Section 92-01-02-11.1 is amended as follows:

92-01-02-11.1. Attorney's fees.

92-01-02-11.1. Attorney's fees. Upon receipt of a certificate of program completion from the decision review office, fees for legal services provided by employees' attorneys and legal assistants working under the direction of employees' attorneys will be paid when an administrative order reducing or denying benefits is submitted to administrative hearing, district court, or supreme court and the employee prevails; or when a managed care decision is submitted to binding dispute resolution and the employee prevails subject to the following:

1. The organization shall pay attorneys at one hundred ~~thirty-five~~forty dollars per hour for all actual and reasonable time other than travel time. The organization shall pay attorney travel time at ~~sixty-five~~seventy dollars per hour.

2. The organization may pay legal assistants and third-year law students or law school graduates who are not licensed attorneys who are practicing under the North Dakota senior practice rule acting under the supervision of employees' attorneys up to ~~seventy~~eighty-five dollars per hour for all actual and reasonable time other than travel time. The organization shall pay travel time at ~~thirty-five~~forty dollars per hour. A "legal assistant" means any person with a bachelor's degree, associate's degree, or correspondence degree in a legal assistant or paralegal program from an accredited college or university or other accredited agency, or a legal assistant certified by the national association of legal assistants or the national federation of paralegal associations. The term may also include a person employed as a paralegal or legal assistant who has a bachelor's degree in any field and experience working as a paralegal or legal assistant.

3. Total fees paid by the organization for all legal services in connection with a dispute regarding an administrative order may not exceed the following:

a. Except for an initial determination of compensability, twenty percent of the additional amount awarded.

b. Two thousand ~~six~~seven hundred dollars, plus reasonable costs incurred, following issuance of an administrative order under North Dakota Century Code chapter 28-32 reducing or denying benefits, for services provided if a hearing request is resolved by settlement or amendment of the administrative order before the hearing is called to order.

c. Five thousand ~~three~~five hundred dollars, plus reasonable costs incurred, if the employee prevails after the hearing is called to order by the administrative law judge. If the employee prevails after the hearing, and the organization appeals the final order, the organization shall pay attorney's fees at a rate of one hundred twenty-five percent of the maximum fees specified in subdivisions d and e when the employee prevails on

appeal, as defined by North Dakota Century Code section 65-02-08, to the district court or to the supreme court. However, the organization may not pay attorney's fees if the employee prevails at the district court but the organization prevails at the supreme court in the same appeal.

d. ~~Five thousand nine~~Six thousand one hundred dollars, plus reasonable costs incurred, if the employee's district court appeal is settled prior to submission of briefs. ~~Seven thousand nine~~Eight thousand two hundred dollars, plus reasonable costs incurred, if the employee prevails after hearing by the district court.

e. Nine thousand ~~six~~nine hundred dollars, plus reasonable costs incurred, if the employee's North Dakota supreme court appeal is settled prior to hearing. Ten thousand ~~four~~eight hundred dollars, plus reasonable costs incurred, if the employee prevails after hearing by the supreme court.

f. One thousand ~~five~~six hundred dollars, plus reasonable costs incurred, if the employee requests binding dispute resolution and prevails.

g. Should a settlement or order amendment offered during the DRO process be accepted after the DRO certificate of completion has been issued, no attorney's fees are payable. This contemplates not only identical offers and order amendments but those which are substantially similar.

4. The maximum fees specified in subdivisions b, c, d, and e of subsection 3 include all fees paid by the organization to one or more attorneys, legal assistants, law students, and law graduates representing the employee in connection with the same dispute regarding an administrative order at all stages in the proceedings. A "dispute regarding an administrative order" includes all proceedings subsequent to an administrative order, including hearing, judicial appeal, remand, an order resulting from remand, and multiple matters or proceedings consolidated or considered in a single proceeding.

5. All time must be recorded in increments of no more than six minutes (one-tenth of an hour).

6. If the organization is obligated to pay the employee's attorney's fees, the attorney shall submit to the organization a final statement upon resolution of the matter. All statements must show the name of the employee, claim number, date of the statement, the issue, date of each service or charge, itemization and a reasonable description of the legal work performed for each service or charge, time and amount billed for each item, and total time and amounts billed. The employee's attorney must sign the fee statement. The organization may deny fees and costs that are determined to be excessive or frivolous.

7. The following costs will be reimbursed:

a. Actual postage, if postage exceeds three dollars per parcel.

b. Actual toll charges for long-distance telephone calls.

c. Copying charges, at eight cents per page.

d. Mileage and other expenses for reasonable and necessary travel. Mileage and other travel expenses, including per diem, must be paid in the amounts that are paid state officials as provided by North Dakota Century Code sections 44-08-04 and 54-06-09. Out-of-state travel expenses may be reimbursed only if approval for such travel is given, in advance, by the organization.

e. Other reasonable and necessary costs, not to exceed one hundred fifty dollars. Other costs in excess of one hundred fifty dollars may be reimbursed only upon agreement, in advance, by the organization. Costs for typing and clerical or office services will not be reimbursed.

8. The following costs will not be reimbursed:

a. Facsimile charges.

b. Express mail.

c. Additional copies of transcripts.

d. Costs incurred to obtain medical records.

e. Online computer-assisted legal research.

f. Copy charges for documents provided by the organization.

The organization shall reimburse court reporters for mileage and other expenses, for reasonable and necessary travel, in the amounts that are paid state officials as provided by North Dakota Century Code sections 44-08-04 and 54-06-09.

History: Effective June 1, 1990; amended effective November 1, 1991; January 1, 1994; January 1, 1996; May 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2008; April 1, 2009; July 1, 2010; April 1, 2012; April 1, 2014.
General Authority: NDCC 65-02-08, 65-02-15
Law Implemented: NDCC 65-02-08, 65-02-15, 65-10-03

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-11.1.
Title of Section: Attorney's fees.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-11.1.
Title of Section: Attorney's fees.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-01-02-11.1.

ADMINISTRATIVE RULE TITLE: Attorney's fees.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No significant impact is anticipated. The proposed rule change will increase attorney fees by approximately 3.8 percent or approximately $11,000 per year.

DATE: May 23, 2013

Section 92-01-02-12 is amended as follows:

92-01-02-12. Mileage and per diem for travel to and from medical treatment.

