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

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

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

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

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

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

    c. Five thousand ~~one~~ three hundred dollars, plus reasonable costs incurred, if the employee prevails after an evidentiary hearing is held. If the employee prevails after an evidentiary hearing and the organization wholly rejects the recommended decision, and the employee appeals from the organization's final order, the organization shall pay attorney's fees at a rate of one hundred twenty-five percent of the maximum fees specified in subdivisions d and e when the employee prevails on appeal, as defined by North Dakota Century Code section 65-02-08, to

the district court or to the supreme court. However, the organization may not pay attorney's fees if the employee prevails at the district court but the organization prevails at the supreme court in the same appeal.

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

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

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

g. ~~Five hundred dollars for review of a proposed settlement, if the employee to whom the settlement is offered was not represented by counsel at the time of the offer of settlement.~~

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

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

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

6. If the organization is obligated to pay the employee's attorney's fees, the attorney shall submit to the organization a final statement upon resolution of the matter. All statements must show the name of the employee, claim number, date of the statement, the issue, date of each service or charge,

itemization and a reasonable description of the legal work performed for each service or charge, time and amount billed for each item, and total time and amounts billed. The employee's attorney must sign the fee statement. The organization may deny fees and costs that are determined to be excessive or frivolous.

7. The following costs will be reimbursed:

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

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

    c. Copying charges, at eight cents per page.

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

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

8. The following costs will not be reimbursed:

    a. Facsimile charges.

    b. Express mail.

    c. Additional copies of transcripts.

    d. Costs incurred to obtain medical records.

    e. On-line 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; amended April 1, 2010.
General Authority: NDCC 65-02-08, 65-02-15
Law Implemented: NDCC 65-02-08, 65-02-15, 65-10-03

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-11.1
Title of Rule: Attorney's Fees

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-11.1
Title of Rule: Attorney's Fees

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-01-02-12. Mileage and per diem for travel to and from medical treatment. Workforce safety and insurance recognizes payment for travel to and from medical treatment as a reasonable and necessary medical expense. These expenses will be paid according to North Dakota Century Code section 65-05-28, except that reimbursement for out-of-state lodging may not exceed one hundred twenty-five percent of the allowance for in-state lodging. ~~Intracity mileage may not be reimbursed.~~

History: Effective August 1, 1988; amended effective April 1, 1997; amended , April 1, 2010.

General Authority: NDCC 65-02-08

Law Implemented: NDCC 65-02-08, 65-05-28

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-12

Title of Rule: Mileage and per diem for travel to and from medical treatment.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-12

Title of Rule: Mileage and per diem for travel to and from medical treatment.

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational**

standards required in the proposed rule: None

E. Exempting sm all entities from all or part of the rule's requirements: None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-01-02-13. Merger, exchange, or transfer 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 of which a surviving entity is composed.

   c. "Surviving entity" means the business entity resulting from a merger, exchange, or transfer of business assets from one or more constituent businesses.

2. **Experience rating.** The surviving entity resulting from a merger, exchange, or transfer of business assets will be assigned an experience rating derived from the combined premium, payroll, and loss history of all the employer accounts involved in the merger, exchange, or transfer. The employer accounts of the constituent businesses shall merge, exchange 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 will transfer to its continuation or extension. Future experience rates will 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 the premium liability to the surviving entity or decline coverage until the 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 basic continuity of the constituent business in the surviving entity as shown by retention of key personnel, assets, and general business operations.

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

(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 taxable payroll for the period of time involved. 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 periodof time involved.

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

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-13
Title of Rule: Merger, exchange, or transfer of business.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: **92-01-02-13**
Title of Rule: Merger, exchange, or transfer of business.

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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 annually 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 annually a form on which the employer shall report payroll expenditures from the preceding payroll year. An electronic report of payroll information in a format approved by the organization is acceptable. The employer shall complete the report and send it to the organization either by regular mail or electronic transmission. The report must be received by the organization by the last day of the month following the expiration date of the employer's payroll period. The organization shall consider an unsigned or incomplete submission to be 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 and the payment due date. 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 indicted on the premium billing statement.

3. If the organization does not receive full payment or the minimum installment payment indicated on the premium 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 by written binder if the organization and the employer have agreed in writing to a payment schedule on a delinquent account. If the employer is in default of the agreed payment schedule, however, 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 delinquency. The notification must indicate that the organization may assess a penalty of up to two thousand dollars against the employer's account.

7. If the payroll report is not received within forty-five days following the expiration of the employer's payroll year, the organization shall assess a penalty of fifty dollars. The organization shall notify the employer by electronic transmission or regular mail addressed to the employer's last-known address that the employer is uninsured.

8. At any time after sixty days following the expiration of the employer's payroll year, when the employer has failed to submit a payroll report, the organization may bill the employer at the wage cap per employee using the number of employees reported per rate classification from a previous year of actual or estimated payroll reported to the organization. The organization may also bill an employer account using data obtained from job service North Dakota to bill an employer who has failed to submit a payroll report. 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. The organization may also cancel the employer's account.

9. If the organization receives an employer payroll report more than sixty days after the expiration of the employer's payroll period, the employer's premium billing ~~due date is fifteen days following the expiration of the employer's payroll period.~~ statement may have a "past due" premium billing due date. Any employer account billed without benefit of the employer payroll report ~~has a~~ may have a "past due" premium billing due date. ~~which is fifteen days following the expiration of the employer's payroll year~~.

10. 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.

11. Upon receipt of an incomplete or unsigned payroll report, ~~The~~ 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 two 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; amended April 1, 2010.
General Authority: NDCC 65-02-08, 65-04-33
Law Implemented: NDCC 65-04-33

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-14
Title of Rule: Procedure for penalizing employers accounts for failure to pay premium or failure to submit payroll reports

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-14
Title of Rule: Procedure for penalizing employers accounts for failure to pay premium or failure to submit payroll reports

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-01-02-15. Altering payroll reporting periods for employers.
The organization~~, upon an employer's request,~~ 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 April 1, 2010.
General Authority: NDCC 65-02-08, 65-04-33
Law Implemented: NDCC 65-04-33

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-15
Title of Rule: Altering payroll reporting periods for employers

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: **92-01-02-15**
Title of Rule: Altering payroll reporting periods for employers.

