COMMENTS ON DUKE UNIVERSITY HEALTH SYSTEM D/B/A DUKE RALEIGH HOSPITAL'S MACON POND CANCER CENTER RENOVATION CON APPLICATION (PROJECT ID #J-11057-15)

submitted by

REX HOSPITAL, INC.

In accordance with N.C. GEN. STAT. § 131E-185(a1)(1), Rex Hospital, Inc. ("Rex") submits the following comments related to Duke Raleigh Hospital's ("Duke") application to renovate its Macon Pond Cancer Center. Rex's comments include *"discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with the relevant review criteria, plans and standards."* See N.C. GEN. STAT. § 131E-185(a1)(1)(c). In order to facilitate the Agency's review of these comments, Rex has organized its discussion by issue, noting the general CON statutory review criteria and specific regulatory criteria and standards creating the non-conformity relative to each issue.

SCOPE OF THE PROJECT

On page 8 of the application, Duke describes the scope of the project, in part, as follows: *"This application proposes the renovation of clinic space and acquisition of imaging equipment at the Duke Cancer Center Macon Pond....to support existing and proposed oncology services at this location....Duke Raleigh Hospital intends to locate its breast and women's cancer outpatient services primarily at Macon Pond, in order to provide optimally coordinated patient care for patients with breast and gynecological cancers. This will create a focused center that delivers comprehensive women's cancer care spanning support services, radiology, and medical, surgical, and radiation oncology. This project includes the renovation of clinic space to accommodate breast surgical clinical consultations and clinic procedures, and the development of on-site imaging to support the existing and planned oncology services. Duke Raleigh will acquire one ultrasound machine and one mammography unit for radiology procedures and two ultrasounds for image-guided needle biopsy clinic procedures."*

The line drawings in Exhibit 15 show two mammography rooms, two ultrasound rooms, and one procedure room. However, on page 9 the application states: *"One mammography unit will be purchased. Three ultrasound units will be purchased; one that will be installed for use by radiology for screening and diagnostic imaging procedures, and two mobile ultrasound units for image-guided biopsy procedures by the breast surgeons in their clinic procedures."* Moreover on page 28 of the application, Duke lists one mammography unit, one ultrasound imaging unit, and two ultrasound units for surgical clinic procedures. Page 63 of the application lists the acquisition of one new mammography unit, one new ultrasound unit, and two used ultrasound units from the Tolnitch practice. Thus, the application is inconsistent in defining the scope of the project. Specifically:

- The line drawings show two mammography rooms, but other parts of the application indicate the acquisition of only one mammography unit. The application fails to demonstrate a need for two mammography units, particularly given that the one unit accounted for in Section IV, page 28 of the application is projected to be underutilized at only 47 percent of defined capacity.

- The line drawings show two ultrasound rooms, but other parts of the application indicate the acquisition of only one fixed ultrasound unit, with the other two used units as mobile

ultrasound units, neither of which would require the second room for fixed installation. The application fails to demonstrate a need two ultrasound units for imaging procedures, particularly given that the one unit accounted for in Section IV, page 28 of the application is projected to be underutilized at only 62 percent of the defined capacity.

- The line drawings show a procedure room, which is not discussed or accounted for elsewhere in the application, including no demonstration of need for the room, projected utilization, or projected financials. Page 14 of the application states that the renovation is needed in part because *"[t]he existing clinic rooms at Macon Pond are uniformly small and not well adapted to surgical consultation and biopsy services. Needle biopsy procedures do not require anesthesia or an operating room, but they do entail use of equipment that warrants a larger area, including ultrasound equipment for image-guided procedures. Renovating the clinic space will therefore increase patient comfort and operational efficiency."* Based on the statement on page 14, the renovation is needed in part to create larger exam rooms so that surgical oncologists can perform needle biopsy procedures using the mobile ultrasound equipment in those larger exam rooms. Page 27 of the application indicates the surgical oncology procedure projections are for surgical procedures using ultrasound. Based on a collective read of the statements in the application, Duke is proposing to renovate the facility to create larger exam rooms to accommodate surgical procedures using ultrasounds. These are the only procedures discussed in the application; therefore, Duke has failed to demonstrate at a minimum the scope of, need for, utilization of, or financial projections for the procedure room shown on the line drawings. Further, the existing exam rooms have been utilized for many years by at least three oncologic surgeons now employed by Duke who performed biopsies and other diagnostic procedures without the renovations Duke is proposing. Thus, Duke has failed to demonstrate why the procedures rooms are no longer effective in performing the same procedures without renovation.

