COMMENTS REGARDING CERTIFICATE OF NEED APPLICATIONS FILED FOR SINGLE-SPECIALTY AMBULATORY SURGERY OPERATING ROOMS IN THE TRIANGLE AREA
Submitted by WakeMed Health & Hospitals
January 3, 2010

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Obesity Management Center of the Carolinas, LLC CON Application (Project No. J-8620-10), to develop a single-specialty ambulatory surgery facility demonstration project with two operating rooms in Wake County.

Obesity Management Center of the Carolinas' ("OMCC") CON Application proposes to develop a single-specialty general surgery ambulatory surgery center ("ASC") with two surgical operating rooms, to be located in Cary in Wake County. The application proposes to be dedicated to general surgery cases that focus on the needs of obese patients and specifically proposes to perform as part of its highest volume of procedures, gastric banding procedures (Application p. 30).

OMCC's application does not fulfill the basic principle and rationale which supported the identification of a need for a single-specialty ambulatory surgery facility demonstration project in the 2010 State Medical Facilities Plan, and should be disapproved on the following grounds.

(1) The OMCC proposal is non-conforming with the special criteria for single-specialty ambulatory surgery facility demonstration projects promulgated in 10A NCAC 14C .2102(d) which provides as follows

> ***(d) An applicant proposing to establish a new single specialty separately licensed ambulatory surgical facility pursuant to the demonstration project in the 2010 State Medical Facilities Plan shall provide:***
>
> ***(3) a commitment that the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least seven percent of the total revenue collected for all surgical cases performed in the proposed facility;***
>
> ***(6) for each of the first three full fiscal years of operation, the total Medicare allowable amount for the self-pay surgical cases to be served in the proposed facility, i.e., provide the projected Medicare allowable amount per self-pay surgical case and multiply that amount by the projected number of self-pay surgical cases;***

OMCC has proposed to focus on performing a procedure at the ASC that is not covered by Medicaid, and that is also not consistently covered by commercial insurance and managed care payors. As noted in the application on page 103: "Weight-loss surgery is an elective procedure which is currently has [*sic*] restricted access: many third party payors do not reimburse for the service and patients who are covered by these payors must cover the surgery out-of-pocket

which is only financially feasible for a few people." OMCC attempts to demonstrate conformity with this special criterion through its charity care policy which states that OMCC will cover costs, or a portion of the costs, of the surgical services and procedures performed by OMCC for individuals with income less than 400% of the federal poverty level. However, this charity care policy will not allow OMCC to be in compliance with this criterion for the following reasons:

(a) As noted in the application on pages 32-33, patients receiving bariatric surgery require extensive pre-operative and post-operative appointments and tests, including psychological and nutritional consultations, multiple radiology and laboratory tests, an EKG, a sleep study, lap band adjustments, etc. Numerous clinical professionals provide these services and the gastric banding procedure itself, including psychologists, nutritionists, pathologists, radiologists, and anesthesiologists. Except for the surgeon, these professionals are not members of OMCC or Triangle Area Bariatric Surgeons, LLC (TABS), and the documentation included in the application (see Application Exhibits 8 and 11) does not state that OMCC's charity care policy will cover these additional costs.

Although professional fees were not provided in the application, based on information obtained from the website for some of the physician owners (see Attachment A), it is estimated that the *anesthesiology expense alone* will be approximately $1,600. It is unlikely that patients who qualify for the charity care policy will be able to pay these out-of-pocket expenses. Therefore, it appears that OMCC has overstated the number of self pay/charity care patients it will serve.

(b) The degree of charity care proposed is questionable given existing charity care policies for OMCC owners Rex Healthcare and the physician groups which are much less generous (see Attachments B and C). Although the applicant states that the charity care policy can work because the costs are being shared between the physician and hospital, the increase in charity care is suspect given that it is so significant as compared to the physicians' actual history.

A review of the payor mix for the 236 bariatric patients at WakeMed Cary Hospital from September 1, 2009 – August 31, 2010, all of whom were operated on by members of TABS, showed that only two patients were Self Pay/Medicaid, or 0.86% of total, significantly less than the 25% of bariatric procedure patients proposed on Application page 185. Looking at all inpatient volumes for the five physician applicants (source: Thomson Reuters), less than 8% of their total inpatients were Self Pay/Medicaid for both FFY 2009 and the first nine months of FFY 2010. Eight percent (8%) represents less than half of the Self Pay/Medicaid percentage for all outpatient procedures proposed in the application, 17.7% (see Application pages 185 and 188). While it is understood that inpatient data may not be completely comparable to outpatient data, it can serve as a reasonable proxy and the Thomson Reuters inpatient data is generally considered to be more reliable than the outpatient data. Therefore, existing data demonstrate that the physicians in the application do not have a history of treating Self Pay/Medicaid patients at the levels they are projecting.