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-01-02-16. Expiration date change. ~~At an employer's request, the~~ 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; amended April 1, 2010.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-01

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-16
Title of Rule: Expiration date change

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-16
Title of Rule: Expiration date change

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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. "~~Five~~-Three-year losses" means the total sum of ratable losses accrued on claims occurring during the first ~~five~~ three of the ~~six~~ four years immediately preceding the premium year being rated.
   b. "~~Five~~-Three-year payroll" means the total sum of limited payroll reported for the first ~~five~~ three of the ~~six~~ four years immediately preceding the premium year being rated.
   c. "~~Five~~-Three-year premium" means the total sum of earned premium for the first ~~five~~ three of the ~~six~~ 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 as completed three consecutive payroll periods and has developed aggregate manual premiums of at least ~~twenty-five~~ fifteen thousand dollars for the rating period used in developing the experience modification factor.

3. For accounts with ratable manual premium of ~~twenty-five~~ 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 (Ap), which consist of the sum of those ~~five~~ three-year losses, comprising the first ten thousand dollars of each individual claim.
      (2) Calculate the actual excess losses (Ae), which consist of thesum of those ~~five~~ three-year losses in excess of the first ten 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 (Et), which are determined by adding the products of the actual payroll for each year of the ~~five~~ 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 (Ee), which are determined by adding the products of the actual payroll for each year of the ~~five~~ 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:

$$EMF = \frac{Ap + (Z \times Ae) + [(1.00 - Z) \times Ee] + B}{Et + B}$$

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; amended July 1, 2010
General Authority: NDCC 65-02-08, 65-04-17
Law Implemented: NDCC 65-04-01

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-18
Title of Rule: Experience Rating System

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: **92-01-02-18**
Title of Rule: Experience Rating System

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational**

standards required in the proposed rule: None

E. Exempting sm all entities from all or part of the rule's requirements: None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-01-02-24. Rehabilitation services.

1. When 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 e of subsection 2 of North Dakota Century Code section 65-05.1-06.1 only when 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. When 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 must 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 thirty 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 will 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 ~~twenty-five percent wage loss~~ rehabilitation allowance ~~to maintain two domiciles~~ as provided in subdivision b of subsection 2 of North Dakota Century Code section 65-05.1-06.1 may continue only while the employee is actually enrolled

or participating in the training program~~, and is actually maintaining two domiciles~~.

~~5. An employee who is required to be in attendance at a training facility for at least three days a week is determined to be attending on a daily basis for purposes of determining eligibility for the twenty-five percent second domicile allowance.~~

~~6~~ 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 only for the specified number of weeks of training.

~~7~~ 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 claims analyst~~ the organization. All claims for reimbursement must be supported by the original vendor receipt 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. ~~Mileage calculations will be based upon atlas or map mileage from city limit to city limit and will not include intracity mileage~~ The calculation for reimbursement for travel by motor vehicle must be calculated using miles actually and necessarily traveled. The organization may not reimburse mileage or travel expenses when 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].

History: Effective November 1, 1991; amended effective January 1, 1996; April 1, 1997; February 1, 1998; May 1, 2002; July 1, 2006; amended effective April 1, 2010.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05.1

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-24
Title of Rule: Rehabilitation services

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-24
Title of Rule: Rehabilitation services

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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 doctors arising from the evaluation that affects the amount of the award. It does not include disputes regarding proper interpretation or application of the American medical association guides to the evaluation of permanent impairment, fifth edition.

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 doctor" means a doctor of medicine or osteopathy, chiropractor, dentist, optometrist, podiatrist, or psychologist acting within the scope of the doctor's license 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, fifth edition, and modified by this section. All permanent impairment reports must include the opinion of the doctor 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 establish a list of medical specialists who have 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, fifth edition. When an employee requests an evaluation of impairment, the organization shall schedule an evaluation with a physician from the list. The organization may not schedule a permanent impairment evaluation with the employee's treating doctor. The organization and employee may agree to an evaluation by a physician not on the current list. In the event of a medical dispute, the organization ~~shall furnish the list of appropriate specialists to the employee. The organization and the employee, if they cannot agree on an independent medical specialist, shall choose a specialist by striking names of medical specialists from the list until a name is chosen.~~ will identify qualified specialists and submit all objective medical documentation regarding the dispute to specialist(s) who have the knowledge, training, and experience in the application of the American medical association guides to the evaluation of permanent impairment, fifth edition. To the extent more than one physician is identified, the organization will consult with the employee before appointment of the physician.

4. Upon receiving a permanent impairment rating report from the doctor, 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 18 of the guides when there is no accompanying rating under the conventional organ and body system ratings of impairment. In addition, no rating for pain may be awarded when the evaluating physician determines the individual being rated has low credibility, when the individual's pain is ambiguous or the diagnosis is a controversial pain syndrome. A controversial pain syndrome is a syndrome that is not widely accepted by physicians and does not have a well-defined pathophysiologic basis.

   b. An evaluating physician qualified in application of the guides to determine permanent impairment shall conduct an informal pain assessment and evaluate the individual under the guide's conventional rating system according to the body part or organ system specific to that person's impairment. If the body system impairment rating adequately encompasses the pain, no further assessment may be done.

   c. If the pain-related impairment increases the burden of the individual's condition slightly, the evaluating physician may increase the percentage attributable to pain by up to three percent and, using the combined values chart of the fifth edition, calculate a combined overall impairment rating.

d. If the pain-related impairment increases the burden of the individual's condition substantially, the evaluating physician shall conduct a formal pain assessment using tables 18-4, 18-5, and 18-6 of the guides and calculate a score using table 18-7.

e. The score from table 18-7 correlates to an impairment classification found in table 18-3.

f. If the score falls within classifications two, three, or four of table 18-3, the evaluating physician must determine whether the pain is ratable or unratable.

g. To determine whether the pain is ratable or unratable, the evaluating physician must answer the three questions in this section. If the answer to all three of the following questions is yes, the evaluating physician should consider the pain ratable. If any question is answered no, the pain is unratable.

(1) Do the individual's symptoms or physical findings, or both, match any known medical condition?

(2) Is the individual's presentation typical of the diagnosed condition?

(3) Is the diagnosed condition one that is widely accepted by physicians as having a well-defined pathophysiologic basis?

h. If the pain is unratable, no percentage may be assigned to the impairment.

i. If the pain is ratable, the evaluating physician shall classify the individual into one of the categories in table 18-3 and, using the combined values chart of the fifth edition, calculate a combined overall impairment rating.

j. The impairment percentages assigned to table 18-3 are:

(1) Class 1, mild: one to three percent.

