



September 6, 2012

Amber Cronk
North Carolina Industrial Commission
4336 Mail Service Center
Raleigh, NC 27699

Re: Comments on Proposed Amendments to 4 NCAC 10F – Addition of Electronic Billing Rules

PMSI appreciates the opportunity to provide our input into the continued efforts of the North Carolina Industrial Commission (NCIC) in working with impacted stakeholders during development of eBilling regulations. As way of background, PMSI is a provider of pharmacy and other ancillary medical services explicitly for the workers' compensation marketplace. PMSI currently provides services in all 50 states, and we have extensive knowledge of the many regulatory requirements impacting delivery of pharmacy and medical services provided to injured workers, including eBilling.

PMSI continues to support the development of eBilling rules and guidance in North Carolina and other states. Additionally, PMSI supports utilization of IAIABC eBilling standards and guidance as well as utilization of the ASC x12 – 835-5010 standards for medical care (professional and institutional providers) and the NCPDP D.0 standards for pharmacy care (retail and mail-order pharmacies).

PMSI would like to comment on key points within the proposed rule which we believe need additional examination and consideration prior to adoption to ensure a smooth implementation and ongoing administration of eBilling in North Carolina for workers' compensation. Our comments, concerns and requests for clarification are as follows:

1. We urge the NCIC to review the proposed rule and ensure usage of consistent compliance dates. We have found instances where dates for system participants to be compliant seem to conflict. Some state January 1, 2014; others state March 1, 2014.
2. We urge the NCIC to insert a definition of healthcare provider, provider agent, and/or third party biller or assignee in the proposed rules. There is a proposed definition for "payer" and "payer agent" in proposed 4 NCAC 10F .0102, but no such analogous terms defined for providers and other associated billing entities. Recent workers' compensation eBilling rule developments and implementations in other states include some form of these definitions. We would encourage the NCIC to look to definitions used by the California Division of Workers' Compensation in their eBilling regulations and companion guide as good examples for inclusion of these related terms. There are multiple entities involved in eBilling and bill processing that should be recognized and accounted for to ensure their continued participation and to add clarity to the overall process.



3. We urge the NCIC to specifically state and allow “mutually agreed upon alternative formats” between providers and payors which are different from the state-prescribed eBilling formats. All workers’ compensation eBilling efforts implemented to date specifically allow providers and payors to use alternative formats. There are many payors and providers who are already engaged in eBilling practices and are utilizing long-standing electronic billing formats and connectivity which differ from the proposed standards. Additionally, many providers, bill processors, clearing houses and PBMs have national contracts with insurance carriers and TPAs and are currently billing globally on alternative standards or iterations of the national standards. To not allow the usage of “alternative” standards would force these entities to change processes only for North Carolina as all other eBilling developments to date have included the usage of alternative standards. These proposed, and any final adopted, rules should not punish these “ahead of the curve” stakeholders.
4. We urge the NCIC not to mandate eBilling but rather, as with other states, make eBilling voluntary for providers but require payors to be capable of properly handling, processing and reimbursing any eBill sent from a provider. At a minimum, we urge the state to (if they wish to mandate eBilling) allow a transition time of at least two years or provide exemptions for providers and payors who handle very limited numbers of workers’ compensation claims/patients.
5. We urge the NCIC to clarify if they will be adopting an eBilling “companion guide” to provide additional clarification. There appears to be only one vague reference to “the” companion guide in proposed 4 NCAC 10F .0105(b)(4)(F). To date other state efforts to implement eBilling requirements have included the subsequent publication of an associated eBilling “companion guide” to provide more comprehensive instructions that may include certain technical or state-specific nuances that may differ from the nationally accepted standards.
6. We request the NCIC to clarify their intent to adopt specific standards related to attachments (such as medical reports or notes) for medical services. The language in proposed 4 NCAC 10F .0105(a)(1)(C) appears to be vague – only requiring payors and their agents to “support methods to receive electronic documentation required for the adjudication of a bill,” leaving it uncertain as to what is or is not required. Later proposed detail also only addresses documentation in the form of electronic mail. This leaves us with the following questions for clarification:
 - a. Is this the only permissible form of documentation submission, or are others, such as fax, permitted?
 - b. If other forms of documentation are permitted, what data is required to be present on those other modes of submission – as the proposed rules only address content for email?
7. We request the NCIC to clarify what date is to be used as the “received” date for an electronic bill. Proposed 4 NCAC 10F .0105(c)(9) states that proof of the received date is to be the transmission of an Implementation Acknowledgement and acceptance of a complete file, but proposed 10F .0106(b) states that the received date is the actual date all of the contents of a



complete eBill are successfully received by the claims payor – which, by the proposed rule’s own time frames, can be two different dates. PMSI believes clarification is warranted to explain if the received date is to be the day actually received or the day the receipt acknowledgement is sent to the bill submitter by the claims payor.

8. We request the NCIC to clarify payment and remittance notification time frames. We found instances where these time frames conflict within the proposed rules and with existing payment time frames. For example, proposed 4 NCAC 10F .0106(i) states that payment is to be made “within 30 days;” however, this seems to conflict with the existing statutory language that establishes a 60-day payment time frame under § 97-18 of the Workers’ Compensation Act. Is the NCIC proposing a shortened payment time frame specifically for electronic bills, and if so, how does that coincide or conflict with the existing statutory time frame?
9. We urge the NCIC to address the usage of remittance advice codes for pharmacy transactions and to provide clarification as to their intent to utilize standard NCPDP reject and ASC X12 835-5010 referenced CARC and RARC codes. PMSI poses the following question for clarification by the NCIC: Is it the intent of the proposed rules to require use of only the NCPDP reject codes in submitting remittance notification to a pharmacy in the 835 format and use of only the other code sets (CARC, RARC, etc.) in submitting remittance notification to a professional or institutional provider?

The proposed language in 4 NCAC 10F .0105(e)(3) appears to state such, but that conflicts with what some other states have adopted in their rules. Other states have only referenced the NCPDP reject codes in relation to acknowledgements, leaving use of only the CARC and RARC codes for actual remittance notification and only conveyed through use of the 835 format.

Finally, we **strongly urge** the NCIC to utilize national codes, avoiding a “one-off” situation with only North Carolina eBilling, and to provide clarity around what context they are or are not to be used.

10. As mentioned in the above point, we **strongly urge** the NCIC to avoid creation and utilization of state-specific remittance advice codes. Such “one-offs” create a substantial burden on providers, payors and their systems in order to properly use, store and crosswalk unique codes to more commonly accepted code sets used nationally in the industry.
11. We urge the NCIC to insert language into the proposed rule providing a lead time and clarification on utilization of the HIPAA-prescribed standards. Since workers’ compensation is exempted from HIPAA standards, providers and payors in that market are not as cognizant of changes to HIPAA standards. Thus, insertion of language which allows a 12 to 18-month lead time (from implementation of a HIPAA standard change) for eBilling and processing will give impacted stakeholders time to properly update all systems and processes.



We again appreciate the opportunity afforded to provide these written comments, and we look forward to a continued relationship with the NCIC during the continued rule-making process. PMSI supports eBilling efforts for workers' compensation but believes that for any electronic billing initiative to be successful it must ensure limited additional costs related to implementation, avoid business interruption and equally serve the interest of the payor and the provider. But most importantly, any eBilling initiative must ensure continued delivery of quality and timely care to injured workers. Should you have any questions concerning our comments, please free to reach out to me.

