Fiscal Impact Analysis for
Permanent Rule Readoption without Substantial Economic Impact

Agency Proposing Rule Change

Department of Health and Human Services, Division of Health Service Regulation

Contact Persons

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Impact Summary

Federal Government Impact	No
Local Government Impact	Minimal
Private Sector Impact	Minimal
State Government Impact	Minimal
Substantial Economic Impact	No

Statutory Authority

G.S. 131E-177
G.S. 131E-183(b)

Rule Citations

10A NCAC 14C – Certificate of Need

- .1401 Definitions
- .1403 Performance Standards
- .2703 Performance Standards

See proposed rule text in Appendix A.

BACKGROUND AND PURPOSE

Article 9 of Chapter 131E of the North Carolina General Statutes (CON Law) requires that a person obtain a certificate of need (CON) from the Department of Health and Human Services (Department) before developing or offering a "new institutional health service." The term "new institutional health service" is defined in G.S. 131E-176(16). The new institutional health services relevant to this fiscal impact analysis include:

- Neonatal Services
- Magnetic Resonance Imaging (MRI) scanners

The Department delegated the authority to enforce the CON Law to the Healthcare Planning and Certificate of Need Section (Section) to the Division of Health Service Regulation (Division).

In order to obtain a CON, a person must submit a completed application form and be approved by the Section to develop the proposed project. The average time that it takes an analyst to analyze each CON application varies by complexity. Non-complex applications average approximately 40 hours to analyze while complex/competitive applications can take between 48-64 hours to review. The CON cannot be issued until all appeals are resolved.

The Section is required to review all CON applications using the review criteria found in G.S. 131E-183(a). In addition, pursuant to G.S. 131E-183(b), the Division is authorized to adopt rules for the review of proposals which may vary based on the type of health service.

The CON Law authorizes the Department to develop the State Medical Facilities Plan (SMFP), which is prepared annually by the Department and the North Carolina State Health Coordinating Council (SHCC), a 25-member advisory body appointed by the Governor. The SMFP is approved by the Governor each year. Pursuant to G.S. 150B-2(8a)k, the SMFP is **not** a rule. Session Law 2003-229 amended the Administrative Procedure Act to state that the State Medical Facilities Plan is exempt from the Act and its procedural and analytical requirements for rulemaking.

In 2018, the Division reviewed 63 CON rules to determine if each rule was:

- Unnecessary;
- Necessary with substantive public interest; or
- Necessary without substantive public interest.

Twenty-one rules were determined to be unnecessary, and they expired February 1, 2019 pursuant to G.S. 150B-21.3A. Three rules were determined to be necessary without substantive public interest effective January 19, 2019. In 2018, 39 rules were determined to be necessary with substantive public interest. These rules must be readopted by 2024 and they will be readopted in four groups. The first group (Group 1) consisting of 10 rules was readopted, effective January 1, 2021. The second group (Group 2) consisting of 8 rules was readopted, effective January 1, 2022. The third group (Group 3) consisting of 9 rules that was readopted, effective January 1, 2022. This final group (Group 4) consists of 3 rules: 2 that require readoption and 1, additional, temporary rule that the Agency proposes be made permanent.

SECTION .1400 – CRITERIA AND STANDARDS FOR LEVEL IV NEONATAL INTENSIVE CARE SERVICES

10A NCAC 14C .1401 Definitions - The Division proposes to delete the 13 existing terms and replace them with six terms. The proposed text sets forth a standard calculation by which applicants can consistently project their neonatal intensive care unit (NICU) occupancy rates.

10A NCAC 14C .1403 Performance Standards - The Division proposes to delete paragraphs (a) and (b). The proposed text of the new paragraph (a) deletes the historical utilization requirements and describes what an applicant must include in its certificate of need application if proposing to develop a new neonatal intensive care service. The proposed text of the new paragraph (b) describes what an applicant must include in its certificate of need application if proposing to increase NICU beds. The proposed text reduces projected utilization from 75 percent to 65 percent at the conclusion of the third full fiscal year of operations and removes reference to a need determination for NICU beds in the SMFP.