(2) Class 2, moderate: four to five percent.

(3) Class 3, moderately severe: six to seven percent.

(4) Class 4, severe: eight to nine percent.

5. Permanent mental and behavioral disorder impairment ratings.

a. Any evaluating physician determining permanent mental or behavioral disorder impairment shall:

(1) Include in the rating only those mental or behavioral disorder impairments not likely to improve despite medical treatment;

(2) Use the instructions contained in the American medical association guides to the evaluation of permanent impairment, fifth edition, giving specific attention to:

(a) Chapter 13, "central and peripheral nervous system"; and

(b) Chapter 14, "mental and behavioral disorders"; and

(3) Complete a full psychiatric assessment following the principles of the American medical association guides to the evaluation of permanent impairment, fifth edition, including:

(a) A nationally accepted and validated psychiatric diagnosis made according to established standards of the American psychiatric association as contemplated by the American medical association guides to the evaluation of permanent impairment, fifth edition; and

(b) A complete history of the impairment, associated stressors, treatment, attempts at rehabilitation, and pre-morbid history and a determination of ~~causality and~~ apportionment.

~~b.~~ If the permanent impairment is due to organic deficits of the brain and results in disturbances of complex integrated cerebral function, emotional disturbance, or consciousness disturbance, then chapter 13, "central and peripheral nervous system", must be consulted and may be used, when appropriate, with chapter 14, "mental and behavioral disorders". The same permanent impairment may not be rated in both sections. The purpose is to rate the overall functioning, not each specific diagnosis. ~~The impairment must be rated in accordance with the "permanent mental impairment rating work sheet" incorporated as appendix A to this chapter.~~

c. ~~The permanent impairment report must include a written summary of the mental evaluation and the "report work sheet" incorporated as appendix A to this chapter.~~ The overall permanent impairment rating for depression and/or anxiety must be based upon objective psychological test results, utilizing the following accepted procedures and tests.

(1.) Two symptom validity tests shall be conducted: Green's Word Memory Test (WMT) and, in addition, either the Computer Assessment of Response Bias (CARB) or the Victoria Symptom Validity Test (VSVT).

If the evaluator determines good effort is not demonstrated on one or both of the symptom validity tests, the patient should be informed of the lack of effort and be provided with the opportunity to re-take the test or tests. If lack of effort is again demonstrated on either or both tests, testing is terminated and no impairment rating is reported.

(1) If chronic pain is rated, the Pain Patient Profile (P3) and either the MMPI-2 or the MMPI-2 RF may be administered.

(2) Upon determination of the level of depression and/or anxiety through objective valid psychological test results, the evaluating physician shall classify the individual into one of the categories in Table 14-1 of the guides.

The levels of permanent mental impairment percentages assigned to Table 14-1 are:

Percent	Category
0%	Class 1. No Impairment
1-15%	Class 2. Mild permanent Impairment
16-25%	Class 3. Moderate Permanent Impairment
26-50%	Class 4. Marked Permanent Impairment
51-100%	Class 5. Extreme Permanent Impairment

(3) The permanent impairment report must include a written summary of the mental evaluation.

d. If other work-related permanent impairment exists, a combined whole-body permanent impairment rating may be determined.

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

6. Errata sheets and guides updates. Any updates, additions, or revisions by the editors of the fifth edition of the guides to the evaluation of permanent impairment as of April 1, ~~2009~~ 2010, are adopted as an update, addition, or revision by the organization.

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; amended April 1, 2010.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-12.2

APPENDIX A

WORKFORCE SAFETY AND INSURANCE

PERMANENT MENTAL IMPAIRMENT RATING REPORT

WORK SHEET

Since the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition, does not provide a quantified method for assigning permanent impairment percentages under Chapter 14, "Mental and Behavioral Disorders", the evaluating physician shall utilize this form. When using this form, the evaluating physician shall:

a. Become familiar with the content of the work sheet and develop an understanding of the percentages and categories listed in "I. Level of Permanent Mental Impairment" and Table 14-1 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition;

b. Enter the permanent mental category rating associated with each item in all sections of "II. Areas of Function" as it applies to the injured worker; and

c. Enter a rating for the "Overall Permanent Impairment Rating" provided within this appendix. The "Overall Permanent Impairment Rating" must be based upon the categories provided in Table 14-1.

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

The various degrees of permanent impairment from "II. Areas of Function" on within this appendix are not added, combined, or averaged. The overall mental rating should be based upon clinical judgment and Table 14-1, and be consistent with other chapters of the AMA guides.

-PLEASE PHOTOCOPY AS NEEDED-

PERMANENT MENTAL IMPAIRMENT RATING

REPORT WORK SHEET

Patient Name _____ DOB _____

WC# _____ SSN _____

I. LEVELS OF PERMANENT MENTAL IMPAIRMENT - as identified in Table 14-1 of the AMA Guides to the Evaluation of Permanent Impairment, Fifth Edition:

Percent	Category
0%	Class 1. No Impairment
1-15%	Class 2. Mild permanent Impairment
16-25%	Class 3. Moderate Permanent Impairment
26-50%	Class 4. Marked Permanent Impairment
51-100%	Class 5. Extreme Permanent Impairment

II. AREAS OF FUNCTION

1. **Activities of Daily Living**

_____ Self-care personal hygiene (urinating, defecating, brushing teeth, combing hair, dressing oneself, bathing, eating, preparing meals, and feeding oneself)