92-01-02-12. Mileage and per diem for travel to and from medical treatment. Workforce safety and insurance recognizes payment for travel to and from medical treatment as a reasonable and necessary medical expense. Lodging expenses will be reimbursed if they are necessary and reasonable. These expenses will be paid according to North Dakota Century Code section 65-05-28, except that reimbursement for out-of-state lodging may not exceed one hundred twenty-five percent of the allowance for in-state lodging. The number of miles actually traveled is rebuttably presumed to be the least number of miles listed by MapQuest at www.mapquest.com between the start and end points of travel.

History: Effective August 1, 1988; amended effective April 1, 1997; July 1, 2010; April 1, 2012; April 1, 2014.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08, 65-05-28

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-12.
Title of Section: Mileage and per diem for travel to and from medical treatment.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-12
Title of Section: Mileage and per diem for travel to and from medical treatment.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-01-02-12.

ADMINISTRATIVE RULE TITLE: Mileage and per diem for travel to and from medical treatment.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No impact is anticipated.

DATE: May 23, 2013

Subsection 2 of Section 92-01-02-23 is amended as follows:

92-01-02-23. **Installment payment of premiums.**

92-01-02-23. Installment payment of premiums.

1. On March thirty-first of each year, the organization shall establish the interest rate to be charged to accounts with policy periods renewing between July first and June thirtieth of the following year, which elect to pay premium by installments. For the purposes of North Dakota Century Code sections 65-04-20 and 65-04-33, the interest rate is the base rate posted by the Bank of North Dakota plus two and one-half percent. The interest rate may not be lower than six percent.

2. Premium subject to installments will be limited to the premium for the advance premium only. The organization may apply alternative installment options. Prior period premium deficiencies must be paid in full within the original premium due date.

3. Default of any installment payment causes the entire premium balance to be due immediately.

History: Effective November 1, 1991; amended effective January 1, 1996; May 1, 2002; April 1, 2014.
General Authority: NDCC 65-02-08, 65-04-20
Law Implemented: NDCC 65-04-20, 65-04-24

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-23
Title of Section: Installment payment of premiums.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-23
Title of Section: Installment payment of premiums.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-01-02-23

ADMINISTRATIVE RULE TITLE: Installment payment of premiums.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No impact is anticipated.

DATE: May 23, 2013

Subsection 2 of Section 92-01-02-29 is amended as follows:

92-01-02-29. Medical services – Definitions.

92-01-02-29. Medical services - Definitions. The definitions found in North Dakota Century Code title 65 apply to terms contained in this title. In addition, unless the context otherwise requires, for purposes of sections 92-01-02-27 through 92-01-02-48:

1. "Attending doctor" means a doctor who is primarily responsible for the treatment of a claimant's compensable injury.

2. "Bill audit" means the review of medical bills and associated medical records by the organization or the managed care vendor, including review for duplications, omissions, actual delivery of billed services and items, accuracy of charges and associated coding, coding documentation ~~in accordance with health care finance administration~~ guidelines, coverage, concurrent billing ~~for services~~ for covered and noncovered services, and application of fee schedules.

3. "Case management" means the ongoing coordination of medical services provided to a claimant, including:

   a. Developing a treatment plan to provide appropriate medical services to a claimant.

   b. Systematically monitoring the treatment rendered and the medical progress of the claimant.

   c. Assessing whether alternative medical services are appropriate and delivered in a cost-effective manner based upon acceptable medical standards.

   d. Ensuring the claimant is following the prescribed medical plan.

   e. Formulating a plan for keeping the claimant safely at work or expediting a safe return to work.

4. "Concurrent review" means the monitoring by the organization or the managed care vendor for medical necessity and appropriateness, throughout the period of time in which designated medical services are being provided to the claimant, of the claimant's condition, treatments, procedures, and length of stay.

5. "Consulting doctor" means a licensed doctor who examines a claimant, or the claimant's medical record, at the request of the attending doctor to aid in diagnosis or treatment. A consulting doctor, at the request of the attending doctor, may provide specialized treatment of the compensable injury and give advice or an opinion regarding the treatment being rendered or considered for a claimant's injury.

6. "Elective surgery" means surgery that may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function, or health. Pain, of itself, does not constitute a surgical emergency.

7. "Emergency" means a medical condition that manifests itself by symptoms of sufficient severity, which may include severe pain, to cause a prudent layperson possessing an average knowledge of health and medicine to reasonably conclude that immediate medical treatment is required to avoid serious impairment of a bodily function, or serious dysfunction of any body part, or jeopardizing the person's life.

8. "Fee schedule" means the publication entitled "Workforce Safety and Insurance Medical and Hospital Fees".

9. "Functional capacity evaluation" means an objective, directly observed, measurement of a claimant's ability to perform a variety of physical tasks combined with subjective analyses of abilities by the claimant and the evaluator. A physical tolerance screening and a Blankenship's functional evaluation are functional capacity evaluations.

10. "Managed care" means services performed by the organization or a managed care vendor, including utilization review, preservice reviews, disability management services, case management services, ambulatory reviews, concurrent reviews, retrospective reviews, preadmission reviews, and medical bill audit.

11. "Managed care vendor" means an organization that is retained by the organization to provide managed care services.

12. "Medical service" means a medical, surgical, chiropractic, psychological, dental, hospital, nursing, ambulance, and other related or ancillary service, including physical and occupational therapy and drugs, medicine, crutches, a prosthetic appliance, braces, and supports, and physical restoration and diagnostic services, or a service outlined in section 92-01-02-30.

13. "Medical service provider" means a doctor, health care provider, hospital, medical clinic, or vendor of medical services.

14. "Medically stationary" means the "date of maximum medical improvement" as defined in North Dakota Century Code section 65-01-02 has been reached.

15. "Notice of nonpayment" means the form by which a claimant is notified of charges denied by the organization which are the claimant's personal responsibility.

16. "Palliative care" means a medical service rendered to alleviate symptoms without curing the underlying condition.

17. "Physical conditioning" means an individualized, graded exercise program designed to improve the overall cardiovascular, pulmonary, and neuromuscular condition of the

claimant prior to or in conjunction with the claimant's return to any level of work. Work conditioning is the same as physical conditioning.

18. "Preservice review" means the evaluation by the organization or a managed care vendor of a proposed medical service for medical necessity, appropriateness, and efficiency prior to the services being performed.

