CHAPTER 92-01-02
RULES OF PROCEDURE - NORTH DAKOTA WORKERS' COMPENSATION ACT

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92-01-02-01. Definitions.

Repealed effective January 1, 2026.

92-01-02-02. Claims - Forms.

Repealed effective July 1, 2006.

92-01-02-02.1. Temporary partial disability benefits.

If, after a compensable injury, an injured employee cannot return to full-time employment, or returns to work at a wage less than that earned at the time of the injured employee's first or recurrent disability, the injured employee is eligible for a temporary partial disability benefit. Pursuant to North Dakota Century Code section 65-05-10, the temporary partial disability rate is to be fixed by the organization.

1. An injured employee may earn up to ten percent of the injured employee's average weekly wage without the organization reducing temporary total disability benefits; however, all postinjury wages, from any source, must be reported to the organization to determine whether a reduction is required.

2. If an injured employee is receiving temporary partial disability benefits under North Dakota Century Code section 65-05-10, the injured employee shall submit documentation of paystubs or income earned every pay period. If the organization does not receive this documentation, the organization may not pay temporary partial disability benefits. If the organization does not receive this documentation for a period in excess of ninety days, the organization shall discontinue temporary partial disability benefits.

History: Effective June 1, 1990; amended effective April 1, 1997; February 1, 1998; July 1, 2006; April 1, 2020; January 1, 2022; January 1, 2026.
General Authority: NDCC 65-02-08, 65-05-10
Law Implemented: NDCC 65-02-08, 65-05-09

92-01-02-02.2. Additional twenty-five percent rehabilitation allowance benefit payment.

Repealed effective January 1, 1996.

92-01-02-02.3. First report of injury.

Repealed effective January 1, 2026.

92-01-02-02.4. Treating health care provider's opinion.

Repealed effective January 1, 2026.

92-01-02-02.5. Contributing cause of mental or psychological condition defined.

Repealed effective January 1, 2026.

92-01-02-02.6. Verification of disability.

If an injured employee's disability benefits are discontinued under subsection 6 of North Dakota Century Code section 65-05-08.1, and verification of disability is not received within one hundred twenty days from the date disability benefits are discontinued, the organization may not pay any further disability or vocational rehabilitation benefits, unless the injured employee meets the requirements of a reapplication as found in North Dakota Century Code section 65-05-08.

History: Effective April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-08.1

92-01-02-03. Informal hearing.

Repealed effective April 1, 1997.

92-01-02-04. Rehearing - Formal hearing.

Repealed effective April 1, 1997.

92-01-02-05. Notice of formal hearing - Specification of issues.

Repealed effective April 1, 1997.

92-01-02-06. Evidence.

Repealed effective April 1, 1997.

92-01-02-07. Subpoena - Depositions.

Repealed effective April 1, 1997.

92-01-02-08. Information not presented at a formal hearing.

Repealed effective April 1, 1997.

92-01-02-09. Decision.

Repealed effective April 1, 1997.

92-01-02-10. Appeal.

Repealed effective April 1, 1997.

92-01-02-11. Attorneys.

Any party has a right to be represented by an attorney at any stage in the proceedings regarding a claim. An attorney who represents an injured employee in a proceeding regarding a claim shall file a notice of legal representation signed by the injured employee prior to or together with the attorney's first communication with the organization. The notice of legal representation remains in effect for five years from the date it is signed by the injured employee or until revoked by the injured employee, whichever occurs first.

History: Amended effective June 1, 1990; April 1, 1997; April 1, 2008; July 1, 2017; April 1, 2020.
General Authority: NDCC 65-02-08, 65-10-03
Law Implemented: NDCC 65-02-08, 65-10-03

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 must be paid if an administrative order reducing or denying benefits is submitted to administrative hearing, district court, or supreme court and the employee prevails; or if 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 two hundred five dollars per hour for all actual and reasonable time other than travel time. The organization shall pay attorney travel time at one hundred three 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 one hundred twenty-five dollars per hour for all actual and reasonable time other than travel time. The organization shall pay travel time at sixty-three dollars per hour. A "legal assistant" means a 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 also may 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 is an amount equal to twenty percent of the additional amount awarded except for an order litigating the initial determination of compensability. Awards include those arrived at by a mutually agreed upon settlement. Total fees paid under an administrative order may not exceed the following:

   a. Four thousand seven hundred four 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.

   b. Seven thousand four hundred fifty-five dollars, plus reasonable costs incurred, if the hearing request is resolved by settlement or amendment of the administrative order after the hearing is called to order but before a written decision is issued by the administrative law judge; or the employee prevails after the hearing is called to order by the administrative law judge.

   c. Eight thousand two hundred ninety-five dollars, plus reasonable costs incurred, if the employee's district court appeal is settled prior to submission of briefs. Eleven thousand seventy-eight dollars, plus reasonable costs incurred, if the employee prevails after hearing by the district court.

   d. Thirteen thousand two hundred eighty-three dollars, plus reasonable costs incurred, if the employee's North Dakota supreme court appeal is settled prior to hearing. Fourteen thousand five hundred ninety-five dollars, plus reasonable costs incurred, if the employee prevails after hearing by the supreme court.

   e. Two thousand two hundred five dollars, plus reasonable costs incurred, if the employee requests binding dispute resolution and prevails.

   f. 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 a, b, c, and d 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 shall sign the fee statement. The organization may deny fees and costs that are determined to be excessive or frivolous.

7. The following costs must 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 ten 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 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 reasonable and necessary costs in excess of one hundred fifty dollars may be reimbursed upon agreement, in advance, by the organization. Costs for typing and clerical or office services may not be reimbursed.

8. The following costs may 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; April 1, 2016; January 1, 2018; April 1, 2020; January 1, 2022; January 1, 2024; January 1, 2026.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08, 65-10-03

92-01-02-11.2. Attorney time statements.

An attorney representing a claimant shall submit to the organization, at least once a month, a statement of the time spent representing that claimant during that month. The statement must include the name and claim number of the claimant represented, the type of work performed, which attorney or legal assistant performed the work, and the dates each service was performed. The organization may not pay fees which were not included on a monthly statement submitted as required by this section.

History: Effective April 1, 1997.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08

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

Workforce safety and insurance recognizes payment for travel and lodging to and from medical treatment if reasonable and necessary. These expenses will be paid according to North Dakota Century Code section 65-05-28. The number of miles actually traveled is rebuttably presumed to be the least number of miles listed by Google Maps 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; July 1, 2017; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08, 65-05-28

92-01-02-13. Merger, transfer, or sale of business.

1. **Definitions.** In this section:

   a. "Business entity" means any form of business organization, including proprietorships, partnerships, limited partnerships, cooperatives, limited liability companies, and corporations.

   b. "Constituent business" means a business entity or entities of which a surviving entity is composed. The constituent business may also be referred to as the "predecessor entity" or "seller".

   c. "Surviving entity" means the business entity resulting from a merger, transfer, or sale of business assets from one or more constituent businesses. The surviving entity may also be referred to as "successor entity" or "buyer".

2. **Experience rating.** The surviving entity resulting from a merger, transfer, or sale of business assets must be assigned an experience rating derived from the combined premium, payroll, and loss history of all the employer accounts involved in the merger, transfer, or sale. The employer accounts of the constituent businesses shall merge or transfer into the surviving entity. The organization may change the experience rating of the surviving entity.

   If the organization determines a business entity is a continuation or extension of an already existing business entity and not a surviving entity composed of one or more constituent businesses, and the existing business entity is already experience-rated, the experience rate of the existing business entity must transfer to its continuation or extension. Future experience rates must be calculated using the combined premium, payroll and loss history from the existing business entity and its continuations or extensions.

3. **Compensation coverage.**

   a. The organization may transfer compensation coverage of any constituent business to the surviving entity. The organization may require the surviving entity to provide information

on the constituent businesses of which it is comprised and its owners, officers, directors, partners, and managers. If the organization determines a surviving entity is merely a continuation of the constituent business or businesses, the organization may transfer any liability to the surviving entity or decline coverage until any delinquency is resolved.

b. Factors the organization may consider in determining if a surviving entity is a mere continuation of a constituent business include:

(1) Whether there is continuity of the constituent business in the surviving entity as shown by retention of key personnel, assets, liabilities, customers, contracts, and general business operations.

(2) Whether the surviving entity continues to use the same business location .

(3) Whether employees transferred from the constituent business to the surviving entity.

(4) Whether the surviving entity holds itself out as the effective continuation of the constituent business.

c. The organization shall calculate premium based on actual payroll, subject to the payroll cap, for the relevant period of time. The organization may prorate the payroll cap based on one-twelfth of the statutory payroll cap per month per employee at the beginning of the relevant period of time.

History: Effective June 1, 1990; amended effective January 1, 1992; April 1, 1997; May 1, 2002; July 1, 2004; July 1, 2010; January 1, 2026.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-01

92-01-02-13.1. General contractors.

For purposes of application of North Dakota Century Code section 65-04-26.2, the relationship between a general contractor and subcontractor may be identified by the organization in any industry.

History: Effective January 1, 2018.
General Authority: NDCC 65-02-08, 65-04-26.2
Law Implemented: NDCC 65-04-26.2

92-01-02-14. Procedure for penalizing employers accounts for failure to pay premium or failure to submit payroll reports.

1. The organization shall bill each employer for premiums as provided by North Dakota Century Code chapter 65-04. If an employer has an open account with the organization, the organization may send to the employer a payroll report on which the employer shall submit payroll expenditures for the preceding payroll reporting period. The employer shall provide on the payroll report all information requested by the organization, including the name, social security number, rate classification, and gross payroll for each employee. The employer shall submit an electronic report of payroll information in a format approved by the organization. The report must be received by the organization by the last day of the month following the expiration date of the employer's payroll reporting period. The organization shall consider an unsigned or incomplete submission a failure or refusal to furnish the report.

2. The organization shall send the first billing statement to the employer by regular mail to the employer's last-known address or by electronic transmission. The first billing statement must identify the amount due from the employer. The statement must explain the installment payment option. The payment due date for an employer's account is thirty days from the date

of billing indicated on the billing statement. If a previous delinquency exists on the employer account, the billing statement indicates a past-due status.

3. If the organization does not receive full payment or the minimum installment payment indicated on the billing statement, on or before the payment due date, the organization shall send a second billing statement.

4. If the minimum installment payment remains unpaid thirty days after the organization sends the second billing statement to the employer, the organization shall notify the employer by regular mail to the employer's last-known address or by electronic transmission that:

   a. The employer is in default and may be assessed a penalty of two hundred fifty dollars plus two percent of the amount of premium, penalties, and interest in default;

   b. The employer's account has been referred to the collections unit of the policyholder services department; and

   c. Workforce safety and insurance may cancel the employer's account.

5. The organization may extend coverage if the organization and the employer have agreed in writing to a payment schedule on a delinquent account. If the employer defaults on the agreed payment schedule, that employer is not insured.

6. If the employer's payroll report is not timely received by the organization, the organization shall notify the employer, by electronic transmission or regular mail addressed to the last-known address of the employer of the employer's failure to submit the payroll report. The notification must indicate that the organization may assess a penalty of up to five thousand dollars against the employer's account.

7. If the payroll report is not received by the due date provided by letter from the organization to the employer, the organization shall assess a penalty of fifty dollars. A second fifty-dollar penalty is assessed against the employer if the payroll report remains unsubmitted after an additional fifteen days. The organization shall notify the employer of the penalty by electronic transmission or regular mail addressed to the employer's last-known address.

8. At any time after sixty days following the expiration of the employer's payroll period, when the employer has failed to submit a payroll report, the organization may bill the employer consistent with North Dakota Century Code section 65-04-19. An employer whose premium has been calculated under this subsection may submit actual wages on an employer payroll report for the period billed and the organization shall adjust the employer's account unless the organization determines the information submitted by the employer is unreliable or inaccurate.

9. The organization may cancel an employer's account which has failed to pay premium owing or failed to submit a payroll report.

10. If the organization receives an employer payroll report more than sixty days after the expiration of the employer's payroll period, the employer's billing statement may show a past-due premium billing due date. Any employer account billed without benefit of the employer payroll report may show a past-due billing due date.

11. If the employer does not have an open account with the organization, the organization shall send the employer an application for coverage by regular mail or by electronic transmission. The organization shall notify the employer of the penalties provided by North Dakota Century Code chapter 65-04 and this section.

12. Upon receipt of an incomplete or unsigned payroll report, the employer shall submit the completed payroll report within fifteen days of the organization's request. The organization

shall consider an unsigned or incomplete submission to be a failure or refusal to furnish the report. If the payroll report is not timely received by the organization, the organization may assess a penalty of up to five thousand dollars and shall notify the employer that the employer is uninsured.

History: Effective June 1, 1990; amended effective January 1, 1994; January 1, 1996; May 1, 2002; March 1, 2003; July 1, 2006; April 1, 2009; July 1, 2010; April 1, 2016; January 1, 2018; April 1, 2020; January 1, 2022.
General Authority: NDCC 65-02-08, 65-04-06, 65-04-19, 65-04-33
Law Implemented: NDCC 65-04-33

92-01-02-15. Altering payroll reporting periods for employers.

