THE NORTH CAROLINA DEPARTMENT OF INSURANCE
BEFORE THE COMMISSIONER OF INSURANCE
RALEIGH, NORTH CAROLINA
DOCKET NO. 1614

IN THE MATTER OF THE 1 DECEMBER 2011 DECISION OF THE NORTH CAROLINA DEPARTMENT OF INSURANCE AND THE NORTH CAROLINA COMMISSIONER OF INSURANCE	))))))

FINAL AGENCY DECISION GRANTING SUMMARY JUDGMENT IN FAVOR OF PETITIONER AND DENYING THE CROSS MOTION FOR SUMMARY JUDGMENT FILED BY INTERVENORS NCHA, INC. ET AL.

This matter came on for hearing before the undersigned Hearing Officer of the North Carolina Department of Insurance on 20 September 2012 on cross motions for summary judgment filed by (1) Petitioner Blue Cross and Blue Shield of North Carolina ("BCBSNC") and Intervenors Aetna Life Insurance Company and Aetna Health Inc. (hereinafter collectively referred to as "Aetna") and (2) Intervenors North Carolina Hospital Association, Inc. ("NCHA"), the North Carolina Medical Society ("NCMS"), and the North Carolina Chapter of the American College of Radiology, Inc.("NCCACR") (hereinafter collectively referred to as "the Provider Associations"). The motions for summary judgment filed by BCBSNC and Aetna were supported by briefs filed by State Employees Association of North Carolina, Inc. ("SEANC") and North Carolina Farm Bureau Federation, Inc. ("NCFB"). The North Carolina Department of Insurance ("Department") was represented by Daniel S. Johnson and David W. Boone (Special Deputies Attorney General with the North Carolina Department of Justice) at the hearing. The Department, by and through Messrs. Johnson and Boone, filed a brief that discusses principles of statutory construction, and Mr. Johnson was heard at the oral argument of this matter. The Department did not file a summary judgment motion in this proceeding and did not join in either of the cross motions for summary judgment filed by the other parties.

Nature of the Proceeding and Procedural Background

On 25 October 2011, the Provider Associations sent a complaint letter to the Department with respect to a new corporate medical policy that BCBSNC intended to implement effective 1 December 2011 with respect to certain outpatient radiology procedures ("Radiology CMP"). Following the filing of a written response by BCBSNC to the Provider Associations' complaint, the Department issued a preliminary decision ("1 December 2011 Decision") stating that BCBSNC could not implement the Radiology CMP without first complying with the procedures set out in Part 7 of Article 50 of Chapter 58 of the North Carolina General Statutes ("Part 7"), regulating "amendments" to contractual agreements between health benefit plans and health care providers. Part 7 comprises N.C. Gen. Stat. §§ 58-50-270 *et seq.*

On 27 January 2012, BCBSNC filed a Petition For Final Agency Decision and Request For Public Hearing. Thereafter, the Provider Associations intervened in support of the preliminary decision of the Department and were afforded full party status. Additionally, Aetna was permitted to intervene in support of BCBSNC and was afforded full party status. SEANC and NCFB were permitted to intervene for the limited purpose of filing written briefs on any dispositive motions and on the merits of this case.

On 27 February 2012, the Department, by and through Messrs. Johnson and Boone, filed a motion to dismiss BCBSNC's petition as moot. Following briefing of that issue, the Hearing Officer conducted a hearing on this motion to dismiss on 16 July 2012 and denied that motion on that date.

At the status conference of 24 August 2012, the parties agreed to a discovery and briefing schedule. The parties have submitted a set of stipulations in connection with the pending summary judgment motions, as well as various affidavits, interrogatory responses, and deposition transcripts. On 19 September 2012, BCBSNC requested that the Hearing Officer take judicial notice with respect to certain facts. On 20 September 2012, the Department, by and through Messrs. Johnson and Boone, also requested that the Hearing Officer to take judicial notice of various other facts. No party objected to either of these motions for judicial notice, and those motions are accordingly granted.

On 20 September 2012, the Hearing Officer heard oral argument from counsel for BCBSNC, Aetna, the Provider Associations, and the Department with respect to the cross motions for summary judgment. On 20 September 2012, the Hearing Officer closed the record with respect to the cross motions for summary judgment (except for the submission of proposed orders).