19. "Remittance advice" means the form used by the organization to inform payees of the reasons for payment, reduction, or denial of medical services.

20. "Retrospective review" means the organization's or a managed care vendor's review of a medical service for medical necessity, appropriateness, and efficiency after treatment has occurred.

21. "Special report" means a medical service provider's written response to a specific request from the organization for information, including information on causation, aggravation, preexisting conditions, and clarification of complex medical conditions, requiring the creation of a new document or the previously unperformed analysis of existing data. The explanatory reports required for procedures designated as "by report" under section 92-01-02-27 are not special reports.

22. "Utilization review" means an evaluation of the necessity, appropriateness, efficiency, and quality of medical services provided to a claimant, based on medically accepted standards and an objective evaluation of the medical services.

23. "Utilization review department" means the organization's utilization review department.

24. "Work hardening" means an individualized, medically prescribed and monitored, work-oriented treatment process which involves the claimant participating in simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the claimant to a specified job.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; April 1, 2014.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-29.
Title of Section: Medical services - Definitions.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-29.
Title of Section: Medical services - Definitions.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-01-02-29.

ADMINISTRATIVE RULE TITLE: Medical services - Definitions.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No impact is anticipated.

DATE: May 23, 2013

Section 92-01-02-29.1 is amended as follows:

92-01-02-29.1. Medical necessity.

1. A medical service or supply necessary to diagnose or treat a compensable injury, which is appropriate to the location of service, is medically necessary if it is widely accepted by the practicing peer group and has been determined to be safe and effective based on published, peer-reviewed, scientific studies.

2. Services that present a hazard in excess of the expected medical benefits are not medically necessary. Services that are controversial, obsolete, experimental, or investigative are not reimbursable unless specifically preapproved or authorized by the organization. Requests for authorization must contain a description of the treatment and the expected benefits and results of the treatment.

3. The organization will not authorize or pay for the following treatment:

a. Massage therapy or acupuncture unless specifically preapproved or otherwise authorized by the organization. Massage therapy must be provided by a licensed physical therapist, licensed occupational therapist, licensed chiropractor, or licensed massage therapist.

b. Chemonucleolysis; acupressure; reflexology; rolfng; injections of colchicine except to treat an attack of gout precipitated by a compensable injury; injections of chymopapain; injections of fibrosing or sclerosing agents except where varicose veins are secondary to a compensable injury; and injections of substances other than cortisone, anesthetic, or contrast into the subarachnoid space (intrathecal injections).

c. Treatment to improve or maintain general health (i.e., prescriptions or injections of vitamins, nutritional supplements, diet and weight loss programs, programs to quit smoking) unless specifically preapproved or otherwise authorized by the organization. Over-the-counter medications may be allowed in lieu of prescription medications when approved by the organization and prescribed by the attending doctor. Dietary supplements, including minerals, vitamins, and amino acids are reimbursable if a specific compensable dietary deficiency has been clinically established in the claimant. Vitamin B-12 injections are reimbursable if necessary because of a malabsorption resulting from a compensable gastrointestinal disorder.

d. Articles such as beds, hot tubs, chairs, Jacuzzis, vibrators, heating pads, home furnishings, waterbeds, exercise equipment, cold packs, and gravity traction devices are not compensable except at the discretion of the organization under exceptional circumstances.

e. Vertebral axial decompression therapy (Vax-D treatment).

f. Intradiscal electrothermal annuloplasty (IDET).

g. Prolotherapy (sclerotherapy).

h. Surface electromyography (surface EMG).

i. Athletic trainer services that are provided to a claimant via an agreement, or a contract of employment between a trainer and a claimant's employer, or an entity closely associated with the employer.

4. If a claimant has had opioids continually prescribed during a period after the claim has been filed which exceeds ninety consecutive days, the organization may require a claimant to undergo testing conducted by a health care provider, qualified technician, or chemist to assess the appropriateness of opioid treatment. A claimant who refuses or fails, without good cause, to submit to testing required by the organization forfeits entitlement to payment of any further opioid prescriptions under all existing claims.

5. It is rebuttably presumed that no opioid treatment is appropriate after a second time within twenty-four months that testing indicates that any prescribed opioids are absent from a claimant's body and thereafter the organization may not pay for any opioids under any existing claim for a period of thirty-six months. As used in this subsection "testing" means a test that is administered after a claim is filed and is conducted by a health care provider, qualified technician, or chemist, and is not limited to testing required by the organization.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2008; April 1, 2009; July 1, 2010; April 1, 2012; April 1, 2014.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-29.1
Title of Section: Medical necessity.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-29.1.
Title of Section: Medical necessity.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-01-02-29.1.

ADMINISTRATIVE RULE TITLE: Medical necessity.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: Not quantifiable. The proposed rule is expected to reduce claim costs. To the extent reductions occur it will be reflected in future premium rate levels.

DATE: June 19, 2013

Subsection 7 of Section 92-01-02-29.3 is amended as follows:

92-01-02-29.3. Motor vehicle purchase or modification.

1. An injured worker must obtain a doctor's order of medical necessity before the purchase of a specially equipped motor vehicle or modification of a vehicle may be approved.

2. The organization may require assessments to determine the functional levels of an injured worker who is being considered for a specially equipped motor vehicle or vehicle modification and to determine what modifications are medically necessary.

3. If an existing vehicle cannot be repaired or modified, the organization, in its sole discretion, may approve the purchase of a specially equipped motor vehicle.

4. A minimum of two itemized cost quotes may be requested by the organization. The organization may decrease or add the number of cost quotes needed accordingly.

5. Actual vehicle or modification purchase may not occur until the organization reviews the request and issues recommendations or decisions as to whether eligible for the benefit.

6. Cost quotes must be itemized.

7. Any available vehicle rebates or tax exemptions shall be applied back to the lifetime benefit ~~of one hundred thousand dollars~~ amount as provided in N.D.C.C. Section 65-05-07(5).

Subsection 5 of

8. Any appeal of a decision under this section shall be adjudicated pursuant to North Dakota Century Code section 65-02-20.

History: Effective April 1, 2009; amended effective April 1, 2012; April 1, 2014.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-07(5)(b)

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-29.3
Title of Section: Motor vehicle purchase or modification.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-29.3.
Title of Section: Motor vehicle purchase or modification.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-01-02-29.3.

