NORTH DAKOTA ADMINISTRATIVE CODE

VOLUME 2

Supplements 146 through 151

August 1991
September 1991
October 1991
November 1991
December 1991
January 1992

Prepared by the Legislative Council staff
for the
Administrative Rules Committee

TITLE 38

Highway Patrol

JANUARY 1992

38-06-02-01. General rules.

1. The North Dakota highway patrol may issue single trip permits for the movement of oversize or overweight, or both, vehicles and loads. Unless otherwise exempted by the superintendent, permits will not be issued for loads that can be reasonably made to conform to legal limits.

2. All single trip permits must be in possession of the permittee prior to starting movement unless prior approval is obtained from the highway patrol.

3. Single trip permits includes self-issuing single trip movement approval forms.

History: Effective January 1, 1988; amended effective January 1, 1992.
General Authority: NDCC 39-12-02
Law Implemented: NDCC 39-12-02

38-06-02-03. Escort requirements.

1. All movements exceeding fourteen feet six inches [4.42 meters] in overall width but not exceeding sixteen feet [4.87 meters] in overall width shall have one pilot car precede the movement at a distance of three hundred to seven hundred feet [91.44 to 213.36 meters] on two-lane highways. In lieu of the pilot car requirement, the overwidth vehicle itself, or vehicle towing or hauling an overwidth load, may be equipped with a lighted rotating or flashing amber light or lights that are visible from front and rear for a minimum five hundred feet [152.4 meters]. On four-lane divided highways there are no pilot car requirements for movements of this size.

2. All movements exceeding sixteen feet [4.88 meters] in overall width shall have one pilot car precede the movement at a distance of three hundred to seven hundred feet [91.44 to 213.36 meters] and shall have one pilot car follow the movement at a distance of three hundred to seven hundred feet [91.44 to 213.36 meters] on two-lane highways. On four-lane divided highways one pilot car shall follow the movement at a distance of three hundred to seven hundred feet [91.44 to 213.36 meters].

3. All movements exceeding one hundred twenty feet [36.57 meters] in overall length shall have one pilot car follow the movement at a distance of three hundred to seven hundred feet [91.44 to 213.36 meters].

4. All movements exceeding eighteen feet [5.49 meters] in overall height shall have one pilot car precede the movement at a distance of three hundred to seven hundred feet [91.44 to 213.36 meters].

5. The ~~highway~~ North Dakota department of transportation chief engineer, bridge engineer, district engineers, or highway patrol may require pilot cars for movements that are overweight.

History: Effective January 1, 1988; amended effective January 1, 1992.
General Authority: NDCC 39-12-02
Law Implemented: NDCC 39-12-02

38-06-02-04. Routing of movements. Permit issuing personnel may designate routes of travel where adequate width or height for safe traffic movement cannot be provided, or when restricted by maps as provided by ~~highway~~ North Dakota department of transportation engineers.

History: Effective January 1, 1988; amended effective January 1, 1992.
General Authority: NDCC 39-12-02
Law Implemented: NDCC 39-12-02

38-06-02-05. Insurance requirements.

1. When towing or hauling oversize mobile home or modular units, the towing vehicle must have minimum insurance coverage of one hundred thousand dollars bodily injury liability for one person, three hundred thousand dollars bodily injury liability for one accident, and fifty thousand dollars property damage liability.

2. When requesting permits for movements exceeding two hundred thousand pounds [90,718 kilograms] gross vehicle weight, or when otherwise required by the highway patrol or ~~highway~~ department of transportation engineers, the applicant must

provide written verification of liability and property damage insurance coverage.

History: Effective January 1, 1988; amended effective January 1, 1992.
General Authority: NDCC 39-12-02
Law Implemented: NDCC 39-12-02

38-06-02-06. Size and weight limitations.

1. Unless otherwise authorized by the superintendent, single trip permits for overdimensional movements may not exceed fourteen feet six inches [4.42 meters] in overall width, fifteen feet six inches [4.72 meters] in overall height, and one hundred twenty feet [36.58 meters] in overall length.

2. Limitations for single trip permits for overweight movements must be as determined by ~~highway~~ department of transportation engineers.

History: Effective January 1, 1988; amended effective January 1, 1992.
General Authority: NDCC 39-12-02
Law Implemented: NDCC 39-12-02

38-06-03-01. Permit fees. The following fees are to be effective January 1, 1988; however, fees may be paid prior to January 1, 1988, for those permitted movements to be made after January 1, 1988.

1. The fee for registered motor vehicles hauling or towing overdimensional or overweight, or both, loads is ten dollars per each single trip permit.

2. The fee for registered motor vehicles that exceed legal size or legal weight, or both, limitations is ten dollars per each single trip permit.

3. The fee for nonregistered self-propelled special mobile equipment that exceeds legal weight limitations is fifteen dollars per each single trip permit.

4. The fee for nonregistered self-propelled special mobile equipment that exceeds legal size limitations only is ten dollars per each single trip permit.

5. The fee for each identification supplement, identifying a motor vehicle and axle configuration so that self-issuing single trip permits can be used, is ten dollars each.

6. The fee for exceeding the federal gross vehicle weight limitation of eighty thousand pounds [36,287 kilograms] on the interstate highway system is five dollars per each "interstate only" single trip permit.

7. The fee for vehicles hauling overwidth loads of hay bales or haystacks, overwidth self-propelled fertilizer spreaders, and overwidth hay grinders is fifty dollars per year.

8. The fee when movement requires ~~highway~~ department of transportation engineer approval is fifteen dollars in addition to permit fee.

9. There is an additional heavyweight fee of seventy dollars per ton for all weight in excess of one hundred five thousand five hundred pounds [47,910 kilograms] gross vehicle weight but not to exceed two hundred thousand pounds [90,718 kilograms] gross vehicle weight. The fee may be prorated on a monthly basis and does not apply on those motor vehicles which are North Dakota titled and registered.

10. There is an additional ton/mile fee on all those movements that exceed two hundred thousand pounds [90,718 kilograms] gross vehicle weight. The following ton/mile fee is assessed upon that portion of gross vehicle weight exceeding the maximum legal gross weight of one hundred five thousand five hundred pounds [47,910 kilograms].

Gross Vehicle Weight	Ton/Mile Fee	Minimum
200,001 to 210,000	$ .05	$ 50.00
210,001 to 220,000	.10	50.00
220,001 to 230,000	.15	50.00
230,001 to 240,000	.20	50.00
240,001 to 250,000	.25	50.00
250,001 to 275,000	.50	100.00
275,001 to 300,000	2.00	200.00
300,001 to 325,000	3.00	350.00
325,001 to 350,000	4.00	500.00
350,001 to 400,000	7.00	1,000.00
400,001 to 450,000	10.00	2,000.00
450.001 to 500,000	15.00	3,000.00
500.001 to 550,000	20.00	5,000.00
550,001 to 600,000	30,00	7,500.00
600,001 to 650,000	40.00	10,000.00
650,001 to 700,000	50.00	15,000.00
700,001 to 750,000	75.00	25,000.00
750,001 or more	100.00	Minimum one mile

11. On those movements of extraordinary size or weight that require highway patrol escort there is an escort service fee of thirty cents per mile [kilometer] and thirty dollars per hour.

History: Effective January 1, 1988; amended effective May 1, 1988; January 1, 1992.
General Authority: NDCC 39-12-02, 39-12-04
Law Implemented: NDCC 39-12-02

38-06-04-01. Liability of permit applicant.

1. The applicant or permittee, as a condition for obtaining an oversize or overweight, or both, permit, shall assume all responsibility for accidents, damage, or injury to any persons or damage to public or private property caused by the movement of any oversize or overweight, or both, vehicle or load covered by the permit while upon public highways of the state.

2. The applicant or permittee agrees to indemnify and hold harmless the North Dakota ~~highway~~ department of transportation, the North Dakota highway patrol, their officers, and employees from any and all claims resulting directly or indirectly from the movement of an oversize or overweight, or both, vehicle or load on any public highway of the state of North Dakota.

History: Effective January 1, 1988; amended effective January 1, 1992.
General Authority: NDCC 39-12-02
Law Implemented: NDCC 39-12-02

TITLE 45

Insurance, Commissioner of

45-02-02-16. Notification of criminal convictions and administrative actions - Duty of licensee. Each licensed insurance agent, broker, or consultant shall notify the commissioner of their having been convicted of any crime punishable by incarceration within thirty days of the entering of an order of conviction and shall notify the commissioner of any administrative action taken against his license in another state within thirty days of the entering of the administrative order in that state.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-42(5)(12)

45-02-04-11. Reciprocity. If a nonresident licensee's state of residence has mandatory continuing education requirements substantially similar to the requirements of this state, the commissioner may accept as a report of compliance for continuing education credit, certification of the licensee's compliance in the state of residence. Licensees must submit proof of certification from their state of residence in conformance with section 45-02-04-09 along with the filing fee required in North Dakota Century Code chapter 26.1-26. The determination that another state's continuing education requirements are substantially similar to the requirements of this state shall be solely in the discretion of the commissioner.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-31.7

45-02-04-12. Nonresident letter of certification required. Each nonresident licensee shall submit a current letter of certification from

their state of residence at the time their continuing education report of compliance is due in this state.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-31.7

45-02-04-13. Penalty. All agents who are late in filing the required report of continuing education compliance shall pay a penalty of twenty-five dollars in addition to the fee required by North Dakota Century Code section 26.1-26-31.4.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-26-49
Law Implemented: NDCC 26.1-26-31.1, 26.1-26-31.4

45-03-05-04. Forms - General requirements.

1. ~~Form A and Form B~~ Forms A, B, C, and D are intended to be guides in the preparation of the statements required by North Dakota Century Code sections 26.1-10-03 and 26.1-10-04. They are not intended to be blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted; provided, the answers are prepared so as to indicate to the reader the coverage of the items without the necessity of the reader referring to the text of the items or the instructions thereto. All instructions, whether appearing under the items of the form or elsewhere in the form, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

2. Two complete copies of each statement including exhibits and all other papers and documents filed as a part of the statement shall be filed with the commissioner by personal delivery or mail addressed to: Commissioner of Insurance, Fifth Floor, State Capitol, Bismarck, North Dakota 58505, Attention: Legal Department. A copy of Form C must be filed in each state in which an insurer is authorized to do business, if the commissioner of that state has notified the insurer of its request in writing, in which case the insurer has ten days from the receipt of the notice to file such form. At least one of the copies shall be manually signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement.

3. Statements should be prepared on paper eight and one-half inches by eleven inches or eight and one-half inches by thirteen inches [21.59 centimeters by 27.94 centimeters or 21.59 centimeters by 33.02 centimeters] in size and preferably bound at the top or the top left-hand corner. Exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size. All copies of any statement, financial statements, or exhibits shall be clear, easily readable, and suitable for photocopying. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into United States currency.

History: Effective January 1, 1982; amended effective January 1, 1992.
General Authority: NDCC 26.1-10-12
Law Implemented: NDCC 26.1-10-03, 26.1-10-04

45-03-05-05. Forms - Incorporation by reference, summaries, and omissions.

1. Information required by any item of Form A ~~or~~, Form B, or Form D may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A ~~or~~, Form B, or Form D provided such document or paper is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents already on file with the commissioner which were filed within three years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where such incorporation would render the statement incomplete, unclear, or confusing.

2. Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the most important provisions of the document. In addition to the statement, the summary or outline may incorporate by reference particular parts of any exhibit or document on file with the commissioner which were filed within three years and may be qualified in its entirety by the reference. In any

case where two or more documents required to be filed as exhibits are substantially identical in all material respects ~~expect~~ except as to the parties thereto, the dates of execution, or other details, a copy of only one of the documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which the documents differ from the documents a copy of which is filed.

History: Effective January 1, 1982; amended effective January 1, 1992.
General Authority: NDCC 26.1-10-12
Law Implemented: NDCC 26.1-10-03, 26.1-10-04

45-03-05-07. Forms - Additional information and exhibits. In addition to the information expressly required to be included in Form A ~~and~~, Form B, Form C, and Form D, there shall be added such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. Such exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Forms A, B, C, or D must include on the top of the cover page the phrase: "Change No. (insert number) to" and must indicate the date of the change and not the date of the original filing.

History: Effective January 1, 1982; amended effective January 1, 1992.
General Authority: NDCC 26.1-10-12
Law Implemented: NDCC 26.1-10-03, 26.1-10-04

45-03-05-08. Forms - Amendments. Any amendment for Form A ~~or~~, Form B, Form C, and Form D shall include on the top of the cover page the phrase: "Amendment No. (insert number) to" and shall indicate the date of the amendment and not the date of the original filing.

History: Effective January 1, 1982; amended effective January 1, 1992.
General Authority: NDCC 26.1-10-12
Law Implemented: NDCC 26.1-10-03, 26.1-10-04

45-03-05-09. Definitions.

1. "Executive officer" means ~~any individual charged with active management and control in an executive capacity (including a president, vice president,~~ chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers) of a person, whether incorporated or unincorporated.

2. "Foreign insurer" includes an alien insurer except where clearly noted otherwise.

3. "Ultimate controlling person" means that person which is not controlled by any other person.

4. Unless the context otherwise requires, other terms found in this chapter and in North Dakota Century Code section 26.1-10-01 are used as defined in that section. Other nomenclature or terminology is according to the Insurance Code, or industry usage if not defined in the code.

History: Effective January 1, 1982; amended effective January 1, 1992.
General Authority: NDCC 26.1-10-12
Law Implemented: NDCC 26.1-10-01

45-03-05-12. Amendments to Form A. The applicant shall promptly advise the commissioner of any changes in the information so furnished on Form A arising subsequent to the date upon which such information was furnished but prior to the commissioner's disposition of the application.