Sincerely,

A handwritten signature in black ink, appearing to read "Kevin C. Tribut", is written over a long, thin horizontal line that extends across the page.

Kevin C. Tribut
Executive Director of Government Affairs, PMSI

cc: File

Cronk, Amber

From: Harvey, James M. <James.Harvey@sedgwickcms.com>
Sent: Saturday, August 25, 2012 6:17 PM
To: Cronk, Amber
Cc: Tolbert, Desiree; Howell, Jeannine; Wertz, Theda; Gilbertson, Chandra; Garka, Zona
Subject: North Carolina Proposed E-billing Rules - Subchapter 10F

Amber,

In the area indicating that payment for all uncontested portion of a complete medical bill has to be made within 30 calendar days of receipt of the original bill, it is our recommendation that this be amended to 45 days, after the proper submission of a medical bill. This would allow additional time that may be necessary for bill adjudication, including potential clinical review for complex medical bill review.

Please let me know if you need additional information.

Thank you.

JAMES M. HARVEY | Vice President | Managed Care Practice
Sedgwick, Inc.

Direct 214-922-0715 | Fax 770-901-3360

Cell 312-835-5729 | Email James.Harvey@sedgwickcms.com

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Cronk, Amber

From: Tammy Dixon <tdixon@carolinacasemgmt.com>
Sent: Tuesday, August 21, 2012 12:05 PM
To: Cronk, Amber
Subject: Proposed new rules for rehab professionals

Hi,
I wanted to offer my support in regards to the concerns about the proposed rule changes presented by IARP recently. I stand in favor with IARP of all items of concern mentioned and believe all rehabilitation professionals should be offered the respect of the commission to please make note and address these concerns.

Thank you in advance for your time and consideration in this matter.

Please note new office phone and fax #'s.

Tammy Dixon, RN, MSN, COHN-S

Supervisor

Carolina Case Management

118 Wind Chime Court

Raleigh, NC 27615

Local Office: 1-336-709-9568

Toll Free: 1-800-546-9636 Ext. 237

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Cronk, Amber

From: Pam Teague <pteague@carolinacasegmt.com>
Sent: Monday, August 20, 2012 8:16 AM
To: Cronk, Amber
Subject: Revision to Rehab Rules

Importance: High

I would just like to voice my opinion regarding the changes to the NC Industrial Commission Rules for Rehabilitation Professionals. As a Rehabilitation Professional I agree with all of the recommendations that have been presented by the International Association of Rehabilitation Professionals and feel they speak for us as a profession. As these are rules for us as a profession I feel this organization's opinions should be highly considered and respected when addressing these changes.

Thank you,

Pamela Teague, BSN, RN, CCM
Case Manager
Carolina Case Management
336-944-5910 (PLEASE NOTE THIS IS A NEW PHONE NUMBER)
800-853-5612 Fax

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Cronk, Amber

From: David Steinbeck <dsteinbeck@carolinacasemgmt.com>
Sent: Monday, August 20, 2012 7:34 PM
To: Cronk, Amber
Subject: Note on the revision to the Rehabilitation Rules.

I am a vocational case manager with Carolina Case Management and a former member of the Rehab Advisory Committee with the Industrial Commission. I am also a member of the North Carolina chapter of IARP. I am writing in support of the recommendations made by IARP concerning the Rules revision. I have been in the rehabilitation field for over 30 years and the Rehabilitation Rules affect us in our job on a daily basis. I wanted to voice my support for the revision as listed through the IARP and I believe it is very important that these revisions be approved. Thank you for your time and consideration of this issue.

David A. Steinbeck, MS, CRC
Senior Case Manager
Carolina Case Management & Rehabilitation Services, Inc.
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IARP of the Carolinas
Position Statement Regarding the Proposed Rehabilitation Rules Changes

IARP of the Carolinas is the local chapter of the International Association of Rehabilitation Professionals. We have approximately 200 members with approximately 85% of the membership residing in and working in North Carolina. The current officers of the chapter include:

President	Carla Marshburn, RN, CCM
President Elect	Kathy Thaman, MS, CRC, CLCP, MSCC
Secretary	Adele Doering, MS, CCM, CVE, CEAS,
Treasurer	Tonya Ballard, MS, CDMS
Members At Large:	Michelle Morgan, MS, CRC
	George Page, CCM, CDMS, CVE, PVE
	Cindy Boyd, RN, BSN, CRRN, CCM, CBIS
	Donna Irby, RN, CCM
	Chad Betters, PhD, CRC, CVE, PVE, CDMS

IARP of the Carolinas has reviewed the Proposed Rehabilitation Rule Changes related to reforms in the Workers' Compensation law of North Carolina. We appreciate the amount of work the North Carolina Industrial Commission has put into revising the Rules to make them applicable to the revised workers' compensation law. We do not respond regarding the law or legal implications, rather the membership has provided the following comments related to our concerns about the proposed rules from the perspective of rehabilitation practitioners.

Subchapter 10C – North Carolina Industrial Commission Rules for Utilization of Rehabilitation Professionals in Workers' Compensation claims

Section .0103

Definitions

(2) Medical Rehabilitation

(a) Case assessment: The words "including a personal interview with the injured worker" have been struck in the proposed change. We strongly believe the wording requiring a personal interview should remain. Neither a rehabilitation nurse nor vocational case manager can provide a good assessment for case management purposes without a personal interview with the injured individual. Telephonic medical case managers are able to do a personal interview with the injured worker by telephone.

(3) "Vocational rehabilitation means the delivery and coordination of services..... return to suitable employment as defined by Item (5) of this Rule or applicable statute. ~~and to substantially increase the employee's wage earning capacity.~~

We propose to strike "and to substantially increase the employee's wage earning capacity and include the following: "... or applicable statute, achieve the employee's wage earning capacity to the extent that is possible based on the injured worker's unique abilities, aptitudes, education, skill level, and geographically specific job market."

Comment: The purpose of vocational rehabilitation has never been to substantially increase an individual's wage earning capacity. The purpose of vocational rehabilitation is to assist an individual with identifying his/her skills, aptitudes, and interests and help the individual identify appropriate employment within the identified skill set/aptitudes/interest and in accordance with what is available in the local job market. While every vocational case manager would be delighted to work with an individual whose return to the job market resulted in substantially increased wage earning capacity, this is not possible for every individual and should not be set forth as a legal expectation.

.0105 (d) To qualify as a qualified rehabilitation professional, a rehabilitation professional must:" We propose to add the following:
meet Qualification 1) **OR** 2). We feel it is important to distinguish that the rehabilitation professional not have to meet both of these categories, rather meets Category 1 with one of the appropriate certifications or Category 2.
Under .0105 (d) Section (1) we recommend:
Leave (1) A-H as written

ADD another certification as letter I. PVE Professional Vocational Evaluator This is a relatively new designation. There are a number of PVEs in North Carolina and it makes sense to add this credential because the CVE, Certified Vocational Evaluator is no longer very well supported at a national level and its numbers have declined. When CCWAVES (Commission on Certification of Work Adjustment and Vocational Evaluation Specialists) ceases to exist in September 2008, professional vocational evaluators were no longer able to obtain a CVE credential. The Vocational Evaluation and Work Adjustment Association and the Vocational Evaluation and Career Assessment Professionals association worked together to create a new credential, the PVE. This allows

evaluators to obtain a credential to certify their training and expertise in the field of Vocational Evaluation. People who had obtained a CVE are able to maintain it through the Commission on Rehabilitation Counselor Certification, but the CRCC does not offer the CVE exam.