Background

A CON is required before any person may: (1) develop a new neonatal intensive care service; or (2) increase the number of neonatal intensive care unit beds on a hospital's license. The SMFP includes a need methodology for acute care beds, of which NICU beds are a sub-category or sub-set.

The proposed language adds and defines the term "occupancy rate" to ensure a consistent calculation of the occupancy rate, which is utilized to project need for the service; reduces the projected utilization threshold requirement by 10%;, and eliminates the historical utilization requirement as the SMFP includes a need methodology for acute care beds.

Summary of Expected Costs and Benefits

Federal Government Impact	No impact as the Federal Government is not subject to the NC CON Law.
Local Government Impact	The workload for the local government sector may be minimally impacted as a result of the proposed streamlines to the application process, elimination of the historical utilization requirements, and the reduction in projected utilization requirements.
Private Sector Impact	The workload for the private sector may be minimally impacted as a result of the proposed streamlines to the application process, elimination of the historical utilization requirements, and the reduction in projected utilization requirements.
State Government Impact	The workload for State Government may be minimally impacted if the proposed text results in an increase in CON applications.

Federal Government Impact

Health service facilities owned by the Federal Government and located in North Carolina are not subject to the North Carolina CON Law. Thus, they are not required to file a CON application and are not impacted by the proposed text.

Local Government and Private Sector Impact

Most CON applications are submitted by the private sector but there are health service facilities in North Carolina owned by a local government entity, such as a county or hospital authority. However, the expected impact on both sectors is expected to be identical.

The proposed text of 10A NCAC 14C .1401 and .1403 may have a minimal beneficial impact on the workload of local government or private sector applicants proposing to develop a new neonatal intensive care service or NICU beds. The proposed text streamlines the application process, provides a clear calculation for the occupancy rate, and reduces the required projected utilization threshold.

State Government Impact

The issue is whether the proposed text of 10A NCAC 14C .1401 and .1403 would significantly change the number of applications received by the Section in a given year which propose to develop a new neonatal intensive care service or increase the number of neonatal intensive care beds on the hospital's license. The Agency concludes that the workload to State Government will be minimally impacted, if at all.

A CON is required to establish a new neonatal intensive care service or to develop new acute care beds. Certificate of need applications for acute care beds are highly competitive and often result in litigation. Neonatal intensive care beds are a sub-category of acute care bed. However, as shown in Tables 1 and 2, the Section received no CON applications to develop neonatal intensive care services or to develop new neonatal intensive care beds during the last five years. The last time that the Agency received an application to develop this service was in 2009. Conversely, hospitals opted to submit CON applications solely for acute care beds.

Table 1: Neonatal Intensive Care Service CON Applications*

Calendar Year	Number of CON Applications Received
2018	0
2019	0
2020	0
2021	0
2022	0

*The SMFP does not project need for Neonatal Intensive Care Services in the State. As such, there are no SMFP need determinations to report.

Table 2: Acute Care Bed CON Applications in Which Neonatal Intensive Care Unit Beds Were Either Developed or Increased

Calendar Year	Number of Acute Care Bed Need Determinations in the SMFP	Number of CON Applications Received to Develop Acute Care Beds	Number of CON Applications Received to Develop Neonatal Intensive Care Beds (as part of an Acute Care Bed Application)
2018	72	3	0
2019	143	7	0
2020	319	8	0
2021	283	7	0
2022	274	10	0

In North Carolina, 21 counties are maternal care deserts.[1] Reduced access to prenatal care correlates to infant morbidity and mortality and increases NICU admission rates.[2] Although speculative, the expense of operating a Level IV neonatal intensive care service (e.g. reserving acute care bed capacity within the NICU that could be used for adult inpatients, recruiting and retaining specially trained staff to provide care to babies that are born pre-term and/or have medically complex health conditions) may be a contributing factor to the lack of CON applications filed to establish or expand these services in the last five years.