History: Effective January 1, 1982; amended effective January 1, 1992.
General Authority: NDCC 26.1-10-12
Law Implemented: NDCC 26.1-10-03, 26.1-10-04

45-03-05-12.1. Acquisition of subsection 1 of North Dakota Century Code section 26.1-10-03 insurers.

1. If the person being acquired is deemed to be a "domestic insurer" solely because of the provisions of subsection 1 of North Dakota Century Code section 26.1-10-03, the name of the domestic insurer on the cover page must be indicated as follows:

   "ABC Insurance Company, a subsidiary of XYZ Holding Company."

2. Where subsection 1 of North Dakota Century Code section 26.1-10-03 insurer is being acquired, references to "the insured" contained in Form A must refer to both the domestic subsidiary insurer and the person being acquired.

History: Effective January 1, 1992.
General Authority: NDCC 28-32
Law Implemented: NDCC 26.1-02-02, 26.1-06.1-01, 26.1-10-05

45-03-05-13. ~~Registration~~ Annual registration of insurers - ~~Statement~~ Annual registration filing. An insurer required to file ~~a~~ an annual registration statement pursuant to North Dakota Century Code section 26.1-10-04 shall furnish the required information on Form B, hereby made a part of this chapter.

History: Effective January 1, 1982; amended effective January 1, 1992.

General Authority: NDCC 26.1-10-12
Law Implemented: NDCC 26.1-10-04

45-03-05-13.1. Summary of registration - Statement filing. An insurer required to file an annual registration statement pursuant to North Dakota Century Code section 26.1-10-04 is also required to furnish information required on Form C. An insurer shall file a copy of Form C in each state in which the insurer is authorized to do business, if requested by the commissioner of that state.

History: Effective January 1, 1992.
General Authority: NDCC 28-32
Law Implemented: NDCC 26.1-10-04

45-03-05-14. Amendments to Form B.

1. An amendment to Form B shall be filed within fifteen days after the end of ~~any~~ the month in which ~~any of the following occurs:~~ there is a material change to the information provided in the annual registration statement.

   ~~a. There is a change in the control of the registrant, in which case the entire Form B shall be made current.~~

   ~~b. There is a material change in the information given in Item 5 or Item 6.~~

2. ~~An amendment to Form B shall be filed within one hundred twenty days after the end of each fiscal year of the ultimate controlling person of the insurance holding company system. The amendment shall make current all information in Form B~~ Amendments must be filed in the Form B format with only those items which are being amended reported. Each such amendment must include at the top of the cover page: "Amendment No. (insert number) to Form B for (insert year)" and must indicate the date of the change and not the date of the original filings.

History: Effective January 1, 1982; amended effective January 1, 1992.
General Authority: NDCC 26.1-10-12
Law Implemented: NDCC 26.1-10-04

45-03-05-16. Exemptions.

~~1. A foreign or alien insurer otherwise subject to North Dakota Century Code section 26.1-10-04 shall not be required to register pursuant to that section:~~

   ~~a. If it is admitted in the domiciliary state of the principal insurer and in that state is subject to~~

~~disclosure requirements and standards adopted by statute or regulation which are substantially similar to those contained in North Dakota Century Code section 26.1-10-04; provided, the commissioner may require a copy of the registration statement or other information filed with the domiciliary state; or~~

~~b. Until July 1, 1981.~~

~~2. The state of entry of an alien insurer shall be deemed to be its domiciliary state for the purposes of North Dakota Century Code section 26.1-10-04.~~

~~3. Any insurer not otherwise exempt or excepted from North Dakota Century Code section 26.1-10-04 may apply for an exemption from the requirements of that section by submitting a statement to the commissioner setting forth its reasons for being exempt.~~ Repealed effective January 1, 1992.

History: ~~Effective January 1, 1982.~~
General Authority: ~~NDCC 26.1-10-12~~
Law Implemented: ~~NDCC 26.1-10-04~~

45-03-05-17.1. Transactions subject to prior notice - Notice filing. An insurer required to give notice of a proposed transaction pursuant to North Dakota Century Code section 26.1-10-05 shall furnish the required information on Form D, hereby made a part of these rules.

History: Effective January 1, 1992.
General Authority: NDCC 28-32
Law Implemented: NDCC 26.1-10-05

45-03-05-18. Extraordinary dividends and other distributions.

1. Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

   a. The date established for payment of the dividend.

   b. A statement as to whether the dividend is to be in cash or other property and, if in property, a description of the property, its cost, and its fair market value together with an explanation of the basis for valuation.

   c. ~~The amounts and dates of all dividends (including regular dividends) paid within the period of twelve consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month~~

~~in the last preceding year~~ The amount of the proposed dividend.

d. A copy of the calculations determining that the proposed dividend is extraordinary. The workpaper must include the following information:

(1) The amounts, dates, and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer's own securities) paid within the period of twelve consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

(2) Surplus as regards policyholders (total capital and surplus) as of the next preceding December thirty-first;

(3) If the insurer is a life insurer, the net gain from operations for the twelve-month period ending the next preceding December thirty-first;

(4) If the insurer is not a life insurer, the net income less realized capital gains for the twelve-month period ending the next preceding December thirty-first and the two preceding twelve-month periods; and

(5) If the insurer is not a life insurer, the dividends paid to stockholders excluding distributions of the insurer's own securities in the preceding two calendar years.

e. A balance sheet and statement of income for the period intervening from the last annual statement filed with the commissioner and the end of the month preceding the month in which the request for dividend approval is submitted.

~~e.~~ f. A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

2. ~~The payment of an extraordinary dividend by an insurer, whose total liabilities, as calculated for national association of insurance commissioners annual statement purposes, are less than ten percent of its assets both before and after payment thereof is deemed automatically approved. The insurer, however, shall give written notice to the commissioner of the~~

~~declaration pursuant to subsection 4 of North Dakota Century Code section 26.1-10-04~~ Subject to subsections 3, 4, and 5 of North Dakota Century Code section 26.1-10-05, each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen business days following the declaration thereof, including the same information required by paragraphs 1 through 4 of subdivision d.

History: Effective January 1, 1982; amended effective January 1, 1992.
General Authority: NDCC 26.1-10-12
Law Implemented: NDCC 26.1-10-04

45-03-05-19. Adequacy of surplus. The factors set forth in subsection 2 of North Dakota Century Code section 26.1-10-05 are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's surplus, no single factor shall be controlling. The commissioner, instead, will consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the commissioner will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the commissioner will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

History: Effective January 1, 1982; amended effective January 1, 1992.
General Authority: NDCC 26.1-10-12
Law Implemented: NDCC 26.1-10-05

FORM A
STATEMENT REGARDING THE
ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

_____
Name of Domestic Insurer

BY

_____
Name of Acquiring Person (Applicant)

Filed with the Insurance Department of _____
(State of domicile of insurer being acquired)

Dated: _____, 19 ___

Name, title, address, and telephone number of individual to whom notices and correspondence concerning this statement should be addressed:

_____

_____

_____

_____

ITEM 1. INSURER AND METHOD OF ACQUISITION.

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT.

1. State the name and address of the applicant seeking to acquire control over the insurer.

2. If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.

3. Furnish a chart or listing clearly presenting the identities of the interrelationships among the applicant and all affiliates of the applicant. No affiliate need be identified if its total assets are equal to less than one-half of one percent of the total assets of the ultimate controlling person affiliated with the applicant. Indicate in such chart or

listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization, e.g., corporation, trust, partnership, and the state or other jurisdiction of domicile. If court proceedings ~~looking toward~~ involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings, and the date when commenced.

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT.

State the following with respect to (1) the applicant if the applicant is an individual or (2) all persons who are directors, executive officers, or owners of ten percent or more of the voting securities of the applicant if the applicant is not an individual:

1. Name and business address.

2. Present principal business activity, occupation, or employment including position and office held and the name, principal business, and address of any corporation or other organization in which such employment is carried on.

3. Material occupations, positions, offices, or employment during the last five years, giving the starting and ending dates of each and the name, principal business, and address of any business corporation or other organization in which each such occupation, position, office, or employment was carried on; if any such occupation, position, office, or employment required licensing by or registration with any federal, state, or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension, or disciplinary proceedings in connection therewith.

4. Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

ITEM 4. NATURE, SOURCE, AND AMOUNT OF CONSIDERATION.

1. Describe the nature, source, and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose

of acquiring, holding, or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes, and security arrangements relating thereto.

2. Explain the criteria used in determining the nature and amount of such consideration.

3. If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, the applicant must specifically request that the identity be kept confidential.

ITEM 5. FUTURE PLANS ~~FOR~~ OF INSURER.

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons, or to make any other material change in its business operations or corporate structure or management.

ITEM 6. VOTING SECURITIES TO BE ACQUIRED.

State the number of shares of the insurer's voting securities which the applicant, its affiliates, and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement, or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.

ITEM 7. OWNERSHIP OF VOTING SECURITIES.

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates, or any person listed in Item 3.

ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER.

Give a full description of any contracts, arrangements, or understandings with respect to any voting security of the insurer in which the applicant, its affiliates, or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss, or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements, or understandings have been entered into.

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES.

Describe any purchases of any voting securities of the insurer by the applicant, its affiliates, or any person listed in Item 3 during the twelve calendar months preceding the filing of this statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any such shares so purchased are hypothecated.

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE~~.~~

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates, or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates, or any person listed in Item 3 during the twelve calendar months preceding the filing of this statement.

ITEM 11. AGREEMENTS WITH BROKER-DEALERS~~.~~

Describe the terms of any agreement, contract, or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender, and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard thereto.

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS~~.~~

1. Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

2. The financial statements shall include the annual financial statements of the persons identified in Item 2 ~~(3)~~ (c) for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. Such statements may be prepared on either an individual basis, or, unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

   The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified~~,~~, provided they are based on the ~~annual statement~~ Annual Statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance

or other accounting principles prescribed or permitted under the law and regulations of such state.

3. File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto~~,~~, any proposed employment, consultation, advisory, or management contracts concerning the insurer~~,~~, annual reports to the stockholders of the insurer, and the applicant for the last two fiscal years~~,~~, and any additional documents or papers required by Form A or sections 45-03-05-04 and 45-03-05-06.

ITEM 13. SIGNATURE AND CERTIFICATION~~.~~

Signature and certification ~~of the following form~~ required as follows:

SIGNATURE

Pursuant to the requirements of North Dakota Century Code section 26.1-10-03, _____ has caused this application to be duly
Name of Applicant
signed on its behalf in the City of _____ and State of _____, on the _____ day of _____, 19___.

(SEAL)

_____
Name of Applicant

BY: _____
(Name) (Title)

Attest:

_____
(Signature of officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that the applicant has duly executed the attached application dated _____, 19 ___, for and on behalf of _____; that the applicant is the
(Name of applicant)
_____ of such company and that the applicant is
(Title of officer)
authorized to execute and file such instrument. ~~The deponent~~ Deponent further says that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of deponent's knowledge, information, and belief.

(Signature) _____

(Type or print name beneath) _____

FORM B
INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of _____

By

_____
Name of Registrant

On Behalf of the Following Insurance Companies

Name Address

_____

_____

_____

_____

_____

Date: _____, 19 ___

Name, title, address and telephone number of individual to whom notices and correspondence concerning this statement should be addressed:

_____

_____

_____

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT.

Furnish the exact name of each insurer registering or being registered (hereinafter called "the registrant"), the home office address and principal executive offices of each; the date on which each registrant became part of the insurance holding company system; and the methods by which control of each registrant was acquired and is maintained.

ITEM 2. ORGANIZATIONAL CHART.

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. No affiliate need be shown if its total assets

are equal to less than one-half of one percent of the total assets of the ultimate controlling person within the insurance holding company system unless it has assets valued at or exceeding (insert amount). The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization, e.g., corporation, trust, partnership, and the state or other jurisdiction of domicile.

ITEM 3. THE ULTIMATE CONTROLLING PERSON~~.~~

As to the ultimate controlling person in the insurance holding company system furnish the following information:

1. Name.

2. Home office address.

3. Principal executive office address.

4. The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.

5. The principal business of the person.

6. The name and address of any person who holds or owns ten percent or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.

7. If court proceedings ~~looking toward~~ involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings, and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION~~.~~

Furnish the following information for the directors and executive officers of the ultimate controlling person; the individual's name and address, the ~~his or her~~ individual's principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years.

ITEM 5. TRANSACTIONS~~,~~ ~~RELATIONSHIPS,~~ AND AGREEMENTS~~.~~

~~1.~~ Briefly describe the following agreements in force~~,~~ ~~relationships subsisting,~~ and transactions currently outstanding or which have occurred during the last calendar year between the registrant and its affiliates:

~~a.~~ 1. Loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the registrant or of the registrant by its affiliates~~.~~;

~~b.~~ 2. Purchases, sales, or exchanges of assets~~.~~;

~~c.~~ 3. Transactions not in the ordinary course of business~~.~~;

~~d.~~ 4. Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the registrant's business~~.~~;

~~e.~~ 5. All management ~~and~~ agreements, service contracts, and all cost-sharing arrangements~~, other than cost allocation arrangements based upon generally accepted accounting principles.~~;

~~f.~~ 6. Reinsurance agreements ~~covering all or substantially all of one or more lines of insurance of the ceding company.~~;

7. Dividends and other distributions to shareholders;

8. Consolidated tax allocation agreements; and

9. Any pledge of the registrant's stock or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

~~2.~~ No information need be disclosed if such information is not material for purposes of Section 26.1-10-04 of the North Dakota Century Code.