.0106 Professional Responsibility of the Rehabilitation Professional in Workers' Comp Claims

- (d) Recommend striking: ~~“As case consultants or expert witnesses”~~. This is a Rule about CASE MANAGEMENT services which help coordinate rehabilitation of injured workers. We do not feel it should encompass consultants or expert witnesses. Consultants and expert witnesses are not providing a direct rehabilitation case management service to the injured worker. The expert witness or consultant is generally serving as an educator to the Court/Commission, or provides a professional opinion about a particular aspect of a case.

Also under (d) we have some concerns about the Codes of Ethics, particularly the potential for a Code of Ethics statement/requirement to conflict with a North Carolina workers' compensation statute. We request clarification that in such a situation, the North Carolina law will be the prevailing requirement.

- (g) We recommend striking the language, “during his or her assignment in the case”. We propose to never be involved in claims negotiation or investigative activities whether during or after closure of a case as this may represent a violation of the various Codes of Ethics/Codes of Conduct.

.0107 Communication

- (a) IARP recommends an addition to this section to include the following: “The Commission will forward a letter to the injured worker and attorney, if represented, to document the Commission’s expectation of cooperation with the rehabilitation program.” By adding this requirement to cooperate with rehabilitation efforts at the beginning of the process, a great deal of time and wasted money can be avoided. The Commission will have fewer motions to comply to deal with and such items would not crowd their calendar. Employers/Carriers will not waste money on attempts at rehabilitation efforts; rather the Injured Worker and Rehabilitation Professional will work together at the outset.

- (b) We recommend inclusion of “a Summary of the Rules”. We do not believe a majority of injured workers want or may be able to fully comprehend the full set of Rules. While it should be available to the Injured Worker if requested, the Summary is a more user friendly document for the Injured Worker. The Commission developed the Summary for this reason. We understand that inclusion of a Summary will mean additional work for the Commission in order to bring the Summary in line with the pending changes in the Rules for the Utilization of Rehabilitation Professionals and with the changes in the Statute that passed in the Legislature last year. While the time demands on the Commission will increase to complete the task of revising the Summary, the Summary appears to have been helpful to Injured Workers since it became available.
- (f) “The rehabilitation professional shall make periodic.....completely the rehabilitation activity of the case.” The current writing of this proposed rule takes what is perceived by IARP as a very negative perspective and appears to insinuate that rehabilitation professionals are hiding information. Everything a Case Manager does is, and should be, “rehabilitation activity”. The current Rules for the Utilization of Rehabilitation Professionals have been instrumental in helping to assure that all communication is open communication.

IARP recommends additional language to this section that compliments the Statute’s recognition of the employer’s ability to obtain “other” medical information that may be relevant to the current workers’ compensation claim. In the opinion of the IARP membership, language that makes the following point would be appropriate: “Rehabilitation Professionals are allowed to obtain medical information outside of the immediate claim treatment records when the parties are in agreement for the rehabilitation professional to facilitate the gathering of such information.”

Therefore, when a situation presents itself and a need for medical information outside of the workers’ compensation injury itself, for example need for a cardiac clearance for surgery, the case manager would be able to obtain the needed information when the Injured Worker/attorney, if represented, and Employer/Insurance Carrier are in agreement for the case manager to obtain said information.

- (i) We believe this should remain as originally written and state, "The initial meeting of the injured worker and rehabilitation professional SHALL IF REQUESTED by the injured worker's attorney, take place at the office of the injured worker's attorney and shall occur within 20 days of the request." We disagree that there should be a legal mandate for every initial meeting to occur in the office of the attorney. There are a number of plaintiff attorneys who have good working relationships with certain rehabilitation professionals and it should be left to the discretion of the attorney as to whether or not his/her client will benefit by having the first meeting in the office of the attorney. If the attorney does not find this to be necessary, the first meeting may take place at another appropriate venue.
- (j) We believe that this section does NOT apply to rehabilitation professionals. Compliance is a legal issue and should be addressed by the attorneys and/or the Commission. It is not the responsibility of the rehabilitation professional to prove or disprove the compliance of an individual with the statute.

.0109

Vocational Rehabilitation Services and Return to Work

- (d) "When an employee requests retraining..... which includes an evaluation of:"
We propose adding:
(6) the rehabilitation professional's assessment of the Injured Worker's ability to successfully complete the requested education or training and obtain related work at the completion of the education/training.
- (e) Sentence structure is confusing in this section. Request clarification
- (h) Should remain as it was in the existing Rules for the Utilization of Rehabilitation Professionals

The Dictionary of Occupational Titles (DOT) is completely outdated. The United States Department of Labor opted not to pursue a revision nor complete another DOT. There are many modern jobs that do not appear in the last revision of the DOT. While the Social Security Administration continues to use the DOT in determining an applicant's ability to earn a wage, SSA has decided to try to do its own update of the DOT because the US Dept of Labor is not going to do an update. No one knows how many years this will take. The Handbook for Analyzing Jobs was a companion document to the DOT. These resources are

useful in many cases and while they are the current standard for Social Security Disability Determination, it would be foolish to adopt only these two (2) resources knowing they will be changing. Excellent on site Job Analysis, both written and digital, are available in the market place now and are a more reasonable scenario in providing an appropriate Job Analysis to help a physician make a determination regarding the appropriateness of the injured worker returning to a given job. We recommend adding, "Job Analysis may also incorporate the independent professional judgment of the rehabilitation professional."

.0110 Change of Rehabilitation Professional

- (a) The membership of IARP takes exception to the term "manifest injustice", and cannot imagine any sort of issue or occurrence in a workers' compensation rehabilitation case that would warrant such language.

We recommend adding the word, "simultaneously" regarding serving the Executive Secretary, the parties, and the rehab professional with motion to remove to read, "with the Executive Secretary's Office and served upon all parties, including the rehabilitation professional simultaneously." The addition of this word insures that the individual filing the motion with the Executive Secretary will copy the rehabilitation professional at the same time that the motion is sent to the Executive Secretary.

.0200 Suspension of Rules

We find the addition of this section to the Rules unnecessary and very inappropriate. Why would the State of North Carolina grant any Commission the power and authority to ignore any part of the Workers' Compensation Statute or any law of the State. The Rules for the Utilization of Rehabilitation Professionals are to be followed by rehabilitation professionals.

.0202 Sanctions

- (a) "failure to respond to lawful orders.....the Commission shall MAY prohibit or restrict a rehabilitation professional, or group of rehabilitation professionals, further participation by particular workers, employers, health care providers, groups or classes of them, or all of them."

We believe the following should be struck: "~~further participation by particular workers, employers, health care providers, groups or classes of them, or all of them.~~"

The IARP membership suggests completing the sentence as follows:
“rehabilitation professionals or rehabilitation companies.”

We see no reason to include health care providers, whether they are physicians, therapists, etc. or employers in the subsection that is dealing with the Rules for the Utilization of Rehabilitation Professionals. Health care providers are not providing rehabilitation case management services. The Rules were originally designed to provide parameters for case management services and are not appropriate to apply to direct health care providers and therapists.

We object strenuously to the term “manifest injustice” anywhere in this document. In the opinion of the IARP membership, this is not appropriate in workers’ compensation.