_____ Communication (writing, typing, seeing, hearing, speaking)

_____ Physical activity (standing, sitting, reclining, walking, climbing stairs)

_____ Travel (driving, riding, flying)

_____ Nonspecialized hand activities (grasping, lifting, tactile discrimination)

_____ Sexual function (orgasm, ejaculation, lubrication, erection)

_____ Sleep (restful, nocturnal sleep pattern)

2. **Social Functioning**

_____ Get along with others

_____ Initiate social contacts

_____ Communicate clearly with others

_____ Interact and actively participate in group activities

_____ Cooperative behavior, consideration for others, and awareness of others' sensitivities

_____ Interacts appropriately with the general public

_____ Asks simple questions or requests assistance

_____ Accepts instructions and responds appropriately to criticism from supervisors

_____ Gets along with coworkers and peers without distracting them or exhibiting behavioral extremes

_____ Maintains socially appropriate behavior

_____ Adheres to basic standards of neatness and cleanliness

3. Memory, Concentration, Persistence, and Pace

_____ Comprehend/follow simple commands

_____ Works with or near others without being distracted

_____ Sustains an ordinary routine without special supervision

_____ Ability to carry out detailed instructions

_____ Maintain attention and concentration for specific tasks

_____ Makes simple work-related decisions

_____ Performs activities within a given schedule

_____ Maintains regular attendance and is punctual within customary tolerances

_____ Completes a normal workday and workweek without interruptions from psychologically based symptoms

_____ Maintains regular attendance and is

punctual within customary tolerances

4. Deterioration or Decompensation in Complex or Worklife Settings (Adaptation to Stressful Circumstances)

_____	Withdraws from the situation or experiences exacerbation of signs and symptoms of a mental disorder
_____	Decompensates and has difficulty maintaining performance of activities of daily living (ADLs), continuing social relationships, or completing tasks
_____	Able to make good autonomous decisions/exercises good judgment
_____	Perform activities on schedule
_____	Interacts appropriately with supervisors and peers
_____	Responds appropriately to changes in work setting
_____	Aware of normal hazards and takes appropriate precautions
_____	Able to use public transportation and can travel to and within unfamiliar places
_____	Sets realistic goals
_____	Makes plans independent of others

OVERALL PERMANENT IMPAIRMENT RATING _____

IMPAIRMENT CAUSED BY WORK _____

Physician _____ **Date** _____

(signature)

PERMANENT WORK-RELATED MENTAL IMPAIRMENT RATING

REPORT WORK SHEET

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-25
Title of Rule: Permanent impairment evaluations and disputes.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-25
Title of Rule: Permanent impairment evaluations and disputes.

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-01-02-29.1. Medical necessity.

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

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

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

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

    b. Chemonucleolysis; acupressure; reflexology; 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 attending doctor. Dietary supplements, including minerals, vitamins, and amino acids are reimbursable if a specific compensable dietary deficiency has been clinically established in the claimant. Vitamin B-12 injections are reimbursable if necessary because of a malabsorption resulting from a compensable gastrointestinal disorder.

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

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

    f. Intradiscal electrothermal annuloplasty (IDET).

g. Prolotherapy (sclerotherapy)

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; amended April 1, 2010.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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

1. Only treatment that falls within the scope and field of the treating medical service provider's license to practice is reimbursable.

2. Paraprofessionals who are not independently licensed must practice under the direct supervision of a licensed medical service provider whose scope of practice and specialty training includes the service provided by the paraprofessional, in order to be reimbursed.

3. Health care providers may be refused reimbursement to treat cases under the jurisdiction of the organization.

4. 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 observe and comply with the organization's orders and medical service rules, including cooperation with the organization's managed care vendors.

    d. 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.

    e. Failure to recognize emotional and social factors impeding recovery of claimants.

    f. Unreasonable refusal to comply with the recommendations of board-certified or qualified specialists who have examined the claimant.

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

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

    i. Pattern of submission of inaccurate or misleading bills.

    j. Pattern of submission of false or erroneous diagnosis.

k. ~~Knowingly submitting bills to a claimant for treatment of a work-related condition for which the organization has accepted liability, charging or attempting to charge claimants fees in addition to the fee paid by the organization for care of the occupational injury, or billing~~ Billing the difference between the maximum allowable fee set forth in the organization's fee schedule and usual and customary charges, or billing the claimant any other fee in addition to the fee paid, or to be paid, by the organization for individual treatments, equipment, and products.

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

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

n. 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.

o. Certifying disability in excess of the actual medical limitations of the claimant.

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

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

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

s. Disciplinary action by a licensing board.

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

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-31
Title of Rule: Who may be reimbursed.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-31
Title of Rule: Who may be reimbursed.

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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

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

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

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

    a. Durable medical equipment.

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

        (2) The claims analyst will authorize and pay for prosthetics and orthotics as needed by the claimant because of a compensable work injury when substantiated by the attending doctor. If those items are furnished by the attending doctor or another provider, the organization will reimburse the doctor or the provider pursuant to its fee schedule. Providers and doctors shall supply the organization with a copy of their original invoice showing actual cost of the item upon request of the organization. The organization will repair or replace originally provided damaged, broken, or worn-out prosthetics, orthotics, or special equipment devices upon documentation from the attending doctor that replacement or repair is needed. Prior authorization for replacements is required.

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

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

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

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

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

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

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

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

   b. All nonemergent major surgery. When the attending doctor or consulting doctor believes elective surgery is needed to treat a compensable injury, the attending doctor or the consulting doctor with the approval of the attending doctor, shall give the utilization review department actual notice at least twenty-four hours prior to the proposed surgery. Notice must give the medical information that substantiates the need for surgery, an estimate of the surgical date and the postsurgical recovery period, and the hospital where surgery is to be performed. When elective surgery is recommended, the utilization review department may require an independent consultation with a doctor of the organization's choice. The organization shall notify the doctor who requested approval of the elective surgery, whether or not a consultation is desired. When requested, the consultation must be completed within thirty days after notice to the attending doctor. Within seven days of the consultation, the organization shall notify the surgeon of the consultant's findings. If the attending doctor and consultant disagree about the need for surgery, the organization may request a third independent opinion pursuant to North Dakota Century Code section 65-05-28. If, after reviewing the third opinion, the organization believes the proposed surgery is excessive, inappropriate, or ineffective and the organization cannot resolve the dispute with the attending doctor, the requesting doctor may request binding dispute resolution in accordance with section 92-01-02-46.

   c. Magnetic resonance imaging, a myelogram, discogram, bonescan, arthrogram, or computed axial tomography. Tomograms are subject to preservice review if requested in conjunction with a myelogram, discogram, bonescan, arthrogram, computed axial tomography scan, or magnetic resonance imaging. The organization may waive preservice review requirements for procedures listed in this subdivision when requested by a doctor who is performing an independent medical examination or permanent partial impairment evaluation at the request of the organization.

   d. Physical therapy and occupational therapy treatment beyond the first ten treatments or beyond thirty 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 thirty days after therapy services are originally prescribed, whichever occurs first. Postoperative physical therapy and occupational therapy may not be started beyond ninety days after surgery date. The organization may waive this requirement in conjunction with programs designed to ensure the ongoing evolution of managed care to meet the needs of injured claimants or providers.

e. Electrodiagnostic studies, which may only be performed by electromyographers who are certified or eligible for certification by the American ~~b~~Board of e~~E~~lectrodiagnostic ~~m~~Medicine, American ~~b~~Board of ~~p~~Physical ~~m~~Medicine and ~~r~~Rehabilitation, or the American ~~b~~Board of ~~n~~Neurology and ~~p~~Psychiatry's certification in the specialty of clinical neurophysiology. Nerve conduction study reports must include either laboratory reference values or literature-documented normal values in addition to the test values.

f. Thermography.

g. Intra-articular injection of hyaluronic acid.