Sales, purchases, exchanges, loans, or extensions of credit ~~or~~, investments, or guarantees involving one-half of one percent or less of the registrant's admitted assets as of the ~~thirty first day of December~~ next preceding December thirty-first shall not be deemed material.

~~3.~~ The description shall be in a manner as to permit the proper evaluation thereof by the commissioner, and shall include at least the following: the nature and purpose of the transaction~~,~~, the nature and amounts of any payments or transfers of assets between the parties~~,~~, the identity of all parties to such transaction~~,~~, and relationship of the affiliated parties to the ~~registrant~~ Registrant.

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS~~.~~

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of

which the property of any such person is or was the subject; give the names of the parties and the court or agency in which such litigation or proceeding is or was pending:

1. Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto~~.~~; and

2. Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership, or other ~~corporation~~ corporate reorganizations.

~~ITEM 7. FINANCIAL STATEMENTS AND EXHIBITS.~~

ITEM 7. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS

1. Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

2. The financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

   If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis, or unless the commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

   Unless the commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law.

If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the annual statement of such insurer filed with the insurance department of the insurer's domiciliary state and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

3. Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or North Dakota Administrative Code sections 45-03-05-04 and 45-03-05-06.

ITEM 9. FORM C REQUIRED

A Form C, Summary of Registration Statement, must be prepared and filed with this Form B.

ITEM 10. SIGNATURE AND CERTIFICATION

~~SIGNATURES.~~

~~Signatures~~ Signature and certification ~~of the form~~ required as follows:

SIGNATURE

Pursuant to the requirements of ~~North Dakota Century Code section 26.1-10-12~~ Section 26.1-10-04 of the North Dakota Century Code, the registrant has caused this annual registration statement to be duly signed on its behalf in the City of _____, and State of _____ on the _____ day of _____, 19 ___.

(SEAL)

_____
(Name of registrant)

By: _____
(Name) (Title)

Attest:

_____
(Signature of officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that the undersigned has duly executed

the attached annual registration statement dated _____, 19 ___,
for and on behalf of _____; that the
(Name of company)
undersigned is the _____ of such company, and that
(Title of officer)
the undersigned has authority to execute and file such instrument. The deponent further says that deponent is familiar with such instrument and that the facts therein set forth are true to the best of deponent's knowledge, information, and belief.

(Signature) _____

(Type or print name beneath) _____

_____

FORM C
SUMMARY OF REGISTRATION STATEMENT

Filed with the Insurance Department of the State of _____

BY

_____
Name of Registrant

On Behalf of the Following Insurance Companies

Name Address

_____

_____

_____

_____

Date: _____, 19____

Name, title, address, and telephone number of individual to whom notices and correspondence concerning this statement should be addressed:

_____

_____

_____

_____

Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the commissioner, and shall include specific references to item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of ten percent or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where: an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the

ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 26.1-10-04 of the North Dakota Century Code, the registrant has caused this summary of registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19 ____.

(SEAL) _____

(Name of Applicant)

By: _____

(Name) (Title)

Attest:

_____

(Signature of officer)

_____

(Title)

CERTIFICATION

The undersigned deposes and says that the deponent has duly executed the attached summary of registration statement dated _____, 19 ____, for and on behalf of _____; that the deponent
(Name of company)
is the _____ of such company; and that the deponent is
(Title of officer)

authorized to execute and file such instrument. Deponent further says that deponent is familiar with such instrument and the contents thereof,

and that the facts therein set forth are true to the best of deponent's knowledge, information, and belief.

(Signature) _____

(Type or print name beneath) _____

FORM D
PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of _____

BY

_____
Name of Registrant

On Behalf of the Following Insurance Companies

Name Address

_____

_____

_____

_____

Date: _____, 19____

Name, title, address, and telephone number of individual to whom notices and correspondence concerning this statement should be addressed:

_____

_____

_____

_____

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

Furnish the following information for each of the parties to the transaction:

1. Name.

2. Home office address.

3. Principal executive office address.

4. The organizational structure, i.e. corporation, partnership, individual, trust, etc.

5. A description of the nature of the parties' business operations.

6. Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.

7. Where the transaction is with a nonaffiliate, the names of the affiliates which will receive, in whole or in substantial part, the proceeds of the transaction.

ITEM 2. DESCRIPTION OF THE TRANSACTION

Furnish the following information for each transaction for which notice is being given:

1. A statement of the nature of the transaction.

2. The proposed effective date of the transaction.

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES, OR INVESTMENTS

Furnish a brief description of the amount and source of funds, securities, property, or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements, and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost, and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit, or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee, or other arrangement, state the time period during which the investment, guarantee, or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees, or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit, or guarantee is less than: (a) in the case of nonlife insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders, or (b) in the case of life insurers, three percent of the

insurer's admitted assets, each as of the next preceding December thirty-first.

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NONAFFILIATE

If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of duns, securities, property, or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost, and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of nonlife insurers, the lesser of three percent of the insurer's admitted assets or twenty-five percent of surplus as regards policyholders or, with respect to life insurers, three percent of the insurer's admitted assets, each as of the next preceding December thirty-first.

ITEM 5. REINSURANCE

If the transaction is a reinsurance agreement or modification thereto, as described by Section 26.1-10-04(2)(6) of the North Dakota Century Code, furnish a description of the known or estimated amount of liability to be ceded or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and nonaffiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer's liabilities in connection with the reinsurance agreement or modification thereto is less than five percent of the insurer's surplus as regards policyholders, as of the next preceding December thirty-first.

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS, AND COST-SHARING ARRANGEMENTS

For management and service agreements, furnish:

1. A brief description of the managerial responsibilities or services to be performed.

2. A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

For cost-sharing arrangements, furnish:

1. A brief description of the purpose of the agreement.

2. A description of the period of time during which the agreement is to be in effect.

3. A brief description of each party's expenses or costs covered by the agreement.

4. A brief description of the accounting basis to be used in calculating each party's costs under the agreement.

ITEM 7. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Sections 26.1-10-04 and 26.1-10-05 of the North Dakota Century Code, _____ has caused this notice to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19 ____.

(SEAL) _____
(Name of Applicant)

By: _____
(Name) (Title)

Attest:

_____
(Signature of officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that the deponent has duly executed the attached notice dated _____, 19 ____, for and on behalf of _____; that the deponent is the _____ of
(Name of Applicant) (Title of officer)

such company and that the deponent is authorized to execute and file such instrument. Deponent further says that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of deponent's knowledge, information, and belief.

(Signature) _____

(Type or print name beneath) _____

STAFF COMMENT: Chapters 45-03-12, 45-03-13, 45-03-14, 45-03-15, and 45-03-16 contain all new material but are not underscored so as to improve readability.

CHAPTER 45-03-12
INVESTMENT, CAPITAL, AND SURPLUS REQUIREMENTS

45-03-12-01. Capital and surplus requirements. In the reasonable exercising of the commissioner's discretion, additional capital and surplus may be required based upon the type, volume, and nature of insurance business transacted.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-02, 26.1-06.1-01, 26.1-10-05

45-03-12-02. Investments. All companies doing business in the state shall have an investment portfolio which is diversified as to type and issue and which maintains liquidity.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-02, 26.1-05-19, 26.1-06.1-01, 26.1-10-06

45-03-12-03. Admitted assets. The authorized investments enumerated in North Dakota Century Code chapter 26.1-05 and other assets not prohibited under North Dakota Century Code chapter 26.1-05 nor required to be scheduled as nonadmitted assets in the annual statement, as prescribed by the commissioner, are considered admitted assets, if and to the extent the commissioner finds the asset to be an appropriate investment of policyholder obligation funds. All admitted assets must be valued in accordance with chapter 45-03-15.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02

Law Implemented: NDCC 26.1-02-02, 26.1-06.1-01, 26.1-10-05

CHAPTER 45-03-13
REGULATION OF AND STANDARDS FOR COMPANIES DEEMED TO BE IN HAZARDOUS FINANCIAL CONDITION

45-03-13-01. Standards. The following standards, either singly or a combination of two or more, may be considered by the commissioner to determine whether the continued operation of any insurer transacting an insurance business in this state might be deemed to be hazardous to the policyholders, creditors, or the general public. The commissioner may consider:

1. Adverse findings reported in financial condition and market conduct examination reports.

2. The national association of insurance commissioners insurance regulatory information system and its related reports.

3. The ratios of commission expense, general insurance expense, policy benefits, and reserve increases as to annual premium and net investment income which could lead to an impairment of capital and surplus.

4. The insurer's asset portfolio when viewed in light of current economic conditions is not of sufficient value, liquidity, or diversity to assure the company's ability to meet its outstanding obligations as they mature.

5. The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the company's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer.

6. The insurer's operating loss in the last twelve-month period or any shorter period of time, including, but not limited to, net capital gain or loss, change in nonadmitted assets, and cash dividends paid to shareholders, is greater than fifty percent of such insurer's remaining surplus as regards policyholders in excess of the minimum required.

7. Whether any affiliate, subsidiary, or reinsurer is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligation.

8. Contingent liabilities, pledges, or guaranties which either individually or collectively involve a total amount which in the opinion of the commissioner may affect the solvency of the insurer.

9. Whether any "controlling person" of an insurer is delinquent in the transmitting to, or payment of, net premiums to such insurer.

10. The age and collectibility of receivables.

11. Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of such insurer, fails to possess and demonstrate the competence, fitness, and reputation deemed necessary to serve the insurer in such position.

12. Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry.

13. Whether management of an insurer either has filed any false or misleading sworn financial statement, or has released false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer.

14. Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner.

15. Whether the company has experienced or will experience in the foreseeable future cash flow or liquidity problems, or both.

History: Effective January 1, 1992.
General Authority: NDCC 28-32
Law Implemented: NDCC 26.1-01-03.1, 26.1-05-04, 26.1-05-32, 26.1-06.1-01(3)(a), 26.1-06.1-11

45-03-13-02. Commissioner's authority.

1. For the purposes of making a determination of an insurer's financial condition under this chapter, the commissioner may:

   a. Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired, or otherwise subject to a delinquency proceeding.

b. Make appropriate adjustments to asset values attributable to investments in or transactions with parents, subsidiaries, or affiliates.

c. Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor.

d. Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve-month period.

2. If the commissioner determines that the continued operation of the insurer licensed to transact business in this state may be hazardous to the policyholders or the general public, then the commissioner may, upon his determination, issue an order requiring the insurer to:

a. Reduce the total amount of present and potential liability for policy benefits by reinsurance.

b. Reduce, suspend, or limit the volume of business being accepted or renewed.

c. Reduce general insurance and commission expenses by specified methods.

d. Increase the insurer's capital and surplus.

e. Suspend or limit the declaration and payment of dividend by an insurer to its stockholders or to its policyholders.

f. File reports in a form acceptable to the commissioner concerning the market value of an insurer's assets.

g. Limit or withdraw from certain investments or discontinue certain investment practices to the extent the commissioner deems necessary.

h. Document the adequacy of premium rates in relation to the risks insured.

i. File, in addition to regular annual statements, interim financial reports on the form adopted by the national association of insurance commissioners or on such format as promulgated by the commissioner.

If the insurer is a foreign insurer, the commissioner's order may be limited to the extent provided by statute.

3. Any insurer subject to an order under subsection 2 may request a hearing to review that order. The notice of hearing must be served upon the insurer pursuant to North Dakota Century Code chapter 28-32. The notice of hearing must state the time and place of hearing, and the conduct, condition, or ground upon which the commissioner based the order. Unless mutually agreed between the commissioner and the insurer, the hearing must occur not less than ten days nor more than forty-five days after notice is served and must be in the place to be designated by the commissioner. The commissioner shall hold all hearings under this subsection privately, unless the insurer requests a public hearing, in which case the hearing must be public.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-01-03.1, 26.1-05-04, 26.1-05-32, 26.1-06.1-01(3)(a), 26.1-06.1-11(1)

CHAPTER 45-03-14
ADMINISTRATIVE SUPERVISION MODEL

45-03-14-01. Definitions. As used in this chapter:

1. "Consent" means agreement to administrative supervision by the insurer.

2. "Exceeded its powers" means the following conditions:

   a. The insurer has refused to permit examination of its books, papers, accounts, records, or affairs by the commissioner, commissioner's deputies, employees, or duly commissioned examiners.

b. A domestic insurer has unlawfully removed from this state books, papers, accounts, or records necessary for an examination of the insurer.

c. The insurer has failed to promptly comply with the applicable financial reporting statutes or rules and departmental requests relating thereto.

d. The insurer has neglected or refused to observe an order of the commissioner to make good, within the time prescribed by law, any prohibited deficiency in its capital, capital stock, or surplus.

e. The insurer is continuing to transact insurance or write business after its license has been revoked or suspended by the commissioner.

f. The insurer, by contract or otherwise, has unlawfully or has in violation of an order of the commissioner or has without first having obtained written approval of the commissioner if approval is required by law.

(1) Totally reinsured its entire outstanding business; or

(2) Merged or consolidated substantially its entire property or business with another insurer.

g. The insurer engaged in any transaction inwhich it is not authorized to engage under the laws of this state.

h. The insurer refused to comply with a lawful order of the commissioner.

3. "Insurer" means and includes every person engaged as indemnitor, surety or contractor in the business of entering into contracts of insurance or of annuities as limited to any insurer doing business, or has transacted insurance in this state, and against whom claims arising from that transaction may exist now or in the future.

History: Effective January 1, 1992.
General Authority: NDCC 28-32
Law Implemented: NDCC 26.1-01-03.1, 26.1-05-04, 26.1-05-32, 26.1-06.1-01(3)(a), 26.1-06.1-11

45-03-14-02. Applicability. The provisions of this chapter apply to:

1. All domestic insurers.

2. Any other insurer doing business in this state whose state of domicile has asked the commissioner to apply the provisions of this chapter as regards such insurer.