ADMINISTRATIVE RULE TITLE: Motor vehicle purchase or modification.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No significant impact is anticipated. The proposed rule change conforms to a statutory change from 2013 Senate Bill 2178, NDCC Section 65-05-07(5)(b), wherein the statutory vehicle and vehicle adaptation allowance was increased from $100,000 to $150,000.

DATE: May 23, 2013

Section 92-01-02-29.4 is amended as follows:

92-01-02-29.4. Home modifications.

1. An injured worker must obtain a doctor's order of medical necessity before the payment for home modifications can be approved.

2. The organization may require assessments to determine the functional levels of an injured worker who is being considered for home modifications and to determine what modifications are medically necessary.

3. A minimum of two itemized cost quotes may be requested by the organization. The organization may decrease or add the number of cost quotes needed accordingly.

4. Actual construction or modification cannot occur until the organization reviews the request and issues recommendations or decisions as to eligibility for the benefit.

5. Cost quotes must be itemized.

6. Payment by the organization may not occur until the modification work is completed, or at least, completed in documented phases or at the discretion of the organization.

7. The organization may request that the contractor for proposed home modification be in good standing (example: licensed in the state, bonded, etc.)

8. Real estate modifications to driveways, sidewalks, or passageways may only be approved if evidence supports that those routes are needed to provide safe passageway for the injured worker.

9. Any appeal of a decision under this section shall be adjudicated pursuant to North Dakota Century Code section 65-02-20.

History: Effective April 1, 2012; April 1, 2014.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-07

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-29.4
Title of Section: Home modifications.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-29.4.
Title of Section: Home modifications.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-01-02-29.4.

ADMINISTRATIVE RULE TITLE: Home modifications.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No impact is anticipated.

DATE: May 23, 2013

Subdivision a of subsection 5 of Section 92-01-02-34, and subsection 7 of Section 92-01-02-34 are amended as follows:

92-01-02-34. Treatment requiring authorization, preservice review, and retrospective review.

1. Certain treatment procedures require prior authorization or preservice review by the organization or its managed care vendor. Requests for authorization or preservice review must include a statement of the condition diagnosed; their relationship to the compensable injury; the medical documentation supporting medical necessity, an outline of the proposed treatment program, its length and components, and expected prognosis.

2. Requesting prior authorization or preservice review is the responsibility of the medical service provider who provides or prescribes a service for which prior authorization or preservice review is required.

3. Medical service providers shall request prior authorization directly from the claims analyst for the items listed in this subsection. The claims analyst shall respond to requests within fourteen days.

   a. Durable medical equipment.

      (1) The organization will pay rental fees for equipment if the need for the equipment is for a short period of treatment during the acute phase of a compensable work injury. The claims analyst shall grant or deny authorization for reimbursement of equipment based on whether the claimant is eligible for coverage and whether the equipment prescribed is appropriate and medically necessary for treatment of the compensable injury. Rental extending beyond thirty days requires prior authorization from the claims analyst. If the equipment is needed on a long-term basis, the organization may purchase the equipment. The claims analyst shall base its decision to purchase the equipment on a comparison of the projected rental costs of the equipment to its purchase price. The organization shall purchase the equipment from the most cost-efficient source.

      (2) The claims analyst will authorize and pay for prosthetics and orthotics as needed by the claimant because of a compensable work injury when substantiated by the attending doctor. If those items are furnished by the attending doctor or another provider, the organization will reimburse the doctor or the provider pursuant to its fee schedule. Providers and doctors shall supply the organization with a copy of their original invoice showing actual

cost of the item upon request of the organization. The organization will repair or replace originally provided damaged, broken, or worn-out prosthetics, orthotics, or special equipment devices upon documentation from the attending doctor that replacement or repair is needed. Prior authorization for replacements is required.

(3) If submitted charges for supplies and implants exceed the usual and customary rates, charges will be reimbursed at the provider's purchase invoice plus twenty percent.

(4) Equipment costing less than five hundred dollars does not require prior authorization. This includes crutches, cervical collars, lumbar and rib belts, and other commonly used orthotics, but specifically excludes tens units.

(5) An injured worker must obtain a doctor's order of medical necessity before the purchase of a mobility assistance device.

(6) The organization may require assessments to determine the functional levels of an injured worker who is being considered for a mobility assistance device.

b. Biofeedback programs; pain clinics; psychotherapy; physical rehabilitation programs, including health club memberships and work hardening programs; chronic pain management programs; and other programs designed to treat special problems.

c. Concurrent care. In some cases, treatment by more than one medical service provider may be allowed. The claims analyst will consider concurrent treatment when the accepted conditions resulting from the injury involve more than one system or require specialty or multidisciplinary care. When requesting consideration for concurrent treatment, the attending doctor must provide the claims analyst with the name, address, discipline, and specialty of all other medical service providers assisting in the treatment of the claimant and with an outline of their responsibility in the case and an estimate of how long concurrent care is needed. When concurrent treatment is allowed, the organization will recognize one primary attending doctor, who is responsible for prescribing all medications if the primary attending doctor is a physician authorized to prescribe medications; directing the overall treatment program; providing copies of all reports and other data received from the involved medical service providers; and, in time loss cases, providing adequate certification evidence of the claimant's ability to perform work. The claims analyst will approve concurrent care on a

case-by-case basis. Except for emergency services, all treatments must be authorized by the claimant's attending doctor to be reimbursable.

d. Telemedicine. The organization may pay for audio and video telecommunications instead of a face-to-face "hands on" appointment for the following appointments: office or other outpatient visits that fall within CPT codes 99241 through 99275, inclusive; new and established evaluation and management visits that fall within CPT codes 99201 through 99215, inclusive; individual psychotherapy visits that fall within CPT codes 90804 through 90809, inclusive; and pharmacologic management visits that fall within CPT code 90862. As a condition of payment, the patient must be present and participating in the telemedicine appointment. The professional fee payable is equal to the fee schedule amount for the service provided. The organization may pay the originating site a facility fee, not to exceed twenty dollars.

4. Notwithstanding the requirements of subsection 5, the organization may designate certain exemptions from preservice review requirements in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured workers and providers.