The organization may alter an employer's payroll reporting period to conform with regular quarter endings (March thirty-first, June thirtieth, September thirtieth, December thirty-first) in cases where an employer's payroll reporting period would not normally coincide with a quarter's end.

History: Effective June 1, 1990; amended effective July 1, 2010.
General Authority: NDCC 65-02-08, 65-04-33
Law Implemented: NDCC 65-04-33

92-01-02-16. Expiration date change.

The organization may change the expiration date on the employer's account. The organization shall calculate premium based on actual taxable payroll for each employee up to the statutory payroll cap, prorated for the actual number of days in the adjusted payroll period.

History: Effective June 1, 1990; amended effective January 1, 1994; April 1, 1997; May 1, 2002; July 1, 2010.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-01

92-01-02-17. Reporting payroll for period of noncompliance.

If the noncompliance period of a new account is less than twelve months, the organization must prorate the payroll based on one-twelfth of the statutory payroll cap per employee, per month, for the period of time involved. If the payroll is less than one-twelfth of the statutory payroll cap per employee, per month, the full month is reportable. An account in noncompliance is uninsured until a completed application for workers' compensation insurance coverage is received by the organization and the premium is paid.

History: Effective June 1, 1990; amended effective January 1, 1994; January 1, 1996; May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-09-01

92-01-02-18. Experience rating system.

The following system is established for the experience rating of risks of employers contributing to the fund:

1. Definitions. In this section, unless the context otherwise requires:

   a. "Three-year losses" means the total sum of ratable losses accrued on claims occurring during the first three of the four years immediately preceding the premium year being rated.

b. "Three-year payroll" means the total sum of limited payroll reported for the first three of the four years immediately preceding the premium year being rated.

c. "Three-year premium" means the total sum of earned premium for the first three of the four years immediately preceding the premium year being rated.

d. "Manual premium" means the actual premium, prior to any experience rating, for the premium year immediately preceding the premium year being rated for claims experience.

2. An employer's account is not eligible for an experience rating until the account has completed three consecutive payroll periods and has developed aggregate manual premiums of at least fifteen thousand dollars for the rating period used in developing the experience modification factor.

3. For accounts with ratable manual premium of fifteen thousand dollars or more:

a. The experience rating must be applied prior to the inception of each premium year for all eligible accounts. A claim is deemed to occur in the premium year in which the injury date occurs.

b. The experience modification factor (EMF) to be applied to the current estimated portion of an employer's payroll report is computed as follows:

(1) Calculate the actual primary losses (A_p), which consist of the sum of those three-year losses, comprising the first fifteen thousand dollars of each individual claim.

(2) Calculate the actual excess losses (A_e), which consist of the sum of those three-year losses in excess of the first fifteen thousand dollars of losses of each individual claim, limited to the maximum loss amount contained in the most recent edition of North Dakota workforce safety and insurance rating plan values which is hereby adopted by reference and incorporated within this subsection as though set out in full.

(3) Calculate the total expected losses (E_t), which are determined by adding the products of the actual payroll for each year of the three-year payroll times the class expected loss rate for each year. The class expected loss rates, taking into consideration the hazards and risks of various occupations, must be those contained in the most recent edition of North Dakota workforce safety and insurance rating plan values, which is hereby adopted by reference and incorporated within this subsection as though set out in full.

(4) Calculate the expected excess losses (E_e), which are determined by adding the products of the actual payroll for each year of the three-year payroll times the class expected excess loss rates. The class expected excess loss rates, taking into consideration the hazards and risks of various occupations, must be those contained in the most recent edition of North Dakota workforce safety and insurance rating plan values, which is hereby adopted by reference and incorporated within this subsection as though set out in full.

(5) Calculate the "credibility factor" (Z) based on the formula that is contained in the most recent edition of North Dakota workforce safety and insurance rating plan values, which is hereby adopted by reference and incorporated within this subsection as though set out in full.

(6) The experience modification factor is then calculated as follows:

(a) Calculate the "ballast amount" (B) which is contained in the most recent edition of North Dakota workforce safety and insurance rating plan values, which is hereby adopted by reference and incorporated within this subsection as though set out in full.

(b) Add the actual primary losses to the product of the actual excess losses times the credibility factor.

(c) To this sum add the product of the expected excess losses times the difference between one dollar and the credibility factor.

(d) To this sum add the ballast amount (B).

(e) Divide this total sum by the sum of the total expected losses plus the ballast amount (B).

The resulting quotient is the experience modification factor to be applied in calculating the estimated premium for the current payroll year.

(7) The formula for the above-mentioned calculation is as follows:

$$EMF = \frac{A_p + (Z \times A_e) + [(1.00 - Z) \times E_e] + B}{E_t + B}$$

4. Small account credit or debit program. Accounts that fall below the eligibility standard for experience rating outlined in subsection 2 are subject to the small account credit or debit program. The rating period and ratable losses used to determine eligibility for the small account credit or debit program are the same as those used for the experience rating program outlined above. The amount of the credit or debit will be determined annually in conjunction with the development of rating plan values for the prospective coverage period.

5. The organization shall include any modification to the North Dakota workforce safety and insurance rating plan values in its ratemaking process pursuant to North Dakota Century Code section 65-04-01.

History: Effective June 1, 1990; amended effective July 1, 1993; July 1, 1994; April 1, 1997; July 1, 2001; July 1, 2006; July 1, 2009; July 1, 2010; July 1, 2016.
General Authority: NDCC 65-02-08, 65-04-17
Law Implemented: NDCC 65-04-01

92-01-02-18.1. Application of discount to experience rate for employers establishing operations in this state.

If an employer who is beginning operations in this state can prove that for similar operations in another jurisdiction the employer received an experience-rate-based discount on workers' compensation premiums in that jurisdiction, the organization may discount that employer's premium in this state. The employer must be setting up a permanent operation and the discount must be part of an economic development package. The discount will be applied after one year. Premium discounts for the employer's second through fourth years of operation in this state will be retrospectively based on the employer's most recent out-of-state experience rate. Premiums for the employer's fifth year of operation in this state will be based on the applicable experience rating programs in this state. The out-of-state employer discount may not exceed the maximum allowable discount under the organization's experience rating plans. An employer who self-insured in another jurisdiction is not eligible for the discount.

History: Effective April 1, 1997; amended effective May 1, 2002; July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-01, 65-04-17

92-01-02-19. Employer relief after third-party recovery.

Upon third-party recovery pursuant to North Dakota Century Code section 65-01-09 in claims which have been accepted by the organization and when the employer's experience rating has been affected, relief will be given to the employer from the date of injury to the balance of the experience rating period. Relief will be given to the extent of the actual net recovery made by or on behalf of the organization, after deduction from the gross recovery of the costs and attorney fees allowable under North Dakota Century Code section 65-01-09.

"Relief will be given" indicates that the amount of money recovered by the organization in a third-party action will be deducted from the amount charged against the employer's experience rating. This may result in a decreased premium for policy periods impacted by the revised experience rates. An account that has been canceled is not entitled to relief under this section.

Relief will also be given to the extent of the employer reimbursement paid by the employer pursuant to North Dakota Century Code section 65-04-04.4, provided that the net recovery made by or on behalf of the organization is equal to or exceeds the total chargeable expenditures made by the organization on the claim plus the reimbursement made by the employer. An employer who has not timely paid reimbursement under North Dakota Century Code section 65-04-04.4 forfeits any right to relief for that reimbursement.

History: Effective June 1, 1990; amended effective January 1, 1996; May 1, 2002; July 1, 2004; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-01-09, 65-04-04.3, 65-04-04.4, 65-04-17

92-01-02-20. Classification of employments - Premium rates.

Classifications and premium rates must be those classifications contained in the documents entitled "Classification Manual" and "Workforce Safety and Insurance Rates". When classifying employment or assigning a premium rate, the organization must use the edition of the manuals in effect during the policy period in which the premium is incurred. Rate classifications are assigned by the organization. Rate classifications of any employer may be modified by the organization at any time. Premium rates must be adjusted annually as recommended by the organization's actuaries based upon the criteria found in North Dakota Century Code section 65-04-01.

History: Effective June 1, 1990; amended effective July 1, 1990; July 1, 1991; July 1, 1992; July 1, 1993; July 1, 1994; July 1, 1996; May 1, 2002; July 1, 2006; April 1, 2020.
General Authority: NDCC 65-02-08, 65-04-01
Law Implemented: NDCC 65-04-01

92-01-02-21. Employee staffing arrangements.

Repealed pursuant to North Dakota Century Code section 28-32-18.1, effective July 16, 2003.

92-01-02-22. Out-of-state injuries.

An employee may be deemed to regularly work at or from an employment principally localized in this state as defined in North Dakota Century Code sections 65-08-01 and 65-08.1-01 if the employee's out-of-state injury is sustained under circumstances in which the employee has worked outside this state for a period of not more than thirty consecutive calendar days.

History: Effective July 1, 1991; amended effective January 1, 1994.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-08.1-02, 65-08.1-05

92-01-02-22.1. Out-of-country injuries.

The organization may, at its sole discretion, extend workers' compensation coverage by written agreement to North Dakota employers for their employees hired in North Dakota and working outside the United States for a limited period of time, provided the workers' compensation system of the foreign country is not applicable to the employer and the employer provides sufficient documentation in advance of the foreign exposure of its inability to obtain any coverage in the private insurance market.

History: Effective April 1, 2008.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-08-01(1)(d)

92-01-02-22.2. Out-of-state coverage for law enforcement training.

The organization may, at its sole discretion, extend workers' compensation coverage by written agreement to North Dakota employers for their employees engaged in law enforcement training outside the state for a limited period of time, provided the North Dakota employer provides documentation that the workers' compensation system of that state is not applicable to the employer.

History: Effective October 1, 2011.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-08-01(1)(a), 65-02-13.1

92-01-02-23. Interest rate - 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 is limited to the premium for the advance premium only. Prior period premium deficiencies must be paid in full within the original premium due date. All payments made by an employer are applied to the oldest balance first. The organization may apply alternative installment options.

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; April 1, 2020.
General Authority: NDCC 65-02-08, 65-04-20
Law Implemented: NDCC 65-04-20, 65-04-24

92-01-02-23.1. Payment by credit card.

The organization, in its sole discretion, may accept payment by credit card for premiums, assessments, penalties, interest, reimbursements, or any other payment that is due the organization.

History: Effective January 1, 1996; amended effective April 1, 1997; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 54-06-08.2

92-01-02-23.2. Employers to provide security instrument.

The organization may require an employer to provide a bond, letter of credit, cash deposit, or other security instrument approved by the organization to guarantee payment of workers' compensation premium. The required security instrument is in addition to any other required installment payment obligations.

1. A security instrument or cash deposit may be required when:

   a. The employer does not have a permanent place of business in this state;

   b. The employer is not a resident of this state;

   c. The employer does not have a payment history or previously underwritten account with the organization; or

   d. The employer has a previous delinquency with the organization.

2. The security required by an employer may be the amount of premium calculated for the applicable premium year. The security amount may be adjusted by the organization based on changes in premium and anticipated payroll. The organization may consider all aspects of an employer's account, including premium, rate classifications, and premium and assessment delinquencies to determine the security required.

3. Failure to provide a security instrument as required by the organization results in the employer being deemed uninsured and in default.

4. The organization may permit withdrawal of the security if the employer has made all premium and assessment payments timely for two policy periods and complied with all requirements of the organization.

5. Once an employer account is in a closed status, and any balance due on the account is paid, the security instrument will be released.

History: Effective January 1, 2018.
General Authority: NDCC 65-02-08, 65-04-22
Law Implemented: NDCC 65-04-22

92-01-02-24. Rehabilitation services.

1. If an employment opportunity suited to an employee's education, experience, and marketable skills is identified within thirty-five miles [56.33 kilometers] from the employee's home, the appropriate priority option must be identified as return to related occupation in the local job pool under subdivision e of subsection 4 of North Dakota Century Code section 65-05.1-01, and relocation expense under subsection 3 of North Dakota Century Code section 65-05.1-06.1 may not be paid.

2. The organization may award services to move an employee's household where the employee has actually located work under subdivision f of subsection 2 of North Dakota Century Code section 65-05.1-06.1 or under subsection 3 of North Dakota Century Code section 65-05.1-06.1 if the employee identifies the job the employee will perform, the employee's employer, and the employee's destination. A relocation award must be the actual cost of moving the household to the location where work has been obtained. A minimum of two bids detailing the costs of relocation must be submitted to the organization for approval prior to incurring the cost. The organization shall pay per diem expenses, as set forth under subsection 2 of North Dakota Century Code section 65-05-28, for the employee only. Reimbursement for mileage expenses may not be paid for more than one motor vehicle.