(c) It appears that OMCC is planning on serving very few people who do not qualify for charity care and must pay out-out-pocket for the procedure. In its financial projections, OMCC

apparently has assumed that no more than three bariatric patients in Fiscal Year 1 will be paying for the procedure out-of-pocket (Form E, $38,908 Net Revenue ÷ Form D $12,392 Average Gross Revenue = 3.1 patients). This represents 0.5% of the total patients served at the facility.

By predicting such a low percentage of revenue actually being paid by individuals, OMCC is able to increase the percentage of total revenue attributable to Self Pay and Medicaid revenue in order to meet the 7% requirement set forth in the special criteria. Specifically, the SMFP contemplates that when calculating whether the facility's total collected revenue that is attributed to Self Pay and Medicaid is at least 7%, the facility will count the entire amount of revenue Medicare would allow if the Self Pay patient pays $0.00; however, if the Self Pay patient pays the facility some amount toward the surgical procedure that amount will be deducted from the Self Pay revenue calculation.

The example provided in the SMFP is if Medicare allows $300 for a surgical procedure and the Self Pay patient pays $0.00 then $300.00 is considered Self Pay revenue; however, if the Self Pay patient pays $50.00 then only $250.00 is considered Self Pay revenue. In order to demonstrate that Self Pay patients comprise 7% of the total revenue, OMCC has to indicate that it will actually receive a very small percentage of collections from Self Pay patients and thus it can count the entire allowable cost of the surgical procedure as Self Pay revenue. This calculation is flawed when one considers that pursuant to OMCC's charity care polices patients having incomes between 300% and 400% of the Federal poverty level will be responsible for paying 5-50% of their total bills (based on a discount of 50-95%).

(2) OMCC's application is non-conforming with Review Criterion 3 which states: *The applicant shall identify the population to be served by the proposed project, and shall demonstrate the need that this population has for the services proposed, and the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.*

As set forth above, OMCC has inadequately proposed a way for low income persons and other underserved groups to access the services proposed. Additionally, the 2010 State Medical Facilities Plan ("SMFP") identifies the Triangle area, composed of Wake, Durham, and Orange counties, as eligible for the single specialty ASC. However, only 3.25% of OMCC's patients are projected to come from Durham County and only 0.48% of OMCC's patients are projected to come from Orange County. So while the single-specialty ASC project contemplated that the project approved would serve Wake, Durham and Orange counties, the majority of OMCC's patients are coming from Wake (64%) and Johnston (13%) counties (Application page 124).

Finally, throughout the application, OMCC failed to provide assumptions and data supporting the methodology used to create its projections in the application. Most notably, while the physicians that are part of OMCC and who will be treating patients at OMCC have performed lap band procedures in the past, the application does not reference the actual number of such

procedures done by these physicians last year, which would be relevant to the number of procedures to be performed at OMCC. This data should be readily available to the applicants. While OMCC describes the obese population, it does not provide sufficient information or methodology to support what percentage of the obese population seek to undergo bariatric surgery or that would receive the procedure after completing the extensive pre-application procedures. For example, while the application references that patients must undergo a psychological assessment, it does not note that many people are not appropriate candidates for bariatric surgery. In fact, research indicates that approximately 75% of patients seeking bariatric surgery are appropriate candidates based on psychological assessments (see Attachment D).

(3) OMCC's application is non-conforming with Review Criterion 4 which states: *Where alternative methods of meeting the needs for the proposed project exist, the applicant shall demonstrate that the least costly or most effective alternative has been proposed.*

OMCC discusses the alternatives of developing a freestanding ambulatory surgery center and maintaining the status quo. Given the underutilization of rooms currently available at Rex-Cary and the ability to perform procedures at other facilities, the application does not show a need for two additional operating rooms in the future, and its proposed project is therefore not an effective way to address the single specialty concerns.