Materials Filed in Connection with the Cross Motions for Summary Judgment

In addition to the briefing and oral argument, the undersigned Hearing Officer has considered all pleadings and filings in this proceeding. The Record before the Hearing Officer in connection with these motions includes the following:

1. The Stipulated Facts submitted by the parties (including attached exhibits);
2. Affidavit of Bill Battershall;
3. Affidavit of Mary Beth Foil;
4. Affidavit of Sue Haswell (including attached exhibits);
5. Affidavit of Don Bradley (including attached exhibits);
6. Affidavit of Mark Werner;
7. Affidavit of Lisa Cade;
8. Affidavit of Henry Miller (including attached exhibit);
9. Transcript of Deposition of Ted Hamby, dated 14 September 2012;
10. Transcript of Deposition of Robert Lisson, dated 12 September 2012;
11. Transcript of Deposition of Snezana Vukina, dated 12 September 2012;
12. Affidavit of Deborah Medlin (including attached exhibits);
13. Affidavit of Jarvis Leigh, dated 14 March 2012;
14. Affidavit of Jarvis Leigh, dated 17 September 2012 (including attached exhibits);
15. Answers and Objections of the Provider Associations to the Interrogatories of BSBSNC;
16. Affidavit of Brian C. Vick (including attached exhibits);
17. Supplemental Affidavit of Brian C. Vick (including attached exhibits);
18. Request for Judicial Notice filed by BCBSNC and documents referenced therein;
19. Request for Judicial Notice filed by the Department and accompanying documents.

The Hearing Officer considered this Record in its entirety in determining the undisputed facts in this matter.

Summary of Undisputed Facts

1. BCBSNC is a North Carolina nonprofit hospital and medical service corporation licensed under Article 65 of Chapter 58 of the General Statutes.

2. Aetna Life Insurance Company is an insurance company domiciled in Connecticut and licensed under the provisions of Chapter 58 of the General Statutes. Aetna Life Insurance Company offers health insurance products to customers in North Carolina.

3. Aetna Health Inc. is a Pennsylvania corporation that holds a license as a health maintenance organization ("HMO") in North Carolina and offers HMO products in North Carolina.

4. In 2011, Aetna issued a new reimbursement policy for multiple radiological procedures entitled "Multiple Procedure Reductions for CT scans, MRIs or Ultrasounds." Under Aetna's reimbursement policy, the initial CT scan, MRI, or Ultrasound is reimbursed at 100% and any "subsequent scans performed on the same day are allowed at 50 percent." The reduced reimbursement rate for the second and subsequent scans applied to "technical charges, global charges, and scans performed on contiguous body areas." Aetna has withheld implementation of its radiology reimbursement policy in North Carolina because of the Department's interpretation of Part 7.

5. The Department is an administrative agency of the State of North Carolina with the power and duty to administer the North Carolina Insurance Law, N.C. Gen. Stat. §§ 58-1-1 *et seq.*

6. Intervenor NCHA is a nonprofit corporation and trade association organized under the laws of North Carolina. Members of NCHA include hospitals that are affected by the proposed Radiology CMP.

7. Intervenor NCMS is a nonprofit corporation and trade association organized under the laws of North Carolina. Members of NCMS include physicians who are affected by the proposed Radiology CMP.

8. Intervenor NCCACR is a nonprofit corporation and trade association organized under the laws of North Carolina. Members of NCCACR include physicians who are affected by the proposed Radiology CMP.

9. Intervenor NCFB is a nonprofit corporation organized under the laws of North Carolina. Members of NCFB include farming and rural families who are affected by the 1 December 2011 Decision.

10. Intervenor SEANC is a North Carolina nonprofit corporation whose members are current and retired State employees. Members of SEANC are affected by the 1 December 2011 Decision.

11. On 30 September 2011, BCBSNC notified each provider in its network of preferred providers that it was implementing a new corporate medical policy, the Radiology CMP, to be effective 1 December 2011. The Radiology CMP would change how BCBSNC reimburses the "technical component" of certain outpatient radiology procedures, which were identified by CPT code in the policy ("Covered Radiology Services").

12. The "technical component" of these radiology services includes such items as clinical labor (patient check-in, preparation, operating the radiology equipment, etc.) and supplies (gown, contrast material, etc.).

