA.

Because the Commission was required to comply with the fiscal note requirements in adopting a new fee schedule for ambulatory surgical centers and failed to do so, the Commission

exceeded its statutory authority and employed an unlawful procedure. N.C. Gen. Stat. § 150B-51(c).

Therefore, this Court finds and concludes that the Petitioner is entitled to the declaratory ruling that the Commission's attempted adoption of a new fee schedule for ambulatory surgical center services, but limited solely to those services, as set forth in 04 NCAC 10J. 0103(g) and (h) (also referenced in 04 NCAC 10J..0103(i)), and the amendment of the Prior Rule 04 NCAC 10J .0101(d)(3), (5), and (6), to the extent that the amendment removed the old fee schedule for ambulatory surgical centers, are invalid and of no effect.

IT IS THEREFORE ORDERED, ADJUDGED, AND DECREED that the relief sought by SCA in its Request for Declaratory Ruling and Petition for Judicial Review is GRANTED and the Declaratory Ruling entered by the Commission is REVERSED.

The Commission's attempted adoption of a new fee schedule for ambulatory surgical center services, but limited solely to those services, as set forth in 04 NCAC 10J. 0103(g) and (h) (also referenced in 04 NCAC 10J. 0103(i)), and the amendment of the Prior Rule, specifically 04 NCAC 10J .0101(d)(3), (5), and (6), to the extent that the amendment removed the old fee schedule for ambulatory surgical centers, are invalid and of no effect.

This the 9 day of August 2016.

The Honorable Paul C. Ridgeway
Superior Court Judge

Wake County Superior Court Order Allowing a Stay of the Decision

STATE OF NORTH CAROLINA COUNTY OF WAKE	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION 16 CVS 00600
SURGICAL CARE AFFILIATES, LLC, *Petitioner* v. NORTH CAROLINA INDUSTRIAL COMMISSION, *Respondent*	ORDER ALLOWING STAY

THIS MATTER comes before the undersigned upon Respondent's Motion to Stay the Final Judgment of the Superior Court pursuant to N.C. Gen. Stat. § 150B-52 and Rule 62 of the North Carolina Rules of Civil Procedure. On August 9, 2016, the Superior Court, by and through the undersigned, issued its final judgment in the above-captioned matter, wherein the Court reversed the Respondent's Declaratory Ruling and granted the relief requested by the Petitioner. Respondent seeks, through its motion, to preserve the *status quo* of the subject matter while pursuing an appeal of the Court's final judgment. The Court has considered the record proper and the arguments of counsel.

For good cause shown, and in the discretion of the Court, the Court finds and concludes that the Motion to Stay should be allowed. Therefore, it is ORDERED that the application and effect of the Court's Final Judgment entered on August 9, 2016 in this matter is STAYED until such time that the Court of Appeals of North Carolina can rule on the matter or until this order is modified by a court of competent jurisdiction.

So ORDERED, this the 2nd day of September, 2016.

Paul C. Ridgeway, Superior Court Judge

Industrial Commission's Notice of Appeal to the NC Court of Appeals

STATE OF NORTH CAROLINA

COUNTY OF WAKE

IN THE GENERAL COURT OF JUSTICE
SUPERIOR COURT DIVISION
16-CVS-000600

FILED
2016 SEP -6 P 2:14
WAKE COUNTY C.S.C.
BY

SURGICAL CARE AFFILIATES, LLC,

Appellee,

v.

NORTH CAROLINA INDUSTRIAL COMMISSION,

Appellant.

NOTICE OF APPEAL

TO THE HONORABLE NORTH CAROLINA COURT OF APPEALS:

NOW COMES the North Carolina Industrial Commission, pursuant to N.C.G.S. §§ 1-277 and 7A-27, and hereby give notice of appeal to the North Carolina Court of Appeals from the Decision entered on 9 August 2016 by the Honorable Paul C. Ridgeway, Judge Presiding, Superior Court, Wake County, that upon judicial review reversed the declaratory ruling previously entered by the North Carolina Industrial Commission pertaining to the applicability of a fee schedule promulgated pursuant to N.C. Session Law 2013-410 and N.C.G.S. § 97-26.

Respectfully submitted this the 6 day of September, 2016.

ROY COOPER
Attorney General

Amar Majmundar
Special Deputy Attorney General
N.C. State Bar No. 24668
N.C. Department of Justice
Post Office Box 629
Raleigh, N.C. 27602
(t) 919.716.6821
(f) 919.716.6759
amajmundar@ncdoj.gov

Bethany Burgon
Assistant Attorney General
N.C. State Bar No. 33369
N.C. Department of Justice
Post Office Box 629
Raleigh, N.C. 27602
(t) 919.716.6886
(f) 919.716.6756
bburgon@ncdoj.gov

Counsel for Appellant

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this day served the foregoing **NOTICE OF APPEAL** in the above titled action upon all other parties to this cause by:

[ ] Hand-delivering a copy hereof to each said party or to the attorney thereof

[X] Transmitting a copy hereof to each said party via email; or

[X] Depositing a copy hereof, first-class postage pre-paid, in the United States mail, properly addressed to:

Renee J. Montgomery
Matthew W. Wolfe
PARKER POE ADAMS & BERNSTEIN LLP
Post Office Box 389
Raleigh, NC 27602-0389
reneemontgomery@parkerpoe.com

Frank Kirschbaum, Esq.
Wyrick, Robbins, Yates & Ponton LLP
The Summit
4101 Lake Boone Trail, Suite 300
Raleigh, NC 27607
fkirschbaum@wyrick.com

This the 6 day of September, 2016.