Additionally, while the application tries to support the project by describing it as a "Disease Management Center" (see Application pages 35, 97-98), this characterization is inappropriate. OMCC details the extensive treatment and procedures necessary both before and after the lap band procedure in support of the need for this particular single specialty ASC project. Bariatric surgery patients typically work closely with their surgeon and a bariatric coordinator to coordinate their care; however, the proposed facility provides an area for lap band procedures to take place but nothing more. The only physician office at the facility is located within the surgery recovery area and is not an appropriate location to provide consultations to patients returning for post-operative check-ups or ongoing coordination of care (see Application Exhibit 10). The application states on page 36 that a Bariatric Coordinator will provide pre- and post-operative education; however, the staffing pattern shown on page 37 indicates that education will be provided only on the day of surgery.

Only one of the physicians who will be performing bariatric surgery at OMCC appears to have an office at the Rex-Cary campus and would possibly have the ability to coordinate care at Rex-Cary. However, according to the Rex-Cary website, this physician (Dr. Ng) practices at a total of six locations, which will limit his availability to coordinate care through the Rex-Cary campus. Furthermore, none of the physician support letters indicate that they will be moving their offices to the Rex-Cary campus. Therefore, the patient will be required to visit other locations "as they continue to seek guidance and care to treat the disease of obesity."

(4) OMCC's application is non-conforming with Review Criterion 5 which states: *Financial and operational projections for the project shall demonstrate the availability of funds for*

capital and operating needs as well as the immediate and long-term financial feasibility of the proposal, based upon reasonable projections of the costs of and charges for providing health services by the person proposing the service.

The key driver of the financial projections is the projected utilization for the proposed operating rooms. Given issues with OMCC's utilization projections, the financial feasibility of the project is questionable. Please reference the discussion in paragraph (b) under Review Criterion 6.

(5) OMCC's application is non-conforming with Review Criterion 6 which provides: ***The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.***

Because OMCC has failed to demonstrate that it has reasonably projected utilization or demonstrated a need for two operating rooms at OMCC, the project is not consistent with Review Criterion 6. It is not sufficient for there to be an identified need for a single specialty ASC. OMCC cannot comply with this criterion unless it can demonstrate the need for two additional operating rooms at its facility through reasonable, well-founded projections.

(a) According to utilization data provided in the OMCC application on page 48, Rex-Cary's utilization in 2010 was 2,765 cases, a decrease of 6% from the 2,945 outpatient surgical procedures performed at Rex-Cary in 2009. This equates to a surplus of 1.8 ORs, as shown in the calculations below:

2,765 outpatient cases x 1.5 hours per case = 4,147.5 outpatient hours, rounded to 4,148
4,148 outpatient hours ÷ 1,872 hours per OR per year = 2.22 ORs needed, rounded to 2.2
2.2 ORs needed minus 4 existing ORs = *surplus of 1.8 ORs*

Because the service area has more than 10 operating rooms, a deficit of at least 1.5 ORs is required in order to generate a need for two additional ORs. The case volume at Rex-Cary must increase by at least 4,099 cases in order to support at least 5.5 ORs.

5.5 ORs x 1,872 hours per OR per year = 10,296 available hours
10,296 hours ÷ 1.5 hours per case = 6,864 cases
6,864 cases minus 2,765 cases performed in 2010 = 4,099 additional cases required

OMCC's CON application contains letters from 20 physicians specifying the number of cases they will shift to Rex-Cary; however, every one of these support letters includes the clause: "...which could mean as many as...". While the totals provided by the physicians add up to 2,820 cases; Rex assumed in its methodology that 100% of these cases would be shifted, which is unrealistic, and as shown above, does not justify the addition of two ORs. In February 2010, these same physicians committed to shifting volume to Rex-Cary; however, as noted in the data provided by Rex, the number of cases performed at Rex-Cary actually declined in 2010. Therefore, it is not reasonable to assume that these physicians will actually shift these patients

in 2011. OMCC has not demonstrated that its project will not duplicate existing health care facilities.

(b) OMCC's methodology utilizes an arbitrary and excessive annual growth rate (12.4%) to project surgical procedures. Based on population data provided in the application on page 83, the CAGRs for Wake County and the Triangle Area are less than 3% annually, yet OMCC has projected a growth rate more than four times greater than the population growth, based on the physician applicants' growth that has occurred only at Rex, not taking into consideration trends in case loads at other facilities.

