CHAPTER 23 - INDUSTRIAL COMMISSION

SUBCHAPTER 23A - WORKERS' COMPENSATION RULES

SECTION .0100 - ADMINISTRATION

11 NCAC 23A .0101 LOCATION OF MAIN OFFICE AND HOURS OF BUSINESS

The main office of the North Carolina Industrial Commission is located in the Dobbs Building, 430 North Salisbury Street, Raleigh, North Carolina. Documents that may be filed via hand-delivery in accordance with Rule .0108 of this Section may be filed at the main office between the hours of 8:00 a.m. and 5:00 p.m. only. Documents permitted to be filed electronically may be filed until 11:59 p.m. on the required filing date.

History Note: *Authority G.S. 97-80(a);*
Eff. January 1, 1990;
Amended Eff. January 1, 2016; November 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10A .0101 Eff. June 1, 2018;
Amended Eff. December 1, 2018.

11 NCAC 23A .0102 OFFICIAL FORMS

(a) Copies of the Commission's rules and forms may be obtained by:

(1) contacting the Commission in person at the address in Rule .0101 of this Section, by written request mailed to North Carolina Industrial Commission, 1236 Mail Service Center, Raleigh, NC 27699-1236, Attn.: Office of the Clerk, or

(2) accessing or downloading the rules or forms from the Commission's website at http://www.ic.nc.gov/abtrules.html and http://www.ic.nc.gov/forms.html.

(b) Insurance carriers, self-insured employers, attorneys, and other parties may reproduce current Commission forms for their own use, provided:

(1) no statement, question, or information blank contained on the Commission form is omitted from the substituted form; and

(2) the substituted form is identical in size and format to the Commission form.

History Note: *Authority G.S. 97-80(a); 97-81(a);*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10A .0102 Eff. June 1, 2018;
Amended Eff. December 1, 2018.

11 NCAC 23A .0103 NOTICE OF ACCIDENT AND CLAIM OF INJURY OR OCCUPATIONAL DISEASE

To give notice of an accident or occupational disease and to make a workers' compensation claim, an employee may complete a Form 18 Notice of Accident to Employer and Claim of Employee, Representative, or Dependent and file it in accordance with Rule .0108 of this Section.

History Note: *Authority G.S. 97-22; 97-24; 97-58; 97-80(a); 97-81;*
Eff. January 1, 1990;
Amended Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0103 Eff. June 1, 2018;
Amended Eff. December 1, 2018.

11 NCAC 23A .0104 EMPLOYER'S REQUIREMENT TO FILE FIRST REPORT OF INJURY

(a) The form required to be provided by G.S. 97-92(a) is the Form 19 Employer's Report of Employee's Injury or Occupational Disease to the Industrial Commission. The Form 19 shall be used when the injury causes the employee to be absent from work for more than one day or when the charges for medical compensation exceed four thousand dollars ($4,000). The Form 19 shall be filed with the Commission in accordance with Rule .0108(d) of this Section.

(b) The employer, carrier, or administrator shall provide the employee with a copy of the completed Form 19 Employer's Report of Employee's Injury or Occupational Disease to the Industrial Commission, along with a blank

Form 18 Notice of Accident to Employer and Claim of Employee, Representative, or Dependent for use by the employee in making a claim.

History Note: *Authority G.S. 97-80(a); 97-92;*
Eff. March 15, 1995;
Amended Eff. November 1, 2014; January 1, 2011; August 1, 2006; March 1, 2001; June 1, 2000;
Recodified from 04 NCAC 10A .0104 Eff. June 1, 2018;
Amended Eff. December 1, 2020.

11 NCAC 23A .0105 ELECTRONIC PAYMENT OF COSTS

History Note: *Authority G.S. 97-80(a);*
Eff. January 1, 2011;
Rule Expired July 18, 2013 (see S.L. 2013-294, s. 1);
Recodified from 04 NCAC 10A .0105 Eff. June 1, 2018.

11 NCAC 23A .0106 FILING OF ANNUAL REPORT REQUIREMENT

Every carrier, individual self-insurer, group self-insurer, and member self-insurer as defined by G.S. 97-130 shall submit on a yearly basis a Form 51 *Annual Consolidated Fiscal Report of "Medical Only" and "Lost Time" Cases*.

History Note: *Authority G.S. 97-80(a); 97-92; 97-93; 97-130;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0106 Eff. June 1, 2018.

11 NCAC 23A .0107 COMPUTATION OF TIME AND NOTICE BY THE COMMISSION

(a) Except as otherwise provided by statute or rule, in computing any period of time prescribed or allowed by the Commission Rules, order of the Commission, or any applicable statute, the day of the act, event, or default after which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a holiday established by the State Human Resources Commission pursuant to 25 NCAC 01E .0901 and any subsequent amendments thereto, in which event the period runs until the end of the next State business day. When the period of time prescribed or allowed is less than seven days, intermediate Saturdays, Sundays, and holidays shall be excluded in the computation. Whenever a party has the right to do some act or take some proceedings within a prescribed period after the service of any document by mail, three days shall be added to the prescribed period.

(b) If service is provided by electronic mail, notice pursuant to G.S. 97-86 is complete one hour after it is sent by the Commission, provided that:

(1) notice sent after 5:00 p.m. shall be complete at 8:00 a.m. the following State business day; and

(2) notice sent by electronic mail that is not readable by the recipient is not complete. Within five State business days of receipt of an unreadable document, the receiving party shall notify the Commission of the unreadability of the document.

(c) If service is provided by U.S. Mail, notice pursuant to G.S. 97-86 shall be complete upon the Commission's placing the item to be served, enclosed in a wrapper addressed to the party to be served, in the custody of the Mail Service Center or an official depository of the United States Postal Service.

History Note: *Authority G.S. 97-80; 97-81; 97-86;*
Eff. November 1, 2014;
Amended Eff. May 1, 2018;
Recodified from 04 NCAC 10A .0107 Eff. June 1, 2018.

11 NCAC 23A .0108 ELECTRONIC FILINGS WITH THE COMMISSION; HOW TO FILE

(a) All documents filed with the Commission in workers' compensation cases shall be submitted electronically in accordance with this Rule. Any document transmitted to the Commission in a manner not in accordance with this Rule shall not be accepted for filing. Any document filed with the Commission that requires contemporaneous payment of a processing fee pursuant to Rule 11 NCAC 23E .0203 shall not be deemed filed until the fee has been paid in full. The electronic filing requirements of this Rule shall not apply to employees or non-insured employers without legal representation. Employees and non-insured employers without legal representation may file all

documents with the Commission via the Commission's Electronic Document Filing Portal ("EDFP") or by sending the documents to the Clerk of the Industrial Commission via electronic mail (dockets@ic.nc.gov), facsimile, U.S. Mail, private courier service, or hand delivery.
(b) Except as set forth in Paragraphs (d) and (e) of this Rule, all documents required to be submitted electronically to the Commission shall be filed via EDFP. Information regarding how to use EDFP is available at http://www.ic.nc.gov/training.html. In the event EDFP is inoperable, all documents required to be filed via EDFP shall be transmitted to the Commission via electronic mail to edfp@ic.nc.gov. Documents required to be filed via EDFP that are sent to the Commission via electronic mail when EDFP is operable shall not be accepted for filing.
(c) Transcripts of depositions shall be filed with the Commission pursuant to this Rule by the court reporting service. Transcripts filed with the Commission shall have only one page of text per page and shall include all exhibits. The parties shall provide the Commission's court reporting service with the information necessary to effectuate filing of the deposition transcripts and attached exhibits via EDFP. If an exhibit to a deposition is in a form that makes submission of an electronic copy impracticable, counsel for the party offering the exhibit shall make arrangements with the Commission to facilitate the submission of the exhibit. Condensed transcripts and paper copies of deposition transcripts shall not be accepted for filing.
(d) A Form 19 shall be filed as the first report of injury (FROI) via electronic data interchange (EDI), except in claims involving non-insured employers, in claims for lung disease, in claims with multiple employers or multiple carriers, or in claims with six-character IC file numbers, in which case the Form 19 shall be filed electronically via EDFP or as otherwise permitted pursuant to Paragraph (a) of this Rule. Information regarding how to register for and use EDI is available at www.ncicedi.info.
(e) Documents to be filed with the Criminal Investigations & Employee Classification Division regarding fraud complaints shall be submitted electronically to fraudcomplaints@ic.nc.gov. Documents to be filed with the Criminal Investigations & Employee Classification Division regarding employee misclassification shall be submitted electronically to emp.classification@ic.nc.gov. Safety rules to be filed with the Commission under 11 NCAC 23A .0411 shall be submitted electronically to safety@ic.nc.gov.
(f) A self-insured employer, carrier or guaranty association, third-party administrator, court reporting service, medical provider, or law firm may apply to the Commission for an emergency temporary waiver of the electronic filing requirement set forth in Paragraph (a) of this Rule when it is unable to comply because of temporary technical problems or lack of electronic mail or internet access. The request for an emergency temporary waiver shall be included with any filing submitted via facsimile, U.S. Mail, or hand delivery due to such temporary technical or access issues.
(g) A Notice of Appeal to the North Carolina Court of Appeals shall be accepted for filing by the Commission via EDFP, U.S. Mail, hand delivery, or any other means allowed by the Rules of Appellate Procedure or applicable statutes governing appeals from the General Courts of Justice. Notwithstanding the foregoing, employees and non-insured employers without legal representation may file all documents with the Commission as provided in Paragraph (a) of this Rule.

History Note: *Authority G.S. 97-80; 97-81; 97-86;*
Eff. February 1, 2016;
Amended Eff. February 1, 2017;
Recodified from 04 NCAC 10A .0108 Eff. June 1, 2018;
Amended Eff. March 1, 2021; December 1, 2018.

11 NCAC 23A .0109 CONTACT INFORMATION
(a) "Contact information" for purposes of this Rule shall include telephone number, facsimile number, email address, and mailing address.
(b) All attorneys of record with matters before the Commission shall provide and maintain current contact information via the Commission's Electronic Document Filing Portal ("EDFP").
(c) All unrepresented persons or entities with matters before the Commission shall inform the Commission upon any change to their contact information in the following manner:
(1) All employees who are not represented by counsel shall inform the Commission of any change in contact information by filing a written notice via EDFP, email to contactinfo@ic.nc.gov, facsimile to (919) 715-0282, U.S. mail sent to Office of the Clerk, 1236 Mail Service Center, Raleigh North Carolina 27699-1236, private courier service in accordance with Rule .0101 of this Section, or hand delivery in accordance with Rule .0101 of this Section.

(2) All non-insured employers that are not represented by counsel shall inform the Commission of any change in contact information by filing a written notice via EDFP, email to contactinfo@ic.nc.gov, facsimile to (919) 715-0282, U.S. mail sent to Office of the Clerk, 1236 Mail Service Center, Raleigh North Carolina 27699-1236, private courier service in accordance with Rule .0101 of this Section, or hand delivery in accordance with Rule .0101 of this Section.

(d) All carriers, third party administrators, and self-insured employers shall provide the Commission, by sending an email to contactinfo@ic.nc.gov, with an email address for service of claim-related documents in cases where the Commission does not have email contact information for a specific representative assigned to the claim.

(e) Instructions on how to provide and update contact information via EDFP are available at https://www.ic.nc.gov/docfiling.html.

History Note: *Authority G.S. 97-80;*
Eff. January 1, 2019;
Amended Eff. March 1, 2021.

SECTION .0200 – NOTICE OF ACT

11 NCAC 23A .0201 POSTING REQUIREMENT FOR EMPLOYERS

(a) The form required to be posted by G.S. 97-93(e) is the Form 17 *Workers' Compensation Notice to Injured Workers and Employers*, that includes the following:

(1) name of insurer;
(2) policy number; and
(3) dates of coverage.

(b) If there is a change in coverage, the Form 17 *Workers' Compensation Notice to Injured Workers and Employers* shall be amended within five working days.

History Note: *Authority G.S. 97-80(a); 97-93;*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; March 15, 1995;
Recodified from 04 NCAC 10A .0201 Eff. June 1, 2018.

SECTION .0300 - INSURANCE

11 NCAC 23A .0301 PROOF OF INSURANCE COVERAGE

(a) Every employer, either personally or through its carrier or third party administrator, subject to the provisions of the Workers' Compensation Act shall file with the Commission proof that it has obtained workers' compensation insurance, and shall post notice of proof of insurance to employees consistent with Rule .0201 of this Subchapter.

(b) Upon actual notice of a workers' compensation claim or upon reporting a workers' compensation claim to a carrier, third party administrator, servicing agent, professional employer organization as defined in G.S. 58-89A-5(14), or the Commission, all employers shall provide the injured worker with the name of their insurance carrier and policy number or shall inform the injured worker of their self-insured status, membership in a self-insurance group or relationship with a professional employer organization that provides the insurance coverage.

(c) Every carrier, third party administrator, servicing agent, or other entity filing a Form 19 *Employer's Report of Employee's Injury or Occupational Disease to the Industrial Commission* shall identify by name and address any professional employer organization and the name of the client company employing the employee who is the subject of the Form 19 *Employer's Report of Employee's Injury or Occupational Disease to the Industrial Commission*.

(d) A professional employer organization shall, within 30 days of initiation or termination of the professional employer organization's relationship with any client company, notify the Commission of either the initiation or termination of the relationship and the status of the client company's workers' compensation coverage.

(e) Upon notice from the Commission that an employer is non-insured, coverage has lapsed or been canceled, or coverage or self-insured status cannot be verified, an employer shall show proof of coverage to the Commission by:

(1) a certificate of insurance issued by the insurance agent who procured workers' compensation insurance on behalf of the employer;
(2) submitting a copy of the letter of approval, license or amended license with subsidiary information, if applicable, from the North Carolina Department of Insurance notifying or

indicating the employer has qualified as a self-insured employer for workers' compensation purposes;

(3) submitting a copy of the Form 18WC Application for Membership indicating the employer is a member of a self-insurance group or fund;

(4) submitting a copy of a declaration of coverage page from an insurance policy procured in another state that indicates North Carolina is a covered jurisdiction under the workers' compensation policy;

(5) submitting the names of the general contractor, subcontractor, professional employer organization or other entity that has provided workers' compensation coverage for the employer; provided however, that coverage shall be verified by the Commission in order to be removed from the non-insured docket; or

(6) submitting other documentation or information relevant to the workers' compensation claim upon request of the Commission.

(f) A principal contractor, intermediate contractor or subcontractor may satisfy the requirements of G.S. 97-19 by obtaining a certificate of insurance issued by the insurance agent who procured insurance on behalf of the subcontractor or a certificate of compliance issued by the Department of Insurance to a self-insured subcontractor. If the subcontractor has notice that the policy of insurance has lapsed, is cancelled, is not renewed, or the subcontractor ceases to qualify as a self-insured employer, the subcontractor shall, within 24 hours, notify any contractor to whom it has provided a certificate of insurance that the certificate or certificate of compliance is no longer valid.

History Note: *Authority G.S. 97-19; 97-80(a); 97-93;*
Eff. January 1, 1990;
Amended Eff. January 1, 2013; June 1, 2000;
Recodified from 04 NCAC 10A .0301 Eff. June 1, 2018.

11 NCAC 23A .0302 REQUIRED CONTACT INFORMATION FROM CARRIERS

All insurance carriers, third party administrators, and self-insured employers shall designate a primary contact person for workers' compensation issues in North Carolina and shall maintain and provide annually on July 1 to the Director of Claims Administration of the Commission via the Commission's Electronic Document Filing Portal ("EDFP") the primary contact person's current contact information, including direct telephone and facsimile numbers, mailing addresses, and email addresses. Contact information shall be updated within 30 days of any change.

History Note: *Authority G.S. 97-80(a); 97-94;*
Eff. January 1, 2011;
Amended Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0302 Eff. June 1, 2018;
Amended Eff. December 1, 2018;
Amended Eff. March 1, 2021.

SECTION .0400 – DISABILITY, COMPENSATION, FEES

11 NCAC 23A .0401 CALCULATING THE SEVEN-DAY WAITING PERIOD

(a) When the injured employee is not paid wages for the entire day on which the injury occurred, the seven-day waiting period prescribed by the Workers' Compensation Act shall include the day of injury regardless of the hour of the injury.

(b) When the injured employee is paid wages for the entire day on which the injury occurred and fails to return to work on his next regular workday because of the injury, the seven-day waiting period shall begin with the first calendar day following the injury, even though this may or may not be a regularly scheduled workday.

(c) All days, or parts of days, when the injured employee is unable to earn a full day's wages, or is not paid a full day's wages due to injury, shall be counted in computing the waiting period even though the days may not be consecutive, or regularly scheduled workdays.

(d) There is no seven-day waiting period when the permanent partial disability period added to the temporary disability period, exceeds 21 days.

History Note: *Authority G.S. 97-28; 97-80(a);*

Eff. January 1, 1990;
Amended Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0401 Eff. June 1, 2018.

11 NCAC 23A .0402 SUBMISSION OF EARNINGS STATEMENT REQUIRED

(a) Within 30 days of a request by the employee or the Commission, the employer shall submit a verified statement of the specific days worked and the earnings of the employee during the 52-week period immediately preceding the injury to the Commission and the employee's attorney of record or the employee, if not represented.

(b) In all cases involving a fractional part of a week, the average weekly wage shall be computed based upon the applicable fractional portion of the week worked.

History Note: *Authority G.S. 97-2(5); 97-18(b); 97-80(a); 97-81;*
Eff. January 1, 1990;
Amended Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0402 Eff. June 1, 2018.

11 NCAC 23A .0403 MANNER OF PAYMENT OF COMPENSATION

(a) All payments of compensation shall be made directly to the employee, dependent, guardian or personal representative. Payment of compensation shall be mailed by first class mail, postage pre-paid, to an address specified by the employee, unless another method is specified by and agreed upon by the parties.

(b) All payments of compensation shall be made in accordance with the award issued by the Commission.

History Note: *Authority G.S. 97-18; 97-80(a);*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10A .0403 Eff. June 1, 2018.

11 NCAC 23A .0404 TERMINATION AND SUSPENSION OF COMPENSATION

(a) No application to terminate or suspend compensation shall be approved by the Commission without a formal hearing if the effect of the approval is to set aside the provisions of an award of the Commission.

(b) When an employer, carrier, or administrator seeks to terminate or suspend temporary total disability compensation being paid pursuant to G.S. 97-29 for a reason other than those specified in G.S. 97-18(d) (payment without prejudice), G.S. 97-18.1(b) (trial return to work), or G.S. 97-29(b) (expiration of 500-week limit on disability compensation (only for claims arising on or after June 24, 2011)), the employer, carrier, or administrator shall notify the employee's attorney of record or the employee, if not represented, on Form 24, *Application to Terminate or Suspend Payment of Compensation*. This form requests:

(1) the date of injury or accident and date the disability began;
(2) the nature and extent of injury;
(3) the number of weeks of compensation paid and the date range(s) during which such compensation was paid;
(4) the total amount of indemnity compensation paid to date;
(5) whether one of the following events has occurred:
    (A) an agreement was approved by the Commission and the date;
    (B) an employer admitted employee's right to compensation pursuant to G.S. 97-18(b);
    (C) an employer paid compensation to the employee without contesting the claim within the statutory period provided under G.S. 97-18(d); or
    (D) any other event related to the termination or suspension of compensation;
(6) whether the application is made to terminate or suspend compensation and the grounds; and
(7) whether the employee is in managed care.

(c) The employer, carrier, or administrator shall specify the grounds and the alleged facts supporting the application and shall complete the blank space in the "Important Notice to Employee" portion of Form 24 *Application to Terminate or Suspend Payment of Compensation* by inserting a date 17 days from the date the employer, carrier, or administrator serves the completed Form 24 *Application to Terminate or Suspend Payment of Compensation* on the employee's attorney of record by e-mail or facsimile, or the employee, if not represented, by first class mail. The Form 24 *Application to Terminate or Suspend Payment of Compensation* and attached documents shall be sent to the Commission via upload to the Electronic Document Filing Portal in accordance with Rule .0108 of this Subchapter,

and shall be contemporaneously served on employee's counsel by e-mail or facsimile, or on the employee, if unrepresented, by first class mail.

(d) The Form 24 *Application to Terminate or Suspend Payment of Compensation* shall specify the number of pages of documents attached which are to be considered by the Commission. If the employee or the employee's attorney of record objects by the date inserted on the employer's Form 24 *Application to Terminate or Suspend Payment of Compensation*, the Commission shall set the case for an informal hearing, unless waived by the parties in favor of a formal hearing. The objection shall be filed in accordance with Rule .0108 and shall be accompanied by all currently available supporting documentation. A copy of any objection shall be contemporaneously served on the employer, carrier, or administrator. The Form 24 *Application to Terminate or Suspend Payment of Compensation* or objection may be supplemented with any additional relevant documentation received after the initial filing. The term "carrier" or "administrator" also includes any successor in interest in the pending claim.

(e) If an employee does not object within the allowed time, the Commission shall review the Form 24 *Application to Terminate or Suspend Payment of Compensation* and any attached documentation, and an Administrative Decision and Order shall be rendered without an informal hearing as to whether there is a sufficient basis under the Workers' Compensation Act to terminate or suspend compensation, except as provided in Paragraph (g) of this Rule. Either party may seek review of the Administrative Decision and Order as provided by Rule .0702 of this Subchapter.

(f) If the employee timely objects to the Form 24 *Application to Terminate or Suspend Payment of Compensation*, the Commission shall conduct an informal hearing within 25 days of the receipt by the Commission of the Form 24 *Application to Terminate or Suspend Payment of Compensation*, unless the time is extended for good cause shown. The informal hearing may be by telephone conference between the Commission and the parties or their attorneys of record. The informal hearing may be conducted with the parties or their attorneys of record personally present with the Commission. The Commission shall make arrangements for the informal hearing with a view towards conducting the hearing in the most expeditious manner. The informal hearing shall be no more than 30 minutes, with each side given 10 minutes to present its case and five minutes for rebuttal. Notwithstanding the above, the employer, carrier, or administrator may waive the right to an informal hearing and proceed to a formal hearing by filing a request for hearing on a Form 33 *Request that Claim be Assigned for Hearing*.

(g) Either party may appeal the Administrative Decision and Order of the Commission as provided by Rule .0702 of this Subchapter. A Deputy Commissioner shall conduct a hearing which shall be a hearing de novo. The hearing shall be peremptorily set and shall not require a Form 33 *Request that Claim be Assigned for Hearing*. The employer has the burden of producing evidence on the issue of the employer's application for termination or suspension of compensation. If the Deputy Commissioner reverses an order previously granting a Form 24 *Application to Terminate or Suspend Payment of Compensation* motion, the employer, carrier, or administrator shall promptly resume compensation or otherwise comply with the Deputy Commissioners decision, notwithstanding any appeal or application for review to the Full Commission pursuant to G.S. 97-85.

(h) If the Commission is unable to reach a decision after an informal hearing, the Industrial Commission shall issue an Administrative Decision and Order to that effect that shall be in lieu of a Form 33 *Request that Claim be Assigned for Hearing*, and the case shall be placed on the formal hearing docket. If additional issues are to be addressed, the employer, carrier, or administrator shall within 30 days of the date of the Administrative Decision and Order file a Form 33 *Request that Claim be Assigned for Hearing* or notify the Commission that a formal hearing is not currently necessary. The effect of placing the case on the docket shall be the same as if the Form 24 *Application to Terminate or Suspend Payment of Compensation* were denied, and compensation shall continue until such time as the case is decided by a Commissioner or a Deputy Commissioner following a formal hearing.

(i) The Commission shall send a copy of the Administrative Decision and Order to a non-prevailing party who is without legal representation by certified mail.

(j) No order issued as a result of an informal Form 24 *Application to Terminate or Suspend Payment of Compensation* hearing shall terminate or suspend compensation retroactively to a date preceding the filing date of the Form 24 *Application to Terminate or Suspend Payment of Compensation*. Compensation may be terminated retroactively to a date preceding the filing date of the Form 24 *Application to Terminate or Suspend Payment of Compensation* without a formal hearing where there is agreement by the parties, where allowed by statute, or where the employee is incarcerated. Otherwise, retroactive termination or suspension of compensation to a date preceding the filing of a Form 24 *Application to Terminate or Suspend Payment of Compensation* may be ordered as a result of a formal hearing. Additionally, nothing shall impair an employer's right to seek a credit pursuant to G.S. 97-42.

(k) Any Administrative Decision and Order or other Commission decision allowing the suspension of compensation on the grounds of noncompliance with medical treatment pursuant to G.S. 97-25 or G.S. 97-27, noncompliance with

vocational rehabilitation pursuant to G.S. 97-25 or G.S. 97-32.2, or unjustified refusal to return to work pursuant to G.S. 97-32 must specify what action the employee must take to end the suspension and reinstate the compensation.

History Note: *Authority G.S. 97-18.1(c); 97-18.1(d); 97-32.2(g); 97-80(a);*
Eff. January 1, 1990;
Amended Eff. February 1, 2016; November 1, 2014; June 1, 2000; March 15, 1995;
Recodified from 04 NCAC 10A .0404 Eff. June 1, 2018.

11 NCAC 23A .0404A TRIAL RETURN TO WORK

(a) Except as provided in Paragraph (g) of this Rule, when compensation for total disability being paid pursuant to G.S. 97-29is terminated because the employee has returned to work for the same or a different employer, the termination is subject to the provisions of G.S. 97-32.1 (trial return to work). When compensation is terminated under these circumstances, the employer, carrier, or administrator shall, within 16 days of the termination of compensation, file a Form 28T *Notice of Termination of Compensation by Reason of Trial Return to Work* with the Commission and provide a copy of it to the employee's attorney of record or the employee, if unrepresented.

(b) If during the trial return to work period, the employee must stop working due to the injury for which compensation had been paid, the employee may complete and file with the Commission a Form 28U *Employee's Request that Compensation be Reinstated after Unsuccessful Trial Return to Work*, without regard to whether the employer, carrier or administrator has filed a Form 28T *Notice of Termination of Compensation by Reason of Trial Return to Work* as required by Paragraph (a) of this Rule, and provide a copy of the completed form to the employer and carrier or administrator. A Form 28U *Employee's Request that Compensation be Reinstated after Unsuccessful Trial Return to Work* contains a section that shall be completed by the physician who imposed the restrictions or one of the employee's authorized treating physicians, certifying that the employee's injury for which compensation had been paid prevents the employee from continuing the trial return to work. If the employee returned to work with an employer other than the employer at the time of injury, the employee may complete the "Employee's Release of Employment Information" section of a Form 28U *Employee's Request that Compensation be Reinstated after Unsuccessful Trial Return to Work*. An employee's failure to provide a Form 28U *Employee's Request that Compensation be Reinstated after Unsuccessful Trial Return to Work* does not preclude a subsequent finding by the Commission that the trial return to work was unsuccessful.

(c) Upon receipt of a completed Form 28U *Employee's Request that Compensation be Reinstated after Unsuccessful Trial Return to Work*, the employer, carrier, or administrator shall resume payment of compensation for total disability. If the employee fails to provide the required certification of an authorized treating physician as specified in Paragraph (b) of this Rule, or if the employee fails to execute the "Employees Release and Request" section of a Form 28U *Employee's Request that Compensation be Reinstated after Unsuccessful Trial Return to Work*, if required pursuant to Paragraph (b) of this Rule, the employer, carrier, or administrator is not required to resume payment of compensation. Instead, the employer, carrier, or administrator shall return a Form 28U *Employee's Request that Compensation be Reinstated after Unsuccessful Trial Return to Work* to the employees attorney of or the employee, if unrepresented, along with a statement explaining the reason the Form 28U *Employee's Request that Compensation be Reinstated after Unsuccessful Trial Return to Work* is being returned and the reason compensation is not being reinstated.

(d) The reinstated compensation shall be due and payable and subject to the provisions of G.S. 97-18(g) on the date and for the period commencing on the date the employer, carrier, or administrator receives a completed Form 28U *Employee's Request that Compensation be Reinstated after Unsuccessful Trial Return to Work* certifying an unsuccessful return to work. Such resumption of compensation does not preclude the employee's right to seek, nor the employer's, carrier's, or administrator's right to contest, the payment of compensation for the period prior or subsequent to the reinstatement. If it is thereafter determined by the Commission that any temporary total or temporary partial compensation, including the reinstated compensation, was not due and payable, a credit shall be given against any other compensation determined to be owed.

(e) When the employer, carrier, or administrator has received a completed Form 28U *Employee's Request that Compensation be Reinstated after Unsuccessful Trial Return to Work* and contests the employee's right to reinstatement of total disability compensation, the employer, carrier, or administrator may suspend or terminate compensation only as provided in G.S. 97-18.1, G.S. 97-83 or G.S. 97-84.

(f) Upon resumption of payment of compensation for total disability, the employer, carrier, or administrator shall complete and file a Form 62 *Notice of Reinstatement or Modification of Compensation* or such other forms as may be required by the Workers' Compensation Act or by Commission rule. A copy of the Form 62 *Notice of*

Reinstatement or Modification of Compensation shall be sent to the employee's attorney of record or the employee, if unrepresented.

(g) The trial return to work provisions do not apply to the following:

(1) cases in which the employee is not absent from work for more than one day or in which medical expenses are less than two thousand dollars ($2,000);

(2) cases in which the employee has missed fewer than eight days from work;

(3) cases in which the employee has been released to return to work by an authorized treating physician as specified in Paragraph (b) of this Rule without restriction or limitation except that if the physician, within 45 days of the employee's return to work date, determines that the employee is not able to perform the job duties assigned, then the employer, carrier, or administrator shall resume benefits. If within the same time period, the physician determines that the employee may work only with restrictions, then the employee is entitled to a resumption of benefits commencing as of the date of the report, unless the employer is able to offer employment consistent with the restrictions, in which case a trial return to work period shall be deemed to have commenced at the time of the employee's initial return to work;

(4) cases in which the employee has accepted or agreed to accept compensation for permanent partial disability pursuant to G.S. 97-31, unless the trial return to work follows reinstatement of compensation for total disability under G.S. 97-29; and

(5) claims pending on or filed after 1 January 1995, when the employer, carrier, or administrator contests a claim pursuant to G.S. 97-18(d) within the time allowed thereunder.

(h) This Rule applies to any employee who leaves work on or after February 15, 1995 due to a compensable injury.

History Note: *Authority G.S. 97-18(h); 97-29; 97-32.1; 97-80(a);*
Eff. February 15, 1995;
Amended Eff. November 1, 2014; August 1, 2006; June 1, 2000;
Recodified from 04 NCAC 10A .0404A Eff. June 1, 2018.

11 NCAC 23A .0405 REINSTATEMENT OF COMPENSATION

(a) In a claim in which the employer, carrier, or administrator has admitted liability, when an employee seeks reinstatement of compensation pursuant to G.S. 97-18(k), the employee may notify the employer, carrier, or administrator and the employer's, carrier's, or administrator's attorney of record on a Form 23 *Application to Reinstate Payment of Disability Compensation* or by the filing of a Form 33 *Request that Claim be Assigned for Hearing*.

(b) When reinstatement is sought by the filing of a Form 23 *Application to Reinstate Payment of Disability Compensation*, the original Form 23 *Application to Reinstate Payment of Disability Compensation* and the attached documents shall be filed with the Commission in accordance with Rule .0108 of this Subchapter, and a copy of the Form 23 and attached documents shall contemporaneously be sent to the employer, carrier, or administrator and the employer's, carrier's, or administrator's attorney of record. The employee shall specify the grounds and the alleged facts supporting the application and shall complete the blank space in the "Important Notice to Employer" portion of Form 23 *Application to Reinstate Payment of Disability Compensation* by inserting a date 17 days from the date the employee serves the completed Form 23 *Application to Reinstate Payment of Disability Compensation* on the employer, carrier, or administrator and the attorney of record, if any. The Form 23 *Application to Reinstate Payment of Disability Compensation* shall specify the number of pages of documents attached that are to be considered by the Commission. Within 17 days from the date the employee serves the completed Form 23 *Application to Reinstate Payment of Disability Compensation* on the employer, carrier, or administrator and the attorney of record, if any, the employer, carrier, or administrator shall complete Section B of the Form 23 *Application to Reinstate Payment of Disability Compensation* and file it with the Commission in accordance with Rule .0108 of this Subchapter and send a copy contemporaneously to the employee or the employee's attorney of record.

(c) If the employer, carrier, or administrator does not object within the time allowed, the Commission shall review the Form 23 *Application to Reinstate Payment of Disability Compensation* and the attached documentation and, without an informal hearing, issue an Administrative Decision and Order as to whether there is sufficient basis under the Workers' Compensation Act to reinstate compensation. This Administrative Decision and Order shall be issued within five days of the expiration of the time within which the employer, carrier, or administrator could have filed a response to the Form 23 *Application to Reinstate Payment of Disability Compensation*. Either party may seek review of the Administrative Decision and Order as provided by Rule .0702 of this Subchapter.

(d) If the employer, carrier, or administrator timely objects to the Form 23 *Application to Reinstate Payment of Disability Compensation*, the Commission shall conduct an informal hearing within 25 days of the receipt by the Commission of the Form 23 *Application to Reinstate Payment of Disability Compensation* unless the time is extended for good cause shown. The informal hearing may be conducted with the parties or their attorneys of record personally present with the Commission. The Commission shall make arrangements for the informal hearing with a view toward conducting the hearing in the most expeditious manner. The informal hearing shall be no more than 30 minutes, with each side being given 10 minutes to present its case and five minutes for rebuttal. Notwithstanding the foregoing, the employee may waive the right to an informal hearing and proceed to a formal hearing by filing a request for hearing on a Form 33 *Request that Claim be Assigned for Hearing*. Either party may appeal the Administrative Decision and Order of the Commission as provided by Rule .0702 of this Subchapter. A Deputy Commissioner shall conduct a hearing which shall be a hearing de novo. The hearing shall be peremptorily set and shall not require a Form 33 *Request that Claim be Assigned for Hearing*. The employee has the burden of producing evidence on the issue of the employee's application to reinstate compensation. If the Deputy Commissioner reverses an order previously granting a Form 23 *Application to Reinstate Payment of Disability Compensation* motion, the employer shall promptly terminate compensation or otherwise comply with the Deputy Commissioner's decision, notwithstanding any appeal or application for review to the Full Commission under G.S. 97-85.
(e) If the Commission is unable to render a decision after the informal hearing, the Commission shall issue an order to that effect, which shall be in lieu of a Form 33 *Request that Claim be Assigned for Hearing*, and the case shall be placed on the formal hearing docket. If additional issues are to be addressed, the employee, employer, carrier, or administrator shall file a Form 33 *Request that Claim be Assigned for Hearing* or notify the Commission that a formal hearing is not currently necessary within 30 days of the date of the Administrative Decision or Order. The effect of placing the case on the docket shall be the same as if the Form 23 *Application to Reinstate Payment of Disability Compensation* was denied, and compensation shall not be reinstated until such time as the case is decided by a Commissioner or a Deputy Commissioner following a formal hearing.

History Note: *Authority G.S. 97-18(k); 97-80(a);*
Eff. January 1, 1990;
Amended Eff. February 1, 2016; November 1, 2014;
Recodified from 04 NCAC 10A .0405 Eff. June 1, 2018.

11 NCAC 23A .0406 DISCOUNT RATE TO BE USED IN DETERMINING COMMUTED VALUES

To compute the present value of unaccrued compensation payments, the parties shall utilize the Internal Revenue Service's Applicable Federal Rate or the discount rate that is:

(1) used to determine the present value of an annuity, an interest for life or a term of years, or a remainder or reversionary interest,
(2) set monthly by the Internal Revenue Service for Section 7520 interest rates, and
(3) found in the Index of Applicable Federal Rate (AFR) Rulings. The Index of AFR Rulings 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, https://apps.irs.gov/app/picklist/list/federalRates.html 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.

History Note: *Authority G.S. 97-40; 97-44; 97-80(a);*
Eff. January 1, 1990;
Amended Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0406 Eff. June 1, 2018;
Amended Eff. October 1, 2019.

11 NCAC 23A .0407 FEES FOR MEDICAL COMPENSATION

History Note: *Authority G.S. 97-18(i); 97-25.6; 97-26; 97-80(a); 138-6;*
Eff. January 1, 1990;
Amended Eff. June 1, 2000; March 15, 1995;
Repealed Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0407 Eff. June 1, 2018.

11 NCAC 23A .0408 APPLICATION FOR OR STIPULATION TO ADDITIONAL MEDICAL COMPENSATION

(a) An employee may file an application for additional medical compensation with the Office of the Executive Secretary for an order for payment of additional medical compensation within two years of the date of the last payment of medical or indemnity compensation, whichever occurs last. An application may be made on a Form 18M Employee's Application for Additional Medical Compensation or by written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33 Request that Claim be Assigned for Hearing with the Commission pursuant to Rule .0602 of this Subchapter.

(b) Upon receipt of a Form 18M Employee's Application for Additional Medical Compensation or a written request, the Commission shall notify the employer, carrier, or administrator that the claim has been received by providing a copy of the Form 18M Employee's Application for Additional Medical Compensation or the written request. Within 30 days, the employer, carrier, or administrator may send to the Commission and the employee's attorney of record or the employee, if unrepresented, a written statement as to whether the request is accepted or denied. If the request is denied, the employer, carrier, or administrator may state in writing the grounds for the denial and shall attach any supporting documentation to the statement of denial.

(c) The parties may, by agreement or stipulation consistent with the Workers' Compensation Act, provide for additional medical compensation.

(d) This Rule applies to injuries occurring on or after July 5, 1994.

History Note: *Authority G.S. 97-25.1; 97-80(a);*
Eff. March 15, 1995;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10A .0408 Eff. June 1, 2018;
Amended Eff. December 1, 2020.

11 NCAC 23A .0409 CLAIMS FOR DEATH BENEFITS

(a) An employer shall notify the Commission of the occurrence of a death resulting from an injury or occupational disease allegedly arising out of and in the course of employment by filing a Form 19 Employer's Report of Employee's Injury or Occupational Disease to the Industrial Commission within five days of knowledge of the death.

(b) An employer, carrier, or administrator shall conduct an investigation to determine the names and addresses of decedent's potential beneficiaries under G.S. 97-38 and identify them on the Form 29 Supplemental Report for Fatal Accidents. The Form 29 Supplemental Report for Fatal Accidents shall be filed with the Commission within 45 days of notification of a death or allegation of death resulting from an injury or occupational disease arising out of and in the course of employment.

(c) If the employer, carrier, or administrator disputes that an employee's death is compensable or denies it has liability for the claim, the employer, carrier, or administrator shall notify the Commission on a Form 61 Denial of Workers' Compensation Claim. When the employer, carrier, or administrator denies liability for a claim involving an employee's death, the employer, carrier, or administrator shall send the form to all known potential beneficiaries, their attorneys of record, if any, all health care providers that have submitted bills to the employer, carrier, or administrator, and the Commission.

(d) If the employer, carrier, or administrator accepts liability for a claim involving an employee's death and there are no issues necessitating a hearing for determination of beneficiaries or their respective rights, the parties shall submit either a Form 30 Agreement for Compensation for Death as set forth in Rule .0501 of this Subchapter or a proposed Opinion and Award.

(e) If the parties submit a Form 30 Agreement for Compensation for Death, the agreement shall be filed in accordance with Rule .0108 of this Subchapter with the following:

(1) a stipulation as to average weekly wage;
(2) any affidavits regarding dependents;
(3) the employee's death certificate;
(4) a Form 29 Supplemental Report for Fatal Accidents;
(5) a Form 42 Application for Appointment of Guardian ad Litem, if any beneficiary is a minor or incompetent;
(6) proof of beneficiary status, such as marriage license, birth certificate, or divorce decree;
(7) a funeral bill or stipulation as to payment of the funeral benefit;

(8) a Form 30D Award Approving Agreement for Compensation for Death; and
(9) an affidavit or itemized statement in support of an award of attorney's fees if an attorney is seeking fees for representation of one or more beneficiaries.

(f) If the parties seek a written Opinion and Award from the Commission regarding the payment of death benefits in lieu of submitting a Form 30 Agreement for Compensation for Death, the parties shall file, in accordance with Rule .0108 of this Subchapter, a proposed Opinion and Award with the following:

(1) a stipulation regarding all jurisdictional matters;
(2) the decedent's name, social security number, employer, insurance carrier or servicing agent, and the date of the injury giving rise to this claim;
(3) a stipulation as to average weekly wage;
(4) any affidavits regarding dependents;
(5) the employee's death certificate;
(6) a Form 29 Supplemental Report for Fatal Accidents;
(7) a Form 42 Application for Appointment of Guardian ad Litem, if any beneficiary is a minor or incompetent;
(8) proof of beneficiary status, such as marriage license, birth certificate, or divorce decree;
(9) medical records, if any;
(10) a statement of payment of medical expenses incurred, if any;
(11) a funeral bill or stipulation as to payment of the funeral benefit; and
(12) an affidavit or itemized statement in support of an award of attorney's fees if an attorney is seeking fees for representation of one or more beneficiaries.

(g) If an issue exists as to whether a person is a beneficiary pursuant to G.S. 97-38 or if any other disputed issue exists in an accepted claim, the employer, carrier, administrator, potential beneficiary, or any person asserting a claim for benefits may request a hearing by filing a Form 33 Request that Claim be Assigned for Hearing in accordance with Rule .0602 of this Subchapter.

(h) Upon approval by the Commission of a Form 30 Agreement for Compensation for Death or upon the issuance of a final order of the Commission directing payment of death benefits pursuant to G.S. 97-38, payment shall be made by the employer, carrier, or administrator directly to the beneficiaries, with the following exceptions:

(1) any applicable award of attorney's fees shall be paid directly to the attorney; and
(2) benefits due to a minor or incompetent.

(i) In all cases involving minors and incompetent persons who are potential beneficiaries, a guardian ad litem shall be appointed pursuant to Rule .0604 of this Subchapter.