Respectfully Submitted:
Kathy Thaman, President Elect
On behalf of IARP of the Carolinas

AUG 15 '12

SOUTHERN REHABILITATION NETWORK, INC.

NC Industrial

August 14, 2012

To: The NC Industrial Commission
Re: August 6, 2013 Hearing on Rehab Rules.

My name is Jane Rouse and I am President of Southern Rehab Network, a medical and vocational case management company. I am speaking for Southern Rehab.

I am an RN and have a Masters in Rehab Counseling with certifications of CCM, CRC, CDMS and LPC. I have been a Rehab Professional for 31 years. I was around with the original start of the Rules and would like to stress the "Spirit of the Rules" They were a joint effort by all parties to establish Guidelines to promote cooperation and promote the Professionalism of Rehabilitation of the Injured worker. In paraphrasing a National Rehab definition, it is an effort to return an injured individual to as normal a life as possible that they had prior to injury. We now have credentialed, experienced Rehab Professionals both medical and vocational, with the intent of assisting the Injured worker in their recovery and return to the work place.

For the most part, we like the Rules. It gives everyone an idea of our job and gives us Guidelines and backup when we are asked to do things outside our boundaries or are not allowed to do things in a timely manner.

I agree with the IARP of the Carolinas recommendations of the updated Rules.

Also of note are a couple of additions: under interaction with MD's 10C 0108 line 3 we suggest use of a company ID or Professional Business card as proof of ID and this is very appropriate and should be mandated upon entry to the office. Due to Privacy issues and Identity theft, I would not recommend my folks present a driver's license. Also line 29 mentions consent. This should be oral or written consent, as much of the time oral is what is given due to time constraints. Also I see no mention of Summary of the Rules. This has been a very valuable tool. The complexity of the wording is confusing and most folks prefer the simple explanation. If the full version is requested, by all means it is available.

In regards to vocational placement: I don't know of any vocational person that would not like to have the perfect case and help someone become much more than they were when they got hurt. The adjuster for sure would have a better case to settle. Yet we have to deal with what we have and by using all criteria in an assessment to get them the best possible outcome. The Vocational Hierarchy that was included in the old Rules is the standard that all should abide by for Vocational placement.

To promote a cooperative effort and do what we could to improve our industry, we met 7-8 years ago with the Commissioners and gave them our plan to assist in this effort.

Number 1: Establish a Registry of all Rehab Professionals and this has been done. It helps keep folks credentialed and licenses up to date. Also if you are not on the Registry, you cannot work files.

Number 2: Education of all Rehab Professionals. A program was established and approved by all parties for a class to teach the Rules and give feedback to promote cooperation. We started the classes about 3 years ago and to date there are over 830 some folks that have taken the course and 100 plus enrolled for a Webinar on Oct 8. Most of the Webinar folks are out of state

(telephonic). This has been an eye opening experience to see the number of people that were not aware of the Rules. There are also companies that I have never heard of, so no doubt more will register over the next 9 months to comply with the Mandate for completion by June of 2013. Now they know about the Rules and laws of NC and I am sure a much better percentage of cooperation, will be established. There are folks from as far as Washington State, Texas, New York, Florida managing Work Comp Case Management. To date I would estimate at least 200 that are out of state telephonic that have taken, are scheduled to take or on list to take the next class.

Number 3: Peer Review. If there is a question, we have the NC Advisory Committee to help determine appropriateness of the Rehab actions.

In conclusion, we as Rehab Professionals have over the years tried to promote our occupation and we only want respect, input and acknowledgement that we are experts in our field just like PTs, OTs, etc. We don't want to be adjusters or lawyers. We just want to do our jobs and help the injured worker to return to his/her pre-injury status.

I stand behind our professional organization and I am proud of my employees and trust that they are out to do the right thing. All we ask is to let us do our jobs, give us reasonable Rules and the injured worker will hopefully benefit beyond the claim.

Respectfully submitted,

Jane Rouse 

Jane Rouse
President
Southern Rehab Network, Inc



August 6, 2012

Amber Cronk
amber.cronk@ic.nc.gov
North Carolina Industrial Commission
420 North Salisbury Street
Raleigh, NC 27603

Re: PMSI Testimony and Initial Comments to Proposed North Carolina eBilling Rules – 4 NCAC 10F .0101, .0103, .0104, .0105, .0106, .0107, .0108 and .0109

Good morning, my name is Kevin Tribout and I am the Executive Director of Government Affairs for PMSI, a provider of pharmacy services and medical equipment explicitly for the workers' compensation marketplace. PMSI currently provides pharmacy services (PBM retail pharmacy and mail-order pharmacy) in all 50 states, and we have extensive knowledge of the many regulatory requirements impacting delivery of pharmacy and medical services provided to injured workers. Additionally, PMSI is a member of CompPharma, a trade association and advocacy group representing workers' compensation PBMs and assisting public policy makers in development of public policies relating to provision of pharmacy services in the workers' compensation marketplace.

First and foremost, PMSI and CompPharma appreciate the ability to speak today and the continued efforts of the North Carolina Industrial Commission in working with impacted stakeholders during development of these eBilling rules. Second, PMSI continues to support the development of eBilling rules and guidance in North Carolina and other states. Additionally, PMSI supports utilization of IAIABC eBilling standards and guidance as well as utilization of the ASC x12 – 835-5010 standards for medical care and the NCPDP D.0 standards for pharmacy care.

My goal today is to provide insight and comments on key points within the proposed rule which need additional examination and consideration prior to adoption to ensure a smooth implementation and ongoing administration of eBilling in North Carolina. PMSI will also file written comments which also include these points and expand upon other additional points of comment and concern.

- 1- We urge the NCIC to review the proposed rule and ensure usage of consistent effective dates. We have found instances where effective dates seem to conflict.

- 2- We urge the NCIC to create a definition of provider, provider agent, third party biller or assignee in the proposed rules. Recent eBilling rule development and implementations in all states includes these specific definitions.
- 3- We urge the NCIC to specifically state and allow “mutually agreed upon alternative formats” between providers and payors which are different than the state indicated eBilling formats. All workers’ compensation eBilling efforts implemented to date specifically allow providers and payors to use alternative formats. There are many payors and providers who are already engaged in eBilling practices and are utilizing long-standing electronic billing formats and connectivity which differ from the proposed standards. These proposed, and any final adopted, rules should not punish these “ahead of the curve” stakeholders.
- 4- We urge the NCIC not to mandate eBilling, but rather as with other states, make eBilling voluntary for providers but require payors to be capable of properly handling, processing and reimbursing any eBill sent from a provider. At a minimum, we urge the state to (if they wish to mandate eBilling) allow a transition time of at least 2 years or provide exemptions for providers and payors who handle very limited numbers of workers’ compensation claims.
- 5- We urge the NCIC to clarify if they will be adopting an eBilling “companion guide” to provide additional clarification. To date other state efforts to implement eBilling requirements have included the subsequent publication of an associated eBilling “companion guide.”
- 6- We request the NCIC to clarify their intent to adopt specific standards related to attachments (such as medical reports or notes) for medical services. The current language appears to be vague.
- 7- We request the NCIC to clarify payment and remittance time frames. We found instances where these time frames conflict within the proposed rule and with existing payment time frames.
- 8- We urge the NCIC to address the usage of remittance codes for pharmacy transactions and to provide clarification as to their intent to utilize standard NCPDP and ASC X12 835-5010 codes. We strongly urge the NCIC to utilize these national codes and avoid creation and utilization of state specific codes
- 9- We urge the NCIC to insert language into the proposed rule providing a lead time and clarification on utilization of HIPAA standards. Since workers compensation is exempted from HIPAA standards, providers and payors are not as cognizant of changes to HIPAA standards. Thus, insertion of language which allows a 12 to 18 month lead time (from implementation of a HIPAA standard change) for eBilling will give impacted stakeholders time to properly update all eBilling systems and processes.