13. BCBSNC proposed the Radiology CMP to change the way it reimburses the "technical component" of the Covered Radiology Services only when two or more are performed during a single outpatient radiology session ("Multiple Radiology Session").

14. BCBSNC developed this policy because, even though many of the items that compose the "technical component" are only supplied to a patient once during a Multiple Radiology Session regardless of how many scans are performed, providers routinely bill BCBSNC for the "technical component" of every scan, thus seeking to be reimbursed multiple times for services that are provided only once.

15. On 25 October 2011, the Provider Associations filed a complaint with the Department asking that BCBSNC be required to comply with Part 7 before implementing the Radiology CMP.

16. The 1 December 2011 Decision states that BCBSNC cannot lawfully implement the Radiology CMP without first complying with Part 7. The Department did not provide any

reasoning or analysis in the 1 December 2011 Decision to explain or justify its decision. However, Department employees later explained that the Department had concluded that Part 7 applied because the Radiology CMP would "change provider payment" and, therefore, the Department believed that the Radiology CMP "modifies fee schedules" and/or "conflicts with or overrides" the terms of BCBSNC's provider contracts.

17. As set out in the Conclusions of Law below, Part 7 requires health insurance companies to follow certain specific steps to modify their contracts with health care providers whenever the proposed change "modifies fee schedules."[1] Although Part 7 does not define the term "fee schedule," that term is a technical term within the health insurance industry and is generally understood within the industry to mean the maximum allowable amount that a provider can receive for a covered service under any set of circumstances.

18. BCBSNC operates a provider network and currently has provider contracts with over 14,000 providers throughout the State. Under BCBSNC provider contracts approved by the Department, each provider agrees to participate in and comply with all of BCBSNC's programs, policies, and procedures, including those in effect at the time of the execution of the contracts and any programs, policies, and procedures that may be enacted and revised by BCBSNC from time to time.

19. BCBSNC's provider contracts do not contain any provision that guarantees a provider will be paid a specific amount for providing a specific service. Rather, each provider contract contains a "Reimbursement Exhibit" that sets forth certain methodologies that BCBSNC will use to determine the maximum amount that the provider can be paid for any service in any instance. BCBSNC uses this information to develop a "fee schedule" for the provider that establishes the maximum fee the provider could be paid for every available CPT code, even ones that BCBSNC does not cover and ones that the provider may not be qualified to perform. "Fee schedule" is defined in BCBSNC provider contracts as "a list of the maximum per unit allowed amounts established for Covered Services."[2]

20. The Radiology CMP at issue does not: (1) conflict with or override any term contained in any of BCBSNC's provider contracts; (2) change, alter, or otherwise modify the maximum per

[1] *See* N.C. Gen. Stat. § 58-50-270(1).
[2] Exhibit SH-3 to the Affidavit of Sue Haswell.

unit allowed amount that a provider could receive for any Covered Radiology Services; or (3) change, alter, or otherwise modify any CPT or other code set out in the fee schedule. The Radiology CMP does not conflict with or override any term of a provider contract, including contract fee schedules.

21. The Current Procedural Terminology (CPT) code set is maintained by the American Medical Association. The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

22. The reason that BCBSNC's "fee schedules" contain pricing information for services for which a provider could not be reimbursed under any circumstance is based on their function in BCBSNC's claims process. When a claim is submitted for reimbursement, the "fee schedule" is applied as the first step in the claims process and every code that appears on the claim is priced to the "fee schedule" amount regardless of whether the provider will actually be paid for that code. After the "fee schedule" has been applied, the claims process determines the actual amount the provider will be paid, if any, through the application of the member's benefits and BCBSNC's policies and procedures. However, as the first step in the claims process for every claim, the provider's "fee schedule" is applied and each code submitted for reimbursement is priced to the maximum amount that the provider could be paid under any circumstance for that code.

23. BCBSNC has presented evidence that once it is authorized to implement the Radiology CMP, BCBSNC and consumers will save approximately $16,000,000 per year by not paying the full "technical component" when the patient is not receiving the full "technical component" (i.e., certain clinical labor and supplies are simply not provided more than once when multiple scans occur during the same session). Of this $16,000,000 per year in cost savings, approximately $5,000,000 of this total is attributable to savings by the State Health Plan and current and retired State employees.