(j) Any benefits due to a minor pursuant to G.S. 97-38 shall be paid directly to the minor's parent, legal guardian, or legal custodian, if the minor remains in the physical custody of such person, or another person if ordered by the Commission for good cause shown. The benefits shall be for the exclusive use and benefit of the minor. When a beneficiary reaches the age of 18, any remaining benefits shall be paid directly to the beneficiary.

(k) The Commission shall order that the benefits for an incompetent beneficiary shall be paid to the person or entity authorized to receive funds on behalf of the beneficiary pursuant to a federal or state court order, or to the Clerk of Court in the county in which the beneficiary resides, for the beneficiary's exclusive use and benefit.

(l) Upon a change in circumstances, any interested party may request that the Commission amend the terms of any award with respect to a minor or incompetent person to direct payment to another party on behalf of the minor or incompetent person.

(m) In the case of benefits commuted to present value, only those sums that have not accrued at the time of the approval of a Form 30 Agreement for Compensation for Death or entry of a final order of the Commission directing payment of death benefits pursuant to G.S. 97-38 are subject to commutation pursuant to Rule .0406 of this Subchapter.

History Note: *Authority G.S. 97-38; 97-39; 97-80(a);*
Eff. June 1, 2000;
Amended Eff. November 1, 2014; January 2, 2011;
Recodified from 04 NCAC 10A .0409 Eff. June 1, 2018;
Amended Eff. December 1, 2020.

11 NCAC 23A .0410 COMMUNICATION FOR MEDICAL INFORMATION

(a) When an employer seeks to communicate pursuant to G.S. 97-25.6(c)(2) with an employee's authorized health care provider 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), the employer may use the Commission's Medical Status Questionnaire.

(b) When an employee seeks a protective order under G.S. 97-25.6(d)(4) or G.S. 97-25.6(f), the employee shall provide the following to the Commission:

(1) the proposed written communication and any proposed additional information from which the employee seeks a protective order;
(2) description of any attempt to resolve the issue cooperatively;
(3) grounds for the protective order; and
(4) any alternative methods to discover the information.

(c) When responding to an employee's request under G.S. 97-25.6(d)(4) or G.S. 97-25.6(f), for a protective order, the employer shall provide the following to the Commission:

(1) the statutory provision on which the proposed communication is based;
(2) description of any attempts which have been made to resolve the issue cooperatively;
(3) description of any other attempts which have been made to obtain the relevant medical information; and
(4) justification for the communication.

(d) When an employer seeks the Commission's authorization for other forms of communication pursuant to G.S. 97-25.6(g), the employer shall follow the procedures for motions in Rule .0609 of this Subchapter.

History Note: *Authority G.S. 97-25.6; 97-80(a);*
Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0410 Eff. June 1, 2018.

11 NCAC 23A .0411 SAFETY RULES

The process for the Commission to approve safety rules or regulations adopted by an employer as set forth in G.S. 97-12 is as follows:

(1) The rules shall comply with the general provisions of the safety rules outlined by the American National Standards Institute and the Occupational Safety and Health Act. These standards can be purchased at http://ansi.org/ and accessed free of charge at https://www.osha.gov/law-regs.html, respectively.
(2) The rules shall be filed by the employer in writing with the Commission in accordance with Rule .0108 of this Subchapter.
(3) The rules shall be reviewed by the Commission or the Commission's designee and approved if they are found to be in compliance with Item (1) of this Rule. The Commission shall return to the employer a copy of the rules bearing a certificate of approval from the Commission indicating that the rules have been approved by the Commission pursuant to G.S. 97-12. An employer may revise and resubmit the rules if not approved by the Commission.

History Note: *Authority G.S. 97-12; 97-80(a);*
Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0411 Eff. June 1, 2018;
Amended Eff. December 1, 2018.

SECTION .0500 – AGREEMENTS

11 NCAC 23A .0501 AGREEMENTS FOR PROMPT PAYMENT OF COMPENSATION

(a) To facilitate the payment of compensation within the time prescribed in G.S. 97-18, the Commission shall accept memoranda of agreement on Commission forms. These forms include the Form 21 Agreement for Compensation for Disability, Form 26 Supplemental Agreement as to Payment of Compensation, Form 26A Employer's Admission of Employee's Right to Permanent Partial Disability, Form 26D Agreement for Payment of Unpaid Compensation in Unrelated Death Cases, and Form 30 Agreement for Compensation for Death.

(b) No agreement for permanent disability shall be approved until the relevant medical and vocational records, including a job description if the employee has permanent work restrictions and has returned to work for the employer of injury, known to exist in the case have been filed with the Commission. When requested by the Commission, the parties shall file any additional documentation necessary to determine whether the employee is

receiving the disability compensation to which he or she is entitled and that an employee qualifying for disability compensation under G.S. 97-29 or G.S. 97-30, and G.S. 97-31 has the benefit of the more favorable remedy.

(c) After the employer, carrier, or administrator has received a memorandum of agreement that has been signed by the employee and the employee's attorney of record, if any, the employer, carrier, or administrator shall submit the memorandum of agreement within 20 days to the Commission for review and approval. Agreements conforming to the provisions of the Workers' Compensation Act shall be approved by the Commission and a copy returned to the employer, carrier, or administrator, and a copy sent to the employee.

(d) Upon submission to the Commission of the executed agreement, the employer, carrier, administrator, or the attorney of record, if any, shall provide the employee, beneficiary, or attorney of record, if any, with a copy of the executed agreement that was submitted to the Commission.

(e) All memoranda of agreement for cases that are calendared for hearing before a Commissioner or Deputy Commissioner shall be addressed to that Commissioner or Deputy Commissioner, and filed in accordance with Rule .0108 of this Subchapter. Before a case is calendared, or once a case has been continued or removed, or after the filing of an Opinion and Award, all memoranda of agreement shall be addressed to the Claims Section of the Commission, and filed in accordance with Rule .0108 of this Subchapter.

History Note: *Authority G.S. 97-18; 97-80(a); 97-82;*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; August 1, 2006;
Recodified from 04 NCAC 10A .0501 Eff. June 1, 2018;
Amended Eff. December 1, 2020.

11 NCAC 23A .0502 COMPROMISE SETTLEMENT AGREEMENTS

(a) The Commission shall not approve a compromise settlement agreement unless it contains the following:

(1) The employee knowingly and intentionally waives the right to further benefits under the Workers' Compensation Act for the injury that is the subject of this agreement.

(2) The parties' agreement, if any, as to the payment of the costs due to the Commission pursuant to 11 NCAC 23E .0203, and any mediation costs pursuant to 11 NCAC 23G .0107. If there is no agreement as to the payment of some or all of these costs, the compromise settlement agreement shall include the credits, including the amounts, to be applied by the employer or carrier against the settlement proceeds.

(3) An affirmative statement that no rights other than those arising under the provisions of the Workers' Compensation Act are compromised or released by this agreement.

(4) Whether the employee has, or has not, returned to work.

(5) If the employee has returned to work, whether the employee is earning the same or greater average weekly wage.

(6) If the employee has returned to work at a lower average weekly wage, a description of the specific job or position, the name of the employer, and the average weekly wage earned. This Subparagraph does not apply if the employee is represented by counsel or if the employee certifies that partial wage loss due to an injury or occupational disease is not being claimed.

(7) If the employee has not returned to work, a summary of the employee's age, educational level, past vocational training, past work experience, and any emotional, mental, or physical impairment that predates the current injury or occupational disease. This Subparagraph does not apply if:

(A) it places an unreasonable burden upon the parties;

(B) the employee is represented by counsel; or

(C) the employee certifies that total wage loss due to an injury or occupational disease is not being claimed.

(b) No compromise settlement agreement shall be considered by the Commission unless the following requirements are met:

(1) The relevant medical, vocational, and rehabilitation reports known to exist, including those pertinent to the employee's future earning capacity, are submitted with the agreement to the Commission by the employer, carrier, administrator, or the attorney for the employer.

(2) The employee, the employee's attorney of record, if any, and an attorney of record or other representative who has been given the authority to sign for the employer, carrier and administrator, have signed the agreement.

(3) In a claim where liability is admitted or otherwise has been established, the employer, carrier, or administrator has undertaken to pay all medical expenses for the compensable injury to the date of the settlement agreement.

(4) In a claim in which the employer, carrier, or administrator has not agreed to pay all medical expenses of the employee related to the injury up to the date of the settlement agreement, the settlement agreement contains a list of all known medical expenses of the employee related to the injury to the date of the settlement agreement. This list of known medical expenses shall include:
   (A) All expenses that have been paid by the employer, carrier, or administrator;
   (B) All expenses that the employer, carrier, or administrator disputes;
   (C) All expenses that have been paid by the employee;
   (D) All expenses that have been paid by a health benefit plan;
   (E) All unpaid expenses that will be paid by the employer, carrier, or administrator; and
   (F) All unpaid expenses that will be paid by the employee.

(5) The settlement agreement provides that a party who has agreed to pay a disputed unpaid medical expense will notify the unpaid health care provider in writing of the party's responsibility to pay the unpaid medical expense. Other unpaid health care providers will be notified in writing of the completion of the settlement by the party specified in the settlement agreement:
   (A) when the employee or the employee's attorney has notified the unpaid health care provider in writing under G.S. 97-90(e) not to pursue a private claim against the employee for the costs of medical treatment; or
   (B) when the unpaid health care provider has notified the employee or the employee's attorney in writing of its claim for payment for the costs of medical treatment and has requested notice of a settlement.

(6) Any obligation of any party to pay an unpaid disputed medical expense pursuant to a settlement agreement does not require payment of any medical expense in excess of the maximum allowed under G.S. 97-26.

(7) The settlement agreement contains a finding that the positions of the parties to the agreement are reasonable as to the payment of medical expenses.

(c) When a settlement has been reached, the written agreement shall be submitted to the Commission upon execution in accordance with Rule .0108 of this Subchapter. All compromise settlement agreements shall be distributed for review in accordance with Paragraphs (a) through (c) of Rule .0609 of this Subchapter. Any changes or addenda to the agreement submitted to the Commission shall be served upon the opposing party contemporaneously with submission to the Commission.

(d) The employer, carrier, or administrator shall furnish an executed copy of the agreement to the employee's attorney of record or the employee, if unrepresented.

(e) An employee's attorney who seeks fees in connection with a compromise settlement agreement shall submit a copy of the fee agreement with the employee. Further, if the employee's attorney is aware of a fee being claimed by a prior attorney for the employee, the employee's attorney shall advise the Commission at the time of the submission of a compromise settlement agreement whether an agreement has been reached with the prior attorney regarding a division of the fee and, if so, the division proposed.

History Note: *Authority G.S. 97-17; 97-80(a); 97-82;*
Eff. January 1, 1990;
Amended Eff. February 1, 2016; November 1, 2014; August 1, 2006; June 1, 2000; March 15, 1995;
Recodified from 04 NCAC 10A .0502 Eff. June 1, 2018;
Amended Eff. January 1, 2019.

11 NCAC 23A .0503 NOTICE OF LAST PAYMENT FILING REQUIREMENT

The form(s) required to be provided by G.S. 97-18(h) include the following:

(1) Form 28B Report of Employer or Carrier/Administrator of Compensation and Medical Compensation Paid and Notice of Right to Additional Medical Compensation; and

(2) Form 28C Report of Employer or Carrier/Administrator of Compensation and Medical Compensation Paid Pursuant to a Compromise Settlement Agreement.

History Note: *Authority G.S. 97-18(h); 97-80(a);*

Eff. January 1, 1990;
Amended Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0503 Eff. June 1, 2018;
Amended Eff. December 1, 2018.

SECTION .0600 – CLAIMS ADMINISTRATION AND PROCEDURES

11 NCAC 23A .0601 EMPLOYER'S OBLIGATIONS UPON NOTICE; DENIAL OF LIABILITY; AND SANCTIONS

(a) Upon the employee's filing of a claim for compensation with the Commission, the Commission may order sanctions pursuant to G.S. 97-18(j) against the employer or its insurance carrier if it does not, within 30 days following notice from the Commission of the filing of the claim, or 90 days when a disease is alleged to be from exposure to chemicals, fumes, or other materials or substances in the workplace, do one of the following:

(1) File a Form 60 *Employer's Admission of Employee's Right to Compensation* to notify the Commission and the employee in writing that the employer is admitting the employee's right to compensation and, if applicable, satisfy the requirements for payment of compensation under G.S. 97-18(b);

(2) File a Form 61 *Denial of Workers' Compensation Claim* to notify the Commission and the employee that the employer denies the employee's right to compensation consistent with G.S. 97-18(c);

(3) File a Form 63 Notice to Employee of Payment of Compensation Without Prejudice consistent with G.S. 97-18(d).

For purposes of this Rule, sanctions ordered pursuant to G.S. 97-18(j) shall not prohibit the employer or its insurance carrier from contesting the compensability of and its liability for the claim.

Requests for extensions of time to comply with G.S. 97-18(j) shall be addressed to the Claims Administration Section.

(b) When liability in any case is denied, the employer or insurance carrier shall provide a detailed statement of the basis of denial that shall be set forth in a letter of denial or Form 61 *Denial of Workers' Compensation Claim*, and that shall be sent to the employee's attorney of record or the employee, if unrepresented, all known health care providers who have submitted bills and provided medical records to the employer or carrier, and the Commission.

History Note: *Authority G.S. 97-18; 97-80(a); 97-81(a);*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; August 1, 2006; June 1, 2000;
Recodified from 04 NCAC 10A .0601 Eff. June 1, 2018.

11 NCAC 23A .0602 REQUEST FOR HEARING

(a) Contested claims shall be set on the hearing docket only upon the written request of one of the parties for a hearing or rehearing of the case in dispute. Any request for hearing shall contain the following:

(1) the basis of the disagreement between the parties, including a statement of the issues raised by the requesting party;
(2) the date of injury;
(3) the part of the body injured;
(4) the city and county where the injury occurred;
(5) the names and addresses of all doctors and other expert witnesses whose testimony is needed by the requesting party;
(6) the names of all lay witnesses to be called to testify for the requesting party;
(7) an estimate of the time required for the hearing of the case; and
(8) the telephone number(s), email address(es), and mailing address(es) of the party(ies) requesting the hearing and their legal counsel.

(b) A Form 33 Request that Claim be Assigned for Hearing, completed in full, shall constitute compliance with this Rule. The request for a hearing shall be filed with the Office of the Clerk in accordance with Rule .0108 of this Subchapter. A copy of the Form 33 Request that Claim be Assigned for Hearing shall be forwarded to the attorneys for all opposing parties, or to the opposing parties themselves, if unrepresented.

History Note: *Authority G.S. 97-80(a); 97-83;*

Eff. January 1, 1990;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10A .0602 Eff. June 1, 2018;
Amended Eff. December 1, 2018.

11 NCAC 23A .0603 RESPONDING TO A PARTY'S REQUEST FOR HEARING

(a) No later than 45 days from receipt of a request for hearing from a party, the opposing party or parties shall file with the Commission a response to the request for hearing.

(b) The response shall contain the following:

(1) the basis of the disagreement between the parties, including a statement of the issues raised by the moving party that are conceded and the issues raised by the moving party that are denied;

(2) the date of the injury, if it is contended to be different than that alleged by the moving party;

(3) the part of the body injured, if it is contended to be different than that alleged by the moving party;

(4) the city and county where the injury occurred, if they are contended to be different than that alleged by the moving party;

(5) an estimate of the time required for the hearing of the case; and

(6) the telephone number(s), email address(es), and mailing address(es) of the party or parties responding to the request for hearing and their legal counsel.

(c) A Form 33R Response to Request that Claim be Assigned for Hearing, completed in full and filed with the Office of the Clerk in accordance with Rule .0108 of this Subchapter, shall constitute compliance with this Rule. A copy of the Form 33R Response to Request that Claim be Assigned for Hearing shall be forwarded to the attorneys for all opposing parties or the opposing parties themselves, if unrepresented.

History Note: *Authority G.S. 97-80(a); 97-83;*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10A .0603 Eff. June 1, 2018;
Amended Eff. December 1, 2018.

11 NCAC 23A .0604 APPOINTMENT OF GUARDIAN AD LITEM

(a) Minors or incompetent individuals may bring an action only through their guardian ad litem. Upon the written application on a Form 42 Application for Appointment of Guardian Ad Litem, the Commission shall appoint the person as guardian ad litem, if the Commission determines it to be in the best interest of the minor or incompetent individual. The Commission shall appoint the guardian ad litem only after due inquiry as to the fitness of the person to be appointed.

(b) No compensation due or owed to an incompetent individual shall be paid directly to the guardian ad litem, unless the guardian ad litem has authority to receive the money pursuant to a federal or state court order. No compensation due or owed to a minor shall be paid directly to the guardian ad litem, except that a parent, legal guardian, or legal custodian may receive compensation on behalf of a minor in his or her capacity as parent, legal guardian, or legal custodian.

(c) The Commission may assess a fee to be paid by the employer or the insurance carrier to an attorney who serves as a guardian ad litem for services rendered upon receipt of an affidavit of time spent in representation of the minor or incompetent individual as part of the costs.

History Note: *Authority G.S. 97-50; 97-79(e); 97-80(a); 97-91;*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; January 1, 2011; June 1, 2000; March 15, 1995;
Recodified from 04 NCAC 10A .0604 Eff. June 1, 2018;
Amended Eff. January 1, 2019.

11 NCAC 23A .0605 DISCOVERY

In addition to depositions provided for in G.S. 97-80, parties may obtain discovery by the use of interrogatories and requests for production of documents as follows:

(1) Any party may serve upon any other parties written interrogatories, up to 30 in number, including subparts thereof, to be answered by the party served or, if the party served is a public or private

corporation or a partnership or association or governmental agency, by any officer or agent, who shall furnish such information as is available from the party interrogated.

(2) Interrogatories may, without leave of the Commission, be served upon any party after the filing of a Form 18 *Notice of Accident to Employer and Claim of Employee, Representative, or Dependent,* Form 18B *Claim by Employee, Representative, or Dependent for Benefits for Lung Disease,* or Form 33 *Request that Claim be Assigned for Hearing,* or after the acceptance of liability for a claim by the employer.

(3) Each interrogatory shall be answered separately and in writing under oath, unless it is objected to, in which event the reasons for objection shall be stated in lieu of an answer. The answers shall be signed by the person making them and the objections shall be signed by the party making them. The party on whom the interrogatories have been served shall serve a copy of the answers and objections, if any, within 30 days after service of the interrogatories. The parties may stipulate to an extension of time to respond to the interrogatories. A motion to extend the time to respond shall state that an attempt to reach agreement with the opposing party to informally extend the time for response has been unsuccessful and the opposing party's position or that there has been an attempt to contact the opposing party to ascertain its position.

(4) If there is an objection to or other failure to answer an interrogatory, the party submitting the interrogatories may move the Commission for an order compelling answer.

(5) Interrogatories and requests for production of documents shall relate to matters that are not privileged, that are relevant to an issue in dispute, or that the requesting party reasonably believes may later be disputed. The signature of a party or attorney serving interrogatories or requests for production of documents constitutes a certificate by such person that he or she has personally read each of the interrogatories and requests for production of documents, that no such interrogatory or request for production of documents will oppress a party or cause any unnecessary expense or delay, that the information requested is not known or equally available to the requesting party, and that the interrogatory or requested document relates to an issue presently in dispute or that the requesting party reasonably believes may later be in dispute. A party may serve an interrogatory, however, to obtain verification of facts relevant to an issue presently in dispute. Answers to interrogatories may be used to the extent permitted by Chapter 8C of the North Carolina General Statutes.

(6) The parties may serve requests for production of documents without leave of the Commission until 35 days prior to the date of hearing.

(7) Additional methods of discovery as provided by the North Carolina Rules of Civil Procedure may be used only upon motion and approval by the Commission or by agreement of the parties. The Commission may approve the motion if it is shown to be in the interests of justice or to promote judicial economy.

(8) Discovery requests and responses, including interrogatories and requests for production of documents, shall not be filed with the Commission, except for the following:

(a) notices of depositions;

(b) discovery requests and responses deemed by filing party to be pertinent to a pending motion;

(c) responses to discovery following a motion or order to compel; and

(d) post-hearing discovery requests and responses.

The above-listed documents shall be filed with the Commission, as well as served on the opposing party.

(9) Sanctions shall be imposed under this Rule for failure to comply with a Commission order compelling discovery unless the Commission excuses the failure based on an inability to comply with the order. A motion by a party or its attorney to compel discovery under this Rule and Rule .0607 of this Subchapter shall represent that informal means of resolving the discovery dispute have been attempted in good faith and state the opposing party's position or that there has been a reasonable attempt to contact the opposing party and ascertain its position.

History Note: *Authority G.S. 97-80(a); 97-80(f); S.L. 2014-77;*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10A .0605 Eff. June 1, 2018.

11 NCAC 23A .0606 DISCOVERY - POST HEARING

Discovery may not be conducted after the initial hearing on the merits of a case unless allowed by order of a Commissioner or Deputy Commissioner. In determining whether to allow further discovery, the Commissioner or Deputy Commissioner shall consider whether further discovery is in the interests of justice or to promote judicial economy.

History Note: *Authority G.S. 97-80(a); 97-80(f);*
Eff. January 1, 1990;
Amended Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0606 Eff. June 1, 2018.

11 NCAC 23A .0607 DISCOVERY OF RECORDS AND REPORTS

(a) Upon written request, any party shall provide to the requesting party without cost, a copy of all medical, vocational and rehabilitation reports, employment records, Commission forms, and written communications with health care providers in its possession, within 30 days of the request, unless objection is made within that time period. The duty to respond exists whether or not a request for hearing has been filed and is a continuing one, and any such reports and records that come into the possession of a party after receipt of a request pursuant to this Rule shall be provided to the requesting party within 15 days from the party's receipt of these reports and records.
(b) Upon receipt of a request, a carrier or administrator for an employer's workers' compensation program shall inquire of the employer concerning the existence of records encompassed by the request.

History Note: *Authority G.S. 97-80(a); 97-80(b); 97-80(f);*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; June 1, 2000; March 15, 1995;
Recodified from 04 NCAC 10A .0607 Eff. June 1, 2018.

11 NCAC 23A .0608 STATEMENT OF INCIDENT LEADING TO CLAIM

(a) Upon the request of the employer or the employer's agent to take a written or a recorded statement, the employer or the employer's agent shall advise the employee that the statement may be used to determine whether the claim will be paid or denied. Any employee who gives his or her employer, the employer's carrier, or any agent of the employer either a written or recorded statement of the facts and circumstances surrounding his or her injury shall be furnished a copy of the statement within 45 days after a request by the employee. Further, any employee who gives a written or recorded statement of the facts and circumstances surrounding his or her injury shall, without request, be furnished a copy of the statement within 45 days after the filing of a Form 33 Request that Claim be Assigned for Hearing. The copy shall be furnished at the expense of the person, firm, or corporation at whose direction the statement was taken.
(b) If any person, firm, or corporation fails to comply with this Rule, then a Commissioner or Deputy Commissioner may, if it is in the interest of justice, enter an order prohibiting that person, firm, or corporation, or its representative, from introducing the statement into evidence or using any part of the statement.

History Note: *Authority G.S. 97-80(a);*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10A .0608 Eff. June 1, 2018;
Amended Eff. December 1, 2018.

11 NCAC 23A .0609 MOTIONS PRACTICE

(a) Motions and responses before a Deputy Commissioner:
(1) in cases that are currently calendared for hearing before a Deputy Commissioner shall be filed in accordance with Rule .0108 of this Subchapter.
(2) to reconsider or amend an Opinion and Award, made prior to giving notice of appeal to the Full Commission, shall be addressed to the Deputy Commissioner who authored the Opinion and Award and filed in accordance with Rule .0108 of this Subchapter.

(b) Motions and responses shall be filed with the Office of the Executive Secretary in accordance with Rule .0108 of this Subchapter:

(1) when a case is not calendared before a Deputy Commissioner;
(2) once a case has been continued or removed from a Deputy Commissioner's calendar; or
(3) after the filing of an Opinion and Award when the time for taking appeal has run.

(c) Motions and responses before the Full Commission:

(1) in cases calendared for hearing before the Full Commission shall be addressed to the Chair of the Full Commission panel and filed in accordance with Rule .0108 of this Subchapter.
(2) filed after notice of appeal to the Full Commission has been given but prior to the calendaring of the case shall be addressed to the Chair of the Commission and filed in accordance with Rule .0108 of this Subchapter.
(3) in cases continued from the Full Commission hearing docket, shall be addressed to the Chair of the panel of Commissioners who ordered the continuance and filed in accordance with Rule .0108 of this Subchapter.
(4) filed after the filing of an Opinion and Award by the Full Commission but prior to giving notice of appeal to the Court of Appeals or the expiration of the period allowed to give notice of appeal to the Court of Appeals shall be addressed to the Commissioner who authored the Opinion and Award and filed in accordance with Rule .0108 of this Subchapter.

(d) Motions requesting an award of attorney's fees from ongoing compensation pursuant to G.S. 97-90 that are not required to be filed with a Deputy Commissioner or the Full Commission pursuant to Paragraphs (a) and (c) of this Rule shall be filed with the Commission's Claims Administration Section in accordance with Rule .0108 of this Subchapter.

(e) All motions and responses thereto, including requests for extensions of time and requests to withdraw motions, shall include a caption containing the Industrial Commission file number(s), party names, and a title identifying the nature of the motion or response. Motions and responses set forth in the body of electronic mail correspondence or contained in a brief will not be accepted for filing by the Commission. This Paragraph does not apply to parties without legal representation.

(f) A motion shall state with particularity the grounds on which it is based, the relief sought, and the opposing party's position, if known, and any effort made by the moving party to resolve the issue in dispute before filing of the motion. Service shall be made on all opposing attorneys of record, or on all opposing parties if not represented.

(g) Motions to continue or remove a case from the hearing calendar on which the case is set shall be made as far in advance as possible of the scheduled hearing and may be made in written or oral form. In all cases, the moving party shall provide the basis for the motion and state that the other parties have been advised of the motion and relate the position of the other parties regarding the motion, or that there has been a reasonable attempt to contact the opposing party and ascertain its position regarding the motion.

(h) Oral motions shall be followed with a written motion from the moving party, if requested by a hearing officer considering the interests of justice.

(i) The responding party to a motion shall have 10 days after a motion is served during which to file and serve copies of a response in opposition to the motion. The Commission may shorten or extend the time for responding to any motion in the interests of justice or to promote judicial economy. Parties in agreement may submit a written stipulation to a single extension of time for responding to any motion, except for medical motions pursuant to Rule .0609A of this Section. The parties submitting a stipulation shall agree to an extension of a reasonable time, not to exceed 30 days.

(j) Motions shall be ruled upon without oral argument unless the Commission determines that oral argument is necessary for a complete understanding of the issues.

(k) All written motions and responses thereto shall include a proposed Order in Microsoft Word format to be considered by the Commission. The proposed Order shall include:

(1) the Industrial Commission file number(s);
(2) the case caption;
(3) the subject of the proposed Order;
(4) the procedural posture; and
(5) the party appearances or contact information. If a party is represented by counsel, then the appearance shall include the attorney and firm name, email address, telephone number, and fax number. If a party is unrepresented, then the proposed Order shall include the party's email address, telephone number, and fax number, if available.

History Note: *Authority G.S. 97-79(b); 97-80(a); 97-84; 97-91;*
Eff. January 1, 1990;

Amended Eff. February 1, 2016; November 1, 2014; June 1, 2000; March 15, 1995;
Recodified from 04 NCAC 10A .0609 Eff. June 1, 2018;
Amended Eff. January 1, 2019.

11 NCAC 23A .0609A MEDICAL MOTIONS AND EMERGENCY MEDICAL MOTIONS

(a) Medical motions brought pursuant to G.S. 97-25 and responses thereto shall be brought before either the Office of the Chief Deputy Commissioner or the Executive Secretary and shall be submitted in accordance with Rule .0108 of this Subchapter. For parties to whom the electronic filing requirements of Rule .0108(b) of this Subchapter apply, motions, responses, and notices of appeal shall be submitted under the EDFP category "Medical Motions and Responses." The submitting party shall contemporaneously serve a copy of the filing to the opposing party or opposing party's counsel, if represented.

(b) In addition to any notice of representation contained in a medical motion or response, an attorney who is retained by a party to prosecute or defend a medical motion or appeal before the Commission shall file a notice of representation in accordance with Rule .0108 of this Subchapter and send a copy of the notice to all other counsel and all unrepresented parties involved in the proceeding.

(c) Motions submitted pursuant to G.S. 97-25 and requesting medical relief other than emergency relief shall contain the following:

(1) a designation as a "Medical Motion" brought pursuant to G.S. 97-25 and a statement directly underneath the case caption clearly indicating the request is for either an administrative ruling by the Executive Secretary or an expedited full evidentiary hearing before a Deputy Commissioner;
(2) a statement of the treatment or relief requested;
(3) a statement of the medical diagnosis of the employee and the name of any health care provider having made a diagnosis or treatment recommendation that is the basis for the motion;
(4) a statement as to whether the claim has been admitted on a Form 60, Employer's Admission of Employee's Right to Compensation, Form 63, Notice to Employee of Payment of Compensation without Prejudice (G.S. 97-18(d)) or Payment of Medical Benefits Only without Prejudice (G.S. 97-2(19) & 97-25), Form 21, Agreement for Compensation for Disability, or is subject to a prior Commission Opinion and Award or Order finding compensability, with supporting documentation attached;
(5) a statement of the time-sensitive nature of the request, if any;
(6) an explanation of opinions known and in the possession of the movant by any relevant experts, independent medical examiners, and second opinion examiners;
(7) if the motion requests a second opinion examination pursuant to G.S. 97-25, the motion shall specify whether the employee has made a prior written request to the defendants for the examination, as well as the date of the request and the date of the denial, if any;
(8) a representation that informal means of resolving the issue have been attempted in good faith, and a statement of the opposing party's position or that there has been a reasonable attempt to contact the opposing party and ascertain its position; and
(9) a proposed Order in Microsoft Word format, in accordance with Rule .0609 of this Section.

(d) Motions submitted pursuant to G.S. 97-25 and requesting emergency medical relief shall contain the following:

(1) a boldface or otherwise emphasized designation as "Emergency Medical Motion";
(2) if the employee is unrepresented, the employee's telephone number and, if available, the employee's email address and fax number;
(3) the adjuster's name, email address, telephone number, and fax number if counsel for the employer/carrier has not been retained;
(4) an explanation of the medical diagnosis and treatment recommendation of the health care provider that requires emergency attention;
(5) a statement of the need for a shortened time period for review, including relevant dates and the potential for adverse consequences if the recommended relief is not provided emergently;
(6) an explanation of opinions known and in the possession of the movant by any relevant experts, independent medical examiner, and second opinion examiners;
(7) a representation that informal means of resolving the issue have been attempted in good faith, and a statement of the opposing party's position or that there has been a reasonable attempt to contact the opposing party and ascertain its position;
(8) documents known and in the possession of the movant relevant to the request, including relevant medical records; and

(9) a proposed Order in Microsoft Word format, in accordance with Rule .0609 of this Section.

(e) Upon receipt of an emergency medical motion, the non-moving party(ies) shall be advised by the Commission of any time allowed for response and whether informal telephonic oral argument is necessary. The Commission shall consider the interests of justice or judicial economy when determining the time allowed for response and whether informal telephonic oral argument is necessary.

(f) A party may appeal an Order of the Executive Secretary on a motion brought pursuant to G.S. 97-25(f)(1) or receipt of a ruling on a motion to reconsider filed pursuant to Rule .0702(b) of this Subchapter by filing notice of appeal in accordance with Rule .0108 of this Subchapter within 15 calendar days of receipt of the Order. Notices of appeal shall be submitted via EDFP under the category "Medical Motions and Responses." A letter or motion expressing an intent to appeal a decision of the Executive Secretary shall be considered a request for an expedited hearing pursuant to G.S. 97-25 and G.S. 97-84. The letter or motion shall specifically identify the Order from which the appeal is taken and shall indicate that the appeal is from an administrative Order by the Executive Secretary entered pursuant to G.S. 97-25(f)(1). After receipt of a notice of appeal, the appeal shall be assigned to a Deputy Commissioner and an Order under the name of the Deputy Commissioner to which the appeal is assigned shall be issued within five days of receipt of the notice of appeal.

(g) Depositions, if requested by the parties or ordered by the Deputy Commissioner, shall be taken in accordance with Rule .0612 of this Section and on the Deputy Commissioner's order pursuant to G.S. 97-25. In full evidentiary hearings conducted by a Deputy Commissioner pursuant to G.S. 97-25(f)(1) and (f)(2), depositions shall be completed and all transcripts, briefs, and proposed Opinion and Awards filed with the Deputy Commissioner in accordance with Rule .0108 of this Subchapter within 60 days of the filing of the motion or appeal. The Deputy Commissioner may reduce or enlarge the timeframe contained in this Paragraph for good cause shown or upon agreement of the parties.

(h) A party may appeal the decision of a Deputy Commissioner filed pursuant to G.S. 97-25(f)(2) by filing notice of appeal to the Full Commission within 15 calendar days of receipt of the decision in accordance with Rule .0108 of this Subchapter. A letter expressing an intent to appeal a Deputy Commissioner's decision filed pursuant to G.S. 97-25 shall be considered notice of appeal to the Full Commission, provided that the letter specifically identifies the decision from which appeal is taken and indicates that the appeal is taken from a decision by a Deputy Commissioner pursuant to G.S. 97-25(f)(2). After receipt of notice of appeal, the appeal shall be acknowledged by the Commission within three days by sending an Order under the name of the Chair of the Panel to which the appeal is assigned. The Order shall set the schedule for filing briefs. A Full Commission hearing on an appeal of a medical motion filed pursuant to G.S. 97-25 shall be held telephonically and shall not be recorded unless unusual circumstances arise and the Commission so orders. All correspondence, briefs, and motions related to the appeal shall be addressed to the Chair of the Panel and shall be filed in accordance with Rule .0108 of this Subchapter.

(i) A party may appeal the administrative decision of the Chief Deputy Commissioner or the Chief Deputy Commissioner's designee filed pursuant to G.S. 97-25(f)(3) by filing notice of appeal electronically in accordance with Rule .0108 of this Subchapter within 15 calendar days of receipt of the Order. A letter or motion expressing an intent to appeal the Chief Deputy Commissioner's or the Chief Deputy Commissioner's designee's Order filed pursuant to G.S. 97-25(f)(3) shall be considered a notice of appeal, provided that the letter specifically identifies the Order from which appeal is taken and indicates that the appeal is from an Order of a Deputy Commissioner entered pursuant to G.S. 97-25(f)(3). After receipt of notice of appeal, the appeal shall be acknowledged within five days by sending an Order under the name of the Deputy Commissioner to whom the appeal is assigned. The appeal of the administrative decision of the Chief Deputy Commissioner or the Chief Deputy Commissioner's designee shall be subject to G.S. 97-25(f)(2) and G.S 97-84.

History Note: *Authority G.S. 97-25; 97-78(f)(2); 97-78(g)(2); 97-80(a); S.L. 2014-77;*
Eff. January 1, 2011;
Amended Eff. February 1, 2016; November 1, 2014;
Recodified from 04 NCAC 10A .0609A Eff. June 1, 2018;
Amended Eff. December 1, 2018.

11 NCAC 23A .0610 PRE-TRIAL AGREEMENT

(a) A Pre-Trial Agreement shall be signed by the attorneys and filed with the Commission in accordance with Rule .0108 of this Subchapter 10 days before the hearing, unless a shorter time period is ordered upon agreement of the parties.

(b) The Pre-Trial Agreement shall be prepared in a form that conforms to the Order on Final Pre-Trial Conference adopted in the North Carolina Rules of Practice for the Superior and District Courts. Should the parties fail to

comply with a Pre-Trial Order, the Commissioner or Deputy Commissioner shall remove the case from the hearing docket if required in the interests of justice or to promote judicial economy. Should the parties comply with the Pre-Trial Order after the removal of the case, the Pre-Trial Agreement shall be directed to the Commissioner or Deputy Commissioner who removed the case from the docket and filed in accordance with Rule .0108 of this Subchapter. The Commissioner or Deputy Commissioner shall order the case returned to the hearing docket as if a Request for Hearing had been filed on the date of the Order to return the case to the hearing docket. No new Form 33 Request that Claim be Assigned for Hearing is required.
(c) If the parties need a conference, a Commissioner or Deputy Commissioner shall order the parties to participate in a pre-trial conference. This conference shall be conducted at such place and by such method as the Commissioner or Deputy Commissioner deems appropriate in the interests of justice or judicial economy, including conference telephone calls.
(d) Any party may request a pre-trial conference to aid in settling the case or resolving contested issues prior to trial. Requests for such pre-trial conferences shall be directed to the Commissioner or Deputy Commissioner before whom the claim has been calendared.

History Note: *Authority G.S. 97-80(a); 97-80(b); 97-83;*
Eff. January 1, 1990;
Amended Eff. February 1, 2016; November 1, 2014; January 1, 2011; June 1, 2000; March 15, 1995;
Recodified from 04 NCAC 10A .0610 Eff. June 1, 2018;
Amended Eff. December 1, 2018.

11 NCAC 23A .0611 HEARINGS BEFORE THE COMMISSION
(a) The Commission may, on its own motion, order a hearing or rehearing of any case in dispute. The Commission shall set a contested case for hearing in a location deemed convenient to witnesses and the Commission.
(b) In setting contested cases for hearing, cases in which the payment of workers' compensation benefits is at issue take precedence.
(c) The Commission shall give notice of hearings in every case. Postponement or continuance of a duly scheduled hearing shall be allowed only in the discretion of a Commissioner or Deputy Commissioner before whom the case is set if required in the interests of justice or to promote judicial economy. When a party has not notified the Commission of the attorney representing the party prior to the mailing of calendars for hearing, notice to that party constitutes notice to the party's attorney.
(d) In a contested case, the record includes all prior Opinion and Awards, filed Commission forms, form agreements, awards, and orders of the Commission. Any other documents that the parties wish to have included in the record shall be introduced and received into evidence.
(e) In the event of inclement weather or natural disaster, hearings set by the Commission shall be cancelled or delayed and rescheduled if the proceedings before the General Court of Justice in that county are cancelled or delayed.

History Note: *Authority G.S. 97-79; 97-80(a); 97-84; 97-91;*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10A .0611 Eff. June 1, 2018;
Amended Eff. December 1, 2018.

11 NCAC 23A .0612 DEPOSITIONS
(a) Prior to a hearing before a Deputy Commissioner, the parties shall confer to determine the methods by which medical evidence will be submitted. The parties shall stipulate in a Pre-Trial Agreement to the admission of all relevant medical records, reports, and forms, as well as opinion letters from the employee's health care providers with the goal of minimizing the use of post-hearing depositions. The parties shall state all experts to be deposed post-hearing. The parties shall certify that the parties have conferred to determine the methods by which medical evidence will be submitted. If there is a disagreement about the stipulation of medical evidence, the parties shall state the nature and basis of the disagreement.
(b) When medical or other expert testimony is requested by the parties for the disposition of a case, a Deputy Commissioner or Commissioner may order expert depositions to be taken on or before a day certain not to exceed

60 days from the date of the hearing; provided, however, the time allowed may be enlarged or shortened in the interests of justice or to promote judicial economy, or where required by the Act.
(c) The employer shall pay for the costs of up to two post-hearing depositions requested by the employee of health care providers who evaluated or treated the employee. The employer shall also bear the costs of a deposition of a second opinion doctor selected jointly by the parties or ordered by the Commission pursuant to G.S. 97-25.
(d) The parties may notice depositions of additional experts, and the costs thereof shall be borne by the party noticing the depositions; provided, however, if a ruling favorable to the employee is rendered and is not timely appealed by the employer, or the employer's appeal is dismissed or withdrawn, then the employer shall reimburse the employee the costs of such additional expert depositions.
(e) In claims pursuant to G.S. 97-29(d) or cases involving exceptional, unique, or complex injuries or diseases, the Commission may allow additional depositions of experts to be taken at the employer's expense, when requested by the employee and when necessary to address the issues in dispute, in which case the employee shall state, and the Commission shall consider when determining whether or not the employer shall bear the costs of such depositions such factors as:

(1) the name and profession of the proposed deponent;
(2) if the proposed deponent is a health care provider, whether the health care provider evaluated, diagnosed or treated the employee;
(3) the issue to which the testimony is material, relevant and necessary;
(4) the availability of alternate methods for submitting the evidence and the efforts made to utilize alternate methods;
(5) the severity or complexity of the employee's condition;
(6) the number and complexity of the issues in dispute;
(7) whether the testimony is likely to be duplicative of other evidence; and
(8) the opposing party's position on the request.

(f) The term "costs" as used in this Rule shall mean the expert's fee as approved by the Commission for the deposition, including the expert's time preparing for the deposition, if applicable. The term shall include fees associated with the production and delivery of a transcript of the deposition to the Commission, including the court reporter's appearance fee. The term shall not include costs for a party to obtain his or her own copy of the deposition transcript, or attorney's fees associated with the deposition, unless so ordered by the Commission pursuant to G.S. 97-88.1.
(g) Notwithstanding Paragraphs (c) and (d) of this Rule, the parties may come to a separate agreement regarding reimbursement of deposition costs, which shall be submitted to the Commission for approval.
(h) If the claimant is unrepresented at the time of a full evidentiary hearing before a Deputy Commissioner, the Commission shall confer with the parties and determine the best method for presenting medical evidence, if necessary, and the party responsible for bearing associated costs.
(i) If a party refuses to stipulate to relevant medical evidence, and as a result, the case is reset or depositions are ordered for testimony of medical or expert witnesses, a Deputy Commissioner or Commissioner may assess the costs of such hearing or depositions, including reasonable attorney fees, against the party who refused the stipulation, pursuant to G.S. 97-88.1.
(j) All evidence and witnesses other than those tendered as an expert witness shall be offered at the hearing before the Deputy Commissioner. Non-expert evidence may be offered after the hearing before the Deputy Commissioner by order of a Deputy Commissioner or Commissioner. The costs of obtaining non-expert testimony by deposition shall be borne by the party making the request unless otherwise ordered by the Commission in the interests of justice or to promote judicial economy.