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

i. Facet joint injections.

j. Sacroiliac joint injections.

k. Facet nerve blocks.

l. Epidural steroid injections.

m. Nerve root blocks.

n. Peripheral nerve blocks.

o. Botox injections.

p. Stellate ganglion blocks.

q. Cryoablation.

r. Radio frequency lesioning.

s. Facet rhizotomy.

~~t. Prolotherapy.~~

~~u.~~ t. Implantation of stimulators and pumps.

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

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

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 twenty-four hours, or the next business day, of receiving the necessary information to complete a review and make a recommendation on the service, unless the organization or managed care vendor requires a review by the organization's medical director. If a review by the medical director is performed, the organization or the managed care vendor must respond to the provider's request within seventy-two hours of receiving the necessary information. Within the time for review, the organization or managed care vendor must recommend approval or denial of the request, request additional information, request the claimant obtain a second opinion, or request an examination by the claimant's doctor. A recommendation to deny medical services must specify the reason for the denial.

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

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

b. If preservice review or prior authorization of a medical service is not requested by a provider and the provider can prove, by a preponderance of the evidence, that the injured employee did not inform the provider, and the provider did not know, that the condition was, or likely would be, covered under workers' compensation. All medical service providers are required to cooperate with the managed care vendor for retrospective review and are required to provide, without additional charge to the organization or the managed care vendor, the medical information requested in relation to the reviewed service.

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

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

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

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. Establishing less stringent compliance or reporting requirements: None

B. Establishing less stringent schedules or deadlines for compliance or report: None

C. Consolidating or simplifying compliance or reporting requirements: None

D. Establishing performance standards that replace design or operational standards required in the proposed rule: None

E. Exempting sm all entities from all or part of the rule's requirements: None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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

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

   a. To establish a diagnosis or to clarify a prior diagnosis that may be controversial or ill-defined.

   b. To outline a program of rational treatment, if treatment or progress is controversial.

   c. To establish medical data from which it may be determined whether the medical condition is related, or not related, to the injury.

   d. To determine whether and to what extent a preexisting medical condition is aggravated by an occupational injury.

   e. To establish when the claimant has reached maximum medical improvement or medically stationary status.

   f. To establish a percentage of rating for permanent impairment.

   g. To determine whether a claim should be reopened for further treatment on the basis of aggravation of a compensable injury or significant change in a medical condition.

   h. To determine whether overutilization by a health care provider has occurred.

   i. To determine whether a change in health care provider is indicated.

   j. To determine whether treatment is necessary if the claimant appears to be making no progress in recuperation.

   k. When the attending doctor has not provided current medical reports.

2. It is the organization's intention to obtain objective examinations to ensure that correct determinations are made of all benefits to which the injured claimant might be entitled.

3. Examiners must be willing to testify or be deposed on behalf of the claimant, employer, or the organization.

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

5. As used in subsection 3 of North Dakota Century Code section 65-05-28 regarding doctors designated or approved by the organization, "duly qualified doctor" means a person chosen by the organization who is a doctor of medicine or osteopathy, chiropractor, dentist, optometrist, podiatrist, or psychologist who has the specialization necessary to perform an independent medical examination. The organization's determination of whether an individual it has chosen is a duly qualified doctor, and the organization's choice of the duly qualified doctor who will perform an independent medical examination 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.

6. 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 doctors 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 a claimant 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; amended April 1, 2010.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-41
Title of Rule: Independent medical examinations.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-41
Title of Rule: Independent medical examinations.

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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

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

2. All bills must be fully itemized, including ICD-9-CM codes, and services must be identified by code numbers found in the fee schedules or as provided in these rules. The definitions of commonality in the guidelines found in the current procedural terminology must be used as guides governing the descriptions of services, except as provided in the fee schedules or in these rules. All bills must be submitted to the organization within one year of the date of service or within one year of the date the organization accepts liability for the work injury or condition.

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

   a. The claimant's full name and address;

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

   c. Date and nature of injury;

   d. Area of body treated, including ICD-9-CM code identifying right or left, as appropriate;

   e. Date of service;

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

   g. Name of medical service provider providing the service;

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

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

   j. Type of service;

k. Appropriate procedure code or hospital revenue code;

l. Description of service;

m. Charge for each service;

n. Units of service;

o. If dental, tooth numbers;

p. Total bill charge;

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

r. Date of bills.

4. All records submitted by providers, including notes, except those provided by an emergency room physician and those on forms provided by the organization, must be typed to ensure that they are legible and reproducible. Copies of office or progress notes are required for all followup visits. Office notes are not acceptable in lieu of requested narrative reports. Communications may not refer to more than one claim.

5. Providers shall submit with each bill a copy of medical records or reports which substantiate the nature and necessity of a service being billed and its relationship to the work injury, including the level, type, and extent of the service provided to claimants. Documentation required includes:

   a. Laboratory and pathology reports;

   b. X-ray findings;

   c. Operative reports;

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

   e. Consultation reports;

   f. History, physical examination, and discharge summaries;

   g. Special diagnostic study reports; and

   h. Special or other requested narrative reports.

~~6. Providers submitting bills for filling prescriptions also shall include the prescribing provider's name on the bill.~~

~~7.~~ 6. When a provider submits a bill to the organization for medical services, the provider shall submit a copy of the bill to the claimant to whom the services were provided. The copy must be stamped or printed with a legend that clearly indicates that it is a copy and is not to be paid by the claimant.

~~8.~~ 7. If the provider does not submit records with a bill, and still does not provide those records upon request of the organization, the charges for which records were not supplied may not be paid by the organization, unless the provider submits the records before the decision denying payment of those charges becomes final. The provider may also be liable for the penalty provided in subsection 6 of North Dakota Century Code section 65-05-07.

