David A Stoller
State Farm Insurance Companies
4140 Parklake Avenue, Suite 400
Raleigh, NC 27612

September 12, 2012

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

RE: WRITTEN COMMENT Proposed Workers Compensation Rules
Proposed Rules 4 NCAC 10A, Section .0404, Section .0405, Section .0608
Proposed Rule 4 NCAC 10C, Section 103 (3).

Dear Ms Cronk:

I write on behalf of State Farm Insurance Companies to provide comment regarding the above referenced Proposed Workers Compensation Rules. State Farm respectfully submits the following comments for your consideration.

4 NCAC 10A, Sections .0404 and .0405. Proposed Rule .0404 (a). As written, the proposed rule provides that "there is a rebuttable presumption that disability continues until the employee returns to suitable employment." We suggest eliminating this clause as it is directly contrary to established law. Numerous appellate decisions have confirmed that form agreements for the payment of compensation do not create the presumption of disability. This provision likewise has no statutory basis. Proposed Rule .0404 (d), at lines 3 through 5 of page 2 refers to the filing of the Form 24 and provides, in part, that the form shall specify the number of pages of documents attached which are to be considered by the Commission. "Failure to specify the number of pages shall result in the refusal of the Commission to accept the same for filing." Proposed Rule .0405 (b), at lines 23 through 25, includes the same provision regarding the filing of a Form 23. In both cases, the proposed change makes mandatory ("shall") the penalty for failing to specify the number of pages to be considered which has previously been permissive ("may"). Neither rule identifies what constitutes "failure to specify the number of pages" leaving open the possibility that an inadvertent miscount or misprint on the form results in a mandatory refusal to file the form. This proposed change is unnecessary, and removes any discretion on the part of the Commission to overlook minor, technical, or inadvertent errors. It should be the role of the Commission, and of the rules, to lead to well considered decisions on the merits of the case, rather than having cases decided on the basis of inflexible technical points. We respectfully suggest that leaving the current discretionary standard of "may", rather than the proposed inflexible standard of "shall" in imposing penalties retains the ability of the Commission to prevent abuses of the rules,

while allowing some flexibility in applying penalties for minor, technical, or inadvertent errors and increases the probability cases will be decided on the merits, rather than on technicalities.

4 NCAC 10A .0608. Proposed Rule .0608 relates to written or recorded statements. At line 7, the proposed rule provides that a plaintiff shall be furnished a copy of the statement within 45 days "after request." While it appears the intent of the proposed rule is that "after request" means "after request from the plaintiff", the language is unclear in that regard and might be interpreted to mean a copy must be furnished within 45 days after the employer requests to take a statement, which in many cases would be unworkable. The proposed rule goes on to provide, at line 9, that a copy of the statement must be furnished no less than 45 days from the filing of a Form 33. There is no exception for situations where a copy of the statement has previously been provided, nor is there any exception for the situation where the statement and its contents do not form any part of the issue for which the Form 33 has been filed. This will result in inflexibility and unnecessary expense. Finally, subsection (b) of the proposed rule makes it mandatory that any violation of the rule, no matter how slight or unavoidable, must always result in an order prohibiting the use of the statement or any part of it. There is no exception for circumstances such as the inability of the reporter to complete the transcript, or the failure of the delivery service to complete the delivery of the transcript within the allotted time period, neither of which would be in the control of the employer or carrier. We respectfully suggest the proposed rule should be changed to clarify that a copy of the transcript must be provided when requested by the plaintiff, that a copy must be provided when a Form 33 is filed unless a copy has previously been provided or will not be used in the hearing, and should be changed to allow the Commission discretion in entering orders on the use of a transcript when the failure to meet the time requirements is inadvertent, or the consequence of circumstances beyond the control of the employer or carrier.

4 NCAC 10C .0103 (3). As written, the proposed rule redefines "Vocational Rehabilitation" to include services not simply designed to achieve a return to suitable employment, but also to "to substantially increase the employee's wage-earning capacity." We believe this provision is without statutory basis, is contrary to the spirit and purpose of the Workers' Compensation Act and is directly contradictory to the recently revised N.C.G.S §97-2(22) and §97-32(2). It has long been established that when an injured worker returns to employment earning their pre-injury wage, their disability, defined as a loss of wage earning capacity resulting from an injury, ceases. As written, the proposed rule is vague and appears to circumvent the statutory definitions of suitability and vocational rehabilitation. We suggest this provision be removed from the proposed rule.

Thank you for your kind consideration of these comments.

Sincerely,

State Farm Insurance Companies
David A. Stoller
Legislative Liaison/Claim Attorney

Cronk, Amber

From: Amy Hazel <ahazel@carolinacasemgmt.com>
Sent: Friday, September 14, 2012 6:20 PM
To: Cronk, Amber
Subject: Support of the Recommendations made by IARPS

As a vocational rehabilitation specialist/case manager, supervisor and a member of IARPS, I support the recommendations of IARPS for the proposed changes to the NCIC Rules of Rehabilitation.

Thank you.

PLEASE NOTE: My new office number is 252-822-2637

Amy Hazel, MS, CRC, CVE
Asst. Director of Vocational Services/Supervisor
Carolina Case Management
252-822-2637
Fax- 1-800-853-5612

AMERICAN INSURANCE ASSOCIATION

2101 L Street NW
Suite 400
Washington, DC 20037
202-828-7100
Fax 202-293-1219
www.aiadc.org

September 14, 2012

VIA ELECTRONIC MAIL

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

Re: Proposed Readoption with Amendments of Workers' Compensation Rules

Dear Ms. Cronk,

The American Insurance Association ("AIA") welcomes the opportunity to submit comments on the proposed readoption with amendments of the rules of the Industrial Commission relating to workers' compensation. AIA represents approximately 300 major property and casualty insurers that write more than $383 million in workers' compensation insurance in North Carolina, representing more than 33% of the market.

Following is a summary of our concerns with various aspects of the proposal:

Rule 10A.0105 – Electronic Payment of Costs: The proposed amendments would require electronic payment for all fees and costs owed to the Industrial Commission, whereas electronic payment is currently "authorized." AIA opposes mandating electronic payment for all fees and costs because it would impose a large resource burden on insurers, particularly smaller insurers who write only workers' compensation insurance. Requiring insurers to make payments by either electronic check or credit card would create financial control issues, since these instruments are typically not accessible by administrative employees – either because insurers have prudently decided (or, in the case of publicly traded companies under the federal Sarbanes-Oxley Act, are required) to institute tight controls over these methods of payment.

Rule 10A.0301(a) – Proof of Coverage: The proposed amendments would eliminate language that currently permits employers to satisfy the proof of insurance coverage (POC) reporting requirement by a notice from the employer's insurer, through the Rate Bureau, certifying that coverage has been received. AIA opposes eliminating this option, since it would unnecessarily burden employers by requiring them to report

POC information that workers' compensation insurers already file with both the Rate Bureau and NCCI.

Rule 10J.0101(c) – Fees for Medical Compensation: We believe readoption of subsection (c), relating to hospital fees, fails to satisfy the requirement in §150B-21.9 of the Administrative Procedure Act that rules be within the authority delegated to the agency by the General Assembly. The cited statutory authority, §97-26(b) of the Workers' Compensation Act, provides that "payment for medical treatment and services rendered to workers' compensation patients by a hospital shall be a *reasonable fee* determined by the (Industrial) Commission" (emphasis added). However, the Hospital Fee Schedule adopted by the Commission provides that payments for inpatient (at least the outlier component), outpatient and ambulatory surgical center (ASC) services are based on a percentage of a hospital's charges.

Charge-based reimbursement results in inherently unreasonable fees, since it provides hospitals with an incentive to report charges that bear no relation to the actual cost of providing services. In its 2007 Biennial Report, Florida's "Three Member Panel"[1] noted that charge-based reimbursement systems lack accountability and control mechanisms and create inappropriate incentives to use one type of facility over another for financial rather than clinical reasons. North Carolina's charge-based approach to reimbursing hospital services has resulted in inordinately high payments for these services, burdening the state's employers with unnecessary additional costs.

Studies by the Workers' Compensation Research Institute (WCRI) suggest that overall payments to hospitals in North Carolina as of 2007 were about 23% higher per claim for inpatient hospital services and 32% higher for outpatient hospital services compared to the median for 12 states studied by WCRI. North Carolina ranked second only to Illinois for average medical payments to hospitals for each workers' compensation claim, with an average of $6,400 compared to the median of $5,212. WCRI also found, in studies performed in 2003 and 2007, that the average unit prices paid for hospital services in North Carolina were significantly higher than in other states. Average hospital prices were 21% higher than the median in the 2003 study and 43% higher in the 2007 study, which indicates that North Carolina hospital payments and prices are becoming increasingly disproportionate. For both studies, North Carolina costs for hospital services were highest among all 12 states.

Furthermore, while the hospital fee rule was amended in 2009 to reduce the percentage of charges that may be billed, there is preliminary evidence that hospitals drastically increased charges in advance of the rule's effective date, and that current fees for hospital services in North Carolina are up to 500% higher than fees for identical services in Georgia and South Carolina.

The standard for hospital reimbursement should be scientifically based and widely used – values which are embodied in payment systems adopted by Medicare, the most

[1] The Three Member Panel consists of the Chief Financial Officer and employer and employee representatives appointed by the Governor.

ubiquitous reimbursement system in the country. There is nothing inherent to a Medicare-based fee schedule that is adverse to either payors or providers. The policy issue is how best to ensure access by injured workers to high-quality medical care, without workers' compensation effectively subsidizing losses under other payor systems, and at a cost affordable to employers who pay the premiums. States that have adopted a Medicare-based reimbursement system for hospital services include California, Colorado, North Dakota, Pennsylvania, South Carolina, Tennessee, Texas and Washington.

Accordingly, AIA recommends adoption of Medicare-based systems for reimbursing all hospital costs. For outpatient and ASC services, this means adopting the Ambulatory Patient Classification (APC) approach. For inpatient services, while the Commission has already adopted the State Health Plan's Diagnosis Related Group (DRG) approach, it has adopted a different outlier system for workers' compensation that provides an incentive for hospitals to overbill above the DRG amount by guaranteeing payment of at least 75% of charges. Accordingly, we recommend adoption of the State Health Plan's outlier system, which is based on length of stay.

We also believe there should be a reasonable standard for reimbursing hospitals for implants and supplies, which are currently excluded from the cost plus 20% provision billed on Form UB-92 and only allowed if they are billed on Form HCFA-1500. As a result, billings for implants and supplies are often 200%-500% more than their actual cost and sometimes constitute more than 50% of the entire bill submitted. We recommend adopting the actual cost plus 20% approach used in South Carolina.

Finally, we oppose the elimination of language in subsection (d) that effectively reduces, from 60 to 30 days, the amount of time an insurer has to pay a medical bill before a penalty is applied. This is a significant reduction in time that will be difficult to meet.

Rule 10A.0502(b)(4) – Compromise Settlement Agreements: There is no statutory authority to require the employer or insurance carrier to pay all disputed and unpaid medical expenses when liability for the claim is denied. Since medical providers generally seek pre-authorization to treat injured workers, they are aware that payment may be withheld where a claim is being disputed.

Rule 10A.0603(a) – Responding to a Party's Request for Hearing: There is no statutory authority to require the insurance carrier respond to an employee's hearing request without requiring the employee to respond to a similar request made by a defendant.

Rule 10A.0604(c) – Appointment of Guardian Ad Litem: There is no statutory authority to assess a fee to be paid by the employer or insurance carrier to an attorney who serves as a guardian *ad litem*.

Rule 10A.0611(e) – Hearings Before the Commission: While the rule does not specify the party against whom hearing costs shall be assessed, in practice they are

uniformly assessed against employers. We recommend amending the rule to provide that costs shall either be assessed against the party requesting a hearing or borne equally by both parties.

Rule 10A.0902 – Notice: There is no statutory authority for this notice, which insurance carriers must send to employees by certified mail before using check endorsement language on the back of an employee's benefit check pursuant to Rule 10A.0901. This is a burdensome requirement that is redundant of the check endorsement language.

Rule 10C.0107(h) – Rehabilitation Professionals – Initial Meeting: This rule requires the initial meeting of the injured worker and rehabilitation professional to take place at the office of the worker's attorney, if requested by the injured worker or his or attorney. AIA objects to the requirement of an in-person meeting where requested because many insurers' business models utilize rehabilitation professionals who conduct all of their activities telephonically for the sake of efficiency. It would be very wasteful to commit several hours of travel for what may be an extremely short meeting that the rules already contemplate may be handled telephonically, as the definition of "rehabilitation professional" in Rule 10C.0103(1) includes professionals providing vocational rehabilitation services "whether on site, telephonic, or in or out of state." Accordingly, we recommend either eliminating the option of requesting an in-person meeting or permitting insurers to decline such requests.

Rule 10G.0104A(e) – Foreign Language Interpreters: We object to the requirement that the employer or insurer pay the fee for an employee's foreign language interpreter at a mediation where the employee is represented by an attorney, since the attorney must be able to communicate with his or her client.

****

Once again, we appreciate the opportunity to comment on the proposed readoption of the Commission's rules, and we look forward to working with you to ensure that the final product is beneficial and cost-effective for all stakeholders. If you have any questions about these comments, please feel free to contact me at (202) 828-7167 or kstoller@aiadc.org.

Respectfully submitted,

Kenneth A. Stoller
Assistant General Counsel

cc: John B. McMillan
Raymond G. Farmer

Progressive Medical
More control. Better outcomes.

250 Progressive Way
Westerville, OH 43082

Phone: 614.794.3300
Toll Free: 800.777.3574

progressive@progressive-medical.com
www.progressive-medical.com

September 13, 2012

Amber Cronk
North Carolina Industrial Commission
430 North Salisbury Street
Room 2173
Raleigh, NC 27603

Delivered via Email: amber.cronk@ic.nc.gov

Re: Comments on Proposed Rule Change 10F

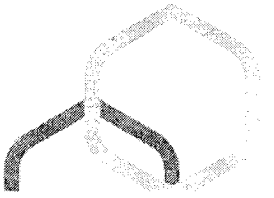
Dear Ms. Cronk:

Thank you for the opportunity to submit written comments to the proposed rule changes in North Carolina. This letter will summarize our verbal testimony provided at the hearing on August 6, 2012.

Progressive Medical, Inc. is an industry leader and innovator, providing pharmacy benefit management services for injured workers across the United States. Our unique strategies incorporate the latest technological tools and strategic alliances that allow us to effectively manage pharmacy and durable medical services for injured workers. Our sister company, P2P Link, is one of the nation's leading providers of e-billing services for providers and payors in the workers' compensation system. We have extensive experience and expertise in the e-billing arena.

Our comments are focused on the changes proposed for Section 10F – Electronic Billing. Progressive Medical and P2P Link encourage states to develop e-billing systems that are in harmony with the standards established by the IAIABC. And specifically, as it relates to pharmacy services, we support using the NCPDP D.0 standard. In keeping with the IAIABC strategy, Progressive Medical and P2P Link also strongly recommend that the Commission adopt a companion guide that can provide more specific detail and instruction related to specific data elements and transaction processes. While we support regulation to implement and require electronic billing solutions, we also support enough flexibility in the system to allow the marketplace to remain competitive and innovative and able to evolve as technology and learning advances.

We applaud the Commission's effort and commitment to e-billing, but Progressive Medical and P2P Link do have some specific recommendations and concerns regarding the proposed rule. They are outlined by section below:



Rule 10F .0102 – Definitions

Progressive Medical and P2P Link recommend adding a definition for "Processing Agent" – a third party entity that contracts with providers to process claims, assume assignment of rights to claims and act in behalf of the provider.

Processing agents are commonly used in the pharmacy area to handle workers' compensation claims. Adding a definition recognizes their role in the system and clarifies their right to act in behalf of the provider and their responsibility to comply with the rules established by the Commission.

Rule 10F .0103 – Formats for Medical Bill Processing

Progressive Medical and P2P Link recommend modifying paragraph (b) as follows:

(b) Nothing in this Subchapter shall prohibit payers and health care providers from using a direct data entry methodology, **or other mutually agreed upon format** for complying with these requirements, provided the methodology complies with the data content requirements of the adopted formats and these rules.

There are a number of entities already connected electronically and regularly exchanging information. In some cases these entities may be using formats that are slightly different than the IAIABC standards, but still contain all of the required data elements. To require a major programming change would be costly and have little benefit in the system and would have a chilling effect on innovation in the e-billing world. Most states adopting e-billing standards have inserted a provision in their rules allowing for mutually agreed upon formats to continue and to be developed as long as the required data elements are secured.

Rule 10F .0105 – Electronic Medical Billing, Reimbursement, and Documentation

In paragraph 5 of this section, Progressive Medical and P2P Link recommend adding "business days" and allowing for three business days to send an acknowledgement.

Adding business days will allow for staffing and resource flexibility over weekends and holidays. While in most cases two business days is sufficient time, three business days allows for a cushion in the event of system or programmatic glitches that occasionally occur.

Rule 10F .0107 – Communication Between Health Care Providers and Payers

Progressive Medical and P2P Link has a general concern with the wording in paragraph (a) requiring communication to be "of sufficient specific detail to allow the responder to easily identify the information required to resolve…" Our concern is who will be the judge and how will they judge what is meant by "sufficient specific detail." Additionally, paragraph (b) encourages the use of the ASC X12 Reason Codes. Has the Commission determined that those codes and their associated definitions meet the standard established by paragraph (a)? These are important questions as the interpretation or intent of the Commission will determine whether

current programming standards used in other jurisdictions are sufficient or whether entities will have to undertake extensive and expensive programming modifications to comply with the intent/requirements of this section.

Thank you for your thoughtful consideration of our comments, both verbal and written. We remain committed to assisting North Carolina in implementing an effective and efficient e-billing initiative in their workers' compensation system. If you have any questions regarding our comments or require any other assistance, please do not hesitate to contact Brian Allen at 801-230-8379 or via email at Brian.Allen@progressive-medical.com.

Sincerely,

Brian Allen
Vice President
Government Affairs

Express Scripts
One Express Way
St Louis, MO 63121

September 13, 2012

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

Re: North Carolina Proposed e-Billing Rules – 4 NCAC 10F .0101, .0103, .0104, .0105, .0106, .0107, .0108 and .0109

Attention: Amber Cronk

Express Scripts, Inc. is responding to the North Carolina Industrial Commission published Proposed Rule changes.

Express Scripts, Inc. is one of the largest pharmacy benefit management (PBM) companies in North America, providing PBM services to thousands of client groups, including managed-care organizations, insurance carriers, employers, third-party administrators, public sector, workers' compensation, and union-sponsored benefit plans. Express Scripts takes a strategic approach to workers' compensation, structuring customized client solutions around best-in-class core services, which are supported by advanced trend-management and clinical-review programs, to ensure safety for injured workers, while aggressively controlling costs.

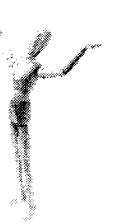
Express Scripts is submitting the following comments and questions for consideration by NCIC. We ask for further examination of the following prior to adoption:

1. 4 NCAC 10F .0101 – Clarification is needed on the effective date.
    a. Within the language it states: "Carriers and medical providers shall comply with the Rule on or before January 1, 2014."
    b. We also suggest that the NCIC look at the effective date for the section of the Rule. Currently it states: January 1, 2013 – the remaining sections have an effective date if: March 1, 2014.

2. 4 NCAC 10F .0102 –
    a. ESI suggests that the NCIC create and provide a definition in the proposed rules for:
        i. Provider
        ii. Provider Agent
        iii. Third Party Biller or Assignee
    b. We also suggests that the NCIC look at the effective date for the section of the Rule. Currently it states: March 1, 2014, with section 10F .0101 showing January 1, 2014 and January 1, 2013.

3. 4 NCAC 10F .0103 –
    a. ESI suggests the NCIC add language to allow providers and payors to use "mutually agreed upon alternative formats", as many payors and providers who are engaged in eBilling practices may already have established billing formats; other implemented eBilling formats allow providers and payors to use alternative formats.
    b. ESI suggests voluntary eBilling participation for providers but require payors to be capable of properly handling, processing and reimbursing any electronic bill sent from a provider. If the decision is to mandate ebilling, we suggest allowing a transition period of 2 years.
    c. ESI would like to know if the NCIC will be creating an eBilling "companion guide" to provide additional clarification on billing and payment requirements. ESI suggests the NCIC establish and include an associated companion guide as other states who have adopted eBilling requirements have also provided a state specific eBilling "companion guide."
    d. We also suggest that the NCIC look at the effective date for the section of the Rule. Currently it states: March 1, 2014, with section 10F .0101 showing January 1, 2014 and January 1, 2013.

4. 4 NCAC 10F .0105 –
    a. ESI requests the NCIC to clarify payment and remittance time frames due to conflict between the proposed rule and existing payment timeframes.
        i. Proposed 4 NCAC 10F .0106(i) states 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.
    b. ESI suggests the NCIC add the wording "calendar" to further describe how the "day count" is calculated on the payment time frames.
        i. For Example: "... a complete medical bill shall be paid within 30 "calendar" days of receipt of the original bill..."
    c. ESI supports the NCIC's proposed usage of standard NCPDP and ASC X12 835-5010 reject/reason codes.



d. We also suggest that the NCIC look at the effective date for the section of the Rule. Currently it states: March 1, 2014, with section 10F .0101 showing January 1, 2014 and January 1, 2013.

Express Scripts appreciates the opportunity to provide input to the North Carolina Industrial Commission and looks forward to the opportunity to provide insight and assistance in future discussions.

Sincerely,

Kristie Griffin
Compliance Manager, Workers' Compensation

Cronk, Amber

From: Joni Liebel, MHS, CCM, CDMS, CLCP <liebelcasemgt@aol.com>
Sent: Friday, September 14, 2012 4:49 PM
To: Cronk, Amber
Subject: NCIC Rule changes

I wanted to share my support for the suggested changes to the NC Rehab Rules proposed by IARP

Joni Liebel, MHS, CCM, CDMS, CLCP
Concord, NC

North Carolina Hospital Association
Serving North Carolina's Hospitals & Health Systems

September 14, 2012

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

RE: Comment on Proposed Hospital Fee Schedule Rule

Dear Ms. Cronk:

The North Carolina Hospital Association represents North Carolina's hospitals on legislative, regulatory, and other issues impacting hospitals and has worked with the Industrial Commission and others on medical fee schedule issues in the past. I am responding to comments filed late yesterday by the Employers Coalition of North Carolina (ECNC) alleging that the proposed rule improperly establishes the hospital fee schedule.