3. If the rehabilitation award is for retraining, the organization shall pay the actual cost of books, tuition, and school supplies required by the school. The school shall provide documentation of the costs necessary for completion of the program in which the employee is enrolled. Reimbursable school costs may not exceed those charged to other students participating in the same program. The award for school supplies may not exceed twenty-five dollars per quarter or fifty dollars per semester unless the employee obtains prior approval of the organization by showing that the expenses are reasonable and necessary. A rehabilitation award for retraining may include tutoring assistance to employees who require tutoring to maintain a passing grade. Payment of tutoring services must be authorized when these services are not available as part of the training program. The award for tutoring services may not exceed the usual and customary rate established by the school. Expenses such as association dues or subscriptions may be reimbursed only if that expense is a course requirement.

4. An award for retraining which includes an additional rehabilitation allowance as provided in subdivision b of subsection 2 of North Dakota Century Code section 65-05.1-06.1 may continue while the employee is actually enrolled or participating in the training program.

5. An award of a specified number of weeks of training means training must be completed during the specified period of weeks, and rehabilitation benefits may be paid for the specified number of weeks of training.

6. The organization may reimburse an employee's travel and personal expenses for attendance at an adult learning center or skill enhancement program at the request of the employee and upon the approval of the organization. All claims for reimbursement must be supported by the original vendor receipt, when appropriate, and must be submitted within one year of the date the expense was incurred. The organization shall reimburse these expenses at the rates in effect on the date of travel or the date the expense was incurred at which state employees are paid per diem and mileage, or reimburse the actual cost of meals and lodging plus mileage, whichever is less. The calculation for reimbursement for travel by motor vehicle must be calculated using miles actually and necessarily traveled. The number of miles actually traveled is rebuttably presumed to be the least number of miles listed by Google Maps between the start and end points of travel. The organization may not reimburse mileage or travel expenses if the distance traveled is less than fifty miles [80.47 kilometers] one way, unless the total mileage in a calendar month equals or exceeds two hundred miles [321.87 kilometers].

7. The organization may pay for retraining equipment required by an institution of higher education, an institution of technical education, or an adult learning center institution specializing in a skill enhancement program on behalf of a student attending that institution. The organization may pay for equipment to enhance the employability skills of an injured employee absent a determination of a retraining program. The organization will award an injured employee one thousand two hundred dollars for the purchase of computer, warranty, software, maintenance, and internet access. Securing and maintaining these items are the injured employee's responsibility. Failure to maintain or secure these items does not constitute good cause for noncompliance with vocational rehabilitation. Improper maintenance of the equipment does not constitute good cause for noncompliance with vocational rehabilitation.

8. The organization may provide certain selected services to assist an injured employee and the injured employee's family with coping and financial strategies while in the recovery process. The recovery process includes the medical recovery, the ability to return to gainful employment, and the need for financial stability. The services may include up to six sessions with a contracted behavioral health professional and up to four sessions with a contracted financial services professional. Injured employee participation in these sessions is voluntary. The granting or denial of contemplated services is not appealable, and costs of the program will be made against the general fund.

History: Effective November 1, 1991; amended effective January 1, 1996; April 1, 1997; February 1, 1998; May 1, 2002; July 1, 2006; July 1, 2010; April 1, 2012; April 1, 2016; July 1, 2017; January 1, 2022; January 1, 2024; January 1, 2026.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05.1-01(2), 65-05.1-02, 65-05.1-06.3

92-01-02-25. Permanent impairment evaluations and disputes.

1. Definitions:

   a. Amputations and loss as used in subsection 11 of North Dakota Century Code section 65-05-12.2.

      "Amputation of a thumb" means disarticulation at the metacarpal phalangeal joint.

      "Amputation of the second or distal phalanx of the thumb" means disarticulation at or proximal to the interphalangeal joint.

      "Amputation of the first finger" means disarticulation at the metacarpal phalangeal joint.

      "Amputation of the middle or second phalanx of the first finger" means disarticulation at or proximal to the proximal interphalangeal joint.

      "Amputation of the third or distal phalanx of the first finger" means disarticulation at or proximal to the distal interphalangeal joint.

      "Amputation of the second finger" means disarticulation at the metacarpal phalangeal joint.

      "Amputation of the middle or second phalanx of the second finger" means disarticulation at or proximal to the proximal interphalangeal joint.

      "Amputation of the third or distal phalanx of the second finger" means disarticulation at or proximal to the distal interphalangeal joint.

      "Amputation of the third finger" means disarticulation at the metacarpal phalangeal joint.

      "Amputation of the middle or second phalanx of the third finger" means disarticulation at or proximal to the proximal interphalangeal joint.

      "Amputation of the fourth finger" means disartriculation at the metacarpal phalangeal joint.

      "Amputation of the middle or second phalanx of the fourth finger" means disarticulation at or proximal to the proximal interphalangeal joint.

      "Amputation of the leg at the hip" means disarticulation at or distal to the hip joint (separation of the head of the femur from the acetabulum).

      "Amputation of the leg at or above the knee" means disarticulation at or proximal to the knee joint (separation of the femur from the tibia).

      "Amputation of the leg at or above the ankle" means disarticulation at or proximal to the ankle joint (separation of the tibia from the talus).

      "Amputation of a great toe" means disarticulation at the metatarsal phalangeal joint.

      "Amputation of the second or distal phalanx of the great toe" means disarticulation at or proximal to the interphalangeal joint.

"Amputation of any other toe" means disarticulation at the metatarsal phalangeal joint.

"Loss of an eye" means enucleation of the eye.

b. "Maximum medical improvement" means the injured employee's recovery has progressed to the point where substantial further improvement is unlikely, based on reasonable medical probability and clinical findings indicate the medical condition is stable.

c. "Medical dispute" means an employee has reached maximum medical improvement in connection with a work injury and has been evaluated for permanent impairment, and there is a disagreement between health care providers arising from the physical evaluation that affects the amount of the award. The dispute to be reviewed must clearly summarize the underlying medical condition. It does not include disputes regarding proper interpretation or application of the American medical association guides to the evaluation of permanent impairment, sixth edition. It does not include disputes arising from an impairment percentage rating or an impairment opinion given by a health care provider when the health care provider is not trained in the American medical association guides to the evaluation of permanent impairment, sixth edition, and when the health care provider's impairment percentage rating or impairment opinion do not meet the requirements of subsection 5 of North Dakota Century Code section 65-05-12.2.

d. "Potentially eligible for an impairment award" means the medical evidence in the claim file indicates an injured employee has reached maximum medical improvement and has a permanent impairment caused by the work injury that will likely result in a monetary impairment award.

e. "Treating health care provider" means an allied health care professional who has physically examined or provided direct care or treatment to the injured employee.

2. Permanent impairment evaluations must be performed in accordance with the American medical association guides to the evaluation of permanent impairment, sixth edition, and modified by this section. All permanent impairment reports must include the opinion of the health care provider on the cause of the impairment and must contain an apportionment if the impairment is caused by both work-related and non-work-related injuries or conditions.

3. The organization shall schedule an evaluation with a health care provider who has the training and experience necessary to conduct an evaluation of permanent impairment and apply the American medical association guides to the evaluation of permanent impairment, sixth edition. The organization may not use nor consider a permanent impairment evaluation conducted by the employee's treating health care provider or any health care provider who has treated the injured employee for the work-related injury. In the event of a medical dispute, the organization will identify qualified specialists and submit all objective medical documentation regarding the dispute to specialists who have the knowledge, training, and experience in the application of the American medical association guides to the evaluation of permanent impairment, sixth edition.

4. Upon receiving a permanent impairment rating report from the health care provider, the organization shall audit the report and shall issue a decision awarding or denying permanent impairment benefits.

a. Pain impairment ratings. A permanent impairment award may not be made upon a rating solely under chapter 3 of the sixth edition.

b. Mental and behavioral disorders are not independently compensable and are encompassed within the rating for physical impairment.

c. In chapters that include assessment of the functional history as one of the nonkey factors to adjust the final impairment rating within a class by using a self-report tool, the examining health care provider is to score the self-report tool and assess results for consistency and credibility before adjusting the impairment rating higher or lower than the default value. The evaluating health care provider must provide rationale for deciding that functional test results are clinically consistent and credible.

d. A functional history grade modifier may be applied only to the single, highest diagnosis-based impairment.

e. All permanent impairment reports must include an apportionment if the impairment is caused by both work and non-work injuries or conditions.

5. Pollicization procedures will be rated as an impairment under subsection 11 of North Dakota Century Code section 65-05-12.2, relating to scheduled injury, and may not be rated as a whole body impairment, unless otherwise specified under subsection 11 of North Dakota Century Code section 65-05-12.2.

History: Effective November 1, 1991; amended effective January 1, 1996; April 1, 1997; May 1, 1998; May 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2009; July 1, 2010; April 1, 2012; July 1, 2017; January 1, 2018; April 1, 2020; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-12.2

92-01-02-26. Binding arbitration.

Repealed effective July 1, 2006.

92-01-02-27. Medical and hospital fees - Reimbursement methods.

Maximum medical and hospital fees paid by the organization, including reimbursement for pharmaceuticals and durable medical equipment, are determined in accordance with the most current edition of the organization's fee schedule guidelines or the organization's formulary and medication restrictions list. Reimbursement for services and procedures not addressed within the fee schedules or lists will be determined on a "by report" basis, in which case a description of the nature, extent and need for the procedure or service, including the time, skills, equipment, and any other pertinent facts necessary to furnish the procedure or service, must be provided to the organization.

History: Effective January 1, 1992; amended effective January 1, 1994; October 1, 1998; January 1, 2000; May 1, 2002; April 1, 2020; January 1, 2026.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08

92-01-02-28. Health care advisory board.

Repealed effective October 1, 1998.

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. "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 guidelines, coverage, concurrent billing for covered and noncovered services, and application of fee schedules.

2. "Case management" means the ongoing coordination of medical services provided to an injured employee, including:

   a. Developing a treatment plan to provide appropriate medical services to an injured employee.

   b. Systematically monitoring the treatment rendered and the medical progress of the injured employee.

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

   d. Ensuring the injured employee is following the prescribed medical plan.

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

3. "Consulting health care provider" means a licensed health care provider who examines an injured employee, or the injured employee's medical record, at the request of the primary health care provider to aid in diagnosis or treatment. A consulting health care provider, at the request of the primary health care provider, may provide specialized treatment of the compensable injury and give advice or an opinion regarding the treatment being rendered or considered for an injured employee's injury.

4. "Debilitating side effects" means an adverse effect to a treatment or medication which in and of itself precludes return to employment or participation in vocational rehabilitation services.

5. "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.

6. "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.

7. "Fee schedule" means the organization's rules and maximum payment amounts that govern how health care providers are reimbursed.

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

9. "Improved pain control" means the effectiveness of a treatment or medication which results in at least thirty percent reduction in pain scores.

10. "Increase in function" means the effectiveness of a treatment or medication which results in either a resumption of activities of daily living, a return to employment, or participation in vocational rehabilitation services.

11. "Managed care" means services performed by the organization or a managed care vendor, including prior authorization or preservice reviews, disability management services, case

management services, ambulatory reviews, retrospective reviews, preadmission reviews, and medical bill audit.

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

13. "Medical service" means a medical, surgical, chiropractic, psychological, dental, hospital, nursing, ambulance, and other related or ancillary service, including physical and occupational therapy, medications, durable medical equipment, and physical restoration and diagnostic services, or a service outlined in section 92-01-02-30.

14. "Medical service provider" means an allied health care professional, hospital, medical clinic, or vendor of medical services.

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

16. "Notice of nonpayment" means the form by which an injured employee is notified of charges denied by the organization which are the injured employee's personal responsibility.

17. "Pharmacy services" means services rendered by a pharmacist in pharmaceutical care, selection, counseling, dispensing, use, administration, prescription monitoring, medication therapy management, disease state management, drug utilization evaluation or review, vaccination, testing, or collaborative therapy management provided in a pharmacy, clinic, hospital or medical institution.

18. "Primary health care provider" means a health care provider who is primarily responsible for the treatment of an injured employee's compensable injury.

19. "Prior authorization" or "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 based on medically accepted standards and an objective evaluation of the medical services.

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

21. "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.

22. "Special report" means an allied health care professional'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.

23. "Utilization review" means the provision of prior authorization or preservice review, the review of medical patterns and trends, and the analysis of the appropriateness of medical services provided to an injured employee based on medically accepted standards and an objective evaluation of the medical services.