~~9.~~ 8. Disputes arising out of reduced or denied reimbursement are handled in accordance with section 92-01-02-46. In all cases of accepted compensable injury or illness under the jurisdiction of the workers' compensation law, a provider may not pursue payment from a claimant for treatment ~~rendered to that claimant,~~ equipment, or products unless a claimant desires to receive them and has accepted responsibility for payment, or unless the payment for the treatment was denied because:

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

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

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

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

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

n. The claimant is subject to North Dakota Century Code section 65-05-28.2, and the provider requesting payment is not a preferred provider and has not

been approved as an alternative provider under subsection 2, 3, or 4 of North Dakota Century Code section 65-05-28.2.

~~10.~~ 9. A medical service provider may not bill for services not provided to a claimant and may not bill multiple charges for the same service. Rebilling must indicate that the charges have been previously billed.

~~11.~~ 10. Pursuant to North Dakota Century Code section 65-05-33, a medical service provider may not submit false or fraudulent billings.

~~12.~~ 11. Only one office visit designation may be used at a time except for those code numbers relating specifically to additional time.

~~13.~~ 12. When a claimant is seen initially in an emergency department and is admitted subsequently to the hospital for inpatient treatment, the services provided immediately prior to the admission are part of the inpatient treatment.

~~14.~~ 13. Hot and cold pack as a modality will be considered as a bundled charge and will not be separately reimbursed.

~~15.~~ 14. Limit of two modalities per visit for outpatient physical therapy services, outpatient occupational therapy services, and chiropractic visit.

~~16.~~ 15. When a medical service provider is asked to review records or reports prepared by another medical service provider, the provider shall bill review of the records using CPT code 99080 with a descriptor of "record review". The billing must include the actual time spent reviewing the records or reports and must list the medical service provider's normal hourly rate for the review.

~~17.~~ 16. When there is a dispute over the amount of a bill or the necessity of services rendered, the organization shall pay the undisputed portion of the bill and provide specific reasons for nonpayment or reduction of each medical service code.

~~18.~~ 17. If medical documentation outlines that a non-work-related condition is being treated concurrently with the compensable injury and that condition has no effect on the compensable injury, the organization may reduce the charges submitted for treatment. In addition, the attending doctor must notify the organization immediately and submit:

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

b. A description of the treatment being rendered.

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

The attending doctor shall include a thorough explanation of how the non-work-related condition affects the compensable injury when the doctor requests

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

~~19.~~ 18. In cases of questionable liability when the organization has not rendered a decision on compensability, the provider has billed the claimant or other insurance, and the claim is subsequently allowed, the provider shall refund the claimant or other insurer in full and bill the organization for services rendered.

~~20.~~ 19. The organization may not pay for the cost of duplicating records when covering the treatment received by the claimant. If the organization requests records in addition to those listed in subsection 5 or records prior to the date of injury, the organization shall pay a minimum charge of five dollars for five or fewer pages and the minimum charge of five dollars for the first five pages plus thirty-five cents per page for every page after the first five pages.

~~21.~~ 20. The provider shall assign the correct approved billing code for the service rendered using the appropriate provider group designation. Bills received without codes will be returned to the provider.

~~22.~~ 21. 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.

~~23.~~ 22. A provider shall comply within thirty calendar days with the organization's request for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the organization's determination of compensability, medical necessity, or excessiveness or the organization may refuse payment for services provided by that provider.

23. A provider may not bill a claimant 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 claimant any other fee in addition to the fee paid, or to be paid, by the organization for individual treatments, equipment, and products.

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

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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" ~~in a state other than a qualified state~~ means business operations of an employer for fewer than thirty consecutive days in ~~which~~ a state where the employer has no other significant 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~~ whose operations do not require the employer to purchase workers' compensation insurance under the laws of that state.

   e. "Significant contacts" means contacts defined as significant by the workers' compensation laws of that other state which are sufficient to subject the employer to liability for payment of workers' compensation premium in that other state.

~~e. "Incidental operations" in a qualified state means operations of an employer for fewer than thirty days in a state in which the employer has no other significant contacts. "Significant contacts" in a qualified state means operations of an employer in that state~~

~~for thirty or more consecutive days.~~

~~f. "Qualified state" means a state in which an insurance company, formed pursuant to North Dakota Century Code chapter 65-08.1, is qualified to sell, and does sell, workers' compensation insurance.~~

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

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

5. 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.

6. 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 65-05-07.2, will be assessed on all claims brought under this section.

7. 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.

8. 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; amended April 1, 2010
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-08.1-02, 65-08.1-05

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-01-02-55. Dividend programs. The organization may offer dividends to qualifying employers. Eligibility and distribution:

1. Dividends are not guaranteed. ~~Dividends may only be declared by the workforce safety and insurance board of directors.~~

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. The distribution of a dividend may not reduce an employer's premium below the minimum premium.

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

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-55
Title of Rule: Dividend programs.
GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-55
Title of Rule: Dividend programs.

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exem pting small entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

CHAPTER 92-01-03
~~OFFICE OF INDEPENDENT REVIEW~~ DECISION REVIEW OFFICE

Section
92-01-03-01 History and Functions of the ~~Office of Independent Review~~ Decision Review Office.
92-01-03-02 Definitions
92-01-03-03 Request for Assistance - Timely Request for Reconsideration or Rehearing
92-01-03-04 Procedure for Dispute Resolution
92-01-03-05 Informal Benefit Review Conference - Notice [Repealed]

92-01-03-01. History and functions of the ~~office of independent review~~ Decision Review Office.

1. **History.** Legislation enacting the ~~office of independent review~~ Decision Review Office was passed in 1995 and is codified as North Dakota Century Code section 65-02-27. The legislation took effect on August 1, 1995.

2. **Functions.** The program has been developed to educate and provide assistance to injured employees in the workers' compensation system. The goal is to resolve claims disputes in a timely and professional manner. If an employee has a concern with a claim, the employee may contact the ~~office of independent review~~ decision review office and request assistance.

History: Effective April 1, 1996; amended effective May 1, 2000; amended effective April 1, 2010.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-27

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-03-01
Title of Rule: History and function of the ~~office of independent review~~ Decision Review Office.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-03-01
Title of Rule: History and function of the ~~office of independent review~~ Decision Review Office.