ECNC asserts, among other things, the following:

- That hospitals charge what they want
- That they charge more for services for services to injured workers than they charge to other plans
- That there is no fee schedule
- That the Industrial Commission has not reviewed and updated the fee schedule

The Industrial Commission has in fact established a fee schedule for inpatient and outpatient rates paid by workers' compensation. Inpatient rates are paid on a DRG system, subject to a payment corridor based on a percentage of charges. Outpatient rates are based on a percentage discount off of charges. Both of these types of payment schedules (DRGs and discounts off of charges) are commonly used for other payers in this State and establish what a hospital will be paid for each service. Although states take different approaches as to how they regulate workers' compensation reimbursement for hospitals, discounts off of charges are one of the methods used to establish the fees that hospitals will be paid. Hospitals' charge increases are dictated by rising labor costs, increased costs for improved technology used in medical treatment, an aging population and workforce that uses these services, and many other factors, not by workers' compensation. Workers' compensation accounts for a very small percentage of a hospital's services and does not drive pricing.

Hospitals do <u>not</u> charge workers' compensation carriers more to treat injured workers than they charge other payers. In fact, every patient is charged the same, regardless of who is paying the bill. G.S. 97-26(c) prohibits hospitals from charging workers compensation carriers and employers more than their usual fee. Medicare law also prohibits differential charges. What ECNC appears to be complaining about is the amount that workers compensation carriers pay (i.e., how much of a discount they receive).

The Industrial Commission frequently reviews issues relating to workers compensation reimbursement, including reviewing the same reports that ECNC, NCHA, and many others see annually from WCRI. The Commission spent a great deal of time looking at this issue a few years ago, including having an advisory panel of business, provider, labor, and insurer representatives look at these issues. Following the work of the panel and an in-depth cost analysis of the proposed fee schedule changes (which were projected to reduce hospital reimbursement by more than $30 million annually), the Commission adopted the current fee schedule that is contained in the proposed rule.

G.S. 97-26 gives the Commission three responsibilities in setting the fees for providers: (i) ensure that injured workers are provided the standard of services and care intended by the Workers Compensation Act, (ii) ensure that providers are reimbursed reasonable fees for providing these services, and (iii) ensure that medical costs are adequately contained. Many payers overlook the significance of the first standard: ensuring that injured workers get the care they need. When the Commission adjusted the fee schedule a few years ago -- and as it looks at medical cost trends and other issues each year when reviewing WCRI data and other data on medical costs -- it is balancing all three of these standards as it's required to do under the law. Had the Commission adopted some of the proposals that have been offered during the past few years to severely reduce reimbursement to hospitals, it likely would have resulted in some hospitals curtailing or ending non-emergency workers' compensation services – creating a major access problem for injured workers.

As NCHA has noted many times to insurers in discussing the hospital fee schedule, workers' compensation is the most labor-intensive payment system that hospitals face. The Commission has been provided evidence in the past that hospitals spend much more time with medical records issues and other administrative tasks for workers compensation than they do for other payment systems. Workers compensation also takes 2 to 3 times longer to pay than health plans. Larger health insurance plans usually offer better efficiencies and much more timely payment to hospitals than workers' compensation insurers. Their discounts reflect these efficiencies and timely payment.

NCHA is always willing to discuss reimbursement, changes to the fee schedule, and related issues with the business, labor, and insurer communities. However, concerns over the level of reimbursement set by the Commission are not grounds for calling into question the validity of the proposed rule. Please feel free to contact us if you have any questions.

With best regards,

Linwood Jones

Linwood Jones
General Counsel
North Carolina Hospital Association

ORBOCK RUARK & DILLARD, PC
ATTORNEYS AT LAW

BARBARA E. RUARK
ROGER L. DILLARD, JR.†
KENT C. FORD
MARK A. LEACH
JESSICA E. LYLES

†DRC CERTIFIED MEDIATOR

MAUREEN TIERNEY ORBOCK – RETIRED

1690 WESTBROOK PLAZA DR.
SUITE 102
WINSTON-SALEM, NC 27103

TELEPHONE: (336) 760-8848
FAX: (336) 760-5903

WRITER'S E-MAIL: markleach@ord-law.com

September 14, 2012

Via Email: amber.cronk@ic.nc.gov;

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

Re: Comments and objections to proposed rules

Dear Ms. Cronk:

Following are objections and comments pertaining to the draft Workers' Compensation Rules (subchapter 10A) posted on the Commission's website as of this date. These observations are tendered with appreciation for the work being done by the Commission, and with respect for any countervailing observations the Commission may consider in this process.

Rule .0301(e): Consider revising to read at lines 29-30, "Upon notice from the Commission *seeking confirmation of coverage or self-insured status*, an employer shall show proof of coverage..." Consider revising (e)(6) to read, "...upon *reasonable* request of the Commission."

Rule .0301(f) Consider striking first sentence and revising second sentence to read, "If any subcontractor allows its insurance to lapse and ceases to qualify as a self-insured employer, then it shall, within twenty-four hours, notify any contractor..." First sentence is duplicative of the statute and unnecessary. Revision to second sentence eliminates unnecessary verbiage and acknowledges that any contracting entity having provided providing a certificate of insurance to a contractor would be a "subcontractor."

Rule .0401(b) and (c): The rule is confusing. It mandates counting the calendar day after the injury in some situations even if disability has not yet arisen, which conflicts with N.C. Gen. Stat. §97-28. It is also ambiguous as to whether, if the employee fails to return to work the next regular workday after an injury, the second calendar day is to be counted, assuming it was not a workday.

Consider striking this rule because it is either duplicative of the statute or unnecessarily interpretive of it.

Rule .0402(b): The precise mechanism of computing the average weekly wage is not clear other than that it must be based in some unspecified way upon the applicable fractional portion of the week worked. The rule could be revised to specify exactly how the fractional week should be included in the computation; but a better revision would be to eliminate this subsection because it is unnecessary; appellate case law in the area of average weekly wage is subject to development; and there are numerous other aspects of average weekly wage computation that are not addressed directly in the rules, without there being a special need to address fractional weeks.

Rule .0404: The first sentence of subsection (a) duplicates the statute. The text in subsection (a), "Where the award is to pay compensation during disability, there is a rebuttable presumption that disability continues until the employee returns to suitable employment" should be stricken because it is erroneous and in conflict with North Carolina law. The law on presumptions is complex, debatable, subject to judicial development, and in existence without needing to be restated in the rules. In subsection (b) the need to list the various contents in the Form 24 is not apparent, and this has not been done in other sections pertaining to other forms. Some of the service provisions in subsection (c) are redundant, and accordingly the text in lines 33 through 34, "...*Application to Terminate or Suspend Payment of Compensation* on the employee's attorney of record or the employee if not represented, by e-mail, facsimile or U.S. Mail" may be deleted. Likewise, the text in lines 1 and 2 of the following page, "If the Form 24 *Application to Terminate or Suspend Payment of Compensation* if served by U.S. Mail, a copy shall also be uploaded to the Electronic Document Feed Portal" is superfluous. The requirement conditioning review on completion of the blank specifying pages is unnecessary and unnecessarily inflexible. In the next sentence, on line 6, "objects" could be replaced by "files objection" to clear ambiguity. Line 10 could be revised to read, "contemporaneously served by the same method of transmission on the employer..." The first sentence of subsection (e) is duplicative of the statute. Relevant text in lines 23-25 could be condensed to read simply, "The informal hearing may be by telephone conference or in person."

The sentence allowing for appeal under Rule 703 at lines 18 to 19 is duplicative of similar text at line 33 and 34 within subsection (g). The statement at line 36 of subsection (g) and going onto the next page at line 1 regarding the employer's purported burden of producing evidence is arguably erroneous and in conflict with North Carolina law. At a bare minimum the rule should be silent as to the burdens of production and proof and allow the parties to argue such issues with appropriate citation to North Carolina law. The first sentence within subsection (h) could conclude with the clause, "on a preemptive basis," to better comport with the statute. The next sentence could be revised for clarity to state (beginning with the language on line 9), "...Form 33 *Request that Claim be Assigned for Hearing,* or if the parties agree, they may notify the Commission that a Formal hearing is not currently necessary." Language within subsection (j) from lines 17 to 18 could be cleaned up to read, "...*Compensation,* unless there is agreement by the parties, where allowed by statute, or where the employee is incarcerated."

Rule .0404A: This draft rule should have a zero before the period to be in conformity with the numbering of the other rules. The rule is objectionable because it would mandate reinstitution of compensation in some cases with legitimate factual, medical, or legal issues calling into question

the employee's entitlement to disability benefits. This defect may be cured by allowing an employer to deny reinstatement of benefits on reasonable grounds. This revision could be accomplished by inserting the clause, "absent legal grounds supporting a denial of compensation" at the end of the sentence ending in line 25 within subsection (c); adding the clause, "unless there are reasonable grounds supporting the employer's denial of compensation" to the end of the first sentence of subsection (d); deleting subsection (e) and renumbering the remaining subsections accordingly; adding the clause, "unless there are reasonable grounds supporting denial of compensation" to the sentence ending at line 25 within subsection (g)(3); striking the word "and" from the end of subsection (g)(4); replacing the period with "; and" at the end of subsection (g)(5); and adding (g)(6), claims where there are reasonable grounds supporting the employer's denial of compensation.

The text in lines 17 to 18 under subsection (g)(1), "the employee is not absent from work for more than one day..." is unnecessary and superseded by subsection (g)(2). At line 25, the clause, "unless there are reasonable grounds supporting denial of compensation" should be added to the end of the first sentence under subsection (g)(3), and the second sentence at lines 25 to 29 should be deleted as it fails to capture all fact patterns where reasonable grounds may exists to contest the reinstatement of benefits, including a termination for cause, working for a different employer with restrictions, etc.

It is well settled that in workers' compensation cases, a claimant ordinarily has the burden of proving both the existence of his disability and its degree[1]. If there are reasonable grounds supporting a denial of reinstitution of compensation, then an employer should not be forced to pay compensation that is not owed pending adjudication of whether the employee has proven entitlement to benefits.

Rule. 0405: There is a minor inconsistency within subsections (b) and (c) in that the defendants have ten days to *send* a response to the Form 23 to the Commission but the order is to be rendered within five days of the expiration of time within which the employer could have *filed* a response. The requirement within subsection (b) to specify the number of pages is unnecessary and unnecessarily inflexible. On the next page, within subsection (d), line 5 could read, "telephone conference *or in person* between the Commission..." Text at lines 14 to 15 within subsection (e) could be clarified to read, "...a Form 33 *Request that Claim be Assigned for Hearing* or if the parties agree, they may notify the Commission that a formal hearing is not currently necessary." The final two sentences in subsection (e) at lines 15 to 19 are duplicative and may be deleted.

Rule .0408: The sentence beginning at line 18 would be more precise if revised to read, "within 30 days *of its receipt of such notice from the Commission*, the employer..." At line 22 of subsection (b), the rule could read, "and *may* attach supporting documentation to the statement of denial." It would be to the employer's own peril not to attach documentation in most cases, but in some cases paper documentation may not be available or necessary. The word "as" within subsection (c) at line 30 is superfluous.

Rule .0409: Text within subsection (e) at lines 25 through 26 could be made more concise to read "...to the Commission on a Form 30 *Agreement for Compensation for Death* as set forth in

[1] *Hilliard v. Apex Cabinet Co.*, 305 N.C. 593, 595, 290 S.E.2d 682, 683 (1982).

Rule .0501 of this Subchapter." Consider adding modifier "minor" to word dependents in line 29 within subsection (f). Subsection (g) is controversial. It is objectionable because there is no statutory authority supporting it; and it places an impracticable burden on the employer to know "potential" beneficiaries and their current addresses.

Rule .0410: Within subsection (a) at lines 4 through 5, the text, "in writing without the express authorization of the employee, to obtain relevant medical information not available in the employee's medical records under G.S. 97-25.6 (c)(1)" is superfluous.

Rule .0501: The proposal to change "material" to "relevant" medical records should be reconsidered. The need for submission of immaterial records is questionable. The concluding clause within subsection (c) in lines 14 and 15 should be reconsidered. As it currently exists this language is subject to the interpretation that the Commission may unilaterally modify the terms of an agreement. The Commission generally lacks statutory or other authority to reform agreements in this way, and an agreement so reformed would cease to be an agreement. Subsection (f) is objectionable because there is no statutory authority for it, and a memorandum of agreement signed by only one party is not an agreement at all.

Rule .0502: Subsection (a)(2) could be revised to read, "A certification of payment of the costs for consideration of the agreement." The word "that" which is stricken in line 23 under subsection (a)(5) does not need to be stricken. On page 2, under subsection (b)(1), the submission of relevant but immaterial records should not be mandated. Subsection (b)(3) would be more clear and consistent with the statute (N.C. Gen. Stat.§97-17) if at line 17 it read, "has undertaken to pay all *authorized or admittedly compensable* medical expenses for the compensable injury to the date of the settlement agreement." Consider deleting subsection (b)(4). The compensability of medical expenses is often one element of complex dispute and compromise among the parties. The statute already compels the Commission to determine whether the positions of the parties are reasonable as to the payment of medical expenses, after considering several specific relevant factors, which are themselves listed in the statute. Likewise, subsection (b)(5) is duplicative with the statute, as is the first sentence of subsection (b)(6). The second sentence of subsection (b)(6) exceeds the statutory requirements, as does subsection (b)(7). (b)(9) is duplicative of the statute [N.C. Gen. Stat.§97-17(a)(3)]. The requirement in subsection (c) for submission of an agreement "upon execution" is unnecessary and unnecessarily inflexible because there are cases when the parties agree to hold a signed agreement while attempting to extricate information from CMS. At line 21, subsection (d) could be revised to read, "Once a compromise settlement agreement has been *submitted to or* approved by the Commission..." This revision acknowledges that the employer often copies the employee contemporaneously when submitting the agreement, and clarifies that it is not necessary to submit the agreement to the employee again after it has been approved by the Commission, if it did so when originally submitting it.

Rule .0503: This rule is confusing because N.C. Gen. Stat. §97-18(h) only refers to one form but the proposed rule refers to two separate forms. The rule is unnecessary in any event if the forms exist apart from the rule.

Rule .0600: This rule and others purporting to authorize the Commission to assess broad sanctions not specifically authorized by statute are controversial and arguably in conflict with North Carolina law. At the very least, there are many unresolved questions regarding the boundaries of

the Commission's authority to sanction, and a delineation of such boundaries is not within the scope of the Commission's rulemaking mandate and authority, but rather within the province of the courts and the legislature.

Rule .0602: Replace "needed" with "expected to be taken" within subsection (a)(5) and revise to read all lay witnesses *expected* to be called to testify... in subsection (a)(6). There are some occasions when each witness cannot be identified for certain at the time of the filing of a hearing request, and there should be some flexibility rather than a strict mandate to identify all witnesses without any enforcement scheme regarding noncompliance with such mandate.

Rule .0603: Consider similar changes to those discussed above for Rule .0602 to subsections (b)(5) and (6) regarding witnesses whose testimony is "expected to be taken by the responding party." Consider changing "and" to "or" in line 24, such that the employer is not required to state an email address on the Form 33R if represented by counsel, for example. The basis for relieving the employee of the obligation to respond to a hearing request is not apparent and should be reconsidered. Notice pleading tends to promote judicial economy.

Rule .0605: The introductory sentence couches the remaining subsections as pertaining to the use of interrogatories, but some of the remaining subsections deal with other items. Subsection (6) could be revised to strike the clause, "up to the time a matter is calendared for a hearing," in that the parties may have from one to three months' notice of a hearing and ample time to conduct necessary discovery including document requests (which might include requests for medical records only learned about through the first round of discovery, etc.) It is of questionable necessity to preclude under subsection (9) motions to compel production of information otherwise obtainable under G.S. 97-25.6. It is also unclear what a party must do to demonstrate the unavailability of information conceivably attainable under G.S.§97-25.6.

Rule .0606: Consider eliminating this rule. It is not unusual for disputes to arise between the parties after an initial hearing in a workers' compensation claim. Exchanging information through discovery promotes judicial economy in most cases, but it can be objected to if it is being abused.

Rule .0608: Consider changing "shall" to "may" in line 13 of subsection (b), consistent with current practice. The rule as currently written would conclusively forbid the introduction into evidence of an important recorded statement not requested by the employee, even if the employer produced it only one day after the 45-day deadline, and even if a period of months went by thereafter before the hearing itself, and even if the statement contained outcome-determinative relevant evidence not otherwise available from any other source. A deputy should have discretion to allow the statement into evidence if he or she believes it should be admitted.

Rule .0609: On page 2, at the beginning of subsection (h), at line 13, consider striking "Where," and replacing it with, "Except as otherwise set forth in these Rules, where..." This revision would acknowledge other occasions within the proposed draft rules where the employee is to be copied by U.S. mail on documents filed electronically with the Commission by the employer.

Rule .0609A: At line 27, within subsection (c), instead of requiring that IMEs be denied absent demonstrated need, consider allowing IMEs if "reasonably necessary." The five-day

deadline for submission of written arguments and briefs places a difficult burden on practitioners. There should be an allowance for a possible extension for good cause. On page 2 on line 6, in text which appears to still be within subsection (d), there is a reference that the docket section will send an order "under the name of the Chair of the Panel to which the appeal is assigned." The implication is that this order will go out from the docket section without being authored or even seen by the Panel Chair whose name it bears. This practice should be rethought.

Subsection (f)(3) is duplicative and unnecessary; subsection (f)(4) is confusing and should be stricken; and vagueness in subsection (f)(5) could be cured by changing "most recent" medical records to "any recent and relevant" medical records.

The existing proposed rule appears to leave the period of time allowable for the submission of evidence on a medical motion to the deputy's discretion. This is good because different cases require a different balance among (1) the medical urgency of the request; (2) whether the request may be irreversible or outcome-determinative in the litigation; (3) the practical difficulties with submitting complex medical evidence including depositions of busy physicians on an inflexible and abbreviated timetable; and (4) the premature finality of an initial administrative decision, if there is an inadequate opportunity for either side to present and develop the relevant medical evidence, and if appeals are dismissed by the higher courts as interlocutory. Rule 609 could encourage consideration of factors such as these. Medical issues must move through the system commensurate with their urgency, but without sacrificing evidence and sound adjudication for speed.

Rule .0611: Consider softening the "manifest injustice" standard for continuances to manifest injustice "or for judicial economy." The basis for assessment of full hearing costs under proposed subsection (e) even for cases that are settled immediately after being calendared is questionable and sometimes produces an unfair result.

Rule .0612: Consider making subsection (d) more concise at lines 16 through 19 to read, "...shall be offered at the hearing before the Deputy Commissioner or by order of a Commissioner or Deputy Commissioner."

Rule .0614: This rule is outside the scope of this comment.

Rule .0615: Consider adding "*by the timely* filing of a Form 33..." to subsection (c) at line 13. The rule should also expressly require that removal may not allow a litigant to evade or extend otherwise-existing legal deadlines.

Rule .0616: Consider adding a section allowing for the dismissal of claims that are shown by clear and convincing evidence to be patently frivolous.

Rule .0617: Consider eliminating the last sentence from subsection (a). The existing rule is vague as to "other applicable law," and offers little guidance over communications between an employee and an employer that are permissible and unavoidable in the workplace setting if the case involves an employee who has returned to work for the employer. There is also an errant hyphen in line 13 under subsection (b) of this rule.

Rule .0701: Consider eliminating or softening the requirement to state "with particularity" the grounds for review and assignments of error, to bring the rule into conformity with revised rules of appellate practice. Add, "absent an order by the Commission" to the end of subsection (e). A modification like this is necessary because the proposed rule currently precludes extensions beyond thirty days in all cases. In some cases an extension beyond thirty days may be required to prevent severe injustice. Consider striking the last sentence of subsection (f) because the rule is vague as to "the time of the hearing of the request for review"; and because if this means oral argument, then there may be special cases where the Commission may wish to hear such motions before oral argument.

Rule .0702: Line 22 within subsection (a) should read, in pertinent part, "...and applications for lump sum payments of compensation. Such decisions shall be reviewed upon the ..."

Rule .0703: Subsection (a) is duplicative of the statute. Subsection (b) does not correspond to the title.

Rule .0802: See comments and objections to Rule .0600, above.

Rule .0903: Consider changing "shall" to "may" in line 16. If the employee agrees that his benefits should not be reinstated, he should not be compelled to submit a written request to reinstate them.

Rule .1000: This rule is outside the scope of this comment.

It is apparent that tremendous effort has gone into the rulemaking process thus far, by the Commission, and by many other thoughtful participants. It will be of immeasurable benefit to litigants and practitioners in this area when the work is completed.

Sincerely,

Mark A. Leach
Orbock, Ruark & Dillard, PC

MAL/tmw

Patterson | Harkavy
LLP

Burton Craige
Narendra K. Ghosh
Jonathan R. Harkavy*
Michael G. Okun
Henry N. Patterson, Jr.

Of Counsel:
Nahomi Harkavy*

* *practice limited to serving as ADR neutrals*

ATTORNEYS AT LAW

100 EUROPA DRIVE, SUITE 250
CHAPEL HILL, NORTH CAROLINA 27517
TELEPHONE (919) 942-5200
FACSIMILE (919) 942-5256

RALEIGH OFFICE
1312 Annapolis Drive
Raleigh, NC 27608

GREENSBORO OFFICE
101 South Elm Street
Greensboro, NC 27401

Reply to Chapel Hill Office

September 14, 2012

Honorable Pamela T. Young, Chair
North Carolina Industrial Commission
Raleigh, North Carolina

Via Electronic Mail

Attention: Amber Cronk, Agency Legal Specialist

Re: Comments on Proposed Rules

Dear Chair Young:

Please accept my comments on the proposed rules that were the subject of the public hearing on August 6, 2012.

4 NCAC 10A.0102
FORMS

This proposed rule provides for the distribution of Commission forms but omits a procedure for the adoption or amendment of forms. The content of Commission forms often affect the substantive rights of the parties. It is essential, therefore, that the Commission allow for public review and comment on forms affecting substantive rights prior to their adoption, repeal or amendment.

The forms themselves should not be subject to the Administrative Procedures Act. But the public should receive prior notice and have the opportunity to comment on forms before they are adopted by the Commission. This is important to assure that the Commission has before it all of the significant ramifications of language in a new or revised form before adoption.

The rule designated 4 NCAC 10A.0102 thus should be revised to add the following paragraph:

> (c) Prior to adopting, repealing, or amending any form affecting substantive rights, the Industrial commission shall give at least 30 days notice of the proposed form or change in the form. Such notice will be given by publication of the text in the North Carolina Register and on the Commission's website. Such notice shall include an invitation to any interested party to submit in writing an objection, suggestion or other comment with respect to the proposed form or change and to appear before the Full Commission at a time and place designated in the notice for the purpose of being heard with respect to this.

The authority for this rule, of course, is found in N.C. Gen. Stat. §97-81(a). I have discussed the form with the North Carolina Office of Administrative Hearings which found its text appropriate.

4 NCAC 10A.0605
DISCOVERY

Paragraph (6) providing for "requests for production of documents without leave of the Commission" should be deleted. This is an unnecessary expansion of the discovery methods presently available to the parties.