24. "Work hardening" or "work conditioning" means an individualized, medically prescribed and monitored, work-oriented treatment process which involves the injured employee participating in an exercise program or simulated or actual work tasks that are structured and graded to

progressively increase physical tolerances, stamina, endurance, and productivity to return the injured employee to any level of work or a specified job.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; April 1, 2014; April 1, 2016; April 1, 2020; January 1, 2022; January 1, 2024; January 1, 2026.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

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

   b. Chemonucleolysis; acupressure; reflexology; rolfing; 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 health care provider and dispensed and processed according to the current pharmacy transaction standard. 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, hot 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.

j. Spine strengthening program (e.g. MedX or SpineX or other substantially equivalent program).

k. Electrodiagnostic studies performed by electromyographers who are not 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 to be eligible for payment.

l. Trigger point injections. 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 count as a single injection.

m. Acupuncture therapy. No more than eighteen treatments may be paid for the life of the claim. 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 workers and providers.

n. Dry needling.

o. Opioid therapy exceeding ninety milligrams morphine equivalents daily unless the following criteria are met when a prescription exceeding ninety milligrams morphine equivalents daily is exceeded and as the organization deems necessary:

(1) Documented treatment plan consistent with the organization's utilization review process;

(2) Participation in a psychosocial consult with a health care provider, preferably a licensed psychologist or psychiatrist outside the health care provider's network, to address the risk and harms of opioid use under the centers for disease control and prevention "Guideline for Prescribing Opioids for Chronic Pain". The psychosocial consult should include standardized screening using validated tools for mental health and substance abuse conditions, as well as a risk stratification plan; and

(3) Recent documentation of attempts to taper opioid use and employ non-opioid therapies for pain control.

p. Benzodiazepine therapies extending beyond a cumulative duration of four weeks, unless prescribed for treatment of a compensable anxiety disorder. In addition, the following criteria must be met when the cumulative duration of four weeks is exceeded and as the organization deems necessary:

(1) A documented treatment plan consistent with the organization's utilization review process;

(2) Participation in a psychosocial consult with a health care provider, preferably a licensed psychologist or psychiatrist outside the health care provider's network, to address the risk and harms of benzodiazepine use. The psychosocial consult should include standardized screening using validated tools for mental health and substance abuse conditions, as well as a risk stratification plan; and

(3) Recent documentation of attempts to taper benzodiazepine use and employ non-benzodiazepine therapies.

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; April 1, 2016; July 1, 2017; April 1, 2020; January 1, 2022.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07, 65-05-40

92-01-02-29.2. Acceptance of rules and fees.

Medical service providers rendering treatment of any kind, regardless of the state or country where services are provided, including inpatient and outpatient services, to a claimant who comes under the organization's jurisdiction must comply with managed care services under these rules. All providers shall cooperate with the organization and the managed care vendor and shall provide to the organization or the managed care vendor, without additional charge, the medical information requested in relation to the reviewed service.

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

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

1. An order is required from the primary health care provider with documentation of objective medical evidence that supports the necessity for purchase of a specially equipped motor vehicle or modification of an existing motor vehicle directly due to the compensable work injury.

    a. The order must be obtained and submitted to the organization prior to consideration of a purchase or modification.

    b. The order must include the date of an in-person office visit that coincides with the date of the order.

2. Prior to any motor vehicle modification or specially equipped motor vehicle purchase, the organization shall complete a review to determine if the most appropriate assistive device is currently being utilized by an injured employee for the injured employee's functional needs. The review by the organization may require the following criteria:

    a. A primary health care provider shall provide a referral for a mobility assessment.

    b. The mobility assessment must be performed by a licensed or certified occupational or physical therapist with specific training in rehabilitation mobility or functional evaluations.

    c. The mobility assessment report must contain clear documentation of functional limits of standing and walking with an assistive device and documentation to support how the other assistive devices were ruled out as not medically appropriate for functional needs.

3. If the appropriate assistive device is determined through the mobility assessment process, the organization may begin the review for a specially equipped motor vehicle purchase or motor vehicle modification eligibility, if appropriate.

4. Upon completion of the mobility assessment, if a manual wheelchair, power mobility device, or both are needed, the following must occur:

a. A primary health care provider shall provide a referral for a wheelchair or seating evaluation.

b. The wheelchair or seating evaluation must be completed by an assistive technology professional or similarly situated professional, which includes an itemization of all elements needed for the manual wheelchair or power mobility device and matches the functional deficits outlined in the mobility assessment.

c. Upon completion of the wheelchair or seating evaluation, an analysis must be completed by the assistive technology professional or similarly situated professional to determine the appropriate vehicle modifications that match the mobility assessment and the wheelchair or seating evaluation.

5. 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.

6. The organization may request a minimum of two itemized cost quotes. The organization may decrease or add the number of cost quotes needed accordingly.

7. 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.

8. Any appeal of a decision under this section must 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; July 1, 2017; April 1, 2020; January 1, 2026.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-07(5)(b)

92-01-02-29.4. Home modifications.

1. An order is required from the primary health care provider with documentation of objective medical evidence that supports the necessity for home modifications directly due to the compensable work injury.

   a. The order must be obtained and submitted to the organization prior to consideration of a home modification.

   b. The order must include the date of an in-person office visit that coincides with the date of the order.

2. Prior to any home modifications, the organization shall complete a review to determine if the most appropriate assistive device is currently being utilized by an injured employee for the injured employee's functional needs. The review by the organization may require the following criteria:

   a. A primary health care provider referral for a mobility assessment.

   b. The mobility assessment must be performed by a licensed or certified occupational or physical therapist with specific training in rehabilitation mobility or functional evaluations.

   c. The mobility assessment report must contain clear documentation of functional limits of standing and walking with an assistive device and have documentation to support how the other assistive devices were ruled out as not medically appropriate for functional needs.

3. If the appropriate assistive device is determined through the mobility assessment process, the organization may begin the review for home modification eligibility, if appropriate.

4. A primary health care provider shall make a referral for an in-home functional assessment to be completed in the home environment:

   a. The in-home functional assessment shall be performed by a licensed or certified occupational or physical therapist with specific training in rehabilitation mobility or functional evaluations.

   b. The in-home functional assessment must be completed in-person. Virtual assessments may be approved as determined by the organization.

   c. The in-home functional assessment report must contain documentation of the functional limitation the modification is addressing and the medical need for that modification.

5. The organization may request a minimum of two itemized cost quotes. The organization may decrease or add the number of cost quotes needed accordingly.

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

7. 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.

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

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

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

11. Modifications will be considered upon receipt of documentation establishing injured employee's ownership of the residence to be permanently modified.

12. Modifications within new construction will be considered upon receipt of the original floor plan/specifications and cost estimate, as well as the modified floor plan and cost estimate.

History: Effective April 1, 2012; amended effective April 1, 2014; April 1, 2016; July 1, 2017; April 1, 2020; January 1, 2026.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-07

92-01-02-29.5. Power mobility devices.

1. An order is required from the primary health care provider with documentation of objective medical evidence that supports the necessity for a power mobility device directly due to the compensable work injury.

   a. The order must be obtained and submitted to the organization prior to consideration of a purchase.

   b. The order must include the date of an in-person office visit that coincides with the date of the order.

2. Prior to any power mobility device purchase, the organization shall complete a review to determine if the most appropriate assistive device is currently being utilized by an injured employee for the injured employee's functional needs. The review by the organization may require the following criteria:

   a. A primary health care provider shall provide a referral for a mobility assessment.

   b. The mobility assessment must be performed by a licensed or certified occupational or physical therapist with specific training in rehabilitation mobility or functional evaluations.

   c. The mobility assessment report must contain clear documentation of the functional limits of standing and walking with an assistive device. Documentation contained in the mobility assessment must support reasons why a cane, walker, or manual wheelchair cannot be used to complete activities of daily living.

3. If the appropriate assistive device is determined through the mobility assessment process, the organization may begin the review for power mobility device eligibility, if appropriate.

4. Upon completion of the mobility assessment, if a manual wheelchair, power mobility device, or both are needed, the following must occur:

   a. A primary health care provider shall provide a referral for a wheelchair or seating evaluation.

   b. The wheelchair or seating evaluation must be completed by an assistive technology professional or similarly situated professional, which includes an itemization of all elements needed for the manual wheelchair or power mobility device and matches the functional deficits outlined in the mobility assessment.

   c. The organization may request a minimum of one itemized cost quote for the power mobility device from the medical service provider. The organization may request a second itemized cost quote from the medical service provider at the organization's discretion.

5. If the power mobility device is primarily intended for outdoor use or recreational purposes, the device is not medically necessary.

6. Upgrades to a power mobility device are not considered medically necessary if the upgrade is intended primarily for luxury, outdoor, or recreational purposes. Specific items such as power tilt or recline seating will only be approved if the injured employee is at risk of additional medical complications, has issues with transfer, or an upgrade will help manage the injured employee's tone and spasticity.

7. If an injured employee does not sustain a catastrophic injury or if exceptional circumstances do not exist as provided in subsection 5 of North Dakota Century Code section 65-05-07, but the injured employee is approved for a power mobility device, the organization, in its sole discretion, may approve a vehicle modification or adaptation for the injured employee, but may not approve a vehicle purchase.

8. All initial and replacement requests for power mobility devices must meet the criteria in this section.

9. An appeal of a decision made by the organization under this section must be adjudicated pursuant to North Dakota Century Code section 65-02-20.

History: Effective July 1, 2017; amended effective April 1, 2020; January 1, 2026.
General Authority: NDCC 65-02-08

Law Implemented: NDCC 65-05-07

92-01-02-29.6. Footwear.

1. An order is required from the primary health care provider with documentation of objective medical evidence that supports the necessity for purchase of footwear directly due to the compensable work injury.

   a. The order must be obtained and submitted to the organization prior to consideration of purchase.

   b. The order must include the date of an in-person office visit that coincides with the date of the order and a specific description of the footwear being requested.

2. The organization shall purchase one pair of footwear per claim during the acute rehabilitation phase.

3. The organization shall pay a medical service provider for modifications to regular footwear purchased by an injured employee after a billing is received by the medical service provider if the modifications are due to the work injury and there is objective medical evidence to support the necessity of the modifications.

4. Custom orthotic inserts and custom-made medical orthotic shoes must be preapproved by the organization. There must be objective medical evidence to support custom orthotic inserts and custom-made medical orthotic shoes must be a necessity due to the work injury.

5. The organization shall approve the footwear prior to purchase. If the footwear is approved, the organization shall pay the medical service provider after a billing is received. The organization may not prepay an injured employee to purchase footwear and may not place orders for footwear for an injured employee.

6. An appeal of a decision made by the organization under this section must be adjudicated pursuant to North Dakota Century Code section 65-02-20.

History: Effective April 1, 2020: amended effective January 1, 2024; January 1, 2026.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-29.7. Prosthetic devices.

1. For the initial prosthesis an order is required from the primary health care provider with documentation of objective medical evidence that supports the necessity for purchase of a prosthesis directly due to the compensable work injury.

   a. The order must be obtained and submitted to the organization prior to consideration of purchase.

   b. The order must include the date of an in-person office visit that coincides with the date of the order and a specific description of the type of prosthesis being requested.

2. An injured employee shall undergo an evaluation and assessment by a treating provider, therapist, or prosthetist and that evaluation must contain recommendations based on medical necessity and conform to the primary health care provider's order.

3. The organization may require additional assessments to determine the functional levels of an injured employee who is being considered for the prosthesis.

4. The organization will purchase and maintain a single prosthesis per affected limb absent extraordinary circumstances. Extraordinary circumstances are determined by the organization in its sole discretion. Extraordinary circumstances may not be supported by nonwork activities.

5. The prosthesis must be a body-powered device absent extraordinary circumstances. Extraordinary circumstances are determined by the organization in its sole discretion. Extraordinary circumstances may not be supported by nonwork activities.

6. The organization shall approve the prosthesis prior to purchase. If the prosthesis is approved, the organization shall compensate the medical services provider according to the appropriate fee schedule.

7. Repurchase or repair of a prosthesis must be determined by the organization in its sole discretion.

8. Replacement requests for a prosthesis must meet independently the criteria in this section.

9. A minimum of two itemized cost quotes may be requested by the organization. The organization may decrease or add the number of cost quotes required.

10. An appeal of a decision made by the organization under this section must be adjudicated pursuant to North Dakota Century Code section 65-02-20.

History: Effective January 1, 2024; amended effective January 1, 2026.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-30. Medical services.

1. Medical services.

   a. Medical services that are not medically necessary are not reimbursable.

   b. Frequency and extent of treatment may not be more than the nature of the injury or process of recovery requires, and must be provided in accordance with utilization and treatment standards as prescribed by the organization or the managed care vendor. The organization may require evidence of the efficacy of treatment.

2. Medical services may be reimbursed only when provided according to a written treatment plan. A copy of the treatment plan, signed by the allied health care professional, must be provided to the organization within fourteen days of beginning the treatment or within fourteen days of learning that the treatment is claimed to be work-related, whichever occurs later. However, a treatment plan is not required for a short course of treatment consisting of one or two visits.

3. For purposes of this section, a treatment plan must include:

   a. Objectives, including the degree of restoration anticipated.

   b. Measurable goals.

   c. Modalities and specific therapies to be used.

   d. Frequency and duration of treatments to be provided.

   e. Condition of the claimant which may require periodic modification of the plan of care based on:

(1) Improvements in the claimant's status.

(2) Failure of the claimant to improve as expected.

(3) Intervention of care rendered, including education of the claimant, when appropriate.

(4) Specific operative reports, test results, and consultation reports.

4. The cost of preparing a written treatment plan and supplying progress notes under this section is included in the fee for the medical service.

5. The treatment plan requirements of this section may be modified or waived by the organization.

6. X-ray images must be of diagnostic quality. Billings for x-rays are not reimbursable without a report of the findings. Upon request of either the organization or the managed care vendor, original x-ray images must be forwarded to the organization or the managed care vendor. A reasonable charge may be made for the costs of delivery of images.