Using physician data provided on page 111 of OMCC's application and from WakeMed Cary Hospital's operating room system, WakeMed believes that the 12.4% growth rate is significantly overstated, despite the prevalence of obesity in the service area. Data below show that while case volumes at Rex have increased, they have declined at WakeMed Cary. In total, volumes remained flat or declined for two of the three physicians. While the third physician (Dr. Enochs) showed a significant increase in procedures from FY 2008-2010, it should be noted that he previously performed surgery at Franklin Regional Medical Center (FRMC), and those case volumes are not included below. The CAGR for these three physicians is only 6.4%, and if the FRMC volumes were included, the CAGR would be even lower. Therefore, OMCC has not used a reasonable methodology to project future surgery cases.

Physician	WakeMed Cary (a)			Rex (b)			Total		
	FY 2008	FY 2009	FY 2010	FY 2008	FY 2009	FY 2010	FY 2008	FY 2009	FY 2010
Bruce, Jon	284	254	144	28	65	170	312	319	314
Enochs, Paul (c)	23	47	113	143	138	185	166	185	298
Tyner, Michael	315	261	264	15	18	40	330	279	304
Total	622	562	521	186	221	395	808	783	916
% Change		-9.6%	-7.3%		18.8%	78.7%		-3.1%	17.0%
							Two year CAGR(c)		6.47%

Sources:
(a) WakeMed Cary Hospital OR system, outpatient cases.
Note that the WM Cary data includes only scheduled procedures, not emergency or add-ons.
(b) OMMC CON application, page 111.
(c) Note that the data does not include cases performed by Dr. Enochs at Franklin Regional Medical Center.

Further, if one utilizes OMCC's methodology (see Application pages 113-114), but changes the growth rate to the CAGR for Wake County, which is higher than that for the entire Triangle area, the results show that there a need for only one OR.

	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	FFY 16	CAGR*
Cases	1,157	1,190	1,224	1,259	1,295	1,332	2.83%

PY 1	PY 2	PY 3
1,242	1,277	1,314

*Calculated based on data provided on Application page 83.

1,314 cases x 1.5 hours per case = 1,971 outpatient hours
1,971 outpatient hours ÷ 1,872 hours per OR per year = 1.05 ORs needed, rounded to 1

(c) Throughout the application, OMCC discusses the need for an ASC designed to meet the needs of obese patients. However, in the two Rex operating rooms CON applications filed in 2010 (Project Nos. J-8468-10 and J-8469-10), the physician members of TABS committed to transferring their outpatient cases to Rex-Cary Campus, and according to a recent Securities and Exchange Commission filing, Dr. Enochs is one of the Executive Directors for The Surgical Center of the Carolinas, LLC, which is purchasing 45% of Rex Cary LLC. Obviously, the physicians must feel comfortable that the Rex-Cary facility would meet the needs of their bariatric patients; otherwise, they would not have proposed to shift "as many of these outpatient cases as possible from non-Rex facilities to Rex's Cary facility" (see support letters from Drs. Bruce, Enochs, and Tyner from J-8468-10 and J-8469-10 in Attachment E). Therefore, given that the Rex-Cary facility is underutilized and that it already meets the needs of bariatric patients, approval of the OMCC proposal will result in unnecessary duplication of existing health services facilities.

Additionally, Rex has several CON Section-approved projects under way that will increase both its overall surgical capacity and the number of dedicated outpatient operating rooms in its system, and which would show OMCC's application would be an inappropriate duplication of services. These projects include:

- Orthopaedic Surgery Center of Raleigh (OSCR) (Project No. J-8170-08), which will develop four new, dedicated outpatient operating rooms. Rex is a joint venture partner in this project and expects to shift outpatient surgical cases in orthopedics and certain other specialties from Rex Hospital to OSCR.
- Rex-Wakefield, with 3 dedicated outpatient operating rooms, which opened on April 27, 2009 (J-7657-06).
- Rex Hospital also received approval to relocate four operating rooms from Rex Hospital to a new outpatient surgical facility located near the Rex main campus, Rex-Macon Pond (Project No. J-8053-08).

Based on this analysis, OMCC would appear to be duplicative of existing providers, and will result in only a minimal improvement in access to surgical services in Wake County. Therefore, OMCC does not conform with Review Criterion 6.

(6) The OMCC application is not conforming with Review Criterion 18a which provides:
The applicant shall demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a positive

impact upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.

OMCC will not enhance competition in Wake County because the need for its proposal is not documented. Services can be provided at existing facilities that are underutilized, and the project does not provide other inherent values because the identified obese population will still need to go to multiple other locations for comprehensive treatment. Geographic access is not improved, because the proposed location is adjacent to an existing facility where the procedures can also be performed. Improved access to the underserved population is questionable, because the charity care policy does not extend to pre- and post-operative tests and procedures, thereby requiring out-of-pocket payments that are likely unaffordable. Therefore, the application does not conform with Review Criterion 18(a).