The existing Commission Rule 607, encompassed by 4 NCAC 10A.0607, has for many years provided informally for the production of material documents in the possession of a party. Documents can also be provided voluntarily, pursuant to requests contained in interrogatories, and pursuant to Commission order in appropriate circumstances.

There is no justification for expanding discovery and further complicating preparation or trial beyond the existing methods for discovery. Claimant and spousal tax returns and employment records for employees other than the claimant, for example, should not be the subject of Commission discovery by request for production. Broadly permitting requests for production will inevitably lead to more discovery disputes and litigation that does not go to the merits of claims.

The Commission should administer the provisions of the Act "under summary and simple procedure, distinctly its own, so as to furnish speedy, substantial, and complete relief to the parties bound by the Act. Greene v. Spivey, 236 N.C. 435, 73 S.E.2d 488 (1952)

In the 1994 Reform Act, the General Assembly specifically amended the language in §97-80(a) to require that "discovery" in addition to "processes and procedure" under the Act "shall be as summary and simple as reasonably may be." The Full Commission's own Committee to Address Discovery, in 1999, recommended a number of changes in Rule 605 and Rule 607 to modernize Commission discovery and to curb abuses. These changes, generally accepted by the Full Commission, did not provide for requests for production. An expansion of current discovery to include this unnecessary additional discovery mechanism is inconsistent with the Commission's mandate to maintain the "processes, procedure, and discovery under" the Act "as summary and simple as reasonably may be."

Respectfully,

Henry N. Patterson, Jr.

HNPjr/bo

Cronk, Amber

From: Beasley, Lynn <Lynn_Beasley@Corvel.com>
Sent: Friday, September 14, 2012 3:10 PM
To: Cronk, Amber
Cc: Gore, Randy
Subject: RE: Proposed NC Rehab Provider Rule Changes

Importance: High

Hello;

From what I've read of the proposed rule changes; it appears (and I could be misreading), that the assigned Rehab Nurse (QRP) has no option to request to be able to remove him or herself from a case with agreement of the assigned adjuster, without going to great lengths and details in writing to the NC Industrial Commission.

Speaking from many years of personal experience as a case manager, I strongly disagree with this proposed change. There are times (and they are infrequent when as a professional you do your very best to comply with the very complex rules and appease all parties involved), that a patient/patient's representative and his or her Rehab Professional just don't "click" and there are, unfortunately, times when as a Professional Rehab Provider you are subjected to repeated false allegations by a Claimant for whatever reason (personal issues or secondary gain) that Claimant, and/or their representative may have.

At those times the best option for all parties involved is to allow the Rehab Professional, with agreement of the adjuster to remove themselves, based on their own integrity, from said case involvement. Otherwise you subject the Claimant to additional stress and concerns regarding what the Professional Rehab Provider may be required to detail in writing to the Industrial Commission, as well as subjecting the Professional Rehab Provider to unnecessary involvement.

As a registered nurse since 1991, I hold true to the NC Nursing Standards of Practice first and foremost; as well as to my CCM credentials which I obtained in 1996, and my QRP designation. I will continue to promote the utmost excellence in my profession, but I will not subject myself to repeated false allegations from any Claimant, their representative, or unprofessional interrogation in the presence of a Claimant attorney by one of my peers at the NC Industrial Commission. I have the integrity to know when to remove myself from a case to protect not only myself from false allegations and irreparable differences, but also , ultimately , to protect the Claimant. For the greater good....

Most sincerely;

Lynn Beasley, RN, CCM, QRP | Medical Case Manager
CorVel Corporation I Charlotte, NC
13024 Ballantyne Corporate Place, Suite 600,Charlotte, NC 28277
T 704-941-2858 I F 866-450-4152 I C 704-576-7619
lynn_beasley@corvel.com I www.corvel.com

GENEX Services, Inc.
5400 Glenwood Avenue
Suite 220
Raleigh, NC 27612
919.787.1045 FAX: 877.211.6810
www.genexservices.com

Siri C Wiik MS, CRC, CCM
Branch Manager, Raleigh
Jeanne Russell MS, CRC, CCM
Branch Manager, Charlotte

GENEX
Solving the Cost/Care Equation

September 14, 2012

Amber Cronk
North Carolina Industrial Commission,
4336 Mail Service Center,
Raleigh, NC 27699-4336;
e-mail: amber.cronk@ic.nc.gov.

Dear Ms. Cronk;

This letter is in follow up to the Proposed Rule changes. We appreciate the opportunity to respond on behalf of the GENEX case management team in North Carolina which encompasses approximately 80 Field Case Managers in the state with another 25 employees, including managers, supervisors and clerical support. We have the opportunity to work for a large national organization that is well respected, that is URAC credentialed and provides comprehensive training, coaching and learning and development opportunity for our case managers and supervisors.

Please note that my counterpart who manages the western part of the state and I managing the eastern part of the state, have been practicing rehabilitation professionals for many years. I have personally been in the business since 1986 and my counterpart Jeanne Russell since 1978. We both hold a Master's Degree in Rehabilitation Counseling with specific emphasis in the medical and vocational rehabilitation of persons with disability. I have been in North Carolina since 1986 and Jeanne, since 1985, both of us practicing as medical and vocational field case managers, supervisors and operations managers in the same industry. I have served as a consultant to large employers on disability and absence management and we have both had the opportunity to serve on many professional committees and organizations during our years of service to disabled individuals.

In 1994, I was president of the North Carolina Chapter of IARP when we began the discussions and development of the Rules for Utilization of Rehabilitation Professionals that went into effect in 2000. Jeanne Russell was President of the North Carolina Rehabilitation Counseling Association at that same time. We worked very hard as a team of diverse professionals representing all interests in achieving a consensus of our roles and emphasizing the importance of communication amongst all parties in the rehabilitation of our mutual clients with disabilities.

We have reviewed the response written by representatives from IARP, our professional organization for Rehabilitation Professionals. We are in agreement of those comments and recommendations that are specific to our role as rehabilitation professionals. GENEX case managers are experienced, credentialed and well versed in the ethical responsibilities of their

roles to facilitate recovery and serve as an effective liaison advocating for our client, the injured worker.

We agree with the credentialing process as well as the CRP and QRP expectations in North Carolina. Our recommendations also include the following:

4NCAC 10C .0103 Definitions

- (3) Vocational Rehabilitation should have the statutory definition with no further explanation.
- (3) Delete "and to substantially increase the employee's wage-earning capacity" as that is a part of one section of the vocational rehabilitation section but should not apply to all vocational rehabilitation cases.
- (5) It would be beneficial to have the definition for Suitable Employment, since these rules are provided to the injured workers and most are not able to go to the statute to obtain the definitions.

4 NCAC 10C .0105 Qualifications Required

- (d) (2) change "have prior employment within the North Carolina Department of Health and Human Services as a vocational rehabilitation provider" to "Employed within the North Carolina Department of Health and Human Services as a vocational rehabilitation provider." This item was originally intended to allow state employees to provide services within the Rules if they did not meet the other qualifications required. Having prior employment does not give the Rehabilitation Professional the automatic qualifications within the Rules. If the RP leaves the state agency, they would need to meet the other qualifications for providing services within the Rules.

4 NCAC 10C .0106 Professional Responsibility of the Rehabilitation Professional in Workers' Compensation Claims

- (c) Delete word "medical" before rehabilitation professional for consistency with the other items and definitions of the rehabilitation professional in the first section.
- (e) Delete websites for certifications as those items change frequently and the Rules should remain more up to date; these items could always be in an addendum if needed but not part of the Rules.
- (g) Delete "activity during his or her assignment in the case" as a rehabilitation professional should not be involved in these activities, even if no longer assigned this case.
- (h) Delete "during his or her assignment in the case" as a rehabilitation professional should not be involved in the legal matters, even if no longer assigned this case.

4 NCAC 10C .0107 Communication

- (b) Request that NCIC provide a Summary of the Rules to provide to the injured workers as was done previously.
- Conflict in wording with the following sections and wording should be consistent with providing relevant information in each section:
    - (b) rehabilitation professional is required to share RELEVANT medical and vocational rehabilitation information
    - (e) rehabilitation professionals shall present ONLY information RELEVANT AND MATERIAL to the workers' medical rehabilitation and vocational rehabilitation
    - (f) Rehabilitation professionals shall make periodic written reports documenting accurately and completely the substance of ALL ACTIVITY in the case, including REHABILITATION ACTIVITY.
    - (g) Communication of activity to all parties...MUST occur when information RELEVANT to the rehabilitation process is obtained.

4 NCAC 10C .0108 Interaction with Physicians

- (f) Wording should be consistent with Communication (d) section; change to "The rehabilitation professional shall provide copies of all written communications with medical care providers electronically to all parties by email or facsimile to all parties without email on the same day and completely record and report all oral communications."

4 NCAC 10C .0109 Vocational Rehabilitation Services and Return to Work

- (d) Written assessment of retraining or education request should also include assessment of feasibility documented with reference to the employee's aptitudes and training, adequate capitalization, and market conditions.
- (h) should leave in previous "recognized standards, which may include but not be limited to" as the Dictionary of Occupational Titles and Handbook for Analyzing Job are out of date and are not planned to be updated; vocational rehabilitation professionals need to utilize the most appropriate tools, not just these two options.

4 NCAC 10C .0110 Change of Rehabilitation Professional

- Delete "to prevent manifest injustice" as these words may lead to an unjust character assassination of the rehabilitation professionals. Questioning a process in a rehabilitation plan should be professionally communicated and worked through rather than allowing such character assassins.

4 NCAC 10C .201 Suspension of the Rules

- Delete "to prevent manifest injustice"
- Would propose that this section be deleted completely. Use of this would void the entire reasoning behind the Rules.

We are hopeful that a fair and reasonable set of rules will be the outcome, rules that facilitate equal and fair professionalism amongst all parties with effective communication, which fosters a positive outcome for the client.

Thank you for the opportunity to present our stance on behalf of the GENEX Services, Inc. team of Rehabilitation Professionals in North Carolina. We welcome the opportunity to review any questions or comments at any time.

Respectfully submitted by,

Siri C Wiik MS CRC CCM

Siri C. Wiik MS, CRC, CCM
Raleigh Branch Manager
GENEX Services, Inc.

Jeanne Russell MS CRC CCM

Jeanne Russell MS, CRC, CCM
Charlotte Branch Manager
GENEX Services, Inc.

Cronk, Amber

From: Frick, David <David_Frick@CORVEL.COM>
Sent: Friday, September 14, 2012 1:06 PM
To: Cronk, Amber
Subject: NCIC Rule Changes

Hello:
I just wanted to submit my opinion that I agree with the rule changes provided by the IARP.

Thank you,

David Frick, M.Ed., CRC, QRP I Vocational Case Manager
CorVel Corporation I Charlotte, NC
13024 Ballantyne Corporate Place, Suite 600, Charlotte, NC 28277
T 704/941-2810 I F 866/450-4152 I C 704/654-2524
david_frick@corvel.com I www.corvel.com

Cronk, Amber

From: Sandy Frost <sfrost@carolinacasemgmt.com>
Sent: Friday, September 14, 2012 12:39 PM
To: Cronk, Amber
Subject: rehab rules

I agree with the IRAP statements regarding the rule changes.

Thank you!

Please note my new phone number 336-944-4832 effective 7/13/12

Sandy Frost, M.S. CRC

Vocational Case Manager
Carolina Case Management & Rehabilitation Services
Tel: 336-944-4832
Fax: 800-853-5612
sfrost@carolinacasemgmt.com

North Carolina General Assembly
Senate

SENATOR DOUGLAS E. BERGER
7TH DISTRICT

OFFICE ADDRESS: 516 LEGISLATIVE OFFICE BUILDING
300 N. SALISBURY STREET
RALEIGH, NC 27603-5925
TELEPHONE: (919) 715-8363
(919) 754-3159 FAX
E-MAIL: dougb@ncleg.net
DISTRICT: POST OFFICE BOX 1101
YOUNGSVILLE, NC 27596
(919) 671-6565

COMMITTEES
APPROPRIATIONS ON HEALTH AND HUMAN SERVICES
COMMERCE
HEALTH CARE
JUDICIARY II
INSURANCE

September 14, 2012

North Carolina Industrial Commission
Attn: Amber Cronk
4336 Mail Service Center
Raleigh, NC 27699-4336
Via email to amber.cronk@ic.nc.gov

Re: Proposed Rules

Dear Commissioners:

I am writing to provide my response to the recent oral and written comments made by the North Carolina Association of Defense Attorneys (NCADA) wherein the NCADA has stated its opinion that proposed Rules 10A.0405 (Reinstatement of Compensation) and 10A.0609A (Medical Motions and Emergency Medical Motions) lack statutory authority under the North Carolina Workers' Compensation Act and the Administrative Procedures Act.

I am uniquely qualified to comment that these proposed rules are within the requirements of the Administrative Procedures Act and are statutorily supported by the Workers' Compensation Act based on 1.) my work as a legislator who drafted N.C. Gen. Stat. §97-18(k); 2.) my past experience as one of the Deputy Commissioners who helped to implement the motions procedure at the Commission; and, 3.) my current experience as a practicing attorney in the area of workers' compensation.

The proposed rules must be viewed in light of the fact that the workers' compensation statute originally was enacted as a compromise to provide medical and limited indemnity benefits in an expeditious manner to injured workers in exchange for limited liability exposure to employers. It would be a breach of this social contract codified by the Workers' Compensation Act to uphold the promise made to employers while breaking the promises made to injured workers, who gave up their rights to pursue their injuries through common law personal injury claims in lieu of a system that would provide limited benefits through an efficient system.

N.C. Gen. Stat. §97-18(k) arose out of a need for an expeditious method to reinstate benefits in cases where liability has already been established and claimants were clearly entitled

to reinstatement, but had to go through a full evidentiary hearing, which delayed the compensation that claimants and their families were forced to depend on due to a claimant's disability. As one of the legislators drafting this particular section, our specific intent was to provide claimants in accepted claims with a less formal procedure than the full evidentiary hearing allowed by N.C. Gen. Stat. §97-83 to reinstate benefits. The language of the statute specifically states that the claimant "may move for reinstatement on a form prescribed by the Commission." The word "move" is significant because it suggests a motions'-type process, which creates a different procedure than that already allowed by N.C. Gen. Stat. §97-83. Additionally, the language of the statute clearly leaves it to the Commission's discretion to prescribe a form on which a claimant may move for reinstatement of benefits. Notably, the statute does not require that the claimant use a Form 33, which would be required for a full evidentiary hearing. In requiring the claimant to move for reinstatement on a form, the language of N.C. Gen. Stat. §97-18(k) clearly authorizes the Commission to create a form that would allow claimants to "move" for reinstatement. N.C. Gen. Stat. §97-18(k) gives employees an additional process by which they may seek reinstatement of benefits.

The Commission immediately implemented a process to carry out N.C. Gen. Stat. §97-18(k) and has now proposed Rule 10A.0405 to codify the process. The experience of claimants to date is that the process is working as was intended by N.C. Gen. Stat. §97-18(k). While the Commission is probably authorized to create the current Form 23 process without needing to adopt a rule, N.C. Gen. Stat. §97-80(a) clearly permits the Commission to create the Form 23 process that it has implemented.

Proposed Rule 10A.0609A carries out the mandatory provision in N.C. Gen. Stat. §97-78(f) & (g). N.C. Gen. Stat. §97-78(f)(2) requires the expeditious resolution of medical issues in accepted claims. N.C. Gen. Stat. §97-78(g)(2) requires the Commission to report to the General Assembly information about the cases where medical issues were not resolved within 45 days of the filing of the motion filed with the Commission. I drafted this language and, therefore, there is no one more qualified than I to provide the intent of what the legislator meant by requiring a report from the Commission of all cases that were not resolved within 45 days by motion. By the use of the word "motion", the legislature clearly intended a different process to resolve medical issues than the process in N.C. Gen. Stat. §97-83, which allows the Commission 180 days from the close of the hearing record to file an opinion and award.

It is important to understand that N.C. Gen. Stat. §97-78 only applies to cases where liability for a claim has already been established. The burden to satisfy due process in the administration of an accepted claim is different than in a denied claim. The Commission has the authority to administer an accepted claim to determine any future issues other than compensability of the claim.

Again, just as with the administration of N.C. Gen. Stat. §97-18(k), in developing the medical and emergency medical motions' process, experience shows that the Commission has properly exercised discretion in deciding whether a request belongs in the expedited process or should be sent for a full evidentiary hearing. When questions of relatedness or costly treatment have arisen, the Commission has exercised its authority to liberally grant the parties with the ability to depose the experts or to refer the claim for a full evidentiary hearing. As such, the

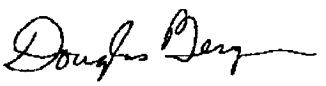
Commission's current procedure clearly has the flexibility to protect the due process rights of NCADA members' clients.

Furthermore, N.C. Gen. Stat. §97-25.3 further supports the current medical motions process insofar as it is a rebuttal to any claims of lack of due process because it already limits the types of medical treatment that allow for a pre-authorization requirement from the carrier and gives a short time limit of no more than 10 days by which the carrier can require pre-authorization in those limited circumstances.

The NCADA objections to proposed Rule 10A.0609A is in contravention of the clear language of N.C. Gen. Stat. §97-78(f)&(g), which clearly allows for an expeditious method of resolving medical disputes in accepted claims such as the current medical motions' process. The practical effect of doing away with the current process would be to require claimants to delay the requested treatment for several months, or even years, if the request runs through the appeals process. All the while a claimant's condition has the potential of getting worse for lack of the treatment, with a possible end effect being that the treatment might be ineffective by the time the process runs through the system. In contrast, the impact to the NCADA members' clients is minimal in that, even with the current expedited process, they retain the right to appeal and request a stay for the pendency of the appeal.

I thank the Commission for the opportunity to provide these comments based on my unique qualifications as a legislator who was deeply engaged in the drafting of the revised Workers' Compensation Act, a former Deputy Commissioner who helped implement the motions' process and my experience practicing law in the field of workers' compensation. I remain,

Respectfully yours,



Senator Doug Berger

Cronk, Amber

From: Norma Talley <Norma.Talley@southernrehab.net>
Sent: Friday, September 14, 2012 12:24 PM
To: Cronk, Amber
Subject: NC Rehab Rules

Hi Amber,
I would like to go on record stating that I support the NC Rehab rule changes as suggested by IARP.
Thanks,
Norma Talley

Norma Talley, RN, CCM
Clinical Coordinator
Southern Rehabilitation Network
800-781-1137 Ext 374
919-210-6513 cell

Cronk, Amber

From: Spencer, Scott R <Scott_Spencer@Corvel.com>
Sent: Friday, September 14, 2012 11:51 AM
To: Cronk, Amber
Subject: IC Rule Change Reccomendations

Dear Ms. Cronk,

I would like to lend my support to the opinions of that IARP presented to the changes in the Rules for Rehabilitation Professionals. I fully support the options they outlined as exceptional for all parties in light of the proposed changes.

Thanks for allowing me to offer my support.

Scott R. Spencer, MA, CRC, QRP | Vocational Case Manager CorVel Corporation | Charlotte, NC
13024 Ballantyne Corporate Place, Suite 600, Charlotte, NC 28277 T 704-941-2831 | F 866-450-4152 | C 704-654-2408
scott_r_spencer@corvel.com | www.corvel.com

CompPharma

September 14, 2012

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

Re: Proposed North Carolina eBilling Rules - 4 NCAC 10F .0101, .0103, .0104, .0105, .0106, .0107, .0108 and .0109

Dear Ms. Cronk:

CompPharma appreciates the opportunity to comment on the proposed eBilling rules for North Carolina. CompPharma is a national association comprised of pharmacy benefit management (PBMs) firms that process more than 80 percent of the workers' compensation prescriptions filled in the United States and North Carolina.

We support the development of eBilling rules and guidance in North Carolina and other states. Additionally, CompPharma 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.

Because we have found instances where effective dates seem to conflict, we ask the commission to review the proposed rule to ensure consistency. We also ask for further examination of the following prior to adoption:

1- 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.

2- 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.

3- 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.

4- 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."

5- 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.

6- 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. 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?

7- We support the state's proposed usage of standard NCPDP and ASC X12 835-5010 reject and reason codes. We believe states should avoid creation and utilization of state-specific codes.

8- 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.

Thank you again for the opportunity to comment. Our members stand ready to provide additional information or clarification on these requests.

Sincerely,

Joe Paduda

Joseph Paduda
President

TheZenith®

September 13, 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

Zenith Insurance Company appreciates the opportunity to provide comments concerning the proposed electronic billing and payment Rules, 4 NCAC Chapter 10F and proposed Fees for Medical Compensation 4 NCAC 10J .0101. Zenith is a workers' compensation insurance specialist and conducts business in over 40 states. We support the regulations as they aid in efficiency and simplification of the billing and payment transaction process between medical providers and payers.

Our experience in implementing e-billing regulations in other states has been that the further you deviate from national standards the more cumbersome and costly the implementation process becomes. We would encourage the Commission, as much as possible; to utilize the national standards and guidance found in IAIABC eBilling, ASC x 12 – 835-5010 for medical care and the rejection only NCPCP D.0 for pharmacy care.

Please consider the following comments and suggestions as you finalize the proposed regulations:

4 NCAC 10F .0101 – ELECTRONIC MEDICAL BILLING AND PAYMENT REQUIREMENT
Carriers and medical providers shall utilize electronic billing and payment in workers' compensation claims. Carriers and medical providers shall develop and implement electronic billing and payment processes consistent with 45 CFR 162. Carriers and medical providers shall comply with this Rule on or before January 1, 2014. 45 9 CFR 162 is hereby incorporated by reference and includes subsequent amendments and editions. A copy may be obtained at no charge from the National Archives and Records Administration'swebsite,http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr162_main_02.tpl, or upon request, at the offices of the Commission, located in the Dobbs Building, 430 North Salisbury Street, Raleigh, North Carolina, between the hours of 8:00 a.m. and 5:00 p.m.

> Comments: It is recommended that exemptions be offered for certain medical providers who handle a small amount of workers' compensation patients. The potential economic burden could affect availability of care in areas where resources are limited.

4 NCAC 10F .0102 – DEFINITIONS
As used in this Subchapter:
(1) "Clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that is an agent of either the payer or the provider and that may perform the following functions:
(A) Processes or facilitates the processing of medical billing information received from a client in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction for further processing of a bill related transaction; or
(B) Receives a standard transaction from another entity and processes or facilitates the processing of medical billing information into nonstandard format or nonstandard data content for a client entity.

(2) "Complete electronic bill" submission means a medical bill that meets all of the criteria enumerated in this Subchapter
(3) "Electronic" refers to a communication between computerized data exchange systems that complies with the standards enumerated in this Subchapter.
(4) "Implementation guide" is a published document for national electronic standard formats as defined in this Subchapter that specifies data requirements and data transaction sets.
(5) "National Provider Identification Number" or "NPI" means the unique identifier assigned to a health care provider or health care facility by the Secretary of the United States Department of Health and Human Services.
(6) "Payer" means the insurance carrier, third-party administrator, managed care organization, or employer responsible for paying the workers' compensation medical bills.
(7) "Payer agent" here means any person or entity that performs 1 medical bill related processes for the payer responsible for the bill. These processes include reporting to government agencies, electronic transmission, forwarding or receipt of documents, review of reports, adjudication of bill, and final payment.