History Note: *Authority G.S. 97-26.1; 97-80(a); 97-88; 97-88.1;*
Eff. June 1, 1990;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10A .0612 Eff. June 1, 2018.

11 NCAC 23A .0613 EXPERT WITNESSES AND FEES

(a) The parties shall file with the Deputy Commissioner or Commissioner in accordance with Rule .0108 of this Subchapter within 15 days following the hearing, a list identifying all expert witnesses to be deposed and the deposition dates unless otherwise extended by the Commission in the interests of justice and judicial economy.
(b) After the deposition of each expert, the party that noticed the deposition shall, within 10 days after receiving the expert's fee invoice, file with the Deputy Commissioner or Commissioner in accordance with Rule .0108 of this

Subchapter a request to approve the costs related to the expert deposition. In these requests, the party shall provide, in a cover letter along with the invoice (if available), the following:

(1) the name of the expert and the expert's practice;
(2) the expert's fax number;
(3) the expert's area of specialty and board certifications, if any;
(4) the length of the deposition;
(5) the length of time the expert spent preparing for the deposition, excluding any time meeting with parties' counsel;
(6) whether the Commission determined that the claim was filed pursuant to G.S. 97-29(d) or involved an exceptional, unique, or complex injury or disease;
(7) whether the deponent was selected by the employee in the Pre-Trial Agreement as an expert to be deposed at employer's expense; and
(8) the party initially responsible for payment of the deposition fee pursuant to Rule .0612 of this Section.

At the time the request is made, the requesting party shall submit a proposed Order that shows the expert's name, practice name and fax number under the "Appearances" section. The proposed Order shall also reflect the party initially responsible for payment of the deposition fee pursuant to Rule .0612 of this Section.

(c) The Commission shall issue an order setting the deposition costs of the expert. The term "costs" as used in this Rule shall mean the expert's fee as approved by the Commission for the deposition, including the expert's time preparing for the deposition, if applicable.

(d) Failure to make payment to an expert witness within 30 days following the entry of a fee order shall result in an amount equal to 10 percent being added to the fee granted in the Order.

(e) A proposed fee for cancellation of a deposition within five days of a scheduled deposition may be filed with the Deputy Commissioner in accordance with Rule .0108 of this Subchapter for consideration and approval if in the interest of justice and judicial economy.

(f) This Rule applies to all expert fees for depositions; provided, however, either party may elect to reimburse a retained expert that did not treat or examine the employee the difference between the fee awarded by the Commission and the contractual fee of the expert.

History Note: *Authority G.S. 97-26.1; 97-80(a); 97-80(d);*
Eff. January 1, 1990;
Amended Eff. February 1, 2016; November 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10A .0613 Eff. June 1, 2018.

11 NCAC 23A .0614 HEALTH CARE PROVIDER FEE DISPUTE PROCEDURE

(a) Health care providers seeking to resolve a dispute regarding payment of charges for medical compensation shall make an inquiry directly to the employer or employer's workers compensation insurance carrier responsible for the payment of medical fees by using an Industrial Commission Form 26I *Medical Provider Dispute Resolution Questionnaire*.

(b) The Commission shall assist a health care provider who has been unsuccessful in obtaining carrier contact information. No information regarding a specific claim shall be provided by the Commission to the health care provider.

(c) When an employer or carrier does not respond to a health care provider's Form 26I *Medical Provider Dispute Resolution Questionnaire* inquiry regarding a medical fee dispute within 20 days, or denies liability as a Form 26I *Medical Provider Dispute Resolution Questionnaire* response, the health care provider may file a written request seeking assistance from the Commission regarding the fee dispute.

(d) The Commission shall conduct a conference between the health care provider and the employer or carrier in an effort to resolve the dispute.

(e) When the health care provider, with assistance from the Commission is unable to resolve the dispute, the health care provider may request limited intervention in the workers' compensation claim for the sole purpose of resolving the fee dispute.

(f) A health care provider seeking limited intervention in a workers' compensation claim shall file a motion to intervene with the Commission. The Motion to Intervene must include the following:

(1) the Commission file number, if known;
(2) the employee's name, address, and last four digits of his or her social security number;

(3) the date of injury and a description of the workplace injury, including the body parts known to be affected;
(4) an itemized list of the medical fees in dispute, including CPT codes relating specific charges to the Workers' Compensation Medical Fee Schedule, and explanations directly relating each charge to the employee's workplace injury;
(5) a copy of the Form 26I *Medical Provider Dispute Resolution Questionnaire* submitted by the health care provider, including all accompanying materials, and any response received back by the health care provider from the employer or carrier contacted;
(6) a copy of the written request for assistance submitted to the Medical Fees Section of the Commission;
(7) a copy of the written summary by the Medical Fees Section of the informal resolution process and outcome;
(8) a sworn affidavit by the health care provider that states:
(A) the health care provider has treated the employee;
(B) the medical fees itemized by the health care provider are current and unpaid; and
(C) the health care provider reasonably believes that the employer or carrier named on the Form 26I *Medical Provider Dispute Resolution Questionnaire* is obligated to pay the fees under the Workers' Compensation Act; and
(9) a certification of service upon both the employee and the employer or carrier named on the Form 26I *Medical Provider Dispute Resolution Questionnaire*.

(g) A health care provider who has been denied intervention may request a review by the Commission by filing a written request with the Docket Section of the Industrial Commission within 10 days of receipt of the order denying intervention.

(h) The request for review by the Commission shall be served on all parties to the workers' compensation claim and include:

(1) a statement of facts necessary to an understanding of the issue(s);
(2) a statement of the relief sought;
(3) a copy of the motion to intervene, including all attachments required by Paragraph (f) of this Rule; and
(4) a copy of the order denying intervention.

(i) Within 10 days after service of a request for review by the Commission, any party to the workers' compensation claim may file a response, including supporting affidavits or documentation not previously filed with the Commission.

(j) The Commission's determination shall be made on the basis of the request for review and any response(s), including supporting documentation. No briefs or oral argument are allowed by the Commission.

(k) In accordance with the G.S. 97-90.1, when a health care provider is allowed to intervene by the Commission, the intervention is limited to the medical fee dispute.

(l) Following intervention, a health care provider may request and obtain information from the Commission related to the medical fee. The request for information must be in writing, include a copy of the order allowing the health care provider to intervene, and be directed to the Claims Section of the Commission.

(m) Discovery by a health care provider shall be allowed following a Commission order allowing intervention but is limited to matters related to the medical fee dispute.

(n) A health care provider who has intervened in a workers' compensation claim may obtain a hearing before the Commission on a medical fee dispute by filing an Industrial Commission Form 33I *Intervenor's Request that Claim be Assigned for Hearing* and paying a filing fee.

(o) Upon resolution of a medical fee dispute, costs shall be determined and assessed by the Commission and the health care provider shall be dismissed from the claim. The health care provider shall retain standing to request review of an order from the Commission.

History Note: *Authority G.S. 97-26(i); 97-80(a);*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; January 1, 2011; June 1, 2000; March 15, 1995;
Recodified from 04 NCAC 10A .0614 Eff. June 1, 2018.

11 NCAC 23A .0615 CASES REMOVED FROM A HEARING CALENDAR

(a) A claim may be removed from a hearing calendar by motion of the party requesting the hearing or by the Commission upon its own motion in the interests of justice or to promote judicial economy.
(b) Upon settlement of a case or approval of a form agreement, the parties shall submit a request to remove a case from a hearing calendar and a proposed Order.
(c) After a case has been removed from a hearing calendar, the case may be reset on a hearing calendar by Order of the Commission or filing of a Form 33 *Request that Claim be Assigned for Hearing* by the party requesting a hearing.

History Note: *Authority G.S. 97-80(a); 97-84; 97-91;*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10A .0615 Eff. June 1, 2018.

11 NCAC 23A .0616 DISMISSALS
(a) No claim filed under the Workers' Compensation Act shall be dismissed without prejudice, except upon order of the Commission in the interest of justice. No voluntary dismissal shall be granted after the record in a case is closed. Unless otherwise ordered by the Commission in the interests of justice, a plaintiff shall have one year from the date of the Order of Voluntary Dismissal Without Prejudice to refile his claim.
(b) Upon notice and opportunity to be heard, any claim may be dismissed with or without prejudice by the Commission on its own motion or by motion of any party if the Commission finds that the party failed to prosecute or to comply with the rules in this Subchapter or any Order of the Commission.
(c) In a denied claim, if a plaintiff has not requested a hearing within two years of the filing of the Order removing the case from a hearing calendar and has not pursued the claim, upon notice and opportunity to be heard, any claim shall be dismissed with prejudice by the Commission, on its own motion or by motion of any party.

History Note: *Authority G.S. 97-80(a); 97-84; 97-91;*
Eff. June 1, 2000;
Amended Eff. November 1, 2014; January 1, 2011;
Recodified from 04 NCAC 10A .0616 Eff. June 1, 2018.

11 NCAC 23A .0617 ATTORNEYS RETAINED FOR PROCEEDINGS
(a) Any attorney who is retained by a party in a proceeding before the Commission shall comply with the applicable rules of the North Carolina State Bar. A copy of a notice of representation shall be served upon all other counsel and all unrepresented parties, and submitted to the Commission in accordance with Rule .0108 of this Subchapter. Thereafter, all notices required to be served on a party shall be served upon the attorney. No direct contact or communication concerning contested matters may be made with a represented party by the opposing party or any person on his or her behalf, without the attorney's permission except as permitted by G.S. 97-32 or other applicable law.
(b) Any attorney who wishes to withdraw from representation in a proceeding before the Commission shall file with the Commission, in writing, a Motion to Withdraw that contains a statement of reasons for the request and that the request has been served on the client. The attorney shall make reasonable efforts to ascertain the last known contact information as defined in Rule .0109 of this Subchapter of the client and shall include this information in the motion. A Motion to Withdraw before an award is made shall state whether the withdrawing attorney requests an attorney's fee from the represented party once an award of compensation is made or approved.
(c) An attorney may withdraw from representation only by written order of the Commission. The issuance of an award of the Commission does not release an attorney as the attorney of record.
(d) An attorney withdrawing from representation whose client wishes to appeal an Order, Decision, or Award to the Full Commission shall timely file a notice of appeal, as set out by this Subchapter, on behalf of his or her client either before or with his or her Motion to Withdraw.
(e) Motions to Withdraw shall be submitted in accordance with Rule .0108 of this Subchapter. The Motion to Withdraw shall include a proposed Order in Microsoft Word format that includes, in the appearances, the last known address of any pro se party or the contact information as defined in Rule .0109 of this Subchapter of new counsel if such counsel has been retained. The proposed Order shall include fax numbers for all parties, if known.

History Note: *Authority G.S. 97-80(a); 97-90; 97-91;*
Eff. January 1, 2011;

Amended Eff. February 1, 2016; November 1, 2014;
Recodified from 04 NCAC 10A .0617 Eff. June 1, 2018;
Amended Eff. January 1, 2019.

11 NCAC 23A .0618 DISQUALIFICATION OF A COMMISSIONER OR DEPUTY COMMISSIONER

History Note: *Authority G.S. 97-79(b); 97-80(a);*
Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0618 Eff. June 1, 2018;
Repealed Eff. December 1, 2018.

11 NCAC 23A .0619 FOREIGN LANGUAGE AND SIGN LANGUAGE INTERPRETERS

(a) When a person who does not speak or understand the English language or who is speech or hearing impaired is either called to testify in a hearing, other than in an informal hearing conducted pursuant to G.S. 97-18.1, or appears unrepresented before the Full Commission for an oral argument, the person, whether a party or a witness, shall be assisted by a qualified interpreter upon request. For purposes of this Rule, "language" means foreign language or sign language.

(b) To qualify as a foreign language interpreter, a person shall possess sufficient experience and education, or a combination of experience and education, speaking and understanding English and the foreign language to be interpreted, to qualify as an expert witness pursuant to G.S. 8C-1, Rule 702. For Spanish language interpretation, the interpreter must be "Level A" certified by the North Carolina Administrative Office of the Courts. A person qualified as an interpreter under this Rule shall not be interested in the claim and shall make a declaration under oath or affirmation to interpret accurately and truthfully, meaning without any additions or deletions, all questions propounded to the witness and all responses thereto.

(c) To qualify as a sign language interpreter, a person shall possess a license from the North Carolina Interpreter and Transliterator Licensing Board, under Chapter 90D of the North Carolina General Statutes.

(d) Any party who is unable to speak or understand English, or who is speech or hearing impaired, or who intends to call as a witness a person who is unable to speak or understand English or who is speech or hearing impaired, shall so notify the Commission and the opposing party, in writing, not less than 21 days prior to the date of the hearing. The notice shall state the language(s) that shall be interpreted for the Commission.

(e) Upon receiving or giving the notice required in Paragraph (d) of this Rule, the employer or insurer shall retain an interpreter who possesses the qualifications listed in Paragraph (b) or (c) of this Rule to appear at the hearing and interpret the testimony or oral argument of all persons for whom the notice in Paragraph (d) of this Rule has been given or received.

(f) The interpreter's fee shall constitute a cost as set forth in G.S. 97-80. A qualified interpreter who interprets testimony or oral argument for the Commission is entitled to payment of the fee agreed upon by the interpreter and employer or insurer that retained the interpreter. Except in cases where a claim for compensation has been prosecuted without reasonable ground, the fee agreed upon by the interpreter and employer or insurer shall be paid by the employer or insurer. When the Commission ultimately determines that the request for an interpreter was unfounded, attendant costs shall be assessed against the movant.

(g) Foreign language interpreters shall abide by the Code of Ethics and Professional Conduct for Court Interpreters, contained in Section 11 of Standards for Language Access Services, North Carolina Judicial Branch and promulgated by the North Carolina Administrative Office of the Courts, and shall interpret, as word for word as is practicable, without editing, commenting, or summarizing, testimony or other communications. The Code of Ethics and Professional Conduct for Court Interpreters is hereby incorporated by reference and includes subsequent amendments and editions. A copy may be obtained at no charge from the North Carolina Administrative Office of the Court's website, https://www.nccourts.gov/assets/inline-files/02_2_NC_Standards_for_Language_Access_0.pdf?NhuszCAEVfS8KkdLetH97b9I4NRBcd.f, or upon request, at the offices of the Commission, located in the Dobbs Building, 430 North Salisbury Street, Raleigh, North Carolina, 27603, between the hours of 8:00 a.m. and 5:00 p.m.

(h) Sign language interpreters shall interpret, as word for word as is practicable, without editing, commenting, or summarizing, testimony or other communications. Sign language interpreters shall abide by the ethical standards communicated in the training required by G.S. 90D-8.

History Note: *Authority G.S. 97-79(b); 97-80(a);*
Eff. November 1, 2014;

Recodified from 04 NCAC 10A .0619 Eff. June 1, 2018;
Amended Eff. April 1, 2020; January 1, 2019.

11 NCAC 23A .0620 WRITTEN COMMUNICATIONS WITH THE COMMISSION

(a) This Rule shall apply to written communications related to a case before the Commission that are not governed by statute or another rule in this Subchapter.

(b) Written communications sent to the Commission shall be contemporaneously sent by the same method of transmission, where possible, to the opposing party or, if represented, to opposing counsel.

(c) Written communications, whether addressed directly to the Commission or copied to the Commission, shall not be used as an opportunity to introduce new evidence or to argue the merits of the case.

History Note: *Authority G.S. 97-80(a);*
Eff. January 1, 2019.

SECTION .0700 - APPEALS

11 NCAC 23A .0701 REVIEW BY THE FULL COMMISSION

(a) Notice of Appeal. Application for review shall be made to the Commission within 15 days from the date when notice of the Deputy Commissioner's Opinion and Award was given. A letter requesting review shall be considered an application for review to the Full Commission within the meaning of G.S. 97-85, provided that the letter specifies the Order or Opinion and Award from which appeal is taken.

(b) Motions to Reconsider to the Deputy Commissioner. A motion to reconsider or to amend the decision of a Deputy Commissioner shall be filed with the Deputy Commissioner within 15 days of receipt of notice of the award. The time for filing a request for review from the decision of a Deputy Commissioner under the rules in this Subchapter shall be tolled until a motion to reconsider or to amend the decision has been ruled upon by the Deputy Commissioner. However, if either party files a letter requesting review of the decision as set forth in Paragraph (a) of this Rule after a motion to reconsider or to amend has been filed with the Deputy Commissioner, jurisdiction shall be transferred to the Full Commission. Any party who had a pending motion to reconsider or amend the decision of the Deputy Commissioner may file a motion with the Chair of the Commission requesting remand to the Deputy Commissioner with whom the motion was pending. Upon remand, jurisdiction shall be transferred to the Deputy Commissioner. Following the Deputy Commissioner's ruling on the motion to reconsider or amend the decision, a party requesting review of the initial decision of the Deputy Commissioner or the ruling on the motion to reconsider or amend the decision shall file a letter requesting review as set forth in Paragraph (a) of this Rule to transfer jurisdiction of the matter back to the Full Commission.

(c) Acknowledging Receipt; Form 44; Joint Certification. The Commission shall acknowledge the request for review by letter. The Commission shall prepare the official transcript and exhibits, if any, and provide them along with a Form 44 Application for Review to the parties involved in the appeal at no charge within 30 days of the acknowledgement letter.

(1) The official transcript and exhibits and a Form 44 Application for Review shall be provided electronically to parties represented by counsel. In such cases, the Commission shall send an email to the parties with directions on how to obtain an electronic copy of the official transcript and exhibits. The e-mail shall also provide instructions for the submission of the parties' acknowledgement of receipt of the Form 44 Application for Review and the official transcript and exhibits to the Commission. Parties represented by counsel shall sign a joint certification acknowledging receipt of the Form 44 Application for Review and the official transcript and exhibits and submit the certification within 10 days of receipt of the Form 44 Application for Review and the official transcript and exhibits. The certification shall stipulate the date the Form 44 Application for Review and the official transcript and exhibits were received by the parties and shall note the date the appellant's brief is due. The Commission shall save a copy of the parties' acknowledgements in the file for the claim to serve as record of the parties' electronic receipt of the Form 44 Application for Review and the official transcript and exhibits.

(2) In cases where it is not possible to provide a party with the official transcript and exhibits electronically, the Commission shall serve the official transcript and exhibits and a Form 44 Application for Review via any class of U.S. Mail that is fully prepaid.

(d) Appellant's Form 44. The appellant shall submit a Form 44 Application for Review stating with particularity all assignments of error and grounds for review, including, where applicable, the pages in the transcript or the record on

which the alleged errors shall be recorded. Grounds for review and assignments of error not set forth in the Form 44 Application for Review are deemed abandoned, and argument thereon shall not be heard before the Full Commission.

(e) Timing Requirements. The appellant shall file the Form 44 Application for Review and brief in support of the grounds for review with the Commission with a certificate of service on the appellee within 25 days after receipt of the transcript or receipt of notice that there will be no transcript. The appellee shall have 25 days from service of the Form 44 Application for Review and appellant's brief to file a responsive brief with the Commission. The appellee's brief shall include a certificate of service on the appellant. When an appellant fails to file a brief, an appellee shall file its brief within 25 days after the appellant's time for filing the Form 44 Application for Review and appellant's brief has expired. A party who fails to file a brief shall not participate in oral argument before the Full Commission. If multiple parties request review, each party shall file an appellant's brief and appellee's brief on the schedule set forth in this Paragraph. If the matter has not been calendared for hearing, a party may obtain a single extension of time not to exceed 15 days by filing a written stipulation pursuant to Rule .0108 of this Subchapter.

(f) Brief Requirements. Briefs to the Full Commission shall not exceed 35 pages, excluding attachments. In no event shall attachments be used to circumvent the 35-page limit or as a means to submit documents into evidence. No page limit applies to the length of attachments. Briefs shall be prepared using a 12 point proportional font and serif typeface, shall be double spaced, and shall be prepared with non-justified right margins. Each page of the brief shall be numbered at the bottom of the page. When a party quotes or paraphrases testimony or other evidence from the appellate record in the party's brief, the party shall include, at the end of the sentence in the brief that quotes or paraphrases the testimony or other evidence, a parenthetic entry that designates the source of the quoted or paraphrased material and the page number within the applicable source. The party shall use "T" to refer to the transcript of hearing testimony and "Ex" for exhibit. For example, if a party quotes or paraphrases material located in the hearing transcript on page 11, the party shall use the following format "(T 11)," and if a party quotes or paraphrases material located in an exhibit on page 12, the party shall use the following format "(Ex 12)." When a party quotes or paraphrases testimony in the transcript of a deposition in the party's brief, the party shall include the last name of the deponent and the page on which such testimony is located. For example, if a party quotes or paraphrases the testimony of John Smith, located on page 11 of such deposition, the party shall use the following format "(Smith 11)." Parties shall not discuss matters outside the record, assert personal opinions or relate personal experiences, or attribute wrongful acts or motives to opposing counsel or members of the Commission.

(g) Reply Briefs. Within 10 days of service of the appellee's brief, a party may request by motion to file a reply brief. The motion shall not contain a reply brief. A reply brief may only be filed if ordered by the Full Commission. Reply briefs shall not exceed 15 pages, excluding attachments. Reply briefs shall be prepared in accordance with the requirements of Paragraph (f) of this Rule. Any reply brief filed shall be limited to a concise rebuttal of arguments set out in the appellee's brief, and shall not reiterate arguments set forth in the appellant's principal brief.

(h) Citations. Case citations shall be to the North Carolina Reports, the North Carolina Court of Appeals Reports, or the North Carolina Reporter, and when possible, to the South Eastern Reporter. An unpublished appellate decision does not constitute controlling legal authority. If a party believes that an unpublished opinion has precedential or persuasive value to a material issue in the case and that there is no published opinion that would serve as well, the party may cite the unpublished opinion. When citing an unpublished opinion, a party shall indicate the opinion's unpublished status. If no reporter citation is available at the time a brief is filed, the party citing to the case shall attach a copy of the case to its brief.

(i) Motions. After a request for review has been submitted to the Full Commission, any motions related to the issues for review shall be filed with the Full Commission, with service on the other parties. Motions related to the issues for review including motions for new trial, to supplement the record, including documents from offers of proof, or to take additional evidence, filed during the pendency of a request for review to the Full Commission, shall be considered by the Full Commission at the time of review of the appeal, except motions related to the official transcript and exhibits. The Full Commission, for good cause shown, may rule on such motions prior to oral argument.

(j) Oral Argument.

(1) Each appellant shall have 20 minutes to present oral argument and may reserve any amount of the twenty-minute total allotment for rebuttal, unless otherwise specified by Order of the Commission. Each appellee shall also have 20 minutes to present oral argument, unless otherwise specified by Order of the Commission. The appellee(s) may not reserve rebuttal time. In the case of cross-appeals, each appealing party may reserve rebuttal time.

(2) Any party may request additional time to present oral argument in excess of the 20-minute allowance. Such requests shall be made in writing and submitted to the Full Commission no less

than 10 days prior to the scheduled hearing date. The written request for additional time shall state with particularity the reason(s) for the request of additional time and the amount of additional time requested.

(3) An employee appealing the amount of a disfigurement award shall personally appear before the Full Commission to permit the Full Commission to view the disfigurement.

(4) A party may waive oral argument or appearance before the Commission at any time with approval of the Commission. Upon the request of a party or on its own initiative, the Commission may review the case and file an Order or Award without oral argument or appearance before the Commission.

(5) If any party fails to appear before the Full Commission upon the call of the case, the Commission may, in the interests of justice or judicial economy, disallow the party's right to present oral argument. If neither party appears upon the call of the case, the Full Commission may decide the case upon the record and briefs on appeal, unless otherwise ordered.

(6) Parties shall not discuss matters outside the record, assert personal opinions, relate personal experiences, or attribute wrongful acts or motives to opposing counsel or members of the Commission.

History Note: *Authority G.S. 97-80(a); 97-85;*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; January 1, 2011; August 1, 2006; June 1, 2000;
Recodified from 04 NCAC 10A .0701 Eff. June 1, 2018;
Amended Eff. January 1, 2019.

11 NCAC 23A .0702 REVIEW OF ADMINISTRATIVE DECISIONS

(a) Administrative decisions include orders, decisions, and awards made in a summary manner, without findings of fact, including decisions on the following:

(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 to change the interval of payments; and

(4) applications for lump sum payments of compensation.

(b) Administrative decisions made in cases not set for hearing before a Commissioner or Deputy Commissioner or before the Full Commission for review shall be reviewed upon the filing of a Motion for Reconsideration, upon a request for hearing on the administrative decision, or upon request for hearing on the ruling on a Motion for Reconsideration. A Motion for Reconsideration shall be filed within 15 days of receipt of the administrative decision and addressed to the Administrative Officer who made the decision. A request for hearing shall be filed within 15 days of the administrative decision or a ruling on a Motion for Reconsideration. Notwithstanding the provisions above, issues addressed by an administrative decision may be raised and determined at a subsequent hearing.

(c) Motions for Reconsideration shall not stay the effect of the order, decision, or award; provided that Administrative Officer making the decision or a Commissioner may enter an order staying its effect pending the ruling on the Motion for Reconsideration or pending a decision by a Commissioner or Deputy Commissioner following a formal hearing. In determining whether or not to grant a stay, the Commissioner or Administrative Officer shall consider whether granting the stay will frustrate the purposes of the order, decision, or award. Motions to Stay shall not be filed with both the Administrative Officer and a Commissioner.

(d) Any request for a hearing to review an administrative decision pursuant to Paragraph (b) shall be filed with the Office of the Clerk. The Commission shall designate a Commissioner or Deputy Commissioner to hear the review. The Commissioner or Deputy Commissioner hearing the matter shall consider all issues de novo, and no issue shall be considered moot solely because the order has been fully executed during the pendency of the hearing.

(e) Any request for review by the Full Commission of an administrative decision by a Commissioner or Deputy Commissioner made during the pendency of a case assigned to them pursuant to G.S. 97-84 shall be filed with the Office of the Clerk. If the administrative decision made by the authoring Commissioner or Deputy Commissioner is a final judgment as to one or more issues or parties and the administrative decision contains a certification that there is no just reason for delay, the request for review shall be referred directly to a panel of the Full Commission. If the administrative decision contains no certification, requests for review will be referred to the Chair of the Commission for a determination regarding the right to immediate review, and the parties shall address the grounds upon which immediate review shall be allowed.

(f) Orders filed by a single Commissioner in matters before the Full Commission for review pursuant to G.S. 97-85, including orders dismissing reviews to the Full Commission or denying a request for immediate review to the Full Commission, are administrative orders and are not final determinations of the Commission. As such, an order filed by a single Commissioner is not appealable to the North Carolina Court of Appeals. A one-signature order filed by a single Commissioner may be reviewed by:

(1) filing a Motion for Reconsideration addressed to the Commissioner who filed the order; or

(2) requesting a review to a Full Commission panel by requesting a hearing within 15 days of receipt of the order or receipt of the ruling on a Motion for Reconsideration.

(g) This Rule shall not apply to medical motions filed pursuant to G.S. 97-25; provided, however, that a party may request reconsideration of an administrative ruling on a medical motion, or may request a stay, or may request an evidentiary hearing de novo, all as set forth in G.S. 97-25.

History Note: *Authority G.S. 97-79(g); 97-80(a); 97-85; S.L. 2014-77;*
Eff. January 1, 1990;
Amended Eff. November 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10A .0702 Eff. June 1, 2018;
Amended Eff. January 1, 2019.

11 NCAC 23A .0702A REMAND FROM THE APPELLATE COURTS

History Note: *Authority G.S. 97-80(a);*
Eff. August 1, 2006;
Repealed Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0702A Eff. June 1, 2018.

11 NCAC 23A .0703 APPEAL TO THE COURT OF APPEALS

(a) The time to file a notice of appeal, and bonds therefrom, including in forma pauperis affidavits, to the North Carolina Court of Appeals from the Full Commission is governed by the provisions of G.S. 97-86.

(b) A motion to reconsider or to amend an award of the Full Commission shall be filed within 15 days of receipt of notice of the award. An award of the Full Commission is not final until the disposition is filed by the Commission on the pending motion to reconsider or to amend an award.

History Note: *Authority G.S. 97-80(a); 97-86;*
Eff. March 15, 1995;
Amended Eff. November 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10A .0703 Eff. June 1, 2018.

11 NCAC 23A .0704 REMAND FROM THE APPELLATE COURTS

When a case is remanded to the Commission from the appellate courts, each party may file a statement, with or without a brief, to the Full Commission setting forth its position on the actions or proceedings, including evidentiary hearings or depositions, required to comply with the court's decision. This statement shall be filed within 30 days of the issuance of the court's mandate and shall be filed with the Commissioner who authored the Full Commission decision or the Commissioner designated by the Chairman of the Commission if the Commissioner who authored the decision is no longer a member of the Industrial Commission. The deadline to submit the statement to the Commission shall be stayed automatically upon a party filing a petition for discretionary review or rehearing to the appellate courts. The stay shall be automatically lifted if the petition for discretionary review or rehearing is denied by the appellate courts.

History Note: *Authority G.S. 97-80(a); 97-86;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0704 Eff. June 1, 2018.

SECTION .0800 – RULES OF THE COMMISSION

11 NCAC 23A .0801 WAIVER OF RULES

In the interests of justice or to promote judicial economy, the Commission may, except as otherwise provided by the rules in this Subchapter, waive or vary the requirements or provisions of any of the rules in this Subchapter in a case pending before the Commission upon request of a party or upon its own initiative only if the employee is not represented by counsel. Notwithstanding oral requests made during a hearing before the Commission, all requests shall be submitted in writing and served upon all opposing parties contemporaneously. By order of the Commission, oral requests shall be submitted in writing within five days of the request. Responses to requests considered pursuant to this Rule may be submitted in accordance with Rule .0609 of this Subchapter within five days of service of the original request. Citation to this Rule or use of the term "waiver" is not required for requests considered pursuant to this Rule. Factors the Commission shall use in determining whether to grant the waiver are:

(1) the necessity of a waiver;
(2) the party's responsibility for the conditions creating the need for a waiver;
(3) the party's prior requests for a waiver;
(4) the precedential value of such a waiver;
(5) notice to and opposition by the opposing parties; and
(6) the harm to the party if the waiver is not granted.

History Note: *Authority G.S. 97-80(a);*
Eff. January 1, 1990;
Amended Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0801 Eff. June 1, 2018;
Amended Eff. January 1, 2019.

11 NCAC 23A .0802 SANCTIONS

History Note: *Authority G.S. 1A-1, Rule 37; 97-18; 97-80(a); 97-88.1;*
Eff. January 1, 1990;
Amended Eff. June 1, 2000;
Repealed Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0802 Eff. June 1, 2018.

11 NCAC 23A .0803 RULEMAKING

History Note: *Authority G.S. 97-80(a);*
Eff. January 1, 1990;
Repealed Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0803 Eff. June 1, 2018.

SECTION .0900 – REPORT OF EARNINGS

11 NCAC 23A .0901 CHECK ENDORSEMENT

If a self-insured employer, carrier or third party administrator places "check endorsement" language on the back of an employee's check, the following language (or language approved by the Commission as equivalent) shall be used:

> By endorsing this check, I certify that I have not worked for or earned wages from any business or individual during the period covered by this check, or that I have reported any earnings to the employer or carrier paying me workers' compensation benefits. I understand that making a false statement by endorsing this benefit check may result in civil and criminal penalties.

History Note: *Authority G.S. 97-80(a); 97-88.2;*
Eff. June 1, 2000;
Amended Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0901 Eff. June 1, 2018.

11 NCAC 23A .0902 NOTICE

A self-insured employer, carrier or third party administrator shall not use check endorsement language on the back of an employee's workers' compensation benefit check unless the employee has been provided the following Notice sent by certified mail return receipt requested:

NOTICE TO EMPLOYEE RECEIVING WORKERS' COMPENSATION BENEFITS

This NOTICE is intended to advise you of important information you must know if you are receiving workers' compensation benefits.
Please TAKE NOTICE of the following:
(a) When you are receiving weekly workers' compensation benefits, you must report any earnings you receive to the insurance company (or employer if the employer is self-insured) that is paying you the benefits. "Earnings" include any cash, wages or salary received from self-employment or from any employment other than the employment where you were injured. Earnings also include commissions, bonuses, and the cash value for all payments received in any form other than cash (e.g., a building custodian receiving a rent-free apartment). Incentives, commissions, bonuses, or other compensation earned before disability but received during the time you are also receiving workers' compensation benefits do not constitute earnings that must be reported.
(b) You must report any work in any business, even if the business lost money or if profits or income were reinvested or paid to others.
(c) Your endorsement on a benefit check or deposit of the check into an account is your certification that you have not worked for or earned wages from any business or individual during the period covered by the check, or that you have reported any earnings to the employer or carrier paying you workers' compensation benefits and that you are entitled to receive workers' compensation benefits. Your signature on a benefit check is further certification that you have made no material false statement or concealed any material fact regarding your right to receive the benefit check.
(d) Making false statements for the purpose of obtaining workers' compensation benefits may result in civil and criminal penalties.

History Note: *Authority G.S. 97-80(a); 97-88.2;*
Eff. June 1, 2000;
Amended Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0902 Eff. June 1, 2018.

11 NCAC 23A .0903 EMPLOYEE'S OBLIGATION TO REPORT EARNINGS

(a) A self-insured employer, carrier, or third-party administrator may require the employee who has filed a claim and is receiving wage loss benefits under G.S. 97-29 or G.S. 97-30 to complete a Form 90 Report of Earnings when reasonably necessary but not more than once every six months.
(b) The Form 90 Report of Earnings shall be sent to the employee by certified mail, return receipt requested, and shall include a self-addressed stamped envelope for the return of the form. When the employee is represented by an attorney, the Form 90 Report of Earnings shall be sent only to the attorney for the employee and shall be sent by any method of transmission that provides proof of receipt, including electronic mail, facsimile, or certified mail, return receipt requested.
(c) The employee shall complete and return the Form 90 Report of Earnings within 15 days after receipt of a Form 90 Report of Earnings. If the employee fails to complete and return the Form 90 Report of Earnings within 30 days of receipt of the form, the self-insured employer, carrier, or third-party administrator may seek to suspend compensation being paid pursuant to G.S. 97-29 by filing a Form 24 Application to Terminate or Suspend Payment of Compensation, as allowed by G.S. 97-18.1 and Rule .0404 of this Subchapter.
(d) If compensation is suspended pursuant to Paragraph (c) of this Rule and the employee subsequently completes and returns the Form 90 Report of Earnings, the self-insured employer, carrier, or third-party administrator shall reinstate payment of compensation to the employee with back payment. However, if the Form 90 Report of Earnings does not indicate continuing eligibility for disability compensation, the self-insured employer, carrier, or third-party administrator is not required to reinstate payment of compensation. If the Form 90 Report of Earnings indicates continuing eligibility for temporary partial disability compensation, the self-insured employer, carrier, or third-party administrator shall make payment of compensation pursuant to G.S. 97-30 with back payment within 14 days of receipt of documentation establishing the amount of compensation due. If payment of compensation is not reinstated

following submission of the completed Form 90 Report of Earnings and the employee claims entitlement to ongoing disability compensation, the employee may seek reinstatement by filing a Form 23 Application to Reinstate Payment of Disability Compensation or Form 33 Request that Claim be Assigned for Hearing.

History Note: *Authority G.S. 97-80(a);*
Eff. June 1, 2000;
Amended Eff. November 1, 2014; August 1, 2006;
Recodified from 04 NCAC 10A .0903 Eff. June 1, 2018;
Amended Eff. December 1, 2020.

SECTION .1000 – PREAUTHORIZATION FOR MEDICAL TREATMENT

11 NCAC 23A .1001 PREAUTHORIZATION FOR SURGERY AND INPATIENT TREATMENT

(a) An insurer that requires preauthorization must establish a preauthorization review policy that describes the process for requesting preauthorization review. The policy must be publicly available on the insurer's website.

(b) As used in this Section:

(1) "insurer" means an insurance carrier, self-insured administrator, managed care organization, employer, or any other entity that conducts preauthorization review;

(2) "preauthorization" means the determination by an insurer that proposed surgical or inpatient treatment is medically necessary; and

(3) "preauthorization review" means a prospective review process conducted by an insurer to determine whether a proposed surgical or inpatient treatment is medically necessary.

(c) Insurers shall, on an annual basis, electronically submit an electronic copy or link for any medical practice guidelines the insurer utilizes in the preauthorization review process to the Commission at the following email address, execsec@ic.nc.gov, by July 1 of each year.

(d) The insurer shall list each surgical procedure and each inpatient service for which preauthorization review is required. These procedures and services shall be publicly available on the insurer's website.

(e) The preauthorization review policy shall include:

(1) procedures for requesting preauthorization, responding to and approving requests for preauthorization, and appealing a denial of preauthorization;

(2) procedures via telephone, fax and email for communicating with the preauthorization agent with decision making powers on a pending request for preauthorization (including Peer Review Physicians) on a continuous basis on every business day (which excludes weekends and holidays) between the hours of 8:00 a.m. and 8:00 p.m. eastern standard time;

(3) methods by which the insurer shall respond to requests for preauthorization and methods by which a health care provider, claimant, person, or entity requesting preauthorization may respond to inquiries or determinations by the insurer;

(4) a statement that the insurer will provide a statement with supporting documentation of the substantive clinical justification for a denial of preauthorization, including the relevant clinical criteria upon which the denial is based. Denials based upon lack of information shall specify what information is needed to make a determination;

(5) an outline of the appeal rights and procedures with instructions on how to submit appeals by mail, email or fax;

(6) a statement that advises the appealing party of the right to seek authorization for any denied treatment from the Commission; and

(7) the name, title, address, telephone number, fax number, email address and other contact information for the person with authority over all decision-making for preauthorization determinations (in addition to the claims adjuster), and the normal business hours and time zone of this contact person.

(f) Delivery of a request for preauthorization to the claims adjuster or other designated Preauthorization Agent at the place (email address, fax number, telephone number) provided by the insurer shall constitute receipt of the preauthorization request by the claims adjuster.

(g) Preauthorization agents shall acknowledge receipt of all communications within two business days of the request, and the acknowledgment shall satisfy G.S. 97-25.3(a)(2).

(h) Upon receipt of a request for preauthorization, the insurer shall provide to the health care provider or person making the request the name, telephone number, fax number and email address of the Preauthorization Agent. The

Preauthorization Agent must be available on a continuous basis, every business day (which excludes weekends and holidays) from 8:00 a.m. to 8:00 p.m. Eastern Standard Time to facilitate responses to insurer communications or determinations.

(i) Insurers that utilize a Peer Review Physician in making preauthorization decisions shall indicate in their preauthorization review policy the name, licensure, and specialty area of that Peer Review Physician and shall provide a profile ("Peer Review Physician Profile") of that Peer Review Physician. The Peer Review Physician shall be licensed in either North Carolina, South Carolina, Georgia, Virginia, or Tennessee and shall hold professional qualifications, certifications, and fellowship training in a like specialty that is at least equal to that of the treating provider who is requesting preauthorization of surgery or inpatient treatment.

(j) Insurers shall, on an annual basis, electronically submit their Peer Review Physician Profiles to the Commission at the following email address, execsec@ic.nc.gov, by July 1 of each year.

(k) All requests for preauthorization by health care providers, claimant's attorneys, or unrepresented claimants, and all preauthorization determinations made by insurers on the preauthorization requests shall be submitted on Industrial Commission Form 25PR. The Preauthorization Agent is responsible for providing the preauthorization review (PR) claim number and for forwarding medical records, communications, and preauthorization review determinations to the proper entities upon receipt, unless the insurer's Preauthorization Plan designates and identifies another person to perform this requirement.

(l) The failure of an insurer to make a determination on a request for preauthorization within seven business days as specified in G.S. 97-25.3 shall result in an automatic waiver of the insurer's right to contest the requested treatment, unless:

(1) an extension of time, not to exceed seven business days, is agreed upon by the insurer and the medical provider requesting preauthorization (or the claimant's attorney or unrepresented claimant, if no medical provider has requested preauthorization); or

(2) an additional extension of time is granted by the Commission pursuant to G.S. 97-25.3(a)(3).

(m) Requests made to the Commission for an extension of time shall be directed to the Office of the Executive Secretary, and shall be simultaneously copied to the requesting health care provider, if any, and to the claimant's attorney or to the claimant, if unrepresented.

(n) In accordance with G.S. 97-18(i), insurers are obligated to pay for any surgery or inpatient treatment provided under G.S. 97-25.3, for which preauthorization was requested for an admitted condition after the right to contest the preauthorization request is waived.

History Note: *Authority G.S. 97-25.3; 97-80(a);*
Eff. November 1, 2014;
Recodified from 04 NCAC 10A .1001 Eff. June 1, 2018;
Amended Eff. January 1, 2026.

SUBCHAPTER 23B – TORT CLAIMS RULES

SECTION .0100 – ADMINISTRATION

11 NCAC 23B .0101 LOCATION OF MAIN OFFICE AND HOURS OF BUSINESS

The main office of the North Carolina Industrial Commission is located in the Dobbs Building, 430 North Salisbury Street, Raleigh, North Carolina. Documents that are not being filed electronically may be filed at the main office between the hours of 8:00 a.m. and 5:00 p.m. only. Documents permitted to be filed electronically may be so filed until 11:59 p.m. on the required filing date.

History Note: *Authority G.S. 143-291; 143-300;*
Eff. January 1, 1989;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0101 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

11 NCAC 23B .0102 OFFICIAL FORMS

(a) Copies of the Commission's rules and forms regarding tort claims may be obtained by contacting the Commission in person at the address in Rule .0101 of this Section; by written request mailed to 1236 Mail Service

Center, Raleigh, NC 27699-1236, Attn.: Office of the Clerk; or from the Commission's website at http://www.ic.nc.gov/abtrules.html and http://www.ic.nc.gov/forms.html.
(b) The use of any printed forms other than those provided by the Commission is prohibited, except that parties may reproduce current Commission forms for their own use, provided:

(1) no statement, question, or information blank contained on the Commission form is omitted from the substituted form; and
(2) the substituted form is identical in size and format to the Commission form.