Again, we appreciate the opportunity to speak today on these key issues and we look forward to a continued relationship with the NCIC during rule-making. PMSI and CompPharma support eBilling efforts for workers' compensation but believe that for any electronic billing initiative to be successful, it must ensure limited additional costs related to implementation, it avoids business interruption and equally serves the interest of the payor and the provider. But most importantly, any eBilling initiative must ensure continued delivery of quality and timely care to injured workers.

We look forward to providing additional and more in-depth comments on the entirety of the proposed rule by the September 14, 2012.

Sincerely,

A handwritten signature in black ink, appearing to be 'Kevin C. Tribout', with a long horizontal line extending to the right.

Kevin C. Tribout
Executive Director of Government Affairs, PMSI

cc: File



North Carolina Association of Defense Attorneys

The Right Affiliation. The Right Resources. The Right Reasons.

MEMORANDUM

TO: North Carolina Industrial Commission
FROM: North Carolina Association of Defense Attorneys
RE: Comments to Industrial Commission Proposed Rule Changes
Date: August 6, 2012

The NCADA appreciates the opportunity to be heard on the proposed rules of the North Carolina Industrial Commission. Below is a list of rules to which the North Carolina Association of Defense Attorneys will provide written comment before September 14, 2012. The NCADA anticipates that we will not be able to address all of our concerns during the public hearing on August 6, 2012 due to the time constraints affiliated therewith.

RULES 10A

Rule .0102 (Official Forms): The NCADA asserts that forms must be revised as part of the Administrative Procedure Act (APA) rule making process.

Rule .0105 (Electronic Payment of Costs): The proposed rule is not supported by statutory authority and is contrary to the APA.

Rule .0301(f) (Proof of Insurance Coverage): The NCADA recommends that this rule be expanded to a principal contractor, intermediate contractor, or subcontractor who has notice that the policy has lapsed, is cancelled, or is not renewed for any reason.

Rule .0404(a) (Termination and Suspension of Compensation): There is no statutory authority for the rule.

Rule .0404(c): There is no statutory authority for payment of costs associated with terminating benefits via the Fee Portal.

Rule .0404(d): There is no statutory authority for the requirement that the Commission "shall" refuse to accept the application to terminate benefits due to the failure to specify the number of pages attached.

Rule .0404(g): The language stating that a hearing is to be set "without delay" is not consistent with statutory authority and attempts to interpret the law without statutory authority, which is a violation of the APA.

Rule .0405 (Reinstatement of Compensation): There is no statutory authority for the telephonic procedure proposed in this rule. If it is determined that the Commission has statutory authority to develop such informal hearing procedures for the reinstatement of benefits, those procedures should track the same timelines for suspension of benefits.



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Rule .0406 (Discount Rate to be Used in Determining Commuted Values): This rule is unclear and ambiguous and has no statutory authority.

Rule .0408 (Application for or Stipulation to Additional Medical Compensation): There is no statutory authority for requiring the employer to state the grounds for and provide supporting documentation that the employee is not entitled to ongoing medical treatment beyond two years. The proposed rule also improperly shifts the burden to the employer.

Rule .0502(2)(b) (Compromise Settlement Agreements): The proposed rule lacks statutory authority.

Rule .0502(3)(d): The proposed rule has no legal basis in that it goes beyond the Commission's authority to approve settlements as set forth in G.S. 97-17.

Rule .0601(b) (Employer's Obligations Upon Notice; Denial of Liability; And Sanctions): There is no statutory authority for requiring the defendants to send a denial to healthcare providers.

Rule .0603 (Responding to a Party's Request for Hearing): There is no statutory authority to make the employer respond to a Form 33 but not an employee. This provision of the rule is not necessary and treats the parties to the claim differently, which is a violation of the due process clause of the US Constitution.

Rule .0604 (Appointment of Guardian Ad Litem): The NCADA asserts there is no statutory authority for the Commission's proposed rule to assess a fee to be paid by the employer to an attorney who serves as a guardian ad litem on behalf of a minor or incompetent.

Rule .0605 (Discovery): There is no statutory authority for Rule 605(9), which states that the parties shall not submit motions to compel production of information otherwise obtainable pursuant to G.S. 97-25.6.

Rule .0607 (Discovery of Records and Reports): The required production of all employment records, even if there is no showing of relevance, is contrary to statutory authority.

Rule .0608 (Statement of Incident Leading to Claim): There is no statutory authority that requires the recorded statement be provided within 45 days after the request for hearing. The NCADA contends that the recorded statement should be subject to discovery rules, namely Rule 605, and that a recorded statement should be produced within 30 days after it is requested.

Rule .0609 (Motions Practice in Contested Claims): There is no statutory authority for implementing a motions practice in contested cases.



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Rule .0609A (Medical Motions and Emergency Medical Motions): The NCADA contends that G.S. 97-78(f) did not provide statutory authority for setting up the expedited process established by the Commission that essentially eliminates live, in person hearings with depositions.

Rule .0612 (Depositions and Additional Hearings): The NCADA contends that there is no statutory authority to charge all deposition fees against the employer.

Rule .0613 (Expert Witnesses and Fees): The NCADA contends that the 10 percent penalty for failure to make payment to an expert witness within 30 days is not supported by statutory authority.

Rule .0616 (Dismissals): The NCADA contends that there is no statutory authority for the deadline for re-filing a claim under Rule 616(c) following removal of a case from a hearing docket.

Rule .0701(b) (Review by the Full Commission): The proposed rule is unclear and ambiguous. The NCADA further contends this rule contravenes G.S 97-29(c) as it relates to extended benefits.

Rule .0701(e): The proposed rule is unclear. The use of the word “paragraph” is not consistent with statutory references such as “subchapter” and “subdivision.”

Rule .0701(f): The proposed rule is unclear and ambiguous. The new sentence that begins “Motions related to the issues for review...” is confusing in that it fails to establish a clear procedure to raise a motion and be heard before the Full Commission.

Rule .0701(i): The proposed rule is unclear. The requirement that exhibits be cited as “Ex 3 p 12,” for example, is superfluous since the hearing transcript issued with a Form 44 does not delineate between the transcript and exhibit pages. All transcript and exhibit pages are consecutively paginated when the evidentiary record is published. Therefore, the NCADA recommends “Ex p 12.”

Rule .0702(a) (Review of Administrative Decisions): The proposed rule is not supported by statutory authority.

Rule .0702(b): The proposed rule is unclear and ambiguous. The phrase “frustrate the purposes of the order, decision, or award” that begins on line 31 suggests a motion to stay may be denied in all cases.

Rule .0704 (Remand from the Appellate Courts): The proposed rule is unclear.

Rule .0801 (Suspension of Rules): The proposed rule is not supported by statutory authority and is in violation of the APA.



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Rule .0802 (Sanctions): The proposed rule is not supported by statutory authority. None of the statutes relied upon by the Commission to promulgate this rule endow the Commission with generalized authority to impose broad sanctions.

