

**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, 15<sup>th</sup> 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](mailto: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.*