The application also fails to appropriately include all components associated with the proposed project. On June 9, 2015 Duke submitted a request to the Agency to confirm that the renovation of the infusion therapy area, lobby, and related support space of the Macon Pond building was not subject to CON review as the capital cost for those components of the project totaled only $1.33 million. On June 10, 2015, the Agency responded to Duke indicating that the project did not require CON review, but that finding was based on the facts represented in the June 9, 2015 correspondence. The Agency's determination specifically stated: *"It should be noted that this determination is binding only for the facts represented in your correspondence. Consequently, if changes are made in the project or in the facts provided in your correspondence referenced above, a new determination as to whether a certificate of need is required would need to be made by this office. Changes in a project include, but are not limited to: (1) increases in the capital cost; (2) acquisition of medical equipment not included in the original cost estimate; (3) modifications in the design of the project; (4) change in location; and (5) any increase in the number of square feet to be constructed."* A short two months later, Duke submitted the application currently under review that proposes to increase the capital cost of renovations to the Macon Pond facility, acquire medical equipment not included in the cost estimate from June 9, modify the design of the Macon Pond renovation, and increase the number of square feet to be renovated at the Macon Pond facility. An examination of the line drawings in Exhibit 15 shows that Duke essentially has proposed to renovate nearly all of the Macon Pond facility, other than the space associated with the linear accelerator[1], yet by not including

[1] Of note, on February 13, 2015, the Agency approved Duke's application to replace the linear accelerator and renovate associated space (Project ID # J-10363-14).

the components previously associated with the no review request has failed to include all components of that renovation in the application under review.

For these reasons, the application should be found non-conforming with Criteria 3, 4, 5 and 12.

UNDERUTILIZATION OF PROPOSED EQUIPMENT

On page 36 of the application, Duke defines capacity for the proposed equipment items to be acquired as 2,000 procedures per year per ultrasound unit and 4,000 procedures per year per mammography unit. According to its volume projections on page 28, however, Duke projects one mammography unit to be utilized at only 47 percent of capacity in the third project year (1,899 procedures / 4,000 capacity = 47 percent). As noted above, Duke's volume projections reflect only one mammography unit, though the project line drawings indicate rooms for two mammography units.

Furthermore, Duke is proposing to acquire additional mammography equipment and "to locate its breast and women's cancer outpatient services primarily at Macon Pond." However, Duke already has underutilized mammography equipment at Duke Raleigh Hospital; the proposed project will only exacerbate that underutilization. Page 25 of the application documents the mammography volume and capacity at Duke Raleigh Hospital, according to its 2015 Hospital License Renewal Application ("HLRA"). Duke Raleigh currently has two mammography units and performed 4,156 procedures in FY 2014. Using the same capacity definition included on page 36 of the application, those two units have capacity to accommodate 8,000 mammography procedures per year, but only achieved 52 percent utilization in FY 2014. Even with the growth in FY 2015 shown on page 17 of the application, the two units were only utilized at 63 percent of capacity. Thus, the acquisition of a third mammography unit would result in total capacity of 12,000 procedures per year, but total utilization of only 6,903 procedures (5,004 + 1,899 = 6,903) or 58 percent, assuming that all the projected volume at the Macon Pond location is incremental new volume to Duke Raleigh. In light of Duke Raleigh's plan to locate its breast and women's cancer center services to Macon Pond, it fails to demonstrate a need to acquire additional mammography equipment when existing equipment at the hospital site is underutilized and the proposed Macon Pond site is projected to be similarly underutilized.

In addition, according to 2015 HLRAs, there are 19 hospital-based mammography units operated by Wake County hospitals, with average procedure volume of 2,074 per unit in FY 2014 as noted in the table below. In contrast to Duke's statement on page 15 of the application—*"Providing mammography capacity at Macon Pond will also provide a screening mammography option for patients in Wake County"*—multiple mammography options exist for patients in Wake County among hospital-based providers alone, and the table below does not include any non-hospital-based providers of which there are multiple choices in Wake County.