CONCLUSION

For the reasons noted above, the OMCC application does not conform with all CON Review Criteria and special rules. WakeMed recommends that the CON Section disapprove OMCC's application.

Attachment A

Self Pay Pricing for Bariatric Surgery

Rex Hospital		WakeMed Cary	
Lap-Band:		**Lap-Band:**	
Surgeon Fee	$4,000.00	Surgeon Fee	$4,000.00
1st year of Adjustments	$1,000.00	1st year of Adjustments	$1,000.00
Hospital Fee	$13,500.00	Hospital Fee	$15,500.00
Anesthesia	$1,600.00	Anesthesia	$1,600.00
Total:	***$20,100.00***	***Total:***	***$22,100.00***

Band Center of the Carolinas

Lap-Band

$9900.00

$1000.00 (1st year of Adjustments)

Gastric Bypass:		Gastric Bypass:	
Surgeon Fee	$7,500.00	Surgeon Fee	$7,500.00
Hospital Fee	$19,000.00	Hospital Fee	$18,500.00
Anesthesia	$2,100.00	Anesthesia	$2,100.00
Total:	***$28,600.00***	***Total:***	***$28,100.00***

Sleeve:		Sleeve:	
Surgeon Fee	$6,000.00	Surgeon Fee	$6,000.00
Hospital Fee	$20,000.00	Hospital Fee	$19,500.00

Anesthesia: Please contact JoAnne Brown 919-873-9533 extension 107

This is the self pay discounted price and may not be the price billed if you have insurance.

Please note this price is an estimate and the actual price of surgery may vary

This price includes only the surgical procedure. It does not include any office visits or any of the pre-surgical testing appointments needed prior to surgery. We will file your insurance, if applicable, for your office visits. You will be responsible for any co-pays, co-insurance, or deductible amount as determined by your insurance company. If your insurance does not offer bariatric benefits or you do not have insurance you will be responsible for payment in full at the time services are rendered.

REX HEALTHCARE, INC
PATIENT FINANCIAL SERVICES
STATEMENT OF POLICY

Areas affected: Patient Financial Services
Effective date: August 3, 2001

PATIENT LIABILITY POLICY

Rex Healthcare, Inc. (Rex) has developed programs to assist patients with personal financial liability related to medical care received at Rex Hospital and Primary Care Offices. The purpose of this policy is to limit or reduce patients' out of pocket expenses in a manner which is impartially applied to all patients regardless of their ability to pay. It is our intent to handle all customer requests adequately and proactively resolve all issues with the highest level of service and satisfaction.

Procedure

I. **OVERVIEW**

A. Patient Liability as defined within the scope of this policy arises from two categories
   1. Uninsured Self-Pay Patient Liability
   2. Patient Liability after Insurance has Paid, Per Plan Benefit Guidelines

B. Patient Liability may be reduced or eliminated through application of one or a combination of the following programs
   1. Medicaid and Medicare Eligibility Assistance
   2. Third Party Coverage (liability insurance) determination
   3. Financial and Charity Assistance
   4. Uninsured Self-Pay Discounts
   5. Prompt Pay Discounts, provided no contracted or governmental insurance covers the service received
   6. Medical Loans

II. **SUMMARY OF PROGRAMS**

All "Uninsured Self-Pay" patients as well as all patients requesting financial assistance, discounts, medical loans or payment plans will be voluntarily screened for Insurance Eligibility and financial assistance (Charity Care) as part of the eligibility process for discounts and/or medical loans.

A. **Pre and Post Discharge Collections at Bedside**
   1. All unscheduled inpatients will be flagged for UFC requested at Bedside in the Star system.
   2. Patients will be informed of Rex's upfront policy at the time of Direct or ED admissions.
   3. Customer Advocates will communicate patient payment expectations at bedside and collect these payments before the patient is discharged. Receipt given to any patient that makes payment and monies collected will be noted in the Star system.
   4. Patients/Authorized representatives are informed to visit the Patient Tower office during admission to pay at their own convenience if unable to pay at time of visit. PFS will offer financial assistance and payment option information to any patients (and anyone who requests assistance with payment).
   5. If patient is willing to pay in full, patient is informed of estimated charges for procedure and will pay 50%; staff will enter a "Prompt Pay discount carrier plan" to the star system for adjustment to be applied.