The 10-percentage point reduction in projected utilization requirements is an effort to make the utilization threshold more attainable to an applicant that determines that the development of this service is needed in the community and is a financially feasible undertaking. The elimination of the historical utilization comports with revisions to the recently readopted CON rules requirements for other services and facilities and may increase, albeit not significantly, the number

[1] Maternity care deserts are defined as any county in the United States without a hospital or birth center offering obstetric care. https://www.marchofdimes.org/peristats/data?reg=99&top=23&stop=641&slev=4&obj=9&sreg=37, <last accessed on 4/14/23.>
[2] Id.

of neonatal services applications received by the Agency.[3] Any estimate would be an unsupported guess as to how many and when they might be submitted.

[3] In February 2023, the Agency received one application to develop 24 NICU beds.

SECTION .2700 – CRITERIA AND STANDARDS FOR MAGNETIC RESONANCE IMAGING SCANNER

10A NCAC 14C .2703 Performance Standards - The Division proposes to amend the performance standards in the rule to comport with the SMFP.

Background

A CON is required before any person may acquire an MRI scanner regardless of the capital cost involved. The SMFP includes a need methodology for **fixed** MRI scanners. There is no need methodology for **mobile** MRI scanners in the SMFP but the SMFP does state that a petition for an adjusted need determination for a mobile MRI scanner must be submitted and approved before an applicant may be approved to obtain a new mobile MRI scanner.

In 2022, the Agency readopted this rule with substantive changes. Later, in 2022, the State Health Coordinating Council approved recommendations from a workgroup comprised of stakeholders, hospital administrators, and technology experts to revise the MRI need methodology, in part, by adjusting the scan procedure times by complexity and the annual operational capacity of MRI scanners to reflect those procedure times. Those recommendations coupled with modifications to the utilization thresholds resulted in minor revisions to the readopted rule so that it would comport with the SMFP.

Summary of Expected Costs and Benefits

Federal Government Impact	No impact as the Federal Government is not subject to the NC CON Law.
Local Government Impact	The workload for the local government sector may be minimally impacted as a result of the proposed text.
Private Sector Impact	The workload for the private sector may be minimally impacted as a result of the proposed text.
State Government Impact	The workload for State Government may be minimally impacted as a result of the proposed text.

Federal Government Impact
Health service facilities owned by the Federal Government and located in North Carolina are not subject to the North Carolina CON Law. Thus, they are not required to file a CON application and are not impacted by the proposed text.

Local Government and Private Sector Impact
Most CON applications are submitted by the private sector but there are health service facilities in North Carolina owned by a local government entity, such as a county or hospital authority. However, the expected impact on both sectors is expected to be identical.

The proposed text of 10A NCAC 14C .2703 may temporarily and minimally impact the workload of local government or private sector applicants proposing to acquire an MRI scanner as described in the State Government Impact section below.

State Government Impact

The issue is whether the proposed text of 10A NCAC 14C .2703 would significantly change the number of applications received by the CON Section in a given year which proposes to acquire an MRI scanner pursuant to a need determination in the SMFP. The Agency projects that there may be a minimal, yet temporary, increase in the receipt of CON applications as a result of this change in calendar years 2023 and 2024. The Agency further projects that there will be a subsequent decrease in the number of CON applications received beginning in calendar year 2025.

As shown in Table 3, during the last five years, the average number of need determinations for fixed MRI scanners is three per year. During the same time frame, the average number of applications received is seven per year.

Table 3: Fixed MRI Scanner CON Applications *

Calendar Year	Number of Need Determinations in the SMFP	Number of MRI Scanner Applications Received
2018	1	1
2019	3	10
2020	3	3
2021	5	13
2022	3	2
Average	**3**	**7**

* There were no need determinations for a mobile MRI scanner during the last five years.