History Note: *Authority G.S. 143-300;*
Eff. January 1, 1989;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0102 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

11 NCAC 23B .0103 FILING FEES

(a) No tort claim shall be accepted for filing with the Commission unless the claim is accompanied by an attorney's check, certified check, money order, or electronic transfer of funds in payment of a filing fee in an amount equal to the filing fee required for the filing of a civil action in the Superior Court division of the General Court of Justice.
(b) The provisions of Paragraph (a) of this Rule notwithstanding, a tort claim that is accompanied by a Petition to Sue as an Indigent shall be accepted for filing upon the date of its receipt.
(c) A Petition to Sue as an Indigent shall consist of an affidavit sufficient to satisfy the provisions of G.S. 1-110, stating that plaintiff is unable to comply with Paragraph (a) of this Rule.
(d) If the Commission determines the plaintiff is able to pay the fee assessed under this Rule, an Order shall be issued directing payment of that fee, and the plaintiff shall, within 30 days from receipt of the Order, forward to the Commission an attorney's check, certified check, money order, or electronic transfer of funds for the full amount required to be paid. Failure to submit the required amount of the filing fee within this time shall result in the tort claim being dismissed without prejudice.
(e) Upon consideration of a prison inmate's Petition to Sue as an Indigent, the Commission shall determine whether the inmate's tort claim is frivolous and whether to dismiss the claim, pursuant to G.S. 1-110. Appeals from the dismissal of a frivolous tort claim pursuant to G.S. 1-110 shall proceed directly to the Full Commission and shall be decided without oral argument.

History Note: *Authority G.S. 143-291.2; 143-300;*
Eff. January 1, 1989;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0103 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

11 NCAC 23B .0104 ELECTRONIC FILINGS WITH THE COMMISSION; HOW TO FILE

(a) All filings to the Commission in tort claims shall be submitted electronically in accordance with this Rule. Any document transmitted to the Commission in a manner not in accordance with this Rule shall not be accepted for filing. Plaintiffs without legal representation may file all documents with the Office of the Clerk of the Commission via the Commission's Electronic Document Filing Portal ("EDFP") or by sending the documents to the Clerk of the Industrial Commission via electronic mail (dockets@ic.nc.gov), facsimile, U.S. Mail, private courier service, or hand delivery.
(b) Information regarding how to use EDFP is available at http://www.ic.nc.gov/training.html. In the event EDFP is inoperable, all documents required to be filed via EDFP shall be transmitted to the Commission via electronic mail to edfp@ic.nc.gov. Documents required to be filed via EDFP that are sent to the Commission via electronic mail when EDFP is operable shall not be accepted for filing.
(c) Any party may apply to the Commission for an emergency temporary waiver of the electronic filing requirement set forth in Paragraph (a) of this Rule if it is unable to comply because of temporary technical problems or lack of electronic mail or internet access. The request for an emergency temporary waiver shall be included with any filing submitted via facsimile, U.S. Mail, or hand delivery due to such temporary technical or access issues.
(d) A Notice of Appeal to the North Carolina Court of Appeals shall be accepted for filing by the Commission via EDFP, U.S. Mail, hand delivery, or any other means allowed by the Rules of Appellate Procedure or applicable

statutes governing appeals from the General Courts of Justice. Notwithstanding the foregoing, plaintiffs without legal representation may file all documents with the Commission as provided in Paragraph (a) of this Rule.

History Note: *Authority G.S. 143-291; 143-293; 143-297; 143-300;*
Eff. May 1, 2000;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10B .0104 Eff. June 1, 2018;
Amended Eff. March 1, 2021; March 1, 2019.

11 NCAC 23B .0105 CONTACT INFORMATION

(a) "Contact information" for purposes of this Rule shall include telephone number, facsimile number, email address, and mailing address.

(b) All persons or entities without legal representation who have matters pending before the Commission shall inform the Commission of any change in contact information by filing a written notice via the Commission's Electronic Document Filing Portal ("EDFP"), email to contactinfo@ic.nc.gov, facsimile to (919) 715-0282, U.S. mail sent to Office of the Clerk, 1236 Mail Service Center, Raleigh North Carolina 27699-1236, private courier service in accordance with Rule .0101 of this Section, or hand delivery in accordance with Rule .0101 of this Section.

(c) A plaintiff without legal representation who was an inmate in the North Carolina Division of Adult Corrections at the time of filing his or her tort claim, shall, within 30 days of release, provide the Commission with written notice of his or her post-release contact information in any manner authorized in Paragraph (b) of this Rule. Following the initial written notice of post-release contact information, the previously incarcerated plaintiff shall continue to inform the Commission of all changes in contact information in accordance with Paragraph (b) of this Rule.

(d) All attorneys of record with matters before the Commission shall provide and maintain current contact information for the Commission's records via EDFP.

(e) Instructions on how to provide and update contact information via EDFP are available at https://www.ic.nc.gov/docfiling.html.

History Note: *Authority G.S. 143-291; 143-300;*
Eff. March 1, 2019;
Amended Eff. March 1, 2021.

11 NCAC 23B .0106 NOTICE BY THE COMMISSION

(a) If service is provided by electronic mail, "receipt of such notice" pursuant to G.S. 143-292 and "receipt of the decision and order" of the Full Commission pursuant to G.S. 143-293 is complete one hour after it is sent by the Commission, provided that:

(1) notice sent after 5:00 p.m. shall be complete at 8:00 a.m. the following State business day; and

(2) notice sent by electronic mail that is not readable by the recipient is not complete. Within five State business days of receipt of an unreadable document, the receiving party shall notify the Commission of the unreadability of the document.

(b) If service is provided by electronic mail, notice of orders or other documents issued pursuant to G.S. 143-296 is complete in accordance with the same provisions set forth in Paragraph (a) of this Rule.

History Note: *Authority G.S. 143-300;*
Eff. December 1, 2020.

SECTION .0200 - CLAIMS PROCEDURES

11 NCAC 23B .0201 RULES OF CIVIL PROCEDURE

History Note: *Authority G.S. 143-300;*
Eff. January 1, 1989;
Amended Eff. January 1, 2011; May 1, 2000;
Repealed Eff. July 1, 2014;
Recodified from 04 NCAC 10B .0201 Eff. June 1, 2018.

11 NCAC 23B .0202 MEDICAL MALPRACTICE CLAIMS BY UNREPRESENTED PRISON INMATES

In any tort claim filed by an unrepresented prison inmate in which the Commission determines that the plaintiff is alleging that a health care provider, as defined in G.S. 90-21.11, failed to comply with the applicable standard of care set forth in G.S. 90-21.12, or the defendant has moved to dismiss the claim for failure to comply with Rule 9(j) of the North Rules of Civil Procedure, all discovery shall be stayed until a recorded non-evidentiary hearing before the Commission is held for the purpose of determining whether a claim for medical malpractice has been stated and, if so, whether:

(1) the plaintiff must meet the requirements of Rule 9(j)(1) or (2) of the North Carolina Rules of Civil Procedure to proceed with the claim; or

(2) the plaintiff has alleged facts establishing negligence under the existing common-law doctrine of res ipsa loquitur.

If the Commission determines that a claim for medical malpractice has been stated and plaintiff must meet the requirements of Rule 9(j)(1) or (2) of the North Carolina Rules of Civil Procedure, the defendant shall produce medical records to the plaintiff within the time period ordered by the Commission. The plaintiff shall have one hundred and twenty (120) days following receipt of the medical records to comply with Rule 9(j) of the North Carolina Rules of Civil Procedure.

History Note: *Authority G.S. 143-300;*
Eff. January 1, 1989;
Recodified from 04 NCAC 10B .0206 Eff. April 17, 2000;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0202 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

11 NCAC 23B .0203 INFANTS AND INCOMPETENTS

(a) Persons seeking to appear on behalf of an infant or incompetent in accordance with G.S. 1A-1, Rule 17 shall apply on a Form T-42 Application for Appointment of Guardian ad Litem. The Commission shall appoint a guardian ad litem if it is in the best interest of the minor or incompetent. The Commission shall appoint the guardian ad litem only after due inquiry as to the fitness of the person to be appointed.

(b) The Commission may assess a fee to be paid to an attorney who serves as a guardian ad litem for actual services rendered upon receipt of an affidavit of actual time spent in representation of the minor or incompetent as part of the costs assessed pursuant to G.S. 143-291.2(a) or Rule 17(b)(2) of the North Carolina Rules of Civil Procedure.

History Note: *Authority G.S. 143-291; 143-295; 143-300;*
Eff. January 1, 1989;
Recodified from 04 NCAC 10B .0307 Eff. April 17, 2000;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0203 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

11 NCAC 23B .0204 MOTIONS

(a) All motions regarding tort claims shall be filed pursuant to Rule .0104 of this Subchapter.

(b) A motion shall state the grounds on which it is based with particularity, the relief sought, and the opposing party's position, or that the opposing party's position could not be ascertained after a good faith effort.

(c) At the same time a motion is filed, the party filing the motion shall provide a copy of the motion to all opposing attorneys of record or on all opposing parties if not represented.

(d) All motions and responses thereto filed electronically shall include a proposed Order in Microsoft Word format.

(e) By motion of the parties or on its own motion, the Commission may enlarge the time for an act required or allowed to be done under the Rules in this Subchapter in the interests of justice or to promote judicial economy. An enlargement of time may be granted either before or after the relevant time requirement has elapsed.

(f) Motions to continue or remove a case from the hearing docket shall be made as much in advance of the scheduled hearing as possible and shall be made in writing. The moving party shall state that the other parties have been advised of the motion and shall state the position of the other parties regarding the motion. Oral motions shall be permitted in emergency situations.

(g) The responding party to a motion, with the exception of motions to continue or to remove a case from a hearing docket, has 10 days after a motion is served during which to file and serve copies of a response in opposition to the motion.
(h) Notwithstanding Paragraph (g) of this Rule, a motion may be acted upon at any time by the Commission, despite the absence of notice to all parties and without awaiting a response. Motions shall be determined without oral argument, unless the Commission orders otherwise in the interests of justice.
(i) Motions to dismiss or for summary judgment filed by the defendant on the ground that plaintiff has failed to name the individual officer, agent, employee, or involuntary servant whose alleged negligence gave rise to the claim, or has failed to properly name the department or agency of the State with whom such person was employed, shall be ruled upon following the completion of discovery.
(j) Motions to reconsider or amend an Order or Decision and Order, made prior to giving notice of appeal to the Full Commission, shall be addressed to the Deputy Commissioner who authored the Order or Decision and Order.

History Note: *Authority G.S. 143-296; 143-300;*
Eff. January 1, 1989;
Recodified from 04 NCAC 10B .0203 Eff. April 17, 2000;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0204 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

11 NCAC 23B .0205 MEDIATION
(a) Any party participating in mediation shall be bound by the Rules for Mediated Settlement and Neutral Evaluation Conferences of the Commission, found in 11 NCAC 23G, except to the extent these Rules conflict with the Tort Claims Act or the other rules in this Subchapter, in which case the Tort Claims Act and the other rules in this Subchapter shall apply.
(b) An employee or agent of the named governmental entity or agency shall either physically attend or be available via telecommunication. Mediation shall not be delayed due to the absence or unavailability of the employee or agent of the named governmental entity or agency.

History Note: *Authority G.S. 143-295; 143-296; 143-300;*
Eff. January 1, 1989;
Amended Eff. July 1, 2014; January 1, 2011; May 1, 2000;
Recodified from 04 NCAC 10B .0205 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

11 NCAC 23B .0206 HEARINGS
(a) The Commission may, on its own motion, order a hearing, rehearing, or pre-trial conference of any tort claim in dispute. The Commission shall set the date, time, and location of the hearing, and provide notice of the hearing to the parties. Any pre-trial conference, as well as hearings of claims in which the plaintiff is incarcerated at the time of the hearing, may be conducted via videoconference or telephone conference in lieu of an in-person hearing. Where a party has not notified the Commission of the attorney representing the party prior to the mailing of calendars for hearing, notice to that party constitutes notice to the party's attorney. Any scheduled hearings shall proceed to completion unless recessed, continued, or removed by Order of the Commission, and shall not be limited by the business hours of the Commission as set forth in Rule .0101 of this Subchapter.
(b) When an attorney is notified to appear for a pre-trial conference, motion hearing, hearing, or any other appearance the attorney shall, consistent with the North Carolina Rules of Professional Conduct, appear or have a partner, associate, or other attorney appear. Counsel for each party or any party without legal representation shall remain in the hearing room throughout the course of the hearing, unless excused by the Commission.
(c) A motion for a continuance shall be allowed by the Commissioner or Deputy Commissioner before whom the case is set in the interests of justice or to promote judicial economy.
(d) In cases involving property damage of less than five hundred dollars ($500.00), the Commission may, upon its own motion or upon the motion of either party, order a videoconference or telephone conference hearing on the matter.
(e) Unless otherwise ordered by the Commission, in the event of inclement weather or natural disaster, hearings set by the Commission shall be cancelled or delayed and rescheduled when the proceedings before the General Courts of Justice in that county are cancelled or delayed.

(f) Unless otherwise ordered or waived by the Commission, applications for issuance of a writ of habeas corpus ad testificandum requesting the appearance of witnesses incarcerated by the North Carolina Division of Adult Corrections, shall be filed with the Commission with a copy to the opposing party or counsel, for review by the Commission in accordance with G.S. 143-296.

History Note: *Authority G.S. 143-296; 143-300;*
Eff. January 1, 1989;
Recodified from 04 NCAC 10B .0202 Eff. April 17, 2000;
Amended Eff. July 1, 2014; January 1, 2011; May 1, 2000;
Recodified from 04 NCAC 10B .0206 Eff. June 1, 2018;
Amended Eff. March 21, 2019.

11 NCAC 23B .0207 HEARINGS OF CLAIMS BY PRISON INMATES

History Note: *Authority G.S. 97-101.1; 143-296; 143-300;*
Eff. January 1, 1989;
Recodified from 04 NCAC 10B .0204 Eff. April 17, 2000;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0207 Eff. June 1, 2018;
Repealed Eff. March 21, 2019.

11 NCAC 23B .0208 HEARING COSTS

Costs assessed pursuant to Rule 11 NCAC 23E .0202 in tort claims shall be due upon receipt of a bill or statement from the Commission.

History Note: *Authority G.S. 7A-305; 143-291.1; 143-291.2; 143-300;*
Eff. July 1, 2014;
Recodified from 04 NCAC 10B .0208 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

SECTION .0300 - APPEALS TO FULL COMMISSION

11 NCAC 23B .0301 SCOPE

The rules in this Section are the applicable Rules for appeals of cases brought pursuant to Article 31 of Chapter 143 of the General Statutes to the Full Commission.

History Note: *Authority G.S. 143-292; 143-300;*
Eff. January 1, 1989;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0301 Eff. June 1, 2018.

11 NCAC 23B .0302 APPEALS TO THE FULL COMMISSION

(a) Notice of appeal shall be made to the Commission within 15 days from the date when notice of the Deputy Commissioner's Order or Decision and Order has been received by the appellant. The notice of appeal shall specify, by tort claim number and filing date, the Order or Decision and Order from which appeal is taken. The notice of appeal shall include a written statement confirming that a copy of the notice of appeal has been sent to the opposing party or parties.

(b) After receipt of the notice of appeal, the Commission shall acknowledge the notice of appeal in writing. Within 30 days of the acknowledgement, the Commission shall prepare and provide, at no charge to the parties, electronic copies of any official transcript, any exhibits, and a Form T-44 Application for Review. In cases where it is not possible to provide a party with the official transcript and exhibits electronically, the Commission shall provide the official transcript, all exhibits, and a Form T-44 Application for Review via any class of U.S. mail that is fully prepaid.

(c) Within 25 days of receipt of the official transcript and exhibits or receipt of notice that there will be no official transcript and exhibits, the appellant shall submit a Form T-44 Application for Review or written statement stating with particularity all assignments of error and grounds for review, including, where applicable, the pages in the

transcript or the record on which the alleged errors are recorded. The Form T-44 Application for Review or the written statement shall be accompanied by confirmation that a copy of the document has been sent to the opposing party or parties. Failure to state the proposed issues on appeal, either by Form T-44 Application for Review or by written statement, shall be grounds for dismissal of the appeal either upon the motion of the non-appealing party or upon the Full Commission's own motion.

(d) An appellant may file a brief in support of the grounds for appeal with the Commission, with a written statement confirming that a copy of the brief has been sent to the opposing party or parties, within 25 days after receipt of the official transcript and exhibits or receipt of notice that there will be no official transcript and exhibits. The appellee shall have 25 days from service of the appellant's brief to file a reply brief with the Commission with a written statement confirming that a copy of the brief has been sent to the opposing party or parties. If the appellant fails to file a brief, the appellee shall file a brief within 25 days after the appellant's time for filing a brief has expired. If multiple parties appeal, each party may file an appellant's brief and appellee's brief on the schedule set forth in this Rule. If the matter has not been calendared for hearing, any party may file a written stipulation to a single extension of time not to exceed 15 days with the Office of the Clerk. The cumulative extensions of time shall not exceed 30 days. A party who fails to file a brief shall not be allowed oral argument before the Full Commission.

(e) Briefs to the Full Commission shall not exceed 35 pages, excluding attachments. No page limit applies to the length of attachments. Typed briefs shall be prepared using 12-point proportional type, shall be double spaced, and shall be prepared with non-justified right margins. Each page of the brief shall be numbered at the bottom right of the page. If a party quotes or paraphrases testimony or evidence from the official transcript or exhibits in a brief, the party shall include, at the end of the sentence, a parenthetic entry that designates the source and page number of the quoted or paraphrased material. The party shall use "T" for transcript and "Ex" for exhibit. For example, (1) if a party quotes or paraphrases material located in the transcript on page 11, the party shall use the following format "(T 11)," and (2) if a party quotes or paraphrases material located in an exhibit on page 12, the party shall use the following format "(Ex 12)". If a party quotes or paraphrases testimony or other evidence in the transcript of a deposition, the party shall include, at the end of the sentence, a parenthetic entry that contains the name of the person deposed and the page number in the transcript of the deposition. For example, if a party quotes or paraphrases the testimony of John Smith located on page 11 of the transcript of the deposition, the party shall use the following format "(Smith 11)". Cases shall be cited to the North Carolina Reports, the North Carolina Court of Appeals Reports, or the North Carolina Reporter and, if possible, to the South Eastern Reporter. Briefs shall be based upon the record in the matter, pursuant to G.S. 143-292.

(g) A request for review by the Full Commission of an order by a Commissioner or Deputy Commissioner made during the pendency of a case assigned to them shall be filed with the Office of the Clerk. If the order made by the authoring Commissioner or Deputy Commissioner is a final judgment as to one or more issues or parties and the order contains a certification that there is no just reason for delay, the request for review shall be referred directly to a panel of the Full Commission. If the order contains no certification, requests for review shall be referred to the Chair of the Commission for a determination regarding the right to immediate review, and the parties shall address the grounds upon which immediate review shall be allowed.

History Note: *Authority G.S. 143-292; 143-300;*
Eff. January 1, 1989;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0302 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

11 NCAC 23B .0303 PROPOSED ISSUES ON APPEAL

History Note: *Authority G.S. 143-292; 143-300; 362 N.C. 191 (2008);*
Eff. January 1, 1989;
Amended Eff. July 1, 2014; January 1, 2011; May 1, 2000;
Recodified from 04 NCAC 10B .0303 Eff. June 1, 2018;
Repealed Eff. March 1, 2019.

11 NCAC 23B .0304 DISMISSALS OF APPEALS

History Note: *Authority G.S. 143-300;*
Eff. January 1, 1989;

Recodified from 04 NCAC 10B .0305 Eff. April 17, 2000;
Amended Eff. May 1, 2000;
Repealed Eff. July 1, 2014;
Recodified from 04 NCAC 10B .0304 Eff. June 1, 2018.

11 NCAC 23B .0305 BRIEFS TO THE FULL COMMISSION

History Note: *Authority G.S. 143-296; 143-300;*
Eff. January 1, 1989;
Recodified from 04 NCAC 10B .0306 Eff. April 17, 2000;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0305 Eff. June 1, 2018;
Repealed Eff. March 1, 2019.

11 NCAC 23B .0306 MOTION FOR NEW HEARING

History Note: *Authority G.S. 143-292; 143-296; 143-300;*
Eff. January 1, 1989;
Recodified from 04 NCAC 10B .0310 Eff. April 17, 2000;
Amended Eff. May 1, 2000;
Repealed Eff. July 1, 2014;
Recodified from 04 NCAC 10B .0306 Eff. June 1, 2018.

11 NCAC 23B .0307 MOTIONS BEFORE THE FULL COMMISSION

(a) After notice of appeal has been given to the Full Commission, all motions related to the claim before the Full Commission shall be in writing and filed with the Full Commission with a statement confirming that copies have been provided to the other parties. A Motion for a New Hearing shall be supported by an Affidavit.

(b) Motions related to the issues on appeal, including motions for new trial, to amend the record, or to take additional evidence, filed during the pendency of an appeal to the Full Commission shall be argued before the Full Commission at the time of the hearing of the appeal.

History Note: *Authority G.S. 143-296; 143-300;*
Eff. January 1, 1989;
Recodified from 04 NCAC 10B .0308 effective April 17, 2000;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0307 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

11 NCAC 23B .0308 STAYS

If a case is appealed to the Full Commission, all Orders or Decision and Orders of a Deputy Commissioner shall be stayed pending appeal.

History Note: *Authority G.S. 143-292; 143-296; 143-300;*
Eff. May 1, 2000;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10B .0308 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

11 NCAC 23B .0309 NEW EVIDENCE

History Note: *Authority G.S. 143-300;*
Eff. January 1, 1989;
Amended Eff. May 1, 2000;
Repealed Eff. July 1, 2014;
Recodified from 04 NCAC 10B .0309 Eff. June 1, 2018.

11 NCAC 23B .0310 ORAL ARGUMENT

(a) A party may waive oral argument at any time with approval of the Commission. Upon the request of a party or on its own initiative, the Commission may review the case and file an Order or Decision and Order without oral argument.

(b) When presenting oral argument, each appellant shall have 20 minutes to present oral argument and may reserve any amount of the 20-minute total allotment for rebuttal, unless otherwise specified by Order of the Commission. Each appellee shall also have 20 minutes to present oral argument, unless otherwise specified by Order of the Commission; however, the appellees shall not reserve rebuttal time. In cross-appeals, each appealing party may reserve rebuttal time.

(c) A party may request additional time to present oral argument in excess of the standard 20-minute allowance. Such requests shall be made in writing and submitted to the Full Commission no less than 10 days prior to the scheduled hearing date. The written request for additional time shall state with specificity the reasons for the request of additional time and the amount of additional time requested.

(d) If a party fails to appear before the Full Commission upon the call of the case, the Commission may, upon consideration of the interests of justice and judicial economy, disallow the party's right to present oral argument. If neither party appears upon the call of the case, the Full Commission may, upon consideration of the interests of justice and judicial economy, decide the case upon the record and briefs on appeal, unless otherwise ordered.

(e) Oral arguments shall be based upon the record in the matter, pursuant to G.S. 143-292.

History Note: *Authority G.S. 143-292; 143-296; 143-300;*
Eff. January 1, 1989;
Recodified from 04 NCAC 10B .0311 Eff. April 17, 2000;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0310 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

SECTION .0400 - APPEALS TO THE COURT OF APPEALS

11 NCAC 23B .0401 SCOPE

The rules in this Section are the applicable Rules for appeals to the Court of Appeals pursuant to Article 31 of Chapter 143 of the General Statutes.

History Note: *Authority G.S. 143-293; 143-300;*
Eff. January 1, 1989;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10B .0401 Eff. June 1, 2018.

11 NCAC 23B .0402 STAYS

If a case is appealed to the Court of Appeals, all Orders or Decision and Orders of the Full Commission shall be stayed pending appeal.

History Note: *Authority G.S. 143-292; 143-294; 143-296; 143-300;*
Eff. January 1, 1989;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0402 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

11 NCAC 23B .0403 MOTIONS FOR COURT OF APPEALS CASES

(a) Prior to the docketing of the record on appeal in the Court of Appeals, all motions filed by the parties regarding an appeal to the Court of Appeals shall be addressed to and ruled upon by the Chair of the Commission, or the Chair's designee.

(b) A motion to reconsider or to amend an award of the Full Commission shall be filed within 15 days of receipt of notice of the award. An award of the Full Commission is not final until the disposition is filed by the Commission on the pending motion to reconsider or to amend an award.

History Note: *Authority G.S. 143-293; 143-300;*

Eff. January 1, 1989;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0403 Eff. June 1, 2018.

11 NCAC 23B .0404 REMAND FROM APPELLATE COURTS

When a case is remanded to the Commission from the appellate courts, each party may file a statement, with or without a brief to the Full Commission, setting forth its position on the actions or proceedings, including evidentiary hearings or depositions, required to comply with the court's decision. This statement shall be filed within 30 days of the issuance of the court's mandate and shall be filed with the Commissioner who authored the Full Commission decision or the Commissioner designated by the Chairman of the Commission if the Commissioner who authored the decision is no longer a member of the Commission.

History Note: *Authority G.S. 143-292; 143-296; 143-300;*
Eff. January 1, 1989;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0404 Eff. June 1, 2018.

SECTION .0500 – RULES OF THE COMMISSION

11 NCAC 23B .0501 WAIVER OF RULES

In the interests of justice or to promote judicial economy, the Commission may, except as otherwise provided by the rules in this Subchapter, waive or vary the requirements or provisions of any of the rules in this Subchapter in a case pending before the Commission upon request of a party or upon its own initiative only if the plaintiff is not represented by counsel. Factors the Commission shall use in determining whether to grant the waiver are:

(1) the necessity of a waiver;
(2) the party's responsibility for the conditions creating the need for a waiver;
(3) the party's prior requests for a waiver;
(4) the precedential value of such a waiver;
(5) notice to and opposition by the opposing parties; and
(6) the harm to the party if the waiver is not granted.

History Note: *Authority G.S. 143-291; 143-300;*
Eff. January 1, 1989;
Amended Eff. July 1, 2014; May 1, 2000;
Recodified from 04 NCAC 10B .0501 Eff. June 1, 2018;
Amended Eff. March 1, 2019.

11 NCAC 23B .0502 RULEMAKING

History Note: *Authority G.S. 143-300;*
Eff. January 1, 1989;
Repealed Eff. July 1, 2014;
Recodified from 04 NCAC 10B .0502 Eff. June 1, 2018.

11 NCAC 23B .0503 SANCTIONS

The Commission may, on its own initiative or motion of a party, impose a sanction against a party, or attorney, or both, when the Commission determines that such party, or attorney, or both failed to comply with the Rules in this Subchapter, an Order of the Commission, the North Carolina Rules of Civil Procedure, and North Carolina Rules of Professional Conduct, or other applicable law.

History Note: *Authority G.S. 1A-1, Rule 11 and Rule 37; 143-291; 143-296; 143-300;*
Eff. January 1, 2011;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10B .0503 Eff. June 1, 2018;
Amended Eff. March 21, 2019.

SUBCHAPTER 23C - NORTH CAROLINA INDUSTRIAL COMMISSION RULES FOR UTILIZATION OF REHABILITATION PROFESSIONALS IN WORKERS' COMPENSATION CLAIMS

SECTION .0100 – ADMINISTRATION

11 NCAC 23C .0101 APPLICABILTY OF THE RULES

(a) The rules in this Subchapter apply to:

(1) cases in which the employer is obligated to provide medical compensation, and the injured worker is obligated to accept medical compensation under the Workers' Compensation Act, or in which such compensation is provided by agreement, and during any period when the employer is paying temporary total disability benefits without prejudice in accordance with G.S. 97-18(d); and

(2) any rehabilitation professional as defined in Item (1) of Rule .0103 of this Subchapter, who is assigned under the Workers' Compensation Act and approved by the Commission pursuant to Rule .0105 of this Subchapter.

(b) Any rehabilitation professional who is not assigned under the Workers' Compensation Act and approved by the Commission pursuant to Rule .0105 of this Subchapter must disclose his or her role to the health care provider at the time of the initial contact and any other person from whom the non-approved rehabilitation professional seeks information about the case.

History Note: *Authority G.S. 97-18(d); 97-25.4; 97-25.5; 97-32.2; 97-80;*
Eff. January 1, 1996;
Recodified from 04 NCAC 10C .0103, Eff. April 17, 2000;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10C .0101 Eff. June 1, 2018.

11 NCAC 23C .0102 PURPOSE OF THE RULES

History Note: *Authority G.S. 97-25.4;*
Eff. January 1, 1996;
Repealed Eff. November 1, 2014;
Recodified from 04 NCAC 10C .0102 Eff. June 1, 2018.

11 NCAC 23C .0103 DEFINITIONS

As used in this Subchapter:

(1) "Rehabilitation professional" means a medical case manager, a coordinator of medical rehabilitation services, or a vocational rehabilitation professional providing vocational rehabilitation services, including state, private, or carrier based, whether on site, telephonic, or in or out of state. Physical therapists, occupational therapists, speech therapists, and other direct care providers are not rehabilitation professionals under the Rules in this Subchapter.

(2) "Medical rehabilitation" means the planning and coordination of health care services by a medical case manager or coordinator, with the goal of assisting an injured worker to be restored as nearly as possible to the worker's pre-injury level of physical function. Medical case management includes:

(a) case assessment;

(b) development, implementation and coordination of a care plan with health care providers, the worker, and his or her family;

(c) evaluation of treatment results;

(d) planning for community re-entry and return to work; and

(e) referral for further vocational rehabilitation services.

(3) "Vocational rehabilitation" means the delivery and coordination of services under an individualized written plan, with the goal of assisting the injured worker to return to suitable employment or participate in education or retraining, as defined by Item (5) of this Rule or applicable statute.

(4) "Return to work" means placement of the injured worker into suitable employment, as defined by Item (5) of this Rule or applicable statute.

(5) For claims arising before June 24, 2011, "suitable employment" means employment in the labor market or self-employment that is reasonably attainable and that offers an opportunity to restore the worker as soon as possible and as nearly as practicable to pre-injury wage, while giving due consideration to the worker's qualifications (age, education, work experience, physical and mental capacities), impairment, vocational interests, and aptitudes. No one factor shall be considered solely in determining suitable employment. For claims arising on or after June 24, 2011, the statutory definition of "suitable employment," G.S. 97-2(22), applies.

(6) "Conditional rehabilitation professional" means a rehabilitation professional who has not met the requirements for qualified rehabilitation professionals under of Rule .0105(d) of this Subchapter and who desires to provide services as a rehabilitation professional in cases subject to the rules in this Subchapter.

History Note: *Authority G.S. 97-2(22); 97-25.4; 97-25.5; 97-32.2; 97-80;*
Eff. January 1, 1996;
Recodified from 04 NCAC 10C .0101 Eff. April 17, 2000;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10C .0103 Eff. June 1, 2018.

11 NCAC 23C .0104 GOALS OF REHABILITATION

History Note: *Authority G.S. 97-25.4;*
Eff. January 1, 1996;
Repealed Eff. June 1, 2000;
Recodified from 04 NCAC 10C .0104 Eff. June 1, 2018.

11 NCAC 23C .0105 QUALIFICATIONS REQUIRED

(a) Rehabilitation professionals in cases subject to the rules in this Subchapter shall follow the Code of Ethics specific to their certification as well as any statutes specific to their occupation.

(b) 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.

(c) To provide medical rehabilitation services and vocational rehabilitation services in cases subject to the Rules in this Subchapter, rehabilitation professionals must either be a qualified rehabilitation professional or a conditional rehabilitation professional as set forth in this Rule.

(d) To qualify as a qualified rehabilitation professional, a rehabilitation professional must:

(1) possess one of the following certifications:

(A) Certified Rehabilitation Counselor (CRC), as certified by the Commission on Rehabilitation Counselor Certification;

(B) Certified Registered Rehabilitation Nurse (CRRN), as certified by the Rehabilitation Nursing Certification Board;

(C) Certified Disability Management Specialist (CDMS), as certified by the Certification of Disability Management Specialists Commission;

(D) Certified Vocational Evaluator (CVE), as certified by the Commission on Rehabilitation Counselor Certification;

(E) Certified Occupational Health Nurse-Specialist (COHN-S), as certified by the American Board of Occupational Health Nurses;

(F) Certified Occupational Health Nurse (COHN), as certified by the American Board of Occupational Health Nurses;

(G) Orthopaedic Nurse Certified (ONC), as certified by the Orthopaedic Nurses Certification Board; or

(H) Certified Case Manager (CCM), as certified by the Commission for Case Manager Certification; or

(2) have prior employment within the North Carolina Department of Health and Human Services as a vocational rehabilitation provider.

(e) A qualified rehabilitation professional must also:

(1) possess two years of full-time work experience, or its equivalent, in workers' compensation case management, where at least 30 percent of the rehabilitation professional's time was spent managing medical or vocational rehabilitation services to persons with disabling conditions or diseases within the past 15 years; and

(2) complete the comprehensive course entitled, "*Workers' Compensation Case Management in NC: A Basic Primer for Medical and Vocational Case Managers*," provided by the Commission or the International Association of Rehabilitation Professionals of the Carolinas.

(f) To maintain "qualified" status, a rehabilitation professional shall attend a two-hour refresher course every five years, beginning with the date of the original course completion. Rehabilitation professionals who completed the course in its pilot phase prior to March 17, 2011 have until July 1, 2016 to meet the refresher program mandate.

(g) Effective July 1, 2013, any rehabilitation professional on the Commission's Registry of Workers' Compensation Rehabilitation Professionals who does not hold a certificate of completion for the mandated course shall lose "qualified" rehabilitation professional status and may work as a conditional rehabilitation professional under supervision of a qualified rehabilitation professional for no longer than six months before completing the required course.

(h) After July 1, 2013, any rehabilitation professional who begins providing rehabilitation services in cases subject to the Rules in this Subchapter shall have six months to obtain a certificate of completion of the mandated course.

(i) The Commission shall oversee the implementation and ongoing administration of the mandated course and training.

(j) Conditional rehabilitation professionals permitted to provide services in cases subject to the rules in this Subchapter include:

(1) individuals who possess one of the certifications for qualified rehabilitation professionals listed in Subparagraph (d) and (e) of this Rule, but who do not possess the workers' compensation case management experience required by the rules in this Subchapter;

(2) individuals with a post-baccalaureate degree in a health-related field from an institution accredited by an agency recognized by the United States Department of Education and one year of experience providing rehabilitation services to persons with disabling conditions or diseases;

(3) individuals with a baccalaureate degree in a health-related field from an institution accredited by an agency recognized by the United States Department of Education and two years of experience providing rehabilitation services to individuals with disabling conditions or diseases; and

(4) individuals with current North Carolina licensure as a registered nurse and three years of experience in clinical nursing providing care for adults with disabling conditions and diseases.

(k) To provide services as a rehabilitation professional in cases subject to the rules in this Subchapter, a conditional rehabilitation professional must work under the direct supervision of a qualified rehabilitation professional, who shall ensure that the conditional rehabilitation professional's work meets the requirements of the rules in this Subchapter and any applicable statute, and whose name, address and telephone number shall be on all documents identifying the conditional rehabilitation professional.

(l) As used in this Rule, direct supervision includes regular case review between the conditional rehabilitation professional and the qualified rehabilitation professional supervisor, review by the qualified rehabilitation professional supervisor of all reports, and periodic meetings that occur at least on a quarterly basis.

(m) A rehabilitation professional may maintain conditional rehabilitation professional status for a period of two years only. To continue providing services as a rehabilitation professional in cases subject to the rules in this Subchapter beyond the two year period, the conditional rehabilitation professional must obtain the qualifications for a qualified rehabilitation professional listed under Paragraph (d) of this Rule.

(n) Rehabilitation professionals shall, upon request, provide a resume of their qualifications and credentials during initial meetings with parties and health care providers.

History Note: *Authority G.S. 97-25.4; 97-32.2; 97-25.5; 97-80;*
Eff. January 1, 1996;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10C .0105 Eff. June 1, 2018.

11 NCAC 23C .0106 PROFESSIONAL RESPONSIBILITY OF THE REHABILITATION PROFESSIONAL IN WORKERS' COMPENSATION CLAIMS

(a) A rehabilitation professional shall exercise independent professional judgment in making and documenting recommendations for medical and vocational rehabilitation for an injured worker, including any alternatives for medical treatment and cost-effective return-to-work options. It is not the role of the rehabilitation professional to direct medical care.

(b) A rehabilitation professional shall inform the parties of his or her assignment and role in the case. Upon assignment, a rehabilitation professional shall disclose to health care providers and the parties any possible conflict of interest, including any compensation and the carrier's or employer's ownership of or affiliation with the rehabilitation professional.

(c) Subject to the provisions for medical care and treatment set forth in the Workers' Compensation Act, the medical rehabilitation professional may explain medical information to the worker and shall discuss with the worker all treatment options appropriate to the worker's conditions, but shall not advocate any one source for treatment or change in treatment.

(d) As case consultants or expert witnesses, rehabilitation professionals shall provide unbiased, objective opinions. The limits of their relationships shall be defined through written or oral means in accordance with the following, applicable professional codes of ethics or professional conduct, which are hereby incorporated by reference, including subsequent amendments and editions:

(1) for Certified Rehabilitation Counselors and Certified Vocational Evaluators, the Commission on Rehabilitation Counselor Certification Code of Professional Ethics;

(2) for Certified Registered Rehabilitation Nurses and Orthopaedic Nurse Certifieds, the Code of Ethics for Nurses;

(3) for Certified Disability Management Specialists, the Certification of Disability Management Specialists Commission Code of Professional Conduct;

(4) for Certified Occupational Health Nurses and Certified Occupational Health Nurse-Specialists, the American Association of Occupational Health Nurses, Inc. Code of Ethics; and

(5) for Certified Case Managers, the Code of Professional Conduct for Case Managers.

(e) Copies of the codes of ethics or professional conduct listed in Subparagraphs (d)(1) through (d)(5) of this Rule may be obtained at no cost, either 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., or at one of the following applicable websites:

(1) for Certified Rehabilitation Counselors and Certified Vocational Evaluators, the Commission on Rehabilitation Counselor Certification Code of Professional Ethics), http://www.crccertification.com/filebin/pdf/CRCCodeOfEthics.pdf;

(2) for Certified Registered Rehabilitation Nurses and Orthopaedic Nurse Certifieds, the Code of Ethics for Nurses, http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.pdf;

(3) for Certified Disability Management Specialists, the Certification of Disability Management Specialists Commission Code of Professional Conduct, http://new.cdms.org/docs/CDMS%20Code%20of%20Professional%20Conduct%2008012011.pdf;

(4) for Certified Occupational Health Nurses and Certified Occupational Health Nurse-Specialists, the American Association of Occupational Health Nurses, Inc. Code of Ethics,https://www.aaohn.org/dmdocuments/Code_of_Ethics_2009.pdf; and

(5) for Certified Case Managers, the Code of Professional Conduct for Case Managers http://www.ccmcertification.org/sites/default/files/downloads/2012/CCMC_Code_of_Conduct%202-22-12.pdf.

(f) Rehabilitation professionals shall practice only within the boundaries of their competence, based on their education, training, professional experience, and other professional credentials.

(g) A rehabilitation professional shall not conduct or assist any party in claims negotiation or investigative activities.

(h) A rehabilitation professional shall not advise the worker as to any legal matter including claims settlement options or procedures, monetary evaluation of claims, or the applicability to the worker of benefits of any kind under the Workers' Compensation Act during his or her assignment in the case. The rehabilitation professional shall advise the non-represented worker to direct such questions to the Information Specialists at the Commission, and the represented worker to direct questions to his or her attorney.

(i) Rehabilitation professionals shall not accept any compensation or reward from any source as a result of settlement.

History Note: *Authority G.S. 97-25.4; 97-25.5; 97-32.2; 97-80;*
Eff. January 1, 1996;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10C .0106 Eff. June 1, 2018.

11 NCAC 23C .0107 COMMUNICATION

(a) The insurance carrier shall notify the Commission and all parties on a Form 25N Notice to the Commission of Assignment of Rehabilitation Professional when a rehabilitation professional is assigned to a case and identify the purpose of the rehabilitation involvement.

(b) At the initial meeting, the rehabilitation professional shall provide the injured worker with a copy of the Rules in this Subchapter, and shall inform the injured worker that the rehabilitation professional is required to share relevant medical and vocational rehabilitation information with the employer and insurance carrier and that the rehabilitation professional may be compelled to testify regarding any information obtained.

(c) The rehabilitation professional shall timely inform injured workers that the Rehabilitation Professional will share relevant and material information with the employer and insurance carrier and that the Rehabilitation Professional may be compelled to testify regarding any information obtained.

(d) In cases where the employer is paying medical compensation to a provider rendering treatment under the Workers' Compensation Act, the injured worker, if requested by a rehabilitation professional, shall sign a Form 25C Authorization for Rehabilitation Professional to Obtain Medical Records of Current Treatment authorizing the rehabilitation professional to obtain records of the current treatment.

(e) The rehabilitation professional shall provide copies of all correspondence and reports contemporaneously to all parties by the same mode of transmission.

(f) In preparing written and oral reports, the rehabilitation professional shall present only information relevant and material to the worker's medical rehabilitation and vocational rehabilitation and shall make every effort to avoid invasion of the worker's privacy.

(g) The rehabilitation professional shall make periodic written reports documenting accurately and completely the substance of all activity in the case, including rehabilitation activity. The rehabilitation professional shall furnish a worker who is unrepresented by counsel with a copy of each periodic report, or, in the alternative, the rehabilitation professional shall advise the worker either orally or in writing (at least as often as reports are produced) as to the plan for and progress of the case, and that the worker has the right to request a copy of the reports under 11 NCAC 23A .0607.