Comments:
Suggest adding several definitions, including but not limited to complete bill, duplicate bill, healthcare provider, and/or third party biller or assignee similar to those found in the CA Medical Billing and Payment Guide, Section 1.0. It is important to define these additional system participants and bill types so that they have the same meaning for all stakeholders as follows:

"Complete Paper Bill" means a bill submitted on the correct uniform billing form/format, with the correct uniform billing code sets, filled out in compliance with the form/format requirements of the Companion Guide with the required reports and/or supporting documentation as set forth in 10F .0105 (b).

"Assignee" means a person or entity that has purchased the right to receive payments for medical services from the health care provider or health care facility and is authorized to collect payment from the responsible payer.

"Duplicate bill" means a bill that is exactly the same as a bill that has been previously submitted and with no new services added, except that the duplicate bill may have a different "billing date."

"Health Care Provider" means a provider of medical treatment, including but not limited to a physician, a non-physician or any other person or entity who furnishes medical treatment, in the normal course of business and within the scope of their degree and/or license.

4 NCAC 10F .0103 - FORMATS FOR ELECTRONIC MEDICAL BILL PROCESSING
(a) Beginning March 1, 2014, electronic medical billing transactions shall be conducted using the electronic formats adopted under the Code of Federal Regulations, Title 45, part 162, subparts K, N, and P. Whenever a standard format is replaced with a newer standard, the most recent standard shall be used. The requirement to use a new version shall commence on the effective date of the new version as published in the Code of Federal Regulations. The Code of Federal Regulations, Title 45, part 162, subparts K, N, and P is hereby incorporated by reference and includes subsequent amendments and editions. A copy may be obtained at no charge from the Internal Revenue Service's website, http://ecfr.gpoaccess.gov, or upon request, at the offices of the Commission, located in the Dobbs Building, 430 North Salisbury Street, Raleigh, North Carolina, between the hours of 8:00 a.m. and 5:00 p.m. (b) Nothing in this Subchapter shall prohibit payers and health care providers from using a direct

data entry methodology for complying with these requirements, provided the methodology complies with the data content requirements of the adopted formats and these rules.

Comments: Effective date for this section is 3/1/2014 which is inconsistent with NCAC 10F. 0101. One effective date should be chosen so that so that consistent timelines can be effectively managed. It is also recommend that alternative forms/format or procedures be allowed by mutual agreement and suggest adding language to this section as (c) similar to CA Medical Billing and Payment Guide, Section 7.4 (b), as follows:
This Medical Billing and Payment Guide does not prohibit a claims administrator or health care provider, health care facility or billing agent/assignee from using alternative forms/format or procedures provided such forms/format or procedures are specified in a written agreement between the claims administrator and the health care provider, health care facility, billing agent/assignee or clearinghouse, as long as the alternative billing and transmission format provides all the required information set forth in this Rule or in the Companion Guide.

4 NCAC 10F .0105 (b)(4)(F) - ELECTRONIC MEDICAL BILLING, REIMBURSEMENT, AND DOCUMENT ATION
(b) To be considered a complete electronic medical bill, the bill or supporting transmissions shall:
(4) identify the:
(F) any other requirements as presented in the companion guide; and

Comment: We strongly urge the Commission to make the Companion Guide referenced above in 10F.0105 (b) (4) (F) available well before the implementation date of electronic billing and payment.

4 NCAC 10F.0105(c)(5):
(5) A payer shall acknowledge receipt of an electronic medical bill by returning a Health Care Claim Status Response or Acknowledgment (ASC X12 277) transaction (detail acknowledgment) within two days of receipt of the electronic submission.
(A) Notification of a rejected bill is transmitted in an ASC X12N 277 response or acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill or does not meet the edits defined in the applicable implementation guide or guides.
(B) A health care provider or its agent may not submit a duplicate electronic medical bill earlier than 60 days from the date originally submitted if a payer has acknowledged acceptance of the original complete electronic medical bill. A health care provider or its agent may submit a corrected medical bill electronically to the payer after receiving notification of a rejection. The corrected medical bill shall be submitted as a new, original bill.

Comment: Recommend adding (C) A bill which has been previously submitted in one manner (paper or electronic) may not subsequently be submitted in another manner. Also recommend adding language to address a timeline for the waiting period when a payer is notified that an attachment is being sent separately. We suggest five days similar to the CA Medical Billing and Payment Guide, Section 7.1 (a) (3)(A) Claim Pending Status Information, copied here for reference:
"(A) 005010X214 Claim Pending Status Information
(i) A bill submitted, but missing an attachment, or the injured worker"s claim number, shall be held as pending for up to five working days while the attachment and/or claim number is provided, prior to being rejected as incomplete. If the issue is a missing claim number, during the

five working day timeframe the claims administrator shall, if possible, promptly locate and affix the claim number to the bill for processing and payment. All other timeframes are suspended during the time period the bill is pending. The payment timeframe resumes when the claim number is determined, or when the missing attachment is received. The "pending" period suspends the 15 working-day timeframe during the period that the bill is pending, but upon matching the claim number, or receiving the attachment, the timeframe resumes. The 15 working day time period to pay the bill does not begin anew. An extension of the five working day pending period may be mutually agreed upon.
(ii) If a bill is placed in pending status due to a missing attachment or claim number, a Health Care Claim Acknowledgement 005010X214 pending notice shall be sent to the submitter/provider indicating that the bill has been put into pending status and indicating the specific reason for doing so using the appropriate 005010X214 code values.
(iii) If the required information is not received by the claims administrator within the five working days, or the claims administrator is not able to locate and affix the claim number, the bill may be rejected as being incomplete utilizing the ASC X12N/005010X214."

4 NCAC 10F. 0105 (c) (9):
(9) Transmission of an Implementation Acknowledgment under Subsection (c)(2) of this Rule and acceptance of a complete, structurally correct file serves as proof of the received date for an electronic medical bill in this Rule.

Comment: This section creates confusion about the proper receive date. We suggest changing this section to read as follows because the Healthcare Claims Status Response or Acknowledgement is the response sent when the bill is determined to be complete or incomplete:
(9) Transmission of a Healthcare Claims Status Response or Acknowledgement under Subsection (c)(5) of this Rule and acceptance of a complete, structurally correct file serves as proof of the received date for an electronic medical bill in this Rule.

4 NCAC 10F.0105 (d):
(d) Electronic Documentation
(1) Electronic documentation, including but not limited to medical reports and records submitted electronically that support an electronic medical bill, may be required by the payer before payment may be remitted to the health care provider. Electronic documentation may be submitted simultaneously with the electronic medical bill.
(2) Electronic transmittal by electronic mail shall contain the following information:
(A) name of the injured employee;
(B) identification of the worker's employer, the employer's insurance carrier, or the third party administrator or its agent handling the workers' compensation claim;
(C) identification of the health care provider billing for services to the employee, and where applicable, its agent;
(D) date(s) of service; and
(E) workers' compensation claim number assigned by the payer, if known.

Comment: Recommend expanding this section to include language regarding electronic bill attachments. If attachments are submitted separately an indicator is needed on the bill that an attachment will follow under separate cover which will provide cross reference to the medical bill to which it is associated. As an example, the CA Medical Billing and Payment Guide, Section 7.3 is copied here for reference:

"(a) Required reports and/or supporting documentation to support a bill as defined in Complete Bill Section 3.0 shall be submitted in accordance with this section. Unless otherwise agreed by the parties, all attachments to support an electronically submitted bill must either have a header or attached cover sheet that provides the following information:
(1) Claims Administrator - the name shall be the same as populated in the 005010X222, 005010X223, or 005010X224. Loop 2010BB, NM103.
(2) Employer - the name shall be the same as populated in the 005010X222, 005010X223, or 005010X224, Loop 2010BA, NM103.
(3) Unique Attachment Indicator Number - the Unique Attachment Indicator Number shall be the same as populated in the 005010X222, 005010X223, or 005010X224, Loop 2300, PWK Segment: Report Type Code, the Report Transmission Code, Attachment Control Qualifier (AC) and the unique Attachment Control Number. It is the combination of these data elements that will allow a claims administrator to appropriately match the incoming attachment to the electronic medical bill. Refer to the Companion Guide Chapter 2 for information regarding the Unique Attachment Indicator Number Code Sets.
(4) Billing Provider NPI Number – the number must be the same as populated in Loop 2010AA, NM109. If the provider is ineligible for an NPI, then this number is the provider"s atypical billing provider ID. This number must be the same as populated in Loop 2010AA, REF02.
(5) Billing Provider Name.
(6) Bill Transaction Identification Number – This shall be the same number as populated in the ASC 005010X222, 005010X223, or 005010X224 transactions, Loop 2300 Claim Information, CLM01.
(7) Document type – use Report Type codes as set forth in Appendix C of the Companion Guides.
(8) Page Number/Number of Pages the page numbers reported should include the cover sheet.
(9) Contact Name/Phone Number including area code.
(b) All attachments to support an electronically submitted bill shall contain the following information in the body of the attachment or on an attached cover sheet:
(1) Patient"s name
(2) Claims Administrator"s name
(3) Date of Service
(4) Date of Injury
(5) Social Security number (if available)
(6) Claim number (if available)
(7) Unique Attachment Indicator Number
(c) All attachment submissions shall comply with the rules set forth in Section One – 3.0 Complete Bills and Section Three – Security Rules. They shall be submitted according to the protocols specified in the Companion Guide Chapter 8 or other mutually agreed upon methods.
(d) Attachment submission methods:
(1) FAX
(2) Electronic submission – if submitting electronically, the Division strongly recommends using the ASC X12N/005010X210 Additional Information to Support a Health Care Claim or Encounter (275) transaction set. Specifications for this transaction set are found in the Companion Guide Chapter 8. The Division is not mandating the use of this transaction set. Other methods of transmission may be mutually agreed upon by the parties.
(3) E-mail – must be encrypted
(e) Attachment types
(1) Reports
(2) Supporting Documentation
(3) Written Authorization

(4) Misc. (other type of attachment) "

4 NCAC 10F.0105 (e) (3)
(e) Electronic remittance notification
(3) The electronic remittance notification shall contain the appropriate Group Claim Adjustment Reason Codes, Claim Adjustment Reason Codes (CARC) and associated Remittance Advice Remark Codes (RARC) as specified by ASC X12 835 implementation guide or, for pharmacy charges, the National Council for Prescription Drugs Program (NCPDP) Reject Codes, denoting the reason for payment, adjustment, or denial.

Comment: For ease of implementation, we encourage the Commission to model other states, such as California and Texas, to utilize only the CARC and RARC codes as specified in the ASCx12 835 implementation guide for electronic remittance notification, including NCPDP pharmacy transactions. We agree with using the NCPDP reject codes for the ASCX12 277 responses.

4 NCAC 10F .0106 - EMPLOYER, INSURANCE CARRIER, MANAGED CARE ORGANIZATION, OR AGENTS' RECEIPT OF MEDICAL BILLS FROM HEALTH CARE PROVIDERS
(a) Upon receipt of medical bills submitted in accordance with these rules, a payer shall evaluate each bill's conformance with the criteria of a complete medical bill as follows:
(1) A payer shall not return to the health care provider medical bills that are complete, unless the bill is a duplicate bill.
(2) Within 21 days of receipt of an incomplete medical bill, a payer or its agent shall either:
(A) Complete the bill by adding missing health care provider identification or demographic information already known to the payer; or,
(B) Return the bill to the sender, in accordance with this paragraph.
(b) The received date of an electronic medical bill is the date all of the contents of a complete electronic bill are successfully received by the claims payer.

Comment: Suggest adding a section to address paper bills separate from electronic bills, for example (a) (2) seems to be introducing a different timeline to send back an incomplete (paper) bill as opposed to 4 NCAC 10F .0105 (c) (5) where it says to return an incomplete electronic bill within two days.

NCAC 10F .0106 (i)
(i) Payment of all uncontested portions of a complete medical bill shall be made within 30 days of receipt of the original bill, or receipt of additional information requested by the payer allowed under the law. Amounts paid after the 30 day review period shall accrue an interest penalty of 10 percent per month after the due date. The interest payment shall be made at the same time as the medical bill payment.

Comment: Recommend changing to sixty day timeline to be consistent with Statute § 97-18. Prompt payment of compensation required; installments; payment without prejudice; notice to Commission; penalties.

4 NCAC 10J. 0101 FEES FOR MEDICAL COMPENSATION
(d) A provider of medical compensation shall submit its statement for services within 75 days of the rendition of the service, or if treatment is longer, within 30 days after the end of the month during which multiple treatments were provided. However, in cases where liability is initially denied but subsequently admitted or determined by the Commission, the time for submission of medical bills shall run from the

time the health care provider received notice of the admission or determination of liability. Within 30 days of receipt of the statement, the employer, carrier, or managed care organization, or administrator

on its behalf, shall pay or submit the statement to the Commission for approval or send the provider written objections to the statement. If an employer, carrier, administrator, or managed care organization disputes a portion of the provider's bill, the employer, carrier, administrator, or managed care organization, shall pay the uncontested portion of the bill and shall resolve disputes regarding the balance of the charges through its contractual arrangement or through the Commission.

Comment: Recommend adding back the sixty day timeline to pay a bill language that was removed from this section in order to be consistent with Statute § 97-18. Prompt payment of compensation required; installments; payment without prejudice; notice to Commission; penalties.
Suggest the following language for this section:
If any bill for medical services is not paid within sixty days after it has been approved by the Commission and returned to the responsible party, or within sixty days after it was properly submitted, in accordance with the provisions of this Rule, to an insurer or managed care organization responsible for direct reimbursement there shall be added to such unpaid bill an amount equal to 10 percent, which shall be paid at the same time as, but in addition to, such medical bill, unless late payment is excused by the Commission. When the 10 percent addition to the bill is uncontested, payment shall be made to the provider without notifying or seeking approval from the Commission. When the percent addition to the bill is contested, any party may request a hearing by the Commission pursuant to G.S 97-83, and G.S 97-84.

Thank you for the opportunity to comment on the proposed electronic billing and payment Rules. We look forward to working with the Commission and appreciate all the hard work that went into this Rule development process. If you have any questions please do not hesitate to contact me at the number below.

Sincerely,

Alissen Korsgard

Alissen Korsgard
Zenith Insurance
Compliance Specialist
941-906-5468

EMPLOYERS COALITION OF NORTH CAROLINA

ECNC

2900 Highwoods Blvd., Suite 202, Raleigh, NC 27604
Phone: 919-713-5272
Fax: 919-872-6599
www.ecnc.us

September 14, 2012

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

Re: Objection to Proposed Amendment to 4 NCAC 10J.0101 (Hospital Fee Schedule)

Dear Ms. Cronk:

Employers Coalition of North Carolina (ECNC) consists of the three non-profit employer associations across our state with over 2,500 member employers. ECNC submits this objection to Proposed Amendment 4 NCAC 10J.101 which improperly establishes and reaffirms the existing Hospital Fee Schedule pursuant to NCGS 97-26 (a) and (b). We appreciate the opportunity to summarize why this Proposed Amendment does not comply with 150B-21.9(a)(1).

The Proposed Amendment lacks: 1) the authority delegated to the agency by the General Assembly; 2) the clarity required (to be clear and not ambiguous); and 3) the reasonable necessity to fulfill a duty delegated to the agency.

Under the current rule and Proposed Amendment, hospitals are free, without limitation, to set their charges as high as they choose and change them as often as they choose. There is in actual practice no fee schedule set by the Commission. There is no third-party determination of hospital charges or fees. The Industrial Commission regulates only the percentage of reimbursement allowed against the hospital's unilateral charges.

North Carolina General Statute 97-26(a) requires in part:

. . . the Commission shall adopt a schedule of maximum fees . . .

. . . shall periodically review the schedule . . .

. . . ensure that . . . medical costs are adequately contained . . .

North Carolina General Statute 97-26(b) requires in part:

. . . [hospitals] shall be reimbursed the amount provided for in this section . . .

. . . shall be a reasonable fee determined by the Commission.

By improperly pegging the hospital's fee to a percentage of the hospital's own charges, the Commission has not adopted a fee schedule, has not ensured the charges are appropriate and adequately contained, has not set an "amount", has not reviewed the results of its actions and has not ensured the fee is reasonable.

Employers, and the carriers they support with their premiums, have no set or adopted standard against which to measure or monitor compliance with these statutory mandates. The result is that hospitals unilaterally adjust their charges upward in response to reimbursement percentage adjustments, and they charge significantly more for services to injured workers than private plans of insurance, self-insured group health plans or government health plans. Employers support fees to hospitals that allow coverage of costs and a reasonable margin of profit. Employers cannot financially support a fee schedule that violates statutory mandates and is not a fee schedule at all, but instead a regulatory endorsement of unilateral charges set by hospitals themselves.

Attachments to this letter illustrate 1) WCRI study data showing the hospital response to a 2009 reduction in the allowed reimbursement percentage (they raised charges 16.9% to compensate, resulting in a 2.9% actual net fee increase), and 2) a sample of fees for workers compensation hospital services versus other the same services under other reimbursement plans.

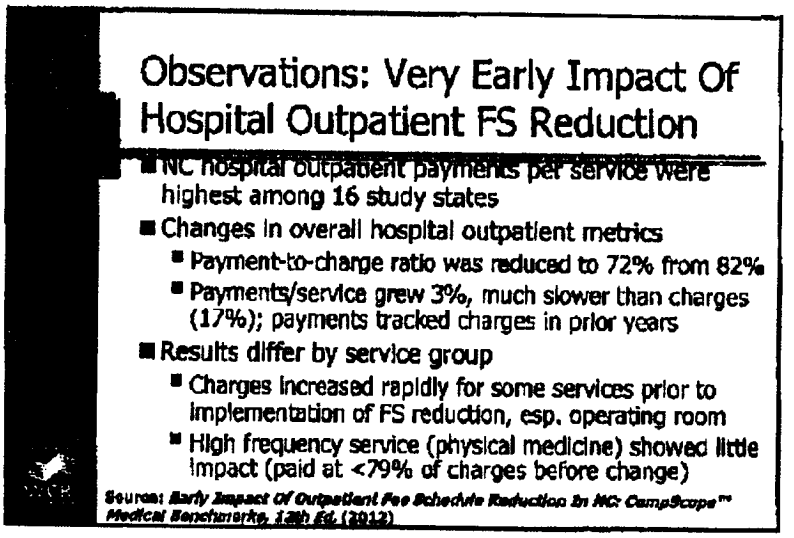
We respectfully request that the Proposed Amendment be rejected and reconsidered under the APA.

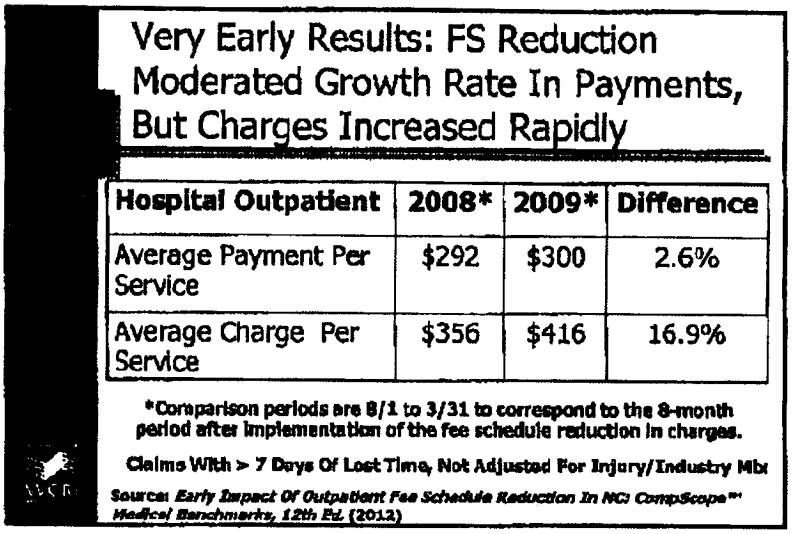
Sincerely,

Connie Wilson

Connie Wilson
ECNC, Government Relations
919-274-0557
Connie @lobbync.com

Early Impact of Outpatient Fee Schedule Reduction In NC ComScope Medical Benchmark, 12th Ed. (2012)
Workers' Compensation Research Institute





PCI Property Casualty Insurers Association of America
Shaping the Future of American Insurance

Trey Gillespie
Senior Workers Compensation Director

September 13, 2012

Amber Cronk
North Carolina Industrial Commission
4336 Mail Service Center
Raleigh, NC 27699-4336
amber.cronk@ic.nc.gov

Re: Proposed New Rules and Amendments to Rules of the Commission
Public Hearing August 6, 2012

Dear Ms. Cronk,

Thank you for setting this matter for rulemaking hearing on August 6, 2012 and allowing PCI and its member companies to participate the hearing.

Property Casualty Insurers Association of America (PCI) is an insurer trade association that represents over 1,000 insurance companies that write approximately 38% of the national commercial property casualty market including 41% of the national workers compensation market. The PCI comments do not necessarily represent the opinions of all member companies.

Proposed Rule 4 NCAC 10F .0106(i) Payment of all uncontested portions of a complete medical bill shall be made within 30 days of receipt of the original bill, or receipt of additional information requested by the payer allowed under the law. Amounts paid after the 30 day review period shall accrue an interest penalty of 10 percent per month after the due date. The interest payment shall be made at the same time as the medical bill payment.

Comment: The Industrial Commission does not have rule making authority to shorten the statutory medical bill payment deadlines found in G.S. 97-18(i). That statute expressly provides that the 10 percent per month interest penalty only applies if the health care provider bill *"...is not paid within 60 days after it has been approved by the Commission and returned to the responsible party, or within 60 days after it was properly submitted, in accordance to the provisions of this Article..."* The Industrial Commission rule making authority found in G.S. 97-26(g1) is limited to the power to adopt rules *"...to require electronic medical billing and payment processes, to standardize the necessary medical documentation for billing adjudication, to provide for effective dates and compliance, and for further implementation of this subsection."* Nothing in this general rule making authority for electronic medical billing is there a grant of authority to modify the specific legislatively mandated prompt payment and penalty provisions of G.S. 97-18(i). This subsection violates the North Carolina Administrative Procedure Act §150B-19(4) and §150B-19.1(a)(1&2).

Recommended wording: **.0106(i)** Payment of all uncontested portions of a complete medical bill shall be made within ~~30~~ 60 days of receipt of the original bill, or receipt of additional information requested by the payer allowed under the law. Amounts paid after the ~~30~~ 60 day review period shall accrue an interest penalty of 10 percent per month after the due date. The interest payment shall be made at the same time as the medical bill payment. Payment of all contested portions of a complete medical bill that have been approved by the Commission shall be made in accordance with G.S. 97-18(i).