B. **Medicaid and Medicare Eligibility Assistance and Third Party Coverage determination**

1. Uninsured patients or those patients determined to have potential need will be evaluated for Medicaid, Medicare or other insurance eligibility.

C. **Rex Assist**

1. Patient or authorized representative complete or provide information to Rex Patient Financial Services to determine patient eligibility.
2. Extenuating circumstances such as catastrophic medical expenses and job loss are considered.
3. Direct PFS intervention and support is provided to assist patients.
4. Requested documents are proof of Adjusted Gross Income, asset disclosure and latest bank statements, last tax return or last two pay stubs.
5. Assistance is provided as defined within attached Table A.

D. **Uninsured Self-Pay Discounts**

1. Patients who do not qualify for Financial/Charity Assistance and have no insurance for the service received are eligible for an automatic 15 % discount on charges.

E. **Prompt Pay Discounts**

1. Uninsured patients may qualify for discounts in addition to II.C.1. (15%).
2. The amount of the discount is determined by the date payment in full is received
   a) 35% for payment in full before or by Final Bill Date (FBD)
   b) 30% for payment in full from Final Bill Date plus 1 to 30 calendar days (FBD + 1 to FBD + 30. (As comparable to NC state statutes related to insurance prompt pay requirements.)
   c) 20% for payment in full from FBD +31 to FBD +60
   d) Assistance is provided as defined within attached Table B.

F. **Medical Loans**

1. Rex provides an extended payment program to all patients who require additional time and/or do not have cash on hand or available credit to pay their personal patient liability.
2. Medical loans apply in combination with prompt pay discounts provided that a completed application and first payment are received within the timelines as specified upon, D.1. -2. Additionally, the medical loan must be completed without payment default.
3. Defaults of Medical Loans will result in recourse of loan to Rex and will invalidate any discounts which were applied.

G. **Monthly Payment Plans**

1. Rex provides an monthly installment plan to all patients who request to Rex Hospital with no interest charge.
2. The following criteria will be used to determine the allowable installment terms by which monthly payments will be made:

Patient Balance	**- Maximum Term**
Up to $1,000	**12 months**
$1,001 to $2,500	**24 months**
$2,501 to $5,000	**36 months**
$5,001+	**48 months**

H. **Other Options**

1. Any payment option exceptions require management approval.
2. Patient (customer) issues or requests which are not answered to the satisfaction of the caller will result in the referral of the customer to a supervisory level for escalation and assistance in prompt issue resolution.

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3. Correspondence confirming discussions and outcomes with customers will be proactively employed.

III. DETAIL PROCEDURAL GUIDELINES

Each program under section II is administered under specific procedural guidelines.

Table A. **Rex Assist Table**

2009 Poverty Guidelines

	2009 Federal Guidelines	Traditional Charity Care – 100% of past and 3 months Future(some exceptions apply)
Forgiveness of Debt		100%
Federal Poverty Guidelines		250%
1	$10,830	$27,075
2	$14,570	$36,425
3	$18,310	$45,775
4	$22,050	$55,125
5	$25,790	$64,475
6	$29,530	$73,825
7	$33,270	$83,175
8	$37,010	$92,525
For each additional person	$3,740	

Table B: **Uninsured and Prompt Pay Discount Table**

Uninsured patients who do not qualify for other programs	Payment in full on or before Final Bill Date (FBD)	Payment in full from FBD + 1 To FBD + 30	Payment in full on or before FBD + 31 to FBD + 60
15% automatic base discount on charges	35% discount added to 15% base discount	30% discount added to 15% base discount	20 discount added to 15% base discount

Keith Boyd Date
Director, Patient Financial Services

Bernadette Spong Date
Vice President, Finance, CFO

Originating area: Patient Financial Services
Origin: August 3, 2001
Revised: November 5, 2001; March 01, 2002, June 9, 2003, March 15, 2004, August 27, 2004, April 1, 2005, June 15, 2006, 02/10
Filename: Patient Liability Policy

Bariatric Specialists of North Carolina, PA

Bariatric Financial Policy

Our doctors are dedicated to providing the highest quality medical care and long term follow-up support for our bariatric patients. Our staff is dedicated to educating our patients both clinically and financially during this life changing journey. Please read and sign the following policy, if you have any questions please ask we are happy to discuss any questions or concerns you may have.