5. Medical service providers shall request preservice review from the utilization review department for:

a. All nonemergent inpatient hospital admissions or nonemergent inpatient surgery and outpatient surgical procedures. ~~For an inpatient stay that exceeds fourteen days, the provider shall request, on or before the fifteenth day, additional review of medical necessity for a continued stay.~~

b. All nonemergent major surgery. When the attending doctor or consulting doctor believes elective surgery is needed to treat a compensable injury, the attending doctor or the consulting doctor with the approval of the attending doctor, shall give the utilization review department actual notice at least twenty-four hours prior to the proposed surgery. Notice must give the medical information that substantiates the need for surgery, an estimate of the surgical date and the postsurgical recovery period, and the hospital where surgery is to be performed. When elective surgery is recommended, the utilization review department may require an independent consultation with a doctor of the organization's choice. The organization shall notify the doctor who requested approval of the elective surgery, whether or not a consultation is desired. When requested, the consultation must be completed within thirty days after notice to the attending doctor. Within seven of the consultant's findings. If the attending doctor and consultant disagree about the need for surgery, the organization may request a

third independent opinion pursuant to North Dakota Century Code section 65-05-28. If, after reviewing the third opinion, the organization believes the proposed surgery is excessive, inappropriate, or ineffective and the organization cannot resolve the dispute with the attending doctor, the requesting doctor may request binding dispute resolution in accordance with section 92-01-02-46.

c. Magnetic resonance imaging, a myelogram, discogram, bonescan, arthrogram, or computed axial tomography. Tomograms are subject to preservice review if requested in conjunction with a myelogram, discogram, bonescan, arthrogram, computed axial tomography scan, or magnetic resonance imaging. Computed axial tomography completed within thirty days from the date of injury may be performed without prior authorization. The organization may waive preservice review requirements for procedures listed in this subdivision when requested by a doctor who is performing an independent medical examination or permanent partial impairment evaluation at the request of the organization.

d. Physical therapy and occupational therapy treatment beyond the first ten treatments or beyond sixty days after first prescribed, whichever occurs first, or physical therapy and occupational therapy treatment after an inpatient surgery, outpatient surgery, or ambulatory surgery beyond the first ten treatments or beyond sixty days after therapy services are originally prescribed, whichever occurs first. Postoperative physical therapy and occupational therapy may not be started beyond ninety days after surgery date. The organization may waive this requirement in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured claimants or providers. Modalities for outpatient physical therapy services and outpatient occupational therapy services are limited to two per visit during the sixty-day or ten-treatment ranges set out in this subsection.

e. Electrodiagnostic studies may only be performed by electromyographers who are certified or eligible for certification by the American board of electrodiagnostic medicine, American board of physical medicine and rehabilitation, or the American board of neurology and psychiatry's certification in the specialty of clinical neurophysiology. Nerve conduction study reports must include either laboratory reference values or literature-documented normal values in addition to the test values.

f. Thermography.

g. Intra-articular injection of hyaluronic acid.

h. Trigger point injections if more than three injections are required in a two-month period. No more than twenty injections may be paid over the life of a claim. If a trigger point injection is administered, the organization may not pay for additional modalities such as cryotherapy and osteopathic manipulations performed in conjunction with the trigger point injection. For purposes of this paragraph, injections billed under CPT code 20552 or 20553 will count as a single injection. Only injections administered on or after May 1, 2002, will be applied toward the maximum number of injections allowed under this subdivision.

i. Facet joint injections.

j. Sacroiliac joint injections.

k. Facet nerve blocks.

l. Epidural steroid injections.

m. Nerve root blocks.

n. Peripheral nerve blocks.

o. Botox injections.

p. Stellate ganglion blocks.

q. Cryoablation.

r. Radio frequency lesioning.

s. Facet rhizotomy.

t. Implantation of stimulators and pumps.

6. Chiropractic providers shall request preservice review from the organization's chiropractic managed care vendor for chiropractic treatment beyond the first twelve treatments or beyond ninety days after the first treatment, whichever occurs first. The evaluation to determine a treatment plan is not subject to review. The organization may waive this subsection in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured claimants or providers. Modalities for chiropractic services are limited to two per visit during the ninety-day or twelve-treatment ranges set out in this subsection.

~~7. Concurrent review of emergency admissions is required within twenty-four hours, or the next business day, of emergency admission~~.

~~8~~7. The organization may designate those diagnostic and surgical procedures that can be performed in other than a hospital inpatient setting.

~~9~~8. The organization or managed care vendor must respond to the medical service provider within three business days of receiving the necessary information to complete a review and make a recommendation on the service. Within the time for review, the organization or managed care vendor must recommend approval or denial of the request, request additional information, request the claimant obtain a second opinion, or request an examination by the claimant's doctor. A recommendation to deny medical services must specify the reason for the denial.

~~10~~9. The organization may conduct retrospective reviews of medical services and subsequently reimburse medical providers only:

a. If preservice review or prior authorization of a medical service is requested by a provider and a claimant's claim status in the adjudication process is pending or closed; or

b. If preservice review or prior authorization of a medical service is not requested by a provider and the provider can prove, by a preponderance of the evidence, that the injured employee did not inform the provider, and the provider did not know, that the condition was, or likely would be, covered under workers' compensation.

All medical service providers are required to cooperate with the managed care vendor for retrospective review and are required to provide, without additional charge to the organization or the managed care vendor, the medical information requested in relation to the reviewed service.

~~11~~10. The organization must notify provider associations of the review requirements of this section prior to the effective date of these rules.

~~12~~11. The organization must respond to the medical service provider within thirty days of receiving a retrospective review request.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; March 1, 2003; July 1, 2004; July 1, 2006; April 1, 2008; April 1, 2009; July 1, 2010; April 1, 2012; April 1, 2014.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-34.
Title of Section: Treatment requiring authorization, preservice review, and retrospective review.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-34.
Title of Section: Treatment requiring authorization, preservice review, and retrospective review.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-01-02-34.

ADMINISTRATIVE RULE TITLE: Treatment requiring authorization, preservice review, and retrospective review.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No impact is anticipated.

DATE: May 23, 2013

Subdivision b of subsection 3 of Section 92-01-02-40 is amended as follows:

92-01-02-40. Palliative care.

1. After the employee has become medically stationary, palliative care is compensable without prior approval from the organization only when it is necessary to monitor administration of prescription medication required to maintain the claimant in a medically stationary condition or to monitor the status of a prosthetic device.