Revisions to the operating room and acute care bed need methodologies in prior SMFPs resulted in temporary increases in need determinations in the first one to two years following those revisions. It is reasonable to assume that the number of MRI scanner applications received may do the same in the first and second years following the revision to the MRI need methodology but will then level out.[4] Additionally, recently enacted legislative changes to the CON law will exempt the acquisition and development of MRI scanners from CON requirements in counties with a population greater than 125,000 and will further reduce the number of MRI applications that the Agency receives.[5] The amount of this reduction is difficult to forecast as the State Health Coordinating Council will need to review and further revise the MRI need methodology.

SUMMARY

The intent of these rule changes is to enhance clarity and ensure uniformity across the CON definitions and performance standards and to comport with revisions to the SMFP. These changes are expected to have a minimal impact on the number of CON applications received by the state because it is more likely that an increase in applications will be driven by the SMFP need determinations (when applicable) and an applicant's resources.

[4] In this instance, the revisions to the SMFP MRI need methodology resulted in the generation of nine need determinations throughout the state in the 2023 SMFP.

[5]This legislation becomes effective three years from the date the Department of Health and Human Services (DHHS) issues the first directed payment in accordance with the Healthcare Access and Stabilization Program (HASP) under G.S. 108A-148.1, as enacted by Section 1.4 of the act, and applies to activities occurring on or after that date. https://www.ncleg.gov/Sessions/2023/Bills/House/PDF/H76v5.pdf

10A NCAC 14C .1401 is proposed for readoption with substantive changes as follows:

SECTION .1400 – CRITERIA AND STANDARDS FOR LEVEL IV NEONATAL INTENSIVE CARE SERVICES

10A NCAC 14C .1401 DEFINITIONS

~~The definitions in this Rule shall apply to all rules in this Section:~~

~~(1) "Approved neonatal service" means a neonatal service that was not operational prior to the beginning of the review period.~~

~~(2) "Existing neonatal service" means a neonatal service in operation prior to the beginning of the review period.~~

~~(3) "High-risk obstetric patients" means those patients requiring specialized services provided by an acute care hospital to the mother and fetus during pregnancy, labor, delivery and to the mother after delivery. The services are characterized by specialized facilities and staff for the intensive care and management of high-risk maternal and fetal patients before, during, and after delivery.~~

~~(4) "Level I neonatal services" means services provided by an acute care hospital to full-term and pre-term neonates that are stable, without complications, and may include neonates that are small for gestational age or large for gestational age.~~

~~(5) "Level II neonatal service" means services provided by an acute care hospital in a licensed acute care bed to neonates and infants that are stable without complications but require special care and frequent feedings; infants of any weight who no longer require Level III or Level IV neonatal services, but still require more nursing hours than normal infants; and infants who require close observation in a licensed acute care bed.~~

~~(6) "Level III neonatal service" means services provided by an acute care hospital in a licensed acute care bed to neonates or infants that are high risk, small (approximately 32 and less than 36 completed weeks of gestational age) but otherwise healthy, or sick with a moderate degree of illness that are admitted from within the hospital or transferred from another facility requiring intermediate care services for sick infants, but not intensive care. Level III neonates or infants require less constant nursing care than Level IV services, but care does not exclude respiratory support.~~

~~(7) "Level IV neonatal service" means neonatal intensive care services provided by an acute care hospital in a licensed acute care bed to high-risk medically unstable or critically ill neonates (approximately under 32 weeks of gestational age) or infants requiring constant nursing care or supervision not limited to continuous cardiopulmonary or respiratory support, complicated surgical procedures, or other intensive supportive interventions.~~

~~(8) "Neonatal bed" means a licensed acute care bed used to provide Level II, III or IV neonatal services.~~

~~(9) "Neonatal intensive care services" shall have the same meaning as defined in G.S. 131E-176(15b).~~

~~(10) "Neonatal service area" means a geographic area defined by the applicant from which the patients to be admitted to the service will originate.~~

~~(11) "Neonatal services" means any of the Level I, Level II, Level III or Level IV services defined in this Rule.~~

~~(12) "Obstetric services" means any normal or high-risk services provided by an acute care hospital to the mother and fetus during pregnancy, labor, delivery and to the mother after delivery.~~

~~(13) "Perinatal services" means services provided during the period shortly before and after birth.~~

The following definitions shall apply to all rules in this Section:

(1) "Approved neonatal intensive care unit (NICU) beds" means acute care beds in a hospital that were issued a certificate of need to provide Level IV neonatal intensive care services but are not providing those services as of the application deadline for the review period.