History: Effective January 1, 1992.
General Authority: NDCC 28-32
Law Implemented: NDCC 26.1-01-03.1, 26.1-05-04, 26.1-05-32, 26.1-06.1-01(3)(a), 26.1-06.1-11

45-03-14-03. Notice to comply with written requirements of commissioner - Noncompliance - Administrative supervision.

1. An insurer may be subject to administrative supervision by the commissioner if upon examination or at any other time it appears in the commissioner's discretion that:

   a. The insurer's condition renders the continuance of its business hazardous to the public or to its insureds;

   b. The insurer has exceeded its powers granted under its certificate of authority and applicable law;

   c. The insurer has failed to comply with the applicable provisions of the insurance code;

   d. The business of the insurer is being conducted fraudulently; or

   e. The insurer gives its consent.

2. If the commissioner determines that the conditions set forth in subsection 1 exist, the commissioner shall:

   a. Notify the insurer of the commissioner's determination;

   b. Furnish to the insurer a written list of the requirements to abate this determination; and

   c. Notify the insurer that it is under the supervision of the commissioner and that the commissioner is applying and effectuating the provisions of the chapter. Such action by the commissioner is subject to review pursuant to applicable state administrative procedures under North Dakota Century Code chapter 28-32.

3. If placed under administrative supervision, the insurer shall have sixty days, or another period of time as designated by the commissioner, to comply with the requirements of the commissioner subject to the provisions of this chapter.

4. If it is determined after notice and hearing that the conditions giving rise to the supervision still exist at the

end of the supervision period specified above, the commissioner may extend such period.

5. If it is determined that none of the conditions giving rise to the supervision exist, the commissioner shall release the insurer from supervision.

History: Effective January 1, 1992.
General Authority: NDCC 28-32
Law Implemented: NDCC 26.1-01-03.1, 26.1-05-04, 26.1-05-32, 26.1-06.1-01(3)(a), 26.1-06.1-11

45-03-14-04. Confidentiality of certain proceedings and records.

1. Notwithstanding any other provision of law and except as set forth herein; proceedings, hearings, notices, correspondence, reports, records, and other information in the possession of the commissioner or the department relating to the supervision of any insurer are confidential except as provided herein.

2. The personnel of the department shall have access to these proceedings, hearings, notices, correspondence, reports, records, or information as permitted by the commissioner.

3. The commissioner may open the proceedings or hearings or disclose the notices, correspondence, reports, records, or information to a department, agency, or instrumentality of this or another state of the United States if the commissioner determines that the disclosure is necessary or proper for the enforcement of the laws of this or another state of the United States.

4. The commissioner may open the proceedings or hearings or make public the notices, correspondence, reports, records, or other information if the commissioner deems that it is in the best interest of the public or in the best interest of the insurer, its insureds, creditors, or the general public.

5. This section does not apply to hearings, notices, correspondence, reports, records, or other information obtained upon the appointment of a receiver for the insurer by a court of competent jurisdiction.

History: Effective January 1, 1992.
General Authority: NDCC 28-32
Law Implemented: NDCC 26.1-01-03.1, 26.1-05-04, 26.1-05-32, 26.1-06.1-01(3)(a), 26.1-06.1-11

45-03-14-05. Prohibited acts during period of supervision. During the period of supervision, the commissioner or the commissioner's designated appointee shall serve as the administrative supervisor. The

commissioner may provide that the insurer may not do any of the following things during the period of supervision, without the prior approval of commissioner or the commissioner's appointed supervisor:

1. Dispose of, convey, or encumber any of its assets or its business in force;

2. Withdraw any of its bank accounts;

3. Lend any of its funds;

4. Invest any of its funds;

5. Transfer any of its property;

6. Incur any debt, obligation, or liability;

7. Merge or consolidate with another company;

8. Approve new premiums or renew any policies;

9. Enter into any new reinsurance contract or treaty;

10. Terminate, surrender, forfeit, convert, or lapse any insurance policy, certificate, or contract, except for nonpayment of premiums due;

11. Release, pay, or refund premium deposits, accrued cash or loan values, unearned premiums, or other reserves on any insurance policy, certificate, or contract;

12. Make any material change in management; or

13. Increase salaries and benefits of officers or directors or the preferential payment of bonuses, dividends, or other payments deemed preferential.

History: Effective January 1, 1992.
General Authority: NDCC 28-32
Law Implemented: NDCC 26.1-01-03.1, 26.1-05-04, 26.1-05-32, 26.1-06.1-01(3)(a), 26.1-06.1-11

45-03-14-06. Review and stay of action. During the period of supervision the insurer may contest an action taken or proposed to be taken by the supervisor specifying the manner wherein the action being complained of would not result in improving the condition of the insurer. Denial of the insurer's request upon reconsideration entitles the insurer to request a proceeding under North Dakota Century Code chapter 28-32.

History: Effective January 1, 1992.
General Authority: NDCC 28-32

Law Implemented: NDCC 26.1-01-03.1, 26.1-05-04, 26.1-05-32, 26.1-06.1-01(3)(a), 26.1-06.1-11

45-03-14-07. Administrative election of proceedings. Nothing contained in this chapter precludes the commissioner from initiating judicial proceedings to place an insurer in conservation, rehabilitation, or liquidation proceedings or other delinquency proceedings, however designated under the laws of this state, regardless of whether the commissioner has previously initiated administrative supervision proceedings under this chapter against the insurer.

History: Effective January 1, 1992.
General Authority: NDCC 28-32
Law Implemented: NDCC 26.1-01-03.1, 26.1-05-04, 26.1-05-32, 26.1-06.1-01(3)(a), 26.1-06.1-11

45-03-14-08. Other laws - Conflicts - Meetings between the commissioner and the supervisor. Notwithstanding any other provision of law, the commissioner may meet with a supervisor appointed under this chapter and with the attorney or other representative of the supervisor, without the presence of any other person, at the time of any proceeding or during the pendency of any proceeding held under authority of this chapter to carry out the commissioner's duties under this chapter or for the supervisor to carry out the supervisor's duties under this chapter.

History: Effective January 1, 1992.
General Authority: NDCC 28-32
Law Implemented: NDCC 26.1-01-03.1, 26.1-05-04, 26.1-05-32, 26.1-06.1-01(3)(a), 26.1-06.1-11

45-03-14-09. Immunity. There is no liability on the part of, and no cause of action of any nature may arise against, the insurance commissioner or the department or its employees or agents for any action taken by them in the performance of their powers and duties under this chapter.

History: Effective January 1, 1992.
General Authority: NDCC 28-32
Law Implemented: NDCC 26.1-01-03.1, 26.1-05-04, 26.1-05-32, 26.1-06.1-01(3)(a), 26.1-06.1-11

CHAPTER 45-03-15
ACCOUNTING PRACTICES AND PROCEDURES

45-03-15-01. Accounting practices and procedures. Every insurance company doing business in this state shall file with the commissioner, pursuant to North Dakota Century Code section 26.1-03-07, the appropriate national association of insurance commissioners annual statement blank, prepared in accordance with the national association of insurance commissioners instructions handbook and following the accounting procedures and practices prescribed by the national association of insurance commissioners accounting practices and procedures manuals for property and casualty and life and health insurance.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-03-07, 26.1-03-11.1

45-03-15-02. Reporting of financial information. Every insurance company licensed to do business in this state shall transmit to the commissioner and to the national association of insurance commissioners its most recent financial statements compiled on a quarterly basis, within forty-five days following the calendar quarters ending March thirty-first, June thirtieth, and September thirtieth. The financial statements must be prepared and filed in the form prescribed by the commissioner and in accordance with the national association of insurance commissioners instructions handbook and following the accounting procedures and practices prescribed by the national association of insurance commissioners accounting practices and procedures manuals for property and casualty and life and health insurance. The commissioner may exempt any company or category or class of companies from the filing requirement.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-02-03, 26.1-03-07, 26.1-03-11.1

CHAPTER 45-03-16
VALUATION OF SECURITIES AND OTHER INVESTMENTS

45-03-16-01. Valuation of securities and other investments.

1. All securities and investments must be valued in accordance with published valuation standards of the national association of insurance commissioners including, but not limited to, the "accounting practices and procedure manuals" and publications by the valuation of securities office of the national association of insurance commissioners.

2. All investments of insurers authorized to do business in this state, for which no rule or method of valuation has been otherwise provided, must be valued in the discretion of the commissioner at their fair market value, appraised value, or at amounts determined by the commissioner as their fair market value. If any valuation of an investment by an insurer appears to be an unreasonable estimate of its true value, the commissioner has the authority to cause the investment to be appraised, and the appraised value must be substituted as the true value. The appraisal must be made by two disinterested and competent persons, one to be appointed by the commissioner and one to be appointed by the insurer. In the event these two persons fail to agree, they shall appoint a third disinterested and competent person, and the estimate of the value of the investment, as arrived at by these three persons, must be substituted as the true value.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-03-02, 26-1-03-07, 26.1-03-11.1, 26.1-05-19

45-04-11-01. Financial statement prohibitions.

1. No licensed life insurer shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with this department if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

   a. The primary effect of the reinsurance agreement is to transfer deficiency reserves or excess interest reserves to the books of the reinsurer for a "risk charge" and the agreement does not provide for mortality, morbidity, or surrender benefit participation by the reinsurer consistent with its participation in the deficiency or excess interest portion of the policies reinsured;

   b. The reserve credit taken by the ceding insurer is in excess of the actuarial reserve necessary, under the North Dakota insurance law or rules, including actuarial interpretations or standards adopted by the department, to support the policy obligations transferred under the reinsurance agreement;

   c. The reserve credit taken by the ceding insurer is greater than the underlying reserve of the ceding company supporting the policy obligations transferred under the reinsurance agreement;

   d. The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against

prior years' losses nor payment by the ceding insurer of an amount equal to prior years' losses upon voluntary termination of inforce reinsurance by that ceding insurer shall be considered such a reimbursement to the insurer for negative experience;

~~d.~~ e. The ceding insurer can be deprived of surplus at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the insurer for nonpayment of reinsurance premiums shall not be considered to be such a deprivation of surplus;

~~e.~~ f. The ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded; ~~or~~

~~f.~~ g. No cash payment is due from the reinsurer, throughout the lifetime of the reinsurance agreement, with all settlements prior to the termination date of the agreement made only in a "reinsurance account", and no funds in such account are available for the payment of claims~~.~~ ; or

h. The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income reasonably expected from the reinsured policies.

2. Notwithstanding subsection 1, a licensed life insurer may, with the prior approval of the commissioner, take such reserve credit as the commissioner may deem consistent with the insurance law or rules, including actuarial interpretations or standards adopted by the department.

History: Effective October 1, 1989; amended effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-05-04, 26.1-05-19, 26.1-05-32

STAFF COMMENT: Chapter 45-05-07 and chapter 45-05-08 contain all new material but are not underscored so as to improve readability.

CHAPTER 45-05-07
ADVISORY ORGANIZATION EXEMPTION - HIGHLY PROTECTED RISK MARKET

45-05-07-01. Definition - Highly protected risk market. "Highly protected risk market" consists of commercial property coverage written specifically for large, complex, and multistate commercial and industrial properties. Further, the "highly protected risk market" is characterized by large size, high value, diversity and loss control; and with policyholders who are sophisticated commercial insureds employing professional risk managers and insurance appraisers on staff.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-25-19

45-05-07-02. Exemption. The market commonly known as "highly protected risk market" is exempt from the filing restrictions limiting filings to prospective loss cost filings as found in North Dakota Century Code chapter 26.1-25 and an advisory organization may file fully developed rates on behalf of specific companies for this market.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-25-19

45-05-07-03. Definition - North Dakota automobile insurance plan. The North Dakota automobile insurance plan is an association of all insurance companies licensed to write automobile insurance in North Dakota and is the residual market mechanism for automobile liability insurance in North Dakota, through which applicants who are in good faith entitled to but unable to procure such insurance through ordinary means may obtain such insurance. This plan is managed and operated by the automobile insurance plan services office.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-25-19

45-05-07-04. Exemption. The automobile insurance plan services office is exempt from the filing restrictions limiting filings to prospective loss cost filings as found in North Dakota Century Code chapter 26.1-25 and as an advisory organization may file fully developed rates on behalf of the North Dakota automobile insurance plan.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-25-19

CHAPTER 45-05-08
BINDING INTERCOMPANY ARBITRATION

Section
45-05-08-01 Binding Intercompany Arbitration

45-05-08-01. Binding intercompany arbitration. The commissioner hereby appoints arbitration forums, inc., as the organization responsible for the arbitration and settlement of disputes between insurance companies under North Dakota Century Code section 26.1-41-17. Arbitration forums, inc., must file a procedures manual for approval with the commissioner. Upon filing and approval of such manual, all disputes between insurance companies writing no-fault insurance must be resolved by arbitration pursuant to the procedures set forth in said manual.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 26.1-41-17

STAFF COMMENT: Chapter 45-06-01.1 contains all new material but is not underscored so as to improve readability.

ARTICLE 45-06

ACCIDENT AND HEALTH INSURANCE

Chapter
45-06-01 Medicare Supplement Insurance Minimum Standards [Superseded]
45-06-01.1 Medicare Supplement Insurance Minimum Standards
45-06-02 Intercarrier Health Insurance Pool
45-06-03 Standard Health Insurance Proof of Loss Forms
45-06-04 Advertising Rules
45-06-05 Long-Term Care Insurance Model Regulation

CHAPTER 45-06-01
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

[Superseded by Chapter 45-06-01.1]

CHAPTER 45-06-01.1
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

Section
45-06-01.1-01 Applicability and Scope
45-06-01.1-02 Definitions

45-06-01.1-01. Applicability and scope.