(h) Frequency and timing of periodic reports shall be determined at the time of referral and shall depend on the type of service provided. Communication of activity to all parties by telephone, facsimile, electronic media, or letter must occur when information relevant to the rehabilitation process is obtained, changes or revisions are recommended or occur in medical or vocational treatment plans, or on any other occasion when the worker's understanding and cooperation is critical to the implementation of the rehabilitation plan.

(i) If requested by the injured worker or his or her attorney, the initial meeting of the injured worker and rehabilitation professional shall take place at the office of the worker's attorney and shall occur within 20 days of the request.

(j) The rehabilitation professional may coordinate activities with the injured worker's attorney, and, at the employer or carrier's discretion, with the defense attorney.

(k) If the rehabilitation professional believes the injured worker is not complying with the provision of rehabilitation services, the rehabilitation professional shall detail in writing the actions that the rehabilitation professional believes the injured worker is required to take to return to compliance. In determining whether the injured worker is in compliance with the provision of rehabilitation services, the rehabilitation professional shall rely on his or her independent professional judgment and training and shall focus on the overall effect that the worker's actions or inactions are having on the rehabilitation goals.

History Note: *Authority G.S. 97-25.4; 97-25.5; 97-32.2; 97-2(19); 97-80;*
Eff. January 1, 1996;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10C .0107 Eff. June 1, 2018;
Amended Eff. November 1, 2022.

11 NCAC 23C .0108 INTERACTION WITH PHYSICIANS

(a) At the initial visit with a physician the rehabilitation professional shall provide identification in the form of a company identification or business card and explain the rehabilitation professional's role in the case.

(b) In all cases, the rehabilitation professional shall advise the worker that the worker has the right to a private examination by the health care provider outside of the presence of the rehabilitation professional. If the worker prefers, he or she may request that the rehabilitation professional accompany him or her during the examination. However, if the worker or the worker's attorney notifies the rehabilitation professional in writing that the worker desires a private examination, no subsequent waiver of that right shall be effective unless the waiver is made in writing by the worker or, if represented, by the worker's attorney.

(c) If the rehabilitation professional needs to have an in-person conference with the physician following an examination, the rehabilitation professional shall reserve with the physician sufficient appointment time for the conference. The worker shall be offered the opportunity to attend the conference with the physician. If the worker or the physician does not consent to a joint conference, or if in the physician's opinion it is medically contraindicated for the worker to participate in the conference, the rehabilitation professional shall note this in his or her report, may communicate directly with the physician, and shall report the substance of the communication.

(d) When the rehabilitation professional determines that it is necessary to communicate with a physician other than at a joint meeting, the rehabilitation professional shall first notify the injured worker, or his or her attorney if represented, of the rehabilitation professional's intent to communicate and the reasons therefore. The rehabilitation professional is not required to obtain the injured worker's or his or her attorney's prior consent if:

(1) The communication is limited to scheduling issues or requests for time-sensitive medical records;
(2) A medical emergency is involved;
(3) The injured worker's health or medical treatment would either be adversely affected by a delay or benefited by immediate action;
(4) The communication is limited to advising the physician of the employer or carrier approval for recommended testing or treatment;
(5) The injured worker or attorney has consented to the communications;
(6) The communication is initiated by the physician; or
(7) The injured worker failed to show up for a scheduled appointment or arrived at a time other than the scheduled appointment time.

When a rehabilitation professional communicates with a physician without the prior consent or presence of the injured worker, the rehabilitation professional must document the reasons for and the substance of the communication and report the reasons and substance to the injured worker or his or her attorney, if represented, pursuant to Rule .0106 of this Subchapter.

(e) The following requirements apply to interactions regarding impairment ratings, independent medical examinations, second opinions or consults:

(1) When a party or health care provider requests a consult, second opinion, or independent medical examination that is authorized or ordered, the rehabilitation professional may, if requested, assemble and forward medical records and information, schedule and coordinate an appointment, and, if the worker consents, have a joint meeting with the health care provider and the worker after a private exam.
(2) When any such exam is requested by the carrier, the worker shall receive at least 10 calendar days' notice of the appointment unless the parties agree otherwise or unless otherwise required by statute.

(f) The rehabilitation professional shall simultaneously send to the parties copies of all written communications with health care providers and shall accurately and completely record and report all oral communications.

History Note: *Authority G.S. 97-25.4; 97-25.5; 97-32.2; 97-80;*
Eff. January 1, 1996;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10C .0108 Eff. June 1, 2018.

11 NCAC 23C .0109 VOCATIONAL REHABILITATION SERVICES AND RETURN TO WORK

(a) When performing the vocational assessment and formulating and drafting the individualized written rehabilitation plan for the employee required by G.S. 97-32.2(c), the vocational rehabilitation professional shall follow G.S. 97-32.2.

(b) Job placement activities may not be commenced until after a vocational assessment and an individualized written rehabilitation plan for vocational rehabilitation services specifying the goals and the priority for return-to-work options have been completed in the case in accordance with G.S. 97-32.2. Job placement activities shall be directed as defined by Rule .0103(5) of this Subchapter or by applicable statute.

(c) Return-to-work options should be considered in the following order of priority:

(1) current job, current employer;
(2) new job, current employer;
(3) on-the-job training, current employer;
(4) new job, new employer;
(5) on-the-job training, new employer;
(6) formal education or vocational training to prepare the worker for a job with current or new employer; and
(7) self-employment, only when its feasibility is documented with reference to the employee's aptitudes and training, adequate capitalization, and market conditions.

(d) When an employee requests retraining or education as permitted in G.S. 97-32.2(a), the vocational rehabilitation professional shall provide a written assessment of the employee's request that includes an evaluation of:

(1) the retraining or education requested;
(2) the availability, location, cost, and identity of providers of the requested retraining or education;
(3) the likely duration until completion of the requested retraining or education, the number of credits needed to complete the retraining or education, the course names and schedules for the retraining or education, and identification of which courses are available on-line versus in person;
(4) the current or projected availability of employment upon completion of the requested retraining or education; and
(5) the anticipated pay range for employment upon completion of the requested retraining or education.

(e) The rehabilitation professional shall obtain a list of work restrictions from the health care provider that addresses the demands of any proposed employment. If ordered by a physician, the rehabilitation professional shall schedule an appointment with a third party provider to evaluate an injured employee's functional capacity, physical capacity, or impairments to work.

(f) The rehabilitation professional shall refer the worker only to opportunities for suitable employment, as defined by Rule .0103(5) of this Subchapter or by applicable statute.

(g) If the rehabilitation professional intends to utilize written or videotaped job descriptions in the return-to-work process, the rehabilitation professional shall provide a copy of the description to all parties for review before the job description is provided to the doctor. The employee or the employee's attorney shall have seven business days from the mailing of the job description to notify the rehabilitation professional, 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. This process shall be expedited when job availability is critical. This waiting period does not apply if the employee or the employee's attorney has given prior approval to the job description.

(h) In preparing written job descriptions, the rehabilitation professional shall utilize standards including, but not limited to, the Dictionary of Occupational Titles and the Handbook for Analyzing Jobs published by the United States Department of Labor. These standards can be accessed at no cost at https://www.dol.gov/agencies/oalj/topics/libraries/LIBDOT and https://skilltran.com/index.php/support-area/documentation/1991rhaj, respectively. The Handbook for Analyzing Jobs may also be purchased from major online booksellers for approximately eighty-five dollars ($85.00).

(i) The rehabilitation professional may conduct follow-up after job placement to verify the appropriateness of the job placement.

(j) The rehabilitation professional shall not initiate or continue placement activities that do not appear reasonably likely to result in placement of the injured worker in suitable employment. The rehabilitation professional shall report to the parties when efforts to initiate or continue placement activities do not appear reasonably likely to result in placement of the injured worker in suitable employment.

History Note: *Authority G.S. 97-2(22); 97-25.5; 97-32.2; S.L. 2014-77, s. 6(4);*
Eff. January 1, 1996;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10C .0109 Eff. June 1, 2018;
Amended Eff. April 1, 2023.

11 NCAC 23C .0110 CHANGE OF REHABILITATION PROFESSIONAL

(a) By agreement or stipulation of the parties, the rehabilitation professional may be changed.

(b) A rehabilitation professional may be removed from a case upon motion by either party or by the Commission for good cause. The motion shall be filed with the Executive Secretary's Office and served upon all parties and the rehabilitation professional. Any party or the rehabilitation professional may file a response to the motion within 10 days.

(c) A party or the rehabilitation professional may request reconsideration of a ruling or appeal from an order as provided in 11 NCAC 23A .0702 or pursuant to G.S. 97-83 and G.S. 97-84.

History Note: *Authority G.S. 97-25.4; 97-25.5; 97-32.2; 97-80; 97-83; 97-84;*
Eff. January 1, 1996;
Amended Eff. November 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10C .0110 Eff. June 1, 2018.

SECTION .0200 – RULES OF THE COMMISSION

11 NCAC 23C .0201 WAIVER OF RULES

In the interests of justice or to promote judicial economy the Commission may, except as otherwise provided by the rules in this Subchapter, waive or vary the requirements or provisions of any of the rules in this Subchapter in a case pending before the Commission upon written application of a party or upon its own initiative only if the employee is not represented by counsel. Factors the Commission shall use in determining whether to grant the waiver are:

(1) the necessity of a waiver;
(2) the party's responsibility for the conditions creating the need for a waiver;
(3) the party's prior requests for a waiver;
(4) the precedential value of such a waiver;
(5) notice to and opposition by the opposing parties; and
(6) the harm to the party if the waiver is not granted.

History Note: *Authority G.S. 97-25.4; 97-80;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10C .0201 Eff. June 1, 2018.

SUBCHAPTER 23D – WORKERS' COMPENSATION RULES FOR MANAGED CARE ORGANIZATIONS

SECTION .0100 – RULES

11 NCAC 23D .0101 PURPOSE

The rules in this Subchapter are intended to facilitate the timely and cost-effective delivery of appropriate medical compensation services to fulfill the employer's duty to provide such services as are reasonably necessary to effect a cure, give relief, or shorten the period of disability resulting from compensable injuries through the use of Managed Care Organizations (MCOs). The rules in this Subchapter do not affect informal lists or "employer networks" of providers assembled by employers or insurers for their own referrals.

History Note: *Authority G.S. 97-2(19); 97-2(20); 97-2(21); 97-25; 97-25.2; 97-25.3(e); 97-25.4(a); 97-26(b); 97-26(c);*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10D .0101 Eff. June 1, 2018.

11 NCAC 23D .0102 DEFINITIONS

As used in this Subchapter:

(1) "Employer" means an employer as defined by G.S. 97-2(3) who is obligated by the Workers' Compensation Act to pay or provide indemnity or medical compensation, including any insurance carrier, self-insurance fund, third party administrator or other person, firm or corporation undertaking to pay or adjust claims on behalf of the employer's employees.

(2) "Act" means the North Carolina Workers' Compensation Act, Chapter 97, Article 1 (G.S. 97-1 through G.S. 97-101.1).

(3) "Employer network" means any group of providers assembled by or for an entity liable for medical compensation that agrees to accept the referrals of that entity's workers' compensation patients, and from among whom an adjuster, officer, employee, or insured patient of the entity chooses the initial provider; provided, the entity has no right to sell the services of the providers to a third party.

History Note: *Authority G.S. 58-50-50; 97-2(3); 97-2(20); 97-2(21); 97-25; 97-25.2; 97-26(b); 97-26(c); 97-77; 97-79;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10D .0102 Eff. June 1, 2018.

11 NCAC 23D .0103 QUALIFICATION BY DEPARTMENT OF INSURANCE

History Note: *Authority G.S. 97-2(21); 97-25;*
Eff. January 1, 1996;
Repealed Eff. July 1, 2014;
Recodified from 04 NCAC 10D .0103 Eff. June 1, 2018.

11 NCAC 23D .0104 QUALIFICATION AND REVOCATION

For ineffective delivery of medical services, failure to comply with applicable laws, rules or regulations, and failure to respond to lawful orders of the Commission or other regulatory authorities, the Commission shall change the provider of medical compensation in accordance with the Workers' Compensation Act.

History Note: *Authority G.S. 97-25; 97-25.2;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10D .0104 Eff. June 1, 2018.

11 NCAC 23D .0105 NOTICE TO COMMISSION

(a) Upon contracting with an employer to provide medical compensation services, an MCO shall provide to the Commission the following:

(1) a copy of that portion of the contract containing the provisions specified in Rule .0106 of this Subchapter and the method for determining payment to the MCO, excluding those of its terms kept confidential by the North Carolina Department of Insurance, initialed by the employer;

(2) a copy of its current certificate(s) issued annually by the North Carolina Department of Insurance pursuant to G.S. Chapter 58; and

(3) the name and address of all owners or shareholders, or related groups of owners or shareholders, holding more than 10 percent interest in the MCO, and whether they are or have any relationship with a provider.

(b) Persons or firms are related, for the purpose of this Rule, if either has the following:

(1) a financial interest in the other;

(2) shares officers, agents, or employees; or,

(3) if natural persons, are first cousins or closer in kinship.

(c) An MCO subject to the Rules in this Subchapter shall report its medical compensation expenditures annually on I.C. Form 51.

History Note: *Authority G.S. 97-25.2;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;

Recodified from 04 NCAC 10D .0105 Eff. June 1, 2018.

11 NCAC 23D .0106 CONTRACT PROVISIONS

An MCO's contract with an employer subject to the Rules in this Subchapter shall include:

(1) the principal place(s) of employment of the covered employees, including address(es) and phone number(s) of the workplace(s);

(2) the name, title, mailing address, phone number, fax number, and email address, if any, of an officer or responsible employee of the MCO empowered to assent to the treatment or referral of covered employees, capable of obtaining and providing complete business, administrative and medical records generated pursuant to the contract, and empowered to resolve routine disputes with employees, employers and providers under the Commission's jurisdiction;

(3) the name, title, mailing address, phone number, fax number, and email address, if any, of an adjuster, officer, agent or employee of the employer empowered to negotiate the resolution of routine medical compensation disputes, and receive orders of the Commission on behalf of the employer;

(4) an acknowledgment that the MCO is bound by applicable requirements of Chapters 58 and 97 of the North Carolina General Statutes and the rules in this Subchapter, and is subject to orders of the Commission to the same extent as the employer;

(5) the agreement of the employer that it will cooperate and assist in furnishing its employees and supervisors with a phone number and instructions for obtaining emergency treatment and contacting the MCO upon injury to any employee during the workday or on the employer's premises requiring physician attention;

(6) a dispute resolution plan in accordance with G.S. 97-25.2, including provisions for notice of decision in appeals within 30 days, or within 72 hours of appeal when the regular appeals process would cause a delay in the rendering of health care that would be detrimental to the health of the employee;

(7) a description of physician panels, including specialties represented, and the employee's right to select his or her attending physician from the appropriate panel, and to subsequently change attending physicians once within the members of the panel; and

(8) whether the MCO or employer will be responsible for securing the services of "out of network" providers when needed.

History Note: *Authority G.S. 97-25.2;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10D .0106 Eff. June 1, 2018.

11 NCAC 23D .0107 INFORMATION FOR EMPLOYEE

(a) Following the onset of an injury, the employer or MCO shall provide to the employee a printed explanation of the system being utilized for his care, suitable for sharing with emergency, "out-of-network", and referral physicians, that shall be filed with any Form 19 submitted to the Commission; provided, that electronic filers may otherwise notify the Commission of the identity of the MCO. This statement shall include the following information:

(1) the offices to contact concerning medical treatment for the injury, including a telephone number;

(2) if known at that time, the employee's chosen treating physician, including a phone number for seeking medical assistance outside normal business hours if the injury might cause such a need;

(3) the applicable methods for choosing and changing treating physicians and resolving disputes concerning physicians or treatment pursuant to G.S. 97-25.2;

(4) that the MCO can provide access to licensed physicians of all specialties;

(5) the employer's obligation to pay for treatment for which the employee is referred to the MCO, whether or not the employer admits liability for the injury per G.S. 97-90(e);

(6) the employee's duty to cooperate in treatment, and right to secure treatment at his or her own expense that does not interfere with the treating physician's treatment; and

(7) the Commission's File Number, if known when filed.

(b) Providers may include identifying billing information on the statement.

History Note: *Authority G.S. 97-25.2;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10D .0107 Eff. June 1, 2018.

11 NCAC 23D .0108 INCLUSIVE PROVIDER PANELS

Following the onset of an injury, and upon an employee's first request to change attending physician, the MCO shall provide the employee with a list of reasonably accessible and available panel physicians qualified to treat or manage the primary condition for which the employer has accepted liability or authorized treatment from which the employee may select the attending physician. The employer and MCO shall provide for access to all medical compensation services, and include in its panels, or otherwise make available for the employee's choice, one or more licensed physicians representing all specialties available in the community to provide necessary treatment for the employee's primary compensable condition.

History Note: *Authority G.S. 97-2(19); 97-2(20); 97-25; 97-25.2;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10D .0108 Eff. June 1, 2018.

11 NCAC 23D .0109 QUALITY ASSURANCE AND UTILIZATION REVIEW

An MCO subject to the Rules in this Subchapter shall comply with the requirements of the North Carolina Department of Insurance for quality assurance and utilization review plans, and upon request, provide the Commission with copies of records generated by, or utilized in, the operation of those programs, and copies of plans or amendments to plans not yet filed with the Department of Insurance.

History Note: *Authority G.S. 97-25.2;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10D .0109 Eff. June 1, 2018.

11 NCAC 23D .0110 WAIVER OF RULES

In the interests of justice or to promote judicial economy, the Commission may, except as otherwise provided by the rules in this Subchapter, waive or vary the requirements or provisions of any of the rules in this Subchapter in a case pending before the Commission upon written application of a party or upon its own initiative only if the employee is not represented by counsel. Factors the Commission shall use in determining whether to grant the waiver are:

(1) the necessity of a waiver;
(2) the party's responsibility for the conditions creating the need for a waiver;
(3) the party's prior requests for a waiver;
(4) the precedential value of such a waiver;
(5) notice to and opposition by the opposing parties; and
(6) the harm to the party if the waiver is not granted.

History Note: *Authority G.S. 97-25.2; 97-80(a);*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10D .0110 Eff. June 1, 2018.

SUBCHAPTER 23E – ADMINISTRATIVE RULES OF THE INDUSTRIAL COMMISSION

SECTION .0100 – ADMINISTRATION

11 NCAC 23E .0101 INSTRUCTIONS FOR FILING A PETITION FOR RULE-MAKING

(a) Any person may petition the Commission to adopt a new rule, or amend or repeal an existing rule by submitting a rule-making petition to the Commission at 1240 Mail Service Center, Raleigh, NC 27699-1240. The petition must be titled "Petition for Rule-making" and must include the following information:

(1) the name and address of the person submitting the petition;
(2) a citation to any rule for which an amendment or repeal is requested;
(3) a draft of any proposed rule or amended rule;
(4) an explanation of why the new rule or amendment or repeal of an existing rule is requested and the effect of the new rule, amendment, or repeal on the procedures of the Commission; and
(5) any other information the person submitting the petition considers relevant.

(b) The Commission must decide whether to grant or deny a petition for rule-making within 120 days of receiving the petition. In making the decision, the Commission shall consider the information submitted with the petition and any other relevant information.

(c) When the Commission denies a petition for rule-making, a written notice of the denial must be sent to the person who submitted the request. The notice must state the reason for the denial. When the Commission grants a rule-making petition, the Commission must initiate rule-making proceedings and send written notice of the proceedings to the person who submitted the request.

History Note: *Authority G.S. 97-73; 150B-20;*
Eff. January 1, 1996;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10E .0101 Eff. June 1, 2018;
Amended Eff. April 1, 2020.

11 NCAC 23E .0102 MAILING LIST

(a) Any person or agency desiring to be placed on the mailing list for the Commission's rule-making notices issued pursuant to G.S. 150B-21.2 may file a request in writing to the Chairperson of the Commission at 1240 Mail Service Center Raleigh, NC 27699-1240.

(b) The request shall:

(1) include the person's name and address;
(2) specify the subject areas within the authority of the Commission for which notice is requested; and
(3) state the calendar year(s) for which the notice is desired.

History Note: *Authority G.S. 97-73; 97-80(a); 150B-21.2(d);*
Eff. July 1, 2014;
Recodified from 04 NCAC 10E .0102 Eff. June 1, 2018;
Amended Eff. April 1, 2020.

11 NCAC 23E .0103 ADMISSION OF OUT-OF-STATE ATTORNEYS TO APPEAR BEFORE THE COMMISSION

(a) Attorneys residing in and licensed to practice law in another state who seek to be admitted to practice before the Commission to represent a client in a claim pursuant to G.S. 84-4.1 shall file a motion with the Commission that complies with the requirements of G.S. 84-4.1. The North Carolina attorney with whom the out-of-state attorney associates pursuant to G.S. 84-4.1(5) may file the motion instead as long as it complies with the requirements of G.S. 84-4.1.

(b) The motion shall be filed with the Executive Secretary of the Commission except under the following circumstances:

(1) If the motion is filed in a claim that is set for hearing before or pending decision by a Deputy Commissioner or the Full Commission, the motion shall be filed with the Deputy Commissioner or chair of the Full Commission panel, respectively.
(2) If the motion is filed in a claim involving a form application regarding a death claim, the motion shall be filed with the Director of Claims Administration.
(3) If the motion is filed in a claim involving a stipulated Opinion and Award regarding a death claim, the motion shall be filed with the Chief Deputy Commissioner.

(c) A proposed Order granting *pro hac vice* admission that includes the facsimile numbers for all counsel of record shall be provided with the motion.

(d) Following review of the motion, the Commission shall issue an Order granting or denying the motion. The Commission has the discretionary authority to deny such motions even if they comply with the requirements of G.S. 84-4.1.
(e) Upon receipt of an Order granting a motion for *pro hac vice* admission, the admitted attorney or the associated North Carolina attorney shall pay the fees to the North Carolina State Bar and General Court of Justice required by G.S. 84-4.1 and file a statement with the Executive Secretary documenting payment of said fees and the submission of any *pro hac vice* admission registration statement required by the North Carolina State Bar.

History Note: *Authority G.S. 84-4.1; 97-80(a);*
Eff. July 1, 2014;
Recodified from 04 NCAC 10E .0103 Eff. June 1, 2018.

11 NCAC 23E .0104 SECURE LEAVE PERIODS FOR ATTORNEYS
(a) Any attorney may request one or more secure leave periods each year as provided in this Rule.
(b) For the purpose of this Paragraph only, a "secure leave period" is defined as a partial calendar week or a complete calendar week. Within a calendar year, an attorney is entitled to obtain secure leave periods totaling up to 15 business days for any purpose.
(c) For the purpose of this Paragraph only, a "secure leave period" is defined as a complete calendar week. Within a 24-week period surrounding the birth or adoption of an attorney's child, that attorney is entitled to have the benefit of up to 12 additional secure leave periods.
(d) To request a secure leave period, an attorney shall file a written request, by letter or motion, containing the information required by Paragraph (e) of this Rule with the Office of the Chair within the time period provided in Paragraph (f) of this Rule. Upon such filing, the Chair shall review the request. If the request is made pursuant to Paragraph (b) or Paragraph (c) of this Rule and the request complies with Paragraphs (e) and (f) of this Rule, the Chair shall issue a letter allowing the requested secure leave period. The attorney shall not be required to appear at any trial, hearing, deposition, or other proceeding before the Commission during a secure leave period that is allowed.
(e) The request shall contain the following information:
(1) the attorney's name, mailing address, telephone number, email address, and state bar number;
(2) the date(s) for which secure leave is being requested;
(3) the dates of all other secure leave periods during the current calendar year that have previously been designated by the attorney pursuant to this Rule;
(4) a statement that the secure leave period is not being designated for the purpose of delaying, hindering, or interfering with the disposition of any matter in any pending action or proceeding;
(5) a statement that no action or proceeding in which the attorney has entered an appearance has been scheduled, tentatively set, or noticed for trial, hearing, deposition, or other proceeding during the designated secure leave period; and
(6) for secure leave requests that arise under Paragraph (c) of this Rule, the expected birth date or adoption date of the child.
(f) The request shall be filed:
(1) no later than 90 days before the beginning of the secure leave period; and
(2) before any trial, hearing, deposition, or other matter has been scheduled, peremptorily set, or noticed for a time during the designated secure leave period.
(g) The Chair may, as set forth in Rule .0301 of this Subchapter, make exception to the 15-day aggregate limit set forth in Paragraph (b) of this Rule, the requirement set forth in Subparagraph (e)(5) of this Rule, and the limitations set forth in Paragraph (f) of this Rule. An attorney requesting that the Chair make an exception under this Paragraph shall inform the Chair of all known actions or proceedings involving that attorney that are scheduled, tentatively set, or noticed for trial, hearing, deposition, or other proceeding during the requested secure leave period. The attorney also shall provide notice to all opposing parties or, if represented, opposing counsel of record in all cases subject to the jurisdiction of the Industrial Commission of the beginning and ending dates of the requested secure leave period and of all known actions or proceedings involving that attorney that are scheduled, tentatively set, or noticed for trial, hearing, deposition, or other proceeding during the requested secure leave period.
(h) After a secure leave period has been allowed pursuant to this Rule, if any trial, hearing, or other proceeding is scheduled or tentatively set for a time during the secure leave period, the attorney shall file with the Deputy Commissioner or Chair of the Full Commission panel before which the matter was calendared or set, and serve on

all parties, a copy of the letter allowing the secure leave period with a certificate of service attached. Upon receipt, the proceeding shall be rescheduled for a time that is not within the attorney's secure leave period.
(i) After a secure leave period has been allowed pursuant to this Rule, if any deposition is noticed for a time during the secure leave period, the attorney shall serve on the party that noticed the deposition a copy of the letter allowing the secure leave period with a certificate of service attached, and that party shall reschedule the deposition for a time that is not within the attorney's secure leave period.

History Note: *Authority G.S. 97-80(a);*
Eff. July 1, 2014;
Recodified from 04 NCAC 10E .0104 Eff. June 1, 2018;
Amended Eff. December 1, 2020.

SECTION .0200 – FEES

11 NCAC 23E .0201 DOCUMENT AND RECORD FEES

(a) The fees in this Rule apply to all subject areas within the authority of the Commission.
(b) Upon written request, to the extent permitted by Article 1 of Chapter 97, Article 31 of Chapter 143, and Chapter 132 of the North Carolina General Statutes, transcripts of Commission proceedings, copies of recordings of Commission proceedings, copies of exhibits from Commission proceedings, and copies of all other public documents are available at the "actual cost" as defined by G.S. 132-6.2(b). The Commission shall provide the "actual cost" on the Commission's website.
(c) Certified copies are available upon request at a cost of one dollar ($1.00) per certification in addition to any other applicable cost for the document. Electronic copy certification is not available.
(d) Documents shall be sent via certified mail upon request at the actual cost established by the United States Postal Service.
(e) North Carolina sales tax shall be added if applicable.

History Note: *Authority G.S. 7A-305; 97-73; 97-79; 97-80; 132-6.2; 143-291.1; 143-291.2; 143-300;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10E .0201 Eff. June 1, 2018.

11 NCAC 23E .0202 HEARING COSTS OR FEES

(a) **(Effective until July 1, 2015)** The following hearing costs or fees apply to all subject areas within the authority of the Commission:

(1) one hundred twenty dollars ($120.00) for a hearing before a Deputy Commissioner to be charged after the hearing has been held;
(2) one hundred twenty dollars ($120.00) if a case is continued after the case is calendared for a specific hearing date, to be paid by the requesting party or parties;
(3) one hundred twenty dollars ($120.00) if a case is withdrawn, removed, or dismissed after the case is calendared for a specific hearing date;
(4) two hundred twenty dollars ($220.00) for a hearing before the Full Commission to be charged after the hearing has been held; and
(5) one hundred twenty dollars ($120.00) if one of the following occurs after an appeal or request for review is scheduled for a specific hearing date before the Full Commission:
    (A) the appeal or request for review is withdrawn; or
    (B) the appeal or request for review is dismissed for failure to prosecute or perfect the appeal or request for review.

In workers' compensation cases, these fees shall be paid by the employer unless the Commission orders otherwise, except as specified in Subparagraph (a)(2) above.
(a) **(Effective July 1, 2015)** The following hearing costs or fees apply to all subject areas within the authority of the Commission other than workers' compensation cases:

(1) one hundred twenty dollars ($120.00) for a hearing before a Deputy Commissioner to be charged after the hearing has been held;
(2) one hundred twenty dollars ($120.00) if a case is continued after the case is calendared for a specific hearing date, to be paid by the requesting party or parties;

(3) one hundred twenty dollars ($120.00) if a case is withdrawn, removed, or dismissed after the case is calendared for a specific hearing date;
(4) two hundred twenty dollars ($220.00) for a hearing before the Full Commission to be charged after the hearing has been held; and
(5) one hundred twenty dollars ($120.00) if one of the following occurs after an appeal or request for review is scheduled for a specific hearing date before the Full Commission:
(A) the appeal or request for review is withdrawn; or
(B) the appeal or request for review is dismissed for failure to prosecute or perfect the appeal or request for review.

(b) The Commission may waive fees set forth in Paragraph (a) of this Rule, or assess such fees against a party or parties pursuant to G.S. 97-88.1 if the Commission determines that the hearing has been brought, prosecuted, or defended without reasonable ground.

History Note: *Authority G.S. 97-73; 97-80; 97-88.1; 143-291.1; 143-291.2; 143-300; S.L. 2014-77;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10E .0202 Eff. June 1, 2018.

11 NCAC 23E .0203 FEES SET BY THE COMMISSION

(a) In workers' compensation cases, the Commission sets the following fees:
(1) four hundred dollars ($400.00) for the processing of a compromise settlement agreement to be paid 50 percent by the employee and 50 percent by the employer(s) or the employer's carrier(s). The employer(s) or the employer's carrier(s) shall pay such fee in full when submitting the agreement to the Commission and, unless the parties agree otherwise, shall be entitled to a credit for the employee's 50 percent share of such fee against settlement proceeds;
(2) two hundred dollars ($200.00) for the processing of a I.C. Form MSC5, *Report of Mediator*, to be paid 50 percent by the employee and 50 percent by the employer(s) or the employer's carrier(s). The employer(s) or the employer's carrier(s) shall pay such fee in full upon receipt of an invoice from the Commission and, unless the parties agree otherwise, shall be reimbursed for the employee's share of such fees when the case is concluded from any compensation that may be determined to be due to the employee. The employer(s) or the employer's carrier(s) may withhold funds from any award for this purpose; and
(3) a fee equal to the filing fee required to file of a civil action in the Superior Court division of the General Court of Justice for the processing of a Form 33I *Intervenor's Request that Claim be Assigned for Hearing*, to be paid by the intervenor.

(b) In tort claims cases, the filing fee is an amount equal to the filing fee required to file a civil action in the Superior Court division of the General Court of Justice.

History Note: *Authority G.S. 7A-305; 97-17; 97-26(i); 97-73; 97-80; 143-291.2; 143-300; S.L 2014-77;*
Eff. November 1, 2014;
Amended Eff. July 1, 2015;
Recodified from 04 NCAC 10E .0203 Eff. June 1, 2018.

11 NCAC 23E .0204 ACCIDENT PREVENTION AND SAFETY EDUCATIONAL PROGRAM FEES

(a) The following fees shall be assessed for accident prevention and safety educational programs:
(1) one hundred twenty-five dollars ($125.00) per person for an Accident Prevention Awareness (APCAP) Workshop;
(2) seventy-five dollars ($75.00) per person for an Advanced APCAP Workshop;
(3) thirty dollars ($30.00) per person for a Safety and Health Workshop;
(4) twenty dollars ($20.00) per person for a First Aid, CPR, and AED Course, plus fifteen dollars ($15.00) per person for materials;
(5) fifteen dollars per person ($15.00) for a First Aid Course, plus twelve dollars ($12.00) per person for materials;
(6) fifteen dollars per person ($15.00) for a CPR and AED Course, plus twelve dollars ($12.00) per person for materials;
(7) twenty dollars ($20.00) per person for a Defensive Driving Course, plus four dollars ($4.00) per person for materials;

(8) fifty dollars ($50.00) per person for a Hazardous Waste Operations and Emergency Response (HAZWOPER) Course or Refresher Course;
(9) thirty dollars ($30.00) per person for a HAZWOPER Awareness Course;
(10) twenty-five dollars ($25.00) per person for a Work Zone Flagger Course, plus five dollars ($5.00) for materials;
(11) thirty dollars ($30.00) per person for a Trenching Competent Person Course;
(12) thirty-five dollars ($35.00) per person for a Competent Person Scaffolding Course;
(13) forty-five dollars ($45.00) per person for an eight-hour National Fire Protection Association (NFPA) E Arc Flash Course;
(14) thirty dollars ($30.00) per person for a four-hour NFPA E Arc Flash Course;
(15) fifty dollars ($50.00) per person for a Safety for Supervisors Course;
(16) one hundred fifty dollars ($150.00) per person for a Safety Leadership Course;
(17) a two hundred dollar ($200.00) flat fee for a (five to eight-hour) Workplace Training;
(18) a one hundred-fifty dollar ($150.00) flat fee for a (three to four-hour)Workplace Training (3-4 hours); and
(19) a one hundred dollar ($100.00) flat fee for a (one to two-hour) Workplace Training.

(b) In addition to the fees listed in Paragraph (a), each individual or group registering for a class must pay a four dollar and ninety-five cent ($4.95) registration processing fee to the Commission's third party vendor upon registering for an educational program listed in Paragraph (a).

History Note: *Authority G.S. 97-73; 97-80;*
Eff. July 1, 2014;
Recodified from 04 NCAC 10E .0204 Eff. June 1, 2018.

SECTION .0300 – RULES OF THE COMMISSION

11 NCAC 23E .0301 WAIVER OF RULES

In the interests of justice or to promote judicial economy, the Commission may, except as otherwise provided by the rules in this Subchapter, waive or vary the requirements or provisions of any of the rules in this Subchapter in a case pending before the Commission upon written application of a party or upon its own initiative only if the employee is not represented by counsel. Factors the Commission shall use in determining whether to grant the waiver are:
(1) the necessity of a waiver;
(2) the party's responsibility for the conditions creating the need for a waiver;
(3) the party's prior requests for a waiver;
(4) the precedential value of such a waiver;
(5) notice to and opposition by the opposing parties; and
(6) the harm to the party if the waiver is not granted.

History Note: *Authority G.S. 97-25.2; 97-25.4; 97-73; 97-80; 130A-425(d); 143-166.4; 143-296; 143-300;*
Eff. July 1, 2014;
Recodified from 04 NCAC 10E .0301 Eff. June 1, 2018.

11 NCAC 23E .0302 EMERGENCY ORDERS AND DIRECTIVES OF THE CHIEF JUSTICE OF THE NORTH CAROLINA SUPREME COURT

(a) This Rule applies to all matters within the authority and jurisdiction of the Commission and to all Subchapters of the Commission's rules.

(b) In the interests of justice or to protect the public health or safety, the Commission may waive or modify any portion of its rules in order to bring them in conformity with an emergency Order or directive of the Chief Justice of the North Carolina Supreme Court that is in effect. The Commission shall consider the following factors in determining whether to grant the waiver or modification:
(1) the necessity of waiving or modifying the rule; and
(2) the impact of waiving or modifying the rule on the regulated parties and on the Commission.

If the Commission waives or modifies a rule to bring it into conformity with any emergency Order or directive of the Chief Justice of the North Carolina Supreme Court, the Commission shall post a notice of the waiver or modification of the rule on its website unless the waiver or modification is case-specific and not generally applicable to the regulated public. For a waiver or modification that is case-specific and not generally applicable to the

regulated public, the Commission shall notify the parties in the case of the waiver or modification via an order of the Commission.
(c) During any period that an emergency Order or directive of the Chief Justice of the North Carolina Supreme Court authorizes the taking of oaths and verifications outside the presence of a notary public, the Commission shall accept any pleading, motion, petition, supporting affidavit, or other document with an affirmation or representation not attested to before a notary public so long as the subscriber affirms the truth of the matter to be verified by an affirmation or representation in substantially the same language as that allowed by the emergency Order or directive of the Chief Justice of the North Carolina Supreme Court.
(d) Any waiver or modification made pursuant to this Rule shall only remain in effect during the duration of any emergency Order or directive of the Chief Justice of the North Carolina Supreme Court upon which that waiver or modification is based.

History Note: *Authority G.S. 97-80; 130A-425(d); 143-166.4; 143-296; 143-300;*
Emergency Adoption Eff. November 6, 2020;
Temporary Adoption Eff. January 29, 2021;
Eff. August 1, 2021.

SUBCHAPTER 23F –ELECTRONIC BILLING RULES

SECTION .0100 –ADMINISTRATION

11 NCAC 23F .0101 ELECTRONIC MEDICAL BILLING AND PAYMENT REQUIREMENT

Carriers and licensed health care providers shall utilize electronic billing and payment in workers' compensation claims. Carriers and health care providers shall develop and implement electronic billing and payment processes consistent with 45 CFR 162. Carriers and health care providers shall comply with this Rule on or before March 1, 2014. 45 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's website, 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.

History Note: *Authority G.S. 97-26(g1); 97-80;*
Eff. July 1, 2014;
Recodified from 04 NCAC 10F .0101 Eff. June 1, 2018.

11 NCAC 23F .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.
(3) "Health Care Provider" is as set forth in G.S. 97-2(20).
(4) "Health Care Provider Agent" is a person or entity that contracts with a health care provider establishing an agency relationship to process bills for services provided by the health care

provider under the terms and conditions of a contract between the agent and health care provider. Such contracts may permit the agent to submit bills, request reconsideration, receive reimbursement, and seek medical dispute resolution for the health care provider services.

(5) "Implementation guide" is a published document for national electronic standard formats as defined in this Subchapter that specifies data requirements and data transaction sets.

(6) "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.

(7) "Payer" means the insurance carrier, third-party administrator, managed care organization, or employer responsible for paying the workers' compensation medical bills.

(8) "Payer agent" means any person or entity that performs 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.

History Note: *Authority G.S. 97-26; 97-26(g1); 97-80;*
Eff. January 1, 1996;
Recodified from 04 NCAC 10F .0101 Eff. July 1, 2014;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10F .0102 Eff. June 1, 2018.

11 NCAC 23F .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.

(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.

History Note: *Authority G.S. 97-26; 97-26(g1); 97-80;*
Eff. January 1, 1996;
Recodified from 04 NCAC 10F .0102 Eff. July 1, 2014;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10F .0103 Eff. June 1, 2018.

11 NCAC 23F .0104 BILLING CODE SETS

Billing codes and modifier systems identified below are valid codes for the specified workers' compensation transactions, in addition to any code sets defined by the standards adopted in 11 NCAC 23F .0103:

(1) "CDT-4 Codes" that refers to the codes and nomenclature prescribed by the American Dental Association.

(2) "CPT-4 Codes" that refers to the procedural terminology and codes contained in the "Current Procedural Terminology, Fourth Edition," as published by the American Medical Association.

(3) "Diagnosis Related Group (DRG)" that refers to the inpatient classification scheme used by CMS for hospital inpatient reimbursement.

(4) "Healthcare Common Procedure Coding System" (HCPCS) that refers to a coding system which describes products, supplies, procedures, and health professional services and that includes CPT-4 codes, alphanumeric codes, and related modifiers.

(5) "ICD-9-CM Codes" that refers to diagnosis and procedure codes in the International Classification of Diseases, Ninth Revision, Clinical Modification published by the United States Department of Health and Human Services.

(6) "ICD-10-CM/PCS" that refers to diagnosis and procedure codes in the International Classification of Diseases, Tenth Edition, Clinical Modification/Procedure Coding System.

(7) National Drug Codes (NDC) of the United States Food and Drug Administration.

(8) "Revenue Codes" that refers to the 4-digit coding system developed and maintained by the National Uniform Billing Committee for billing inpatient and outpatient hospital services, home health services, and hospice services.

(9) "National Uniform Billing Committee Codes" that refers to the code structure and instructions established for use by the National Uniform Billing Committee (NUBC).

History Note: *Authority G.S. 97-26(g1); 97-80;*
Eff. July 1, 2014;
Recodified from 04 NCAC 10F .0104 Eff. June 1, 2018.

11 NCAC 23F .0105 ELECTRONIC MEDICAL BILLING, REIMBURSEMENT, AND DOCUMENTATION

(a) Payers and payer agents shall:

(1) accept electronic medical bills submitted in accordance with the standards adopted in this Subchapter;

(2) transmit acknowledgments and remittance advice in compliance with the standards adopted in this Subchapter in response to electronically submitted medical bills; and

(3) utilize methods to receive electronic documentation required for the adjudication of a bill.

(b) A health care provider shall:

(1) exchange medical bill data in accordance with the standards adopted in this Subchapter;

(2) submit medical bills as defined by this Rule to any payers who have established connectivity with the health care provider system or clearinghouse;

(3) submit required documentation in accordance with Paragraph (d) of this Rule; and

(4) receive and act upon any acceptance or rejection acknowledgment from the payer.

(c) To be considered a complete electronic medical bill, the bill or supporting transmissions shall:

(1) be submitted in the correct billing format, with the correct billing code sets as presented in this Rule;

(2) be transmitted in compliance with the format requirements described in this Rule;

(3) include in legible text all medical reports and records, including evaluation reports, narrative reports, assessment reports, progress reports and notes, clinical notes, hospital records and diagnostic test results that are necessary for adjudication;

(4) identify the:

(A) injured employee;

(B) employer;

(C) insurance carrier, third party administrator, managed care organization or its agent;

(D) health care provider; and

(E) medical service or product;

(5) comply with any other requirements as presented in a companion guide published by the Commission; and

(6) use current and valid codes and values as defined in the applicable formats defined in this Subchapter.

(d) Electronic Acknowledgment:

(1) Interchange Acknowledgment (TA1) notifies the sender of the receipt of, and structural defects associated with, an incoming transaction.