7. A generic brand of therapeutic equivalence must be dispensed, provided the generic medication costs less. If the injured employee does not accept the generic equivalent at a lower price, the injured employee is responsible for the cost difference between the generic and brand name prescription medication. A branded equivalent of a generically available medication requires prior approval by the organization and will be covered only when objective medical evidence exists that the injured employee developed an adverse response to the generic medication.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; October 1, 2006; April 1, 2020; January 1, 2024.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-31. Who may be reimbursed.

1. Treatment that falls within the scope and field of the treating allied health care professional's license to practice is reimbursable.

2. Paraprofessionals who are not independently licensed shall practice under the direct supervision of a licensed allied health care professional whose scope of practice and specialty training includes the service provided by the paraprofessional to be reimbursed.

3. Medical service providers may be refused reimbursement to treat cases under the jurisdiction of the organization.

4. An entity operating under the authority of the federal government and granted authority to receive direct reimbursement for payments made for medical treatment determined to be related to the workers' compensation injury may be reimbursed.

5. Reasons for holding a medical service provider ineligible for reimbursement include one or more of the following:

a. Failure, neglect, or refusal to submit complete, adequate, and detailed reports.

b. Failure, neglect, or refusal to respond to requests by the organization for additional reports.

c. Failure, neglect, or refusal to respond to requests by the organization for drug testing.

d. Failure, neglect, or refusal to observe and comply with the organization's orders and medical service rules, including cooperation with the organization's managed care vendors.

e. Failure to notify the organization immediately and prior to burial in any death if the cause of death is not definitely known or if there is question of whether death resulted from a compensable injury.

f. Failure to recognize emotional and social factors impeding recovery of injured employees.

g. Unreasonable refusal to comply with the recommendations of board-certified or qualified specialists who have examined the injured employee.

h. Submission of false or misleading reports to the organization.

i. Collusion with other persons in submission of false or misleading information to the organization.

j. Pattern of submission of inaccurate or misleading bills.

k. Pattern of submission of false or erroneous diagnosis.

l. Billing the difference between the maximum allowable fee set forth in the organization's fee schedule and usual and customary charges, or billing the injured employee any other fee in addition to the fee paid, or to be paid, by the organization for individual treatments, equipment, and products.

m. Failure to include physical conditioning in the treatment plan. The medical service provider should determine the injured employee's activity level, ascertain barriers specific to the injured employee, and provide information on the role of physical activity in injury management.

n. Failure to include the injured employee's functional abilities in addressing return-to-work options during the recovery phase.

o. Treatment that is controversial, experimental, or investigative; which is contraindicated or hazardous; which is unreasonable or inappropriate for the work injury; or which yields unsatisfactory results.

p. Certifying disability in excess of the actual medical limitations of the injured employee.

q. Conviction in any court of any offense involving moral turpitude, in which case the record of the conviction is conclusive evidence.

r. The excessive use, or excessive or inappropriate prescription for use, of narcotic, addictive, habituating, or dependency inducing drugs.

s. Declaration of mental incompetence by a court of competent jurisdiction.

t. Disciplinary action by a licensing board resulting in suspension or revocation of the allied health care provider's license.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; July 1, 2010; July 1, 2017; January 1, 2018; April 1, 2020; January 1, 2026.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-32. Physician assistant rules.

Physician assistants may be reimbursed within the scope of their licenses for services performed under the supervision of a licensed physician.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; April 1, 2009; April 1, 2020.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-32.1. Physical therapy assistants, certified occupational therapy assistants, and certified athletic trainers.

Physical therapist assistants, certified occupational therapist assistants, and certified athletic trainers may be reimbursed when providing treatment under the direction and general supervision of the physical therapist or occupational therapist. Physical and occupational therapists are responsible for the assistants under their direction and supervision. Examination, evaluation, diagnosis, prognosis, and outcomes are the sole responsibility of the physical therapist and occupational therapist. Physical therapist assistants, certified occupational therapist assistants, and certified athletic trainers are not allowed to perform functional capacity evaluations. Treatment by physical therapy aides or physical therapy technicians is neither recognized nor will be reimbursed.

History: Effective July 1, 2017; amended effective April 1, 2020.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-33. Utilization review and quality assurance.

The organization has instituted a program of utilization review and quality assurance to monitor and control the use of health care services. The organization shall develop and identify the mode and manner of submissions for utilization review and quality assurance requests.

1. Prior authorization for services must be obtained from the organization or its managed care vendor at least seventy-two hours or three business days in advance of providing certain medical treatment, equipment, or supplies. Medical services requiring prior authorization or preservice review are outlined in section 92-01-02-34. Emergency medical services may be provided without prior authorization, but notification is required within twenty-four hours of, or by the end of the next business day following, initiation of emergency treatment. Reimbursement may be withheld, or recovery of prior payments made, if utilization review does not confirm the medical necessity of emergency medical services.

2. Documentation of the need for and efficacy of continued medical care by the allied health care professional is required at the direction or request of the organization or the managed care vendor while a claim is open.

3. The organization may require second opinion consultations prior to the authorization of reimbursement for surgery and for conservative care which extends past sixty days following the initial visit.

4. The organization may require preoperative psychosocial screens and psychological evaluations prior to the authorization of reimbursement for surgery. The organization may select the evaluators who will perform the screens and evaluations.

5. The organization may use the Official Disability Guidelines, the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Guide to Physical Therapy Practice, The Medical Disability Advisor, Diagnosis and Treatment for Physicians and Therapists Upper Extremity Rehabilitation, Treatment Guidelines of the

American Society of Hand Therapists, American Medical Association Guides to the Evaluation of Disease and Injury Causation, or any other treatment and disability guidelines or standards it deems appropriate to administer claims.

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; July 1, 2006; April 1, 2012; July 1, 2017; April 1, 2020.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-34. Treatment requiring prior 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 prior 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 allied health care professional who provides or prescribes a service for which prior authorization or preservice review is required.

3. Allied health care professionals shall request prior authorization directly from the claims adjuster for the items listed in this subsection. The claims adjuster shall respond to requests within fourteen days.

    a. Durable medical equipment.

        (1) The organization shall 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 adjuster shall grant or deny authorization for reimbursement of equipment based on whether the injured employee is eligible for coverage and whether the equipment prescribed is appropriate and medically necessary for treatment of the compensable injury. Rental extending beyond sixty days requires prior authorization from the claims adjuster. If the equipment is needed on a long-term basis, the organization may purchase the equipment. The claims adjuster 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 adjuster shall authorize and pay for durable medical equipment, including prosthetics and orthotics, as needed by the injured employee because of a compensable work injury when substantiated by the health care provider. If the items are furnished by the medical service provider or another provider, the organization shall reimburse the medical service provider pursuant to its fee schedule. Medical service providers shall supply the organization with a copy of their original invoice showing actual cost of the item upon request of the organization. Actual cost is a factor considered in determining cost-effectiveness under North Dakota Century Code section 65-02-20. The organization shall repair or replace originally provided damaged, broken, or worn-out prosthetics, orthotics, or special equipment devices upon documentation from the health care provider that replacement or repair is needed. Prior authorization for replacements is required.

        (3) Equipment costing less than five hundred dollars does not require prior authorization but remains subject to the organization's durable medical equipment guidelines.

(4) An injured employee shall obtain a health care provider's order of medical necessity before the purchase of a mobility assistance device.

(5) The organization may require assessments to determine the functional levels of an injured employee 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 adjuster shall consider concurrent treatment if the accepted conditions resulting from the injury involve more than one system or require specialty or multidisciplinary care. If requesting consideration for concurrent treatment, the primary health care provider shall provide the claims adjuster with the name, address, discipline, and specialty of all other medical service providers assisting in the treatment of the injured employee; an outline of the provider's responsibility in the case; and an estimate of how long concurrent care is needed. If concurrent treatment is allowed, the organization shall recognize one primary health care provider who is responsible for prescribing all medications if the primary health care provider is 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 injured employee's ability to perform work. The claims adjuster shall approve concurrent care on a case-by-case basis. Except for emergency services, all treatments must be authorized by the injured employee's primary health care provider to be reimbursable.

d. Telehealth. The organization may pay for audio and video telecommunications instead of a face-to-face "hands on" appointment for CPT codes designated by the American medical association as telehealth codes. As a condition of payment, the injured employee 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 at the scheduled amount.

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

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

a. All nonemergent inpatient hospital admissions or nonemergent inpatient surgery and outpatient surgical procedures.

b. All nonemergent major surgery. If the primary health care provider or consulting health care provider believes elective surgery is needed to treat a compensable injury, the primary health care provider or the consulting health care provider, with the approval of the primary health care provider, shall give the utilization review department actual notice at least seventy-two 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 facility where surgery is to be performed. If elective surgery is recommended, the utilization review department may require an independent consultation with a health care provider of the organization's choice. The organization shall notify the health care provider who requested approval of the elective surgery, whether or not a consultation is desired. If requested, the consultation must be

completed within thirty days after notice to the primary health care provider. Within seven days of the consultation, the organization shall notify the surgeon of the consultant's findings. If the primary health care provider 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 primary health care provider, the requesting health care provider 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 prior authorization or 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 prior authorization or preservice review requirements for procedures listed in this subdivision when requested by a health care provider 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 initiated 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 employees 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. The number of units performed and billed per visit may not exceed four unless otherwise approved.

e. All nonemergent air ambulance services. If the primary health care provider or consulting health care provider believes transfer to another treatment facility is needed to treat a compensable injury, the primary health care provider or the consulting health care provider or the transferring treatment facility, with the approval of the primary health care provider, shall give the utilization review department actual notice prior to the proposed transfer to the receiving treatment facility. Notice must give the medical information that substantiates the need for transfer via air ambulance service, the name of the treatment facility where transfer will occur, air service provider, and estimated cost. The organization shall review the cost effectiveness and alternatives and provide notice to the requesting health care provider or treatment facility within twenty-four hours, or by the end of the next business day.

f. Thermography.

g. Intra-articular injection of hyaluronic acid.

h. Facet joint injections.

i. Sacroiliac joint injections.

j. Facet nerve blocks.

k. Epidural steroid injections.

l. Nerve root blocks.

m. Peripheral nerve blocks.

n. Botox injections.

o. Stellate ganglion blocks.

p. Cryoablation.

q. Radio frequency lesioning.

r. Facet rhizotomy.

s. Implantation of stimulators and pumps.

t. Speech therapy.

6. The organization will review all opioid therapies for medical necessity following the conclusion of a chronic opioid therapy. For injured employees whose chronic opioid therapies have been discontinued for noncompliance with North Dakota Century Code section 65-05-39, any subsequent opioid therapies may not exceed ninety days.

7. Chiropractic providers shall request prior authorization or preservice review from the organization's chiropractic managed care vendor for chiropractic treatment beyond the first ten treatments or beyond sixty 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 employees or providers. Modalities for chiropractic services are limited to two per visit during the sixty-day or ten-treatment ranges set out in this subsection.

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

9. 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 injured employee obtain a second opinion, or request an examination by the injured employee's health care provider. A recommendation to deny medical services must specify the reason for the denial.

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

    a. If preservice review or prior authorization of a medical service is requested by a medical service provider and an injured employee'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 medical service provider and the medical service provider can prove, by a preponderance of the evidence, that the injured employee did not inform the medical service provider, and the medical service 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. The organization shall notify medical service provider associations of the review requirements of this section prior to the effective date of these rules.

12. The organization shall 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; April 1, 2016; July 1, 2017; April 1, 2020; January 1, 2026.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-35. Determining medically stationary status.

Repealed effective October 1, 1998.

92-01-02-36. Elective surgery.

Repealed effective October 1, 1998.

92-01-02-37. Concurrent care.

Repealed effective October 1, 1998.

92-01-02-38. Changes of health care providers.

1. All changes from one health care provider to another must be approved by the organization. Normally, changes will be allowed only after the injured employee has been under the care of the primary health care provider for sufficient time for the health care provider to complete necessary diagnostic studies, establish an appropriate treatment regimen, and evaluate the efficacy of the therapeutic program.

2. North Dakota Century Code section 65-05-28 governs choice of health care provider. For purposes of this rule, the following are not considered changes of health care provider by the injured employee:

   a. Emergency services by a health care provider;

   b. Examinations at the request of the organization;

   c. Consultations or referrals initiated by the health care provider;

   d. Referrals to radiologists and pathologists for diagnostic studies;

   e. When injured employees are required to change health care providers to receive compensable medical services or time loss authorization because their health care provider is no longer qualified as a primary health care provider; or

   f. Changes of primary health care provider required due to conditions beyond the injured employee's control. This would include when the health care provider terminates practice or leaves the area.

3. The injured employee must be advised when and why a change is denied. The organization reserves the right to require an injured employee to select another health care provider or specialist for treatment:

   a. When more conveniently located health care providers, qualified to provide the necessary treatment, are available;

   b. When the attending health care provider fails to observe or comply with the organization's rules;

   c. When, in a time loss case, reasonable progress toward return to work is not shown;

   d. When an injured employee requires specialized treatment, which the primary health care provider is not qualified to render, or which is outside the scope of the primary health care provider's license to practice; or

   e. When the health care provider is not qualified to treat each of several accepted conditions. This does not preclude concurrent care when indicated as outlined in section 92-01-02-34.