2. If the organization or its managed care vendor believes palliative care provided under subsection 1 is excessive, inappropriate, ineffectual, or in violation of the rules regarding the performance of medical services, review must be performed according to section 92-01-02-46.

3. After the claimant has reached medically stationary status and the claimant's doctor believes that palliative care is necessary, the doctor shall request authorization for palliative care through the managed care vendor prior to the commencement of the treatment. If the palliative care request is approved, services are payable from the date the approved treatment begins. The request must:

    a. Contain all objective findings, and specify if there are none.

    b. Before the date on which Centers for Medicare & Medicaid Services implements ICD-10-CM, ~~i~~dentify the medical condition by ICD-9-CM diagnosis for which the palliative treatment is proposed. On and after the date on which Centers for Medicare & Medicaid Services implements ICD-10-CM, identify the medical condition by ICD-10-CM diagnosis for which the palliative treatment is proposed.

    c. Provide a proposed treatment plan that includes the specific treatment modalities, the name of the provider who will perform the treatment, and the frequency and duration of the care to be given.

    d. Describe how the requested palliative care is related to the accepted compensable condition.

    e. Describe how the proposed treatment will enable the claimant to continue employment or to perform the activities of daily living, and what the adverse effect would be to the claimant if the palliative care is not approved.

    f. Any other information the organization or managed care vendor may request.

4. The managed care vendor shall approve palliative care only when:

   a. Other methods of care, including patient self-care, structural rehabilitative exercises, and lifestyle modifications are being utilized and documented;

   b. Palliative care reduces both the severity and frequency of exacerbations that are clinically related to the compensable injury; and

   c. Repeated attempts have been made to lengthen the time between treatments and clinical results clearly document that a significant deterioration of the compensable condition has resulted.

5. If the attending doctor does not receive written notice from the organization within thirty days of the receipt of the request for palliative care, which approves or disapproves the care, the request will be considered approved.

6. When the request for palliative care is not approved, the organization shall provide, in writing, specific reasons for not approving the care.

7. When the organization approves or disapproves the requested palliative care, the attending doctor, employer, or claimant may request binding dispute resolution under section 92-01-02-46.

8. For the purposes of this section only, a claimant's condition must be determined to be medically stationary when the attending doctor or a preponderance of medical evidence indicates the claimant is "medically stationary" or uses other language meaning the same thing. When there is a conflict in the medical opinions, more weight must be given to medical opinions that are based on the most accurate history, on the most objective findings, on sound medical principles, and on clear and concise reasoning. When expert analysis is important, deference must be given to the opinion of the doctor with the greatest expertise in the diagnosed condition. The date a claimant is medically stationary is the earliest date that preponderance is established under this section. The date of the examination, not the date of the report, controls the medically stationary date. When a specific date is not indicated but the medical opinion states the claimant is medically stationary, the claimant is presumed medically stationary on the date of the last examination. This subsection does not govern determination of maximum medical improvement relating to a permanent impairment award.

History: Effective January 1, 1994; amended effective October 1, 1998; May 1, 2002; July 1, 2004; April 1, 2014.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-40.
Title of Section: Palliative care.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-40.
Title of Section: Palliative care.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-01-02-40.

ADMINISTRATIVE RULE TITLE: Palliative care.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No impact is anticipated.

DATE: May 23, 2013

Subsection 2 of Section 92-01-02-45.1, and subdivisions d, h, and i of subsection 3 of Section 92-01-02-45.1 are amended as follows:

Section 92-01-02-45.1. Provider responsibilities and billings.

92-01-02-45.1. Provider responsibilities and billings.

1. A provider may not submit a charge for a service which exceeds the amount the provider charges for the same service in cases unrelated to workers' compensation injuries.

2. All bills must be fully itemized, including ICD-~~9-CM~~ codes, and services must be identified by code numbers found in the fee schedules or as provided in these rules. The definitions of commonality in the guidelines found in the current procedural terminology must be used as guides governing the descriptions of services, except as provided in the fee schedules or in these rules. All bills must be submitted to the organization within one year of the date of service or within one year of the date the organization accepts liability for the work injury or condition. Before the date on which Centers for Medicare & Medicaid Services implements ICD-10-CM, all bills must be coded with ICD-9-CM codes. On and after the date on which Centers for Medicare & Medicaid Services implements ICD-10-CM, all bills must be coded with ICD-10-CM codes.

3. All medical service providers shall submit bills referring to one claim only for medical services on current form UB 04 or form CMS 1500, except for dental billings which must be submitted on American dental association J510 dental claim forms and pharmacy billings which must be submitted electronically to the organization's pharmacy managed care vendor using the current pharmacy transaction standard. Bills and reports must include:

   a. The claimant's full name and address;

   b. The claimant's claim number and social security number;

   c. Date and nature of injury;

   d. Before the date on which Centers for Medicare & Medicaid Services implements ICD-10-CM, Aarea of body treated, including ICD-9-CM code identifying right or left, as appropriate. On and after the date on which Centers for Medicare & Medicaid Services implements ICD-10-CM, area of body treated, including ICD-10-CM code identifying right or left, as appropriate;

   e. Date of service;

f. Name and address of facility where the service was rendered;

g. Name of medical service provider providing the service;

h. Physician's or supplier's billing name, address, zip code, telephone number; physician's ~~unique physician identification number (UPIN) or~~ national provider identifier (NPI)~~, or both~~; physician assistant's North Dakota state license or certification number; physical therapist's North Dakota state license number; advanced practice registered nurse's ~~UPIN or~~ NPI~~, or both,~~ or North Dakota state license number;

i. Referring or ordering physician's ~~UPIN or~~ NPI~~, or both~~;

j. Type of service;

k. Appropriate procedure code or hospital revenue code;

l. Description of service;

m. Charge for each service;

n. Units of service;

o. If dental, tooth numbers;

p. Total bill charge;

q. Name of medical service provider providing service along with the provider's tax identification number; and

r. Date of bills.

4. All records submitted by providers, including notes, except those provided by an emergency room physician and those on forms provided by the organization, must be typed to ensure that they are legible and reproducible. Copies of office or progress notes are required for all followup visits. Office notes are not acceptable in lieu of requested narrative reports. Communications may not refer to more than one claim. Addendums and late entries to notes or reports must be signed and must include the date they were created. Addendums or late entries to notes or reports created more than sixty calendar days after the date of service may be accepted at the organization's sole discretion.