Thank you for considering these comments prior to adoption and implementation.

Respectfully submitted,

Trey Gillespie
PCI
700 Lavaca Suite 1435
Austin, TX 78701
512-334-6636
trey.gillespie@pciaa.net

stevens martin vaughn & tadych, PLLC
attorneys at law

Hugh Stevens
C. Amanda Martin
K. Matthew Vaughn
Michael J. Tadych

Hugh Stevens
hugh@smvt.com

13 September 2012

Via E-Mail and Hand Delivery

North Carolina Industrial Commission
Dobbs Building, Sixth Floor
430 North Salisbury Street
Raleigh, North Carolina 27603

Attn: Ms. Amber Cronk

Re: **Comments to Proposed Change to Rule NCAC 10A .0301 PROOF OF INSURANCE COVERAGE**

Ladies and Gentlemen:

Thank you for this opportunity to heartily endorse and urge the implementation of the Commission's proposed changes to Rule NCAC10A.0301, entitled "Proof of Insurance Coverage."

By way of an introduction to the comments that follow, I would like to explain why I am submitting them.

I am an attorney and have been licensed to practice law in North Carolina since 1968. Much of my legal career has been devoted to issues related to openness and transparency in government, including requesting, pursuing and obtaining public records from federal, state and local government agencies on behalf of news organizations and other clients. I also have been and continue to be an advocate for public policies and laws that enhance government transparency and the peoples' opportunity to obtain public records and information. Among other roles, I served for many years as general counsel and lobbyist for the North Carolina Press Association, in which capacity I worked with members of the General Assembly to broaden and clarify the North Carolina Public Records Law, particularly with respect to electronic records. I am a founding member and current board member of the North Carolina Open Government Coalition.

In the course of my work I have assisted both media and non-media clients in requesting public records related to workers' compensation insurance from the

Commission, from the North Carolina Rate Bureau, and from the North Carolina Department of Insurance. Otherwise I have no connection to the Commission or to workers' compensation insurance except as an employer who is required to, and does, carry such insurance pursuant to G.S. § 97-93. I do not practice before the Commission, and I have never handled a workers' compensation claim, either on behalf of a claimant or on behalf of an employer.[1] Accordingly, my comments are directed only to the proposed change to rule NCAC 10A.0301, which relates to Proof of Insurance Coverage.

My specific comments are as follows:

1. I endorse this rule change because it reflects the Commission's acknowledgement of and commitment to the responsibility imposed on it by N.C. Gen. Stat. §97-94, which requires that all employers subject to the Workers' Compensation Act "shall file with the Commission, in the form prescribed by it," proof that they provide the coverage mandated by the Act. The collection and maintenance of core employer compliance data is critical to the Commission's performance of its most basic duty, which is to protect workers and honest employers from those that would endanger and disadvantage them.

2. I endorse this rule change because – assuming that the Commission intends to make the compliance data available to the public -- it reflects and abets the Commission's public commitment to greater transparency. (See comment #6, below.)

3. I endorse this rule change because its adoption would cure a direct and festering conflict of interest by removing the North Carolina Rate Bureau from the process of collecting, maintaining and disseminating employer compliance data. The Commission's current practice of relying on the Rate Bureau as its only source of employer compliance data is unhealthy and unwise, because the Rate Bureau's goals and purposes inherently conflict with the Commission's. Whereas the Commission's statutory responsibility is to protect the interests of both employers and employees by adopting and implementing policies and procedures that maximize the availability and use of workers' compensation insurance, the members of the Rate Bureau have a direct pecuniary interest in limiting competition and keeping workers' compensation insurance rates high. They have no interest in fostering competition or choice or in making workers' compensation insurance as affordable as possible. As the direct consequence of this conflict of interests, the Rate Bureau often withholds or imposes untenable (and legally questionable) conditions on the Commission's access to and use of the very compliance data that it collects on the Commission's behalf. Indeed the Rate Bureau, which was established by the General Assembly and which has many other structural and operational attributes of a public agency, takes the position that it is a private organization that bears no burden of transparency or accountability. Representatives of the Commission have lamented to me that the current arrangement puts the Commission at the mercy of the Rate Bureau with respect to the employer compliance data that is critical to its work.[2]

---

[1] In the course of preparing these comments I have conferred with several lawyers whose practices are devoted entirely to handling workers' compensation cases, both on behalf of injured workers and employers. In these conversations I have been struck by the agreement between plaintiff's lawyers and defense counsel that everyone involved in the workers' compensation system would benefit from greater compliance with the Act, and that compliance would be significantly abetted by the availability of more and more accurate coverage data.

[2] It is important to note that there is a clear distinction between the data needed by the Commission to monitor and enforce compliance with the Workers' Compensation

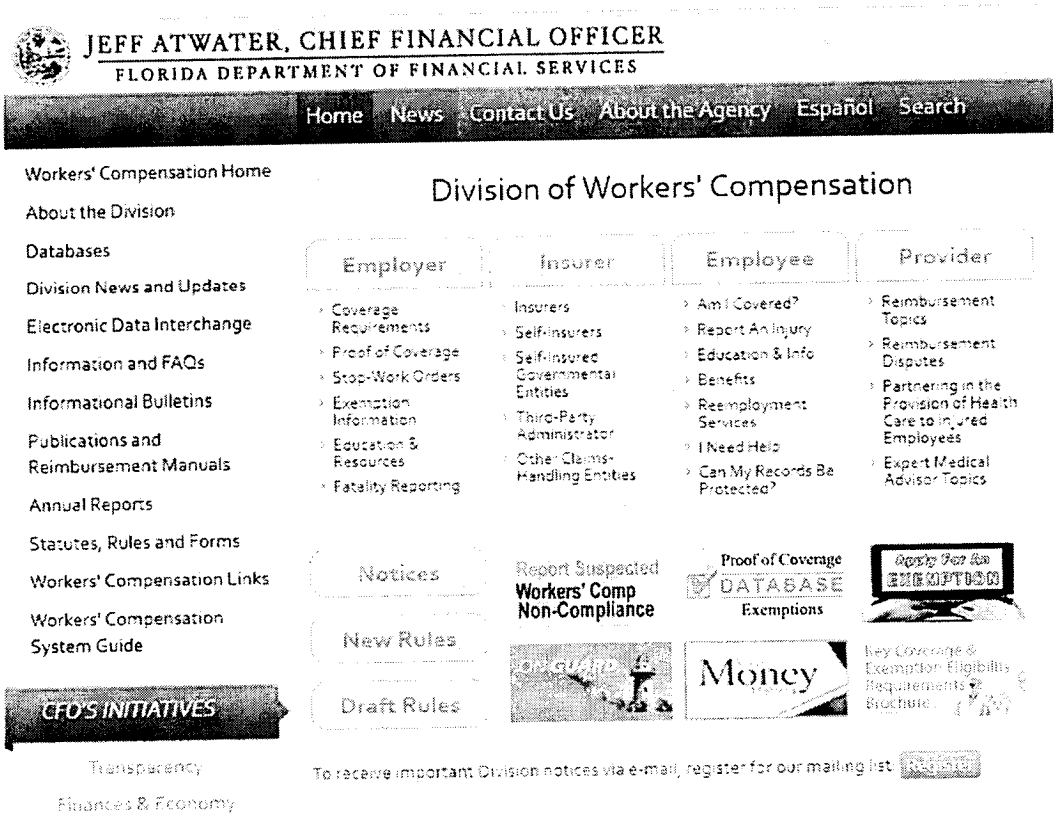
4. I endorse this rule change because its implementation would enable the Commission to collect and maintain employer compliance data that are more accurate and complete than the data currently being provided to the Commission by the Rate Bureau. As *The News & Observer* reported in April, 2012, the Rate Bureau's database lists only about 140,000 workers' compensation policies in effect in North Carolina, but the Commission's parent agency, the North Carolina Department of Commerce, says the state has 170,000 or more employers who are responsible for providing coverage for their employees. *The News & Observer's* more recent series of articles about "ghost workers" has further illuminated the vast compliance gap with respect to workers' compensation insurance that apparently exists in North Carolina. If the Commission is to be able to enforce the Workers' Compensation Act it needs to be able to obtain complete and current compliance data from every employer subject to the Act. The proposed change to NCAC 10A.0301 would provide the Commission with the ability to break the Rate Bureau's stranglehold on the data it collects, which is inadequate to begin with, and to comply fully with G.S. § 97-94.

5. I endorse this rule change because, as the accompanying fiscal analysis indicates, it can be implemented at no cost to the State. In the past Mr. Leggott and other representatives of the Commission have stated publicly that the Commission lacks both the funds and the technological facilities or prowess to collect the compliance data required of employers by G.S. § 97-94. Indeed, *The News & Observer* has quoted the Commission's chairwoman as saying, "If you have a business out there that does not have any intention of having workers' compensation, how do you capture that? How do you find these people?"[3] I believe the answer to Ms. Young's question can be found by the Commission's looking to and contracting with any of several experienced and neutral data-gathering service organizations to cross-reference data from multiple sources and compile them into a single comprehensive public database that includes both information about every North Carolina employer that is subject to the act and the compliance data filed (or not filed) by each such employer. The operative word here is "neutral." That is, the contractor must be tasked with assembling all available compliance data for the Commission in the absence of any conflicting political or pecuniary interest. Because such companies customarily collect a fee from employers or their insurers for filing and maintaining their compliance data, the Commission should be able to enter into such a contract at no net cost to the State; in fact, it is highly likely that the Commission would be able to negotiate an agreement that would actually produce badly needed revenue for the Commission.

Act and the information used by the Rate Bureau to calculate proposed rates on behalf of its members or experience ratings for employers. Over the years two neutral and well-established standards for compliance data have emerged: the IAIABC, to which the Commission currently subscribes, and the WCPOLS, which was developed by the Workers Compensation Insurance Organization. Each of these standards defines the data that states need to monitor and enforce compliance with their worker protection statutes. Different standards developed by the two organizations deal separately with the data required by the Rate Bureau. The comments made on behalf of the Rate Bureau's members at the August 6 public hearing clearly indicate that they want to conflate the two standards and maintain their stranglehold on the Commission's compliance data.

[3] "N.C. agency will force employers to pay injured workers," *The News & Observer*, April 19, 2012.

6. Finally, I endorse the proposed rule change because if it is fully implemented it could provide North Carolina consumers with constant, real-time access to information as to whether employers are complying with the Workers' Compensation Act. I commend to the Commission the example of Florida, where such information is comprehensive, readily accessible on line, and updated daily. To view Florida's compliance data, go to http://www.myfloridacfo.com/wc/, which will bring up the home page for the Workers' Compensation Division of the Florida Department of Financial Services, which looks like this:



Visitors to the site who click on the icon for the "Proof of Coverage Database" (the one with the red check mark) are taken to a page where they can search for any Florida employer's compliance data. The home page also includes the icon for a link where anyone can initiate or review referrals concerning employers suspected of being non-compliant. My personal experience includes reviewing the compliance data for the retirement complex where my 96-year-old mother-in-law resides to verify that the institution provides coverage for the aide who comes to her apartment each day to assist her with bathing and dressing. By contrast, I am not aware of any way that a potential employee or anyone else currently can verify that my law firm carries workers' compensation coverage.[4]

[4] I understand that NCCI, the country's largest rate bureau, supplies data to the Division concerning both workers' comp policies and self-insured group members. In the course of my research I became aware of a 2008 report by Steven Alexander, an actuary with the Florida Office of the Consumer Advocate, entitled "The Case for Reform - State of Florida Workers Compensation Insurance" in which he described NCCI as a cartel. "A cartel," he wrote, "is an alliance of businesses

The Florida Division of Workers' Compensation is not alone in maintaining a publicly accessible compliance database that the Commission would do well to emulate. Oregon, New York and several other states maintain similarly comprehensive and current databases. See, e.g., http://www4.cbs.state.or.us/ex/wcd/cov/and http://www.wcb.ny.gov. I assume the officials in any of those states happily would assist the Commission in planning for and implementing the operation of an equally comprehensive and current public compliance database for North Carolina.

In conclusion, I sympathize with the Commission's feeling that it is unduly subservient to the Rate Bureau and with its apparent intention to break the Rate Bureau's self-serving stranglehold on compliance data in this State. I encourage the Commission to separate the task of assembling and maintaining the compliance data from an entity whose only role in life seems to be to repeatedly petition for higher and higher workers compensation rates and make it available to the public. As *The News & Observer's* recent articles have shown, non-compliance hurts workers and employers alike and adds immeasurably to the Commission's administrative burdens.

Thank you again for the opportunity to comment on this proposed rule change, and for publishing this and all other comments for the public to see.

Very truly yours,

STEVENS MARTIN VAUGHN & TADYCH, PLLC

Hugh Stevens

formed to control production, competition or prices. The NCCI is a cartel in the classic sense." Mr. Alexander's definition would seem to be equally applicable to the North Carolina Rate Bureau.

North Carolina Medical Society
Established 1849
Leadership in Medicine

September 13, 2012

Ms. Amber Cronk, JD
NC Industrial Commission
4336 Mail Service Center
Raleigh, NC 27699-4336

Sent via email to amber.cronk@ic.nc.gov

Re: Comments from the North Carolina Medical Society on Proposed Rules for Workers' Compensation

Dear Ms. Cronk,

The North Carolina Medical Society writes today regarding the North Carolina Industrial Commission's proposed workers' compensation rules that appeared in the North Carolina Register on July 16, 2012. We appreciate the opportunity to provide the following comments on the Commission's proposals, as well as the opportunity to testify at the public hearing offered by the Commission last month.

The North Carolina Medical Society is a professional organization composed of more than 12,000 medical doctors, doctors of osteopathy, residents, and physician assistants. As the largest physician organization in the state, the Society devotes itself to representing the interests of physicians, advancing the medical profession, and improving the quality of patient care. Physicians of many different specialties provide care to our state's injured workers and interact constantly with the workers' compensation system.

04 NCAC 10A .0410 Communications for Medical Information

Proposed Rule .0410 contains some important provisions that clarify how N.C.G.S. 97-25.6 as should function following the passage of House Bill 709 (S.L. 2011-287) and House Bill 237 (S.L. 2012-135).

We agree with and support the Industrial Commission's intention to retain the use of the Medical Status Questionnaire (MSQ) by employers or carriers who wish to communicate in writing with the employee's treating physician about the employee's care. The statutory revisions in 2011 that recast when and how employers could communicate with physicians left the fate of the MSQ in question. We believe paragraph (a) resolves that ambiguity satisfactorily. Many medical practices have grown accustomed to this form and NCMS supports its continued use.

04 NCAC 10A .0502 Compromise Settlement Agreements

The Industrial Commission has proposed significant changes to Rule .0502 regarding Compromise Settlement Agreements (CSAs). Overall, the NCMS believes that these changes will increase the level of transparency in the settlement process, not only to the benefit of the parties and the Commission, but also for medical practices.

Physicians and practices are commonly forced to await a settlement between the parties before receiving compensation for care provided to the employee-patient. The current process for finalizing CSAs has, at times, proven problematic for physicians for some of the following reasons:

- Physicians are restricted from pursuing payment from the employee-patient while a workers' compensation claim is pending.
- Medical practices lack the resources and expertise to continually track the progress of every active workers' compensation claim and to know the status of settlement discussions.
- Rule .0502 currently lacks a requirement that anybody notify an unpaid medical provider that a settlement has been reached. To be fair, some parties and counsel have made it common practice to notify medical practices and satisfy unpaid medical expenses with settlement proceeds. However this practice has not been uniform.
- Rule .0502 is also silent about how a physician practice may seek redress for unpaid bills after a settlement has been reached but the expenses were not paid. This has resulted far too often in avoidable uncompensated care.

Under the Proposed Rule .0502, many of these problems would be reduced or eliminated in the future. We'd particularly like to highlight the changes appearing in paragraph (b) of the proposal. For a CSA to be considered by the Commission, the Rule would require the parties to identify in the agreement all known medical expenses related to the injury (subparagraph (5)), to list all unpaid medical expenses and identify the responsible party for each such expense (subparagraph (6)), and to notify each unpaid medical provider that a settlement has been reached (subparagraph (7)).

NCMS supports the proposed changes to Rule .0502 and ask that they be adopted. We believe these changes comport with G.S. 97-17, and that they will assist the Commission in determining whether the three criteria of G.S. 97-17(b) have been satisfied.

04 NCAC 10A .0613 Expert Witnesses and Fees

As frequent sources of expert testimony, physicians are commonly deposed in connection with workers' compensation cases. The new language proposed, including the 10% late payment penalty, will help to ensure the timely payment of expert witness fees and assist physicians in directing their inquiries to the proper parties. We appreciate the Commission's acknowledgement of the importance of prompt payment, and its willingness to propose these helpful changes. The NCMS requests that they be adopted.

04 NCAC 10A .0614 Medical Provider Fee Dispute Procedure

Proposed Rule .0614 details a new fee dispute resolution process available to medical providers as contemplated by G.S. 97-26(i). The NCMS applauds the Commission's decision to formalize a process that has gone unaddressed for a number of years.

We understand that the Commission expects the large majority of providers who rely on this new process to reach resolution with the carriers during the informal stages described in paragraphs (a) through (d) of the proposed rule. We hope this will be the case since the requirements for limited intervention seem onerous for an average medical practice to meet. In other words, we suspect that the number of medical practices who pursue limited intervention in a given year to be very small. We will be monitoring the effectiveness of this new dispute process closely.

The NCMS supports this rule unequivocally and is grateful to the Commission for designing a mechanism to handle payment disputes between physicians and carriers. We do request that the Commission allocate adequate resources internally to ensure that the dispute resolution process be implemented as set forth in rule.

04 NCAC 10A .1001 Preauthorization for Medical Treatment

Preauthorization is a daily obstacle for physicians who care for workers' compensation patients. The accompanying hassle factor is a frequent reason cited by medical practices in their decision to discontinue treating workers' compensation patients. Because the use of preauthorization is pervasive, many medical practices have adjusted their workflows to treat every procedure as if it requires preauthorization, for fear of receiving payment denials for lack of authorization. This negative environment hurts the ability of employee-patients to access the care they need, delays care for employee-patients who need services, and places enormous administrative burdens on physicians and their medical practice staff.

While the proposed rule offers some relief from these burdens, the NCMS recommends that the Industrial Commission give Proposed Rule .1001 additional consideration. We offer the following observations about the rule as it has been proposed.

1. Which medical procedures and services may insurers subject to preauthorization review?

The NCMS views this rule as an enormous opportunity for the Industrial Commission to clarify once and for all the types of medical procedures and services that an insurer may lawfully subject to preauthorization review.

The Workers' Compensation Act states – rather unambiguously – that "[a]n insurer may require preauthorization for inpatient admission to a hospital, inpatient admission to a treatment center, and inpatient or outpatient surgery." G.S. 97-25.3. Our position is that the Workers' Compensation Act only allows insurers to rely on preauthorization review for medical procedures and services specifically authorized in the statute.

Nevertheless, insurers continue to commonly require preauthorization on many other procedures, services, and treatments beyond inpatient admissions and surgical cases. For example, insurers require preauthorization for nearly all imaging procedures, for rehabilitation therapy sessions, for prescriptions, and more.

Finally, we note that HB 709 strengthened the employer's ability to choose and change which physician or medical practice may care for an injured employee. As you are also aware, the bill

simultaneously increased the employer's ability to access its employee's "relevant medical information" throughout the course of treatment.

With these tools at their disposal and because industry practice has departed so markedly from the spirit of G.S. 97-25.3, the NCMS believes the time has come for the Commission to limit an insurer's ability to scrutinize clinical decision-making prospectively. The appropriate treatment should be a decision left to the patient and the physician. Therefore, the NCMS requests that the Industrial Commission include a provision in Rule .1001 to resolve the imbalance. We offer the following provision that could appear as new paragraph (a):

> "An insurer may not require preauthorization for procedures, imaging, medications, or any other medical services other than those enumerated in G.S. 97-25.3(a)."

2. Preauthorization requirements should be uniform and transparent across insurers.

The NCMS supports the portions of the proposed rule that require greater transparency from insurers. Paragraph (a) requires insurers to post publicly their preauthorization review policies, and Paragraph (f) requires insurers to post publicly a listing of all the procedures and services that the insurer subjects to preauthorization review. We believe these changes will help medical practices better navigate each insurer's preauthorization review processes.

3. Compliance with the Commission's preauthorization rules should be a priority.

The Proposed Rule places great emphasis on an insurer's establishment of a preauthorization review policy. The preauthorization review policy must include a litany of items, delineated in paragraph (g). However, one glaring omission is the basic requirement that the insurer abides by the terms of its own policy and keep the posted policy up to date. While well-intentioned, we fear that this portion of the proposed rule will devolve into an administrative chore that insurers perform each year and then forget about.

Instead the NCMS recommends that the Commission restructure the proposed rule to establish clear parameters for insurers that utilize preauthorization review. An insurer's completion and publication of an accurate preauthorization review policy could be included as one such parameter.

04 NCAC Subchapter 10F Electronic Billing Rules

NCMS applauds the Industrial Commission's effort to propose agency rules that will bring electronic billing and payments to North Carolina's workers' compensation system. We offer only two points related to the effective date of this subchapter.

1. The Commission should clarify that the effective date of the e-billing rules is March 1, 2014.

NCMS would like to note for the Commission an inconsistency within the e-billing rules concerning the subchapter's effective date. Proposed Rule .0101, "Electronic Medical Billing and Payment Requirement," seems to establish the e-billing compliance date for medical providers and

carriers as January 1, 2014. Proposed Rule .0109, entitled "Effective Date," states that "[t]his Chapter applies to all medical services and products provided on or after March 1, 2014."

The NCMS supports the March 2014 effective date for the e-billing and payment rules, and requests that the Commission strike the third sentence of Proposed Rule .0101 to eliminate the ambiguity.

2. The NCMS requests that the Industrial Commission finalize the March 14, 2014 effective date.

The NCMS has received inquiries about whether the timing of the Industrial Commission's transition to an electronic billing regime in workers' compensation will be influenced by the delay in the health care industry's transition from the use of ICD-9 diagnosis codes to the more robust ICD-10 codes. **The overwhelming preference amongst our members is for the Industrial Commission to leave the March 1, 2014 effective date intact.**

The primary rationale supporting this preference is twofold. First, the delay of the ICD-10 implementation date to October 1, 2014 will allow medical practices and their trading partners (clearinghouses, billing entities, and carriers) additional time to focus on transitioning their systems to handle workers' comp bills and payments electronically in the run-up to the March 2014 effective date. In other words, they won't be burdened with transitioning their systems to workers' comp e-billing and ICD-10 *simultaneously*.

Second, delaying the e-bill implementation date to coincide with the new ICD-10 compliance date could backfire. NCMS believes that there is a reasonable probability that the October 1, 2014 compliance date will be delayed by the federal government once again, which will only create additional disruption within the industry. If that in fact occurs, then the Commission will again have to decide whether it wants to push its effective date for all e-billing rules even farther into the future.