4. When the organization finds the change of health care provider to be appropriate and has requested the injured employee to change under this rule, the organization may select a new primary health care provider if the injured employee unreasonably refuses or delays in selecting another primary health care provider.

5. The organization in its discretion may authorize a change when it finds that a change is in the best interest of returning the injured employee to a productive role in society.

History: Effective January 1, 1994; amended effective April 1, 1997; January 1, 2000; April 1, 2020; January 1, 2022.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-39. Hospitalization.

Repealed effective October 1, 1998.

92-01-02-40. Palliative care.

Repealed effective January 1, 2022.

92-01-02-41. Independent medical examinations - Definitions.

1. The organization may request an independent medical examination or independent medical review pursuant to North Dakota Century Code section 65-05-28.

2. The organization shall provide at least fourteen days' notice to the injured employee of an independent medical examination. The organization shall reimburse the claimant's expenses for attending the independent medical examination pursuant to North Dakota Century Code section 65-05-28.

3. As used in subsection 3 of North Dakota Century Code section 65-05-28 regarding allied health care professionals designated or approved by the organization, "duly qualified allied health care professional" means a person chosen by the organization who is an allied health care professional who has the specialization necessary to perform an independent medical examination or an independent medical review. The organization's determination of whether

an individual it has chosen is a duly qualified allied health care professional and the organization's choice of the duly qualified allied health care professional who will perform an independent medical examination or an independent medical review are not appealable decisions and these decisions may not be considered when determining whether a claimant has failed to submit to, or in any way intentionally obstructed, or refused to reasonably participate in an independent medical examination.

4. As used in subsection 3 of North Dakota Century Code section 65-05-28, "reasonable effort" means an attempt by the organization to locate and consider individuals as possible duly qualified allied health care professionals for independent medical examinations using criteria established by the organization. These attempts need not be exhaustive and need not be on a specific case-by-case basis. An attempt may consist of a review performed by the organization from time to time of individuals in North Dakota or other states in order to form an informal group from which the organization may select an examiner. Whether the organization has undertaken reasonable effort may not be considered when determining whether an injured employee has failed to submit to, or in any way intentionally obstructed, or refused to reasonably participate in an independent medical examination. Whether the organization has undertaken reasonable effort may not be considered when weighing the opinion of the examiner who performed the independent medical examination.

History: Effective January 1, 1994; amended effective October 1, 1998; July 1, 2010; April 1, 2020; January 1, 2026.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-42. Durable medical equipment.

Repealed effective October 1, 1998.

92-01-02-43. Home nursing care.

1. When the primary health care provider believes special or attendant (home nurse) care is needed, the health care provider shall submit the following information:

   a. A description of the special or home nursing care required, including the estimated time required (i.e., catheterization, three times per day, thirty minutes; bathing, two times per day, one hour; toilet transfers as needed, dressing change, four times per day, two hours).

   b. The skill level or special training required to administer care (i.e., R.N.; L.P.N.; family member who has received special training; or no special training required).

   c. If known, the name and address of a person or facility willing to provide care.

   d. The length of time special or home nursing care will be required.

2. Fees for home nurse or attendant care are based upon the organization's established fee schedule.

3. The organization may authorize and pay for visiting nurse care necessary for evaluation or instruction of a home health care provider.

4. When the injured employee or injured employee's family makes arrangements for caregivers, the organization shall reimburse those providing the home nursing care.

5. Payment to individuals who provide services under this section does not constitute an employer and employee relationship between the organization and the provider of care.

6. The organization may not pay a rate for home nursing care which exceeds the cost of nursing facility care under the applicable case-mix classification in section 75-02-06-17.

History: Effective January 1, 1994; amended effective October 1, 1998; July 1, 2006; April 1, 2008; April 1, 2020.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-44. Special programs.

The organization may enter into special agreements for services provided by, or under the direction of, licensed medical service providers authorized to bill the organization. Special agreements may be made for services not covered under the fee schedule and may include multidisciplinary or interdisciplinary programs such as pain management, work hardening, and physical conditioning. Special programs include new programs and pilot projects to streamline, waive, or modify selected managed care rules to provide medical care for injured employees with greater efficiency.

The organization shall establish payment rates for special agreements and may establish outcome criteria, measures of effectiveness, minimum staffing levels, certification requirements, special reporting requirements, and other criteria to ensure injured employees receive good quality and effective services at a reasonable cost. The organization may terminate special agreements and programs upon thirty days' notice to the medical service provider.

History: Effective January 1, 1994; amended effective April 1, 1997; October 1, 1998; April 1, 2020.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-45. Organization responsibilities.

1. As soon as reasonably possible after receiving a bill, the organization shall:

   a. Pay the charge or any portion of the bill that is not denied;

   b. Deny all or a portion of the bill on the basis that the injury is not compensable, or the service or charge is excessive or not medically necessary; or

   c. Request specific additional information to determine whether the charge or service is excessive or not medically necessary or whether the condition is compensable.

2. The organization shall provide notice of nonpayment to the injured employee when the injured employee is personally responsible for the payment of a charge. The organization shall provide notice of nonpayment to the medical service provider through a remittance advice of denial of part or all of a charge, or shall provide notice to the medical service provider for any request for additional information. The notice must include:

   a. The basis for denying all or part of a charge because the treatment was not for a compensable injury.

   b. The basis for denying or reducing excessive charges and the specific amounts denied or reduced.

   c. The basis for denying the charge for an excessive service.

   d. The basis for denying a charge as not being medically necessary.

e. A request for records or other information needed to allow proper determination of the bill.

3. Any payment incorrectly made to a medical service provider may be recovered from the medical service provider by the organization.

4. The organization will pay a reasonable fee for a special report as defined in section 92-01-02-29 prepared at the request of the organization. The allied health care professional shall include in the special report the time required to prepare the report or the organization may not pay for the report. Time spent and the complexity of the issues will be considered when determining the reasonableness of the fee. Such services should be billed under current procedural terminology code 99080 with a description of "special report".

History: Effective January 1, 1994; amended effective April 1, 1997; October 1, 1998; April 1, 2020.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

92-01-02-45.1. Medical service provider responsibilities and billings.

1. A medical service provider shall complete the registration process and corresponding forms identified by the organization to receive payments for services.

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

3. All bills must be fully itemized, including ICD 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.

4. All medical service providers shall submit charges for medical services on the most current version of the UB 04, CMS 1500, or ADA form, or the corresponding electronic versions of each. All pharmacy charges must be submitted electronically to the organization's pharmacy managed care vendor using the current pharmacy transaction standard. Accepted electronic medical billing formats are outlined in section 92-01-02-45.2. Medical service bills may not include charges for more than one workers' compensation claim, and must include the following:

   a. The injured employee's full name and address;

   b. The injured employee's claim number;

   c. Date and nature of injury;

   d. The area of the body treated, with the appropriate ICD-10-CM code, including identification of right or left, as appropriate;

   e. Date of service;

   f. Facility's name and address and telephone number where the service was rendered;

   g. Name of allied health care professional providing the service along with the rendering allied health care professional's national provider identifier (NPI);

h. Billing facility's name, address, zip code, telephone number; medical service provider's NPI and tax identification number; along with the billing facility's NPI;

i. Referring or ordering health care provider's NPI;

j. Place of service;

k. Appropriate procedure code or hospital revenue code;

l. Charge for each service;

m. Units of service;

n. If dental, tooth numbers;

o. Total bill charge.

5. All records submitted by medical service providers, including notes, except those provided by an emergency room health care provider 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. Documentation must be authentic to the visit and may not include cloned, copied, or irrelevant documentation for purposes of up-coding a service. 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.

6. Medical service providers shall submit with each bill a copy of medical records or reports which support the necessity of a service being billed and its relationship to the work injury, including the level, type, and extent of the service provided to injured employees. Documentation required includes:

a. Laboratory and pathology reports;

b. X-ray findings;

c. Operative reports;

d. Office notes and physical, chiropractic, 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.

7. If the medical service 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 medical service provider submits the records before the decision denying payment of those charges becomes final. The medical service 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 medical service provider may not pursue payment from an injured employee for treatment, equipment, or products unless an injured employee desires to receive them and has accepted responsibility for payment, or unless the payment for the treatment was denied because:

a. The injured employee sought treatment from that medical service provider for conditions not related to the compensable injury or illness.

b. The injured employee sought treatment from that medical service provider which was not prescribed by the injured employee's primary health care provider. This includes ongoing treatment by the allied health care professional.

c. The injured employee sought treatment from that allied health care professional after being notified that the treatment sought from that allied health care professional has been determined to be unscientific, unproven, outmoded, investigative, or experimental.

d. The injured employee did not follow the requirements of subsection 1 of North Dakota Century Code section 65-05-28 regarding change of health care providers before seeking treatment of the work injury.

e. The injured employee is subject to North Dakota Century Code section 65-05-28.2, and the health care provider requesting payment is not a preferred provider and has not been approved as an alternative health care 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 an injured employee 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. If an injured employee 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. If an allied health care professional is asked to review records or reports prepared by another allied health care professional, the allied health care professional shall bill for the review of the records using CPT code 99080 with a descriptor of "record review".

14. If 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.

15. 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 allied health care professional 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 allied health care professional shall include a thorough explanation of how the non-work-related condition affects the compensable injury if the allied health care professional 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 pre-existing non-work-related condition for which the injured employee 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. If treatment of a non-work-related condition is being rendered, the allied health care professional shall submit reports monthly outlining the effect of treatment on both the non-work-related condition and the compensable injury.

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

17. The organization may not pay for the cost of duplicating records when covering the treatment received by the injured employee. If the organization requests records in addition to those listed in subsection 5, records prior to the date of injury, or records necessary for a coordination of benefits determination, the organization shall pay a charge of no more than twenty dollars for the first twenty-five pages and seventy-five cents per page after twenty-five pages. In an electronic, digital, or other computerized format, the organization shall pay a charge of thirty dollars for the first twenty-five pages and twenty-five cents per page after twenty-five pages. This charge includes any administration fee, retrieval fee, and postage expense.

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

19. 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.

20. A medical service 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 medical service provider.

21. A medical service provider may not bill an injured employee a fee for the difference between the maximum allowable fee set forth in the organization's fee schedule and usual and customary charges, or bill the injured employee 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; April 1, 2016; July 1, 2017; April 1, 2020; January 1, 2022; January 1, 2026.
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

92-01-02-45.2. Medical service provider electronic billing responsibilities.

Medical service providers shall submit electronic medical bills and supporting documentation to the organization unless the health care provider is exempt.

1. A medical service provider is exempt from the requirement of electronic submission of medical bills if:

   a. The provider submits fewer than fifty bills per calendar year; or

   b. The provider can sufficiently demonstrate electronic medical bill implementation will create an unreasonable financial hardship and can provide supporting documentation, such as financial statements or other documentation which reflect the financial hardship. The exemption process must be initiated by the medical service provider. Granting an exemption lies solely within the organization's discretion and is not subject to appeal.

2. The organization shall identify and maintain an electronic billing source to enable the transaction of these services.

3. All medical service providers shall submit the most current version of the following electronic medical bill processing standards:

   a. Professional billing - ASC X12 837P;

   b. Institutional/hospital billing - ASC X12 837I; or

   c. Dental billing - ASC X12 837D.

History: Effective April 1, 2020; amended effective January 1, 2021.
General Authority: NDCC 65-02-08, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07, 65-05-07.3

92-01-02-46. Medical services disputes.

1. This rule provides the procedures followed for managed care disputes. Retrospective review is the procedure provided for disputing the denial of payment for a medical service charge based on failure to request prior authorization or preservice review. Binding dispute resolution is the procedure provided for disputing managed care recommendations, including bill audit and review. Disputes not arising from managed care follow the reconsideration and hearing procedures provided by North Dakota Century Code section 65-01-16.

2. If the organization denies payment for a medical service charge because the medical service provider did not properly request prior authorization or preservice review for that service, the medical service provider may request a retrospective review of that service. Requests for retrospective review must be made in writing, within thirty days after the notice that payment for the service is denied, addressed to the organization utilization review department. Requests for retrospective review should not be sent to the managed care vendor. The request must contain:

   a. The injured employee's name.

   b. The claim number.

   c. The date of service.

   d. A statement of why the medical service provider did not know and should not have known that the injury or condition may be a compensable injury.

e. The information required to perform a preservice review or prior authorization of the service.

If the medical service provider knew or should have known that the patient may have a compensable work injury when the medical services for that injury were provided, the request for retrospective review must be denied. If the medical service provider did not know and should not have known that the patient may have a compensable work injury when the medical services for that injury were provided, a retrospective preservice review or prior authorization may be done. The organization may determine if the medical review is required to determine medical necessity, or if the medical review is waived based on the supporting documentation. If the organization continues to deny payment for the service, the medical service provider may request binding dispute resolution under this rule.