Provider	Mammography Units	FY 2014 Mammography Volume	Volume per Unit
Duke Raleigh	2	4,156	2,078
Rex Hospital	10	24,505	2,451
WakeMed Raleigh (Total)	4	7,182	1,796
New Bern	1	54	54
North Healthplex	1	3,118	3,118
Raleigh Medical Park	1	2,698	2,698
Clayton Medical Park	1	1,312	1,312
WakeMed Cary	3	3,556	1,185
County Total/Average	19	39,399	2,074

Similarly, the volume projections on page 28 estimate 1,248 ultrasound procedures in year three (non-surgical ultrasounds), resulting in utilization of only 62 percent (1,248 procedures / 2,000 capacity = 62 percent). Again, the project line drawings show two fixed ultrasound rooms, although the projections indicate only one fixed ultrasound unit.

In addition, according to 2015 HLRAs, there are 44 hospital-based ultrasound units operated by Wake County hospitals, with average procedure volume of 1,339 per unit in FY 2014 as noted in the table below.

Provider	Ultrasound Units	FY 2014 Ultrasound Volume	Volume per Unit
Duke Raleigh	3	9,037	3,012
Rex Hospital	25	17,390	696
WakeMed Raleigh (Total)	9	24,409	2,712
New Bern	3	13,650	4,550
North Healthplex	2	4,503	2,252
Brier Creek Healthplex	1	1,602	1,602
Garner Healthplex	1	2,154	2,154
Raleigh Medical Park	2	2,500	1,250
WakeMed Cary (Total)	7	8,069	1,153
WakeMed Cary	5	6,305	1,261
Apex Healthplex	2	1,764	882
County Total/Average	44	58,905	1,339

Duke argues in its application on page 25 that other existing providers cannot meet the projected need: *"As this project proposes the renovation of existing outpatient hospital clinic space and the installation of mammography and ultrasound equipment at Macon Pond to support the coordinated multidisciplinary care of cancer patients at this location, other providers would not be able to meet this need."* However, Duke recently took the opposite position with regard to Rex's request to the State Health Coordinating Council for a special need determination for cardiac catheterization equipment generated by Rex's growing demand for those services despite other providers' capacity. In its comment on Rex's petition, Duke states: *"Rex's proposal to adjust the need for cardiac catheterization equipment in Wake County would unnecessarily*

duplicate existing services that are already available to physicians and patients in the service area....Moreover, there is ample capacity in the service area to meet patient needs. All of the hospitals in Wake County with cath lab capacity have open medical staffs, and physicians who find any scheduling difficulties at Rex Hospital are free to seek privileges and schedule procedures at other facilities." Cardiac catheterization procedures certainly require more specialized facilities and experienced teams to perform those procedures than more routine mammography and ultrasound procedures. Despite the documented capacity of both diagnostic tools among hospital-based providers in Wake County alone (not including the non-hospital-based providers of these diagnostic services), Duke proposes to acquire additional equipment that it projects will be underutilized.

In addition to at least one unit of fixed ultrasound equipment Duke proposes to acquire, it also proposes to acquire two used mobile ultrasound units for needle biopsy procedures to be performed by the breast surgeons in exam rooms. On page 28 of the application, Duke projects a total of 1,265 surgical clinic procedures using these ultrasound units. The application does not, however, provide a definition of capacity for these units and fails to demonstrate that it needs two units of ultrasound equipment to perform these procedures.

Although there are no regulatory criteria applicable to this review, the Agency often uses standards defined in the regulatory review criteria to assist in evaluating need for a proposed project under Criterion 3. For example, in its 2008 review of Rex's application to replace and relocate an existing linear accelerator, the Agency specifically cited the regulatory performance standards for linear accelerators in determining that Rex did not conform with Criterion 3, although those performance standards did not apply to the application. Page 13 of those findings (see excerpts in Attachment 1) states: *"Based upon the adjusted ESTV projections Rex demonstrates a need for only three linear accelerators. Further, none of the four sites would be performing at the minimum performance standard of 6,750 ESTVs per linear accelerator."* Of note, the Rex application proposed the replacement and relocation of existing equipment with no additional equipment added to the inventory, whereas the Duke application in this review proposes the acquisition of new equipment for which it projects utilization far below defined capacity. Mammography and ultrasound equipment, when subject to regulatory criteria, are subject to the diagnostic center standards. Those standards require utilization at 80 percent of capacity. Clearly, the proposed project falls short of those standards as a measure of need for the proposed equipment.

For these reasons, the application should be found non-conforming with Criteria 3, 4 and 6.