1. We require a current copy of your insurance card at check-in or you will be considered a self-pay until proof of insurance is received.
2. All co-pays are due at the time of service. If you do not have your co-pay you will need to reschedule your appointment. We accept Cash, Visa, MasterCard, Discover and personal checks.
3. If we are a participating provider with your insurance company you are responsible for all co-payments, co-insurance, deductible amounts and any non-covered service. As a courtesy to you we will file your insurance claims as long as we have all the correct insurance and demographic information.
4. We do not accept Medicaid for bariatric procedures. If we are not participating with your insurance company or your insurance does not provide benefits for weight loss surgery payment in full is due at the time services are rendered.
5. Surgery estimates and any balance due will be taken prior to scheduling surgery. The estimate will only include our charge. Bills for the hospital, anesthesiologist, or laboratory tests are separate please contact these providers directly for estimates or billing questions.
6. If you have an insurance policy that requires referrals please have your primary care physician fax it to our office prior to your appointment date. It is ultimately your responsibility to make sure the authorization is correct and has arrived or you will be responsible for payment.
7. All balances are due and payable upon receipt of your statement. If after 90 days no payment has been made on your account you will be referred to a collection agency.
8. Self pay patients must pay in full at the time services are rendered and surgery prices will be collected at least 10 days prior to surgery. Before scheduling surgery please check your date we charge $20 if you reschedule your surgery.
9. All Medical-form completion will obtain a charge of $10 per form request. If additional information is needed, that cannot already be found in the chart in order to complete the request, a scheduled visit may be required. Once all pertinent information is received, the form will be completed with 7-14 days of submitted payment.
10. Any return check by the bank for "NSF" or "closed account" will be charged a $25 service fee in addition to the amount of the returned check. We reserve the right to not accept personal checks from you if your account has a return check fee charge.
11. Patients are seen by appointment time, not arrival time.
12. Macgregor Sleep Center charges $75 for missed appointments. Please give 24 hours notice if you need to cancel or reschedule your sleep study.

Authorization:

I agree to be responsible for my medical expenses regardless of insurance coverage. I authorize my insurance company, attorney or other parties to provide any payments information regarding my bill and make payment directly to Bariatric Specialists of NC, PA. I agree to pay all costs incurred if my account should become delinquent, including attorneys fees. I have read, understand and agree to this financial policy and I accept full responsibility for any balance due.

I authorize the physician in charge to administer medical care as is necessary, and allow release of medical records and x-rays to any party involved in my treatment.

________________________________ ________________

Signature of Patient or Legal Guardian Date

Table 19
Obesity-Related Review of Organ Systems

Cardiovascular	***Respiratory***
Hypertension	Dyspnea
Congestive heart failure	Obstructive sleep apnea
Cor pulmonale	Hypoventilation syndrome
Varicose veins	Pickwickian syndrome
Pulmonary embolism	Asthma
Coronary artery disease	***Gastrointestinal***
Endocrine	Gastroesophageal reflux disease
Metabolic syndrome	Nonalcoholic fatty liver disease
Type 2 diabetes mellitus	Cholelithiasis
Dyslipidemia	Hernias
Polycystic ovary syndrome, androgenicity	Colon cancer
Amenorrhea, infertility, menstrual disorders	***Genitourinary***
Musculoskeletal	Urinary stress incontinence
Hyperuricemia and gout	Obesity-related glomerulopathy
Immobility	End-stage renal disease
Osteoarthritis (knees and hips)	Hypogonadism (male)
Low back pain	Breast and uterine cancer
Carpal tunnel syndrome	Pregnancy complications
Integument	***Neurologic***
Striae distensae (stretch marks)	Stroke
Stasis pigmentation of legs	Idiopathic intracranial hypertension
Lymphedema	Meralgia paresthetica
Cellulitis	Dementia
Intertrigo, carbuncles	***Psychologic***
Acanthosis nigricans	Depression and low self-esteem
Acrochordon (skin tags)	Body image disturbance
Hidradenitis suppurativa	Social stigmatization

this literature, make drawing definitive conclusions difficult if not impossible. Perhaps psychiatric symptoms that are primarily attributable to weight, such as depressive symptoms and impaired quality of life, may be associated with more positive outcomes, whereas those symptoms representative of psychiatric illness—that is, independent of obesity—are associated with less positive outcomes (**119 [EL 4]**).