(2) As used in this Paragraph, Implementation Acknowledgment (ASC X12 999) transaction is an electronic notification to the sender of the file that it has been received and has been:

(A) accepted as a complete and structurally correct file; or

(B) rejected with a valid rejection code.

(3) As used in this Paragraph, Health Care Claim Status Response (ASC X12 277) or Acknowledgment transaction (detail acknowledgment) is an electronic notification to the sender of an electronic transaction (individual electronic bill) that the transaction has been received and has been:

(A) accepted as a complete, correct submission; or

(B) rejected with a valid rejection code.

(4) A payer shall acknowledge receipt of an electronic medical bill by returning an Implementation Acknowledgment (ASC X12 999) within one business day of receipt of the electronic submission.

(5) Notification of a rejected bill shall be transmitted when an electronic medical bill does not meet the definition of a complete electronic medical bill as described in this Rule or does not meet the edits defined in the applicable implementation guide or guides.

(6) 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.

(7) 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 business days of receipt of the electronic submission.

(8) Notification of a rejected bill shall be transmitted in an ASC X12 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.

(9) 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.

(10) Acceptance of a complete medical bill is not an admission of liability by the payer. A payer may subsequently reject an accepted electronic medical bill if the employer or other responsible party named on the medical bill is not legally liable for its payment.

(11) The subsequent rejection shall occur no later than seven days from the date of receipt of the complete electronic medical bill.

(12) The rejection transaction shall indicate that the reason for the rejection is due to denial of liability.

(13) Acceptance of an incomplete medical bill does not satisfy the written notice of injury requirement from an employee or payer as required in G.S. 97-22.

(14) Acceptance of a complete or incomplete medical bill by a payer does not begin the time period by which a payer shall accept or deny liability for any alleged claim related to such medical treatment pursuant to G.S. 97-18 and 11 NCAC 23A .0601.

(15) Transmission of an Implementation Acknowledgment under Subparagraph (d)(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.

(e) Electronic Documentation

(1) Electronic documentation, including 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) the 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) the date(s) of service; and

(E) the workers' compensation claim number assigned by the payer, if known.

(f) Electronic remittance notification

(1) As used in the Paragraph, an electronic remittance notification is an explanation of benefits (EOB) or explanation of review (EOR), submitted electronically regarding payment or denial of a medical bill, recoupment request, or receipt of a refund.

(2) A payer shall provide an electronic remittance notification in accordance with G.S. 97-18.

(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) or, for pharmacy charges, the National Council for Prescription Drugs Program (NCPDP) Reject Codes, denoting the reason for payment, adjustment, or denial.

(4) The remittance notification shall be sent within two days of:

(A) the expected date of receipt by the health care provider of payment from the payer; or

(B) the date the bill was rejected by the payer. If a recoupment of funds is being requested, the notification shall contain the proper code described in Subparagraph (e)(3) of this Rule and an explanation for the amount and basis of the refund.

(g) A health care provider or its agent may not submit a duplicate paper medical bill earlier than 30 days from the date originally submitted unless the payer has returned the medical bill as incomplete in accordance with this Subchapter. A health care provider or its clearinghouse or agent may submit a corrected paper medical bill to the payer after receiving notification of the return of an incomplete medical bill. The corrected medical bill shall be submitted as a new, original bill.

(h) A payer shall establish connectivity with any clearinghouse that requests the exchange of data in accordance with this Subchapter. A payer or its agent may not reject a standard transaction on the basis that it contains data elements not needed or used by the payer or its agent.

(j) A health care provider that does not send standard transactions shall use an internet-based direct data entry system offered by a payer if the payer does not charge a transaction fee. A health care provider using an Internet-based direct data entry system offered by a payer or other entity shall use the appropriate data content and data condition requirements of the standard transactions.

History Note: *Authority G.S. 97-26(g1); 97-80;*
Eff. July 1, 2014;
Recodified from 04 NCAC 10F .0105 Eff. June 1, 2018.

11 NCAC 23F .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 the rules in this Subchapter, a payer shall evaluate each bill's conformance with the criteria of a complete medical bill. A payer shall not return to the health care provider medical bills that are complete, unless the bill is a duplicate bill. Within 21 days of receipt of an incomplete medical bill, a payer or its agent shall either:

(1) Complete the bill by adding missing health care provider identification or demographic information already known to the payer; or

(2) 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.

(c) The payer may contact the health care provider to obtain the information necessary to make the bill complete. Any request by the payer or its agent for additional documentation to pay a medical bill shall:

(1) be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery;

(2) be specific to the bill or the bill's related episode of care;

(3) describe with specificity the clinical and other information to be included in the response;

(4) be relevant and necessary for the resolution of the bill;

(5) be for information that is contained in or is in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider; and

(6) indicate the reason for which the insurance carrier is requesting the information.

If the payer or its agent obtains the missing information and completes the bill to the point it can be adjudicated for payment, the payer shall document the name and telephone number of the person who supplied the information. Health care providers and payers, or their agents, shall maintain, in a reproducible format, documentation of communications related to medical bill processing.

(d) A payer shall not return a medical bill except as provided in this Rule. When returning an electronic medical bill, the payer shall identify the reason(s) for returning the bill by utilizing the appropriate Reason and Rejection Code identified in the standards identified in this Subchapter.

(e) The proper return of an incomplete medical bill in accordance with this section fulfills the obligation of the payer to provide to the health care provider or its agent information related to the incompleteness of the bill.

(f) Payers shall timely reject bills or request additional information needed to reasonably determine the amount payable as follows:

(1) For bills submitted electronically, the rejection of all or part of the bill shall be sent to the submitter within two days of receipt.

(2) If bills are submitted in a batch transmission, only the specific bills failing edits shall be rejected.

(g) If a payer has reason to challenge the coverage or amount of a specific line item on a bill, but has no reasonable basis for objections to the remainder of the bill, the uncontested portion shall be paid timely, as required in this Rule.

(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. After 60 days an amount equal to 10 percent shall be added to an unpaid bill.

(j) A payer shall not return a medical bill except as provided in this Rule. When returning a medical bill, the payer shall also communicate the reason(s) for returning the bill.

History Note: *Authority G.S. 97-18(a); 97-26(g1); 97-80;*
Eff. July 1, 2014;
Recodified from 04 NCAC 10F .0106 Eff. June 1, 2018.

11 NCAC 23F .0107 COMMUNICATION BETWEEN HEALTH CARE PROVIDERS AND PAYERS

(a) Any communication between the health care provider and the payer related to medical bill processing shall be of sufficient detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "payer improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position do not satisfy the requirements of this Rule.

(b) When communicating with the health care provider, agent, or assignee, the payer may utilize the ASC X12 Reason Codes, or the NCPDP Reject Codes, to communicate with the health care provider, agent, or assignee.

(c) Communication between the health care provider and payer related to medical bill processing shall be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery.

History Note: *Authority G.S. 97-26(g1); 97-80(a);*
Eff. July 1, 2014;
Recodified from 04 NCAC 10F .0107 Eff. June 1, 2018.

11 NCAC 23F .0108 EFFECTIVE DATE

This Chapter applies to all medical services and products provided on or after March 1, 2014. For medical services and products provided prior to March 1, 2014, medical billing and processing shall be in accordance with the rules in effect at the time the health care was provided.

History Note: *Authority G.S. 97-26(g1); 97-80;*
Eff. July 1, 2014;
Recodified from 04 NCAC 10F .0108 Eff. June 1, 2018.

SUBCHAPTER 23G – NORTH CAROLINA INDUSTRIAL COMMISSION RULES FOR MEDIATED SETTLEMENT AND NEUTRAL EVALUATION CONFERENCES

SECTION .0100 – MEDIATION AND SETTLEMENT

11 NCAC 23G .0101 ORDER FOR MEDIATED SETTLEMENT CONFERENCE

(a) Mediation Upon Agreement of the Parties. If the parties to a workers' compensation claim or state tort claim agree to mediate the claim, the parties may schedule and proceed with mediation on their own, or the parties may submit a request for a mediation order pursuant to Paragraph (d) of this Rule. No order from the Commission is necessary if the parties mutually agree to mediate the claim, but the mediator shall file a report of mediation with the Commission as required by Paragraph (g) of Rule .0106 of this Subchapter. If the parties proceed with mediation in the absence of an order from the Commission and the Commission thereafter enters a mediation order, the parties shall notify the Commission that the parties have agreed upon the selection of a mediator or, if the mediated

settlement conference has been completed, that the parties request to be excused from any further mediation obligations pursuant to Paragraph (f) of this Rule.

(b) Referral Upon Receipt of a Form 33 Request that Claim be Assigned for Hearing. In any case in which the Commission receives a Form 33 Request that Claim be Assigned for Hearing, the Commission shall order the case to a mediated settlement conference unless doing so would be contrary to the interests of justice.

(c) By Order of the Commission. Commissioners, Deputy Commissioners, the Commission's Dispute Resolution Coordinator, and such other employees as the Commission Chair designates may, by written order, require the parties and their representatives to attend a mediated settlement conference concerning a dispute within the workers' compensation and state tort claim jurisdiction of the Commission. Requests to dispense with or defer a mediated settlement conference shall be addressed to the Dispute Resolution Coordinator. Unless the context otherwise requires, references to the "Commission" in the rules in this Subchapter shall mean the Dispute Resolution Coordinator.

(d) Mediation Upon Request of a Party. If a case is not otherwise ordered to a mediated settlement conference, a party may move the Commission to order a conference. The motion shall be served on non-moving parties and shall state the reasons why the order should be entered. Responses may be filed in writing with the Commission within 10 days after the date of the service of the motion. Any motion for a mediation order shall be submitted on a form provided by the Commission.

(e) Timing of the Order. The order requiring mediation may be issued whenever it appears that the parties have a dispute arising under the Workers' Compensation Act or the Tort Claims Act.

(f) Motion to Dispense with or Defer Mediated Settlement Conference. Mediation may be dispensed with by the Commission in the interests of justice or judicial economy. As used in this Rule, the term "dispensed with" means setting aside or rescinding the mediation order(s) entered in the case, or excusing the parties from their obligations under the applicable order(s) or the Rules in this Subchapter. Mediation may not be dispensed with by the parties or the mediator unless the parties have agreed, subject to Commission approval, on a full and complete resolution of all disputed issues set forth in the request for hearing filed in the case, and the parties have given notice of the settlement to the Dispute Resolution Coordinator. Within 55 days of the filing of a Form 33 Request that Claim be Assigned for Hearing, or otherwise within the deadline set forth in the Commission's order entered pursuant to Paragraph (c) or Paragraph (d) of this Rule, a party may move to dispense with or defer the mediated settlement conference. The motion shall state the reasons the relief is sought and must be received by the Dispute Resolution Coordinator within the applicable deadline.

(g) Exemption from Mediated Settlement Conference. The State shall not be compelled to participate in a mediation or neutral evaluation procedure with a prison inmate.

(h) Motion to Authorize the Use of Neutral Evaluation Procedures. The parties may move the Commission to authorize the use of a neutral evaluation procedure contained in Rule .0109 of this Subchapter in lieu of a mediated settlement conference. The motion shall be filed on a form provided by the Commission within 55 days of the filing of a Form 33 Request that Claim be Assigned for Hearing, or otherwise within the deadline set forth in the Commission's order entered pursuant to Paragraph (c) or Paragraph (d) of this Rule, and shall state:

(1) that all parties consent to the motion;

(2) that the neutral evaluator and the parties have agreed upon the selection and all terms of compensation of the neutral selected; and

(3) the name, address, and telephone number of the neutral evaluator selected by the parties.

(i) If the parties are unable to agree to the matters listed in Paragraph (h), the Commission shall deny the motion for authorization to use a neutral evaluation procedure, and the parties shall attend the mediated settlement conference as originally ordered by the Commission. If the parties are able to agree on the matters listed in Paragraph (h), the Commission shall order the use of a neutral evaluation proceeding; provided, however, that the Commission shall not order the use of a neutral evaluation proceeding in any case in which the plaintiff is not represented by counsel.

(j) Cases Involving Plaintiffs Not Represented by Counsel. Unless an unrepresented plaintiff requests that the plaintiff's case be mediated, the Commission shall enter an order dispensing with mediation.

History Note: *Authority G.S. 97-80(a),(c); 143-296; 143-300; Rule 1 of Rules for Mediated Settlement Conferences and Other Settlement Procedures in Superior Court Civil Actions;*
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10G .0101 Eff. June 1, 2018.

11 NCAC 23G .0102 SELECTION OF MEDIATOR

(a) By Agreement of Parties. The parties in a workers' compensation case or a state tort claims case may, by agreement, select a mediator certified by the North Carolina Dispute Resolution Commission within 55 days of the filing of a Form 33 Request that Claim be Assigned for Hearing, or otherwise within the deadline set forth in the Commission's order entered pursuant to Paragraph (c) or Paragraph (d) of Rule .0101 of this Subchapter, subject to the Commission's authority to remove the mediator selected by the parties due to a conflict of interest. The stipulation may be transmitted by either party, shall be dated as of the date it is transmitted to the Commission, and must be received by the Dispute Resolution Coordinator within 55 days of the filing of a Form 33 Request that Claim be Assigned for Hearing, or otherwise within the deadline set forth in the Commission's order entered pursuant to Paragraph (c) or Paragraph (d) of Rule .0101 of this Subchapter. The scheduled date of the mediated settlement conference shall be within 120 days of the mediation order. The stipulation shall include the date of the scheduled mediation, the name, address and telephone number of the mediator selected by agreement, and shall confirm that the mediator is certified by the Dispute Resolution Commission. The applicable deadline shall be extended by the Dispute Resolution Coordinator upon request of the parties. Any party may waive the applicable deadline for the selection and suggestion of mediators and request that the Commission appoint a mediator.

(b) Appointment by Commission. If the parties fail to notify the Commission of the parties' selection of a mediator within 55 days of the filing of a Form 33 Request that Claim be Assigned for Hearing, or otherwise within the deadline set forth in the Commission's order entered pursuant to Paragraph (c) or Paragraph (d) of Rule .0101 of this Subchapter, the Commission shall appoint a mediator to hold a mediated settlement conference in the case. The Commission shall appoint a mediator who meets the requirements in Paragraph (b) of Rule .0108 of this Subchapter. In the absence of any suggestions by the parties with regard to the appointment of mediators, the Commission shall select the mediator for the case by random order, unless the Commission determines that, because of unusual circumstances, a particular mediator should be appointed in a particular case.

(c) Disqualification of Mediator. Any party may move the Commission for an order disqualifying a mediator. For good cause, such order shall be entered. If the mediator is disqualified, an order shall be entered for the selection of a replacement mediator pursuant to this Rule. Nothing in this Paragraph shall preclude mediators from disqualifying themselves.

History Note: *Authority G.S. 97-80(a),(c); 143-296; 143-300; Rule 2 of Rules for Mediated Settlement Conferences and Other Settlement Procedures in Superior Court Civil Actions;*
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; January 1, 2011; June 1, 2000
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10G .0102 Eff. June 1, 2018.

11 NCAC 23G .0103 THE MEDIATED SETTLEMENT CONFERENCE

(a) Where Conference Is to Be Held. Unless all parties in a workers' compensation case or a state tort claims case and the mediator otherwise agree, the mediated settlement conference shall be held in the county where the case is pending. The mediator shall reserve a place and make arrangements for the conference and give notice to all attorneys and unrepresented parties of the time and location of the conference.

(b) When Conference Is to Be Held. The conference shall be held at the time agreed to by the parties and the mediator, or if the parties do not agree, at the time specified by the mediator.

(c) Request to Extend Date of Completion. In the interests of justice, the Commission may extend the deadline for completion of the conference upon the Commission's own motion, a motion or stipulation of the parties or the suggestion of the mediator.

(d) Recesses. The mediator may recess the conference at any time and may set times for reconvening. If the time for reconvening is set before the conference is recessed, no further notification is required for persons present at the recessed conference.

(e) The Mediated Settlement Conference Is Not to Delay Other Proceedings. A mediated settlement conference is not cause for delay of other proceedings in the case, including the completion of discovery and the filing or hearing

of motions, unless ordered by the Commission in the interests of justice. No depositions shall be taken following a Commission order requiring mediation until mediation is concluded, except by agreement of the parties or order of the Commission in the interest of justice.

(f) Inadmissibility of Negotiations by Parties and Attorneys. Evidence of statements made and conduct occurring in a mediated settlement conference or other settlement proceeding conducted pursuant to the Rules in this Subchapter, whether attributable to a party, the mediator, other neutral, or a neutral observer present at the settlement conference or proceeding, are not subject to discovery and shall be inadmissible in any proceeding in the action or other actions on the same claim, except:

(1) proceedings for sanctions for violations of the attendance or payment of mediation fee provisions contained in Rule .0104 and Rule.0107 of this Subchapter;
(2) proceedings to enforce or rescind a settlement of the action;
(3) disciplinary proceedings before the North Carolina State Bar or any agency enforcing standards of conduct for mediators or other neutrals, including the Commission; or
(4) proceedings to enforce laws concerning juvenile or elder abuse.

(g) No settlement agreement to resolve any or all issues reached at the settlement conference or proceeding conducted under this Subchapter or reached during a recess in the conference or proceeding shall be enforceable unless the settlement agreement has been reduced to writing and signed by the parties. No evidence otherwise discoverable shall be inadmissible solely because the evidence is presented or discussed in a mediated settlement conference or other settlement proceeding.

(h) Inadmissibility of Mediator Testimony. No mediator, other neutral, or neutral observer present at a settlement proceeding shall be compelled to testify or produce evidence concerning statements made and conduct occurring in anticipation of, during, or as a follow-up to a mediated settlement conference or other settlement proceeding conducted pursuant to the Rules in this Subchapter in any Commission case or civil proceeding for any purpose, including proceedings to enforce or rescind a settlement of the action, except:

(1) to attest to the signing of any settlement agreements;
(2) proceedings for sanctions for violations of the attendance or payment of mediation fee provisions contained in Rule .0104 and Rule .0107 of this Subchapter;
(3) disciplinary proceedings before the North Carolina State Bar or any agency enforcing standards of conduct for mediators or other neutrals, including the Commission; and
(4) proceedings to enforce laws concerning juvenile or elder abuse.

(i) As used in this Subchapter, the term "neutral observer" includes persons seeking mediator certification, persons studying dispute resolution processes, and persons acting as interpreters.

History Note: *Authority G.S. 97-80(a),(c); 143-296; 143-300; Rule 3 of Rules for Mediated Settlement Conferences and Other Settlement Procedures in Superior Court Civil Actions;*
Eff. January 16, 1996;
Amended Eff. October 1, 1998
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; January 1, 2011; June 1, 2000
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10G .0103 Eff. June 1, 2018.

11 NCAC 23G .0104 DUTIES OF PARTIES, REPRESENTATIVES, AND ATTORNEYS

(a) Attendance. The following persons shall attend the mediated settlement conference:

(1) all individual parties;
(2) in a workers' compensation case, a representative of the employer at the time of injury if:
    (A) the employer, instead of or in addition to the insurance company or administrator, has decision-making authority with respect to settlement;
    (B) the employer is offering the claimant employment and the suitability of that employment is at issue; or
    (C) the employer and the claimant have agreed to simultaneously mediate non-compensation issues arising from the injury.

(3) an officer, employee, or agent of any party, that is not a natural person or a governmental entity, who is not the party's outside counsel and who has the authority to decide on behalf of the party whether and on what terms to settle the action;

(4) in a workers' compensation case, an employee or agent of any party that is a governmental entity who is not the party's outside counsel or Attorney General's counsel responsible for the case and who has the authority to decide on behalf of the party whether and on what terms to settle the action;

(5) when the governing law prescribes that the terms of a proposed settlement may be approved only by a board, an employee or agent who is not the party's outside counsel or Attorney General's counsel responsible for the case and who has the authority to negotiate on behalf of and to make a recommendation to the board. In claims with settlements subject to the review and approval by the Industrial Commission under G.S. 143-295, an employee or agent of the named governmental entity or agency is not required to attend the mediated settlement conference. The Attorney General shall attempt to make an employee or agent of the named governmental entity or agency in a State tort claim available via telecommunication, and mediation shall not be delayed due to the absence or unavailability of the employee or agent of the named governmental entity or agency;

(6) the counsels of record. Appearance by counsel does not dispense with or waive the required attendance of the parties listed in Subparagraphs (1) through (5);

(7) a representative of each defendant's primary workers' compensation or liability insurance carrier or self-insured that may be obligated to pay all or part of any claim presented in the action. Each carrier or self-insured shall be represented at the conference by an officer, employee, or agent who is not the party's outside counsel and who has the authority to decide on behalf of the carrier or self-insured whether and on what terms to settle the action, or who has been authorized to negotiate on behalf of the carrier or self-insured and can communicate during the conference with persons who have the decision making authority.

(8) any employer or carrier who may be obligated to pay all or part of any claim presented in the action and who is not required to attend the mediated settlement conference pursuant to Subparagraphs (1) through (7) of this Paragraph may attend the conference if the employer or carrier elects to attend. If, during the conference, the mediator determines that the attendance of one or more additional persons is necessary to resolve the matters in dispute in the subject action, the mediator may recess the conference and reconvene the conference at a later date and time to allow the additional person or persons to attend.

(b) Any party or person required to attend a mediated settlement conference shall attend the conference until an agreement is reduced to writing and signed as provided in Paragraph (e) of this Rule, or until an impasse has been declared. The attendance method for Industrial Commission mediations shall be the same as the attendance method set forth in Rule 4 of the Rules for Mediated Settlement Conferences and Other Settlement Procedures in Superior Court Civil Actions, which is hereby incorporated by reference and includes subsequent amendments and editions. A copy of the Rules for Mediated Settlement Conferences and Other Settlement Procedures in Superior Court Civil Actions may be obtained at no charge from the North Carolina Judicial Branch website, at https://www.nccourts.gov/courts/supreme-court/court-rules/rules-for-mediated-settlement-conferences-and-other-settlement-procedures-in-superior-court-civil-actions, or upon request at the main office of the Industrial Commission, located on the 6th floor of the Dobbs Building, 430 North Salisbury Street, Raleigh, North Carolina 27603, between the hours of 8:00 a.m. and 5:00 p.m. Monday through Friday, excluding holidays established by the State Human Resources Commission. All parties and persons required to attend the conference, including the mediator, shall comply with all public health and safety requirements set forth in the mediation rules approved by the North Carolina Supreme Court for use in the Superior Court division that are in effect at the time of the mediation.

(c) In appropriate cases, the Commission or the mediator, with the consent of the parties, may allow a party or insurance carrier representative who is required to attend a mediated settlement conference in person under this Rule to attend the conference by telephone, conference call, speaker telephone, or videoconferencing. The attending party or representative shall bear all costs of the telephone calls or videoconferencing. In addition, the mediator may communicate directly with the insurance representative with regard to matters discussed in mediation, and the mediator may set a subsequent mediated settlement conference at which all parties and representatives shall attend the mediated settlement conference in person, subject to Paragraph (b) of this Rule. The failure to appear by

telephone or videoconferencing in accordance with this Paragraph shall subject the responsible party or representative to sanctions pursuant to Rule .0105 of this Subchapter.
(d) Notice of Mediation Order. Within seven days after the receipt of an order for a mediated settlement conference, the carrier or self-insured named in the order shall provide a copy of the order to the employer and all other carriers who may be obligated to pay all or part of any claim presented in the workers' compensation case or any related third-party tortfeasor claims, and shall provide the mediator and the other parties in the action with the name, address, and telephone number of all such carriers.
(e) Finalizing Agreement. If an agreement is reached in the mediated settlement conference, the parties shall reduce the agreement to writing, specifying all terms of the agreement that bear on the resolution of the dispute before the Commission, and shall sign the agreement along with their counsel. The parties may use IC Form MSC8, Mediated Settlement Agreement, or MSC9, Mediated Settlement Agreement – Alternative Form, for this purpose. Execution by counsel of a mediated settlement agreement for an employer or carrier who does not physically attend the mediated settlement conference shall be deemed to be in compliance with this Rule and 11 NCAC 23A .0502. By stipulation of the parties and at the parties' expense, the agreement may be electronically or stenographically recorded. All agreements for payment of compensation shall be submitted for Commission approval in accordance with 11 NCAC 23A .0501 and .0502.
(f) Payment of Mediator's Fee. The mediator's fee shall be paid at the conclusion of the mediated settlement conference, unless otherwise provided by Rule .0107 of this Subchapter, or by agreement with the mediator.
(g) Related Cases. Upon application by any party or any person as defined in G.S. 97-2(4), and upon notice to all parties, the Commission may, in the interests of justice, order an attorney of record, party, or representative of an insurance carrier who may be liable for all or any part of a claim pending in a Commission case to attend a mediated settlement conference convened in another related pending case, regardless of the forum in which the other case may be pending, provided that all parties in the other pending case consent to the attendance ordered pursuant to this Paragraph. Any disputed issues concerning such an order shall be addressed to the Commission's Dispute Resolution Coordinator. Unless otherwise ordered, any attorney, party, or carrier representative who attends a mediated settlement conference pursuant to this Paragraph shall not be required to pay any of the mediation fees or costs related to that conference. Requests that a party, attorney of record, or insurance carrier representative in a related case attend a mediated settlement conference in a Commission case shall be addressed to the court or agency where the related case is pending, provided that all parties in the Commission case consent to the requested attendance.

History Note: *Authority G.S. 97-80; 143-296; 143-300;*
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10G .0104 Eff. June 1, 2018;
Emergency Amendment Eff. June 16, 2020;
Amended Eff. August 1, 2020;
Temporary Amendment Eff. August 28, 2020;
Amended Eff. February 1, 2023; March 1, 2021.

11 NCAC 23G .0104A FOREIGN LANGUAGE INTERPRETERS
(a) Any party who is unable to speak or understand English shall so notify the Commission, the mediator, and the opposing party or parties in writing, not less than 21 days prior to the date of the mediated settlement conference. The notice shall contain the party's primary language and how the party plans to communicate in English during the mediation.
(b) The party requesting the assistance of a qualified foreign language interpreter shall bear the costs.
(c) If the certified mediator, in his or her discretion, notifies the parties of the need for a qualified foreign language interpreter, the parties shall retain a disinterested interpreter who possesses the qualifications listed in Paragraph (d) of this Rule to assist at the mediated settlement conference. The fee of the foreign language interpreter and any postponement fees necessitated by the need for a qualified foreign language interpreter shall be shared by the parties unless the parties agree otherwise.
(d) A qualified foreign language interpreter shall possess sufficient experience and education, or a combination of experience and education, in speaking and understanding English and the foreign language to be interpreted, to qualify as an expert witness pursuant to G.S. 8C-1, Rule 702.

(e) Qualified foreign language interpreters shall abide by the Code of Conduct and Ethics of Foreign Language Interpreters and Translators, contained in Part 4 of *Policies and Best Practices for the Use of Foreign Language Interpreting and Translating Services in the North Carolina Court System* and promulgated by the North Carolina Administrative Office of the Courts, and shall interpret, as word for word as is practicable, without editing, commenting, or summarizing, testimony or other communications. The Code of Conduct and Ethics of Foreign Language Interpreters and Translators is hereby incorporated by reference and includes subsequent amendments and editions. A copy may be obtained at no charge from the North Carolina Administrative Office of the Court's website, *http://www.nccourts.org/Citizens/CPrograms/Foreign/Documents/guidelines.pdf*, or upon request, at the offices of the Commission, as set forth in Rule 11 NCAC 23A .0101.

History Note: *Authority G.S. 97-80(a); 97-80(c); 143-296; 143-300;*
Eff. January 1, 2011;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10G .0104A Eff. June 1, 2018.

11 NCAC 23G .0105 SANCTIONS (EFFECTIVE JULY 1, 2014)

If a person or party whose attendance at a mediated settlement conference is required by Rule.0104 of this Subchapter fails to attend or cancels, without Commission approval in accordance with Paragraph (f) of Rule .0101 of this Subchapter, a duly ordered mediated settlement conference without good cause, the Commission may impose upon the party any lawful sanction, including holding the party in contempt or requiring the party to pay fines, attorneys' fees, mediator fees and expenses and loss of earning incurred by persons attending the conference. Any sanctions that are assessed against a party consistent with the Workers' Comp Act, the Tort Claims Act and the Rules in this Subchapter, including mediated settlement conference postponement fees and sanctions for the unauthorized cancellation or failure to appear at the conference, may be assessed against the party depending on whose conduct necessitated the assessment of sanctions.

History Note: *Authority G.S. 97-80(a),(c); 143-296; 143-300; Rule 5 of Rules for Mediated Settlement Conferences and Other Settlement Procedures in Superior Court Civil Actions;*
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10G .0105 Eff. June 1, 2018.

11 NCAC 23G .0106 AUTHORITY AND DUTIES OF MEDIATORS

(a) Control of Conference. The mediator shall at all times be in control of the mediated settlement conference and the procedures to be followed. Except as otherwise set forth in the Rules in this Subchapter with regard to the finalization of the parties' agreement, there shall be no audio, video, electronic or stenographic recording of the mediation process by any participant.

(b) Private Consultation. The mediator may meet and consult privately with any participant prior to or during the conference. The fact that private communications have occurred with a participant shall be disclosed to all other participants at the beginning of the conference.

(c) Scheduling the Conference. The mediator shall make a good faith effort to schedule the conference at a time that is convenient with the parties, attorneys and mediator. In the absence of agreement, the mediator shall select the date for the conference.

(d) Information to the Parties. The mediator shall define and describe the following to the parties at the beginning of the mediated settlement conference:

(1) the process of mediation;
(2) the differences between mediation and other forms of conflict resolution;
(3) the costs of the conference;
(4) the facts that the conference is not a trial or hearing, the mediator is not acting in the capacity of a Commissioner or Deputy Commissioner and shall not act in such capacity in the subject case at any time in the future, and the parties retain their right to a hearing if the parties do not reach a settlement;
(5) the circumstances under which the mediator may meet alone with any of the parties or with any other person;

(6) whether and under what conditions, communications with the mediator will be held in confidence during the conference;
(7) the inadmissibility of conduct and statements as provided by G.S. 8C-1, Rule 408 and Paragraph (f) of Rule. 0103 of this Subchapter;
(8) the duties and responsibilities of the mediator and the parties; and
(9) the fact that any agreement reached will be reached by mutual consent of the parties.

(e) Disclosure. The mediator shall be impartial and advise all parties of any circumstances bearing on possible bias, prejudice or partiality.

(f) Declaring Impasse. The mediator shall determine when mediation is not viable, that an impasse exists, or that mediation should end.

(g) Reporting Results of Conference. In all cases within the Commission's jurisdiction, whether mediated voluntarily or pursuant to an order of the Commission, the mediator shall report the results of the mediated settlement conference on a form provided by the Commission. If an agreement was reached, the report shall state whether the issue or matter under mediation will be resolved by Commission form agreement, compromise settlement agreement, other settlement agreement, voluntary dismissal or removal from the hearing docket, and shall identify the persons designated to file or submit for approval the agreement, or dismissal. The mediator shall not attach a copy of the parties' memorandum of agreement to the mediator's report transmitted to the Commission and, except as permitted under the Rules in this Subchapter, or unless deemed necessary in the interests of justice by the Commission, the mediator shall not disclose the terms of settlement in the mediator's report. The Commission shall require the mediator to provide statistical data for evaluation of the mediated settlement conference program on forms provided by the Commission.

(h) Scheduling and Holding the Conference. The mediator shall schedule the mediated settlement conference in consultation with the parties and conduct the conference prior to the completion deadline set out in the Commission's order. Deadlines for completion of the conference shall be observed by the mediator unless the time limits are changed by the Commission.

(i) Standards of Conduct. All mediators conducting mediated settlement conferences pursuant to the Rules in this Subchapter shall adhere to the Standards of Professional Conduct for Mediators adopted by the Supreme Court of North Carolina and enforced by the North Carolina Dispute Resolution Commission. The Standards of Professional Conduct for Mediators is hereby incorporated by reference and includes subsequent amendments and editions. A copy may be obtained at no charge from the North Carolina Administrative Office of the Court's website, https://www.nccourts.gov/courts/supreme-court/court-rules/standards-of-professional-conduct-for-mediators, 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.

History Note: *Authority G.S. 97-80(a),(c); 143-296; 143-300; Rule 6 of Rules for Mediated Settlement Conferences and Other Settlement Procedures in Superior Court Civil Actions;*
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; June 1, 2000
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10G .0106 Eff. June 1, 2018;
Amended Eff. October 1, 2024.

11 NCAC 23G .0107 COMPENSATION OF THE MEDIATOR

(a) By Agreement. When the mediator is stipulated to by the parties, compensation shall be as agreed upon between the parties and the mediator.

(b) By Commission Order. When the mediator is appointed by the Commission, the mediator's compensation shall be as follows:

(1) Conference Fees. The mediator shall be paid by the parties at the rate of one hundred fifty dollars ($150.00) per hour for mediation services provided at the mediated settlement conference.
(2) Administrative Fees. The parties shall pay to the mediator a one time, per case administrative fee of one hundred fifty dollars ($150.00). The mediator's administrative fee shall be paid in full

unless, within 10 days after the mediator has been appointed, written notice is given to the mediator and to the Dispute Resolution Coordinator that the issues for which a request for hearing was filed have been fully resolved or that the hearing request has been withdrawn.

(3) Postponement Fees. As used in this Subchapter, the term "postpone" means to reschedule or otherwise not proceed with a scheduled mediated settlement conference after the conference has been scheduled to convene on a specific date. After a conference is scheduled to convene on a specific date, the conference may not be postponed unless the requesting party notifies all other parties of the grounds for the requested postponement and obtains the consent and approval of the mediator or the Dispute Resolution Coordinator. If the conference is postponed without good cause, the mediator shall be paid a postponement fee. The postponement fee shall be three hundred dollars ($300.00) if the conference is postponed within seven calendar days of the scheduled date, and one hundred fifty dollars ($150.00) if the conference is postponed more than seven calendar days prior to the scheduled date. Unless otherwise ordered by the Commission in the interests of justice, postponement fees shall be allocated in equal shares to the party or parties requesting the postponement. As used in this Rule, "good cause" shall mean that the reason for the postponement involves a situation over which the party seeking the postponement has no control, including a party or attorney's illness, a death in a party or attorney's family, a demand by a judge that a party or attorney for a party appear in court, or inclement weather such that travel is prohibitive.

(4) The settlement of a case prior to the scheduled date of the mediated settlement conference shall be good cause to cancel the mediation without the approval of the mediator or the Dispute Resolution Coordinator. The parties shall notify the mediator of any cancellation due to settlement. The mediator may charge a cancellation fee of one hundred fifty dollars ($150.00) if notified of the cancellation within 14 days of the scheduled date, or three hundred dollars ($300.00) if notified within seven days of the scheduled date.

(c) Payment by Parties. Payment is due upon completion of the mediated settlement conference; provided, that the State shall be billed at the conference and shall pay within 30 days of receipt of the bill, and insurance companies or carriers whose written procedures do not provide for payment of the mediator at the conference shall pay within 15 days of the conference. Unless otherwise agreed to by the parties or ordered by the Dispute Resolution Coordinator due to a party or parties violating a rule in this Subchapter, the costs of the conference shall be allocated to the parties, as follows:

(1) one share by plaintiff(s);

(2) one share by the workers' compensation defendant-employer or its insurer, or if more than one employer or carrier is involved, or if there is a dispute between employer(s) or carrier(s), one share by each separately represented entity;

(3) one share by participating third-party tort defendants or their carrier, or if there are conflicting interests among them, one share from each defendant or group of defendants having shared interests; and

(4) if applicable, one share by the defendant State agency in a Tort Claims Act case.

Parties obligated to pay a share of the costs are responsible for equal shares; provided, however, that in workers' compensation claims the defendant shall pay the plaintiff's share of mediation, postponement, and substitution fees, as well as defendant's own share. If plaintiff requests postponement of the mediated settlement conference, defendants shall be entitled to a credit for the postponement fee.

(d) Unless the Dispute Resolution Coordinator enters an order allocating such fees to a particular party due to the party violating a Rule in this Subchapter, the fees may be taxed as other costs by the Commission in an Order or Opinion and Award. After the case is concluded, the defendant shall be reimbursed for the plaintiff's share of such fees from any compensation determined to be due to the plaintiff, and the defendant may withhold funds from any award for this purpose.

History Note: *Authority G.S. 97-80(a); 97-80(c); 143-296; 143-300; Rule 7 of Rules for Mediated Settlement Conference and Other Settlement Procedures in Superior Court Civil Actions;*
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10G .0107 Eff. June 1, 2018.

11 NCAC 23G .0108 MEDIATOR CERTIFICATION AND DECERTIFICATION

(a) Party Selection. The parties may, by mutual consent, select any North Carolina Dispute Resolution Commission-certified mediator, with or without the qualifications in Paragraph (b) of this Rule, as the parties' mediator.

(b) Appointment of Mediators. If the parties have agreed or been ordered to mediate, and cannot agree on the selection of a mediator, the Commission shall appoint a mediator, who holds current certification from the North Carolina Dispute Resolution Commission that he or she is qualified to carry out mandatory mediations in the Superior Courts of the State of North Carolina and who has filed a declaration with the Commission, on forms provided by the Commission, stating that the declarant agrees to accept and perform mediations of disputes before the Commission with reasonable frequency when called upon for the fees and at the rates of payment specified by the Commission. A mediator making this declaration shall notify the Commission when any of the facts declared are no longer accurate.

(c) Failure of Mediator to Appear at Conference. If a mediator fails to appear at a scheduled mediated settlement conference, the mediator is not entitled to the administrative fee for the case.

History Note: *Authority G.S. 97-80(a),(c); 143-296; 143-300; Rule 8 of Rules for Mediated Settlement Conferences and Other Settlement Procedures in Superior Court Civil Actions;*
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10G .0108 Eff. June 1, 2018.

11 NCAC 23G .0109 NEUTRAL EVALUATION

(a) Nature of Neutral Evaluation. As used in this Subchapter, neutral evaluation is an abbreviated presentation of facts and issues by the parties to a neutral evaluator at an early stage of the case. The neutral evaluator is responsible for evaluating the strengths and weaknesses of the case, and for providing a candid assessment of liability, settlement value, and a dollar value or range of potential awards if the case proceeds to a hearing. The neutral evaluator is also responsible for identifying areas of agreement and disagreement and suggesting necessary and appropriate discovery.

(b) When Conference Is to Be Held. The provisions applicable to the scheduling of mediated settlement conferences set forth in Rule .0103 of this Subchapter also apply to neutral evaluation proceedings.

(c) Pre-conference Submissions. No later than 20 days prior to the date established for the neutral evaluation conference to begin, each party may, but is not required to, furnish the evaluator with written information about the case, and shall at the same time certify to the evaluator that the party has served a copy of such summary on all other parties in the case. The information provided to the neutral evaluator and the other parties under this Rule shall be a summary of the facts and issues in the case, shall not be more than 10 pages in length, and shall include as attachments copies of any documents supporting the party's summary. Information provided to the neutral evaluator and to the other parties pursuant to this Paragraph shall not be filed with the Commission.

(d) Replies to Pre-conference Submissions. No later than five days prior to the date established for the neutral evaluation conference to begin, any party may, but is not required to, send additional written information to the neutral evaluator responding to the submission of an opposing party. The party's response shall not exceed five pages in length, and the party sending the response shall certify to the neutral evaluator that the party has served a copy of the response on all other parties in the case. The response shall not be filed with the Commission.

(e) Conference Procedure. Prior to a neutral evaluation conference, the neutral evaluator may, if he or she deems it necessary, request additional written information from any party. At the conference, the neutral evaluator may address questions to the parties and give the parties an opportunity to complete their summaries with a brief oral statement.

(f) Modification of Procedure. Subject to the approval of the neutral evaluator, the parties may agree to modify the procedures for neutral evaluation required by the Rules in this Subchapter, or the procedures may be modified by order of the Commission in the interests of justice. The modified procedures may include the presentation of submissions in writing or by telephone in lieu of physical appearance at a neutral evaluation conference, and may also include revisions to the time periods and page limitations concerning the parties' submissions.

(g) Evaluator's Opening Statement. At the beginning of the neutral evaluation conference, the neutral evaluator shall define and describe the following points to the parties:

(1) the facts that:

(A) the conference is not a hearing,

(B) the neutral evaluator is not acting in the capacity of a Commissioner or Deputy Commissioner and shall not act in such capacity in the subject case at any time in the future,
(C) the neutral evaluator's opinions are not binding on any party, and
(D) the parties retain their right to a hearing if the parties do not reach a settlement;
(2) the fact that any settlement reached will be only by mutual consent of the parties;
(3) the process of the proceeding;
(4) the differences between the proceeding and other forms of conflict resolution;
(5) the costs of the proceeding;
(6) the inadmissibility of conduct and statements as provided by G.S. 8C-1, Rule 408 and Paragraph (f) of Rule .0103 in this Subchapter; and
(7) the duties and responsibilities of the neutral evaluator and the participants.

(h) Oral Report to Parties by Evaluator. In addition to the written report to the Commission required under the Rules in this Subchapter, at the conclusion of the neutral evaluation conference, the neutral evaluator shall issue an oral report to the parties advising the parties of the neutral evaluator's opinion of the case. The opinion shall include a candid assessment of liability, estimated settlement values and options, and the strengths and weaknesses of the parties' claims and defenses if the case proceeds to a hearing. The oral report shall also contain a suggested settlement or disposition of the case and the reasons therefor. The neutral evaluator shall not reduce his or her oral report to writing and shall not inform the Commission thereof.

(i) Report of Evaluator to Commission. Within 10 days after the completion of the neutral evaluation conference, the neutral evaluator:

(1) shall submit to the Dispute Resolution Coordinator a written report using a form prepared and distributed by the Commission, stating:
(A) when and where the conference was held,
(B) the names of those persons who attended the conference,
(C) whether or not an agreement was reached by the parties, and
(D) whether the issue or matter will be resolved by Commission form agreement, compromise settlement agreement, other settlement agreement, voluntary dismissal or removal from the hearing docket;
(2) shall identify the persons designated to file or submit for approval such agreement, or dismissal; and
(3) shall provide statistical data for evaluation of the settlement conference programs on forms provided by the Commission.