CONVERSION FROM OFFICE-BASED TO HOSPITAL-BASED

As part of the proposed project, Duke proposes to acquire two used mobile ultrasound units for use with needle biopsy procedures. The application states:

- *"The two additional ultrasound machines for image-guided biopsies are currently owned and operated by the Private Diagnostic Center [sic], the Duke Medicine private faculty practice plan, for use at Tolnitch Surgical Associates, the practice of Dr. Lisa Tolnitch and Dr. Gayle DiLalla."* [page 9]

- *"Pursuant to the project outlined in this application, Duke intends to move the clinic site of the physicians currently practicing at Tolnitch Surgical Associates to Macon Pond, where they will practice in a hospital-based setting in connection with medical oncologist and radiation oncologists, thus providing the ability to coordinate all aspects of a patient's oncology care in one location."* [page 14]

- *"This acquisition [two additional ultrasound machines currently owned and operated at Tolnitch Surgical Associates] does not add to the inventory of such equipment in the service area, but merely reflects a change in ownership resulting from the change in these physicians' practice location."* [page 16]

- In response to Section III.7, regarding the relocation of medical equipment to a new site and the impact of the relocation on the patients served, the application indicates the question is not applicable. [page 26]

The shift of the medical equipment and the related physician practices from office-based to hospital-based represents a significant change that Duke fails to address in its application. First, Duke argues on page 16 that the acquisition of these two items of equipment will not change the inventory in the service area. In fact, it does increase the inventory of hospital-based ultrasound units within the service area. As noted previously, the three hospital providers in Wake County operate a total of 44 hospital-based ultrasound units and perform an average of 1,339 procedures per year on each unit.

Second, the relocation and conversion of this equipment to hospital-based from office-based will have an impact on patients with regard to their out-of-pocket costs for the services involved, in contrast to Duke's "not applicable" response to this question on page 26 of the application. As Wake Forest Baptist Health explains on its website (see Attachment 2): *"Providing services in a hospital-based outpatient clinic costs more and depending on your insurance plan, may result in greater out-of-pocket expenses for you; particularly if you are covered by Medicare or a Medicare Advantage Plan, have insurance with companies with which WFBH does not have a contract (non-contracted private payers), or if you don't have insurance."*

As noted by the Wake Forest Baptist Health explanation, this proposed change will also have an impact on those who do not have insurance or are medically underserved. Throughout Section VI of the Duke application, references are made only to radiation therapy or linear accelerator services in response to questions regarding the availability of services to the medically underserved—services that are not included in the proposed project. The application fails to address the impact of this conversion to hospital-based ultrasound, particularly on those that are medically underserved.

For these reasons, the application should be found non-conforming with Criteria 3a, 4, and 13.

INSUFFICIENT DOCUMENTATION OF FINANCIAL FEASIBILITY

The application fails to demonstrate the financial feasibility of the proposed project, based on a number of factors, including the failure to demonstrate the reasonableness of the proposed costs and charges.

First, page 57 of the application indicates that the proposed project will require 6.51 incremental FTEs to support the new services. However, the assumptions for the financials, including Form C, on page 73 of the application indicate that FTEs range from only 4.26 in the first full year to 5.26 in the fifth full year. Thus, the financials fail to include all the costs associated with the incremental FTEs identified as needed in Section VII.1.(b).

Second, the assumptions for Form C on page 73 of the application indicate costs are included for equipment maintenance for the two new items of equipment—one mammography unit and one fixed ultrasound unit—but there is no indication of equipment maintenance expenses for the two used

mobile ultrasound units. Frequently applicants for replacement equipment reference the increased expense associated with maintenance of older items of equipment as a reason to replace equipment. Thus, it would be reasonable that the older, used items of equipment would require maintenance, yet no expense appears to be included in Form C.

Third, the proposed project shows an escalating loss resulting from the implementation of the proposed project. As noted on page 84, Form C, the service components generated a small income in FY 2015 and similar results are expected in FY 2016. However, with the implementation of the proposed project in FY 2017, the project is projected to incur a net loss of $318,417 in year one, with greater losses in the subsequent years, up to $1,118,813 in year five (FY 2021). Moreover, the project is projected to incur a loss on direct expenses alone, $451,157 in year five (FY 2021). Of note, those losses would be even more significant without "Other Revenue" that totals $1,780,158 in year five, and for which there is no information provided in the application to document the reasonableness of that assumption.