Studies have suggested that mental health professionals unconditionally recommend approximately 75% of bariatric surgery candidates for surgery (**337 [EL 3], 374 [EL 3], 380 [EL 3]**). In the remaining patients, the recommendation typically is to delay bariatric surgery until specific psychosocial or nutritional issues (or both) have been addressed with additional assessment or treatment. The benefits of recommending such a delay, however, should be weighed against the risk of patients not eventually returning for potential surgical treatment.

9.3.2. Physical Examination

For optimal comfort, the physician's office should be equipped properly with armless chairs, extra-large and reinforced examination tables, a suitable scale and stadiometer for measuring weight and height, large gowns, and appropriately sized blood pressure cuffs. The BMI should be computed and categorized by class. A comprehensive examination should be performed, with particular attention paid to signs of metabolic and cardiopulmonary disease. For example, a large neck circumference and a crowded posterior pharynx may be clues to the presence of OSA. Fungal infection in skinfolds may be a sign of undiagnosed diabetes. Observation of gait and breathing effort with modest exertion (for example, walking to the examination room or getting on and off the examination table) may provide clues to poor functional capacity or musculoskeletal disability.

February 10, 2010

Mr. Craig R. Smith, Chief
Certificate of Need Section
701 Barbour Drive
Raleigh, NC 27626

Dear Mr. Smith:

I wish to inform you of my support of the CON applications filed by Rex Healthcare (Rex) to develop an outpatient surgery center in Holly Springs and to add an operating room at Rex's main campus as well. As a surgeon practicing at Rex and other facilities, I am aware of the growth of Rex's surgery volume, and I expect that growth to continue. Rex is well-respected by both patients and physicians for its surgery services, as evidenced by its position as the highest surgery volume provider in the county.

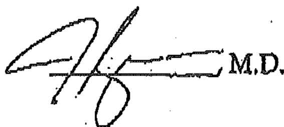
Over the past several years, Rex has thoughtfully developed health care services in the suburban areas of Wake County to meet the need of the patients there. These services now include urgent care and outpatient diagnostic centers in Cary, Knightdale and Wakefield, with two more under development in Raleigh and Holly Springs. Rex's proposed development of a surgery center in Holly Springs is needed to meet the need of the patient population and will compliment the existing and developing physician and outpatient services there.

As a part of this careful planning, in 2007 Rex Healthcare applied for, and was awarded a CON to convert its outpatient surgical center in Cary into an LLC in which physicians could invest (Project ID# J-7878-07). Recently, several other local physicians and I reached an agreement to invest in Rex's Cary surgery facility. This group of physicians includes general surgeons, urologists, orthopedists, gynecologists, and ENT physicians. I am a general surgery physician and in the past, I have scheduled surgical cases between Rex (Main Campus and Cary) and non-Rex facilities. In the twelve months ending June 2009, I performed approximately 600 outpatient surgery cases at non-Rex facilities. As a result of my involvement in Rex's Cary surgery center, over the next few months I intend to shift as many of these outpatient cases as possible from non-Rex facilities to Rex's Cary facility, which could be as many as 500 cases. My patients will benefit from having their surgery in the dedicated ambulatory surgery setting at Rex's Cary facility, which provides patients with the highest possible quality of care.

I appreciate Rex's commitment to its patients as well as its willingness to seek the input of its medical staff. In an effort to enable me to focus on patient care, this letter may resemble the format of those signed by my colleagues; however, that should not detract from the fact that I fully support Rex's proposal to bring surgery capacity to Holly Springs as well as increasing its overall surgery capacity at the hospital.

Please let me know if I can be of further assistance in your efforts.

Sincerely,


M.D.

Jon M.Bruce, MD

February 11, 2010

Mr. Craig R. Smith, Chief
Certificate of Need Section
701 Barbour Drive
Raleigh, NC 27626

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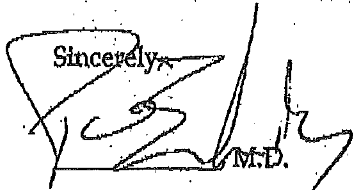

M.D.

Paul Enochs, MD

February 10, 2010

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Certificate of Need Section
701 Barbour Drive
Raleigh, NC 27626

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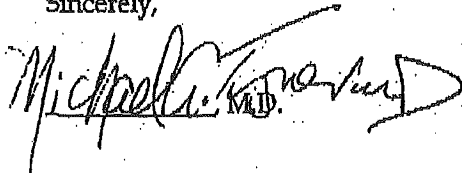

Michael Tyner, MD