3. A party who wishes to dispute a utilization review recommendation first shall exhaust any internal dispute resolution procedures provided by the managed care vendor or the utilization review department. A party who wishes to dispute a final recommendation of a managed care vendor or a prior authorization or preservice review decision under section 92-01-02-34 shall file a written request for binding dispute resolution with the organization within thirty days after the final recommendation or decision. The request must contain:

   a. The injured employee's name.

   b. The claim number.

   c. All relevant medical information and documentation.

   d. A statement of any actual or potential harm to the injured employee from the recommendation.

   e. The specific relief sought.

4. A party who wishes to dispute a denial or reduction of a service charge arising from bill audit and review shall file a written request for binding dispute resolution with the organization within thirty days after the date of the organization's remittance advice reducing or denying the charge. The request must contain:

   a. The injured employee's name.

   b. The claim number.

   c. The specific code and the date of the service in dispute.

   d. A statement of the reasons the reduction or denial was incorrect, with any supporting documentation.

   e. The specific relief sought.

5. The organization shall review the request for binding dispute resolution and the relevant information in the record. The organization may request additional information or documentation. If a party does not provide the requested information within fourteen days, the organization may decide the dispute on the information in the record.

6. The organization may request review by allied health care professionals, at least one of whom must be licensed or certified in the same profession as the allied health care professional whose treatment is being reviewed, or by an external expert in medical coding or other aspects of medical treatment or billing, to assist with its review of the request. The

organization may request an independent medical examination to assist with its review of a request.

7. At the conclusion of its review, the organization shall issue its binding decision. The organization shall issue its decision by letter or notice, or for a decision that is reviewable by law, the organization may issue its decision in an administrative order instead of a letter or notice.

History: Effective January 1, 1994; amended effective April 1, 1997; October 1, 1998; January 1, 2000; May 1, 2002; July 1, 2004; April 1, 2020; January 1, 2022; January 1, 2024; January 1, 2026.
General Authority: NDCC 65-02-08, 65-02-20
Law Implemented: NDCC 65-02-20

92-01-02-46.1. Pharmacy services disputes.

1. Binding dispute resolution must be used for disputing managed care recommendations, including point of sale alterations or denials for pharmacy services. Disputes not arising from managed care must follow the reconsideration and hearing procedures provided by North Dakota Century Code section 65-01-16.

2. When the organization denies payment for a pharmacy service charge the medical service provider or injured employee may request review of that service. Requests for review must be made in writing, within thirty days after the initial denial of payment, addressed to the organization claims adjuster assigned to handle the injured employee's claim. Requests for review may not be sent to the managed care vendor. The request must contain:

   a. The injured employee's name.

   b. The claim number.

   c. The date of service and service denied.

   d. The specific relief sought.

   e. The information required to perform a review of the service. If the organization continues to deny payment for the service, the medical service provider may request binding dispute resolution under this rule.

3. The organization shall review the request for binding dispute resolution and the relevant information in the record. The organization may request additional information or documentation. If a party does not provide the requested information within fourteen days, the organization may decide the dispute on the information in the record.

4. At the conclusion of its review, the organization shall issue its binding decision. The organization shall issue its decision by letter or notice, or for a decision that is reviewable by law, the organization may issue its decision in an administrative order instead of a letter or notice.

History: Effective April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-20

92-01-02-47. Providers performing peer review.

Repealed effective March 1, 2000.

92-01-02-48. Elements of filing.

1. For purposes of this section, unless the context otherwise requires:

   a. "Appropriate record" means a legible medical record or report from a provider, or any other relevant and material information, substantiating the type, nature, extent, and work-relatedness of an injury, which is adequate to verify the level, type, and extent of services provided.

   b. "Bill" means a provider's statement of charges and services rendered for treatment of a work-related injury.

   c. "Bill review" means the review or audit of medical bills and any associated medical records by workforce safety and insurance and may include review for duplications, omissions, actual delivery of billed services and items, accuracy of charges and associated coding, and improper concurrent bills for services involving evaluation or treatment of work-related and non-work-related problems.

   d. "Wage verification" means federal and state income tax returns; W-2 forms; daily, weekly, biweekly, semimonthly, or monthly employer payroll statements; and income statements prepared in accordance with generally accepted accounting practices.

2. The elements of filing for an application for workers' compensation benefits are satisfied when the organization has received:

   a. The first report of injury form completed and signed by the injured employee or someone acting on the injured employee's behalf. The employer's report may be deemed admitted pursuant to North Dakota Century Code sections 65-01-16 or 65-05-01.4;

   b. Wage verification as requested by the organization, if disability benefits are claimed; and

   c. Appropriate records from the provider necessary to determine the type, nature, extent, and potential work-relatedness of the injury or disability.

3. The elements of filing for a reapplication are satisfied when the organization is in receipt of:

   a. The C4 form or other correspondence requesting benefits signed by the employee;

   b. Wage verification as requested by the organization, if disability benefits are claimed; and

   c. Appropriate records from the provider.

4. The elements of filing for payment of a medical bill are satisfied when a bill review is completed and after the organization has received:

   a. A bill from the provider or employee; and

   b. Appropriate records from the provider or employee.

5. If the organization requests additional information from the employee needed to process an application or a reapplication and the employee does not provide the information, elements of filing are not satisfied until the employee provides the requested information.

6. The organization may waive elements of filing in conjunction with programs established for the expedited processing of selected claims.

History: Effective January 1, 1994; amended effective January 1, 1996; April 1, 1997; February 1, 1998; January 1, 2000; July 1, 2006; April 1, 2016; April 1, 2020; January 1, 2022.

General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08, 65-05-02

92-01-02-49. Determination of employment.

1. Any service performed for another for remuneration under any agreement or contract of hire express or implied is presumed to be employment unless it is shown that the individual performing the service is an independent contractor as determined by the "common law" test.

   a. An employment relationship exists when the person for whom services are performed has the right to control and direct the individual person who performs the services, not only as to the result to be accomplished by the work but also as to the details and means by which that result is accomplished. It is not necessary that the employer actually direct or control the manner in which the services are performed; it is sufficient if the employer has the right to do so. The right to discharge is a significant factor indicating that the person possessing that right is an employer. The right to terminate a contract before completion to prevent and minimize damages for a potential breach or actual breach of contract does not, by itself, establish an employment relationship. Other factors indicating an employer-employee relationship, although not necessarily present in every case, are the furnishing of tools and the furnishing of a place to work to the person who performs the services. The fact that the contract must be performed at a specific location such as building site, does not, by itself, constitute furnishing a place to work if the nature of the work to be done precludes a separate site or is the customary practice in the industry. If a person is subject to the control or direction of another merely as to the result to be accomplished by the work and not as to the means and methods for accomplishing the result, the person will likely be an independent contractor. A person performing services as an independent contractor is not as to such services an employee. Persons such as physicians, lawyers, dentists, veterinarians, public stenographers, and auctioneers, engaged in the pursuit of an independent trade, business, or profession, in which they offer their services to the public, are independent contractors and not employees.

   b. In determining whether a person is an independent contractor or an employee under the "common law" test, the following twenty factors are to be considered:

      (1) Instructions. A person who is required to comply with other persons' instructions about when, where, and how the person is to work is ordinarily an employee. This control factor is present if the person or persons for whom the services are performed have the right to require compliance with instructions.

      (2) Training. Training a person by requiring an experienced employee to work with the person, by corresponding with the person, by requiring the person to attend meetings, or by using other methods, indicates that the person or persons for whom the services are performed want the services performed in a particular method or manner.

      (3) Integration. Integration of the person's services into the business operations generally shows that the person is subject to direction and control. When the success or continuation of a business depends to an appreciable degree upon the performance of certain services, the persons who perform those services must necessarily be subject to a certain amount of control by the owner of the business.

      (4) Services rendered personally. If the services must be rendered personally, presumably the person or persons for whom the services are performed are interested in the methods used to accomplish the work as well as in the results.

(5) Hiring, supervising, and paying assistants. If the person or persons for whom the services are performed hire, supervise, and pay assistants, that factor generally shows control over the persons on the job. However, if one person hires, supervises, and pays the other assistants pursuant to a contract under which the person agrees to provide materials and labor and under which the person is responsible only for the attainment of a result, this factor indicates an independent contractor status.

(6) Continuing relationship. A continuing relationship between the person and the person or persons for whom the services are performed indicates that an employer-employee relationship exists. A continuing relationship may exist when work is performed at frequently recurring although irregular intervals.

(7) Set hours of work. The establishment of set hours of work by the person or persons for whom the services are performed is a factor indicating control.

(8) Full time required. If the person must devote substantially full time to the business of the person or persons for whom the services are performed, such person or persons have control over the amount of time the person is able to do other gainful work. An independent contractor, on the other hand, is free to work when and for whom the person chooses.

(9) Doing work on the premises of the person or persons for whom the services are performed. If the work is performed on the premises of the person or persons for whom the services are performed, that factor suggests control over the person, especially if the work could be done elsewhere. Work done off the premises of the person or persons receiving the services, such as at the office of the worker, indicates some freedom from control. This fact by itself does not mean that the person is not an employee. The importance of this factor depends on the nature of the service involved and the extent to which an employer generally would require that employees perform such service on the employer's premises. Control over the place of work is indicated when the person or persons for whom the services are performed have the right to compel the worker to travel a designated route, to canvass a territory within a certain time, or to work at specific places as required.

(10) Order or sequence set. If a person must perform services in the order or sequence set by the person or persons for whom the services are performed, that factor shows that the person is not free to follow the person's own pattern of work but must follow the established routines and schedules of the person or persons for whom the services are performed. Often, because of the nature of an occupation, the person or persons for whom the services are performed do not set the order of the services or set the order infrequently. It is sufficient to show control, however, if such person or persons retain the right to do so.

(11) Oral or written reports. A requirement that the person submit regular or written reports to the person or persons for whom the services are performed indicates control. By contract, however, parties can agree that services are to be performed by certain dates and the persons performing those services can be required to report as to the status of the services being performed so that the person for whom the services are being performed can coordinate other contracts that person may have which are required in the successful total completion of a particular project.

(12) Payment by hour, week, month. Payment by the hour, week, or month indicates an employer-employee relationship, provided that this method of payment is not just a convenient way of paying a lump sum agreed upon as the cost of a job. Payment

made by the job or on a straight commission generally indicates that the worker is an independent contractor.

(13) Payment of business or traveling expenses, or both. If the person or persons for whom the services are performed ordinarily pay the person's business or traveling expenses, or both, the person is an employee. An employer, to be able to control expenses, generally retains the right to regulate and direct the person's business activities.

(14) Furnishing of tools and materials. If the person or persons for whom the services are performed furnished significant tools, materials, and other equipment, it is an indication an employer-employee relationship exists.

(15) Significant investment. If the person invests in facilities that are used by the person in performing services and are not typically maintained by employees (such as the maintenance of an office rented at fair value from an unrelated party), or if the person invests in other business expenses (such as equipment and supplies, vehicles, liability insurance, advertising, or other promotion of services), that factor tends to indicate that the person is an independent contractor. Lack of investment in expenses relative to the performance of services indicates dependence on the person or persons for whom the services are performed for such facilities and indicates the existence of an employer-employee relationship.

(16) Realization of profit or loss. A person who may realize a profit or suffer a loss as a result of the person's services (in addition to the profit or loss ordinarily realized by employees) is generally an independent contractor, but the person who cannot is an employee. If the person is subject to a risk of economic loss due to significant investment or a bona fide liability for expenses, that indicates that the person is an independent contractor. The risk that a person will not receive payment for services, however, is common to both independent contractors and employees and thus does not constitute a sufficient economic risk to support a finding of an independent contractor.

(17) Working for more than one firm at a time. If a person performs services under multiple contracts for unrelated persons or firms at the same time, that generally indicates that the person is an independent contractor. A person who performs services for more than one person may be an employee for each of the persons, especially when such persons are part of the same service arrangement.

(18) Making service available to general public. If a person makes the person's services available to the general public on a regular and consistent basis that indicates an independent contractor relationship.

(19) Right to dismissal. The right to dismiss a person indicates that the person is an employee and the person possessing the right is an employer. An employer exercises control through the right of dismissal, which causes the person to obey the employer's instruction. An independent contractor, on the other hand, cannot be fired without liability for breach of contract so long as the independent contractor produces a result that meets the contract specifications.

(20) Right to terminate. If either person has the right to end the relationship with the person for whom the services are performed at any time the person wishes without incurring liability, that indicates an employer-employee relationship. If a contract can be terminated by the mutual agreement of the parties before its completion or by one of the parties to the contract before its completion to prevent a further breach of

contract or to minimize damages, that indicates an independent contractor relationship.

2. The factors described in paragraphs 3, 6, 15, 16, 17, 18, 19, and 20 of subdivision b of subsection 1 must be given more weight in determining whether an employer-employee relationship exists.

History: Effective January 1, 1994; amended effective January 1, 2007; April 1, 2012.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-01-03

92-01-02-49.1. Determination of employment status.

