SUBCHAPTER 23J – FEES FOR MEDICAL COMPENSATION

SECTION 0100 – FEES FOR MEDICAL COMPENSATION

11 NCAC 23J .0101 GENERAL PROVISIONS

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

(b) 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 11 NCAC 23A .0101.

(c) 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.

(d) A provider of medical compensation shall submit its 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 bill, the employer, carrier, or managed care organization or administrator on its behalf, shall pay the bill or send the provider written objections to the 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.

(e) When the 10 percent addition to the bill pursuant to G.S. 97-18(i) 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.

(f) 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 access to and copies of appropriate records, without charge or fee, to the person(s) chosen by the payor to review and audit the records.

(g) The responsible employer, carrier, managed care organization, or administrator shall pay the 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 it has requested that the physician obtain authorization for referrals or tests. Compliance with the request shall not unreasonably delay the treatment or service to be rendered to the employee.

(h) Employees are entitled to reimbursement for travel expenses 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 any tolls paid. Employees are entitled to lodging and meal expenses, at the rate 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. The current reimbursement rates referenced in this Paragraph are contained in the Form 25T, *Itemized Statement of Charges for Travel*, which shall be used to claim travel expenses.

(i) 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 that 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;
Recodified from 04 NCAC 10J .0101 Eff. June 1, 2018.

11 NCAC 23J .0102 FEES FOR PROFESSIONAL SERVICES

(a) Except as otherwise provided in this Rule, maximum allowable amounts payable to health care providers for professional services shall be based on the current year's Medicare Part B Fee Schedule for North Carolina ("the

Medicare base amount"), as published by the Centers for Medicare & Medicaid Services ("CMS") or its administrative contractor, including subsequent versions and editions. The Medicare Part B Fee Schedule for North Carolina can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(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;
Recodified from 04 NCAC 10J .0103 Eff. June 1, 2018.

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

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

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

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

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

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

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

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

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

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

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

(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the most recently adopted and effective Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems reimbursement formula and factors, including all Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Addenda, as published annually in the Federal Register and on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html ("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.

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

(1) A maximum reimbursement rate of 200 percent shall apply to institutional services that are eligible for payment by CMS when performed at an ASC.
(2) A maximum reimbursement rate of 135 percent shall apply to institutional services performed at an ASC that are eligible for payment by CMS if performed at an outpatient hospital facility, but would not be eligible for payment by CMS if performed at an ASC.

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

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

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

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

History Note: *Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410;*
Eff. April 1, 2015;
Temporary Amendment Eff. January 1, 2017;
Temporary Rule invalidated by Order of Judge G. Bryan Collins, Jr. in North Carolina Ambulatory Center Association, et al. v. North Carolina Industrial Commission, No. 17-CVS-00144 (Wake County Superior Court);
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