1. Except as otherwise specifically provided in sections 45-06-01.1-05, 45-06-01.1-10, 45-06-01.1-11, and 45-06-01.1-19, this chapter applies to:

   a. All medicare supplement policies delivered or issued for delivery in this state on or after the effective date hereof; and

   b. All certificates issued under group medicare supplement policies which certificates have been delivered or issued for delivery in this state.

2. This chapter does not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

History: Effective January 1, 1992.

General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

45-06-01.1-02. Definitions. For purposes of this chapter:

1. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

2. "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

3. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

45-06-01.1-03. Policy definitions and terms. No policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

1. "Accident", "accidental injury", or "accidental means" must be defined to employ "result" language and may not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

   a. The definition may not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force".

   b. Such definition may provide that injuries do not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

2. "Benefit period" or "medicare benefit period" may not be defined more restrictively than as defined in the medicare program.

3. "Convalescent nursing home", "extended care facility", or "skilled nursing facility" may not be defined more restrictively than as defined in the medicare program.

4. "Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Such expenses may not include:

   a. Home office and overhead costs;

   b. Advertising costs;

   c. Commissions and other acquisition costs;

   d. Taxes;

   e. Capital costs;

   f. Administrative costs; and

   g. Claims processing costs.

5. "Hospital" may be defined in relation to its status, facilities, and available services or to reflect its accreditation by the joint commission on accreditation of hospitals, but not more restrictively than as defined in the medicare program.

6. "Medicare" must be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

7. "Medicare eligible expenses" means expenses of the kinds covered by medicare, to the extent recognized as reasonable and medically necessary by medicare.

8. "Physician" may not be defined more restrictively than as defined in the medicare program.

9. "Sickness" may not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers'

compensation, occupational disease, employer's liability, or similar law.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

45-06-01.1-04. Policy provisions.

1. Except for permitted preexisting condition clauses as described in subdivision a of subsection 1 of section 45-06-01.1-05 and subdivision a of subsection 1 of section 45-06-01.1-06, no policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of medicare.

2. No medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

3. No medicare supplement policy or certificate in force in the state may contain benefits which duplicate benefits provided by medicare.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-05. Minimum benefit standards for policies or certificates issued for delivery prior to January 1, 1992. No policy or certificate may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards:

1. General standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule:

   a. A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from

a physician within six months before the effective date of coverage.

b. A medicate supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A medicare supplement policy or certificate must provide that benefits designed to cover cost-sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

d. A "noncancelable", "guaranteed renewable", or "noncancelable and guaranteed renewable" medicare supplement policy may not:

(1) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(2) Be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

e. (1) Except as authorized by the commissioner of this state, an issuer may neither cancel nor nonrenew a medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(2) If a group medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in paragraph 4, the issuer must offer certificate holders an individual medicare supplement policy. The issuer must offer the certificate holder at least the following choices:

(a) An individual medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group medicare supplement policy; and

(b) An individual medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection 2 of section 45-06-01.1-06.

(3) If membership in a group is terminated, the issuer must:

(a) Offer the certificate holder such conversion opportunities as are described in paragraph 2; or

(b) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(4) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the succeeding issuer must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a medicare supplement policy or certificate must be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

2. Minimum benefit standards.

a. Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period.

b. Coverage for either all or none of the medicare part A inpatient hospital deductible amount.

c. Coverage of part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days.

d. Upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent of all medicare part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five days.

e. Coverage under medicare part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under part B.

f. Coverage for the coinsurance amount of medicare eligible expenses under part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the medicare part B deductible (one hundred dollars).

g. Effective January 1, 1990, coverage under medicare part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under part A, subject to the medicare deductible amount.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-06. Benefit standards for policies or certificates issued or delivered on or after January 1, 1992. The following standards are applicable to all medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards:

1. **General standards.** The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this rule:

   a. A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

   b. A medicare supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

   c. A medicare supplement policy or certificate must provide that benefits designed to cover cost-sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

d. No medicare supplement policy or certificate may provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

e. Each medicare supplement policy must be guaranteed renewable and:

(1) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual.

(2) The issurer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under paragraph 5 of subdivision e of subsection 1 of section 45-06-01.1-06, the issuer must offer certificate holders an individual medicare supplement policy which (at the option of the certificate holder):

(a) Provides for continuation of the benefits contained in the group policy; or

(b) Provides for such benefits as otherwise meets the requirements of this subsection.

(4) If an individual is a certificate holder in a group medicare supplement policy and the individual terminates membership in the group, the issuer must:

(a) Offer the certificate holder the conversion opportunity described in paragraph 3 of subdivision e of subsection 1 of section 45-06-01.1-06; or

(b) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(5) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the succeeding issuer must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a medicare supplement policy or certificate must be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

g. (1) A medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medicaid under title XIX of the Social Security Act [42 U.S.C. 1396, et seq.], but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within ninety days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificate holder that portion of the premium attributable to the period of medicaid eligibility, subject to adjustment for paid claims.

(2) If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within ninety days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(3) Reinstitution of such coverages:

(a) May not provide for any waiting period with respect to treatment of preexisting conditions;

(b) Must provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(c) Must provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

2. Standards for basic (core) benefits common to all benefit plans. Every issuer must make available a policy or certificate including only the following basic core package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu thereof:

   a. Coverage of part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period.

   b. Coverage of part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used.

   c. Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of the medicare part A eligible expenses for hospitalization paid at the diagnostic related group day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days.

   d. Coverage under medicare parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

   e. Coverage for the coinsurance amount of medicare eligible expenses under part B regardless of hospital confinement, subject to the medicare part B deductible.

3. Standards for additional benefits. The following additional benefits must be included in medicare supplement benefit plans "B" through "J" only as provided by section 45-06-01.1-07:

   a. Medicare part A deductible: Coverage for all of the medicare Part A inpatient hospital deductible amount per benefit period.

   b. Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare part A.

   c. Medicare part B deductible: Coverage for all of the medicare part B deductible amount per calendar year regardless of hospital confinement.

d. Eighty percent of the medicare part B excess charges: Coverage for eighty percent of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved part B charge.

e. One hundred percent of the medicare part B excess charges: Coverage for all of the difference between the actual medicare part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved part B charge.

f. Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by medicare.

g. Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by medicare.

h. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign county, which care would have been covered by medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

i. Preventive medical care benefit: Coverage for the following preventive health services:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph 2 and patient education to address preventive health care measures.

(2) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(a) Fecal occult blood test or digital rectal examination.

(b) Mammogram.

(c) Dipstick urinalysis for hematuria, bacteriuria, and proteinauria.

(d) Pure tone, air only, hearing screening test, administered or ordered by a physician.

(e) Serum cholesterol screening every five years.

(f) Thyroid function test.

(g) Diabetes screening.

(3) Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster every ten years.

(4) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement must be for the actual charges up to one hundred percent of the medicare-approved amount for each service, as if medicare were to cover the service as identified in American medical association current procedural terminology codes, to a maximum of one hundred twenty dollars annually under this benefit. This benefit may not include payment for any procedure covered by medicare.

j. At-home recovery benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(1) For purposes of this benefit, the following definitions apply:

(a) "Activities of daily living" includes, but is not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administred, and changing bandages or other dressings.

(b) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a

licensed referral agency or licensed nurses registry.

(c) "Home" means any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by medicare. A hospital or skilled nursing facility may not be considered the insured's place of residence.

(d) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a twenty-four-hour period of services provided by a care provider is one visit.

(2) Coverage requirements and limitations.

(a) At-home recovery services provided must be primarily services which assist in activities of daily living.

(b) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by medicare.

(c) Coverage is limited to:

(i) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of medicare-approved home health care visits under a medicare-approved home care plan of treatment.

(ii) The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

(iii) One thousand six hundred dollars per calendar year.

(iv) Seven visits in any one week.

(v) Care furnished on a visiting basis in the insured's home.

(vi) Services provided by a care provider as defined in this section.

(vii) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(viii) At-home recovery visits received during the period the insured is receiving medicare-approved home care services or no more than eight weeks after the service date of the last medicare approved home health care visit.

(3) Coverage is excluded for:

(a) Home care visits paid for by medicare or other government programs; and

(b) Care provided by family members, unpaid volunteers, or providers who are not care providers.

k. New or innovative benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost effective, and offered in a manner which is consistent with the goal of simplification of medicare supplement policies. New or innovative benefits should offer uniquely different or significantly expanded coverages.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-07. Standard medicare supplement benefit plans.

1. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in subsection 2 of section 45-06-01.1-06.

2. No groups, packages, or combinations of medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as may be permitted in subdivision k of subsection 3 of section 45-06-01.1-06 and in section 45-06-01.1-08.

3. Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans "A" through "J" listed in this section and conform to the definitions in section 45-06-01.1-02 and contained in North Dakota Century Code section 26.1-36.1-01. Each benefit must be structured in accordance with the format provided in subsections 2 and 3 of section 45-06-01.1-06 and list the benefits in the order shown in this section. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

4. An issuer may use, in addition to the benefit plan designations required in subsection 3, other designations to the extent permitted by law.

5. Makeup of benefit plans:

   a. Standardized medicare supplement benefit plan "A" is limited to the basic (core) benefits common to all benefit plans, as defined in subsection 2 of section 45-06-01.1-06.

   b. Standardized medicare supplement benefit plan "B" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible as defined in subdivision a of subsection 3 of section 45-06-01.1-06.

   c. Standardized medicare supplement benefit plan "C" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible and medically necessary emergency care in a foreign country as defined in subdivisions a, b, c, and h of subsection 3 of section 45-06-01.1-06, respectively.

   d. Standardized medicare supplement benefit plan "D" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in subdivisions a, b, h, and j of subsection 3 of section 45-06-01.1-06, respectively.

   e. Standardized medicare supplement benefit plan "E" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in subdivisions a,

b, h, and i of subsection 3 of section 45-06-01.1-06, respectively.

f. Standardized medicare supplement benefit plan "F" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, the skilled nursing facility care, the medicare part B deductible, one hundred percent of the medicare part B excess charges, and medically necessary emergency care in a foreign country as defined in subdivisions a, b, c, e, and h of subsection 3 of section 45-06-01.1-06, respectively.

g. Standardized medicare supplement benefit plan "G" may include only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, eighty percent of the medicare part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in subdivisions a, b, d, h, and j of subsection 3 of section 45-06-01.1-06, respectively.

h. Standardized medicare supplement benefit plan "H" may consist of only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined in subdivisions a, b, f, and h of subsection 3 of section 45-06-01.1-06, respectively.

i. Standardized medicare supplement benefit plan "I" may consist of only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, one hundred percent of the medicare part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in subdivisions a, b, e, f, h, and j of subsection 3 of section 45-06-01.1-06, respectively.

j. Standardized medicare supplement benefit plan "J" may consist of only the following: The core benefit as defined in subsection 2 of section 45-06-01.1-06, plus the medicare part A deductible, skilled nursing facility care, medicare part B deductible, one hundred percent of the medicare part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in subdivisions a, b, c, e, g, h, i, and j of subsection 3 of section 45-06-01.1-06, respectively.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-08. Medicare select policies and certificates.

1. a. This section applies to medicare select policies and certificates, as defined in this section.

   b. No policy or certificate may be advertised as a medicare select policy or certificate unless it meets the requirements of this section.

2. For the purposes of this section:

   a. "Complaint" means any dissatisfaction expressed by an individual concerning a medicare select issuer or its network providers.

   b. "Grievance" means dissatisfaction expressed in writing by an individual insured under a medicare select policy or certificate with the administration, claims practices, or provision of services concerning a medicare select issuer or its network providers.

   c. "Medicare select issuer" means an issuer offering, or seeking to offer, a medicare select policy or certificate.

   d. "Medicare select policy" or "medicare select certificate" mean respectively a medicare supplement policy or certificate that contains restricted network provisions.

   e. "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a medicare select policy.

   f. "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

   g. "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a medicare select policy.

3. The commissioner may authorize an issuer to offer a medicare select policy or certificate, pursuant to this section and section 4358 of the Omnibus Budget Reconciliation Act of 1990 [Pub. L. 101-508; 104 Stat. 1388; 42 U.S.C. 1395ss(t)(1)] if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

4. A medicare select issuer may not issue a medicare select policy or certificate in this state until its plan of operation has been approved by the commissioner.

5. A medicare select issuer must file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation must contain at least the following information:

   a. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

      (1) Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation, and after-hour care. The hours of operation and availability of after-hour care must reflect usual practice in the local area. Geographic availability must reflect the usual traveltimes within the community.

      (2) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

         (a) To deliver adequately all services that are subject to a restricted network provision; or

         (b) To make appropriate referrals.

      (3) There are written agreements with network providers describing specific responsibilities.

      (4) Emergency care is available twenty-four hours per day and seven days per week.

      (5) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a medicare select policy or certificate. This paragraph does not apply to supplemental charges or coinsurance amounts as stated in the medicare select policy or certificate.

   b. A statement or map providing a clear description of the service area.

   c. A description of the grievance procedure to be utilized.

   d. A description of the quality assurance program, including:

(1) The formal organizational structure;

(2) The written criteria for selection, retention, and removal of network providers; and

(3) The procedures for evaluating quality of care provided by network providers and the process to initiate corrective action when warranted.

e. A list and description, by specialty, of the network providers.

f. Copies of the written information proposed to be used by the issuer to comply with subsection 9.

g. Any other information requested by the commissioner.