5. Providers shall submit with each bill a copy of medical records or reports which substantiate the nature and necessity of a service being billed and its

relationship to the work injury, including the level, type, and extent of the service provided to claimants. Documentation required includes:

a. Laboratory and pathology reports;

b. X-ray findings;

c. Operative reports;

d. Office notes, physical therapy, and occupational therapy progress notes;

e. Consultation reports;

f. History, physical examination, and discharge summaries;

g. Special diagnostic study reports; and

h. Special or other requested narrative reports.

6. When a provider submits a bill to the organization for medical services, the provider shall submit a copy of the bill to the claimant to whom the services were provided. The copy must be stamped or printed with a legend that clearly indicates that it is a copy and is not to be paid by the claimant.

7. If the provider does not submit records with a bill, and still does not provide those records upon request of the organization, the charges for which records were not supplied may not be paid by the organization, unless the provider submits the records before the decision denying payment of those charges becomes final. The provider may also be liable for the penalty provided in subsection 6 of North Dakota Century Code section 65-05-07.

8. Disputes arising out of reduced or denied reimbursement are handled in accordance with section 92-01-02-46. In all cases of accepted compensable injury or illness under the jurisdiction of the workers' compensation law, a provider may not pursue payment from a claimant for treatment, equipment, or products unless a claimant desires to receive them and has accepted responsibility for payment, or unless the payment for the treatment was denied because:

   a. The claimant sought treatment from that provider for conditions not related to the compensable injury or illness.

   b. The claimant sought treatment from that provider which was not prescribed by the claimant's attending doctor. This includes ongoing treatment by the provider who is a nonattending doctor.

c. The claimant sought palliative care from that provider not compensable under section 92-01-02-40 after the claimant was provided notice that the palliative care service is not compensable.

d. The claimant sought treatment from that provider after being notified that the treatment sought from that provider has been determined to be unscientific, unproven, outmoded, investigative, or experimental.

e. The claimant did not follow the requirements of subsection 1 of North Dakota Century Code section 65-05-28 regarding change of doctors before seeking treatment of the work injury from the provider requesting payment for that treatment.

f. The claimant is subject to North Dakota Century Code section 65-05-28.2, and the provider requesting payment is not a preferred provider and has not been approved as an alternative provider under subsection 2, 3, or 4 of North Dakota Century Code section 65-05-28.2.

9. A medical service provider may not bill for services not provided to a claimant and may not bill multiple charges for the same service. Rebilling must indicate that the charges have been previously billed.

10. Pursuant to North Dakota Century Code section 65-05-33, a medical service provider may not submit false or fraudulent billings.

11. Only one office visit designation may be used at a time except for those code numbers relating specifically to additional time.

12. When a claimant is seen initially in an emergency department and is admitted subsequently to the hospital for inpatient treatment, the services provided immediately prior to the admission are part of the inpatient treatment.

13. Hot and cold pack as a modality will be considered as a bundled charge and will not be separately reimbursed.

14. When a medical service provider is asked to review records or reports prepared by another medical service provider, the provider shall bill review of the records using CPT code 99080 with a descriptor of "record review". The billing must include the actual time spent reviewing the records or reports and must list the medical service provider's normal hourly rate for the review.

15. When there is a dispute over the amount of a bill or the necessity of services rendered, the organization shall pay the undisputed portion of the bill and

provide specific reasons for nonpayment or reduction of each medical service code.

16. If medical documentation outlines that a non-work-related condition is being treated concurrently with the compensable injury and that condition has no effect on the compensable injury, the organization may reduce the charges submitted for treatment. In addition, the attending doctor must notify the organization immediately and submit:

    a. A description or diagnosis of the non-work-related condition.

    b. A description of the treatment being rendered.

    c. The effect, if any, of the non-work-related condition on the compensable injury.

    The attending doctor shall include a thorough explanation of how the non-work-related condition affects the compensable injury when the doctor requests authorization to treat the non-work-related condition. Temporary treatment of a non-work-related condition may be allowed, upon prior approval by the organization, provided the condition directly delays recovery of the compensable injury. The organization may not approve or pay for treatment for a known preexisting non-work-related condition for which the claimant was receiving treatment prior to the occurrence of the compensable injury, which is not delaying recovery of the compensable injury. The organization may not pay for treatment of a non-work-related condition when it no longer exerts any influence upon the compensable injury. When treatment of a non-work-related condition is being rendered, the attending doctor shall submit reports monthly outlining the effect of treatment on both the non-work-related condition and the compensable injury.

17. In cases of questionable liability when the organization has not rendered a decision on compensability, the provider has billed the claimant or other insurance, and the claim is subsequently allowed, the provider shall refund the claimant or other insurer in full and bill the organization for services rendered.

18. The organization may not pay for the cost of duplicating records when covering the treatment received by the claimant. If the organization requests records in addition to those listed in subsection 5 or records prior to the date of injury, the organization shall pay a minimum charge of five dollars for five or fewer pages and the minimum charge of five dollars for the first five pages plus thirty-five cents per page for every page after the first five pages.

19. The provider shall assign the correct approved billing code for the service rendered using the appropriate provider group designation. Bills received without codes will be returned to the provider.

20. Billing codes must be found in the most recent edition of the physician's current procedural terminology; health care financing administration common procedure coding system; code on dental procedures and nomenclature maintained by the American dental association; or any other code listed in the fee schedules.

21. A provider shall comply within thirty calendar days with the organization's request for copies of existing medical data concerning the services provided, the patient' s condition, the plan of treatment, and other issues pertaining to the organization's determination of compensability, medical necessity, or excessiveness or the organization may refuse payment for services provided by that provider.

22. A provider may not bill a claimant a fee for the difference between the maximum allowable fees set forth in the organization's fee schedule and usual and customary charges, or bill the claimant any other fee in addition to the fee paid, or to be paid, by the organization for individual treatments, equipment, and products.

History: Effective January 1, 1994; amended effective April 1, 1996; October 1, 1998; January 1, 2000; May 1, 2002; April 1, 2008; July 1, 2010; April 1. 2012; April 1, 2014.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07, 65-05-28.2

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-45.1.
Title of Section: Provider responsibilities and billings.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-45.1.
Title of Section: Provider responsibilities and billings.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-01-02-45.1.