23. Additional undisputed facts are set out in the Stipulations entered into by the parties. These Stipulations are incorporated herein by reference.

CONCLUSIONS OF LAW

1. The Hearing Officer is authorized to consider and rule upon a motion for summary judgment pursuant to 11 NCAC 01.0416(6).[3]

2. Aetna is a "person aggrieved" within the meaning of N.C. Gen. Stat. § 150B-2(6) in that it is directly affected substantially in its person and property by the Department's 1 December 2011 Decision.

3. Both the plain language of Part 7 and the legislative history of that law demonstrate that the Radiology CMP does not modify any "fee schedule." Accordingly, BCBSNC should be permitted to implement the Radiology CMP without further delay.

Plain Language and Meaning of Part 7

4. Part 7 requires health insurance companies to implement certain procedural steps (such as notice to providers and affording providers the right to object) only when the health insurance company is seeking "[a]ny change to the terms of a contract, including terms incorporated by reference, that modifies fee schedules."[4]

5. Although the term "fee schedule" or "schedule of fees" is not defined in Part 7, this phrase is a technical term within the health insurance industry that means the maximum allowed amount that a provider could receive for that service.

6. Moreover, even though Part 7 does not define the term "fee schedule," Chapter 58 does contain a definition of "fee schedule" in the context of health plans. Specifically, N.C. Gen. Stat. § 58-3-227(a)(6) defines the term "schedule of fees" narrowly to mean "CPT, HCPCS, ICD-9-CM codes, ASA codes, modifiers, and other applicable codes for the procedures billed for that class of provider." This narrow definition of "fee schedule" is consistent with the definition of that term proffered by BCBSNC and Aetna and is inconsistent with the broad definition of "fee schedule" that the Provider Associations have urged the Department to adopt in this

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[3] *See* N.C. Gen. Stat. §§ 58-2-40(1), 58-2-50, 58-2-55, 58-2-70(h); 11 NCAC 01.0414(1); N.C. Gen. Stat. § 150B-38(h); and N.C. R. Civ. P. 56.

[4] N.C. Gen. Stat. § 58-50-270(1).

proceeding. N.C. Gen. Stat. § 58-3-227 also emphasizes that the term "reimbursement policies" has a distinct and separate meaning from the term "fee schedule." N.C. Gen. Stat. § 58-3-227(a)(5) defines "reimbursement policy" to mean "[i]nformation relating to payment of providers and facilities including policies on . . .(a) Claims bundling and other claims editing processes, (b) Recognition or nonrecognition of CPT code modifiers, (c) Downcoding of services or procedures, (d) The definition of global surgery periods, (e) Multiple surgical procedures, and (f) Payment based on the relationship of procedure code to diagnosis code." Part 7 and N.C. Gen. Stat. § 58-3-227 should be read *in pari materia.*

7. When used in the context of provider contracts, the term "fee schedule" is correctly understood to mean the maximum amount that a contracting provider has agreed to receive as payment for a covered service. Thus, the "fee schedule" establishes the amount at which a contracting provider has agreed to cap its fees in order to join an insurer's provider network and gain preferred access to the insurer's members. The common understanding of the term "fee schedule" does not mean the actual amount that a provider will be paid in every instance, but, instead, the maximum amount that a provider could be paid in any instance. This is how "fee schedule" is defined in BCBSNC provider contract templates approved by the Department.[5]

8. The broad definition of the term "fee schedule" advocated by the Provider Associations would severely jeopardize the normal operation and functioning of health care provider networks and would substantially increase the cost of health care to both consumers and businesses throughout North Carolina. It would be illogical to conclude that the General Assembly intended such a detrimental impact upon consumers and health care costs. Had the General Assembly intended such a result, one would expect that it would have used language to clearly spell out that health insurance companies are precluded from issuing policies and procedures unless the health care provider expressly consents to each such policy.

9. BCBSNC's Radiology CMP is not an "amendment" to a provider contract under N.C. Gen. Stat. § 58-50-270(1) and is not subject to the procedural requirements set out in N.C. Gen. Stat. § 58-50-280 for amending provider contracts.

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[5] *See, e.g.,* Exhibit SH-3, SH-5, SH-7, and SH-9 to the Affidavit of Sue Haswell, and by the American Medical Association, *see* Exhibit BCV-5 to the Affidavit of Brian C. Vick.