6. a. A medicare select issuer must file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing such changes. Such changes must be considered approved by the commissioner after thirty days unless specifically disapproved.

b. An updated list of network providers must be filed with the commissioner at least quarterly.

7. A medicare select policy or certificate may not restrict payment for covered services provided by non-network providers if:

a. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition; and

b. It is not reasonable to obtain such services through a network provider.

8. A medicare select policy or certificate must provide payment for full coverage under the policy for covered services that are not available through network providers.

9. A medicare select issuer must make full and fair disclosure in writing of the provisions, restrictions, and limitations of the medicare select policy or certificate to each applicant. This disclosure must include at least the following:

a. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the medicare select policy or certificate with:

(1) Other medicare supplement policies or certificates offered by the issuer; and

(2) Other medicare select policies or certificates.

b. A description (including address, telephone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

c. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

d. A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

e. A description of limitations on referrals to restricted network providers and to other providers.

f. A description of the policyholder's rights to purchase any other medicare supplement policy or certificate otherwise offered by the issuer.

g. A description of the medicare select issuer's quality assurance program and grievance procedure.

10. Prior to the sale of a medicare select policy or certificate, a medicare select issuer must obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection 9 and that the applicant understands the restrictions of the medicare select policy or certificate.

11. A medicare select issuer must have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures must be aimed at mutual agreement for settlement and may include arbitration procedures.

a. The grievance procedure must be described in the policy and certificates and in the outline of coverage.

b. At the time the policy or certificate is issued, the issuer must provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

c. Grievances must be considered in a timely manner and shall be transmitted to appropriate decisionmakers who have authority to fully investigate the issue and take corrective action.

d. If a grievance is found to be valid, corrective action must be taken promptly.

e. All concerned parties must be notified about the results of a grievance.

f. The issuer must report no later than each March thirty-first to the commissioner regarding its grievance procedure. The report must be in a format prescribed by the commissioner and must contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

12. At the time of initial purchase, a medicare select issuer must make available to each applicant for a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate otherwise offered by the issuer.

13. a. At the request of an individual insured under a medicare select policy or certificate, a medicare select issuer must make available to the individual insured the opportunity to purchase a medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer must make such policies or certificates available without requiring evidence of insurability after the medicare supplement policy or certificate has been in force for six months.

b. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for medicare part B excess charges.

14. Medicare select policies and certificates must provide for continuation of coverage in the event the secretary of health and human services determines that medicare select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the medicare select program to be reauthorized under law or its substantial amendment.

a. Each medicare select issuer must make available to each individual insured under a medicare select policy or certificate the opportunity to purchase any medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer must make such policies and certificates available without requiring evidence of insurability.

b. For the purposes of this subsection, a medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the medicare select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the medicare part A deductible, coverage for prescription drugs, coverage for at-home recovery services, or coverage for part B excess charges.

15. A medicare select issuer must comply with reasonable requests for data made by state or federal agencies, including the United States department of health and human services, for the purpose of evaluating the medicare select program.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-09. Open enrollment.

1. No issuer may deny or condition the issuance or effectiveness of any medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six-month period beginning with the first month in which an individual (who is sixty-five years of age or older) first enrolled for benefits under medicare part B. Each medicare supplement policy and certificate currently available from an insurer must be made available to all applicants who qualify under this subsection without regard to age.

2. Subsection 1 may not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before it became effective.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-10. Standards for claims payment.

1. An issuer must comply with section 1882(c)(3) of the Social Security Act [as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203; 101 Stat. 1330; 42 U.S.C. 1395ss(c)(3))] by:

a. Accepting a notice from a medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

b. Notifying the participating physician or supplier and the beneficiary of the payment determination;

c. Paying the participating physician or supplier directly;

d. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a medicare carrier may be sent;

e. Paying user fees for claim notices that are transmitted electronically or otherwise; and

f. Providing to the secretary of health and human services, at least annually, a central mailing address to which all claims may be sent by medicare carriers.

2. Compliance with the requirements set forth in subsection 1 must be certified on the medicare supplement insurance experience reporting form.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-11. Loss ratio standards and refund or credit of premium.

1. Loss ratio standards:

a. A medicare supplement policy form or certificate form may not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(1) At least seventy-five percent of the aggregate amount of premiums earned in the case of group policies; or

(2) At least sixty-five percent of the aggregate amount of premiums earned in the case of individual policies,

calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

b. All filings of rates and rating schedules must demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions must also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

c. For purposes of applying subdivision a of subsection 1 of this section and subdivision c of subsection 3 of section 45-06-01.1-12 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) are deemed to be group policies.

2. Refund or credit calculation:

a. An issuer must collect and file with the commissioner by May thirty-first of each year the data contained in the reporting form contained in appendix A for each type in a standard medicare supplement benefit plan.

b. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation must be done on a statewide basis for each type in a standard medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year must be excluded.

c. A refund or credit may be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund must include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event may it be less than the average rate of interest for thirteen-week treasury notes. A refund or credit against premiums due must be made by September thirtieth following the experience year upon which the refund or credit is based.

3. Annual filing of premium rates. An issuer of medicare supplement policies and certificates issued before or after the effective date of this chapter must file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation must also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration must exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage must be demonstrated for policies or certificates in force less than three years.

   As soon as practicable, but prior to the effective date of enhancements in medicare benefits, every issuer of medicare supplement policies or certificates in this state must file with the commissioner, in accordance with the applicable filing procedures of this state:

   a. (1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment must accompany the filing.

      (2) An issuer must make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein may be made with respect to a policy at any time other than upon its renewal date or anniversary date.

      (3) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this section.

   b. Any appropriate riders, endorsements, or policy forms needed to accomplish the medicare supplement policy or certificate modifications necessary to eliminate benefit

duplications with medicare. Such riders, endorsements, or policy forms must provide a clear description of the medicare supplement benefits provided by the policy or certificate.

4. Public hearings. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this chapter if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing may be furnished in a manner deemed appropriate by the commissioner.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-04

45-06-01.1-12. Filing and approval of policies and certificates and premium rates.

1. An issuer may not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

2. An issuer may not use or change premium rates for a medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

3. a. Except as provided in subdivision b of this subsection, an issuer may not file for approval more than one form of a policy or certificate of each type for each standard medicare supplement benefit plan.

   b. An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard medicare supplement benefit plan, one for each of the following cases:

      (1) The inclusion of new or innovative benefits.

      (2) The addition of either direct response or agent marketing methods.

(3) The addition of either guaranteed issue or underwritten coverage.

(4) The offering of coverage to individuals eligible for medicare by reason of disability.

c. For the purposes of this section, a "type" means an individual policy, a group policy, an individual medicare select policy, or a group medicare select policy.

4. a. Except as provided in paragraph 1, an issuer must continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form may not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

(1) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer may no longer offer for sale the policy form or certificate form in this state.

(2) An issuer that discontinues the availability of a policy form or certificate form pursuant to paragraph 1 may not file for approval a new policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

b. The sale or other transfer of medicare supplement business to another issuer is considered a discontinuance for the purposes of this subsection.

c. A change in the rating structure or methodology is considered a discontinuance under subdivision a unless the issuer complies with the following requirements.

(1) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(2) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

5. a. Except as provided in subdivision b, the experience of all policy forms or certificate forms of the same type in a standard medicare supplement benefit plan must be combined for purposes of the refund or credit calculation prescribed in section 45-06-01.1-11.

   b. Forms assumed under an assumption reinsurance agreement may not be combined with the experience of other forms for purposes of the refund or credit calculation.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-13. Permitted compensation arrangements.

1. An issuer or other entity must provide level commissions or other compensation to an agent or other representative for the sale of a medicare supplement policy or certificate for the year of issuance and no fewer than five renewal years.

2. No issuer or other entity may provide compensation to its agents or other producers and no agent or producer may receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

3. For purposes of this section, "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including, but not limited to, bonuses, gifts, prizes, awards, and finders fees.

4. This section does not apply to an issuer or other entity which provides annual commission or other compensation to an agent or other representative for the sale of a medicare supplement insurance policy or certificate of twenty-five dollars or less.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2)
Law Implemented: NDCC 26.1-36.1-03

45-06-01.1-14. Required disclosure provisions.

1. General rules.

   a. Medicare supplement policies and certificates must include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. Such provision must be appropriately captioned and must appear on the first page of the policy, and must include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

   b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of medicare benefits, all riders or endorsements added to a medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy must require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge must be set forth in the policy.

   c. Medicare supplement policies or certificates may not provide for the payment of benefits based on standards described as "usual and customary", "reasonable and customary", or words of similar import.

   d. If a medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "preexisting condition limitations".

   e. Medicare supplement policies and certificates must have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder has the right to return the policy or certificate within thirty days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

f. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to persons eligible for medicare by reason of age must provide to such applicants a medicare supplement buyer's guide in the form developed jointly by the national association of insurance commissioners and the health care financing administration and in a type size no smaller than twelve-point type. Delivery of the buyer's guide must be made whether or not such policies or certificates are advertised, solicited, or issued as medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the buyer's guide must be made to the applicant at the time of application and acknowledgement of receipt of the buyer's guide must be obtained by the insurer. Direct response issuers must deliver the buyer's guide to the applicant upon request but not later than at the time the policy is delivered.

2. Notice requirements.

a. As soon as practicable, but no later than thirty days prior to the annual effective date of any medicare benefit changes, an issuer must notify its policyholders and certificate holders of modifications it has made to medicare supplement insurance policies or certificates in a format acceptable to the commissioner. Such notice must:

(1) Include a description of revisions to the medicare program and a description of each modification made to the coverage provided under the medicare supplement policy or certificate; and

(2) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in medicare.

b. The notice of benefit modifications and any premium adjustments must be in outline form and in clear and simple terms so as to facilitate comprehension.

c. Such notices may not contain or be accompanied by any solicitation.

3. Outline of coverage requirements for medicare supplement policies.

a. Issuers must provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response

policies, must obtain an acknowledgement of receipt of such outline from the applicant; and

b. If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

c. The outline of coverage provided to applicants pursuant to this section must consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must be in the language and format prescribed below in no less than twelve-point type. All plans "A" through "J" must be shown on the cover page, and the plans that are offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or immediately following the cover page and must be prominently displayed. The premium and mode must be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must be illustrated.

d. The following items must be included in the outline of coverage in the order prescribed below:

[COMPANY NAME]

Outline of Medicare Supplement Coverage—Cover Page:
Benefit Plan(s) _____ [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A." Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (100%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)
				Preventive Care					Preventive Care

PREMIUM INFORMATION

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this state. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

[for agents:]
Neither [insert company's name] nor its agents are connected with medicare.

[for direct response:]
[insert company's name] is not connected with medicare.

This outline of coverage does not give all the details of medicare coverage. Contact your local Social Security Office or consult "The medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to subsection 4 of section 45-06-01.1-07 of this chapter.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$ 0	$628 (Part A Deductible)
61st thru 90th day	All but $157 a day	$ 157 a day	$ 0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$ 314 a day	$ 0
-Once lifetime reserve days are used:			
-Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
-Beyond the Additional 365 days	$ 0	$ 0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $78.50 a day	$ 0	Up to $78.50 a day
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$ 0	Balance

PLAN A

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
Part B Excess Charges(Above Medicare Approved Amounts)	$ 0	$ 0	All Costs
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0

PLAN B

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$ 0
61st thru 90th day	All but $157 a day	$ 157 a day	$ 0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$ 314 a day	$ 0
-Once lifetime reserve days are used:			
-Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
-Beyond the Additional 365 days	$ 0	$ 0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $78.50 a day	$ 0	Up to $78.50 a day
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$ 0	Balance

PLAN B

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
Part B Excess Charges(Above Medicare Approved Amounts)	$ 0	$ 0	All Costs
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0

PLAN C

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$ 0
61st thru 90th day	All but $157 a day	$ 157 a day	$ 0
91st day and after			
-While using 60 lifetime reserve days	All but $314 a day	$ 314 a day	$ 0
-Once lifetime reserve days are used:			
-Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
-Beyond the Additional 365 days	$ 0	$ 0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out patient drugs and inpatient respite care	$ 0	Balance

PLAN C

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare Approved Amounts	80	20%	$ 0
Part B Excess Charges(Above Medicare Approved Amounts)	$ 0	$ 0	All Costs
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare Approved Amounts*	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare Approved Amounts	80%	20%	$ 0

PLAN C

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary emergency care services beginning duringthe first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $ 50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$ 0
61st thru 90th day	All but $157 a day	$ 157 a day	$ 0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$ 314 a day	$ 0
-Once lifetime reserve days are used:			
-Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
-Beyond the Additional 365 days	$ 0	$ 0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$ 0	Balance

PLAN D

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
Part B Excess Charges(Above Medicare Approved Amounts)	$ 0	$ 0	All Costs
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0

PLAN D

MEDICARE (PARTS A & B) - (CONTINUED)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
		PARTS A & B (cont'd.)	
HOME HEALTH CARE - (cont'd)			
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$ 0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$ 0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar year maximum	$ 0	$ 1,600	
		OTHER BENEFITS - NOT COVERED BY MEDICARE	
FOREIGN TRAVEL-NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $ 50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$ 0
61st thru 90th day	All but $157 a day	$ 157 a day	$ 0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$ 314 a day	$ 0
-Once lifetime reserve days are used:			
-Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
-Beyond the Additional 365 days	$ 0	$ 0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$ 0	Balance

PLAN E

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$ 0	$ 100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
Part B Excess Charges(Above Medicare Approved Amounts)	$ 0	$ 0	All Costs
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
	PARTS A & B		
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0