NCMS believes and recommends that the best approach for the Commission is to "lock-in" the March 1, 2014 effective date for the e-billing rules.

04 NCAC 10J .0101 Fees for Medical Compensation

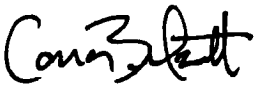
As you are aware, the NCMS is very interested in making sure the medical fee schedule adequately reflects changes in the cost of delivering medical care over time. Doing so would ensure that injured workers have access to the best medical care available. To accomplish this, the General Assembly has required that the medical fee schedule undergo a periodic review and revision. Other than its original adoption by the Industrial Commission, the medical fee schedule has not undergone a comprehensive review and revision since the General Assembly enacted the review and revise mandate in 1993 (See Session Laws 1993 (Reg. Session 1994) c. 679, s. 2.3).

It should be noted that the *status quo ante* set the pecuniary liability of the employers for medical compensation by observing the prevailing rates in the community – a standard that was infinitely more responsive to changing circumstances than the prolonged freeze that has resulted under the current approach.

Accordingly, we would like to work with the Industrial Commission to complete a fee schedule review and revision as soon as possible.

Again, the NCMS sincerely appreciates the opportunity to offer these comments to you. We have been very pleased with the level of collaboration that the NCMS and NCIC have shared over the past few years and all that has been achieved to improve physician interaction with the workers' compensation system. Should the Commission have any additional questions that I may assist you with, please contact me at cbrockett@ncmedsoc.org or (919) 833-3836.

Sincerely,



Conor Brockett
Associate General Counsel

HDi Health Direct, Inc.
1690 New Britain Avenue, Suite 105
Farmington, CT 06032

September 12, 2012

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

Re: Proposed Rule Changes, Comments on 4 NCAC 10C.0105(b)

Dear Ms. Cronk:

The purpose of this letter is to provide Health Direct, Inc.'s (HDI) comments on the changes to 4 NCAC 10C.0105(b) proposed by the North Carolina Industrial Commission. HDI appreciates the opportunity to provide comments and we sincerely hope that the Industrial Commission will carefully consider them. For your information, HDI provides case management for approximately 500 injured North Carolina workers each year through its North Carolina-registered rehabilitation professionals. Our service centers pride themselves on providing the highest quality of medical treatment management that focuses on bringing injured workers back to health and expeditiously returning them to work.

Specifically, we wish to comment on the proposed changes to 4 NCAC 10C.0105(b) published in the *North Carolina Register* on July 16, 2012. The proposed changes are re-printed below:

> (b) ~~RPs~~ Rehabilitation professionals who are Registered Nurses providing medical rehabilitation services in North Carolina must have a North Carolina license to practice and are subject to the requirements of the North Carolina Nursing Practice Act. Rehabilitation professionals who are Registered Nurses providing medical rehabilitation services outside North Carolina must have a license to practice in the state in which the medical care is provided.

As we interpret this proposed provision, the following hypothetical scenario presents itself. Assume that an injured North Carolina worker receives rehabilitation services (specifically, case management) from one of our rehabilitation professionals. Our rehabilitation professional managing that worker's case (the case manager) is a Registered Nurse licensed in North Carolina. For the worker's convenience or perhaps the availability of a higher quality of treatment, the worker will receive rehabilitation treatment in South Carolina. In this case, the proposed rule will require our North Carolina registered and licensed case manager to be registered and licensed in South Carolina as well.

We'd like to point out that such a requirement will impose considerable additional expenses on case management, which added costs will eventually be borne by North

Carolina employers, and that this additional expense will provide little or no benefit to patients. There are numerous situations in which injured North Carolina workers might receive treatment in another state, particularly a bordering state. This is not likely to be an isolated situation and may affect a significant number of North Carolina workers and employers. There are also circumstances in which an injured worker could move to another state, Pennsylvania or Arizona for example, and then we would have to have our case manager registered and licensed in that state as well as North Carolina, etc. During the R.P.'s registration and licensing process in that state, the case manager will not be able to provide case management, thus disrupting and perhaps damaging the quality of the worker's treatment.

We are unaware of any significant problems or issues with current case management that could justify this very onerous and potentially disruptive registration and licensing requirement. We are also not aware of any other state that requires such an inter-state licensing or of any documentation that might justify imposing it. Our rehabilitation professionals are fully licensed and work diligently to provide the best case management possible for injured workers as well as the employer who has lost the worker's services. **Therefore, we urge the Industrial Commission to remove this proposed requirement.**

Nevertheless, should the Industrial Commission feel compelled to place some additional requirement on multi-state issues for the purpose of improving treatment or the management of treatment, we urge a modification to the proposed rule (provided in bold font) as follows:

> (b) ~~RPs~~ Rehabilitation professionals who are Registered Nurses providing medical rehabilitation services in North Carolina must have a North Carolina license to practice and are subject to the requirements of the North Carolina Nursing Practice Act. Rehabilitation professionals who are Registered Nurses providing medical rehabilitation services outside North Carolina must have a license to practice **either** in the state in which the medical care is provided **or in North Carolina.**

Your careful consideration and revision of the proposed rule in this manner is sincerely appreciated.

Yours very truly,

Chris Tomlin
Vice President, Field Operations
Health Direct, Inc.

North Carolina Association of Defense Attorneys

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

September 11, 2012

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

RE: Comments, Objections and Recommendations Relating to Proposed Rules

Dear Ms. Cronk,

Attached please find comments, objections and recommendations of the North Carolina Association of Defense Attorneys ("NCADA") as it relates to the proposed rules published by the North Carolina Industrial Commission. NCADA member firms with a workers' compensation practice have reviewed and are in agreement with these comments, objections and recommendations as noted by their signatures below. Substantial time and effort was expended by numerous attorneys who thoroughly reviewed all of the proposed rules. Thank you for the opportunity to provide feedback on the proposed rules. Please do not hesitate to contact me should the Commission have any questions or need clarification regarding our position on the proposed rules.

Very truly yours,

Lawrence M. Baker
Chair, NCADA Workers' Compensation Group

Julia Ellen Dixon
Vice Chair, NCADA Workers' Compensation Group

Michael Ballance
Dickie McCamey & Chilcote, P.A.

Joy H. Brewer
Brooks Stevens & Pope, P.A.

Angela Farag Craddock
Young Moore & Henderson, P.A.

Charles D. Cheney
McAngus Goudelock & Courie, LLC

3700 National Drive • Suite 212 • Raleigh, NC 27612-4842
Telephone 919-239-4463 • NC WATS 1-800-233-2858 • www.ncada.org

Bruce A. Hamilton
Teague Campbell Dennis & Gorham, LLP

Jeff A. Kadis
Hedrick Gardner Kincheloe & Garofalo, LLP

Jeffrey A. Misenheimer
Lewis & Roberts, PLLC

J. Jared Sims
Gallivan White & Boyd, P.A.

Steven W. Sizemore
Northup McConnell & Sizemore, PLLC

R. G. Spratt, III
Jones Hewson & Woolard

Paul F. Toland
Wilson & Ratledge, PLLC

Jeri L. Whitfield
Smith Moore Leatherwood, LLP

Shannon Warf Wilson
Davis & Hamrick, LLP

NORTH CAROLINA INDUSTRIAL COMMISSION ("NCIC")

PROPOSED RULE REVISIONS

COMMENTS FROM THE NORTH CAROLINA ASSOCIATION OF DEFENSE ATTORNEYS ("NCADA")

Table of Contents

NCIC PROPOSED RULE REVISIONS – NCADA COMMENTS TO 10A

SECTION 0100 – ADMINISTRATION

Rule .0103 (Notice of Accident and Claim of Injury or Occupational Disease): G.S. § 150B-2(8a)d states: "'Rule' means any agency regulation, standard, or statement of general applicability that implements or interprets an enactment of the General Assembly . . . . or that describes the procedure or practice requirements of an agency. The term includes the establishment of a fee and the amendment or repeal of a prior rule. The term does not include the following: . . . d. A form, the **contents or substantive requirements of which are prescribed by rule or statute**." (emphasis added) The NCADA asserts that many if not all NCIC forms currently in use (including, but not limited to the forms listed in current Rule 103) have "contents" and/or "substantive [procedural] requirements" that are not specifically "prescribed by rule or statute," therefore, the NCIC should propose a rule or rules setting out the proposed content of and necessity for each form.

Rule .0105 (Electronic Payment of Costs): The proposed rule is not supported by statutory authority. The NCADA asserts that Chapter 97 does not provide authority for the requirement of electronic payment of non-medical fees and costs. G.S. § 97-81(a) is the only statute that speaks to electronic submission of documents. It notes "[t]he Commission may authorize the use of electronic submission of forms and other means of transmittal of forms and notices when it deems appropriate." However, the statute does not speak to the electronic transmission of fees simultaneous with the submission of documents.

The proposed rule is also contrary to the Administrative Procedure Act. Chapter 150B-19.1(a)(2), notes that "in developing and drafting rules for adoption in accordance with this Article, agencies shall adhere to the following principles . . . (2) An agency shall seek to reduce the burden upon those persons or entities who must comply with the rules. The NCADA asserts that the requirement to simultaneously file electronic documents with fees will place a tremendous burden on all parties, particularly defendants. Although the NCADA is not opposed to the establishment of an electronic document and fee submission protocol as an alternative to paper submissions – i.e., checks – the NCADA recommends that the electronic submission not be required until the parties and the NCIC collaborate to create a system that will be user-friendly, efficient, secure and will not overburden one party.

The proposed rule is also contrary to Chapter 150B-19.1(a)(5) in that no technical, economic or other relevant information has been provided as to the reason it is necessary to require that documents and fees be paid simultaneously through an electronic fee portal. Based on prior reports of the NCIC, the NCADA is under the impression that well over 20,000 settlement agreements, Form 24s and Form 26A Agreements are filed annually. Further, and perhaps most importantly, the NCADA understands that the overwhelming majority of Employers/Insurance Carriers/TPAs/Defense Counsel are currently not utilizing the NCIC's present EDFP system and that many do not have the capability to pay these case-specific processing fees electronically – they are only set up to pay via paper checks and do not have corporate credit cards. The NCIC's

computer system seems ill equipped to manage thousands of document filings together with simultaneous electronic fee submissions.

Finally, on page 4 of the Fiscal Impact Analysis, the document does not address how Rule 105 will have an "Impact on the Private Sector."

SECTION .0300 - INSURANCE

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. This provision correctly places the responsibility on the contractor to notify of a change in its workers' compensation coverage. This provision will assist in a number of G.S. § 97-19 cases where a principal contractor does not have notice that there is a purported problem with an intermediate or subcontractor's workers' compensation coverage and continues to allow the intermediate, subcontractor, or employees of those entities to continue to work on the principal contractor's job site as a result.

Section 0400—DISABILITY, COMPENSATION, FEES

Rule .0404(a) (Termination and Suspension of Compensation): There is no statutory authority for the rule stating that there is a rebuttable presumption that disability continues until the employee returns to suitable employment.

Rule .404(c): There is no statutory authority for payment of the costs associated with terminating benefits via the Fee Portal. ***See comments regarding Rule .0105.***

Rule .404(d): There is no statutory authority for the requirement that the NCIC "shall" refuse to accept the application to terminate benefits due to the failure to specify the number of pages attached.

Rule .404(g): The language stating that a hearing is to be set "without delay" is not consistent with the statutory mandate that a hearing shall be scheduled on a "preemptive basis." A preemptive basis would require the hearing be scheduled in a manner which moves the matter to the head of the hearing schedule—ahead of other non-preemptively set cases. The rule appears to be interpreting "preemptive basis" to mean "without delay," which the NCADA asserts is not proper under the APA. It is also noted that the statutory authority cited for this rule incorrectly states § 97-18(c) and § 97-18(d) instead of § 97-18.1.

Rule .0405 (Reinstatement of Compensation): There is no statutory authority for the telephonic procedure proposed in this rule. The statutory authority in G.S. § 97-18(k) only states that where an employer contests the employee's request for reinstatement of benefits the matter shall be scheduled on a preemptive basis. Unlike the statutory authority contained in G.S. § 97-18.1, which specifically details the telephonic procedure, the legislature made no similar rule here. The fact that the legislature did not set out a specific framework for conducting an informal or telephonic hearing, as was done in §97-18.1 is evidence that the legislature did not intend such an informal telephonic hearing process to take place with the reinstatement of compensation provision. Rather, the only requirement of §97-18(k) is that a preemptive hearing be conducted, which the NCADA contends requires a full evidentiary hearing.

If it is determined that the NCIC has statutory authority to develop such informal telephonic hearing procedures for the reinstatement of benefits, those procedures should track the same timelines for suspension of benefits. Given that there is no legislative authority for the procedure, there is no basis for making the timeframes shorter for reinstating benefits as compared to those for suspending benefits. As proposed, the carrier has only 10 days to respond to a request for reinstatement of benefits (as opposed to 17 days which is provided in a Form 24 or suspension process). If an employer does not contest reinstatement, the rule requires that an administrative decision be rendered within 5 days after the expiration date for the employer to respond. Again, there is no statutory authority for this timeframe and there is no similar timeframe regarding the Form 24 suspension procedure. Finally, if the carrier or employer contest reinstatement of benefits, the rule requires that an informal hearing is scheduled within 7 days of receipt of the objection, whereas a Form 24 suspension procedure allows 25 days for the informal hearing. It is also noted that the Form 24 procedures now eliminate the requirement that

a decision be rendered within 5 days after the completion of the informal hearing. However, the 5 day requirement remains in place for rendering a decision for reinstatement of benefits.

Rule .0406 (Discount Rate to be Used in Determining Commuted Values): This rule is unclear and ambiguous and has no statutory authority. "Commuted Value" is not defined in the statute. The proposed rule ties the rates to the Internal Revenue Services applicable federal rate. These rates change on a monthly basis (e.g., ranging from 1.2% to 1.6% for the first 6 months of this year). There is no guidance on the "trigger date" to determine the applicable rate. For example, if commuted value on a death claim is being paid, would it be based on the rate at the time that the death occurs or at the time that the payments are being agreed to and paid? The changing rate would also result in different benefits being paid to two different individuals who have identical compensation rates and injuries. In addition, the statutorily defined "interest rate" (found in G.S. § 24-1) is 8%. Employers and carriers are still required to pay that interest rate on awards after a hearing. Thus, if a hearing is needed in a commuted value case, the award would be commuted to a much lower rate than the interest awarded on that same amount.

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 employee is not entitled to ongoing medical treatment beyond two years. The statute requires that there be a "substantial risk" of the necessity of future medical treatment, which would be the burden of the employee to show. The proposed rule shifts the burden to the defendant to prove medical treatment is not necessary.

SECTION .0500—AGREEMENTS

Rule .0502(2)(b) (Compromise Settlement Agreements): The proposed rule lacks statutory authority. G.S. § 150B-19(1) notes an agency may not adopt a rule which "implements or interprets a law unless that law or another law specifically authorizes the agency to do so." The proposed rule notes that where liability is denied, the employer/insurer undertakes to pay all unpaid medical expenses to the date of the agreement. The provision is overreaching and has no statutory basis in the North Carolina Workers' Compensation Act. It rewards employees for filing frivolous claims just to get medical bills paid, because the claim cannot otherwise be settled.

Rule .0502(3)(d): The proposed rule has no legal basis in that it goes beyond the NCIC's authority to approve settlements as set forth in G.S. § 97-17. The provision that requires the employer/insurer to provide written notification that a settlement has been approved to all unpaid medical providers is burdensome and not reasonably necessary to implement State law. Furthermore, serious questions often exist about the relatedness versus non-relatedness of certain medical treatment, such that it is frequently unclear exactly what unpaid medical treatment would fall within this provision.

SECTION .0600—CLAIMS ADMINISTRATION AND PROCEDURES

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. The employee is in a much better position to contact the employee's treating doctors and provide any notification needed. The NCADA has no other objections to the proposed revisions to this Rule.

Rule .0603 (Responding to a Party's Request for Hearing): There is no statutory authority for making the defendants 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 as violation of the due process clause of the United States Constitution. The NCADA has no other objections to the proposed revisions to this Rule.

Rule .0604 (Appointment of Guardian Ad Litem): Rule 17(b)(2) allows the taxing of guardian ad litem fees as costs, but only where a guardian ad litem is defending a minor in a civil suit. Rule 17(b)(1) deals with suits by a guardian ad litem in the name of a minor and there is no provision for taxing fees or costs. Therefore, the NCADA does not believe there is statutory authority for the NCIC's proposed rule that the NCIC assess a fee against an employer or carrier to be paid to an attorney who serves as a guardian ad litem on behalf of a minor or incompetent who is also prosecuting the claim. The NCADA has no other objections to the proposed revisions to this Rule.

Rule .0605 (Discovery): The NCADA supports the addition of Rule 605(6) allowing requests for production of documents without leave of the NCIC. There has been some objection to this new rule because G.S. 97-80 provides discovery shall be "as summary and simple as reasonably may be." Those objecting suggest discovery interests are sufficiently met by Rule 607, and that the introduction of request for production of documents will be lead to abuse. However, any such request would *only* be proper "if the information sought appears reasonably calculated to lead to the discovery of admissible evidence." As our economy and labor markets continue to evolve, Rule 607 has become increasingly inadequate in facilitating the disclosure of unprivileged information that could have limited the need to present some factual disputes to the NCIC. Some examples include difficulties under the current scheme for obtaining income tax returns of workers paid as contractors on a Form 1099, or the difficulty in obtaining job descriptions, employment documents, and wage information for employees who have resumed work with a different employer. Therefore, the new rule is advisable because it will help to minimize the issues to be resolved at a hearing before the NCIC. Moreover, the parties will adequately be protected from abuse by their right to object and/or file motions to compel.

However, in this regard, 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 under G.S. 97-25.6. The NCADA recommends that defendants should be able to request

medical records either directly from the medical providers or insist that the employee obtain the medical records for defendants if defendants are unable to obtain them directly. This would be applicable in all cases and especially important where there is an out of state physician.

Rule .0607 (Discovery of Records and Reports): The requirement that all employment records be produced even if there is no showing of relevance is contrary to statutory authority. The NCADA has no objections to the other proposed revisions to this Rule.

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 45 day limit is unreasonable, since defendants routinely do not have recorded statements transcribed until after a hearing request is received. In addition, the sanction for failure to produce the recorded statement within 45 days does not allow for any discretion by the NCIC. The NCADA contends that this Rule should be handled under the discovery rules in Rule 605 and that a recorded statement should be produced within 30 days after it is requested.

Rule .0609 (Motions Practice in Contested Claims): It is unclear if there is statutory authority for implementing a motions practice in contested cases, but it makes sense that the NCIC should have motions procedures. However, such motions procedures should have clearly delineated rules for each such motion within the jurisdiction of the Executive Secretary and which have met the requirements of the APA rule making process. Additionally, the NCADA contends that the section regarding not casting opposing counsel in a bad light should not be taken out of the Rule.

Rule .0609A (Medical Motions and Emergency Medical Motions): The NCADA strenuously objects to the procedures for medical motions and emergency medical motions. It appears that the NCIC is using the 2008 amendment to 97-78(f) as its authority for establishing the medical motions and emergency medical motions procedure. The statutory change indicated that the NCIC shall prepare and implement a strategic plan for accomplishing all of the following: (1) Tracking compliance with the provisions of G.S. 97-18(b), (c), and (d), and establishing a procedure to enforce compliance with the requirements of the subsections; and (2) Expeditiously resolving requests for, or disputes involving, medical compensation under G.S. 97-25, including selection of a physician, change of physician, specific treatment involved, and the provider of such treatment.

However, the application of these provisions has violated defendant's due process rights under the United States Constitution. The NCADA contends that the old system of having medical motions heard at the Executive Secretary level initially and then referred to a deputy commissioner if needed was adequate. The NCADA contends that the expedited telephonic hearing system, with a 30-day timeframe, is not adequate. Defendants are usually not capable of obtaining medical depositions within the given 30 day time frame, and other testimony is

normally insufficient in these cases. The proposed Rule does not mandate a 30-day deadline, but says that depositions deemed necessary shall be set on an expedited schedule and that requests for IMEs shall be denied unless there is a demonstrated need. The basic problem with the whole expedited telephonic procedure is that and the results of a medical motion ruling can usually determine the outcome of a case, yet a defendant can be denied its due process rights to cross examine witnesses and present additional testimony and evidence. In other words, if a surgery is mandated, how do you undo the surgery if it is later determined that it was not necessary or not causally related to the work related injury?

The NCADA recommends that any request for change of treating physicians, or medical treatment that includes surgery, spinal cord stimulators or some extensive and invasive medical treatment procedure be dealt with more formally by being referred to a deputy commissioner for an expedited, full evidentiary hearing. If the issue before the NCIC deals with medications, diagnostic testing, etc., the NCADA does not object to the expedited, telephonic procedure.

The NCADA contends that G.S. 97-78(f) did not provide statutory authority for setting up the expedited process established by the NCIC that essentially eliminates live, in person hearings with depositions. The concern with "informal hearings" or telephonic hearings in the expedited procedures already adopted is that they limit the defendants' due process to introduce evidence. The NCADA contends that requests for change of treating physicians and extensive and invasive medical treatment, such as surgeries and spinal cord stimulators can affect the outcome of a claim.

In addition, because these disputes almost always deal with only a portion of the claim, recent case law has indicated that these matters are interlocutory and therefore not appealable. Therefore, when you have a significant issue such as invasive surgery, (as opposed to a medication, physical therapy, diagnostic testing or a one-time evaluation), which is not only irreversible but likely to significantly impact other issues in the claim such as work restrictions, permanent impairment and/or disability, the NCADA feels that these matters should go to a full evidentiary hearing. However, the NCADA recognizes that these matters need to be handled expeditiously and that a shorter timeline is appropriate. However, given the potential dramatic impact on the claim in its entirety, at least those issues that deal with surgery or other irreversible issues, should be directed to a full hearing.

Rule .0612 (Depositions and Additional Hearings): The statutory authority to assess expert witness fees against the employer is limited. Additionally, the NCADA contends that fees should be assessed only if the employee prevails, and even in such cases the employees should bear some of the costs. The new Rule only mandates that defendants pay for the deposition of any doctor, where the defendant paid for the treatment with that doctor, but then gives the NCIC discretion to order the defendants to pay for all other experts. The NCADA contends that employees should bear the cost of deposing the experts they hire in cases. This is true especially

where the employee chooses out of state experts who provide opinions which may be contrary to generally accepted science. As further commentary and support of the NCADA's concerns regarding the proposed rules, attached please find a memorandum of law in opposition to the NCIC's current rules and practice of assessing costs and fees solely against defendants, which was filed in a current claim and is marked as **Exhibit 1**.

Rule .0613 (Expert Witnesses and Fees): The NCADA contends that the 10% penalty for failure to make payment to an expert witness within 30 days should not be mandatory but discretionary. There are incidents outside the parties' control that delay payments, such as a missing W-9 or some other problem.