ADMINISTRATIVE RULE TITLE: Provider responsibilities and billings.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No impact is anticipated.

DATE: May 23, 2013

Subsection 4 of Section 92-01-02-50 is amended as follows:

92-01-02-50. Other states' coverage.

4. The organization may pay, on behalf of an employer, any regular workers' compensation benefits the employer is obligated to pay under the workers' compensation laws of a state other than North Dakota, with respect to personal injury, illness, or death sustained as a result of work activities by an employee engaged in covered employment in that state, if the employee or the employee's dependents elect to receive benefits under the other state's laws in lieu of benefits available under the North Dakota Workers' Compensation Act. The term "dependents" includes an employee's spouse. The organization may pay benefits on behalf of an employer but may not act nor be deemed as an insurer, nor may the organization indemnify an employer for any liabilities, except as specifically provided in this section.

The benefits provided by this section are those mandated by the workers' compensation laws of the elected state. This includes benefits for injuries that are deemed compensable in that other state but are not compensable under North Dakota Century Code chapters 65-05 and 65-08. Medical benefits provided pursuant to this section are subject to any fee schedule and other limitations imposed by the workers' compensation law of the elected state. The North Dakota fee schedule does not apply to this section.

The organization may reimburse an employer covered by this section for legal costs and for reasonable attorney's fees incurred, at a rate of no more than one hundred ~~thirty~~forty dollars per hour, if the employer is sued in tort in another state by an injured employee or an injured employee's dependents relative to a work-related illness, injury, or death; or if the employer is alleged to have failed to make payment of workers' compensation premium in that other state by the workers' compensation authorities of that state. This reimbursement may be made only if it is determined by the organization or by a court of competent jurisdiction that the employer is subject to the provisions of this section and was not required to purchase workers' coverage in that other state relative to the employment of the injured employee.

The organization may not reimburse any legal costs, attorney's fees, nor any other costs to a coemployee sued in tort by an injured employee.

History: Effective January 1, 1994; amended effective April 1, 1997; July 1, 2004; July 1, 2006; July 1, 2010; April 1, 2014.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-08.1-02, 65-08.1-05

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-50.
Title of Section: Other states' coverage.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-50.
Title of Section: Other states' coverage.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-01-02-50.

ADMINISTRATIVE RULE TITLE: Other states' coverage.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No significant impact is anticipated.

DATE: June 24, 2013

Section 92-02-01-01 is amended as follows:

92-02-01-01. References to other standards.

Any update, amendment, or revision to title 29 of the Code of Federal Regulations, part 1910, occupational safety and health standards for general industry, and part 1926, occupational safety and health standards for the construction industry, both promulgated by the occupational safety and health administration of the United States department of labor effective as of July 1, 2010, and, any update, amendment, or revision to title 30 of the Code of Federal Regulations promulgated by the mine safety and health administration of the United States department of labor effective July 1, 2012, are the standards of safety and conduct for the employers and employees of the state of North Dakota.

History: Amended effective August 1, 1987; June 1, 2000; July 1, 2004; July 1, 2010; April 1, 2014.

General Authority: NDCC 65-03-01
Law Implemented: NDCC 65-03-01

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-02-01-01.
Title of Section: References to other standards.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-02-01-01
Title of Section: References to other standards.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-02-01-01

ADMINISTRATIVE RULE TITLE: References to other standards.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No impact is anticipated.

DATE: May 23, 2013

Section 92-05-02-03 is amended as follows:

92-05-02-03 Eligibility – Billing.

92-05-02-03. Eligibility - Billing. All employers, except participants in the retrospective rating and deductible programs are eligible to participate in the organization's risk management programs.

An employer may elect, subject to the organization's approval, to participate in an alternative risk management program.

The organization, in its discretion, shall determine eligibility for the risk management program. Pursuant to this program, the organization will serve the sector of industry and business that has historically generated high frequency or severity rates, or both.

Volunteer accounts are not eligible for participation in risk management programs.

At the organization's discretion, an employer account that is delinquent, uninsured, or not in good standing pursuant to section 92-05-02-01 may not be eligible for discounts under this article.

Discounts are automatically calculated by the organization~~. At the organization's discretion, discounts earned under section 92-05-02-06 may be payable either~~ and are applied as a credit to the employer's premium billing statement. ~~or as a cash payment to the employer.~~

History: Effective July 1, 2006; amended effective April 1, 2008; July 1, 2010; April 1, 2012; April 1, 2014.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-03-04, 65-04-19.1

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-05-02-03.
Title of Section: Eligibility - Billing.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-05-02-03.
Title of Section: Eligibility - Billing.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-05-02-03.

ADMINISTRATIVE RULE TITLE: Eligibility - Billing.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No impact is anticipated.

DATE: May 23, 2013

Section 92-05-03-01 is amended as follows:

92-05-03-01 Grant programs – Purpose.

92-05-03-01. Grant programs - Purpose. The organization may create grant programs to fund safety interventions or develop other programs to reduce workplace injury and illness. A decision to discontinue a grant program is at the discretion of the organization. A grant award under this section is within the discretion of the organization.

History: Effective July 1, 2006; amended effective April 1, 2008; April 1, 2009; April 1, 2014.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-03-04

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-05-03-01.
Title of Section: Grant programs – Purpose.

GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

This rule is not expected to impact the regulated community in excess of $50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-05-03-01.
Title of Section: Grant programs - Purpose.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** There are no reporting or compliance requirements impacted by the change.

B. **Establishing less stringent schedules or deadlines for compliance or report:** There are no compliance issues impacted by the change.

C. **Consolidating or simplifying compliance or reporting requirements:** There is no compliance or reporting issues impacted by the change.

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** There are no performance standards impacted by the change.

E. **Exempting small entities from all or part of the rule's requirements:** There are no entities impacted by the change.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(3) of the NDCC.

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact.

WORKFORCE SAFETY & INSURANCE
ADMINISTRATIVE RULE
FISCAL NOTE

ADMINISTRATIVE RULE NO: 92-05-03-01.

ADMINISTRATIVE RULE TITLE: Grant Programs - Purpose.

SUMMARY OF PROPOSED RULE: Workforce Safety & Insurance has reviewed the proposed administrative rule in conformance with Section 28-32-08.2 of the North Dakota Century Code.

FISCAL IMPACT: No impact is anticipated.

DATE: May 23, 2013