RULES 10B

Rule .0202(c): The proposed rule contradicts Rule 9(j) of the Rules of Civil Procedure as it relates to the time requirements to designate a medical expert.

RULES 10C

Rule .0101 (Applicability of the Rules): The proposed rule is not reasonably necessary to implement State law and is contrary to G.S. § 97-32.2. The NCADA also recommends that because there are now two statutes that address rehabilitation services (G.S. 97-25.5 and 97.32.2) the rules should delineate between those that apply to medical case managers and those that apply to vocational managers.

Rule .0103(3) (Definitions): There is no statutory authority for defining “Vocational Rehabilitation” to require the goal be to “substantially increase the employee’s wage earning capacity.” The definition is vague and ambiguous. The proposed rule is also unnecessary, redundant and repeats the content of a law in violation of the APA.

Rule .0103(5): There is no statutory authority for the proposed definition of “suitable employment” for claims arising before June 24, 2011.

Rule .0105(d) (Qualifications Required): As written, this rule appears to require both that the rehabilitation professional possess one of the professional certifications listed and have prior employment experience with the North Carolina Department of Health and Human Services as a vocational rehabilitation provider. It would not make sense for qualified medical rehabilitation professionals to have prior experience as vocational rehabilitation professionals for the State.

It is also unclear why subsection (e) is separate from subsection (d) when both appear to enumerate the requirements to serve as a rehabilitation professional.

Rule .0106(a) (Professional Responsibility of the Rehabilitation Professional in Workers’ Compensation Claims): The NCADA asserts the inclusion of the word “retirement” is contradictory to the Act as amended by G.S. 97-32.2.

Rule .0106(e): The incorporation by reference to web sites for professional organizations is unnecessary to implement State law.

Rule .0106(g): It appears that the word “activity” in line 23 is superfluous and should be deleted.

Rule .0107(d) (Communication): There is no statutory authority that requires all correspondence and reports to be sent electronically. In addition, the proposed rule is unclear.

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Rule .0107(j): There is no statutory authority for this rule. The rule is also unnecessary because Rule .0106(a) details the scope of the rehabilitation professional's role. Further, the proposed rule would place an unnecessary burden upon the rehabilitation professional in violation of G.S. 150B-19.1(2) and potentially the ethical codes adopted by the respective professions.

Rule .0108(e) (Interaction with Physicians): There is no statutory authority for limiting the rehabilitation professional from "initiating" a second opinion on a rating, independent medical examination, second opinion and consult. Furthermore, the proposed rule is unclear and ambiguous in that "initiate" is not defined.

Rule .0108(e)(2): The proposed rule is unclear.

Rule .0109(d) (Vocational Rehabilitation Services and Return to Work): The NCADA suggests that this rule needs further clarification.

Rule .0109(i): The proposed rule is not reasonably necessary to implement G.S. 97-2(22) or 97-32.2.

Rule .0110 (Change of Rehabilitation Professional): This rule is unclear and ambiguous in that it allows the rehabilitation professional to be removed "to prevent manifest injustice," but provides no guideline on the definition of "manifest injustice." In addition, there is no statutory authority for this phrase.

Rule .0201 (Suspension of Rules): The proposed rule is not supported by statutory authority and is in violation of the APA. The APA does not allow an administrative agency to suspend its own rules "unless a rule establishes specific guidelines the agency must follow in determining whether to waive or modify the requirements." *See* G.S. 105B-19(6).

Rule .0202 (Sanctions): The proposed rule is not supported by statutory authority. None of the statutes relied upon by the Commission to promulgate this rule endow the Commission with generalized authority to impose broad sanctions.

RULES 10E

Rule .0201 (Document and Record Fees): There is a typographical error on line 9 in that "the actual cost." is noted twice.

Rule .0202(a) (Hearing Costs or Fees): The proposed rule is not supported by statutory authority. The rule does not specify which party shall bear the costs/fees for a given action.

Rule .0202(b): This rule is not supported by the statutory authority listed. Chapter 143 applies only to the Industrial Commission's authority to hear tort claims. It is independent and inapplicable to the Commission's jurisdiction under Chapter 97.



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Rule .0203 (Fees Set By Commission): The NCADA notes the objections to Rule .0202 apply to .0203.

Rule .0301 (Suspension of Rules): This rule is not supported by statutory authority and is in violation of the APA.

Rule .0302 (Sanctions): This rule is not supported by statutory authority. None of the statutes relied upon by the Commission to promulgate this rule endow the Commission with generalized authority to impose broad sanctions.

RULES 10G

Rule .0101(b) (Mediation and Settlement Order for Mediated Settlement Conference): This rule is unclear and ambiguous. The NCADA also notes that inconsistent terms are used throughout all rules such as “plaintiff” versus “employee” versus “injured worker.”

Rule .0103(g) (Mediated Settlement Conference): The NCADA asserts this rule is unclear and ambiguous particularly as it relates to the fact “settlement agreement” is not defined.

Rule .0104(f) (Duties of Parties, Representatives and Attorneys): The NCADA asserts this rule is unnecessary in that there are several examples of settlements wherein the parties cannot submit the settlement agreement to the Commission within 20 days of the conclusion of the mediation conference (e.g., claim where parties are waiting on CMS to approve an MSA before submitting agreement to Commission).

Rule .0104A (Foreign Language Interpreters): This rule is unclear as it relates to the statutory authority that would allow the Commission to charge the employer with translation costs.

Rule .0105 (Sanctions): This rule is in violation of the APA because sanctions related to mediations are not specifically allowed by statute.

Rule .0107(b)(3) (Compensation of the Mediator): This rule is unclear and ambiguous.

Rule .0110 (Suspension of Rules): This rule is not supported by statutory authority and is in violation of the APA.

Rule .0112 (Miscellaneous): This rule violates the APA in that it repeats the content of another rule.

LENNON, CAMAK & BERTICS

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Ms. Amber Cronk
North Carolina Industrial Commission
4336 Mail Service Center
Raleigh, NC 27699

Re: Objection to Proposed Rules

Ms. Cronk:

In accordance with the recent Notice of Rule Making, please accept the following as objections to Subchapter 10C, North Carolina Industrial Commission Rules for Utilization of Rehabilitation Professionals in Workers' Claims. I am a Board Certified Specialist in North Carolina Workers' Compensation Law and have practiced for more than 35 years.

The Industrial Commission Rules for Rehabilitation Professionals published in 2000 were the product of extensive work and discussion. They represent a consensus of opinions from defense attorneys, plaintiff's attorneys, Industrial Commission participants and the rehabilitation professional community. While some changes are necessary to tailor the rules to statutory changes, wholesale revisions are not.

The most constructive change would be for the Industrial Commission to assign all rehabilitation providers and tax the cost to the employer/insurance carrier. This would neutralize a process which has become unnecessarily adversarial. I understand the state of Washington has adopted this practice.

Specific proposals are discussed below:

4 NCAC 10C.0102 should not be repealed. Indeed the fact that the Industrial Commission would propose repealing a rule indicating that the primary concern and commitment of an RP should be to the medical and rehabilitation of the injured worker rather than to the financial interest of the parties and stating that "these Rules are to be interpreted to promote frank and open cooperation" is deeply troubling.