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-01-03-02. Definitions. In this chapter:

1. "Act" means the North Dakota Workers Compensation Act.
2. "~~Advocate~~ Decision Review Specialist" means a person employed by the ~~program~~ office to assist a claimant in a disputed claim.
3. "Attempt to resolve" means a prompt, active, honest, good-faith effort by the claimant to settle disputes with the organization, through the ~~program~~ office.
4. "Benefits" means an obligation of the organization to provide a claimant with assistance as required by the Act.
5. "Certificate of completion" means the form sent to the claimant when the ~~program~~ office closes its file, which acknowledges the claimant made a good-faith effort to resolve the dispute.
6. "Claimant" means an employee who has filed a claim for benefits with the organization.
7. "Constructive denial" occurs when sixty days have passed since all elements of filing under subsection 2 of section 92-01-02-48 have been satisfied, but the organization has not made the decision to accept or deny the claim.
8. "Disputed claim" means a challenge to an order issued by the organization.
9. "Interested party" means:
    a. The claimant.
    b. The claims ~~analyst~~ adjuster assigned to that claimant's claim.
    c. Claims supervisor.
    d. The claimant's employer or immediate supervisor.
    e. The claimant's treating doctor.
    f. A member of the organization's legal department.
    g. Any other person the ~~advocate~~ decision review specialist determines appropriate.
10. "~~Program~~ Office" means the ~~office of independent review~~ decision review office.
11. "Order" means an administrative order issued pursuant to North Dakota Century Code chapter 28-32 or section 65-01-16.

~~11.~~ 12. "Organization" means workforce safety and insurance, or the director, or any department heads, assistants, or employees of the organization designated by the director to act within the course and scope of their employment in administering the policies, powers, and duties of the Act.

~~12.~~ 13. "Vocational consultant's report" means the report issued by the rehabilitation consultant outlining the most appropriate rehabilitation option identified for the claimant.

History: Effective April 1, 1996; amended effective May 1, 2000; July 1, 2004; amended April 1, 2010.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-27

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-03-02
Title of Rule: Defintions.
GENERAL: The following analysis is submitted in compliance with 28-32-08 of the NDCC.

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-03-02
Title of Rule: Definitions.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-01-03-03. Request for assistance - Timely request for consideration or rehearing. A claimant shall request assistance with the resolution of a dispute that arises from an order in writing within thirty days from the date of service of the order. An oral request is sufficient to toll the statutory time limit for requesting rehearing if that request is followed by a written request for assistance which is received by the ~~program~~ office within ten days after the oral request was made.

History: Effective April 1, 1996; amended effective May 1, 1998; May 1, 2000; amended effective April 1, 2010.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-27

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-03-03
Title of Rule: Request for assistance - Timely request for consideration or rehearing.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-03-03
Title of Rule: Request for assistance - Timely request for consideration or rehearing.
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-01-03-04. Procedure for dispute resolution.

1. A claimant may contact the ~~program~~ office for assistance at any time. The claimant shall contact the ~~program~~ office to request assistance with a dispute arising from an order within thirty days of the date of service of the order. The claimant may also contact the ~~program~~ office for assistance when a claim has been constructively denied or when a vocational consultant's report is issued. A claimant must make an initial request in writing for assistance with an order, a constructively denied claim, or a vocational consultant's report.

2. In an attempt to resolve the dispute, the ~~advocate~~ decision review specialist may contact any interested parties. After oral or written contact has been made with the appropriate interested parties, the ~~advocate~~ decision review specialist will attempt to accomplish a mutually agreeable resolution of the dispute between the organization and the claimant. The ~~advocate~~ decision review specialist may facilitate the discussion of the dispute but may not modify a decision issued by the organization.

3. If a claimant has attempted to resolve the dispute and an agreement cannot be reached, the claim examiner shall issue a certificate of completion. The ~~advocate~~ decision review specialist will send the certificate of completion to the claimant and will inform the claimant of the right to pursue the dispute through hearing. To pursue a formal rehearing of the claim, the claimant shall file a request for rehearing with the organization's legal department within thirty days after the certificate of completion is mailed.

4. If a claimant has not attempted to resolve the dispute, the ~~program~~ office shall notify the claimant by letter, sent by regular mail, of the claimant's nonparticipation in the ~~program~~ office and that no attorney's fees shall be paid by workforce safety and insurance should the claimant prevail in subsequent litigation. The ~~advocate~~ decision review specialist shall inform the claimant of the right to pursue the dispute through hearing. To pursue a formal rehearing of the claim, the claimant shall file a request for rehearing with the organization's legal department within thirty days after the letter of noncompliance is mailed.

5. If an agreement is reached, the organization must be notified and an order or other legal document drafted based upon the agreement.

6. The ~~program~~ office will complete action within thirty days from the date that the ~~program~~ office receives a claimant's request for assistance. This timeframe can be extended if the ~~advocate~~ decision review specialist is in the process of obtaining additional information.

History: Effective April 1, 1996; amended effective May 1, 1998; May 1, 2000; July 1, 2004; July 1, 2006; amended effective April 1, 2010.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-27

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-03-04
Title of Rule: Procedure for dispute resolution.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-03-04
Title of Rule: Procedure for dispute resolution.

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-02-01-01. References to other standards. Any update, amendment or revision to Title 29 of the Code of Federal Regulations, part 1910, occupational safety and health standards for general industry, ~~with amendments as of July 1, 2003,~~ and, part 1926, occupational safety and health standards for the construction industry, ~~with amendments as of July 1, 2003,~~ both promulgated by the occupational safety and health administration of the United States department of labor effective as of April 1, 2010, are the standards of safety and conduct for the employers and employees of the state of North Dakota.