Rule .0616 (Dismissals): The NCADA contends that Rule 616(c) is language that remains from current Rule 613(2) which speaks to the removal of a claim from a hearing docket and the right to pursue the claim within two years after removal, which has the effect of a tolling provision. The NCADA contends that there is no statutory authority for the NCIC to create a substantive right (i.e., tolling provision) through a procedural mechanism (i.e., removal of hearing request). Since proposed Rule 616(c) contains language from the former removal rule, the NCADA asserts subsection (c) is improper. If the subsection is allowed to remain, the NCADA recommends that the deadline for re-filing a claim under Rule 616(c) following removal of a case from a hearing docket should be one year instead of two years, which is more consistent with the Rules of Civil Procedure. Further, the deadline for re-filing a claim following a removal of a case from a hearing docket should be no different than the deadline for re-filing following a voluntary dismissal. The employee has one year from the order of a voluntary dismissal without prejudice to re-file a claim.

SECTION .0700—APPEALS

Rule .0701(b) (Review by the Full Commission): The proposed rule is unclear and ambiguous. There is no requirement for the appellant or appellee to certify receipt of the transcript. If the NCIC intends to send all transcripts and Form 44s via electronic mail to parties represented by counsel, the NCADA recommends that the NCIC establish a procedure to ensure that the e-mail has been received by the appellant/appellee. The confirmation procedure could require counsel to respond to the transcript email with a carbon copy to opposing counsel.

Rule .0701(c): The NCADA 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." The NCADA recommends "in this subsection" rather than "in this Paragraph."

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. The NCADA recommends that the proposed rule require a motion to be filed in writing and served on opposing counsel prior to the date of the Full Commission hearing.

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. In line 20, the NCADA recommends that the phrase "or the reinstatement of compensation," be deleted as G.S. § 97-18(k) addresses the right to have a reinstatement hearing, which the NCADA asserts was not intended to be an administrative hearing. The statutory authority for a Form 24 hearing pursuant to G.S. § 97-18.1 is different than 97-18(k). This argument is further detailed in response to Rule .0609A.

Rule .0702(b): The proposed rule is unclear and ambiguous. First, the rule notes a motion to stay may be filed with an Administrative Officer, Commissioner or Deputy Commissioner; however, the rule caption speaks only to review of administrative decisions. Thus, it is not clear when a motion to stay should be filed with an Administrative Officer as compared to a Commissioner or Deputy. Second, the phrase "frustrate the purposes of the order, decision, or award" that begins on line 31 is vague and suggests a motion to stay may be denied in all cases—even in situations wherein the Administrative Officer weighed evidence for one party but did not afford the other party an opportunity to present evidence before issuing the underlying decision, which could be a violation of procedural due process.

Rule .0704 (Remand from the Appellate Courts): The proposed rule is unclear. The NCADA recommends that the rule require the NCIC to issue an order setting forth a new deadline for

submitting a statement on remand when a petition for discretionary review has been filed with the Supreme Court following a remand order from the Court of Appeals.

SECTION 0800—RULES OF THE COMMISSION

Rule .0801 (Suspension of Rules): The proposed rule is not supported by statutory authority and is in violation of the Administrative Procedure Act. Chapter 150B-18(6) does not allow an administrative agency to suspend its own rules unless "the rule establishes specific guidelines the agency must follow in determining whether to waive or modify the requirement." The proposed rule is not sufficient.

Rule .0802 (Sanctions): The proposed rule is not supported by statutory authority. None of the statutes relied upon by the NCIC to promulgate this rule endow the NCIC with generalized authority to impose broad sanctions. For example, the proposed rule notes that sanctions can be assessed for failure to comply with NCIC rules, yet the proposed rule sites to sanctions allowed per Rule 37 of the Rules of Civil Procedure that relate solely to discovery violations. G.S. § 97-80(a) and (f) specifically note that Rule 37 does not govern discovery procedures in workers' compensation claims; therefore, broad sanctions allowed by Rule 37 should not apply in workers' compensation claims. Moreover, while G.S. §§ 97-18 and 97-88.1 allow for sanctions, the statutes are specific and limited. Other than the specific and limited grounds for imposing sanctions there is no statutory authority for broad sanctions under the Act. Finally, the proposed rule allows for attorneys to be sanctioned rather than parties, which could damage the attorney-client relationship and is not supported by G.S. § 97-88.1.

NCIC PROPOSED RULE REVISIONS – NCADA COMMENTS TO 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.

NCIC PROPOSED RULE REVISIONS – NCADA COMMENTS TO 10C

SECTION .0100—ADMINISTRATION

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 Rules for Utilization of Rehabilitation Professionals were originally drafted pursuant to G.S. § 97-25.5. G.S. § 97-32.2 was later adopted and specifically sets out the requirements for vocational rehabilitation. The portion of Rule .0101 that reads "The Rules in this Subchapter apply to: (a) cases in which the employer is obligated to provide, or is providing medical compensation . . ." suggests that vocational rehabilitation can be required in a medicals only claim, which is contrary to G.S. § 97-32.2(a) which notes an employer may engage vocational rehabilitation "in a compensable claim" only.

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." Furthermore, this definition is vague and ambiguous. The NCADA suggests that the defined goal should be to return an employee to suitable employment.

The proposed rule is also unnecessary, redundant and repeats the content of a law in violation of the APA. The NCADA asserts there is no need to define "vocational rehabilitation" in the rule since G.S. § 97-32.2 already defines what vocational rehabilitation services should entail.

Rule .0103(5): There is no statutory authority for the proposed definition of "suitable employment" for claims arising before June 24, 2011. While this definition was contained in the prior rules for Rehabilitation Professionals, there was no statutory authority for that definition.

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 a vocational rehabilitation provider 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.

The NCADA will defer to the rehabilitation professionals regarding the numerous rules dealing with training and qualifications, but seek to continue to have professional and qualified individuals engaged in medical and vocational rehabilitation.

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 references to web sites for professional organizations are 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*** that all correspondence and reports must be sent electronically. In addition, the proposed rule is unclear. For example, is the rehabilitation professional required to e-mail and mail reports to all parties? Or is the rehabilitation professional merely required to mail or fax reports only to parties without e-mail? As written, the rule is subject to numerous interpretations because it is ambiguous.

Rule .0107(j): There is no statutory authority for the requirement that the rehabilitation professional detail in writing the actions that an employee is required to take to become compliant with vocational rehabilitation, including the "overall effect" the actions or inactions of the employee are having on the rehabilitation goals. Rehabilitation professionals should be allowed to exercise their independent judgment and should not be forced to detail actions the injured worker must take to be in compliance with vocational rehabilitation. 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 Chapter 150B-19.1(2) and potentially the ethical codes adopted by their respective professions.

Rule .0108(e) (Interaction with Physicians): There is no statutory authority for limiting the rehabilitation professional from "initiating" a second opinion on the rating, independent medical examination, second opinion and consult. Furthermore, the proposed rule is unclear and ambiguous in that "initiate" is not defined. The NCADA asserts that the rule is unnecessary since the rehabilitation professional is supposed (and even required) to exercise independent judgment on the course of care. This rule unnecessarily curtails the scope of the independent judgment of the rehabilitation professional, which the rules otherwise require the rehabilitation professional to exercise.

Rule .0108(e)(2): The proposed rule needs additional language to make clear that the rehabilitation professional is not required to assemble or forward medical records to an independent medical examiner, second opinion provider or consultant until the request is authorized by the party who has the authority to direct medical treatment pursuant to G.S. § 97-25.

Rule .0109(d) (Vocational Rehabilitation Services and Return to Work): The NCADA suggests that this rule needs further clarification. Given that subsection (c) sets out the priority of return to work options and lists education and training as the sixth option, we believe this

subsection should also ask the rehabilitation professional to address what efforts have been undertaken by the employee to return to work before retraining or education was requested.

Rule .0109(i): The proposed rule is not reasonably necessary to implement G.S. § 97-2(22) or 97-32.2. The definition of suitable employment does not take into account transportation needs. Nor does 97-32.2 note that a vocational rehabilitation professional should consider transportation needs when performing job placement activities

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 guidelines on the definition of "manifest injustice." In addition, there is no statutory authority for this phrase. The statute simply states a change may be ordered "for good cause shown."

Rule .0201 (Suspension of Rules): The proposed rule is not supported by statutory authority and is in violation of the Administrative Procedure Act. The Administrative Procedure Act does not allow an administrative agency to suspend its own rules unless "the rule establishes specific guidelines the agency must follow in determining whether to waive or modify the requirement." The proposed rule is not sufficient.

Rule .0202 (Sanctions): The proposed rule is not supported by statutory authority. None of the statutes relied upon by the NCIC to promulgate this rule endow the NCIC with generalized authority to impose broad sanctions. For example, the proposed rule notes that sanctions can be assessed for failure to comply with NCIC rules, yet the proposed rule sites to sanctions allowed per Rule 37 of the Rules of Civil Procedure that relate solely to discovery violations. G.S. § 97-80(a) and (f) specifically note that Rule 37 does not govern discovery procedures in workers' compensation claims; therefore, broad sanctions allowed by Rule 37 should not apply in workers' compensation claims. Moreover, while G.S. §§ 97-18 and 97-88.1 allow for sanctions, the statutes are specific and limited. Other than the specific and limited grounds for imposing sanctions there is no statutory authority for broad sanctions under the Act. Finally, the proposed rule allows for attorneys to be sanctioned rather than parties, which could damage the attorney-client relationship and is not supported by G.S. § 97-88.1.

NCIC PROPOSED RULE REVISIONS – NCADA COMMENTS TO 10D

Rule .0100 (Rules): The proposed rule is not unclear, ambiguous and is not supported by statutory authority in that the deletion of the word "reasonably" is completely contrary to the requirements in G.S. § 97-25.2 and may allow claimants to seek approval for experimental, non-proven therapies that are not covered by the fee schedule and are extremely costly. The rule may also be construed to be in conflict with G.S. § 97-25.2 in that the statute allows for dispute resolution procedures for managed care organizations that take more time than is allowed by the rule.

Rule .0104 (Qualification and Revocation): The proposed rule is unclear and ambiguous in that it fails to define "ineffective delivery of medical services." The proposed rule is not supported by statutory authority in that G.S. § 97-25.2 does not authorize the NCIC to suspend or revoke a managed care organization's rights under the statute.

NCIC PROPOSED RULE REVISIONS – NCADA COMMENTS TO 10E

SECTION .0200—FEES

As it relates to all fees and costs currently established and assessed by the NCIC, whether currently delineated in the proposed rules, the NCADA notes the following: G.S. §150B-19 states an agency "may not adopt a rule that does one or more of the following: . . . (5) **Establishes a fee or other charge** for providing a service in fulfillment of a duty **unless a law specifically authorizes the agency to do so or the fee or other charge is for one of the following**:

a. A service to a State, federal, or local governmental unit.

b. A copy of part or all of a State publication or other document, the cost of mailing a document, or both.

c. **A transcript of a public hearing.**

d. A conference, workshop, or course.

e. Data processing services.

(emphasis added) G.S. §150B-2 (8a) defines a "rule" as "any agency regulation, standard, or statement of general applicability that **implements or interprets an enactment of the General Assembly** . . . . or **that describes the procedure or practice requirements of an agency. The term includes the establishment of a fee** and the amendment or repeal of a prior rule." (emphasis added) The NCADA asserts that any fee or other charge such as a cost established by the NCIC is the equivalent of the establishment of a rule and should be subject to the APA rule making procedure. Therefore, the NCADA recommends that all fees and costs currently assessed or levied against any party in any claim subject to the jurisdiction of the NCIC be noted specifically in the rules. Further, each rule should note specifically the amount of the fee/other charge/cost and the party responsible for the fee/other charge/cost.

The only statutes that grant the NCIC authority to establish a fee or other charge (i.e., cost) are G.S. §97-73 and G.S. § 97-80. G.S. § 97-73(d) notes specifically that the NCIC may impose a fee against an employer for whom the NCIC provides an educational training program. The fees noted in **Rule .0204 (Accident Prevention and Safety Educational Program Fees)** are therefore appropriate pursuant to the APA because there is specific statutory authority for said fees.

G.S. § 97-73(a) notes that the NCIC may establish a "schedule of fees" that "shall be collected in accordance with rules adopted by the Industrial Commission." Contrary to subsection (d), which specifically notes that fees for educational training programs should be imposed on the employer, subsection (a) of G.S. 97-73 is silent as to which party shall bear the fees/other charges/costs related to "examinations conducted, reports made, documents filed, and agreements reviewed under this Article." Since the General Assembly has shown that it will assign specific fees against employers, the NCADA asserts that had the General Assembly intended for fees related to "examinations conducted, reports made, documents filed, and

agreements reviewed under this Article" be born solely by employers, the General Assembly would have specifically noted this in the statute. Therefore, the NCADA asserts that fees related to examinations conducted, reports made, documents filed, and agreements reviewed under this Article should be shared by all parties.[1] Thus, the NCADA asserts that **Rule .0203 (Fees Set by the Commission)** should be amended to include all fees currently charged by the NCIC for examinations conducted, reports made, documents filed, and agreements reviewed and should note that the fees are to be shared by all parties.

G.S. § 97-80(b) notes the NCIC may ". . . tax [hearing] costs against the **parties . . .**" (emphasis added) G.S. § 97-80(d) speaks to deposition testimony taken in conjunction with a hearing. Both subsections (b) and (d) speak specifically to testimony taken at hearings and expert and lay witness testimony taken by deposition either prior to or after hearings, which become part of the evidentiary record. The NCADA asserts the statute requires that costs related to the taking of testimony at hearing and during deposition must be taxed against the "parties"—pleural. Therefore, the NCADA asserts that all hearing costs as well as fees related to expert and lay deposition testimony (e.g., payment of medical experts, payment of court reporters, etc.) should be shared by all parties and that the rules should specifically delineate the amount of proper fees and the party or parties to bear those fees. Thus, the NCADA recommends that **Rules 10A .0611 (Hearings Before the Commission), 10A .0612 (Depositions and Additional Hearings), 10A .0613 (Expert Witnesses and Fees), 10A .0619 (Foreign Language Interpreters) and 10E .0202 (Hearing Costs or Fees)** be properly amended to comport with the Act and the APA. As further commentary and support of the NCADA's concerns regarding the proposed rules, attached please find a memorandum of law in opposition to the NCIC's current rules and practice of assessing costs and fees solely against defendants, which was filed in a current claim and is marked as **Exhibit 1**.

G.S. § 97-80(c) is the **only** statute that gives the NCIC broad authority to set costs—"the Commission shall determine the manner in which payment of the costs of the mediated settlement conference is assessed." (emphasis added) Therefore, only mediation fees set out in **Rules 10G .0104 (Duties of Parties, Representatives, and Attorneys) and 10G .0104A (Foreign Language Interpreters)** are appropriate.

The NCIC currently assigns costs to employers for hearing transcripts when a claim has been appealed to the Full Commission pursuant to G.S. § 97-85 regardless of whether or not the employer filed the appeal. While G.S. § 97-79 requires the NCIC to "provide for the preparation

---

[1] In the Editor's Note to G.S. § 97-17, there is reference to Session Laws 2003-284, ss. 12.6C(a)-(e) as amended by Session Laws 2004-174, s. 3 and Session Laws 2004-203, s. 77, which provided "(a) The North Carolina Industrial Commission may retain the additional revenue generated by raising the **fee charged to parties** for the filing of compromised settlements from two hundred dollars ($200.00) to an amount that does not exceed two hundred fifty dollars ($250.00) for the purpose of replacing existing computer hardware and software..." This session law provides further support that fees for "agreements reviewed" pursuant to G.S. § 97-73(a) should be borne by all parties not just the employers.

of a record of the hearings and other proceedings," the statute does not authorize the NCIC to charge fees related to those transcripts solely against one party. While the APA allows the NCIC to establish a fee for a hearing transcript, the NCADA asserts that G.S. § 97-80(b), which notes that hearing costs shall be taxed against the "parties," should prevent the NCIC from assigning transcript fees solely against the employer. The NCADA asserts the transcript fees should either be shared by the parties or born by the appealing party as a matter of public policy and in an effort to encourage judicial economy. The NCADA finally asserts that the transcript fees should be limited to transcripts and not exhibit pages and that fees per page should be reasonable and in line with transcript fees of other administrative agencies subject to the APA.

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

Rule .0202(b) (Hearing Costs or Fees): This rule is not supported by the statutory authority listed. Chapter 143 applies only to the NCIC's authority to hear tort claims. It is independent and inapplicable to the NCIC's jurisdiction under Chapter 97. Therefore, the NCADA asserts further penalties should not be allowed in workers' compensation claims for failure to pay fees or costs. If the right to charge penalties for failure to pay fees applies only to tort claims, the NCADA recommends that the rule borrow the phrase from Rule .0203(b) which notes "In tort claims cases, . . ." Finally, Chapter 7A only applies to civil actions filed in superior and district court and is also not valid statutory authority for this rule.

SECTION .0300—RULES OF THE COMMISSION

Rule .0301 (Suspension of Rules): This rule is not supported by statutory authority and is in violation of the Administrative Procedure Act. The Administrative Procedure Act does not allow an administrative agency to suspend its own rules unless "the rule establishes specific guidelines the agency must follow in determining whether to waive or modify the requirement." The proposed rule is not sufficient.

Rule .0302 (Sanctions): This rule is not supported by statutory authority. None of the statutes relied upon by the NCIC to promulgate this rule endow the NCIC with generalized authority to impose broad sanctions. For example, the proposed rule notes that sanctions can be assessed for failure to comply with NCIC rules, yet the proposed rule sites to sanctions allowed per Rule 37 of the Rules of Civil Procedure that relate solely to discovery violations. Because G.S. § 97-80(a) and (f) specifically note that Rule 37 does not govern discovery procedures in workers' compensation claims, broad sanctions listed in Rule 37 provide no authority for this rule. Moreover, while G.S. §§ 97-18 and 97-88.1 allow for sanctions, they are specific and limited. Other than the specific and limited grounds for imposing sanctions there is no statutory authority for sanctions other than those specifically listed in the Act. Finally, the proposed rule allows for attorneys to be sanctioned rather than their clients, which could damage the attorney-client relationship and is not supported by G.S. § 97-88.1.

NCIC PROPOSED RULE REVISIONS – NCADA COMMENTS TO 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.

NCIC PROPOSED RULE REVISIONS – NCADA COMMENTS TO 10J

Rule .0101(a) (Fees for Medical Compensation): The rule is not supported by statutory authority in that G.S. § 97-26(c) sets a maximum reimbursement amount for services; however, the proposed rule suggests that in hardship cases fees in excess of that published may be allowed. In addition, the rule fails to define "hardship cases."

Rule .0101(c): The rule does not list a methodology to determine appropriate medical fees for some medical services that were not delineated in the 1995 fee schedule.

Rule .0101: The rule should address the proper fee to be charged to an appropriate party for communication with a health care provider pursuant to G.S. § 97-25.6(i).

RECOMMENDATIONS FOR ADDITIONAL RULES

Based on the NCIC practice of enforcing unwritten procedures and adopting old minutes as informal rules, it appears the following should also be addressed in rules and should be subject to the APA rule making process:

1. We recommend that rules be promulgated to note the requirements to request and be granted secured leave and for *pro hac vice* admission before the NCIC.

2. We recommend that all procedures for case calendaring be promulgated in rules. For example, the NCIC allows claims to be special set for hearing before one of two deputy commissioners. There are unwritten rules that determine whether a claim is special set. Claimants merely need to allege a hearing will take more than a specified period of time in order to receive a special set, which allows for inappropriate forum shopping. In addition, the Full Commission panel selection process and Deputy Commissioner regional calendaring process should be promulgated in rules.

3. We recommend that all informal rules and procedures followed by the Executive Secretary's office be promulgated in rules. We recommend that rules that apply to various administrative motions be promulgated. For example, the rules should state specifically the grounds upon which a motion for consolidation will be granted. We also recommend that the rules state specifically the grounds upon which a settlement agreement will not be approved by the NCIC particularly as it relates to the different standards that are applied to unrepresented claimants. We further recommend that the rules note specifically the bases upon which a Form 18M will be granted or denied.

4. We recommend that the Form 21, Form 26, and Form 26A approval processes be promulgated in the rules.

5. We recommend that the NCIC's list of hourly fees for each medical and scientific specialty be noted in the rules.

6. We recommend that procedures related to fraud investigations and prosecutions be noted in the rules.

7. We recommend that the electronic mail retention and archiving policies of the NCIC be noted in the rules.

8. We recommend that the NCIC promulgate a rule that requires all unrepresented claimants who have filed claims with the NCIC and all attorneys practicing before the NCIC provide updated contact information to the NCIC within 10 days of a change.

9. We recommend that the NCIC promulgate a rule that addresses procedures for payment of death benefits.

10. We recommend that the NCIC promulgate rules that relate to asbestos and silica claims similar to those found in previous Minutes of the Commission published on or about October 18, 2001.

11. It is unclear if fees for independent medical examinations have been addressed in the rules.
12. We recommend a rule that sets out how credits for overpayments shall be secured.

EXHIBIT 1

Memorandum of Law Regarding the "Traditional" Taxing of Costs for Expert Witness Fees in Workers' Compensation Claims Based on Alleged Authority in Current Rules of the North Carolina Industrial Commission

It has been suggested that "by tradition" defendants have customarily paid expert witness fees for testimony by deposition or at a hearing and that the Full Commission has "traditionally" awarded a reasonable amount of time for expert preparation and for providing testimony. The NCADA objects in equity to having the defendant fund litigation against itself on the basis of a tradition that is not supported by the current Workers' Compensation Rules or is prohibited by North Carolina statutes. Moreover, defendants objects to being assessed costs related to the testimony of an employee's experts without a finding that employee has a work related injury or illness. Such a "tradition," if it could be the basis of such cost shifting, provides no protection for an employer from unfounded and unsupported claims filed against it by employees or their counsel, because the employer is simply being forced to fund an employee's litigation.

1. **Workers' Compensation Act**

There are several statutes in the Workers' Compensation Act that address the current authority of the Industrial Commission to assess the costs of hearings or depositions against a party in an occupational disease claim. As the three statutes indicate, there is no automatic or "traditional" mechanism by which costs should be assessed solely against defendants.

First, N.C. Gen. Stat. § 97-80(b) provides that "the Commission...shall have the power ... to tax costs against the parties" including costs of the depositions ordered to be taken by the Commission pursuant to § 97-80(d). Section 97-80(b) provides authority to

tax costs against "the parties"—not just against defendants. Subsection (d) of this statute provides:

> (d) The Commission may order testimony to be taken by deposition and any party to a proceeding under this Article may, upon application to the Commission, which application shall set forth the materiality of the evidence to be given, cause the deposition of witnesses residing within or without the State to be taken, the costs to be taxed as other costs by Commission. . . .