(j) Evaluator's Authority to Assist Negotiations. If all parties at the neutral evaluation conference request and agree, the neutral evaluator may assist the parties in settlement discussions. If the parties do not reach a settlement during the discussions, the neutral evaluator shall complete the neutral evaluation conference and make his or her written report to the Commission as if the settlement discussions had not occurred.

(k) Finalizing Agreement. If the parties are able to reach an agreement before the conclusion of the neutral evaluation conference and before the evaluator provides his report to the Commission, the parties shall reduce the agreement to writing, specifying all the terms of the parties' agreement that bear on the resolution of the dispute before the Commission, and shall sign the agreement along with the parties' respective counsel. By stipulation of the parties and at their expense, the agreement may be electronically or stenographically recorded. All agreements for payment of compensation shall be submitted for Commission approval and shall be filed with the Commission within 20 days of the conclusion of the conference.

(l) Applicability of Mediation Rules and Duties. All provisions and duties applicable to mediated settlement conferences set forth in Rule .0103 through Rule .0107 of this Subchapter, that are not in conflict with the provisions and duties of Rule .0109 of this Subchapter, apply to neutral evaluation conferences conducted under the Rules in this Subchapter.

(m) Ex Parte Communications Prohibited. Unless all parties agree otherwise, there shall be no ex parte communication prior to the conclusion of the proceeding between the neutral evaluator and any counsel or party on any matter related to the proceeding except with regard to administrative matters.

(n) Adherence to Standards of Conduct for Neutrals. All neutral evaluators conducting neutral evaluation conferences pursuant to the Rules in the Subchapter shall adhere to any applicable standards of conduct that are adopted by the North Carolina Dispute Resolution Commission and are hereby incorporated by reference and include subsequent amendments and editions. A copy may be obtained at no charge from The North Carolina Court System's website, http://www.nccourts.org/Courts/CRS/Councils/DRC/Default.asp, 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.

History Note: *Authority G.S. 97-80(a),(c); 143-296; 143-300; Rule 11 of Rules for Mediated Settlement Conferences and Other Settlement Procedures in Superior Court Civil Actions;*
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10G .0109 Eff. June 1, 2018.

11 NCAC 23G .0110 WAIVER OF RULES

In the interests of justice or to promote judicial economy, the Commission may, except as otherwise provided by the rules in this Subchapter, waive or vary the requirements or provisions of any of the rules in this Subchapter in a case pending before the Commission upon written application of a party or upon its own initiative only if the employee is not represented by counsel. Factors the Commission shall use in determining whether to grant the waiver are:

(1) the necessity of a waiver;
(2) the party's responsibility for the conditions creating the need for a waiver;
(3) the party's prior requests for a waiver;
(4) the precedential value of such a waiver;
(5) notice to and opposition by the opposing parties; and
(6) the harm to the party if the waiver is not granted.

History Note: *Authority G.S. 97-80(a); 97-80(c); 143-296; 143-300;*
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10G .0110 Eff. June 1, 2018.

11 NCAC 23G .0111 MOTIONS

Unless otherwise indicated by the Rules in this Subchapter or an applicable order by the Commission in the interests of justice or judicial economy, motions pursuant to the Rules in this Subchapter shall be addressed to the Commission's Dispute Resolution Coordinator and served on all parties to the claim and the settlement procedure. Responses may be filed with the Commission within 10 days after the date of receipt of the motion. Notwithstanding the above, the Commission may, in the interests of justice, act upon oral motions, or act upon motions prior to the expiration of the 10-day response period. Motions shall be decided without oral argument unless otherwise ordered in the interests of justice. Any appeals from orders issued pursuant to a motion under the Rules in this Subchapter shall be addressed to the attention of the Commission Chair or the Chair's designee for appropriate action.

History Note: *Authority G.S. 97-80(a),(c); 143-296; 143-300;*
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; January 1, 2011; June 1, 2000;
Recodified from 04 NCAC 10G .0111 Eff. June 1, 2018.

11 NCAC 23G .0112 MISCELLANEOUS

Throughout the Rules in this Subchapter any reference to the number of days within which any act may be performed shall mean and refer to calendar days, and shall include Saturdays, Sundays and holidays established by the State Personnel Commission. Provided, however, that if the last day (a) to file a motion, (b) to give notice of the selection of a mediator, or (c) for a pro se plaintiff to give notice that the plaintiff requests mediation is a Saturday, Sunday or holiday established by the State Personnel Commission, the motion or notice may be filed or given on the next day that is not a Saturday, Sunday or holiday established by the State Personnel Commission.

History Note: *Authority G.S. 97-80(a),(c); 143-296; 143-300;*
Eff. January 16, 1996;
Amended Eff. October 1, 1998;
Recodified from 04 NCAC 10A .0616;
Amended Eff. July 1, 2014; June 1, 2000;
Recodified from 04 NCAC 10G .0112 Eff. June 1, 2018.

SUBCHAPTER 23H – RULES OF THE INDUSTRIAL COMMISSION RELATING TO THE PUBLIC SAFETY EMPLOYEES' DEATH BENEFITS ACT

SECTION .0100 – ADMINISTRATION

11 NCAC 23H .0101 LOCATION OF OFFICES AND HOURS OF BUSINESS

For purposes of this Subsection, the offices of the North Carolina Industrial Commission are located in the Dobbs Building, 430 North Salisbury Street, Raleigh, North Carolina. Documents that are not being filed electronically may be filed between the hours of 8:00 a.m. and 5:00 p.m. only. Documents permitted to be filed electronically may be filed until 11:59 p.m. on the required filing date.

History Note: *Authority G.S. 143-166.4;*
Eff. November 1, 1977;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10H .0101 Eff. June 1, 2018.

SECTION .0200 - RULES OF COMMISSION

11 NCAC 23H .0201 DETERMINATION OF CLAIMS BY THE COMMISSION

(a) Upon application for an award under the provisions of the Public Safety Employees' Death Benefits Act, the Commission shall determine whether sufficient evidence is contained in the Commission's workers' compensation or other files upon which to base an order for the payment of benefits. If the Commission is satisfied that such an order should be issued, it shall, without conducting a hearing, file an award directing the payment of benefits.
(b) If the Commission is of the opinion that the Commission's workers' compensation or other files have insufficient evidence upon which to base an award for the payment of benefits, the Commission shall place the case upon the Commission's hearing docket. The Commission shall set a contested case for hearing in a location deemed convenient to witnesses and the Commission.

History Note: *Authority G.S. 143-166.4;*
Eff. August 1, 1979;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10H .0201 Eff. June 1, 2018;
Amended Eff. January 1, 2019.

11 NCAC 23H .0202 HEARINGS BEFORE THE COMMISSION

(a) The Commissioner or Deputy Commissioner before whom a case regarding the Public Safety Employees' Death Benefits Act is set for hearing, shall order the parties to participate in a pre-trial conference. This conference shall be conducted at such place and by such method as the Commissioner or Deputy Commissioner deems appropriate in consideration of the interests of justice and judicial economy, including conference telephone calls.
(b) The Commission shall give notice of hearing in every case. Postponement or continuance of a scheduled hearing shall be granted in the interests of justice or to promote judicial economy.
(c) Notice of the hearing shall be given to the Attorney General of the State of North Carolina, who may appear as amicus curiae.

History Note: *Authority G.S. 143-166.4;*
Eff. August 1, 1979;
Amended Eff. July 1, 2014;

Recodified from 04 NCAC 10H .0202 Eff. June 1, 2018;
Amended Eff. January 1, 2019.

11 NCAC 23H .0203 APPOINTMENT OF GUARDIAN AD LITEM

(a) Infants or incompetents may bring an action under this Subchapter only through their guardian *ad litem*. The Commission shall appoint a person as guardian *ad litem* if the Commission determines it to be in the best interest of the infant or incompetent. The Commission shall appoint a guardian *ad litem* only after due inquiry as to the fitness of the person to be appointed.

(b) No compensation due or owed to the infant or incompetent shall be paid directly to the guardian *ad litem*.

(c) The Commission may assess a fee to be paid to an attorney who serves as a guardian *ad litem* for actual services rendered upon receipt of an affidavit of actual time spent in representation of the infant or incompetent.

History Note: *Authority G.S. 143-166.4;*
Eff. August 1, 1979;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10H .0203 Eff. June 1, 2018.

11 NCAC 23H .0204 WRITTEN OR RECORDED STATEMENT

(a) Upon the request of the employer or his agent to take a written or a recorded statement in an action pursuant to Article 12A of Chapter 143 of the General Statutes, the employer or his agent shall advise any person eligible for payments that the statement may be used to determine whether the claim will be paid or denied. Any person eligible for payments who gives the employer, its carrier, or any agent either a written or recorded statement of the facts and circumstances surrounding the decedent's injury shall be furnished a copy of such statement within 45 days after request. Any person eligible for payments shall immediately be furnished with a copy of the written or recorded statement following a denial of the claim. A copy shall be furnished at the expense of the party to whom the statement was given.

(b) If any party fails to comply with this Rule, a Commissioner or Deputy Commissioner shall enter an order prohibiting that party from introducing the statement into evidence or using any part of the statement.

History Note: *Authority G.S. 143-166.4;*
Eff. August 1, 1979;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10H .0204 Eff. June 1, 2018.

11 NCAC 23H .0205 REVIEW BY THE FULL COMMISSION

(a) A party may request a review of an award filed by a Deputy Commissioner in an action pursuant to Article 12A of Chapter 143 of the General Statutes by filing a letter expressing a request for review to the Full Commission within 15 days of receipt of the award. The award is binding on the parties if not appealed.

(b) After receipt of notice of review, the Commission shall supply to the appellant and to the appellee a transcript of the record upon which the award is based and from which a review is being taken to the Full Commission. The appellant shall, within ten days of receipt of transcript of the record, file with the Commission a written statement of the particular grounds for the appeal, with service on all opposing parties.

(c) Grounds for review not set forth are deemed to be abandoned and argument thereon shall not be heard before the Full Commission.

(d) When a review is made to the Full Commission, the appellant's brief, if any, in support of his ground for appeal shall be filed with the Commission, with service on all opposing parties no less than 15 days prior to the hearing on review. The appellee shall have five days in which to file a reply brief, if deemed necessary, with the Commission, with service on all opposing parties.

(e) Any motions by either party shall be filed with the Full Commission, with service on all opposing parties.

(f) Upon the request of a party, or its own motion, the Commission may waive oral arguments in the interests of justice or to promote judicial economy. In the event of such waiver, the Full Commission shall file an award based on the record and briefs.

History Note: *Authority G.S. 143-166.4;*
Eff. August 1, 1979;
Amended Eff. July 1, 2014;

Recodified from 04 NCAC 10H .0205 Eff. June 1, 2018.

11 NCAC 23H .0206 WAIVER OF RULES

In the interests of justice or to promote judicial economy the Commission may, except as otherwise provided by the rules in this Subchapter, waive or vary the requirements or provisions of any of the rules in this Subchapter in a case pending before the Commission upon written application of a party or upon its own initiative only if the employee is not represented by counsel. Factors the Commission shall use in determining whether to grant the waiver are:

(1) the necessity of a waiver;
(2) the party's responsibility for the conditions creating the need for a waiver;
(3) the party's prior requests for a waiver;
(4) the precedential value of such a waiver;
(5) notice to and opposition by the opposing parties; and
(6) the harm to the party if the waiver is not granted.

History Note: *Authority G.S. 97-80(a); 143-166.4;*
Eff. July 1, 2014;
Recodified from 04 NCAC 10H .0206 Eff. June 1, 2018.

SUBCHAPTER 23I - CHILDHOOD VACCINE-RELATED INJURY RULES OF THE NORTH CAROLINA INDUSTRIAL COMMISSION

SECTION .0100 –ADMINISTRATION

11 NCAC 23I .0101 LOCATIONS OF OFFICES AND HOURS OF BUSINESS

For purposes of this Subsection, the offices of the North Carolina Industrial Commission are located in the Dobbs Building, 430 North Salisbury Street, Raleigh, North Carolina. Documents pertaining to the Childhood Vaccine-Related Injury claims that are not being filed electronically may be filed between the hours of 8:00 a.m. and 5:00 p.m. only. Documents permitted to be filed electronically may be filed until 11:59 p.m. on the required filing date.

History Note: *Authority G.S. 130A-424; 130A-425(d);*
Eff. January 20, 1995;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10I .0101 Eff. June 1, 2018.

11 NCAC 23I .0102 OFFICIAL FORMS

The use of any printed forms related to Childhood Vaccine-Related Injury claims, other than those provided by the Commission is prohibited, except that insurance carriers, self-insurers, attorneys and other parties may reproduce forms for their own use, provided:

(1) no statement, question, or information blank contained on the Commission form is omitted from the substituted form; and
(2) the substituted form is identical in size and format with the Commission form.

History Note: *Authority G.S. 130A-424; 130A-425(d);*
Eff. January 20, 1995;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10I .0102 Eff. June 1, 2018.

SECTION .0200 – RULES OF COMMISSION

11 NCAC 23I .0201 PROCEDURE

When a claim is filed in accordance with G.S. 130A-425(b), the respondent shall determine and report its position to the claimant and the Commission on the issues listed in G.S. 130A-426(a) within 90 days. If the respondent agrees that the claimant has established damages which entitle claimant to money compensation meeting or exceeding the maximum amount set forth in G.S. 130A-427(b), the Commission shall so notify the claimant and respondent, and

further notify them of the services the Department of Human Resources proposes to provide pursuant to G.S. 130A-427(a)(5). The Commission shall allow the parties an opportunity to settle the matter before proceeding to hearing.

History Note: *Authority G.S. 130A-423; 130A-424; 130A-425; 130A-427;*
Eff. January 20, 1995;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10I .0201 Eff. June 1, 2018.

11 NCAC 23I .0202 ATTORNEYS' FEES

An attorney seeking fees pursuant to G.S. 130A-427(a)(4) shall submit to the Commission a copy of the fee agreement, a request for payment of fee, and an affidavit or itemized statement in support of an award of attorneys' fees.

History Note: *Authority G.S. 130A-425(d); 130A-427(a)(4);*
Eff. January 20, 1995;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10I .0202 Eff. June 1, 2018.

11 NCAC 23I .0203 WAIVER OF RULES

In the interests of justice or to promote judicial economy the Commission may, except as otherwise provided by the rules in this Subchapter, waive or vary the requirements or provisions of any of the rules in this Subchapter in a case pending before the Commission upon written application of a party or upon its own initiative only if the employee is not represented by counsel. Factors the Commission shall use in determining whether to grant the waiver are:

(1) the necessity of a waiver;
(2) the party's responsibility for the conditions creating the need for a waiver;
(3) the party's prior requests for a waiver;
(4) the precedential value of such a waiver;
(5) notice to and opposition by the opposing parties; and
(6) the harm to the party if the waiver is not granted.

History Note: *Authority G.S. 97-80(a); 130A-425(d);*
Eff. July 1, 2014;
Recodified from 04 NCAC 10I .0203 Eff. June 1, 2018.

11 NCAC 23I .0204 SANCTIONS

(a) The Commission may, on its own initiative or motion of a party, impose a sanction against a party or attorney or both when the Commission determines that such party, or attorney, or both failed to comply with the Rules in this Subchapter. The Commission may impose sanctions of the type and in the manner prescribed by Rule 37 of the North Carolina Rules of Civil Procedure.

(b) Failure to timely file forms as required by either the Rules in this Subchapter or pursuant to the Childhood Vaccine-Related Injury Compensation Program may result in sanctions.

History Note: *Authority G.S. 130A-425(d);*
Eff. July 1, 2014;
Recodified from 04 NCAC 10I .0204 Eff. June 1, 2018.

SUBCHAPTER 23J – FEES FOR MEDICAL COMPENSATION

SECTION 0100 – FEES FOR MEDICAL COMPENSATION

11 NCAC 23J .0101 GENERAL PROVISIONS

(a) Pursuant to G.S. 97-26, the Commission adopts a Medical Fee Schedule composed of maximum amounts, reimbursement rates, and payment guidelines, as set out in the rules of this Subchapter. The amounts and

reimbursement rates prescribed in the applicable published Medical Fee Schedule shall govern and apply according to G.S. 97-26(c).

(b) The Medical Fee Schedule is available on the Commission's website at http://www.ic.nc.gov/ncic/pages/feesched.asp and in hardcopy at the offices of the Commission as set forth in 11 NCAC 23A .0101.

(c) Insurers and managed care organizations, or administrators on their behalf, may review and reimburse charges for all medical compensation, including medical, hospital, and dental fees, without submitting the charges to the Commission for review and approval.

(d) A provider of medical compensation shall submit its bill 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 bill, the employer, carrier, or managed care organization or administrator on its behalf, shall pay the bill or send the provider written objections to the bill. 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.

(e) When the 10 percent addition to the bill pursuant to G.S. 97-18(i) is uncontested, payment shall be made to the provider without notifying or seeking approval from the Commission. When the 10 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.

(f) When the responsible party seeks an audit of hospital charges, and has paid the hospital charges in full, the payee hospital, upon request, shall provide access to and copies of appropriate records, without charge or fee, to the person(s) chosen by the payor to review and audit the records.

(g) The responsible employer, carrier, managed care organization, or administrator shall pay the bills of medical compensation providers to whom the employee has been referred by the treating physician authorized by the insurance carrier for the compensable injury or body part, unless it has requested that the physician obtain authorization for referrals or tests. Compliance with the request shall not unreasonably delay the treatment or service to be rendered to the employee.

(h) Employees are entitled to reimbursement for travel expenses when the travel is medically necessary and the mileage is 20 or more miles, round trip, at the business standard mileage rate set by the Internal Revenue Service per mile of travel and the actual cost of any tolls paid. Employees are entitled to lodging and meal expenses, at the rate established for state employees by the North Carolina Director of Budget, when it is medically necessary that the employee stay overnight at a location away from the employee's usual place of residence. Employees are entitled to reimbursement for the costs of parking or a vehicle for hire, when the costs are medically necessary, at the actual costs of the expenses. The current reimbursement rates referenced in this Paragraph are contained in the Form 25T, *Itemized Statement of Charges for Travel*, which shall be used to claim travel expenses.

(i) Any employer, carrier, or administrator denying a claim in which medical care has previously been authorized is responsible for all costs incurred prior to the date that notice of denial is provided to each health care provider to whom authorization has been previously given.

History Note: *Authority G.S. 97-18(i); 97-25; 97-25.6; 97-26; 97-80(a); 138-6; S.L. 2013-410;*
Eff. January 1, 1990;
Amended Eff. April 1, 2015; July 1, 2014; January 1, 2013; June 1, 2000;
Recodified from 04 NCAC 10J .0101 Eff. June 1, 2018.

11 NCAC 23J .0102 FEES FOR PROFESSIONAL SERVICES

(a) Except as otherwise provided in this Rule, maximum allowable amounts payable to health care providers for professional services shall be based on the current year's Medicare Part B Fee Schedule for North Carolina ("the Medicare base amount"), as published by the Centers for Medicare & Medicaid Services ("CMS") or its administrative contractor, including subsequent versions and editions. The Medicare Part B Fee Schedule for North Carolina can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html.

(b) The schedule of maximum reimbursement rates for professional services is as follows:

(1) evaluation & management services are 140 percent of the Medicare base amount;

(2) physical medicine services are 140 percent of the Medicare base amount;

(3) emergency medicine services are 169 percent of the Medicare base amount;
(4) neurology services are 153 percent of the Medicare base amount;
(5) pain management services are 163 percent of the Medicare base amount;
(6) radiology services are 195 percent of the Medicare base amount;
(7) major surgery services are 195 percent of the Medicare base amount; and
(8) all other professional services are 150 percent of the Medicare base amount.

(c) The schedule of maximum reimbursement rates for anesthesia services is as follows:

(1) when provided by an anesthesiologist, the allowable amount is three dollars and eighty-eight cents ($3.88) per minute up to and including 60 minutes, and two dollars and five cents ($2.05) per minute beyond 60 minutes; and
(2) when provided by a certified registered nurse anesthetist, the allowable amount is two dollars and fifty-five cents ($2.55) per minute up to and including 60 minutes, and one dollar and fifty-five cents ($1.55) per minute beyond 60 minutes.

(d) The maximum allowable amount for an assistant at surgery is 20 percent of the amount payable for the surgical procedure.

(e) Using the Medicare base amounts and maximum reimbursement rates in Paragraphs (a) through (d) of this Rule the Commission shall publish annually an official Professional Fee Schedule Table listing allowable amounts for individual professional services in accordance with this fee schedule. The allowable amounts contained in the Professional Fee Schedule Table shall take effect January 1 of each year. The Professional Fee Schedule Table is available as set forth in Rule .0101(b) of this Section and in hardcopy at the offices of the Commission as set forth in Rule 11 NCAC 23A .0101.

(f) Maximum allowable amounts for durable medical equipment and supplies ("DME") provided in the context of professional services are 100 percent of those rates established for North Carolina in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies ("DMEPOS") Fee Schedule published by CMS. The DMEPOS can be found at http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html. The Commission will publish annually on its website an official DME Fee Schedule Table listing allowable amounts for individual items and services in accordance with this fee schedule. The allowable amounts contained in the DME Fee Schedule Table will take effect January 1 of each year. The DME Fee Schedule Table is available as set forth in Rule .0101(b) of this Section and in hardcopy at the offices of the Commission as set forth in Rule 11 NCAC 23A .0101.

(g) Maximum allowable amounts for clinical laboratory services are 150 percent of those rates established for North Carolina in the Clinical Diagnostic Laboratory Fee Schedule published by CMS. The CMS Clinical Laboratory Fee Schedule can be found at http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/clinlab.html. The Commission will publish annually on its website an official Clinical Laboratory Fee Schedule Table listing allowable amounts for individual items and services in accordance with this fee schedule. The allowable amounts contained in the Clinical Laboratory Fee Schedule Table will take effect January 1 of each year. The Clinical Laboratory Fee Schedule Table is available as set forth in Rule .0101(b) of this Section and in hardcopy at the offices of the Commission as set forth in Rule 11 NCAC 23A .0101.

(h) The following licensed health care providers may provide professional services in workers' compensation cases subject to physician supervision and other scope of practice requirements and limitations under North Carolina law:

(1) certified registered nurse anesthetists;
(2) anesthesiologist assistants;
(3) nurse practitioners;
(4) physician assistants;
(5) certified nurse midwives; and
(6) clinical nurse specialists.

Services rendered by these providers are subject to the schedule of maximum fees for professional services as provided in this Rule.

History Note: *Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410;*
Eff. April 1, 2015;
Amended Eff. July 1, 2015;
Recodified from 04 NCAC 10J .0102 Eff. June 1, 2018.

11 NCAC 23J .0103 FEES FOR INSTITUTIONAL SERVICES [EFFECTIVE APRIL 1, 2015]

(a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services shall be based on the current federal fiscal year's facility-specific Medicare rate established for each institutional facility by the Centers for Medicare & Medicaid Services ("CMS"). "Facility-specific" rate means the all-inclusive amount eligible for payment by Medicare for a claim, excluding pass-through payments.
(b) The schedule of maximum reimbursement rates for hospital inpatient institutional services is as follows:
(1) Beginning April 1, 2015, 190 percent of the hospital's Medicare facility-specific amount.
(2) Beginning January 1, 2016, 180 percent of the hospital's Medicare facility-specific amount.
(3) Beginning January 1, 2017, 160 percent of the hospital's Medicare facility-specific amount.
(c) The schedule of maximum reimbursement rates for hospital outpatient institutional services is as follows:
(1) Beginning April 1, 2015, 220 percent of the hospital's Medicare facility-specific amount.
(2) Beginning January 1, 2016, 210 percent of the hospital's Medicare facility-specific amount.
(3) Beginning January 1, 2017, 200 percent of the hospital's Medicare facility-specific amount.
(d) Notwithstanding the Paragraphs (a) through (c) of this Rule, maximum allowable amounts for institutional services provided by critical access hospitals ("CAH"), as certified by CMS, are based on the Medicare inpatient per diem rates and outpatient claims payment amounts allowed by CMS for each CAH facility.
(e) The schedule of maximum reimbursement rates for inpatient institutional services provided by CAHs is as follows:
(1) Beginning April 1, 2015, 200 percent of the hospital's Medicare CAH per diem amount.
(2) Beginning January 1, 2016, 190 percent of the hospital's Medicare CAH per diem amount.
(3) Beginning January 1, 2017, 170 percent of the hospital's Medicare CAH per diem amount.
(f) The schedule of maximum reimbursement rates for outpatient institutional services provided by CAHs is as follows:
(1) Beginning April 1, 2015, 230 percent of the hospital's Medicare CAH claims payment amount.
(2) Beginning January 1, 2016, 220 percent of the hospital's Medicare CAH claims payment amount.
(3) Beginning January 1, 2017, 210 percent of the hospital's Medicare CAH claims payment amount.
(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register ("the Medicare ASC facility-specific amount"). Reimbursement shall be based on the fully implemented payment amount in Addendum AA, Final ASC Covered Surgical Procedures for CY 2015, and Addendum BB, Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for 2015, as published in the Federal Register, or their successors.
(h) The schedule of maximum reimbursement rates for institutional services provided by ambulatory surgical centers is as follows:
(1) Beginning April 1, 2015, 220 percent of the Medicare ASC facility-specific amount.
(2) Beginning January 1, 2016, 210 percent of the Medicare ASC facility-specific amount.
(3) Beginning January 1, 2017, 200 percent of the Medicare ASC facility-specific amount.
(i) If the facility-specific Medicare payment includes an outlier payment, the sum of the facility-specific reimbursement amount and the applicable outlier payment amount shall be multiplied by the applicable percentages set out in Paragraphs (b), (c), (e), (f), and (h) of this Rule.
(j) Charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.
(k) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping ("DRG") payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.
(l) For specialty facilities paid outside Medicare's inpatient and outpatient Prospective Payment System, the payment shall be determined using Medicare's payment methodology for those specialized facilities multiplied by the inpatient institutional acute care percentages set out in Paragraphs (b) and (c) of this Rule.

History Note: *Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410;*
Eff. April 1, 2015;
Recodified from 04 NCAC 10J .0103 Eff. June 1, 2018.

11 NCAC 23J .0103 FEES FOR INSTITUTIONAL SERVICES [EFFECTIVE JUNE 1, 2018]]

(a) Except where otherwise provided, maximum allowable amounts for inpatient and outpatient institutional services shall be based on the current federal fiscal year's facility-specific Medicare rate established for each institutional facility by the Centers for Medicare & Medicaid Services ("CMS"). "Facility-specific" rate means the all-inclusive amount eligible for payment by Medicare for a claim, excluding pass-through payments. An institutional facility may only be reimbursed for hospital outpatient institutional services pursuant to this Paragraph and Paragraphs (c), (d), and (f) of this Rule if it qualifies for payment by CMS as an outpatient hospital.

(b) The schedule of maximum reimbursement rates for hospital inpatient institutional services is as follows:

(1) Beginning April 1, 2015, 190 percent of the hospital's Medicare facility-specific amount.

(2) Beginning January 1, 2016, 180 percent of the hospital's Medicare facility-specific amount.

(3) Beginning January 1, 2017, 160 percent of the hospital's Medicare facility-specific amount.

(c) The schedule of maximum reimbursement rates for hospital outpatient institutional services is as follows:

(1) Beginning April 1, 2015, 220 percent of the hospital's Medicare facility-specific amount.

(2) Beginning January 1, 2016, 210 percent of the hospital's Medicare facility-specific amount.

(3) Beginning January 1, 2017, 200 percent of the hospital's Medicare facility-specific amount.

(d) Notwithstanding the Paragraphs (a) through (c) of this Rule, maximum allowable amounts for institutional services provided by critical access hospitals ("CAH"), as certified by CMS, are based on the Medicare inpatient per diem rates and outpatient claims payment amounts allowed by CMS for each CAH facility.

(e) The schedule of maximum reimbursement rates for inpatient institutional services provided by CAHs is as follows:

(1) Beginning April 1, 2015, 200 percent of the hospital's Medicare CAH per diem amount.

(2) Beginning January 1, 2016, 190 percent of the hospital's Medicare CAH per diem amount.

(3) Beginning January 1, 2017, 170 percent of the hospital's Medicare CAH per diem amount.

(f) The schedule of maximum reimbursement rates for outpatient institutional services provided by CAHs is as follows:

(1) Beginning April 1, 2015, 230 percent of the hospital's Medicare CAH claims payment amount.

(2) Beginning January 1, 2016, 220 percent of the hospital's Medicare CAH claims payment amount.

(3) Beginning January 1, 2017, 210 percent of the hospital's Medicare CAH claims payment amount.

(g) Notwithstanding Paragraphs (a) through (f) of this Rule, the maximum allowable amounts for institutional services provided by ambulatory surgical centers ("ASC") shall be based on the most recently adopted and effective Medicare Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems reimbursement formula and factors, including all Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems Addenda, as published annually in the Federal Register and on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/index.html ("the OPPS/ASC Medicare rule"). An ASC's specific Medicare wage index value as set out in the OPPS/ASC Medicare rule shall be applied in the calculation of the maximum allowable amount for any institutional service it provides.

(h) The schedule of maximum reimbursement rates for institutional services provided by ambulatory surgical centers is as follows:

(1) A maximum reimbursement rate of 200 percent shall apply to institutional services that are eligible for payment by CMS when performed at an ASC.

(2) A maximum reimbursement rate of 135 percent shall apply to institutional services performed at an ASC that are eligible for payment by CMS if performed at an outpatient hospital facility, but would not be eligible for payment by CMS if performed at an ASC.

(i) If the facility-specific Medicare payment includes an outlier payment, the sum of the facility-specific reimbursement amount and the applicable outlier payment amount shall be multiplied by the applicable percentages set out in Paragraphs (b), (c), (e), (f), and (h) of this Rule.

(j) Charges for professional services provided at an institutional facility shall be paid pursuant to the applicable fee schedules in Rule .0102 of this Section.

(k) If the billed charges are less than the maximum allowable amount for a Diagnostic Related Grouping ("DRG") payment pursuant to the fee schedule provisions of this Rule, the insurer or managed care organization shall pay no more than the billed charges.

(l) For specialty facilities paid outside Medicare's inpatient and outpatient Prospective Payment System, the payment shall be determined using Medicare's payment methodology for those specialized facilities multiplied by the inpatient institutional acute care percentages set out in Paragraphs (b) and (c) of this Rule.

History Note: *Authority G.S. 97-25; 97-26; 97-80(a); S.L. 2013-410;*
Eff. April 1, 2015;

Temporary Amendment Eff. January 1, 2017;
Temporary Rule invalidated by Order of Judge G. Bryan Collins, Jr. in North Carolina Ambulatory Center Association, et al. v. North Carolina Industrial Commission, No. 17-CVS-00144 (Wake County Superior Court);
Recodified from 04 NCAC 10J .0103 Eff. June 1, 2018;
Amended Eff. June 1, 2018.

SUBCHAPTER 23K – RULES FOR THE EUGENICS ASEXUALIZATION AND STERILIZATION COMPENSATION PROGRAM

SECTION .0100 – ADMINISTRATION

11 NCAC 23K .0101 LOCATION OF OFFICES AND HOURS OF BUSINESS
11 NCAC 23K .0102 OFFICIAL FORMS
11 NCAC 23K .0103 AUTHORITY TO FILE ON BEHALF OF THIRD PARTY

History Note: *Authority G.S. 143B-426.50; 143B-426.52(b),(d);*
Temporary Adoption Eff. December 3, 2013 and shall expire on the earlier of the date all claims made under this section are finally adjudicated or June 30, 2018 pursuant to G.S. 143B-426.52(d);
Recodified from 04 NCAC 10K .0101-.0103 Eff. June 1, 2018;
Temporary Adoption Expired Eff. June 30, 2018.

SECTION .0200 – REVIEW BY DEPUTY COMMISSIONER

11 NCAC 23K .0201 INITIAL DETERMINATION OF CLAIMS BY THE COMMISSION
11 NCAC 23K .0202 REQUESTS FOR ADDITIONAL REVIEW BY THE DEPUTY COMMISSIONER
11 NCAC 23K .0203 HEARINGS BEFORE A DEPUTY COMMISSIONER

History Note: *Authority G.S. 143B-426.52; 143B-426.52(d); 143B-426.53(a),(d);*
Temporary Adoption Eff. December 3, 2013 and shall expire on the earlier of the date all claims made under this section are finally adjudicated or June 30, 2018 pursuant to G.S. 143B-426.52(d);
Recodified from 04 NCAC 10K .0201-.0203 Eff. June 1, 2018;
Temporary Adoption Expired Eff. June 30, 2018.

SECTION .0300 – APPEALS TO THE FULL COMMISSION

11 NCAC 23K .0301 APPEAL TO THE FULL COMMISSION
11 NCAC 23K .0302 MOTIONS FOR RECONSIDERATION BY THE FULL COMMISSION

History Note: *Authority G.S. 143B-426.52(d); 143B-426.53(e);*
Temporary Adoption Eff. December 3, 2013 and shall expire on the earlier of the date all claims made under this section are finally adjudicated or June 30, 2018 pursuant to G.S. 143B-426.52(d);
Recodified from 04 NCAC 10K .0301-.0302 Eff. June 1, 2018;
Temporary Adoption Expired Eff. June 30, 2018.

SECTION .0400 - APPEALS TO THE COURT OF APPEALS

11 NCAC 23K .0401 STAYS
11 NCAC 23K .0402 MOTIONS FOR COURT OF APPEALS CASES
11 NCAC 23K .0403 REMAND FROM APPELLATE COURTS

History Note: *Authority G.S. 143-293; 143-294; 143B-426.50; 143B-426.52(d); 143B-426.53(f);*
Temporary Adoption Eff. December 3, 2013 and shall expire on the earlier of the date all claims made under this section are finally adjudicated or June 30, 2018 pursuant to G.S. 143B-426.52(d).;
Recodified from 04 NCAC 10K .0401-.0403 Eff. June 1, 2018;
Temporary Adoption Expired Eff. June 30, 2018.

SECTION .0500 – RULES OF THE COMMISSION

11 NCAC 23K .0501 WAIVER OF RULES

History Note: *Authority G.S. 143-293; 143B-426.50; 143B-426.52(d);*
Temporary Adoption Eff. December 3, 2013 and shall expire on the earlier of the date all claims made under this section are finally adjudicated or June 30, 2018 pursuant to G.S. 143B-426.52(d);
Recodified from 04 NCAC 10K .0501 Eff. June 1, 2018;
Temporary Adoption Expired Eff. June 30, 2018.

SUBCHAPTER 23L – INDUSTRIAL COMMISSION FORMS

SECTION .0100 – WORKERS' COMPENSATION FORMS

11 NCAC 23L .0101 FORM 21 – AGREEMENT FOR COMPENSATION FOR DISABILITY

(a) The parties to a workers' compensation claim shall use the following Form 21, Agreement for Compensation for Disability, for agreements regarding disability and payment of compensation therefor pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 21, Agreement for Compensation for Disability, shall read as follows:

North Carolina Industrial Commission
Agreement for Compensation for Disability
(G.S. 97-82)

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

_____
Employee's Name

_____
Address

_____
City State Zip

_____
Home Telephone Work Telephone
Last 4 digits of Social Security Number: _____ Sex: ☐ M ☐ F Date of Birth: _____

_____
Employer's Name Telephone Number

_____
Employer's Address City State Zip

_____
Insurance Carrier

_____
Carrier's Address City State Zip

_____
Carrier's Telephone Number Carrier's Fax Number

We, The Undersigned, Do Hereby Agree And Stipulate As Follows:

1. All parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and _____ is the carrier/administrator for the employer.
2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on or by _____.
3. The injury by accident or occupational disease resulted in the following injuries: _____ _____.
4. The employee ☐ was/ ☐ was not paid for the entire day when the injury occurred.
5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____, subject to verification unless otherwise agreed upon in Item 9 below.
6. Disability resulting from the injury or occupational disease began on _____.
7. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $_____ per week beginning _____, and continuing for _____ weeks.
8. The employee ☐ has / ☐ has not returned to work for _____ on _____ , at an average weekly wage of $_____.
9. State any further matters agreed upon, including disfigurement, permanent partial, or temporary partial disability: _____.
10. If applicable, the Second Injury Fund Assessment is $_____. Check ☐ is ☐ is not attached.
11. The date of this agreement is _____. Date of first payment: _____ Amount: _____.

_____
Name Of Employer Signature Title

_____
Name Of Carrier / Administrator Signature Title

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 2 of this form.

_____
Signature of Employee Address

_____
Signature of Employee's Attorney Address

North Carolina Industrial Commission
The Foregoing Agreement Is Hereby Approved:

_____
Claims Examiner Date

_____
Attorney's Fee Approved

☐ Check Box If No Attorney Retained.
☐ Check Box If Employee Is In Managed Care.

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS
If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must file an application for additional medical compensation pursuant to G.S. 97-25.1 within two years, or your right to these benefits may be lost. An application for additional medical compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission forms are available at https://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER

The employee must be provided a copy of the form when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

NEED ASSISTANCE?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.

Form 21
3/2021

Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"):
https://www.ic.nc.gov/docfiling.html
Contact Information:
NCIC- Claims Administration
Telephone: (919) 807-2502
Helpline: (800) 688-8349
Website: https://www.ic.nc.gov

(b) The copy of the form described in Paragraph (a) of this Rule can be accessed at https://www.ic.nc.gov/forms/form21.pdf. The form may be reproduced only in the format available at https://www.ic.nc.gov/forms/form21.pdf and may not be altered or amended in any way.

History Note: *Authority G.S. 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10L .0101 Eff. June 1, 2018;
Amended Eff. March 1, 2021.

11 NCAC 23L .0102 FORM 26 – SUPPLEMENTAL AGREEMENT AS TO PAYMENT OF COMPENSATION

(a) If the parties to a workers' compensation claim have previously entered into an approved agreement on a Form 21, Agreement for Compensation for Disability, or a Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, they shall use the following Form 26, Supplemental Agreement as to Payment of

Compensation, for agreements regarding subsequent additional disability and payment of compensation pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 26, Supplemental Agreement as to Payment of Compensation, shall read as follows:

North Carolina Industrial Commission
Supplemental Agreement as to Payment
of Compensation (G.S. §97-82)

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

_____
Employee's Name

_____
Address

_____
City State Zip

_____
Home Telephone Work Telephone
Last 4 digits of Social Security Number: _____ Sex: ☐ M ☐ F Date of Birth: _____

_____
Employer's Name Telephone Number

_____
Employer's Address City State Zip

_____
Insurance Carrier

_____
Carrier's Address City State Zip

_____
Carrier's Telephone Number Carrier's Fax Number

We, The Undersigned, Do Hereby Agree and Stipulate As Follows:

1. Date of injury: _____.
2. The employee ☐ returned to work / ☐ was rated on _____ (date), at a weekly wage of $_____.
3. The employee became totally disabled on _____.
4. Employee's average weekly wage ☐ was reduced / ☐ was increased on _____, from $_____ per week to $_____ per week.
5. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $_____ per week.

Beginning _____, and continuing for_____ weeks. The type of disability compensation is _____.

6. State any further matters agreed upon, including disfigurement or temporary partial disability: _____.

7. The date of this agreement is _____.

_____
Name Of Employer Signature Title

_____

Name Of Carrier/Administrator Signature Title

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 2 of this form.

_____

Signature of Employee Address

_____

Signature of Employee's Attorney Address

☐ Check box if no attorney retained.

North Carolina Industrial Commission
The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner Date

_____

Attorney's fee approved

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must file an application for additional medical compensation pursuant to G.S. 97-25.1 within two years, or your right to these benefits may be lost. An application for additional medical compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission forms are available at https://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER

This form shall be used only to supplement Form 21, *Agreement for Compensation for Disability* (G.S. 97-82), or an award in cases in which subsequent conditions require a modification of a former agreement or award. The employee must be provided a copy of the form when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission. The employer or carrier/administrator shall file a Form 28B, *Report of Compensation and Medical Compensation Paid*, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

NEED ASSISTANCE?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.

Form 26
3/2021

Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"):
https://www.ic.nc.gov/docfiling.html
Contact Information:
NCIC- Claims Administration
Telephone: (919) 807-2502
Helpline: (800) 688-8349
Website: https://www.ic.nc.gov

(b) The copy of the form described in Paragraph (a) of this Rule can be accessed at https://www.ic.nc.gov/forms/form26.pdf. The form may be reproduced only in the format available at https://www.ic.nc.gov/forms/form26.pdf and may not be altered or amended in any way.

History Note: *Authority G.S. 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10L .0102 Eff. June 1, 2018;
Amended Eff. March 1, 2021.

11 NCAC 23L .0103 FORM 26A – EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO PERMANENT PARTIAL DISABILITY (EFFECTIVE DECEMBER 1, 2020)

(a) The parties to a workers' compensation claim shall use the following Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, for agreements regarding the employee's entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31. Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to G.S. 97-30, may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, shall read as follows:

North Carolina Industrial Commission
Employer's Admission of Employee's Right to Permanent Partial Disability
(G.S. 97-31)

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____
Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

_____
Employee's Name
_____
Address
_____
City State Zip
_____
Home Telephone Work Telephone
Social Security Number: _____ Sex: □ M □ F Date of Birth: _____

_____
Employer's Name Telephone Number
_____
Employer's Address City State Zip
_____

Insurance Carrier

_____

Carrier's Address City State Zip

_____

Carrier's Telephone Number Carrier's Fax Number

WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:

1. All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and _____ is the Carrier/Administrator for the Employer.
2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on _____.
3. The injury by accident or occupational disease resulted in the following injuries: _____.
4. The employee □ was □ was not paid for the 7 day waiting period.