10. N.C. Gen. Stat. § 58-50-285(b) provides that the policies and procedures of a health benefit plan shall not conflict with or override any term of a provider contract, including contract fee schedules. BCBSNC provider contracts include similar language.[6] The Radiology CMP at issue does not: (1) conflict with or override any term of BCBSNC's provider contracts; (2) change, alter, or otherwise modify the maximum per unit allowed amount that a provider could receive for any of the Covered Radiology Services; or (3) change, alter, or otherwise modify any CPT or other code set out in the fee schedule. Rather, it simply ensures that if multiple radiology scans are conducted in the same session, the provider cannot charge BCBSNC for services (such as gowns) that are not actually provided. By reimbursing the technical component for successive radiology services performed in the same session at 50% rather than 100%, the Radiology CMP ensures that BCBSNC and consumers are not billed for services that are not provided.

11. The language of the BCBSNC's network provider agreement confirms that there is no conflict between the Radiology CMP and any fee schedule. By signing the BCBSNC network provider agreement, the provider agrees "to participate in and comply with all of [BCBSNC's] programs and Policies and Procedures," including those in effect at the time and any that "may be enacted and revised by [BCBSNC] from time to time."[7] The Radiology CMP fully complies with N.C. Gen. Stat. § 58-50-285(b).

Legislative History of Part 7

12. As set out above, an examination of the plain language of Part 7 establishes that the complaint filed by the Provider Associations should be dismissed and the 1 December 2011 Decision rescinded. The legislative history of Part 7 confirms that BCBSNC's reading of this statute is correct.

13. At an early stage of its consideration by the General Assembly, the language of Senate Bill 877[8] would have achieved exactly what the Provider Associations are currently asking the

[6] Exhibit SH-3, SH-5, SH-7, and SH-9 to the Affidavit of Sue Haswell.
[7] Exhibit SH-3 to the Affidavit of Sue Haswell.
[8] Act of July 27, 2009, ch. 352, 2009 N.C. Sess. Laws 352; Act of August 26, 2011, ch. 487, sec. 2.(a), 2009 N.C. Sess. Laws 1301.

Department to do. Specifically, the Second Edition of the bill[9] defined the word "amendment" very broadly and expressly included within that definition "changes in the policies or procedures of a health plan or insurer that decreases a health care provider's aggregate compensation under a contract." This language was ultimately deleted from the bill.[10] The fact that the General Assembly considered including policies and procedures within the definition of "amendment" and expressly declined to do so is dispositive here. The General Assembly did not intend for the reach of Part 7 to be as broad as advocated by the Provider Associations.

14. The Department has argued that the Hearing Officer should not consider the fact that an early draft of Senate Bill 877 introduced in the General Assembly broadly defined "amendment" to include policies and procedures but that the final version enacted by the General Assembly rejected this broad definition. The argument that this legislative history should not even be considered is inconsistent with many North Carolina appellate decisions, as well as the position repeatedly and consistently taken by the North Carolina Attorney General for a period of decades in numerous AG opinions and appellate briefs.[11]

15. It is a well-settled rule of statutory construction that legislative history documenting rejection of a statutory provision is probative of the intent to exclude that provision from the statute as enacted. The law in this State is that the omission of language in successive drafts of a bill is persuasive evidence of legislative intent.[12]

16. The suggestion that the decision of the North Carolina Supreme Court in *North Carolina Department of Correction v. North Carolina Medical Board*[13] changes this black letter law is misplaced. As the *Department of Correction* decision recognizes, North Carolina courts have long held that the legislature's failure to pass a bill cannot be said to indicate any intent on the part of the legislature. In that case, the North Carolina Supreme Court simply recognized that a "decision of a legislative committee . . . seventy-three years after the enactment of the statutory

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[9] Senate Bill 877, Health Care Committee Substitute Adopted 5/12/09.

[10] Senate Bill 877, Health Care Committee Substitute Adopted 5/12/09, Third Edition Engrossed 5/13/09.

[11] *See* Brief of Appellant-Petitioner at 18, *Barfield v. N.C. Dept. of Crime Control*, No. COA09-549 (N.C. Ct. App. 2009); 51 N.C.A.G. 17, 1981 N.C. AG LEXIS 34 (1981); __ N.C.A.G. __, 1994 N.C. AG LEXIS 71 (1994); Brief of Defendant-Appellant at 10, *Parkdale Am., LLC v. N.C. Dept. of Revenue*, No. COA09-10 (N.C. Ct. App. 2009).