PLAN E

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $ 50,000	20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$ 0	$ 120	$ 0
Additional charges	$ 0	$ 0	All Costs

PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$ 0
61st thru 90th day	All but $157 a day	$ 157 a day	$ 0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$ 314 a day	$ 0
-Once lifetime reserve days are used:			
-Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
-Beyond the Additional 365 days	$ 0	$ 0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$ 0	Balance

PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$ 0
Remainder of Medicare Approved Amounts	80%	20%	$ 0
Part B Excess Charges(Above Medicare Approved Amounts)	$ 0	100%	$ 0
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare Approved Amounts*	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare Approved Amounts	80%	20%	$ 0

PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $ 50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$ 0
61st thru 90th day	All but $157 a day	$ 157 a day	$ 0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$ 314 a day	$ 0
-Once lifetime reserve days are used:			
-Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
-Beyond the Additional 365 days	$ 0	$ 0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$ 0	Balance

PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
Part B Excess Charges(Above Medicare Approved Amounts)	$ 0	80%	20%
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
	PARTS A & B		
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0

PLAN G

MEDICARE (PARTS A & B) - (CONTINUED)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
	PARTS A & B (cont'd.)		
HOME HEALTH CARE (cont'd)			
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$ 0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$ 0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar year maximum	$ 0	$ 1,600	
	OTHER BENEFITS		
FOREIGN TRAVEL-NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $ 50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$ 0
61st thru 90th day	All but $157 a day	$ 157 a day	$ 0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$ 314 a day	$ 0
-Once lifetime reserve days are used:			
-Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
-Beyond the Additional 365 days	$ 0	$ 0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$ 0	Balance

PLAN H

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
Part B Excess Charges(Above Medicare Approved Amounts)	$ 0	$ 0	All Costs
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
	PARTS A & B		
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0

PLAN H

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$ 250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $ 50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS-NOT COVERED BY MEDICARE			
First $250 each calendar year	$ 0	$ 0	$ 250
Next $2,500 each calendar year	$ 0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$ 0	$ 0	All Costs

PLAN I

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$ 0
61st thru 90th day	All but $157 a day	$ 157 a day	$ 0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$ 314 a day	$ 0
-Once lifetime reserve days are used:			
-Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
-Beyond the Additional 365 days	$ 0	$ 0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$ 0	Balance

PLAN I

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
Part B Excess Charges (Above Medicare Approved Amounts)	$ 0	100%	$ 0
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$ 0	$ 0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$ 0

PLAN I

MEDICARE (PARTS A & B) - (CONTINUED)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
	PARTS A & B (cont'd.)		
HOME HEALTH CARE (cont'd)			
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			Balance
- Benefit for each visit	$ 0	Actual Charges to $40 a visit	
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$ 0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar year maximum	$ 0	$ 1,600	
	OTHER BENEFITS		
FOREIGN TRAVEL-NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges*	$ 0	80% to a lifetime maximum benefit of $ 50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS-NOT COVERED BY MEDICARE			
First $250 each calendar year	$ 0	$ 0	$ 250
Next $2,500 each calendar year	$ 0	50% - $1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$ 0	$ 0	All Costs

PLAN J

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$ 0
61st thru 90th day	All but $157 a day	$157 a day	$ 0
91st day and after:			
-While using 60 lifetime reserve days	All but $314 a day	$314 a day	$ 0
-Once lifetime reserve days are used:			
-Additional 365 days	$ 0	100% of Medicare Eligible Expenses	$ 0
-Beyond the Additional 365 days	$ 0	$ 0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$ 0	$ 0
21st thru 100th day	All but $78.50 a day	Up to $78.50 a day	$ 0
101st day and after	$ 0	$ 0	All costs
BLOOD			
First 3 pints	$ 0	3 pints	$ 0
Additional amounts	100%	$ 0	$ 0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$ 0	Balance

PLAN J

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare Approved Amounts	80%	20%	$ 0
Part B Excess Charges(Above Medicare Approved Amounts)	$ 0	100%	$ 0
BLOOD			
First 3 pints	$ 0	All Costs	$ 0
Next $100 of Medicare Approved Amounts*	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare Approved Amounts	80%	20%	$ 0
CLINICAL LABORATORY SERVICES-BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$ 0	$ 0
	PARTS A & B		
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	$ 0	$ 0
-Durable medical equipment			
First $100 of Medicare Approved Amounts*	$ 0	$100 (Part B Deductible)	$ 0
Remainder of Medicare Approved Amounts	80%	20%	$ 0

PLAN J

MEDICARE (PARTS A & B) - (CONTINUED)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
	PARTS A & B (cont'd.)		
HOME HEALTH CARE (cont'd)			
AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	$ 0	Actual Charges to $40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$ 0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar year maximum	$ 0	$ 1,600	
	OTHER BENEFITS		
FOREIGN TRAVEL-NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$ 0	$ 0	$250
Remainder of Charges	$ 0	80% to a lifetime maximum benefit of $ 50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS-NOT COVERED BY MEDICARE			
First $250 each calendar year	$ 0	$ 0	$ 250
Next $6,000 each calendar year	$ 0	50% - $3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$ 0	$ 0	All Costs

PLAN J

OTHER BENEFITS (cont'd.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$ 0	$ 120	$ 0
Additional charges	$ 0	$ 0	All Costs

4. Notice regarding policies or certificates which are not medicare supplement policies. Any accident and sickness insurance policy or certificate, other than a medicare supplement policy; or a policy issued pursuant to a contract under section 1876 or section 1833 of the Social Security Act [42 U.S.C. 1395 et seq.], disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or other policy identified in subsection 2 of section 45-06-01.1-01, issued for delivery in this state to persons eligible for medicare by reason of age must notify insureds under the policy that the policy is not a medicare supplement policy or certificate. Such notice must either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. Such notice must be in no less than twelve-point type and must contain the following language:

   "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-03, 26.1-36.1-05
Law Implemented: NDCC 26.1-36.1-05

45-06-01.1-15. Requirements for application forms and replacement coverage.

1. Application forms must include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another medicare supplement or other health insurance policy or certificate in force or whether a medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

   [Statements]

   1. You do not need more than one Medicare supplement policy.

   2. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

   3. The benefits and premiums under your Medicare supplement policy will be suspended during your

entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

4. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

[Questions]

To the best of your knowledge,

1. Do you have another Medicare supplement policy or certificate in force (including health care service contract, health maintenance organization contract)?

   a. If so, with which company?

2. Do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate?

   a. If so, with which company?

   b. What kind of policy?

3. If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy [certificate]?

4. Are you covered by Medicaid?

2. Agents shall list any other health insurance policies they have to the applicant.

   a. List policies sold which are still in force.

   b. List policies sold in the past five years which are no longer in force.

3. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, must be returned to the applicant by the insurer upon delivery of the policy.

4. Upon determining that a sale will involve replacement of medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, must furnish the applicant, prior to issuance or delivery of the medicare supplement policy or certificate, a notice regarding replacement of

medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, must be provided to the applicant and an additional signed copy must be retained by the issuer. A direct response issuer must deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of medicare supplement coverage.

5. The notice required by subsection 4 for an issuer must be provided in no less than ten-point type in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

____ Additional benefits.
____ No change in benefits, but lower premiums.
____ Fewer benefits and lower premiums.
____ Other. (please specify)

_____
_____
_____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods,

elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____

(Applicant's Signature)

_____

(Date)

*Signature not required for direct response sales.

6. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02, 26.1-36.1-05

45-06-01.1-16. Filing requirements for advertising. An issuer must provide a copy of any medicare supplement advertisement intended for use in this state whether through written, radio, or television

medium to the commissioner of insurance of this state for review or approval by the commissioner to the extent it may be required under state law.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-07

45-06-01.1-17. Standards for marketing.

1. An issuer, directly or through its producers, must:

   a. Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

   b. Establish marketing procedures to assure excessive insurance is not sold or issued.

   c. Display prominently by type, stamp, or other appropriate means on the first page of the policy the following:

      "Notice to buyer: This policy may not cover all of your medical expenses."

   d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

   e. Establish auditable procedures for verifying compliance with this subsection.

2. In addition to the practices prohibited in North Dakota Century Code chapter 26.1-04, the following acts and practices are prohibited:

   a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

   b. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

c. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

3. The terms "medicare supplement", "medigap", "medicare wraparound", and words of similar import may not be used unless the policy is issued in compliance with this chapter.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-18. Appropriateness of recommended purchase and excessive insurance.

1. In recommending the purchase or replacement of any medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

2. Any sale of medicare supplement coverage that will provide an individual more than one medicare supplement policy or certificate is prohibited.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-19. Reporting of multiple policies.

1. On or before March first of each year, an issuer must report the following information for every individual resident of this state for which the issuer has in force more than one medicare supplement policy or certificate:

   a. Policy and certificate number.

   b. Date of issuance.

2. The items set forth above must be grouped by individual policyholder.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-20. Prohibition against preexisting conditions, waiting periods, elimination periods, and probationary periods in replacement policies or certificates.

1. If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate, the replacing issuer must waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new medicare supplement policy or certificate to the extent such time was spent under the original policy.

2. If a medicare supplement policy or certificate replaces another medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy may not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-02(1)(2), 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1-02

45-06-01.1-21. Separability. If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances may not be affected thereby.

History: Effective January 1, 1992.
General Authority: NDCC 26.1-36.1-03
Law Implemented: NDCC 26.1-36.1

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM

FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w)_____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____

Person Completing This Exhibit _____

Title _____ Telephone Number_____

line		(a) Earned Premium (x)	(b) Incurred Claims(y)
1	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues (z)		
	c. Net (for reporting purposes = 1a - 1b)		
2	Past Years' Experience (All Policy Years)		
3	Total Experience (Net Current Year + Past Years' Experience)		
4	Refunds last year (Excluding Interest)		
5	Previous Since Inception (Excluding Interest)		
6	Refunds Since Inception (Excluding Interest)		
7	Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)		
8	Experienced Ratio Since Inception		

Total Actual Incurred Claims (line 3, col b) = Ratio 2

Tot. Earned Prem.(line 3, col a) - Refunds Since Inception(line 6)

9 Life Years Exposed Since Inception _____

If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10 Tolerance Permitted (obtained from credibility table) _____

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w)_____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number_____

11 Adjustment to Incurred Claims for Credibility

Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the benchmark ratio, then proceed.

12 Adjusted Incurred Claims =

[Tot. Earned Premiums(line 3, col a)-Refunds Since Inception(line 6)]
X Ratio 3(line 11)

13 Refund = Total Earned Premiums (line 3, col a) -
Refunds Since Inception (line 6) -

Adjusted Incurred Claims (line 12)

Benchmark Ratio (Ratio 1)

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10.000 +	0.0%
5.000 - 9.999	5.0%
2.500 - 4.999	7.5%
1.000 - 2.499	10.0%
500 - 999	15.0%

If less than 500, no credibility.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w)_____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number_____

(w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
(x) Includes modal loadings and fees charged.
(y) Excludes Active Life Reserves.
(z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title

_____
Date

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (p)_____
FOR THE STATE OF _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number_____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: (l + n) / (k + m):

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (p)_____
FOR THE STATE OF _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number_____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.4
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: (l + n) / (k + m):

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

APPENDIX B

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

TITLE 48

Board of Animal Health

JANUARY 1992

ARTICLE 48-08

LICENSED MONITORED FEEDLOTS

[Repealed effective January 1, 1992]

TITLE 54

Nursing, Board of

54-02-01-05. Examination results. Examination results will be reported by mail to individual candidates and recorded on the candidate's permanent record in the board office. The examination results for the successful candidate who has completed the nursing education program will include the number of the permanent license that shall be issued to the candidate and a notice that these results constitute permission to continue in the practice of nursing until the permanent license has been issued. Candidates who have not completed the nursing education program will receive the examination results but will not be ~~authorized to practice~~ issued a permanent license number until all requirements for license by examination have been met ~~and the permanent license has been issued~~.

History: Amended effective November 1, 1979; October 1, 1989; December 1, 1991.
General Authority: NDCC 43-12.1-08(18)
Law Implemented: NDCC 43-12.1-10

54-02-01-13. Authorization to practice nursing. Authorization to practice nursing between the dates of ~~graduation~~ program completion and notification of results of the licensing examination will be issued to individuals accepted as candidates for the first licensing examination ~~after program completion~~ for which the candidate is eligible.

History: Effective October 1, 1989; amended effective December 1, 1991.
General Authority: NDCC 43-12.1-08(18)
Law Implemented: NDCC 43-12.1-10

54-02-08-03. Renewal.

1. A temporary practical nurse license may be renewed for ~~two~~ four consecutive calendar years if the licensee meets the following requirements:

   a. Submit a completed renewal application.

   b. Pay the calendar year renewal fee of twenty-five dollars.

   c. Provide the board with proof of enrollment and coursework in a board-approved nursing education program.

2. A temporary registered nurse license may be renewed for four consecutive calendar years if the licensee meets the following requirements:

   a. Submit a completed renewal application.

   b. Pay the calendar year renewal fee of thirty dollars.

   c. Provide the board with proof of enrollment and coursework in a board-approved nursing education program.

3. Nonrenewal of a temporary license because of failure ~~to complete the educational requirements in the allotted time or failure~~ of the applicant to apply for renewal shall be communicated to all health care agencies in North Dakota.

4. A petition for extension of renewal of a temporary license after the four consecutive years of renewal may be considered by the board. The licensee is responsible for submitting sufficient information to the board regarding progression in the educational program for determination if an extension of renewal eligibility is to be allowed.