If not, was salary continued? □ yes □ no. Was employee paid for the date of injury? □ yes □ no

5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____. This results in a weekly compensation rate of $_____.
6. The employee □ has □ has not returned full time to work for _____ on _____, at an average weekly wage of $_____.
7. Claimant was released □ with permanent restrictions □ without permanent restrictions. If claimant was released with permanent restrictions and has returned to work for the employer of injury, attach a job description if known to exist.
8. Permanent partial disability compensation will be paid to the injured worker as follows:

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

Total amount of permanent partial disability compensation is $_____. Date of first payment:_____.

9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: _____.
10. An overpayment is claimed in the amount of $_____. Overpayment was calculated as follows:_____.

If overpayment claimed, a Form 28B, Report of Compensation and Medical Compensation Paid, is attached. □ yes □ no

11. If applicable, the Second Injury Fund Assessment is $ _____. A check □ is □ is not included.

The undersigned hereby certify that the material medical and vocational records related to the injury, including any job description known to exist if the employee has permanent restrictions and has returned to work for the employer of injury, have been provided to the employee or the employee's attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. 97-82(a) and Rule 11 NCAC 23A .0501.

_____

Name Of Employer Signature Title Date

_____

Name Of Carrier/Administrator Signature Direct Phone Number Email Address Title Date

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 3 of this form.

_____

Signature of Employee Address Email Address Date

_____

Signature of Employee's Attorney Address Email Address Date

☐ Check box if no attorney retained.

North Carolina Industrial Commission
The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner Date

_____

Attorney's fee approved

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must apply to the Industrial Commission in writing within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission 18M, Employee's Application for Additional Medical Compensation (G.S. 97-25.1), available at http://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER

The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission, or show cause for not submitting the agreement. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

NEED ASSISTANCE?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.

Form 26A
12/2020

Self-Insured Employer or Carrier Mail to:
NCIC - Claims Administration
4335 Mail Service Center
Raleigh, North Carolina 27699-4335
Main Telephone: (919) 807-2500
Helpline: (800) 688-8349
Website: http://www.ic.nc.gov/

(b) A copy of the form described in Paragraph (a) of this Rule can be accessed at http://www.ic.nc.gov/forms/form26a.pdf. The form may be reproduced only in the format available at http://www.ic.nc.gov/forms/form26a.pdf and may not be altered or amended in any way.

History Note: *Authority G.S. 97-30; 97-31; 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10L .0103 Eff. June 1, 2018;
Amended Eff. December 1, 2020.

11 NCAC 23L .0103 FORM 26A – EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO PERMANENT PARTIAL DISABILITY (EFFECTIVE MARCH 1, 2021)

(a) The parties to a workers' compensation claim shall use the following Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, for agreements regarding the employee's entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31. Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to G.S. 97-30, may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, shall read as follows:

North Carolina Industrial Commission
Employer's Admission of Employee's Right to Permanent Partial Disability
(G.S. 97-31)

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

_____
Employee's Name

_____
Address

_____
City State Zip

_____
Home Telephone Work Telephone
Last 4 digits of Social Security Number: _____ Sex: ☐ M ☐ F Date of Birth: _____

_____
Employer's Name Telephone Number

_____
Employer's Address City State Zip

_____
Insurance Carrier

_____
Carrier's Address City State Zip

_____
Carrier's Telephone Number Carrier's Fax Number

WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:

1. All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and _____ is the Carrier/Administrator for the Employer.
2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on _____.

3. The injury by accident or occupational disease resulted in the following injuries: _____.

4. The employee ☐ was ☐ was not paid for the 7 day waiting period.

If not, was salary continued? ☐ yes ☐ no. Was employee paid for the date of injury? ☐ yes ☐ no

5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____. This results in a weekly compensation rate of $_____.

6. The employee ☐ has ☐ has not returned full time to work for _____ on _____, at an average weekly wage of $_____.

7. Claimant was released ☐ with permanent restrictions ☐ without permanent restrictions. If claimant was released with permanent restrictions and has returned to work for the employer of injury, attach a job description if known to exist.

8. Permanent partial disability compensation will be paid to the injured worker as follows:

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)
____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

Total amount of permanent partial disability compensation is $_____. Date of first payment:_____.

9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: _____.

10. An overpayment is claimed in the amount of $_____. Overpayment was calculated as follows:_____.

If overpayment claimed, a Form 28B, Report of Compensation and Medical Compensation Paid, is attached. ☐ yes ☐ no

11. If applicable, the Second Injury Fund Assessment is $ _____. A check ☐ is ☐ is not included.

The undersigned hereby certify that the material medical and vocational records related to the injury, including any job description known to exist if the employee has permanent restrictions and has returned to work for the employer of injury, have been provided to the employee or the employee's attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. 97-82(a) and Rule 11 NCAC 23A .0501.

_____

Name Of Employer Signature Title Date

_____

Name Of Carrier/Administrator Signature Direct Phone Number Email Address Title Date

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 3 of this form.

_____

Signature of Employee *Address* Email Address Date

_____

Signature of Employee's Attorney Address Email Address Date

☐ Check box if no attorney retained.

North Carolina Industrial Commission
The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner Date

_____

Attorney's fee approved

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS
If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS
If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must file an application for additional medical compensation pursuant to G.S. 97-25.1 within two years, or your right to these benefits may be lost. An application for additional medical compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission forms are available at https://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER
The employee must be provided a copy of the form when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

NEED ASSISTANCE?
If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.

Form 26A
3/2021

Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"):
https://www.ic.nc.gov/docfiling.html
Contact Information:
NCIC- Claims Administration
Telephone: (919) 807-2502
Helpline: (800) 688-8349
Website: https://www.ic.nc.gov

(b) A copy of the form described in Paragraph (a) of this Rule can be accessed at https://www.ic.nc.gov/forms/form26a.pdf. The form may be reproduced only in the format available at https://www.ic.nc.gov/forms/form26a.pdf and may not be altered or amended in any way.

History Note: *Authority G.S. 97-30; 97-31; 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10L .0103 Eff. June 1, 2018;
Amended Eff. December 1, 2020;
Amended Eff. March 1, 2021.

11 NCAC 23L .0104 FORM 36 – SUBPOENA
(a) The parties to a claim shall use the following Form 36, *Subpoena*, to subpoena a person(s) to appear and testify and/or produce documents for inspection before the Commission. The Form 36, *Subpoena*, shall read as follows:

STATE OF NORTH CAROLINA File No. _____
_____ County North Carolina Industrial Commission
_____
VERSUS
_____
SUBPOENA
G.S. 1A-1, Rule 45; G.S. 8-59; G.S. 97-80(e)

Party Requesting Subpoena
___ NCIC/State/Plaintiff ___ Defendant

NOTE TO PARTIES NOT REPRESENTED BY COUNSEL: Subpoenas may be produced at your request, but must be signed and issued by a Commissioner, Deputy Commissioner, or the Executive Secretary.

TO: Name and Address of Person Subpoenaed _____
Alternate Address _____
Telephone No. _____
Alternate Telephone No. _____

YOU ARE COMMANDED TO: (check all that apply):
___ appear and testify, in the above entitled action, before the Industrial Commission at the place, date and time indicated below.
___ appear and testify, in the above entitled action, at a deposition at the place, date and time indicated below.
___ produce and permit inspection and copying of the following items, at the place, date and time indicated below. (A party shall not issue a *subpoena duces tecum* less than 30 days prior to the hearing date except upon prior approval of the Commission. G.S. 97-80(e).)
___ See attached list. (List here if space sufficient)
_____
Location of Hearing/Place of Deposition/Place to Produce _____
Date to Appear/Produce _____
Time to Appear/Produce ___:___ __ AM __ PM
Name and Address of Applicant or Applicant's Attorney _____
Date _____
Signature of Official or Attorney _____
___ Deputy Commissioner ___ Commissioner ___ Executive Secretary ___ Attorney
Telephone No. of Applicant or Applicant's Attorney_____

RETURN OF SERVICE
I certify this subpoena was received and served on the person subpoenaed as follows:
By
___ personal delivery.
___ registered or certified mail, receipt requested and attached.
___ service by Sheriff.
___ I was unable to serve this subpoena. Reason unable to serve: _____

Service Fee $ _____
___ Paid
___ Due
Date Served _____
Name of Authorized Server (Type Or Print) _____
Signature of Authorized Server _____
Title _____

NOTE TO PERSON REQUESTING SUBPOENA: A copy of this subpoena must be delivered, mailed or faxed to the attorney for each party in this case. If a party is not represented by an attorney, the copy must be mailed or delivered to the party.

NOTE: Rule 45, North Carolina Rules of Civil Procedure, Subsections (c) and (d). (With respect to the provisions of Rule 45 cited below as they apply to this subpoena, the North Carolina Industrial Commission is the "court" and the "court in the county." All motions regarding this subpoena shall be filed with the North Carolina Industrial Commission pursuant to 11 NCAC 23A .0609.)

(c) Protection of Persons Subject to Subpoena

(1) Avoid undue burden or expense. - A party or an attorney responsible for the issuance and service of a subpoena shall take reasonable steps to avoid imposing an undue burden or expense on a person subject to the subpoena. The court shall enforce this subdivision and impose upon the party or attorney in violation of this requirement an appropriate sanction that may include compensating the person unduly burdened for lost earnings and for reasonable attorney's fees.

(2) For production of public records or hospital medical records. - Where the subpoena commands any custodian of public records or any custodian of hospital medical records, as defined in G.S. 8-44.1, to appear for the sole purpose of producing certain records in the custodian's custody, the custodian subpoenaed may, in lieu of personal appearance, tender to the court in which the action is pending by registered or certified mail or by personal delivery, on or before the time specified in the subpoena, certified copies of the records requested together with a copy of the subpoena and an affidavit by the custodian testifying that the copies are true and correct copies and that the records were made and kept in the regular course of business, or if no such records are in the custodian's custody, an affidavit to that effect. When the copies of records are personally delivered under this subdivision, a receipt shall be obtained from the person receiving the records. Any original or certified copy of records or an affidavit delivered according to the provisions of this subdivision, unless otherwise objectionable, shall be admissible in any action or proceeding without further certification or authentication. Copies of hospital medical records tendered under this subdivision shall not be open to inspection or copied by any person, except to the parties to the case or proceedings and their attorneys in depositions, until ordered published by the judge at the time of the hearing or trial. Nothing contained herein shall be construed to waive the physician-patient privilege or to require any privileged communication under law to be disclosed.

(3) Written objection to subpoena. - Subject to subsection (d) of this rule, a person commanded to appear at a deposition or to produce and permit the inspection and copying of records, books, papers, documents, electronically stored information, or tangible things may, within 10 days after service of the subpoena or before the time specified for compliance if the time is less than 10 days after service, serve upon the party or the attorney designated in the subpoena written objection to the subpoena, setting forth the specific grounds for the objection. The written objection shall comply with the requirements of Rule 11 of the North Carolina Rules of Civil Procedure. Each of the following grounds may be sufficient for objecting to a subpoena:

a. The subpoena fails to allow reasonable time for compliance.
b. The subpoena requires disclosure of privileged or other protected matter and no exception or waiver applies to the privilege or protection.
c. The subpoena subjects a person to an undue burden or expense.
d. The subpoena is otherwise unreasonable or oppressive.
e. The subpoena is procedurally defective.

(4) Order of court required to override objection. - If objection is made under subdivision (3) of this subsection, the party serving the subpoena shall not be entitled to compel the subpoenaed person's appearance at a deposition or to inspect and copy materials to which an objection has been made except pursuant to an order of the court. If objection is made, the party serving the subpoena may, upon notice to the subpoenaed person, move at any time for an order to compel the subpoenaed person's appearance at the deposition or the production of the materials designated in the subpoena. The motion shall be filed in the court in the county in which the deposition or production of materials is to occur.

(5) Motion to quash or modify subpoena. - A person commanded to appear at a trial, hearing, deposition, or to produce and permit the inspection and copying of records, books, papers, documents, electronically stored information, or other tangible things, within 10 days after service of the subpoena or before the time specified for compliance if the time is less than 10 days after service, may file a motion to quash or modify the subpoena. The court shall quash or modify the subpoena if the subpoenaed person demonstrates the existence of any of the reasons set forth in subdivision (3) of this subsection. The motion shall be filed in the court in the county in which the trial, hearing, deposition, or production of materials is to occur.

(6) Order to compel; expenses to comply with subpoena. - When a court enters an order compelling a deposition or the production of records, books, papers, documents, electronically stored information, or other tangible things, the order shall protect any person who is not a party or an agent of a party from significant expense resulting from complying with the subpoena. The court may order that the person to whom the subpoena is addressed will be reasonably compensated for the cost of producing the records, books, papers, documents, electronically stored information, or tangible things specified in the subpoena.

(7) Trade secrets; confidential information. - When a subpoena requires disclosure of a trade secret or other confidential research, development, or commercial information, a court may, to protect a person subject to or affected by the subpoena, quash or modify the subpoena, or when the party on whose behalf the subpoena is issued shows a substantial need for the testimony or material that cannot otherwise be met without undue hardship, the court may order a person to make an appearance or produce the materials only on specified conditions stated in the order.

(8) Order to quash; expenses. - When a court enters an order quashing or modifying the subpoena, the court may order the party on whose behalf the subpoena is issued to pay all or part of the subpoenaed person's reasonable expenses including attorney's fees.

(d) Duties in Responding to Subpoena

(1) Form of response. - A person responding to a subpoena to produce records, books, documents, electronically stored information, or tangible things shall produce them as they are kept in the usual course of business or shall organize and label them to correspond with the categories in the request.

(2) Form of producing electronically stored information not specified. - If a subpoena does not specify a form for producing electronically stored information, the person responding must produce it in a form or forms in which it ordinarily is maintained or in a reasonably useable form or forms.

(3) Electronically stored information in only one form. - The person responding need not produce the same electronically stored information in more than one form.

(4) Inaccessible electronically stored information. - The person responding need not provide discovery of electronically stored information from sources that the person identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the person responding must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the court may nonetheless order discovery from such sources if the requesting party shows good cause, after considering the limitations of Rule 26(b)(1a) of the North Carolina Rules of Civil Procedure. The court may specify conditions for discovery, including requiring the party that seeks discovery from a nonparty to bear the costs of locating, preserving, collecting, and producing the electronically stored information involved.

(5) Specificity of objection. - When information subject to a subpoena is withheld on the objection that it is subject to protection as trial preparation materials, or that it is otherwise privileged, the objection shall be made with specificity and shall be supported by a description of the nature of the communications, records, books, papers, documents, electronically stored information, or other tangible things not produced, sufficient for the requesting party to contest the objection.

INFORMATION FOR WITNESS

NOTE: If you have any questions about being subpoenaed as a witness, you should contact the person named on Page One of this Subpoena in the box labeled "Name And Address Of Applicant Or Applicant's Attorney."

DUTIES OF A WITNESS

- Unless otherwise directed by the presiding Deputy Commissioner or Commissioner, you must answer all questions asked when you are on the stand giving testimony.
- In answering questions, speak clearly and loudly enough to be heard.
- Your answers to questions must be truthful.
- If you are commanded to produce any items, you must bring them with you to court or to the deposition.
- You must continue to attend court until released by the court. You must continue to attend a deposition until the deposition is completed.

BRIBING OR THREATENING A WITNESS

It is a violation of State law for anyone to attempt to bribe, threaten, harass, or intimidate a witness. If anyone attempts to do any of these things concerning your involvement as a witness in a case, you should promptly report that to the presiding Deputy Commissioner or Commissioner.

Form 36 (Rev. 4/14)

(b) The copy of the form described in Paragraph (a) of this Rule can be accessed at http://www.ic.nc.gov/forms/form36.pdf. The form may be reproduced only in the format available at http://www.ic.nc.gov/forms/form36.pdf and may not be altered or amended in any way.

History Note: *Authority G.S. 1A-1, Rule 45; 8-59; 97-80(a); 97-80(e); 97-81(a); S.L. 2013-294, s. 8.(12); Eff. July 1, 2014; Recodified from 04 NCAC 10L .0104 Eff. June 1, 2018.*

11 NCAC 23L .0105 FORM T-42 – APPLICATION FOR APPOINTMENT OF GUARDIAN AD LITEM

(a) Persons seeking to appear on behalf of an infant or incompetent shall apply on a Form T-42, Application for Appointment of Guardian Ad Litem, in accordance with Rule 11 NCAC 23B .0203. The Form T-42, Application for Appointment of Guardian Ad Litem, shall read as follows:

North Carolina Industrial Commission
IC File # TA- _____
Application for Appointment of Guardian Ad Litem
The use of this Form is required under Rule 11 NCAC 23B .0203

_____ Plaintiff(s) v. _____Defendant(s)

To the North Carolina Industrial Commission:

The undersigned _____ respectfully shows unto the North Carolina Industrial Commission that _____ is an __ infant or __ incompetent without general or testamentary guardian in this State, and that by reason thereof can bring an action only by a guardian ad litem; that the infant or incompetent has a cause of action against the defendants on account of the following matter and things:
_____
The undersigned is a reputable person closely connected with the infant or incompetent having the relationship with the infant or incompetent as follows: _____

Wherefore, the undersigned prays the Commission that a fit and proper person be appointed Guardian Ad Litem for the infant or incompetent for the purpose of bringing on his or her behalf an action as above set out.
Signature of Applicant _____ Date_____

(Please complete page 2 of form)

Order Appointing Guardian Ad Litem

It appearing to the North Carolina Industrial Commission from the above application that _____ is an __ infant or __ incompetent having no general or testamentary guardian within this State and that said infant or incompetent appears to have a good cause of action against the defendant(s); and it further appearing to the Commission after due inquiry that _____ is a fit and proper person to be appointed guardian ad litem for the infant or incompetent for the purpose of bringing this action on his or her behalf;
It is therefore ordered that _____ be and is hereby appointed guardian ad litem of _____ to bring action on his or her behalf.

This _____ day of _____.

Commissioner, Deputy Commissioner, or Executive Secretary
_____

Please type or print:

Full name and address of minor or incompetent:

_____

Birth date of minor: _____

Full name and address of proposed guardian ad litem:

_____

Important Information for Parties

Parties should take notice of the provisions set forth in Rule 11 NCAC 23B .0203.

11 NCAC 23B .0203 Infants and Incompetents

(a) Persons seeking to appear on behalf of an infant or incompetent, in accordance with G.S. 1A-1, Rule 17, shall apply on a Form T-42 Application for Appointment of Guardian ad Litem. The Commission shall appoint a fit and proper person as guardian ad litem, if the Commission determines it to be in the best interest of the minor or incompetent. The Commission shall appoint the guardian ad litem only after due inquiry as to the fitness of the person to be appointed.

(b) The Commission may assess a fee to be paid to an attorney who serves as a guardian ad litem for actual services rendered upon receipt of an affidavit of actual time spent in representation of the minor or incompetent as part of the costs.

ATTORNEYS: File via Electronic Document Filing Portal ("EDFP")
https://www.ic.nc.gov/docfiling.html
UNREPRESENTED PLAINTIFFS: File via EDFP, https://www.ic.nc.gov/docfiling.html OR
Mail to: Industrial Commission Clerk's Office, 1236 Mail Service Center, Raleigh NC 27699-1236 OR
File via hand delivery: Business days from 8 a.m. – 5 p.m., Dobbs Building, 6th floor, 430 N. Salisbury Street, Raleigh NC 27603 OR Fax to (919) 715-0282 OR Email to dockets@ic.nc.gov.

FORM T-42

(b) A copy of the form described in Paragraph (a) of this Rule can be accessed at https://www.ic.nc.gov/forms/formt-42.pdf. The form shall be reproduced only in the format available at https://www.ic.nc.gov/forms/formt-42.pdf and shall not be altered or amended in any way.

History Note: *Authority G.S. 143-291; 143-295; 143-300;*
Eff. March 1, 2019;
Amended Eff. March 1, 2021.

SUBCHAPTER 23M – RULES FOR THE UTILIZATION OF OPIOIDS, RELATED PRESCRIPTIONS, AND PAIN MANAGEMENT TREATMENT IN WORKERS' COMPENSATION CLAIMS

SECTION .0100 – GENERAL PROVISIONS

11 NCAC 23M .0101 PURPOSE AND APPLICABILITY OF THE RULES

(a) The rules in this Subchapter address the utilization of opioids, related prescriptions, and pain management treatment in all claims arising under the provisions of the Workers' Compensation Act. However, Section .0200 of this Subchapter shall not apply to claims in which the employee received treatment with a targeted controlled substance for more than 12 consecutive weeks immediately preceding the effective date of the rules.

(b) The rules in this Subchapter apply to the prescription of targeted controlled substances as defined in Rule .0102 of this Section and the prescription of other modalities of pain management treatment for the outpatient treatment of non-cancer pain in claims in which the employer is providing medical compensation pursuant to the Workers' Compensation Act. The rules in this Subchapter do not apply to prescriptions for medications to be administered in a health care setting.

(c) The rules do not constitute medical advice or a standard of medical care. Disputes regarding the treatment addressed by these Rules shall be governed by G.S. 97-25 and Rule 11 NCAC 23A .0609A.

History Note: *Authority G.S. 97-25; 97-25.4; 97-80(a); S.L. 2017-203, s. 4;*
Eff. May 1, 2018;
Recodified from 04 NCAC 10M .0101 Eff. June 1, 2018.

11 NCAC 23M .0102 DEFINITIONS

As used in this Subchapter:

(1) "Acute phase" means 12 weeks of treatment for pain following an injury by accident, occupational disease, surgery for an injury by accident or occupational disease, or subsequent aggravation of an injury by accident or occupational disease. There may be more than one acute phase during treatment for an injury or occupational disease.

(2) "Chronic phase" means continued treatment for pain immediately following a 12-week period of treatment for pain using a targeted controlled substance.

(3) "Confirmatory urine drug test" means a definitive urine drug test that verifies the results of a presumptive urine drug test. A confirmatory urine drug test identifies individual drugs and drug metabolites. Health care providers shall use a confirmatory drug test for the lowest number of drug classes necessary based on the results of the presumptive urine drug test, not to exceed 21 drug classes.

(4) "CSRS" means the Controlled Substances Reporting System as established by the North Carolina Controlled Substances Reporting System Act, Article 5E of Chapter 90 of the North Carolina General Statutes.

(5) "Long-acting opioid" or "extended-release opioid" means any targeted controlled substance that is formulated to release the drug gradually into the bloodstream or to have a long half-life for prolonged activity with an analgesic effect of 8 to 72 hours or longer.

(6) "Lowest effective dosage" means the lowest dose necessary to achieve the clinical goal.

(7) "Morphine equivalent dose" means conversion of various opioids to an equivalent morphine dose by using the most current conversion guidelines provided by the Centers for Disease Control and Prevention ("CDC"). The CDC Opioid Prescribing Guideline Mobile App and the CDC's guidelines for Calculating Total Daily Dose of Opioids for Safer Dosage are hereby incorporated by reference, including any subsequent amendments or editions. These materials are available online at no cost at https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf and https://www.cdc.gov/drugoverdose/pdf/App_Opioid_Prescribing_Guideline-a.pdf.

(8) "Opioid antagonist" means the term as defined in G.S. 90-12.7(a).

(9) "Pain" means pain resulting from an injury by accident or occupational disease.

(10) "Presumptive urine drug test" means an initial urine drug test that identifies negative specimens and presumptive positive specimens, and is interpreted through visual examination. Examples include dipstick tests and drug test cups. A health care provider who is providing pain management treatment in the chronic phase to an employee may administer a presumptive urine drug test that is qualitative and interpreted or analyzed with instrumental or chemical assistance if the health care provider believes, in his or her medical opinion, that a more sensitive presumptive urine drug test is appropriate and is likely to reduce the need for a confirmatory urine drug test.

(11) "Short-acting opioid" means any targeted controlled substance with a quick onset of action and short duration of analgesic activity that is formulated for dosing at intervals of two to six hours.

(12) "Targeted controlled substance" means any controlled substance included in G.S. 90-90(1) or (2) or G.S. 90-91(d).

History Note: *Authority G.S. 97-25.4; 97-80(a); S.L. 2017-203, s. 4;*
Eff. May 1, 2018;
Recodified from 04 NCAC 10M .0102 Eff. June 1, 2018.

11 NCAC 23M .0103 WAIVER OF RULES

In the interests of justice or to promote judicial economy, the Commission may, except as otherwise provided by the rules in this Subchapter, waive or vary the requirements or provisions of any of the rules in this Subchapter in a case pending before the Commission upon written application of a party or upon its own initiative. Factors the Commission shall use in determining whether to grant the waiver are:

(1) the necessity of a waiver;

(2) the party's responsibility for the conditions creating the need for a waiver;

(3) the party's prior requests for a waiver;
(4) the precedential value of such a waiver;
(5) notice to and opposition by the opposing parties; and
(6) the harm to the party if the waiver is not granted.

History Note: *Authority G.S. 97-25; 97-25.4; 97-80(a); S.L. 2017-203, s. 4;*
Eff. May 1, 2018;
Recodified from 04 NCAC 10M .0103 Eff. June 1, 2018.

SECTION .0200 – UTILIZATION RULES FOR OPIOID AND OTHER PHARMACOLOGICAL PAIN MANAGEMENT TREATMENT

11 NCAC 23M .0201 FIRST PRESCRIPTION OF MEDICATION FOR PAIN IN AN ACUTE PHASE

(a) This Rule applies to the first prescription of any medication to an employee for pain in an acute phase.
(b) Before prescribing a targeted controlled substance, a health care provider shall document his or her medical opinion in the medical record that non-pharmacological and non-opioid therapies are insufficient to treat the employee's pain.
(c) A health care provider shall not prescribe more than one targeted controlled substance at the time of the first prescription. A health care provider shall not provide at the time of the first prescription any additional prescription for a targeted controlled substance to be dispensed at a later time.
(d) A health care provider shall prescribe the lowest number of days' supply of a targeted controlled substance necessary in his or her medical opinion to treat an employee's pain, not to exceed a five-day supply. However, the first prescription of any targeted controlled substance for post-operative pain immediately following a surgical procedure may exceed five days but shall not exceed a seven-day supply.
(e) A health care provider shall prescribe the lowest effective dosage of a targeted controlled substance, not to exceed a 50 mg morphine equivalent dose per day, using only short-acting opioids. However, a health care provider may prescribe more than a 50 mg morphine equivalent dose per day, if the employee was being prescribed a targeted controlled substance immediately prior to the first prescription. The dosage limits in this Paragraph apply only to an opioid prescription being prescribed pursuant to this Rule.
(f) A health care provider shall not prescribe transcutaneous, transdermal, transmucosal, or buccal opioid preparations without documentation in the medical record that oral opioid dosing is medically contraindicated for the employee.
(g) A health care provider shall not prescribe fentanyl for pain in an acute phase.
(h) A health care provider shall not prescribe benzodiazepines for pain or as muscle relaxers in an acute phase.
(i) A health care provider shall not prescribe carisoprodol and a targeted controlled substance in an acute phase.
(j) If an employee is taking benzodiazepines or carisoprodol prescribed by another health care provider, the health care provider shall not prescribe a targeted controlled substance to the employee without advising the employee of the potential risks of combining a targeted controlled substance and benzodiazepines or carisoprodol. The health care provider shall also communicate with the health care provider prescribing the benzodiazepines or carisoprodol to inform that health care provider of the prescription of a targeted controlled substance.
(k) A health care provider shall review the information in the CSRS pertaining to the employee for the 12-month period preceding the first prescription. The health care provider shall document in the medical record the review and any potential contraindications to prescribing a targeted controlled substance found in the CSRS. The effective date of this Paragraph is November 1, 2018, or shall coincide with the date of application in S.L. 2017-74, s. 15.(e), and any amendments thereto, whichever is earlier.

History Note: *Authority G.S. 90-106(a3); 90-113.74C(a); 97-25; 97-25.4; 97-80(a); S.L. 2017-203, s. 4;*
Eff. May 1, 2018;
Recodified from 04 NCAC 10M .0201 Eff. June 1, 2018.

11 NCAC 23M .0202 PRESCRIPTION OF MEDICATION FOR PAIN IN AN ACUTE PHASE FOLLOWING THE FIRST PRESCRIPTION

(a) This Rule applies to prescriptions for medication to an employee for pain during an acute phase that are written after a first prescription as described in Rule .0201 of this Section.

(b) Before prescribing a targeted controlled substance, a health care provider shall document his or her medical opinion in the medical record that non-pharmacological and non-opioid therapies are insufficient to treat the employee's pain.
(c) A health care provider shall not prescribe more than one targeted controlled substance at a time in an acute phase.
(d) A health care provider shall prescribe the lowest number of days' supply of a targeted controlled substance necessary in his or her medical opinion to treat an employee's pain.
(e) A health care provider shall prescribe the lowest effective dosage of a targeted controlled substance, not to exceed 50 mg morphine equivalent dose per day, using only short-acting opioids. However, the health care provider may prescribe a morphine equivalent dose higher than 50 mg per day, but not higher than 90 mg per day, after documenting the medical justification for the prescription, including a comparison of the expected benefits to the employee versus any potential risks of increasing the employee's dosage. If the health care provider prescribes a morphine equivalent dose higher than 50 mg per day in an acute phase, the health care provider shall review at all subsequent evaluations whether the employee experienced the expected benefits and consider whether to continue the higher dosage and document the medical record accordingly. The dosage limits in this Paragraph apply only to an opioid prescription being prescribed pursuant to this Rule.
(f) A health care provider shall not prescribe transcutaneous, transdermal, transmucosal, or buccal opioid preparations without documentation in the medical record that oral opioid dosing is medically contraindicated for the employee.
(g) A health care provider shall not prescribe fentanyl for pain in an acute phase.
(h) A health care provider shall not prescribe benzodiazepines for pain or as muscle relaxers in an acute phase.
(i) A health care provider shall not prescribe carisoprodol and a targeted controlled substance in an acute phase.
(j) If an employee is taking benzodiazepines or carisoprodol prescribed by another health care provider, the health care provider shall not prescribe a targeted controlled substance to the employee without advising the employee of the potential risks of combining a targeted controlled substance and benzodiazepines or carisoprodol. The health care provider shall also communicate with the health care provider prescribing the benzodiazepines or carisoprodol to inform that health care provider of the prescription of a targeted controlled substance.
(k) A health care provider shall review the information in the CSRS pertaining to the employee for the preceding 12-month period every time the health care provider prescribes a targeted controlled substance in an acute phase. The health care provider shall document in the medical record the review and any potential contraindications to prescribing a targeted controlled substance found in the CSRS. The effective date of this Paragraph is November 1, 2018, or shall coincide with the date of application in S.L. 2017-74, s. 15.(e), and any amendments thereto, whichever is earlier.
(l) After an employee has received the first prescription of a targeted controlled substance as described in Rule .0201 of this Section and an additional 30 days of treatment with a targeted controlled substance, the health care provider may only continue treatment with a targeted controlled substance after fulfilling the following requirements:

(1) The health care provider shall administer and document in the medical record the results of a presumptive urine drug test as defined in Rule .0102 of this Subchapter. The health care provider may meet this requirement by requiring that the employee take a random, unannounced urine drug test. If the test results are positive for non-disclosed drugs or negative for prescribed controlled substances, the health care provider shall obtain confirmatory urine drug testing as defined in Rule .0102 of this Section. Nothing herein prevents a health care provider from ordering confirmatory urine drug testing for a medical reason other than the presumptive urine drug test results if the medical reason is documented in the medical record. The health care provider may obtain the confirmatory urine drug test results before prescribing a targeted controlled substance. Alternatively, the health care provider may order a limited supply of a targeted controlled substance pending the results of the confirmatory urine drug test. The results of any confirmatory urine drug test shall be documented in the medical record.
(2) The health care provider shall administer and document in the medical record the results of a tool for screening and assessing opioid risk that has been validated by clinical studies. Examples of these tools include the following:
    (A) NIDA Quick Screen V1.0 and NIDA-Modified ASSIST V2.0 (National Institute on Drug Abuse), available at https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013(1).pdf;

(B) Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0 (Inflexxion, Inc.), available at http://nhms.org/sites/default/files/Pdfs/SOAPP-14.pdf;
(C) SOAPP-Revised (Inflexxion, Inc.), available at https://www.painedu.org; and
(D) Opioid Risk Tool (ORT) (Lynn Webster, MD), available at http://agencymeddirectors.wa.gov/Files/opioidrisktool.pdf.

(3) The health care provider shall review and document in the medical record whether the information obtained by complying with Paragraph (k) of this Rule or Subparagraphs (1) or (2) of this Paragraph, or any other aspects of the employee's medical records or examination, indicate an increased risk for opioid-related harm. If the health care provider continues the prescription of a targeted controlled substance despite any increased risks identified, the health care provider shall document in the medical record the reasons justifying the continued prescription.

History Note: *Authority 97-25; 97-25.4; 97-80(a); S.L. 2017-203, s. 4;*
Eff. May 1, 2018;
Recodified from 04 NCAC 10M .0202 Eff. June 1, 2018.

11 NCAC 23M .0203 PRESCRIPTION OF MEDICATION FOR PAIN IN A CHRONIC PHASE

(a) This Rule applies to prescriptions for medication to an employee for pain during a chronic phase.

(b) Before prescribing a targeted controlled substance, a health care provider shall document his or her medical opinion in the medical record that non-pharmacological and non-opioid therapies are insufficient to treat the employee's pain.

(c) A health care provider shall not prescribe more than one targeted controlled substance at a time in a chronic phase without documentation of justification in the medical record. A health care provider shall not prescribe more than two targeted controlled substances at a time in a chronic phase, to include no more than one short-acting opioid and one long-acting or extended-release opioid.

(d) A health care provider shall prescribe the lowest number of days' supply of a targeted controlled substance necessary in his or her medical opinion to treat an employee's pain.

(e) A health care provider shall prescribe the lowest effective dosage of a targeted controlled substance, not to exceed 50 mg morphine equivalent dose per day.

(1) However, the health care provider may prescribe a morphine equivalent dose higher than 50 mg per day, but not higher than 90 mg per day, after documenting the medical justification for the prescription, including a comparison of the expected benefits to the employee versus any potential risks of increasing the employee's dosage. If the health care provider prescribes a morphine equivalent dose higher than 50 mg per day in the chronic phase, the health care provider shall review at all subsequent evaluations whether the employee experienced the expected benefits and consider whether to continue the higher dosage and document the medical record accordingly.

(2) If a health care provider considers it necessary to prescribe a morphine equivalent dose higher than 90 mg per day to treat an employee's pain, the health care provider shall seek preauthorization from the employer or carrier. If the employer or carrier authorizes, or the Commission orders, authorization of a prescription of a morphine equivalent dose higher than 90 mg per day, the health care provider shall review at all subsequent evaluations whether the employee experienced the expected benefits of the increased dosage and consider whether to continue the higher dosage and document the medical record accordingly.

The dosage limits in this Paragraph apply only to an opioid prescription being prescribed pursuant to this Rule.

(f) A health care provider shall not prescribe transcutaneous, transdermal, transmucosal, or buccal opioid preparations included in G.S. 90-90(1) or (2) without documentation in the medical record that oral opioid dosing is medically contraindicated for the employee.

(g) A health care provider shall seek preauthorization from the employer or carrier before prescribing transdermal fentanyl. A health care provider shall seek preauthorization from the employer or carrier before prescribing methadone for pain in a chronic phase.

(h) A health care provider shall not prescribe benzodiazepines for pain or as muscle relaxers in a chronic phase.

(i) A health care provider shall seek preauthorization from the employer or carrier before prescribing carisoprodol and a targeted controlled substance in a chronic phase. A health care provider shall advise the employee of the potential risks of combining a targeted controlled substance and carisoprodol if both medications are prescribed.

(j) If an employee is taking benzodiazepines or carisoprodol prescribed by another health care provider, the health care provider shall not prescribe a targeted controlled substance to the employee without advising the employee of

the potential risks of combining a targeted controlled substance and benzodiazepines or carisoprodol. The health care provider shall also communicate with the health care provider prescribing the benzodiazepines or carisoprodol to inform that health care provider of the prescription of a targeted controlled substance.
(k) A health care provider shall review the information in the CSRS pertaining to the employee for the preceding 12-month period at every appointment with the employee at which a targeted controlled substance is prescribed or every three months, whichever is more frequent. The health care provider shall document in the medical record the review and any potential contraindications to prescribing a targeted controlled substance found in the CSRS. The effective date of this Paragraph is November 1, 2018, or shall coincide with the date of application in S.L. 2017-74, s. 15.(e), and any amendments thereto, whichever is earlier.
(l) Before first prescribing a targeted controlled substance in a chronic phase, a health care provider shall administer and document in the medical record the results of a presumptive urine drug test as defined in Rule .0102 of this Subchapter.
(m) Following compliance with Paragraph (l) of this Rule, a health care provider shall administer a presumptive urine drug test as defined in Rule .0102 of this Subchapter and document the results in the medical record a minimum of two times per year and a maximum of four times per year during a chronic phase, unless additional urine drug tests are authorized by the employer or carrier at the request of the health care provider. The limitation on the number of urine drug tests to be conducted per year without authorization by the employer or carrier for additional urine drug tests shall not apply in those cases where a patient is being prescribed targeted controlled substances for the purpose of substance use disorder treatment in addition to pain management.
(n) The health care provider may meet the requirements of Paragraphs (l) and (m) by requiring that the employee take random, unannounced urine drug tests.
(o) If the result of a presumptive urine drug test administered pursuant to this Rule is positive for non-disclosed drugs or negative for prescribed medications, the health care provider shall obtain confirmatory urine drug testing as defined in Rule .0102 of this Subchapter. The health care provider may obtain the confirmatory urine drug test results before prescribing a targeted controlled substance. Alternatively, the health care provider may order a limited supply of a targeted controlled substance pending the results of the confirmatory urine drug test. The results of any confirmatory urine drug test shall be documented in the medical record. Nothing herein prevents a health care provider from ordering a confirmatory urine drug test for a medical reason other than the presumptive urine drug test results if the medical reason is documented in the medical record.
(p) If an employee's medical treatment involving the prescription of targeted controlled substances is transferred to a health care provider in a different health care practice from the one that administered the opioid risk screening and assessment tool required by Rule .0202(l)(2) of this Section, the new health care provider shall administer and document in the medical record the results of a tool for screening and assessing opioid risk that has been validated by clinical studies, including those in Rule .0202(l)(1)(A) through (D) of this Section.
(q) A health care provider shall document in the medical record whether the information obtained by complying with Paragraphs (k), (l), (m), (o) or (p) of this Rule indicates an increased risk for opioid-related harm. If the health care provider continues the prescription of a targeted controlled substance despite any increased risks identified, the health care provider shall document in the medical record the reasons justifying the continued prescription.

History Note: *Authority 97-25; 97-25.4; 97-80(a); S.L. 2017-203, s. 4;*
Eff. May 1, 2018;
Recodified from 04 NCAC 10M .0203 Eff. June 1, 2018.

SECTION .0300 – UTILIZATION RULES FOR OPIOID ANTAGONISTS

11 NCAC 23M .0301 CO-PRESCRIPTION OF OPIOID ANTAGONIST

(a) A health care provider prescribing a targeted controlled substance shall consider co-prescribing an opioid antagonist to the following:

(1) employees taking benzodiazepines and a targeted controlled substance;
(2) employees whose dosage exceeds a 50 mg morphine equivalent dose per day;
(3) employees with a history of drug overdose;
(4) employees with a history of substance use disorder;
(5) employees with a history of an underlying mental health condition that places them at an increased risk for overdose;

(6) employees with a medical condition such as respiratory disease, sleep apnea, or other comorbidities that places them at an increased risk for opioid toxicity, respiratory distress, or opioid overdose.

(b) If a health care provider prescribes an opioid antagonist pursuant to one or more of the conditions listed in Paragraph (a) of this Rule, the health care provider shall write the prescription to allow for product selection by the employer or carrier, including an intranasal formulation approved by the United States Food and Drug Administration.

History Note: *Authority 97-25; 97-25.4; 97-80(a); S.L. 2017-203, s. 4;*
Eff. May 1, 2018;
Recodified from 04 NCAC 10M .0301 Eff. June 1, 2018.

SECTION .0400 – UTILIZATION RULES FOR NON-PHARMACOLOGICAL TREATMENT FOR PAIN

11 NCAC 23M .0401 NON-PHARMACOLOGICAL TREATMENT FOR PAIN

(a) A health care provider shall consider and may prescribe non-pharmacological treatments for pain. Examples of these treatments include the following: physical therapy, chiropractic services, acupuncture, massage, cognitive behavioral therapy, biofeedback, and functional restoration programs.

(b) The employer or carrier may request additional information from the health care provider regarding the prescribed treatment by any method allowed pursuant to the Workers' Compensation Act.

History Note: *Authority 97-25.4; 97-80(a); S.L. 2017-203, s. 4;*
Eff. May 1, 2018;
Recodified from 04 NCAC 10M .0401 Eff. June 1, 2018.

SECTION .0500 – UTILIZATION RULES FOR TREATMENT FOR SUBSTANCE USE DISORDER

11 NCAC 23M .0501 TREATMENT FOR SUBSTANCE USE DISORDER INVOLVING A TARGETED CONTROLLED SUBSTANCE

(a) If a health care provider believes, in his or her medical opinion, that an employee may benefit from an evaluation for discontinuation or tapering of a targeted controlled substance or for treatment for substance use disorder involving a targeted controlled substance, the health care provider may refer the employee to a health care provider specializing in such treatment for evaluation. The employer or carrier may request additional information from the health care provider regarding the referral by any method allowed pursuant to the Workers' Compensation Act.

(b) If treatment is recommended following the evaluation referenced in Paragraph (a) of this Rule, the employer or carrier may request additional information from the recommending health care provider regarding the treatment by any method allowed pursuant to the Workers' Compensation Act.

History Note: *Authority 97-25.4; 97-80(a); S.L. 2017-203, s. 4;*
Eff. May 1, 2018;
Recodified from 04 NCAC 10M .0501 Eff. June 1, 2018.