(2) "Average daily census (ADC)" means the total number of NICU days of care provided during a full fiscal year of operation divided by 365 days.

(3) "Existing NICU beds" means acute care beds in a hospital that are providing Level IV neonatal intensive care services as of the application deadline for the review period.

(4) "Level IV neonatal intensive care services" means services provided to high-risk medically unstable or critically ill neonates less than 32 weeks of gestational age, or infants requiring constant nursing care or supervision in NICU beds.

(5) "Occupancy rate" means the ADC divided by the total number of existing, approved, and proposed NICU beds expressed as a percentage.

(6) "Proposed NICU beds" means the acute care beds proposed to be developed a hospital in the application under review.

History Note: *Authority G.S. 131E-177(1); ~~131E-183;~~ 131E-183(b);*
Temporary Adoption Eff. September 1, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. January 4, 1994;
Amended Eff. November 1, 1996;
Temporary Amendment Eff. March 15, 2002;
Amended Eff. April 1, ~~2003.~~ 2003;
Readopted Eff. January 1, 2024.

10A NCAC 14C .1403 is proposed for readoption with substantive changes as follows:

10A NCAC 14C .1403 PERFORMANCE STANDARDS

~~(a) An applicant shall demonstrate that the proposed project is capable of meeting the following standards:~~

~~(1) if an applicant is proposing to increase the total number of neonatal beds (i.e., the sum of Level II, Level III and Level IV beds), the overall average annual occupancy of the combined number of existing Level II, Level III and Level IV beds in the facility is at least 75 percent, over the 12 months immediately preceding the submittal of the proposal;~~

~~(2) if an applicant is proposing to increase the total number of neonatal beds (i.e., the sum of Level II, Level III and Level IV beds), the projected overall average annual occupancy of the combined number of Level II, Level III and Level IV beds proposed to be operated during the third year of operation of the proposed project shall be at least 75 percent; and~~

~~(3) The applicant shall document the assumptions and provide data supporting the methodology used for each projection in this rule.~~

~~(b) If an applicant proposes to develop a new Level III or Level IV service, the applicant shall document that an unmet need exists in the applicant's defined neonatal service area, unless the State Medical Facilities Plan includes a need determination for neonatal beds in the service area. The need for Level III and Level IV beds shall be computed for the applicant's neonatal service area by:~~

~~(1) identifying the annual number of live births occurring at all hospitals within the proposed neonatal service area, using the latest available data compiled by the State Center for Health Statistics;~~

~~(2) identifying the low birth weight rate (percent of live births below 2,500 grams) for the births identified in (1) of this Paragraph, using the latest available data compiled by the State Center for Health Statistics;~~

~~(3) dividing the low birth weight rate identified in (2) of this Paragraph by .08 and subsequently multiplying the resulting quotient by four; and~~

~~(4) determining the need for Level III and Level IV beds in the proposed neonatal service area as the product of:~~

~~(A) the product derived in (3) of this Paragraph, and~~

~~(B) the quotient resulting from the division of the number of live births in the initial year of the determination identified in (1) of this Paragraph by the number 1000.~~

(a) An applicant proposing to develop a new neonatal intensive care service without increasing the total number of acute care beds on the hospital license shall:

(1) provide projected utilization of the proposed NICU beds during each of the first three full fiscal years of operation following completion of the project;

(2) document that the occupancy rate for the proposed NICU beds shall be at least 65 percent during the third full fiscal year of operation following completion of the project; and

(3) provide the assumptions and methodology used for the projected utilization and occupancy rate required by Subparagraphs (1) and (2) of this Paragraph.