[12] Thomas P. Davis, Legislative History in North Carolina, 30 Legal Reference Quarterly 85, 87 (2011); *see Formyduval v. Bunn*, 138 N.C. App. 381, 389, 530 S.E.2d 96, 102 (2000); *Burgess v. Your House of Raleigh, Inc.*, 326 N.C. 205, 209, 388 S.E.2d 136, 140 (1990).

[13] 363 N.C. 189, 202, 675 S.E.2d 641, 650 (2009).

language at issue" was irrelevant in determining "the intent of the enacting legislature."[14] The effort by the Medical Board in *Department of Correction* to use the General Assembly's failure to enact legislation 73 years after the fact in order to show the original intent of the General Assembly is vastly different from the General Assembly's express consideration of language in a proposed bill and its express rejection of that language in the final enacted version of that same bill.

17. The legislative history of Part 7 requires that the position being advocated by the Provider Associations must be rejected. This is particularly true given that the interpretation of Part 7 urged by the Provider Associations, as noted above, would severely jeopardize the normal operation and functioning of health care provider networks and would substantially increase the cost of health care.

18. BCBSNC and other health insurance companies operating in this State should be permitted to implement policies and procedures such as the Radiology CMP (and similar policies) without being required to treat those policies and procedures as an "amendment" to provider contracts as that term is used within Part 7 and defined in N.C. Gen. Stat. § 58-50-270(1), as long as they do not modify fee schedules or conflict with the terms of the contract (neither of which is done by the Radiology CMP).

ENTRY OF JUDGMENT AND FINAL AGENCY DECISION

WHEREFORE, the Hearing Officer hereby enters the following final agency decision in this matter:

1. Summary judgment is granted in favor of BCBSNC and Aetna and against Intervenors NCHA, Inc. et al. and the preliminary decision issued by the North Carolina Department of Insurance on 1 December 2011 in this matter is reversed and rescinded.

2. As a matter of law, the Department now finds and concludes that BCBSNC's issuance of the Radiology CMP was in compliance with all applicable statutory criteria.

3. The Department further finds and concludes that because the Radiology CMP does not modify any "fee schedule" as that term is used in N.C. Gen. Stat. § 58-50-270(1) and because the

[14] 363 N.C. at 202, 675 S.E.2d at 650.

Radiology CMP does not conflict or override any term of BCBSNC's contracts with its providers, the procedural requirements for implementing an "amendment" to a contract between a health benefit plan and health care providers set out in Part 7 of Article 50 of Chapter 58 of the General Statutes are not applicable to the Radiology CMP.

4. The Department's directive in the 1 December 2011 decision that BCBSNC must comply with the procedural requirements of Part 7 of Article 50 of Chapter 58 with respect to an "amendment" to a contract before implementing the Radiology CMP is hereby withdrawn.

5. Upon entry of this Order, the Order will be immediately posted on the Web site of the Department.

6. BCBSNC is directed to immediately post the signed order on its external Web site.

7. Upon the posting of this order on the Web site of the Department or the posting of this order on BCBSNC's external Web site, BCBSNC may begin implementing the Radiology CMP pursuant to the terms of its provider agreements.

8. Because BCBSNC has not expressly requested that the decision of the Department be made retroactive to 1 December 2011 and because that issue is not currently before the Department, the Department will not rule on that issue in this proceeding. If any party or intervenor wants to have this order applied retroactively to 1 December 2011, the party or intervenor is directed to file a separate petition within sixty (60) days after the expiration of the last deadline for judicial or appellate review of this order. Failure to file such a petition within the time set out herein shall be deemed an abandonment of that issue.

This 14th day of November 2012.

William K. Hale

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CERTIFICATE OF SERVICE – DOCKET NUMBER 1614

I, the undersigned attorney, do hereby certify that a copy of the foregoing final agency decision was duly served upon all parties by depositing a copy thereof in the United States mail, first class postage prepaid, addressed to all counsel of record set out below, in accordance with the North Carolina Rules of Civil Procedure.

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This 14th day of November 2012.

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