A person may apply to the organization for a determination of whether that person is an employer as that term is defined by North Dakota Century Code title 65. A person claiming not to be an employer under the Workers' Compensation Act has the burden of proving by a preponderance of the evidence that the person is not an employer. The request for a determination must be in writing and must be supported by evidence of the employment status of the requesting party. If the party is asserting an independent contractor relationship, the party must submit copies of written contracts, if any, establishing the relationship. The organization may request, and the party shall provide promptly, any additional relevant information bearing on the issue of the employer status of the party. After review of the evidence, the organization shall issue its decision determining the employment status of the requesting party under North Dakota Century Code title 65. This determination is effective for no more than one year from the date of the decision and may be reconsidered or revoked at any time by the organization. The requesting party has a continuing obligation to notify the organization of any material change in that party's business relationships, and a failure to notify the organization of a material change shall nullify the organization's certification as of the date of the change.

History: Effective January 1, 1996; amended effective May 1, 1998.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-09-01

92-01-02-49.2. Attorney fee reimbursement for employers.

1. The organization may reimburse attorney fees and costs under this section regardless of the state in which the injury occurred.

2. The organization retains the ability to select or approve counsel secured by the employer.

3. Employers shall submit attorney billing statements from their attorney and all time must be recorded in increments of no more than six minutes, or one-tenth of an hour.

History: Effective January 1, 2026.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-37

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

1. The terms used in this section have the same meaning as in North Dakota Century Code title 65 and in North Dakota Administrative Code title 92, except:

   a. "Covered employment" means hazardous employment principally localized in this state which involves incidental operations in another state. The term "covered employment" does not include employment in which the employer is required by the laws of that other state to purchase workers' compensation coverage in that other state.

b. "Employee" means any North Dakota employee as that term is defined in North Dakota Century Code section 65-01-02 who engages in covered employment and who is eligible to file for workers' compensation benefits in another state if the employee suffers a work-related illness or injury or dies as a result of work activities in that state. The term "employee" also includes a person with optional workers' compensation coverage in this state under North Dakota Century Code section 65-04-29 or 65-07-01 who engages in covered employment and is eligible to file for workers' compensation benefits in another state if that person suffers a work-related illness or injury or dies as a result of work activities in that state.

c. "Employer" means an employer as defined in North Dakota Century Code section 65-01-02, who is not materially delinquent in payment of premium, and who has employees engaged in covered employment. An employer is not materially delinquent in payment of premium if the premium is no more than thirty days delinquent.

d. "Incidental operations" means business operations of an employer for fewer than thirty consecutive days in which the employer has no contacts sufficient, under the workers' compensation laws of that other state to subject the employer to liability for payment of workers' compensation premium in that other state and which operations do not require the employer to purchase workers' compensation insurance under the laws of that state.

2. If an employee, hired in this state for covered employment by an employer covered by the Workers' Compensation Act of this state, receives an injury while employed in incidental operations outside this state, the injury is subject to the provisions of this section if the employee elects to receive benefits under the workers' compensation laws of that other state in lieu of a claim for benefits in this state. This section applies only if the workers' compensation laws of the other state allow the employee to elect to receive benefits under the laws of that state. If the employee does not or cannot elect coverage under the laws of another state, the injury is subject to the provisions of North Dakota Century Code chapter 65-08.

   The provisions of this section do not apply to:

   a. States having a monopolistic state fund.

   b. States having a reciprocal agreement with this state regarding extraterritorial coverage.

   c. Compensation received under any federal act.

   d. Foreign countries.

   e. Maritime employment.

   f. Employer's liability or "stop-gap" coverage.

3. An employee who elects to receive benefits under the workers' compensation laws of another state waives the right to seek compensation under North Dakota Century Code title 65.

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. Reimbursement will be considered only 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. Attorney fees and costs will be paid as set forth in section 92-01-02-11.1. If the other state has an appeal process that differs from the organization, the organization may pay fees consistent with, but may not exceed the fees and caps set forth in section 92-01-02-11.1.

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.

5. If a claim for workers' compensation benefits is compensable in this state and a claim for workers' compensation benefits for the same injury or death is filed in another state, the organization may defend, at the organization's expense, using counsel and resources of the organization's choosing, any claim, proceeding, or suit against a North Dakota covered employer. The organization may exceed the fees and caps set forth in section 92-01-02-11.1 for this subsection. The organization has the right to investigate and settle these claims, proceedings, or suits.

   The organization may not defend a claim for workers' compensation benefits, proceeding, or suit if that claim for workers' compensation benefits is not compensable in this state.

6. The organization may contract with a qualified third-party administrator to adjust and administer claims arising under this chapter. The organization shall pay the costs of the third-party administrator from the general fund.

7. Benefits paid on behalf of an employer pursuant to this section will be charged against the employer's account for experience rating purposes. The experience rating loss will be equal to the actual claim costs. The assessment charge plus appropriate penalties and interest, if any, levied pursuant to North Dakota Century Code section 65-04-04.4, will be assessed on all claims brought under this section.

8. The employer shall notify the organization when a claim is filed in another state by an employee covered by this section. The employer shall notify the organization of the claim in writing. The employer has thirty days after actual knowledge of the filing of a claim in which to notify the organization. That time can be extended for thirty days by the organization if the employer shows good cause for failing to timely notify the organization. If the employer fails to timely notify the organization when a claim is filed in another state by an employee covered under this section, the organization may not pay benefits under this section.

   The organization may not pay costs, charges, or penalties charged against an employer for late reporting of an injury or claim to the workers' compensation authorities of the state of injury.

9. The exclusive remedy provisions of North Dakota Century Code sections 65-01-01, 65-01-08, 65-04-28, and 65-05-06 apply to this section.

History: Effective January 1, 1994; amended effective April 1, 1997; July 1, 2004; July 1, 2006; July 1, 2010; April 1, 2014; April 1, 2016; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-08.1-02, 65-08.1-05

92-01-02-51. Amnesty period for employers, employees, and providers.

Repealed effective July 1, 2006.

92-01-02-51.1. Payment of copies requested by subpoena.

Any person, as defined in North Dakota Century Code section 1-01-49, served with a subpoena by the organization which directs the production of copies of documents may charge the organization copying costs. Those persons shall charge, and the organization shall pay, no more than twenty-five cents per page and up to ten hours for labor not to exceed twenty-five dollars per hour. A payment for copies may exceed the amounts listed herein if, in the discretion of the organization, the production has been or will be uniquely taxing.

History: Effective July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-11

92-01-02-51.2. Work defined.

As used in subsection 3 of North Dakota Century Code section 65-05-08 and North Dakota Century Code section 65-05-33, "work" means physical or mental effort exerted to do or to make something for any amount of remuneration or physical or mental effort exerted to do or to make something that a reasonable person would consider commonly done or made for remuneration.

History: Effective July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-08(3), 65-05-33

92-01-02-52. Procedure for penalizing delinquent employer accounts.

Repealed effective May 1, 2002.

92-01-02-53. Workforce safety and insurance scholarship fund - Application criteria - Refund.

An applicant for a workers' compensation scholarship offered under North Dakota Century Code section 65-05-20.1 must complete the application form required by the organization. The form, at a minimum, must require the applicant provide:

1. Name, address, date of birth, sex, social security number;
2. Educational history, including transcripts if requested;
3. Proof of association to the organizational claim leading to the application;
4. Access to receive information regarding other financial aid or assistance; and
5. Any other information the organization requires to administer this program.

The scholarship committee will use the information on the application form to determine which applicants receive the scholarship and may require an applicant to submit additional supporting information. The minimum required grade point average is a two point zero on a four point zero scale, or its equivalent. The organization may award individual scholarships in any amount up to the maximum amounts provided in North Dakota Century Code section 65-05-20.1. Applicants who are awarded the scholarship one year must reapply to receive the scholarship in a subsequent year. If the amount awarded to the applicant is greater than the amount owed the institution over the course of the school year, the excess award must be refunded to the organization. If the applicant who is awarded a scholarship withdraws from the institution and there are scholarship funds to be refunded, the institution shall refund those funds to the organization according to the refund priorities of the institution.

History: Effective August 1, 1997; amended effective May 1, 2000; July 1, 2006; April 1, 2016; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-20.1

92-01-02-53.1. Vocational rehabilitation grant program.

The organization may award grants to entities to promote injured workers' skill upgrading, remedial education, and optimal transition into the labor force. To be eligible, entities must submit proposals that identify a vocational need and explain how the entity intends to meet it within a suggested period of time. When determining awards, the organization shall consider the validity of the identified need, a proposal's cost-effectiveness and its general impact on vocational services for injured workers. The awarding of grants rests within the discretion of the organization. Upon request, entities that are awarded grants must report to the organization regarding the use and efficacy of a grant with as much specificity as the organization reasonably requires. In event that grant is not used for the purposes for which it was awarded or an entity is nonresponsive to reasonable requests for reports, an entity may be required to repay the grant and the organization may pursue repayment by civil action.

History: Effective April 1, 2012.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05.1-08(3)

92-01-02-54. Deductible programs.

The organization and an employer may contract for a deductible program. When a deductible program contract is entered, the employer shall reimburse the organization for benefits payable on individual claims up to the agreed deductible amount. The organization shall provide a reduced premium to participating employers based on an actuarial analysis of the contracted deductible and the rate classification of the employer. For purposes of calculating premiums, the experience rate utilized will exclude actual and expected primary losses.

For an additional premium, the organization may provide aggregate excess coverage limiting the maximum liability for losses of the employer during a policy period. Premiums will be derived from actuarial analysis and a selected aggregate limit. The aggregate limit will be agreed upon by the employer and the organization.

1. **Eligibility.** Eligibility for participation in a deductible program is based on the financial stability and resources of the employer. Participating employers must be in good standing with the organization.

   The organization may require participating employers to submit to a financial audit to ensure financial stability. The audit may include a credit check and review of company financial reports.

The organization shall analyze each proposed contract based on risk analysis and sound business practices. The organization may refuse any deductible program if it determines that the proposed contract does not represent a sound business practice or decision. Past participation in a deductible program does not guarantee continued eligibility. The organization may decline renewal of any deductible program.

2. **Claim payment.** The organization shall process and pay claims in accordance with North Dakota Century Code title 65. The employer shall reimburse the organization for all costs paid by the organization on individual claims up to the amount of the contractually agreed deductible.

   If a third-party recovery on a claim is made, the recovery will be allocated according to the terms of the contractual agreement between the organization and the employer, subject to North Dakota Century Code section 65-04-19.3.

   The organization shall deduct any delinquent deductible reimbursements from any subrogation amounts recovered on any claim.

3. **Premium payment.** Premium is due at policy inception pursuant to the terms of the contractual agreement between the organization and the employer.

4. **Financial security.** The organization may require an employer to provide a bond, letter of credit, or other security approved by the organization to guarantee payment of future employer obligations incurred by a deductible contract.

History: Effective May 1, 2000; amended effective May 1, 2002; July 1, 2004; July 1, 2006.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.3

92-01-02-55. Dividend programs.

The organization may offer dividends to qualifying employers. Eligibility and distribution:

1. Dividends are not guaranteed.

2. If an employer's account has been in effect for less than an entire premium year, any dividend offered shall be prorated by the number of months the employer's account has been active with the organization. Premiums paid and losses incurred during a dividend review period defined by the organization, and other criteria identified by the organization, may be used to determine the amount of the dividend. Minimum premium and volunteer accounts are not eligible for dividend payments.

3. The organization shall offset past-due balances on any account by the dividend earned on that account.

4. A dividend is distributed in the form of a premium credit to an employer's account and may not reduce an employer's premium below the minimum premium. No monetary disbursements of dividends can be made by the organization.

5. An employer who is noncompliant, delinquent, uninsured, or who has failed to submit a payroll report may be ineligible for a dividend for the payroll period following the year in which the employer was noncompliant, delinquent, uninsured, or failed to submit a payroll report.

History: Effective May 1, 2000; amended effective July 1, 2004; July 1, 2006; July 1, 2010; April 1, 2020; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.3

92-01-02-56. Retrospective rating program.

Repealed effective January 1, 2024.

92-01-02-57. Medical expense assessments.

An employer may file an incident report with the organization through the organization's web site. If an incident report is filed with the organization by midnight central time of the next organization business day following the workplace injury or incident and a claim is filed for benefits within fourteen calendar days of the date of injury, the organization shall waive the two hundred fifty dollar medical expense assessment.

The organization shall notify an employer by electronic transmission or by regular mail of the assessment of a medical expense assessment. The billing statement must inform the employer of the ability to appeal the decision of the organization.

History: Effective July 1, 2006; amended effective April 1, 2008; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-04.4, 65-04-19.3

92-01-02-58. Premium credit for military members.

1. Applicants for this premium credit shall complete and submit a complete application provided by the organization. The organization may decline an application for this program.

2. An applicant must be in good standing, as defined in section 92-05-02-01(2), with the organization to qualify for this program.

3. An applicant to this program who is noncompliant, delinquent, uninsured, or who has failed to submit a payroll report may be ineligible for this program.

History: Effective January 1, 2026.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-19.4