(b) An applicant proposing to develop a new neonatal intensive care service or increase the number of NICU beds on the hospital license shall:

(1) provide projected utilization of all existing, approved, and proposed NICU beds on the hospital license during each of the first three full fiscal years of operation following completion of the project;

(2) document that the occupancy rate for all existing, approved, and proposed NICU beds on the hospital license shall be at least 65 percent during the third full fiscal year of operation following completion of the project; and

(3) provide the assumptions and methodology used for the projected utilization and occupancy rate required by Subparagraphs (1) and (2) of this Paragraph.

History Note: *Authority G.S. 131E-177(1); 131E-183(b);*
Temporary Adoption Eff. September 1, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. January 4, 1994;
Temporary Amendment Eff. March 15, 2002;
Amended Eff. April 1, 2003;
Temporary Amendment Eff. February 1, 2009;
Amended Eff. November 1, 2009;
Temporary Amendment Eff. February 1, 2010;
Amended Eff. November 1, ~~2010.~~ 2010;
Temporary Amendment Eff. January 27, ~~2023.~~ 2023;
Readopted Eff. January 1, 2024.

10A NCAC 14C .2703 is proposed for amendment as follows:

10A NCAC 14C .2703 PERFORMANCE STANDARDS

(a) An applicant proposing to acquire a fixed MRI scanner pursuant to a need determination in the annual State Medical Facilities Plan in effect as of the first day of the review period shall:

(1) identify the existing fixed MRI scanners owned or operated by the applicant or a related entity and located in the proposed fixed MRI scanner service area;

(2) identify the approved fixed MRI scanners owned or operated by the applicant or a related entity and located in the proposed fixed MRI scanner service area;

(3) identify the existing mobile MRI scanners owned or operated by the applicant or a related entity that provided mobile MRI services at host sites located in the proposed fixed MRI scanner service area during the 12 months before the application deadline for the review period;

(4) identify the approved mobile MRI scanners owned or operated by the applicant or a related entity that will provide mobile MRI services at host sites located in the proposed fixed MRI scanner service area;

(5) provide projected utilization of the MRI scanners identified in Subparagraphs (1) through (4) of this Paragraph and the proposed fixed MRI scanner during each of the first three full fiscal years of operation following completion of the project;

(6) provide the assumptions and methodology used to project the utilization required by Subparagraph (5) of this Paragraph;

(7) project that the fixed MRI scanners identified in Subparagraphs (1) and (2) of this Paragraph and the proposed fixed MRI scanner shall perform during the third full fiscal year of operation following completion of the project as follows:

~~(A) 3,364 or more adjusted MRI procedures per fixed MRI scanner if there are four or more fixed MRI scanners in the fixed MRI scanner service area;~~

~~(B) 3,123 or more adjusted MRI procedures per fixed MRI scanner if there are three fixed MRI scanners in the fixed MRI scanner service area;~~

~~(C)~~(A) ~~2,883~~ 3,494 or more adjusted MRI procedures per fixed MRI scanner if there are two or more fixed MRI scanners in the fixed MRI scanner service area;

~~(D)~~(B) ~~2,643~~ 3,058 or more adjusted MRI procedures per fixed MRI scanner if there is one fixed MRI scanner in the fixed MRI scanner service area; or

~~(E)~~(C) ~~1,201~~ 1,310 or more adjusted MRI procedures per MRI scanner if there are no existing fixed MRI scanners in the fixed MRI scanner service area; and

(8) project that the mobile MRI scanners identified in Subparagraphs (3) and (4) of this Paragraph shall perform ~~3,328~~ 3,120 or more adjusted MRI procedures per mobile MRI scanner during the third full fiscal year of operation following completion of the project.