4 NCAC 10C.0106 deletes a section in paragraph (A) stating, "the RP shall realize that the attending physician directs the medical care of an injured worker." This statement is consistent with both case law and the Rules of the Industrial Commission for Worker's Compensation claims. Merely adding a sentence stating "it is not the role of the Rehabilitation Professional to direct medical care" does not settle the issue. The proposed change injects confusion into a settled area of the law for no good reason. The rules should clearly state that an authorized treating physician directs the medical care of an injured worker, not the adjuster. Physicians tell me one of the most frustrating aspects of treating a workers' compensation patient is micro management of medical care by adjusters. The insurance carrier and/or employer have the right to direct initial medical care. However, they clearly do not have the right to

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July 20, 2012
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interfere with care determined reasonably necessary and prescribed by the authorized treating physician. A truly inordinate amount of time and money is spent by counsel and the Industrial Commission dealing with these issues as a direct result of the Industrial Commission's reluctance to enforce its own rules. Certainly, a rule change further confusing the issue is not in anyone's best interest.

4 NCAC 10C.0107 proposes that paragraph (F) allowing an RP to verbally advise an unrepresented worker of developments and saying that the worker has the right to request a copy of the reports being provided to the employer/carrier. This change from the present rule requiring periodic written reports to be provided to all parties at the same time would simply be an invitation for abuse. There is no good reason all parties should not receive all reports at the same time and by the same means. There should be no question as to what information was provided and when. Any deviation from the present, successful rule would simply invite misunderstandings and disputes which could easily be avoided.

In fact, the rule does not go far enough. Counsel and the Commission are aware of instances in which rehabilitation companies allow insurance adjusters direct access to their rehabilitation professional's files and notes by use of a password or other device. At the same time, the injured worker and counsel are simply not provided this access. Another example is the billing process. Rehabilitation professional billing may indicate activities inconsistent with the rules for which have not been disclosed. All billing from rehabilitation professionals and their employers should be disclosed to all parties at the same time.

A further abuse occurs when the charges for medical and vocational rehabilitation are reported as medical charges rather than administrative expenses of the insurance carriers. In the vast majority of cases, the rehabilitation professional is assigned by the insurance carrier to save themselves money rather than because of any legitimate medical reason. In 35 years of practice, I can not recall a physician prescribing or requesting assignment of a rehabilitation professional for anything other than coordinating post-operative care. Given this reality, the Industrial Commission should require costs of any rehabilitation professional not prescribed by the authorized treating physician to be reported as an administrative expense. This will ensure proper accounting of expenses which are truly medical as opposed to expenses which are discretionary with the insurance carrier.

The injured worker should not be compelled to request disclosure of records which are already being provided to the employer/carrier.

4 NCAC 10C.0108

Paragraph (D) (7) should be deleted. If an injured worker failed to attend a scheduled appointment or arrived at a time other than the scheduled appointment time, that is not an excuse for an ex-parte communication by the rehabilitation professional with the physician. The rule should also make it clear that communications with the physician's staff should be subject to the same disclosure requirement as communication with the physician. I have personally had cases which telephone messages were left for doctors saying "FCE" and "employer has light duty work available." These notes

Ms. Amber Cronk
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Page 3

were found in the medical doctor's files in the course of a deposition - which probably would have been unnecessary if the improper communication with the physician via his staff had not occurred.

4 NCAC 10C.0109 dealing with the vocational rehabilitation services and return to work should include at paragraph (d) "(6) the results of appropriate vocational testing evaluating the skills, educational functioning, interests and aptitudes." Vocational testing of this type is routinely used by the Division of Vocational Rehabilitation. In preparing vocational evaluations, these testing services are readily available. Their use should be encouraged by the Industrial Commission to improve the likelihood of a successful placement and reduce the likelihood of litigation which might be avoided.

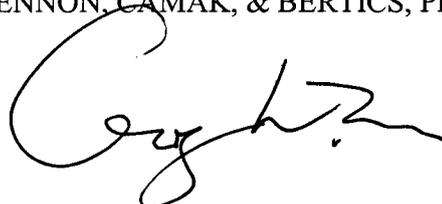
4 NCAC 10C.0110 , Change of Rehabilitation Professional, would provide at paragraph (b) that an RP could be removed only "to prevent manifest injustice." This is a radical, unnecessary change. The term "manifest injustice" is not defined. The proposed rules also do not describe whether rehabilitation services are to be continued while a motion to remove a rehabilitation professional is pending, whether a stay may be issued by the Industrial Commission, or in paragraph (c) how long the effect of an order may be delayed by requesting reconsideration or by appealing.

This rule should clearly state that when the provisions of paragraph (a) are not met, the decision of the Industrial Commission to remove a rehabilitation professional is discretionary and interlocutory on a no-fault basis. Sometimes there are simply personality conflicts which make it difficult for rehabilitation providers and recipients to work together. In these instances, the Industrial Commission should not deprive itself of authority to make a constructive change without ascribing fault to either party. By simplifying and neutralizing the process, continuity of care can be preserved and results fair to all parties obtained.

Thank you for your consideration of this. These proposed rules are of great importance of the parties appearing before the Industrial Commission. The changes suggested are intended to be constructive and to help ensure an effective and cooperative rehabilitation environment.

Sincerely yours,

LENNON, CAMAK, & BERTICS, PLLC



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July 30, 2012

Via e-mail only (amber.cronk@ic.nc.gov)

Chair Pamela T. Young
Attention: Amber Cronk, Legal Assistant
North Carolina Industrial Commission
4336 Mail Service Center
Raleigh, North Carolina 27699-4336

Re: NCAJ Workers' Compensation Section's
Comments on and Objections to Proposed Rules
Public Hearing on August 6, 2012

Dear Chair Young:

Please accept this letter as the comments and objections by the Workers' Compensation Section of the North Carolina Advocates for Justice to the proposed rules that are the subject of the public hearing scheduled for August 6, 2012. I am the current Chair of the Workers' Compensation Section.

The Workers' Compensation Section is grateful to the Commission for its hard work in the rulemaking process. In reviewing the proposed rules, we focused on whether they discriminated on either a procedural or substantive basis and, of course, whether they were consistent with the statutes they implement. We have listed our specific comments and objections below and have organized them by subchapter of the proposed rules.

Workers' Compensation Rules (Subchapter 10A)

4 NCAC 10A.0402(a)—OBJECTION. The proposed rule, as currently worded, is not enforceable because it does not give a deadline in which employers must provide the Form 22. We would respectfully recommend a 30-day compliance period, consistent with the former Industrial Commission Rule 607.

4 NCAC 10A.0404(c)—OBJECTION. The proposed rule requires service of the Form 24 to unrepresented parties by regular United States mail. However, we would propose that service upon unrepresented parties take place by certified mail, return receipt requested, to ensure receipt and notice of the Form 24 upon the unrepresented parties.

In addition, 4 NCAC 10A.0404(c) affirmatively requires that any objection to a Form 24 “shall be accompanied by all currently available supporting documentation.” This mandate is contrary to the language of N.C. Gen. Stat. § 97-18.1(c), which provides an “opportunity to state their position and to submit documentary evidence”—that is, in a non-mandatory way. The mandatory aspect of the proposed rule places unrepresented employees at a distinct disadvantage, since they do normally do not have the documentation needed to combat a Form 24 Application in an expedient fashion, and might be relevant to appellate proceedings on whether the decision on the Form 24 was appropriate.

4 NCAC 10A.0404(f)—OBJECTION. The proposed rule deletes the “good cause” exception for extending the time in which the Commission can hold a Form 24 hearing. However, the language of N.C. Gen. Stat. § 97-18.1(d) specifically calls for that standard.