Bethany Burgon,
Assistant Attorney General

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

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

Rule 04 NCAC 10J .0101
Prior to the April 1, 2015
amendment

SUBCHAPTER 10J – FEES FOR MEDICAL COMPENSATION

SECTION .0100 – FEES FOR MEDICAL COMPENSATION

04 NCAC 10J .0101 FEES FOR MEDICAL COMPENSATION

(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. The amounts prescribed in the applicable published Fee Schedule shall govern and apply according to G.S. 97-26(c).

(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) 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) A provider of medical compensation shall submit its statement 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, the employer, carrier, or managed care organization, or administrator on its behalf, shall pay or submit the statement to the Commission for approval or send the provider written objections to the statement. 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) 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) 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) The responsible employer, carrier, managed care organization, or administrator shall pay the statements 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) 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) 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;*
Eff. January 1, 1990;
Amended Eff. July 1, 2014; January 1, 2013; June 1, 2000.

TEMPORARY RULES
REQUEST FOR TECHNICAL CHANGE

AGENCY: Industrial Commission

RULE CITATION: 04 NCAC 10J .0103

DEADLINE FOR RECEIPT: Monday, December 12, 2016

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:

So that I understand, were the changes made to this Rule in response to public comments?

For purposes of permanent rulemaking, consider whether you need to retain (b)(1) and (2), (c)(1) and (2), and (e)(1) and (2). This is not a change you need to make now, but simply one to consider moving forward.

In (a), lines 7-9, the qualification for payment will be determined by CMS, correct?

In (g), line 33, what is "most recently adopted and effective"? Does your regulated public know?

On line 35, what do you mean by "referenced by website"? If you mean the federal website,I note that in Rule 04 NCAC 10J .0102(g), you state:

> (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 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.

Is there a way to state the information in (g) on line 33 similarly?

On line 35, is "OPPS" the "Outpatient Prospective Payment" on line 34? If so, what does the "S" stand for? And please make it clear what the acronym stands for in the Rule.

In (h)(2), Page 2, does your regulated public know what this means and when the services won't be eligible for payment by CMS?

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: December 7, 2016

Rule 04 NCAC 10J .0103 is amended under temporary procedures as follows:

04 NCAC 10J .0103 FEES FOR INSTITUTIONAL SERVICES

(a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services shall be based on the current federal fiscal year's facility-specific Medicare rate established for each institutional facility by the Centers for Medicare & Medicaid Services ("CMS"). "Facility-specific" rate means the all-inclusive amount eligible for payment by Medicare for a claim, excluding pass-through payments. An institutional facility may only be reimbursed for hospital outpatient institutional services pursuant to this Paragraph and Paragraphs (c), (d), and (f) of this Rule if it qualifies for payment by CMS as an outpatient hospital.

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

(1) Beginning April 1, 2015, 190 percent of the hospital's Medicare facility-specific amount.

(2) Beginning January 1, 2016, 180 percent of the hospital's Medicare facility-specific amount.

(3) Beginning January 1, 2017, 160 percent of the hospital's Medicare facility-specific amount.

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

(1) Beginning April 1, 2015, 220 percent of the hospital's Medicare facility-specific amount.

(2) Beginning January 1, 2016, 210 percent of the hospital's Medicare facility-specific amount.

(3) Beginning January 1, 2017, 200 percent of the hospital's Medicare facility-specific amount.

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

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

(1) Beginning April 1, 2015, 200 percent of the hospital's Medicare CAH per diem amount.

(2) Beginning January 1, 2016, 190 percent of the hospital's Medicare CAH per diem amount.

(3) Beginning January 1, 2017, 170 percent of the hospital's Medicare CAH per diem amount.

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

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

(2) Beginning January 1, 2016, 220 percent of the hospital's Medicare CAH claims payment amount.

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

(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the ~~Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective~~ most recently adopted and effective Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment ~~System~~ Systems reimbursement formula and ~~factors~~ factors, including all OPPS and ASC Addenda, as published annually or referenced by website in the Federal Register ~~("the Medicare ASC facility specific amount").~~ ("the OPPS/ASC Medicare rule"). An ASC's specific Medicare wage index value as set out in the OPPS/ASC Medicare rule shall be applied in the calculation of

the maximum allowable amount for any institutional service it provides. ~~Reimbursement shall be based on the fully implemented payment amount in Addendum AA, Final [AA (Final]ASC Covered Surgical Procedures for CY 2015, [2017)] and Addendum BB, Final [BB (Final]ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2015,[2017)]as published in the Federal Register, or their successors.[The maximum reimbursement rate for institutional services provided by ambulatory surgical centers is 200 percent of the Medicare ASC facility-specific amount.]~~

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

~~(1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility specific amount.~~

~~(2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility specific amount.~~

~~(3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility specific amount.~~

(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.

[~~(h) Notwithstanding Paragraph (g) of this Rule, if surgical procedures listed in Addendum EE (Surgical Procedures Excluded from Payment in ASCs for CY 2017) to the most recently adopted and effective Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems as published in the Federal Register, or its successors, are provided at ASCs, they shall be reimbursed with the maximum amount being the usual, customary, and reasonable charge for the service or treatment rendered.~~]

(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) [~~(g)~~]of this Rule.

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

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

(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.~~ 2015;
Temporary Amendment Eff. January 1, 2017.