History: Amended effective August 1, 1987; June 1, 2000; July 1, 2004; amended April 1, 2010
General Authority: NDCC 65-03-01
Law Implemented: NDCC 65-03-01

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. Establishing performance standards that replace design or operational standards required in the proposed rule: None

E. Exempting sm all entities from all or part of the rule's requirements: None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-05-02-01. Definitions. As used in this article:

1. "Baseline period" means the period of time immediately preceding the premium period being rated for risk management programs. The baseline period may not be less than six months and not more than eighteen months.
2. "Employer" means employer as defined in North Dakota Century Code section 65-01-02.
3. "Frequency rate" means the total number of claims accepted by the organization attributable to an employer in that employer's premium period multiplied by one million dollars and divided by the employer's gross payroll for mandatory coverage and the current wage cap for optional coverage.
4. "Good standing" for purposes of this article means an employer account that is not in default pursuant to North Dakota Century Code section 65-04-22.
5. "Measurement year" means the premium period being rated for the risk management programs.
6. "Organization" means workforce safety and insurance.
7. ~~"Preferred provider" means a designated medical provider of medical services, including consultations or referral by the provider. Any employer may select a designated medical provider pursuant to North Dakota Century Code section 65-05-28.1. The employer must provide written documentation that all employees have been notified of the designated medical provider selection and the employee's option to add additional providers to the employer's selection. The employer must provide written documentation that the employer has notified the designated medical provider that it has elected to participate in the designated medical provider program.~~
8. "Risk management programs" means all premium reduction and premium calculation programs offered and approved by the organization. Participants in the deductible and retrospective rating program are not eligible for discounts under this chapter.
9. "Safety intervention" means any program, practice, or initiative approved by the organization intended to eliminate workplace hazards.
10. "Severity rate" means the rate calculated by multiplying the total number of days for which disability benefits were paid by the organization because of a workplace injury during the measurement year by one million dollars and divided by the employer's gross payroll for mandatory coverage and the current wage cap for optional coverage. The total number of lost time days incurred during the employer's premium period will be calculated only for those claims with acceptance dates in the measurement year and preceding four premium billing periods. Death claims shall be assessed three hundred sixty-five lost time days during the premium billing period in which the workplace death occurs and an additional three hundred sixty-five lost time days for the subsequent premium billing period.

History: Effective July 1, 2006; amended effective July 1, 2007; amended April 1, 2010

General Authority: NDCC 65-02-08

Law Implemented: NDCC 65-03-04, 65-04-19.1

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-05-02-01
Title of Rule: Definitions. As used in this article:

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-05-02-01
Title of Rule: Definitions. As used in this article:

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-05-02-03. Eligibility - Billing.
All employers, except participants in the retrospective rating and deductible programs are eligible to participate in the organization's risk management ~~program plus~~ programs. An employer may elect, subject to the organization's approval, to participate in an alternative risk management program.

The organization, in its discretion, shall determine eligibility for the safety outreach program. Pursuant to this program, the organization will serve the sector of industry and business that has historically generated high frequency or severity rates, or both. Volunteer accounts are not eligible for participation in risk management programs. At the organization's discretion, an employer account that is delinquent, uninsured, or not in good standing pursuant to section 92-05-02-01 may not be eligible for discounts under this article.

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

History: Effective July 1, 2006; amended effective April 1, 2008; amended April 1, 2010

General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-03-04, 65-04-19.1

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-05-02-04 is repealed:

92-05-02-04. Death claims. ~~In exceptional circumstances, and at the sole discretion of the executive director of the organization, the impact of a compensable death claim may be removed from that employer's risk management program plus calculation.~~

~~**History:** Effective July 1, 2006;~~ Repealed effective April 1, 2010
~~**General Authority:** NDCC 65-02-08~~
~~Law Implemented: NDCC 65-03-04, 65-04-19.1~~

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-05-02-04
Title of Rule: Death claims.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-05-02-04
Title of Rule: Death claims.

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-05-02-05 is repealed:

92-05-02-05. Risk management program plus.

~~1. Risk management program plus provides a five percent premium discount for a reduction of at least ten percent in frequency rate and a five percent premium discount for a reduction of at least ten percent in severity rate. If an employer reduces both frequency and severity rates by at least ten percent each in a premium year, that employer is entitled to an additional five percent premium discount. The maximum premium discount available under this program is fifteen percent in a premium year. An employer who has no claims accepted by the organization and no lost time days incurred in the employer's premium period automatically earns the maximum fifteen percent discount. Continued reduction of at least ten percent annually in either an employer's frequency or severity rates, or both, entitles an employer to a discount.~~

~~2. This subsection applies only to accounts experience rated in the measurement year and only to the frequency rate calculation. If an employer does not attain a ten percent reduction in frequency rate, an employer may still earn a five percent frequency discount if the employer's frequency rate is sixty-five percent or less than the organization's calculation of the five-year average frequency rate for the employer's applicable sector code as assigned by the organization and as published in the North American Industry Classification System, United States, 2002 expanded edition with added "bridges". (2002).~~

~~3. An employer who has no claims accepted by the organization and no lost time days incurred in the employer's premium period retains the fifteen percent discount for the current premium period.~~

~~**History:** Effective July 1, 2006;~~ Repealed effective April 1, 2010.
~~**General Authority**: NDCC 65-02-08~~
~~**Law Implemented**: NDCC 65-03-04, 65-04-19.1, 65-04-19.3~~

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-05-02-05
Title of Rule: Risk management program plus

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: **92-05-02-05**
Title of Rule: Risk management program plus

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-05-03-06 is repealed:

92-05-03-06. Hazard elimination learning program.

~~The organization may create grant programs to defray the costs of participation in the organization's hazard elimination learning program. A grant award under this section is within the discretion of the organization.~~

~~**History:** Effective April 1, 2008; amended effective April 1, 2009;~~ Repealed effective April 1, 2010.

~~**General Authority**: NDCC 65-02-08~~

~~**Law Implemented**: NDCC 65-03-04~~

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-05-03-06
Title of Rule: Hazard elimination learning program

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: **92-05-03-06**
Title of Rule: Hazard elimination learning program

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

92-05-02-07. Alternative risk management programs. The organization may create ~~a~~ new ~~program~~ risk management programs, or modify ~~an~~ existing employer premium calculation ~~program~~ programs under this article to provide greater or lesser premium discounts.

History: Effective April 1, 2008; amended August 1, 2010.
General Authority: NDCC 65-02-08
Law Implemented: **NDCC 65-03-04, 65-04-19.1, 65-04-19.3**

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-05-02-07
Title of Rule: Alternative risk management programs

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-05-02-07
Title of Rule: Alternative risk management programs

GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. **Establishing less stringent compliance or reporting requirements:** None

B. **Establishing less stringent schedules or deadlines for compliance or report:** None

C. **Consolidating or simplifying compliance or reporting requirements:** None

D. **Establishing performance standards that replace design or operational standards required in the proposed rule:** None

E. **Exempting sm all entities from all or part of the rule's requirements:** None

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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