Some other notable revisions to the agency's General and Procedural Rules include the following:

- General Rule 1.14: Expressly requires mileage payments to Claimants being interviewed by the Commission or an AJ for approval of compromise settlement or lump sum payment. This Rule has always been interpreted to require mileage payments for such interviews.
- Procedural Rule 2.2: Requires claimants' attorneys to take a number of steps prior to filing a Petition to Controvert, including checking the Commission's online claim portal to determine whether a non-controverted file for the injury exists; checking the Commission's online "proof of coverage" portal to determine insurance coverage for the date of injury; determining and correctly identifying the employer, county of injury, and date of injury for the claim; and filing the employment/fee contract between the attorney and the claimant.
- Procedural Rule 2.4:
    - States that, even if the employer/carrier are granted additional time to answer a petition to controvert, the discovery period on the claim will still begin to run on the original answer due date—i.e., 23 days after the date the Commission mailed the petition to controvert to the employer/carrier.
    - Requires hearing on a request for additional time to answer if the request does not note agreement of the claimant's attorney.
- Procedural Rule 2.5: Requires permission from the AJ to attach to a Prehearing Statement any exhibit that exceeds 50 pages (except for depositions and exhibits to depositions).
- Procedural Rule 2.6:
    - Requires parties to contact each other 14 days prior to a final hearing to discuss settlement.
    - Requires counsel for the employer/carrier to report the results of the conference to the AJ's legal assistant.
- Procedural Rule 2.7:
    - Requires employer to have claims professional handling claim present or available by phone at each evidentiary hearing held in a claim.
    - States that all issues ripe for determination at the time of a hearing shall be addressed at the hearing.
- Procedural Rule 2.9:
    - Requires parties in controverted claims to exchange medical records upon receipt.
    - Clarifies that "narrative reports composed by attorneys which require only the signature of the medical providers" may not be part of medical records that are introduced in lieu of direct testimony at an evidentiary hearing.
    - Requires all medical records filed with Commission to be paginated and arranged in chronological order.
    - Requires attorney offering medical records into evidence to attach to the records the attorney's sworn statement that either (a) the records are true, correct, and complete copy of records received from the medical provider, or (b) opposing

counsel agreed that only the attached excerpts are needed to address the contested issues.

- Procedural Rule 2.12:
    - In settlements containing a designation of funds for a Medicare Set Aside (MSA) arrangement, limits the basis for calculating fees for claimants' attorneys. In such settlements, the 25% allowable attorney fee shall be calculated based only upon the amount of the settlement not proposed as funding the MSA arrangement.
    - Allows Commission to consider a request from a claimant's attorney for payment on a quantum meruit basis in claims where medical benefits are awarded but indemnity has already been paid or is no longer available.
- Procedural Rule 2.15:
    - Changes procedure for approval of settlements with unrepresented claimants.
        - Requires counsel for employer/carrier to file proposed settlement paperwork and supporting documentation with the Commission prior to appearing before the Commission with the unrepresented claimant.
        - States that, after Commission has reviewed the proposed settlement, counsel will be notified by e-mail that the claimant should be brought before Commission for a settlement interview.
    - Adds statement that Commission encourages voluntary alternative dispute resolution and mediation by the parties on the terms they choose.
- Procedural Rule 2.17: Implements a new procedure for filing a Notice of Final Payment (Form B-31)
    - Employer/carrier's filing of a Form B-31 shall constitute compliance with the requirements of Mississippi Code § 71-3-37(7).
    - Claimant or claimant's counsel shall be provided a copy of the Form B-31 in any manner which acknowledges delivery of the B-31.
    - Claimant's signature is not required on the Form B-31, but the presence of the claimant's signature will constitute acknowledged delivery of the B-31 to the claimant.
    - The filing of the Form B-31 with the Commission will start the running of the one-year statute of limitations under Mississippi Code § 71-3-53.
    - If the original or any subsequent Form B-31 filed with the Commission does not furnish all medical or other information required, another Form B-31 containing complete information shall be filed as soon as possible, following the above notice requirements.
- Procedural Rule 2.21: Requires all self-insured employers to maintain a single address, e-mail address, and phone number on file with the Commission.
- Procedural Rule 2.22: Requires parties to file prehearing statements if an evidentiary hearing is required to resolve a motion.