4 NCAC 10A.0404A(b)—OBJECTION. The proposed rule states that the employee “shall” complete and file with the Industrial Commission a completed Form 28U, and that the Form 28U “shall be completed by the physician who imposed the restrictions or one of the employee’s authorized treating physicians....” To the contrary, the Court of Appeals has already held that the submission of a Form 28U is not a mandatory requirement for reinstatement of compensation. See Barbour v. Regis Corp., 167 N.C. App. 449, 458 n.2, 606 S.E.2d 119, 126 n.2 (2004); Burchette v. East Coast Millwork Distrib., 149 N.C. App. 802, 808-809, 562 S.E.2d 459 S.E.2d 459, 463 (2002).

4 NCAC 10A.0501(d)—COMMENT. The language of the proposed rule states that “when the employee signs the forms.” We would recommend, however, that the language should be “when the employee *or appropriate beneficiary* signs the forms,” as the case may be. For example, an employee cannot sign a Form 26D.

4 NCAC 10A.0502(b)(7)—OBJECTION. For the most part, we agree with the proposed rule. However, N.C. Gen. Stat. §44-49 and § 44-50 only require the payment of a prorated amount, and not the full amount, of medical bills during a settlement disbursement. The proposed rule should clarify that the notification to the medical providers will specify the amount of the unpaid medical expenses being paid through the settlement, as approved by the Commission, and the amount of any balance remaining after such payment, if this is the case.

4 NCAC 10A.0601(b)—OBJECTION. The proposed rule deletes the former requirement of a “detailed” statement explaining the denial of benefits. To the contrary, N.C. Gen. Stat. § 97-18(c) requires a “detailed statement of the grounds upon which the right to compensation is denied.”

4 NCAC 10A.0610(a)—COMMENT. The second sentence of the proposed rule (“The parties have 15 days following the hearing within which to schedule the taking of medical depositions unless otherwise extended by the Commission in the interest of justice and judicial economy.”) is duplicative of, or in the very least, belongs in 4 NCAC 10A.0613(a).

4 NCAC 10A.0614(k)—OBJECTION. The proposed rule cites to N.C. Gen. Stat. § 97-90.1(b). However, there are no subparts to N.C. Gen. Stat. § 97-90.1.

4 NCAC 10A.0616(c)—OBJECTION. The proposed rule does not differentiate between requests for hearings in denied claims versus admittedly compensable claims. In denied claims, it makes sense to for a dismissal to be available if the claim is not prosecuted within 2 years. In admitted claims, however, the proposed rule—specifically subsection (c)—makes no sense. For example, if an employee files a Form 33 on the issue of average weekly wage and then removes the case from the hearing calendar, the currently proposed rule appears to allow the employer to move to dismiss the entire claim, even though the Form 33 did not affect the issues of compensability and liability.

4 NCAC 10A.0702(a)—OBJECTION. The first sentence is awkward and difficult to understand. We would suggest clarifying it with additional enumeration, punctuation, and language, such as the following underlined examples:

Administrative decisions include orders, decisions, and awards made in a summary manner, without findings of fact, including decisions on (1) applications to approve agreements to pay compensation and medical bills, (2) applications to approve the termination or suspension or the reinstatement of compensation, (3) applications for change in treatment or providers of medical compensation, (4) applications to change the intervals of payments, and (5) applications for lump sum payments of compensation. Administrative decisions shall be reviewed upon the filing of a Motion for Reconsideration with the Commission addressed to the Administrative Officer who made the decisions or may be reviewed by requesting a hearing within 15 days after receipt of the decision or receipt of the ruling on a Motion to Reconsider. These issues may also be raised and determined at a subsequent hearing.

4 NCAC 10A.1001(i)—OBJECTION. The proposed rule allows peer review from doctors who are licensed in states other than North Carolina. While this is acceptable practice if the doctor practices medicine in the same state in which the employee resides, the reliance upon those doctors' recommendations for patients residing in states in which the doctor is not licensed most likely constitutes the unauthorized practice of medicine if those opinions disrupt the course of medical treatment by a duly licensed medical provider, depending on the laws of the forum state. See, e.g., N.C. Gen. Stat. § 90-1.1(5) (defining "practice of medicine" under North Carolina law.)

Rehabilitation Professionals (Subchapter 10C)

4 NCAC 10C.0110(b)—OBJECTION. The proposed rule states that a rehabilitation professional may be removed "to prevent manifest injustice." This standard is contrary to the plain language of N.C. Gen. Stat. § 97-32.2(b), which allows removal for "good cause."

Managed Care Rules (Subchapter 10D)

No comments or objections.

Administration (Subchapter 10E)

4 NCAC 10E.0201(b)—OBJECTION. There appears to be superfluous language at the end of the proposed rule (“the actual cost”). Furthermore, the subsections go from (b) to (f) with no subsections (c) through (e) between them.

Electronic Billing (Subchapter 10F)

4 NCAC 10F.0101—OBJECTION. The proposed rule requires compliance with the new electronic billing procedures by all medical providers. However, unlicensed medical providers, such as family members providing attendant care services or transportation companies providing “sick travel” under N.C. Gen. Stat. § 97-2(19), should not be compelled to submit their bills electronically. The current proposal does not accommodate these non-professional providers, and an exception should be made to do so.

4 NCAC 10F.0106(i)—OBJECTION. The 30-day period under the proposed rule is inconsistent with the 60-day period under N.C. Gen. Stat. § 97-18(i) when it comes to the 10% penalty.

4 NCAC 10F.0107(b)—COMMENT. The proposed rule misspells “utilize” as “utilizen.”

Mediated Settlement (Subchapter 10G)

10 NCAC 10G.0101(b)—OBJECTION. The proposed rule contains a “contrary to the interests of justice” standard for ordering the case to a mediated settlement conference. However, this standard appears to conflict with the standard set forth set in 4 NCAC 10G.0101(f) (“interest of justice or judicial economy” or “good cause”) for reasons for which the parties or the Commission can dispense with mediation. The two standards should be commensurate with each other.

Medical Fees Compensation (Subchapter 10J)

General—COMMENT. Although it does not appear to do otherwise, the medical fee schedule should confine itself to the establishment of fees for the provision of medical compensation. It should not, as prior opinions from the appellate courts have observed, go beyond this scope and, for example, impose any other conditions on medical compensation, such as preapproval in the section of the fee schedule struck down by *Forrest v. Pitt County*, 100 N.C. App. 119, 394 S.E.2d 659 (1990), *aff’d*, 328 N.C. 327, 401 S.E.2d 366 (1991) (per curiam). See also *Godwin v. Swift & Co.*, 270 N.C. 690, 155 S.E.2d 157 (1967) (restricting prior opinion of *Hatchett v. Hitchcock Corp.*, 240 N.C. 591, 83 S.E.2d 539 (1954), when it comes to preauthorization of attendant care services, based on prior Industrial Commission rule now found in Section 14 of the Medical Fee Schedule).

Thank you for your consideration of these comments and objections. We look forward to discussing them with the Commission on August 6, 2012.

With kindest regards, I am,

Very truly yours,

A handwritten signature in black ink, appearing to read 'V. Sumwalt', written in a cursive style.

Vernon Sumwalt
Chair, NCAJ Workers' Compensation Section

VRS:vrs

cc: WC Section Executive Committee