§ 97-26. Fees allowed for medical treatment; malpractice of physician.

(a) Fee Schedule. – The Commission shall adopt by rule a schedule of maximum fees for medical compensation and shall periodically review the schedule and make revisions.

The fees adopted by the Commission in its schedule shall be adequate to ensure that (i) injured workers are provided the standard of services and care intended by this Chapter, (ii) providers are reimbursed reasonable fees for providing these services, and (iii) medical costs are adequately contained.

The Commission may consider any and all reimbursement systems and plans in establishing its fee schedule, including, but not limited to, the State Health Plan for Teachers and State Employees (hereinafter, "State Plan"), Blue Cross and Blue Shield, and any other private or governmental plans. The Commission may also consider any and all reimbursement methodologies, including, but not limited to, the use of current procedural terminology ("CPT") codes, diagnostic-related groupings ("DRGs"), per diem rates, capitated payments, and resource-based relative-value system ("RBRVS") payments. The Commission may consider statewide fee averages, geographical and community variations in provider costs, and any other factors affecting provider costs.

(b) Hospital Fees. – Each hospital subject to the provisions of this section shall be reimbursed the amount provided for in this section unless it has agreed under contract with the insurer, managed care organization, employer (or other payor obligated to reimburse for inpatient hospital services rendered under this Chapter) to accept a different amount or reimbursement methodology.

The explanation of the fee schedule change that is published pursuant to G.S. 150B-21.2(c)(2) shall include a summary of the data and calculations on which the fee schedule rate is based.

A hospital's itemized charges on the UB-92 claim form for workers' compensation services shall be the same as itemized charges for like services for all other payers.

(c) Maximum Reimbursement for Providers Under Subsection (a). – Each health care provider subject to the provisions of subsection (a) of this section shall be reimbursed the amount specified under the fee schedule unless the provider has agreed under contract with the insurer or managed care organization to accept a different amount or reimbursement methodology. In any instance in which neither the fee schedule nor a contractual fee applies, the maximum reimbursement to which a provider under subsection (a) is entitled under this Article is the usual, customary, and reasonable charge for the service or treatment rendered. In no event shall a provider under subsection (a) charge more than its usual fee for the service or treatment rendered.

(d) Information to Commission. – Each health care provider seeking reimbursement for medical compensation under this Article shall provide the Commission information requested by the Commission for the development of fee schedules and the determination of appropriate reimbursement.

(e) When Charges Submitted. – Health care providers shall submit charges to the insurer or managed care organization within 30 days of treatment, within 30 days after the end of the month during which multiple treatments were provided, or within such other reasonable period of time as allowed by the Commission. If an insurer or managed care organization disputes a portion of a health care provider's bill, it shall pay the uncontested portion of the bill and shall resolve disputes regarding the balance of the charges in accordance with this Article or its contractual arrangement.

(f) Repeating Diagnostic Tests. – A health care provider shall not authorize a diagnostic test previously conducted by another provider, unless the health care provider has reasonable grounds to believe a change in patient condition may have occurred or the quality of

the prior test is doubted. The Commission may adopt rules establishing reasonable requirements for reports and records to be made available to other health care providers to prevent unnecessary duplication of tests and examinations. A health care provider that violates this subsection shall not be reimbursed for the costs associated with administering or analyzing the test.

(g) Direct Reimbursement. – The Commission may adopt rules to allow insurers and managed care organizations to review and reimburse charges for medical compensation without submitting the charges to the Commission for review and approval.

(g1) Administrative Simplification. – The applicable administrative standards for code sets, identifiers, formats, and electronic transactions to be used in processing electronic medical bills under this Article shall comply with 45 C.F.R. § 162. The Commission shall adopt rules to require electronic medical billing and payment processes, to standardize the necessary medical documentation for billing adjudication, to provide for effective dates and compliance, and for further implementation of this subsection.

(h) Malpractice. – The employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of this section, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident, and shall be compensated for as such.

(i) Resolution of Dispute. – The employee or health care provider may apply to the Commission by motion or for a hearing to resolve any dispute regarding the payment of charges for medical compensation in accordance with this Article. (1929, c. 120, s. 26; 1955, c. 1026, s. 3; 1993 (Reg. Sess., 1994), c. 679, s. 2.3; 1995 (Reg. Sess., 1996), c. 548, s. 1; 1997-145, s. 1; 2001-410, s. 3; 2001-413, s. 8.2(a); 2005-448, s. 5; 2007-323, s. 28.22A(o); 2007-345, s. 12; 2011-287, s. 8; 2012-135, s. 3; 2013-410, s. 33(b).)