(b) An applicant proposing to acquire a mobile MRI scanner pursuant to a need determination in the annual State Medical Facilities Plan in effect as of the first day of the review period shall:

(1) identify the existing mobile MRI scanners owned or operated by the applicant or a related entity that provided mobile MRI services at host sites located in the proposed mobile MRI scanner service area during the 12 months before the application deadline for the review period;

(2) identify the approved mobile MRI scanners owned or operated by the applicant or a related entity that will provide mobile MRI services at host sites located in the proposed mobile MRI scanner service area;

(3) identify the existing fixed MRI scanners owned or operated by the applicant or a related entity that are located in the proposed mobile MRI scanner service area;

(4) identify the approved fixed MRI scanners owned or operated by the applicant or a related entity that will be located in the proposed mobile MRI scanner service area;

(5) identify the existing and proposed host sites for each mobile MRI scanner identified in Subparagraphs (1) and (2) of this Paragraph and the proposed mobile MRI scanner;

(6) provide projected utilization of the MRI scanners identified in Subparagraphs (1) through (4) of this Paragraph and the proposed mobile MRI scanner during each of the first three full fiscal years of operation following completion of the project;

(7) provide the assumptions and methodology used to project the utilization required by Subparagraph (6) of this Paragraph;

(8) project that the mobile MRI scanners identified in Subparagraphs (1) and (2) of this Paragraph and the proposed mobile MRI scanner shall perform ~~3,328~~ 3,120 or more adjusted MRI procedures per MRI scanner during the third full fiscal year of operation following completion of the project; and

(9) project that the fixed MRI scanners identified in Subparagraphs (3) and (4) of this Paragraph shall perform during the third full fiscal year of operation following completion of the project as follows:

~~(A) 3,364 or more adjusted MRI procedures per fixed MRI scanner if there are four or more fixed MRI scanners in the fixed MRI scanner service area;~~

~~(B) 3,123 or more adjusted MRI procedures per fixed MRI scanner if there are three fixed MRI scanners in the fixed MRI scanner service area;~~

~~(C)~~(A) ~~2,883~~ 3,494 or more adjusted MRI procedures per fixed MRI scanner if there are two or more fixed MRI scanners in the fixed MRI scanner service area;

~~(D)~~(B) ~~2,643~~ 3,058 or more adjusted MRI procedures per fixed MRI scanner if there is one fixed MRI scanner in the fixed MRI scanner service area; or

~~(E)~~(C) ~~1,201~~ 1,310 or more adjusted MRI procedures per MRI scanner if there are no fixed MRI scanners in the fixed MRI scanner service area.

History Note: *Authority G.S. 131E-177(1); 131E-183(b);*
Temporary Adoption Eff. September 1, 1993 for a period of 180 days or until the permanent rule becomes effective, whichever is sooner;
Eff. February 1, 1994;
Temporary Amendment Eff. January 1, 1999;
Temporary Amendment Eff. January 1, 1999 Expired on October 12, 1999;
Temporary Amendment Eff. January 1, 2000;
Temporary Amendment effective January 1, 2000 amends and replaces a permanent rulemaking originally proposed to be effective August 2000;
Temporary Amendment Eff. January 1, 2001;
Temporary Amendment effective January 1, 2001 amends and replaces a permanent rulemaking originally proposed to be effective April 1, 2001;
Temporary Amendment Eff. January 1, 2002;
Temporary Amendment Eff. January 1, 2002 amends and replaces the permanent rule effective, August 1, 2002;
Temporary Amendment Eff. January 1, 2003;

Amended Eff. August 1, 2004; April 1, 2003;

Temporary Amendment Eff. January 1, 2005;

Amended Eff. November 1, 2005;

Temporary Amendment Eff. February 1, 2006;

Amended Eff. November 1, 2006;

Temporary Amendment Eff. February 1, 2008;

Amended Eff. November 1, 2008;

Readopted Eff. January 1, ~~2022.~~ 2022;

Temporary Amendment Eff. January 27, ~~2023.~~ 2023;

Amended Eff. January 1, 2024.