Moreover, there is no information in the application to indicate the impact of a loss of over $1 million per year on Duke Raleigh Hospital. The application includes a Form B for the entire Duke University Health System, which shows an operating income in FY 2019 of approximately $168 million. However, that operating income is also dependent on non-patient revenue, without which the Health System would experience an operating loss. There is no information provided in the application to document the source of non-patient revenue or the reasonableness that it will continue to sustain the operating income of the system.

For these reasons, the application should be found non-conforming with Criteria 5 and 7.

ATTACHMENT 1

ATTACHMENT - REQUIRED STATE AGENCY FINDINGS

FINDINGS
C = Conforming
CA = Conditional
NC = Nonconforming
NA = Not Applicable

DATE: April 29, 2009

PROJECT ANALYST: F. Gene DePorter
ASSISTANCE CHIEF: Craig R. Smith

PROJECT I.D. NUMBER: J-8265-08/Rex Hospital, Inc. d/b/a Rex Cancer Center of Panther Creek/Replace and relocate an existing linear accelerator from the Rex Hospital campus and provide medical and radiation oncology at a cancer center in Panther Creek in Cary/Wake County.

REVIEW CRITERIA FOR NEW INSTITUTIONAL HEALTH SERVICES

G.S. 131E-183(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) The proposed project shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any health service, health service facility, health service facility beds, dialysis stations, operating rooms, or home health offices that may be approved.

NC

Rex Healthcare, Inc. d/b/a Rex Hospital proposes to develop a hospital- based outpatient cancer center at Panther Creek with the replacement of an existing Seimens Primus-6 linear accelerator and the relocation of the replacement linear accelerator (a Varian Clinac iX) to the Rex Cancer Center at Panther Creek in Cary. Rex Hospital (Lessee/land owner) will lease 16,449 square feet of space from Craig Davis Properties (Lessor/building owner) at the intersection of McCrimmon Parkway and Highway 55 in Cary, NC (Reference application Exhibit 1-Lease Agreement). The applicant does not propose to increase the number of licensed beds in any category, increase the number of operating rooms, add new services, or acquire equipment for which there is a need determination in the *2008 State Medical Facilities Plan (SMFP).* There

The adjusted projections of ESTVs for all Rex Hospital Cancer Center network sites were then distributed according to the following Rex Hospital approach used in Table 10. By FY 2011 Panther Creek will assume 20% of all radiation therapy treatments in the Rex system with 25% at Wakefield and 55% at the Rex Campus. For FY 2012 and 2013 this distribution of procedures will balance out to 25% for Panther Creek, 25% for Wakefield and 50% at the Rex Hospital Campus, as shown in the following table.

Table 12
Rex Healthcare Cancer Center Network
FY 2008-FY 2013 Distribution of ESTVs and Radiation Patients
Across Rex Hospital Radiation Therapy Sites

Fiscal Year	Rex Hospital Cancer Center		Wakefield Cancer Center		Panther Creek Cancer Center		Total	
	ESTVs	Pts.	ESTVs	Pts.	ESTVs	Pts.	ESTVs	Pts.
2008	16,907	797	0	0	0	0	16,907	797
2009	16,776	791	1,118	53	0	0	17,894	844
2010	14,205	670	4,735	223	0	0	18,939	893
2011	11,025	520	5,011	236	4,009	189	20,045	945
2012	10,608	500	5,304	250	5,304	250	21,216	1,000
2013	11,228	529	5,614	265	5,614	265	22,455	1,058

Future utilization of the Rex linear accelerators by site is illustrated in the following table.

Table 13
Rex Healthcare Cancer Center Network
FY 2011-FY 2013 Linear Accelerator Utilization*
Across Rex Hospital Radiation Therapy Sites
(Based Upon Adjusted ESTV Projections)

Fiscal Year	Rex Hospital Cancer Center 2 Linear Accelerators		Wakefield Cancer Center 1 Linear Accelerator		Panther Creek Cancer Center 1 Linear Accelerator		Total 4 Linear Accelerators	
	ESTVs	Units	ESTVs	Units*	ESTVs	Units*	ESTVs	Units*
2011	11,025	1.6	5,011	0.74	4,009	0.59	20,045	3.0
2012	10,608	1.6	5,304	0.80	5,304	0.79	21,216	3.1
2013	11,228	1.7	5,614	0.83	5,614	0.83	22,455	3.3

*Utilization is based upon 6,750 ESTVs per unit. Units, as used in this table refer to the number of Linear Accelerator units needed to serve the projected patient volume.