Based on the authority conferred in § 97-80(b), the Commission previously promulgated Rule 612 which provides:

> When additional medical testimony is necessary to the disposition of a case, the original hearing officer may order the deposition of medical witnesses, such depositions to be taken on or before a day certain not to exceed sixty (60) days from the date of the ruling, provided the date may be postponed for good cause shown. The hearing officer shall issue a written order setting time within which such deposition shall be taken. The costs of such depositions shall be borne by the defendants for those medical witnesses whom defendants paid for the initial examination of the plaintiff, and in those cases where defendants are requesting the depositions, and in any other case in which, in the discretion of the Commission or Deputy Commissioner, it is deemed appropriate.

As a matter of law, the Industrial Commission rules must conform to the statutory mandate. See § 97-80 (a), and *Evans v. Asheville Citizens Times Co.*, 246 N.C. 669, 100 S. E. 2d (1957). As noted above, Rule 612 currently in effect notes the Commission may assess deposition costs to defendants for medical depositions of doctors who examine plaintiff at the **defendant's expense** or for medical depositions taken at the **defendants request**, when deemed necessary by the Deputy Commissioner and so ordered. While the current rule is not supported by statutory authority, the rule only provides for the defendant to be required to pay for the deposition of a treating physician where the defendant paid for the initial exam—which, by definition would occur either in an admitted claim, or a pay without prejudice claim, or as a result of an independent medical

evaluation requested by defendant or agreed to be financed by defendant—such as a panel exam in an occupational disease claim.

Only two cases could be found in North Carolina in which the Industrial Commission awarded an expert witness fee as deposition costs pursuant to N.C. Gen. § 97-80. In *Grantham v. R.G. Barry,* 115 N.C. App. 293, 444 S.E.2d 659 (1994), plaintiff requested expert fees for its expert witness, Dr. Schiller. Citing to §97-80(a), the Court stated that N.C. Gen. Stat. § 97-80(a) (1991 & Supp.) gives the "Commission or any member thereof, or any person deputized by it, . . . the power, for the purpose of [the Workers' Compensation Act], to tax costs against the **parties** . . ." (emphasis added) The Court upheld the Deputy Commissioner's refusal to grant the request for fees of $3,197.60 on the grounds that these charges were "charges incurred by plaintiff to prosecute her claim. Defendants are not responsible for paying bills incurred by plaintiff to obtain expert toxicological support for her claim." *Id.* at 302.

Harvey v. Raleigh Police Dep't, 85 N.C. App. 540, 355 S.E.2d 147 (1987) is the other case in which deposition costs have been assessed based on N.C. Gen. § 97-80. In *Harvey*, the Court did not find that the Deputy Commissioner abused his discretion when he assessed the costs of plaintiff's expert's deposition against the defendant. The opinion does not reflect whether an expert witness fee was awarded or just the cost of the deposition. Thus, *Harvey* and *Grantham* do not set forth a tradition suggesting that defendants should pay all costs for all experts, win or lose.

Second, as it relates solely to occupational disease claims for asbestosis and silicosis, pursuant to N.C. Gen. Stat. § 97-74, "the Industrial Commission shall tax as a part of the costs in cases in which compensation is awarded a reasonable allowance for

the services of members of the advisory medical committee attending such hearings..." The purpose of the Advisory Medical Committee ("AMC"), whose members were selected by the state, was to provide independent and unbiased opinion as to the existence of an occupational disease. Nevertheless, it is significant that § 97-74 only allows the Industrial Commission to tax such costs for the involvement of the AMC when "**compensation is awarded**" to an employee. This statute is consistent with N.C. Gen. Stat. § 6-1, which allows costs to be awarded to "[t]he party for whom judgment is given...." Costs are not awarded to a party who does not prevail. *See generally* N.C. Gen. Stat. § 6-18, 6-19.

Third, pursuant to N.C. Gen. Stat. § 97-88.1, the Industrial Commission may assess costs and attorney's fees if it determines that "any hearing has been brought, prosecuted, or defended **without reasonable ground**[.]" (emphasis added) "In determining whether a hearing has been defended without reasonable ground, the Commission (and a reviewing court) must look to the evidence introduced at the hearing. 'The test is not whether the defense prevails, but whether it is based in reason rather than in stubborn, unfounded litigiousness.'" *Cooke v. P.H. Glatfelter/Ecusta*, 130 N.C. App. 220, 225, 502 S.E.2d 419, 422-23 (1998) (quoting *Sparks v. Mountain Breeze Rest.*, 55 N.C. App. 663, 665, 286 S.E.2d 575, 576 (1982)). Thus, it is not proper to assess all costs against defendants unless there has been a showing that the claim was defended without reasonable ground.

Defendants object to being assessed costs of trial and deposition testimony that it did not request. Such cost shifting means that defendants are required to fund all claims. Further, it ensures that employee's counsel incur no financial risk for bringing claims

against employers and instead rewards an employee for bringing any action whether valid or not. The expense of litigation is a major consideration to defendants—even where defendants know the claim is unjustified by the facts at issue. Often experts are not treating physicians—but experts selected by the employee to develop his claim for trial.

2. North Carolina General Statutes Limit The Definition of Costs

In addition to the issue of whether defendants should be forced to bear the costs of all discretionary expert fees, a second issue arises as to what constitutes "costs." There is no definition of "costs" contained in the Workers' Compensation Act or in the current Workers' Compensation Rules. However, costs related to civil actions are specifically defined by the North Carolina General Statutes. Under North Carolina law, costs can only be reimbursed when expressly allowed by specific statutory authority. *See, e.g., Estate of Smith v. Underwood*, 127 N.C. App. 1, 12, 487 S.E.2d 807, 815 (1997). The items enumerated in Section 7A-305(d) "are complete and exclusive and constitute a limit on the trial court's discretion to tax costs." N.C. Gen. Stat. § 7A-305(d) (2011). While the costs included in Section 7A-305(d) are costs the court is "required to assess," *Springs v. City of Charlotte*, 704 S.E.2d 319, 327 (N.C. Ct. App. Jan. 18, 2011) (citation omitted), those costs include "[r]easonable and necessary fees of expert witnesses *solely* for actual time spent providing testimony at trial, deposition, or other proceedings." N.C. Gen. Stat. § 7A-305(d)(11) (emphasis added). There is "no authority in the current statutes authorizing the trial court to assess costs for an expert witness' preparation time." *Springs*, 704 S.E.2d at 328. The *Springs* holding is consistent with the reasoning in *Grantham v. R.G. Barry,* 115 N.C. App. 293 (1994), supra, in which the Deputy

Commissioner found that fees associated with obtaining expert support for plaintiff's claim would not be proper to assess against defendants.

In summary, neither courts nor the Industrial Commission have authority to award any and all expert fees and costs solely to defendants.

September 10, 2012

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

Sent via e-mail to amber.cronk@ic.nc.gov

Dear Ms. Cronk:

Healthesystems provides workers compensation payers with powerful technology platforms and innovative solutions for pharmacy and ancillary benefits management. We are in support of many of the proposed changes to 4NCAC Chapters 10A though J, as posted in the July 16, 2012 State Register. Please accept these brief comments in support of the proposed rule change and specifically in regard to the following proposed amendments:

Chapter 10F.0101 Electronic Medical Billing and Payment Requirement

Healthesystems fully supports the Industrial Commission's proposal to require all medical providers to send and all carriers to accept electronic billing. Though we are a strong supporter of the proposed rule, we must also ask the Commission to carefully consider the existing landscape of medical billing while these new rules are being promulgated. It appears this section will require compliance on or before January 1, 2014. However this also presumes the rule is adopted by January 1, 2013. It appears that there may be some inconsistency in the effective dates in this section, as compared to section 10F.0109 where the effective date is March 1, 2014. We recommend harmonizing the dates by utilizing a single effective which is 12 months after the date the new rules are officially adopted. This timeframe will allow participants sufficient lead time to either seek out an appropriate e-bill vendor or to program and test internal e-billing systems.

Chapter 10F.0103 – FORMATS FOR ELECTRONIC MEDICAL BILLING PROCESSING

Currently, there are many carriers, third party administrators and medical providers who were early adopters of electronic medical billing and some of these payers have long standing relationships which were customized based on their unique data platforms. It may be advantageous for the Commission to acknowledge the existing connectivity between these parties and consider the capital which has been invested by so many system participants to facilitate electronic billing, before these e-billing rules were being contemplated. The costs associated with re-programming medical bill review systems and carrier claims systems could be significant, and would not add any efficiency for payers, providers or bill review entities who have already successfully implemented e-billing into their day to day business processes.

We urge the Commission not to penalize these early adopters by requiring system changes to comply with the standards as published by IAIABC. We recommend the Commission explicitly permit mutually agreed upon non-standard formats for electronic billing and remittance. This can be accomplished by adding the following new subsection (c) to NCAC 10F.0103:

Nothing in this subchapter shall prohibit payers and healthcare providers from utilizing mutually agreed upon non-standard billing and remittance formats.

Healthesystems anticipates these two recommendations will both add clarity to the rules and ensure no additional costs will be borne by those who proactively embraced processes as part of their current business operations. These recommendations also allow payers, providers, medical bill reviewers and vendors who were ahead of the "e-bill" curve to focus their IT resources on other innovative projects which will add overall system efficiency and quality care to the injured worker. Please do not hesitate to call upon us with any questions or comments for additional discussion on our comments.

Sincerely,

Sandy Shtab

Sandy Shtab
Senior Government Relations Manager
Healthesystems, LLC

PROVEN SOLUTIONS FOR COST CONTAINMENT

175 Kelsey Lane | Tampa, FL 33619 | 1.877.ASK.PMSI | www.pmsionline.com

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,

Kevin C. Tribout
Executive Director of Government Affairs, PMSI

cc: File

Cronk, Amber

From: GHendersonPC@aol.com
Sent: Thursday, September 06, 2012 11:34 AM
To: Cronk, Amber
Subject: Thoughts on proposed rehab Rules changes
Attachments: Thoughts_on_the_new_rulesproofed.doc

Amber,

Karen Smith suggested I send these to you.

Gregg Henderson

I. Definition of **Vocational Rehabilitation**:

The phrase "and to substantially increase the employee's wage earning capacity" should be removed.

Rationale - In my opinion, the job of a vocational case manager is to return the injured worker to appropriate employment as rapidly as possible by making the injured worker as employable as possible in the most cost effective means possible. Typically, the only way to "increase the employee's wage earning capacity" is to provide either training or education which should not be a requirement.

II. Professional responsibility of a **Rehabilitation Professional**:

The phrase "or retirement" should be removed.

Rationale – It would appear, by including the phrase "or retirement," a Rehabilitation Professional will now have to become a benefits specialist thus violating the CRC Code of Professional Ethics, i.e. practicing beyond the boundaries of our competence. Section D.1.a. states: "Rehabilitation Professionals practice only within the boundaries of their competence, based on their education, training, supervised experience, professional credentials, and appropriate professional experience." Unless a Rehabilitation Professional has had specific training in benefits planning, it would appear any Rehabilitation Professional advising (recommending) an injured worker's retirement would be practicing beyond the scope of their training

III. Reinstate **Refusal to sign the Form 25C may constitute non-compliance.**

Reinstate the sentence: "Refusal to sign the consent may be deemed by the Commission to be non-compliance with rehabilitation and may result in the suspension of benefits."

Rationale – Though this would be more of a medical case management issue, by including the word "shall" in the statement "the injured worker, if requested by a Rehabilitation Professional, *shall* sign a Form 25C" makes this activity mandatory. By removing the refusal to sign sentence, the commission is essentially removing any consequences for not signing.

IV. Reinstate **Shall advise all parties.**

If a Rehabilitation Professional believes the injured worker is not cooperating with the provision of rehabilitation services, the Rehabilitation Professional *shall advise all parties.*

Rationale – Before a Rehabilitation Professional can outline in writing the actions necessary for the injured worker to return to compliance, it would seem logical the issues necessitating the action letter should first be addressed in writing.

V. When **Retraining or Education is requested.**

In addition to the required elements of the written assessment of the injured worker's request for retraining or education, there should also be included the Rehabilitation Professional's opinion as to whether the request is logical, or whether continued job placement efforts would be more proper.

Rationale – In that the Rehabilitation Professional and the injured worker are the only individuals actively involved in the job placement process, and it is the Rehabilitation Professional's responsibility

to provide the required written assessment, the Rehabilitation Professional should also be required to include his/her professional opinion as to the legitimacy of the request.

VI. Utilizing the **Dictionary of Occupational Titles** and the **Handbook for Analyzing Jobs** when preparing written job descriptions.

Rehabilitation Professionals are instructed, when preparing job descriptions, that they *shall* use two reference sources that are obsolete.

Rationale – By including the word *shall* when addressing the issue of preparing job descriptions and utilizing the Dictionary of Occupational Titles *and* the Handbook for Analyzing Jobs, the Rehabilitation Professional is being required to utilize two reference source that were last updated in 1991, are essentially defunct and have been replaced by the Onet (Occupational Information Network). Either the word *shall* needs to be replaced with the word *may*, or reference to the Dictionary of Occupational Titles and Handbook for Analyzing Jobs be removed completely and replaced with the Onet.

VII. More clarification for **Change of the Rehabilitation Professional.**

There exists a mechanism putting into process the changing of a Rehabilitation Professional, but no determining body to decide if the removal is actually proper. The NCIC should be the only body that decides the removal of a Rehabilitation Professional.

Rationale – A Rehabilitation Professional may now be removed by agreement or stipulation of the parties. More specifically, whereas the current RULES leave the decision for removal solely at the discretion of the NCIC, the proposed RULES allow for attorneys to use Rehabilitation Professionals as bargaining chips when the two parties are brokering some type of agreement. A Rehabilitation Professional should be removed for good cause only (example: violation of the RULES), and not because a plaintiff's attorney simply doesn't like a Rehabilitation Professional's management style. By removing *for good cause* and replacing with *to prevent manifest injustice*, Rehabilitation Professionals can now be replaced prior to the onset of case management if a plaintiff's attorney can show that a particular Rehabilitation Professional's case management style would be an obvious injustice to his client. No violation of the RULES is necessary, simply reputation only. My concern, even though the carrier assigns the initial Rehabilitation Professional as designated on Form 25N, plaintiff attorneys have inserted themselves as part of this process by asserting the involvement of a particular Rehabilitation Professional would create a *manifest injustice* to his client and should be replaced with a Rehabilitation Professional mutually agreeable to both parties.

If the NCIC's sole responsibility in this matter under the proposed RULES is to simply notify all parties of the request, what happens if all parties can't come to an agreement for the change? Does this now go to a mediator? Additionally, the Rehabilitation Professional can request a "reconsideration of a ruling or appeal from an order." Who considers the appeal since the NCIC is no longer determining the removal if that sentence from the existing RULES has been removed?

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; Werntz, 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
www.sedgwickcms.com | *The leader in innovative claims and productivity management solutions*

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
FAX: 1-866-651-8523
Email: tdixon@carolinacasemgmt.com

Cronk, Amber

From: Pam Teague <pteague@carolinacasemgmt.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

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.
Telephone: (336) 944-5878
Fax: (888)244-0985
dsteinbeck@carolinacasemgmt.com

Please note new office telephone number (336) 944-5878

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 Statue'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

SOUTHERN REHABILITATION NETWORK, INC.

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

9370 Falls of Neuse Road, Suite 101, Raleigh, NC 27615
(919) 781-3149 1-800-772-8914 FAX (919) 781-8593
main.office@southernrehab.net
www.southernrehab.net

(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

3725 National Drive, Suite 123, Raleigh, NC 27612
(919) 781-3149 1-800-772-8914 FAX (919) 781-8593
main.office@southernrehab.net
www.southernrehab.net

PROVEN SOLUTIONS FOR COST CONTAINMENT

175 Kelsey Lane | Tampa, FL 33619 | 1.877.ASK.PMSI | www.pmsionline.com

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,

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.

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.

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.

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.

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.

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.

Thomas "Bev" Reavis, CDMS,CCM
Owner
P.O. Box 3240
Monroe, NC 2811-3240
1-800-458-0504
(704) 276-3316 (Fax)

Jerry D. Pruette, CDMS, CCM
Owner
P.O. Box 49
Vale, NC 28168
1-800-458-0504
(704) 276-3316 (Fax)

Rehabilitation Management, Inc.

August 6, 2012

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

Rehabilitation Management, Inc. (RMI)) has reviewed the Proposed Rehabilitation Rule Changes related to the recent reform in the Worker's Compensation law in North Carolina. We appreciate the efforts of the North Carolina Industrial Commission's to amend the Rules in accordance with House Bill 709.

The owners of Rehabilitation Management, Inc. (RMI)) have related the following concerns regarding the proposed rules:

1. Definition #5: The old definition of suitable employment remains but the new definition is not spelled out with the distinction between Pre MMI and Post MMI. RMI's position is that the definition should be spelled out as it was in the previous rules and as it is in the new Law:
    a. *Employment offered or available to the employee that:*
        i. *prior to reaching MMI is within the EE's work restrictions, including rehabilitative or other noncompetitive employment, with the ER of injury and approved by the EE's authorized health care provider or*
        ii. *after reaching MMI is employment that the EE is capable of performing considering the EE's preexisting and injury-related physical and mental limitations, vocational skills, education, and experience and is located within a 50-miles radius of the EE's residence at the time of injury or the EE's current residence if the EE had a legitimate reason to relocate since the DOI.*
        iii. *No one factor shall be considered exclusively in determining Suitable Employment.*

2. Definition #3 "Vocational Rehabilitation": The phrase....."*and to substantially increase the employee's wage-earning capacity."* RMI's position is this should be removed from the definition of "Vocational Rehabilitation." The most significant portion of the new definition of "Suitable Employment" is that wages have been removed from the definition. As based on the new reform laws, there is no requirement that the post-MMI job offer include any specific likelihood that the claimant will even advance to their pre-injury average weekly wage.

3. Interactions with Physicians: It is our position that as part of the definitions of "Medical Rehabilitation" and "Vocational Rehabilitation", RP's should have the same "Reasonable Access to Medical Information" as outlined in the Law (N.C.G.S 97-25.6): Stating:

    a. *Relevant medical information shall be requested and provided subject to the following provisions:*

i. *An employer is entitled, without the express authorization of the employee, to obtain the employee's medical records containing relevant information from the employee's health care providers.*
ii. *An employer may communicate with the employee's authorized health care provider in writing, without the express authorization of the employee, to obtain relevant information not available in the employee's medical record.*
    1. *The employer shall provide a copy of the health care provider's response to the employee within 10 business days of its receipt by the Employer.*
iii. *An employer may communicate with the employee's authorized health care provider by oral communication to obtain relevant information not contained in the employee's medical records, not available through written communication, and not otherwise available to the employer.*

RMI's position is in written communications to the physician such as in the case with a Job Site Analysis, the precedence set forth in the law regarding providing a copy to the employee within 10 days of the response from the physician should apply. (N.C.G.S. 97-25.6; (c), (2), f.)

4: Vocational Rehabilitation (g): *The worker or the worker's attorney shall have seven business days from the mailing of the description to notify the RP, all parties, and the physician of any objections or amendments thereto. The job description and the objections or amendments, if any, shall be submitted to the physician simultaneously.* RMI does not agree that an attorney can amend a job description. It is also RMI's position that this seems counter to the law. The law specifies any job is reasonable as long as the physician agrees it is part of the treatment or rehabilitation plan of the injured worker.

5: Vocational Rehabilitation (h): *You **shall** reference the DOT#.* RMI does not agree that the DOT should be the sole reference utilized and should not be required on the JSA. RMI's position is this should be removed.

6. Rehabilitation Management, Inc. (RMI)) has concern that the rules do not reflect the new statutes in the law pertaining to vocational rehabilitation and feels that "Vocational Rehabilitation" should reflect the framework of the new law. Example, the new law does not reference the Federal Hierarchy of return to work; however, this priority of return to work remains in the framework of the proposed revision to the new rules. RMI does not agree this should be included as proposed in the revised rules but rather modified to reflect the language in the new law.

a. N.C.G.S 97-32.2; Vocational Rehabilitation (f): Return to work options should be considered, with order of priority given to returning the employee to suitable employment with the current employer, returning the employee to suitable employment with a new employer, and, if appropriate, formal education or vocational training to prepare the employee for suitable employment with the current employer or new employer.

We thank you for your time and attentiveness to the concerns submitted before you today.

Respectfully Submitted,

Alison Crews, MS, CRC, LPC, QRP
Rehabilitation Case Management Supervisor
Rehabilitation Management, Inc.
Phone: 336/609-1400
alison.crews@rmi-us.com

Cc: Jerry Pruette – Owner RMI
Bev Reavis – Owner RMI

LENNON, CAMAK & BERTICS
PROFESSIONAL LIMITED LIABILITY COMPANY
ATTORNEYS AT LAW

GEORGE W. LENNON†
E-MAIL GWL@NCDISABILITY.COM

S. NEAL CAMAK†
E-MAIL SNC@NCDISABILITY.COM

MICHAEL W. BERTICS†
E-MAIL MWB@NCDISABILITY.COM

†BOARD CERTIFIED SPECIALIST IN N.C. WORKERS' COMPENSATION LAW

4700 HOMEWOOD COURT, SUITE 310
RALEIGH, NC 27609-5732
TELEPHONE (919) 856-9000
FACSIMILE (919) 856-9003

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

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 it's 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

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.

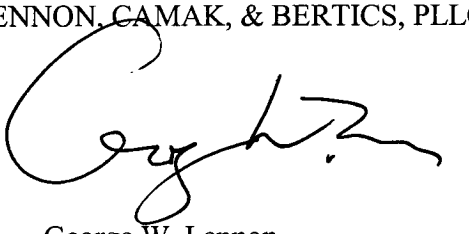
4 NCAC 10C.0110 , Change of Rehabilitation Professional, would provide at paragraph (b) that an RP could be removed only "to prevent manifest injustice." This is a radical, unnecessary change. The term "manifest injustice" is not defined. The proposed rules also do not describe whether rehabilitation 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



George W. Lennon
State Bar No. 7203
Board Certified Specialist in
NC Workers' Compensation Law

Mark T. Sumwalt
Attorney
NC Certified Workers' Compensation Specialist
mark@sumwaltlaw.com

THE Sumwalt
LAW FIRM
www.sumwaltlaw.com

Vernon R. Sumwalt
Attorney
NC Certified Workers' Compensation Specialist
vernon@sumwaltlaw.com

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.

Tel 704.377.3770 Fax 704.377.5292

1114 East Boulevard Charlotte, NC 28203

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.

Tel 704.377.3770 Fax 704.377.5292

1114 East Boulevard Charlotte, NC 28203

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).

Tel 704.377.3770 Fax 704.377.5292

1114 East Boulevard Charlotte, NC 28203

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,

Vernon Sumwalt
Chair, NCAJ Workers' Compensation Section

VRS:vrs

cc: WC Section Executive Committee

Tel 704.377.3770 Fax 704.377.5292

1114 East Boulevard Charlotte, NC 28203