Based upon the adjusted ESTV projections Rex demonstrates a need for only three linear accelerators. Further, none of the four sites would be performing at the minimum performance standard of 6,750 ESTVs per linear accelerator.

ATTACHMENT 2

Wake Forest®
Baptist Health

Hospital-Based Outpatient Clinics

Wake Forest Baptist Medical Center has converted many of its physician clinics to hospital-based outpatient clinics. If you are covered by Medicare or a Medicare Advantage plan, or if you do not have insurance, your out-of-pocket costs for seeing a physician and receiving services in a hospital-based outpatient clinic will be more, compared to the out-of-pocket cost for the same services in a private physician office.

Laboratory and radiology services are provided by the hospital and are billed by the hospital regardless of the type of insurance.

Below are frequently asked questions (FAQs) related to hospital-based outpatient clinics:

Q: What does "Hospital-based Outpatient" mean?

A: Hospital-based outpatient clinics are considered part of the hospital; "private" physician offices are not (generally, these are smaller physician offices out in the community). Clinics located miles away from the main hospital campus may still be considered part of the hospital. Hospital-based outpatient clinics are subject to stricter government rules, making them more complex and more costly to operate. When you see a physician or receive services in a hospital-based outpatient clinic, you are being treated within the hospital rather than the physician's office.

Q: What is different about a hospital-based outpatient clinic?

A: According to Medicare billing rules, when you see a physician in a private office setting, all services and expenses are bundled in a single charge. When you see a physician in a hospital-based outpatient clinic, physician and hospital charges are billed separately. For patients with insurance, physician services are processed under physician benefits which are generally subject to patient liabilities in the form of copayments while hospital services are processed under hospital benefits subject to deductibles and coinsurance amounts. Providing services in a hospital-based outpatient clinic costs more and depending on your insurance plan, may result in greater out-of-pocket expenses for you; particularly if you are covered by Medicare or a Medicare Advantage Plan, have insurance with companies with which WFBH does not have a contract (non-contracted private payers), or if you don't have insurance.

Q: What should I ask my insurance carrier?

A: Making informed healthcare purchasing decisions is important. Ask your insurance company if your benefit plan covers facility charges in a hospital-based outpatient clinic and how much of the charge is covered or will be applied to your deductible or subject to coinsurance.

Q: Does this apply to patients with private insurance like Blue Cross Blue Shield, United Healthcare, MedCost, Cigna or Aetna?

A: Many private insurance companies do not require that we follow the same billing rules required by Medicare and Medicaid. For patients with private insurance, the facility component of the physician office visit will be billed as part of the physician bill and will be processed by the insurance company under the patient's physician benefits. Insurance benefits vary significantly by insurance company, but in general, physician services are processed under the benefit plan's physician benefits and are subject to co-payment amounts from the patient. Laboratory and radiology services are provided by the hospital and are billed by the hospital regardless of the type of insurance. Hospital services are generally processed under the benefit plan's hospital benefits and are subject to deductibles and coinsurance amounts.

Q: How does this affect a patient who has Medicare, Medicare Advantage or Medicaid?

A: In a hospital-based outpatient clinic, Medicare and Medicaid patients will receive two (2) separate bills for services provided in the clinic – one from the doctor and one from the hospital. Adult Medicaid patients will be required to pay two copayments for the clinic visit – one copayment for the physician visit and one copayment for the hospital visit. For patients covered by Medicare or Medicare Advantage plans, non-physician charges billed by the hospital will be subject

to coinsurance.

Q: What if a Medicare patient has secondary insurance coverage?

A: Coinsurance and deductibles may be covered by a secondary insurance. Check your benefits or with your insurance company for details.

Q: Where can a patient call with financial questions or concerns?

A: Wake Forest Baptist Medical Center has staff available through Patient Financial Services to assist with questions. If you have an upcoming appointment, please contact 336-716-1663 or visit us on campus on the Main Floor, Reynolds Tower.

Q: Why does the Medicare Secondary Payer (MSP) questionnaire need to be completed?

A: As a participating Medicare provider, we are required to screen Medicare patients according to the MSP rules. At each visit, you will be asked the MSP questions. These questions help us confirm if Medicare or another payer should process your insurance claim as primary.

Q: What can patients do if they are having difficulty paying for healthcare services?

A: They can contact a Patient Financial Services representative at 336-716-1663 to discuss available options.

Last Updated: 06-25-2015