History: Effective October 1, 1989; amended effective November 1, 1990; December 1, 1991.
General Authority: NDCC 43-12.1-08(18)
Law Implemented: NDCC 43-12.1-08(19)

54-03.1-01-01. Nursing programs approved prior to January 1, 1987. ~~Nursing programs approved by the board prior to January 1, 1987, who plan to seek board approval under article 54-03.1 shall:~~

~~1. Maintain education standards as prescribed by article 54-03 for those students attending classes on or before January 1, 1987;~~

~~2. Submit a written report of plans for program modifications necessary to comply with article 54-03.1 to the board before January 1, 1987; and~~

~~3. Receive board approval as outlined in section 54-03.1-02-05 prior to the admission of any students after January 1, 1987.~~ Repealed effective December 1, 1991.

History: ~~Effective March 1, 1986.~~
General Authority: ~~NDCC 43-12.1-08~~
Law Implemented: ~~NDCC 43-12.1-08(6)(7)(8)~~

54-03.1-01-02. Waiver of hearing. ~~Requirements for a hearing as prescribed in section 54-03-02-01 may be waived for any nursing program that has complied with section 54-03.1-01-01.~~ Repealed effective December 1, 1991.

History: ~~Effective March 1, 1986.~~
General Authority: ~~NDCC 43-12.1-08~~
Law Implemented: ~~NDCC 43-12.1-08(6)~~

54-03.1-01-03. Termination of programs approved under article 54-03. ~~Schools that have a nursing education program approved by the board under article 54-03 and will be terminating the nursing program shall meet the requirements of chapter 54-03-05.~~ Repealed effective December 1, 1991.

History: ~~Effective March 1, 1986.~~
General Authority: ~~NDCC 43-12.1-08~~
Law Implemented: ~~NDCC 43-12.1-08(8)~~

54-03.1-01-04. Candidate eligibility for licensing examination. ~~Graduates of nursing programs approved under article 54-03 shall be eligible for admission to the licensing examination as long as the enrollment and class attendance in the nursing program was on or before January 1, 1987.~~ Repealed effective December 1, 1991.

History: ~~Effective March 1, 1986.~~
General Authority: ~~NDCC 43-12.1-08~~
Law Implemented: ~~NDCC 43-12.1-10~~

54-03.1-11-01. Continuing compliance. The nursing education programs must submit a biennial report and shall be surveyed by the board at least every two years. ~~The board at its discretion may survey a nursing program more often.~~ If a program is accredited by a national nursing accrediting body, the board may acknowledge that the program meets board rules if the program submits a copy of the self-study report and evidence of accreditation. The two year requirement will then be waived and the program will be required to submit a board report and have an onsite visit by board representatives midway through the national accrediting period. The board may survey a program at any time at its discretion.

History: Effective January 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(6)

54-03.1-11-02. Certificate of approval. A certificate of approval shall be issued by the board ~~for a maximum of two years~~ to nursing education programs which meet board rules.

History: Effective January 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 43-12.1-08
Law Implemented: NDCC 43-12.1-08(6)

TITLE 60

Pesticide Control Board

NOVEMBER 1991

60-03-01-05. Certification - Commercial applicators, dealers, private applicators.

1. Categories of certification.

   a. Agricultural pest control (plant and animal). This category includes commercial applicators using restricted use pesticides in production of agricultural crops including cereal grain, feed grains, soybeans, forages, large and small seeded legumes, small fruits, tree fruits, nuts, and vegetables, as well as application to grasslands and noncrop lands. This also includes the use of restricted use pesticides on animals, beef cattle, dairy cattle, swine, sheep, horses, goats, poultry, and other livestock, and also to places on or in which animals are confined.

   b. Seed treatment. This category includes commercial applicators using restricted use pesticides on agricultural crop seeds, other seeds, and vegetative seed stocks.

   c. Fumigation. This category includes applicators using restricted use fumigants for controlling pests in stored and transported agricultural crops, grain milling equipment, and storage facilities. (Effective April 1, 1991, private applicators.)

   d. Ornamental and turf pest control. This category includes commercial applicators using restricted use pesticides to control pests in the production and maintenance of ornamental trees, shrubs, flowers, and turf.

e. Greenhouse. This category includes commercial applicators using restricted use pesticides to control pests in a greenhouse.

f. Right of way. This category includes commercial applicators using restricted use pesticides to control pests in the maintenance of public roads, electric powerlines, pipelines, railways, right of ways, parking lots, or other similar areas.

g. Public health pest control. This category includes state, federal, or other government employees, or applicators working under government contract, using restricted use pesticides in public health programs for the management and control of pests having medical and public health impacts.

h. Research and demonstration pest control. This category is for those individuals who demonstrate or apply restricted use pesticides for education and research or education or research. These would include county agents, extension specialists, state, federal, and commercial employees, plus other persons conducting research or demonstrating the proper application of restricted use pesticides.

i. Home, industrial, and institutional pest control. This category includes commercial applicators using restricted use pesticides in, on, or around food handling establishments, human dwellings, public or private institutions, warehouses, grain elevators, and any other structures or adjacent area, for the control of pests.

j. Wood preservatives. This category includes commercial applicators who apply and treat with restricted use wood preservatives to preserve and protect wood, posts, and various lumber products from pests.

k. Vertebrate. This category includes commercial applicators who use restricted use pesticides for the control of certain pest vertebrate, such as rodents, certain predators, and bats.

l. Other. This is reserved for any future categories that may be required by the United States environmental protection agency or become necessary by order of the pesticide control board.

2. Commercial applicators and dealers.

a. A commercial applicator or dealer, or commercial applicator and dealer certificate shall be issued in accordance with North Dakota Century Code section 4-35-09 or 4-35-12 or sections 4-35-09 and 4-35-12 respectively,

only to those persons who successfully complete the certification examination established by the board, and who pay the certification fee.

b. The board shall establish a certification examination which shall be administered by any North Dakota state university extension designate in accordance with North Dakota Century Code section 4-35-09 or 4-35-12 or sections 4-35-09 and 4-35-12. The examination shall be given by the North Dakota state university extension designate only to those persons who:

(1) Are eighteen years of age or older; and

(2) Complete a certificate application in such form as the board shall require.

c. Commercial applicator's or dealer or commercial applicator and dealer certificates shall expire on April first following the third anniversary of the year of certification or recertification. Every commercially certified person shall be recertified by an approved seminar or an examination at least every third year.

d. Any person who fails an examination may retake such examination after three or more days.

e. All commercial applicators must be certified in the proper category of application.

f. All dealers must be certified in the category of the labels' intended target site.

g. Situations where the pesticide is labeled for more than one of the certification target sites, the dealer only needs to be certified in one of the categories.

3. Private applicators.

a. A private applicator certification shall be issued in accordance with North Dakota Century Code section 4-35-14 only to those persons who:

(1) Are eighteen years of age or older; and

(2) Demonstrate competence in the application of pesticides as provided in subdivisions b, c, d, and e.

b. Persons purchasing, storing, or applying restricted use grain fumigants must be commercially ~~certified in the fumigation category. (Effective April 1, 1991.)~~ trained and must pass a fumigation exam. At the option of the

applicant upon successfully passing the exam, the certificate issued will be for either private or commercial application of restricted use fumigants. The fee for the private and commercial certification will be set by the North Dakota state university extension service.

c. Competence to apply restricted use pesticides shall be demonstrated by a showing of any one of the following to the North Dakota state university extension designate in the applicant's area:

(1) Attendance at an approved educational seminar, signing of a certificate of attendance, and passing an examination.

(2) Completion of a course of self-instruction and passing an examination at the North Dakota state university extension designate's office in the applicant's area.

(3) Completion of a take-home self-study program and passing an examination.

(4) Passing the dealer or commercial applicator certification examination and submitting the passing grade to the appropriate North Dakota state university extension designate.

d. Every private applicator shall be recertified at least once every five years.

e. Competence to apply a single restricted use pesticide by a person who cannot read shall be demonstrated by completion of a course of oral instruction and completion of a procedure to determine teaching-learning effectiveness to the North Dakota state university extension designate in the applicant's area. Such private applicator certification for a single restricted use pesticide shall be for no more than one year and the notation, "Restricted to" followed by the common name of the restricted use pesticide in bold lettering shall appear on the private applicator certificate.

f. In an emergency situation, competence to apply a single restricted use pesticide by a person shall be demonstrated by completion of a course of oral instruction and completion of a procedure to determine teaching-learning effectiveness to the North Dakota state university extension designate in the applicant's area. Such private applicator certification for a single restricted use pesticide shall expire sixty days from issuance and shall be issued to a person only once. The notation,

"Restricted to" followed by the common name of the restricted use pesticide shall appear on the private applicator certificate in bold lettering.

History: Amended effective February 1, 1982; October 1, 1990; November 1, 1991.
General Authority: NDCC 4-35-06, 4-35-12
Law Implemented: NDCC 4-35-08, 4-35-09, 4-35-12, 4-35-14

TITLE 61

Pharmacy, Board of

NOVEMBER 1991

STAFF COMMENT: Chapter 61-04-04 contains all new material but is not underscored so as to improve readability.

CHAPTER 61-04-04
UNPROFESSIONAL CONDUCT

61-04-04-01. Definition of unprofessional conduct. The definition of "unprofessional conduct" for purposes of subdivision i of subsection 1 of North Dakota Century Code section 43-15-10 for disciplinary purposes includes, but is not limited to, the following:

1. The violating or attempting to violate, directly, indirectly, through actions of another, or assisting in or abetting the violation of, or conspiring to violate, any provision or term of North Dakota Century Code chapter 43-15, the Prescription Drug Marketing Act, the Robinson-Patman Act, or of the applicable federal and state laws and rules governing pharmacies or pharmacists.

2. Failure to establish and maintain effective controls against diversion of prescription drugs into other than legitimate medical, scientific, or industrial channels as provided by state or federal laws or rules.

3. Making or filing a report or record which a pharmacist or pharmacy knows to be false, intentionally or negligently failing to file a report or record required by federal or state law, or rules, willfully impeding or obstructing such filing, or inducing another person to do so. Such reports or

records include only those which the pharmacist or pharmacy is required to make or file in his capacity as a licensed pharmacist or pharmacy.

4. Being unable to practice pharmacy with reasonable skill and safety by reason of illness, use of drugs, narcotics, chemicals, or any other type of material, or as a result of any mental or physical condition. A pharmacist affected under this subsection shall at reasonable intervals be afforded an opportunity to demonstrate that the pharmacist can resume the competent practice of pharmacy with reasonable skill and safety to his customers.

5. Knowingly dispensed a prescription drug after the death of a patient.

6. Using a facsimile machine to circumvent documentation, authenticity, verification, or other standards of pharmacy practice.

7. Billing or charging for quantities greater than delivered, or for a brand when a generic is dispensed.

8. Submits fraudulent billing or reports to a third party payor of prescription charges.

9. Refuses to provide information or answer questions when requested to do so by the patient, which affect the patient's use of medications prescribed and dispensed by the pharmacy.

10. Does not address or attempt to resolve and document a possible prescription error or situation of potential harm to the patient when apparent or should have been apparent to the pharmacist.

11. Does not attempt to affect the possible addiction or dependency of a patient to a drug dispensed by the pharmacist, if there is reason to believe that patient may be so dependent or addicted.

12. The assertion or inference in a public manner of material claims of professional superiority in the practice of pharmacy that cannot be substantiated.

13. The publication or circulation of false, misleading, or otherwise deceptive statements concerning the practice of pharmacy.

14. Refusing to compound and dispense prescriptions that may reasonably be expected to be compounded or dispensed in pharmacies by a pharmacist.

15. Participation in agreements or arrangements with any person, corporation, partnership, association, firm, or others involving rebates, kickbacks, fee-splitting, or special charges in exchange for professional pharmaceutical services, including, but not limited to, the giving, selling, donating, or otherwise furnishing or transferring, or the offer to give, sell, donate, or otherwise furnish or transfer money, goods, or services free or below cost to any licensed health care facility or the owner, operator, or administrator of a licensed health care facility as compensation or inducement for placement of business with that pharmacy or pharmacist. Monetary rebates or discounts which are returned to the actual purchaser of drugs as a cost justified discount or to meet competition are permitted if the rebates of discounts conform with other existing state and federal rules and regulations.

16. Discriminating in any manner between patients or groups of patients for reasons of religion, race, creed, color, sex, age, or national origin.

17. Divulging or revealing to others the nature of professional pharmaceutical services rendered to a patient without the patient's express consent orally or in writing or by order or direction of a court. This does not prevent pharmacies from providing information copies of prescriptions to other pharmacies or to the person to whom the prescription was issued and does not prevent pharmacists from providing drug therapy information to physicians for their patients.

18. Improper advertising. Prescription drug price information may be provided to the public by a pharmacy, if all the following conditions are met: No representation or suggestion concerning the drug's safety, effectiveness, or indications for use, is made. No reference is made to controlled substances listed in schedule II - V of the latest revision of the Federal Controlled Substances Act, North Dakota Uniform Controlled Substances Act, and the rules of the board of pharmacy.

Interpretation of this definition of unprofessional conduct is not intended to hinder or impede the innovative practice of pharmacy, the ability of the pharmacist to compound, alter, or prepare medications, subsequent to a practitioner's order for the appropriate treatment of patients. Further, it is not intended to restrict the exercise of professional judgment of the pharmacist when practicing in the best interest of his patient.

History: Effective November 1, 1991.
General Authority: NDCC 28-32-02, 43-15-10(1)(i)(12)(14)
Law Implemented: NDCC 28-32-02

TITLE 62

Plumbing, Board of

62-02-03-05. Renewal of sewer and water contractor and installer certificate and license. The holder of a sewer and water contractor's certificate and license may renew the sewer and water installer's certificate and license upon payment of the installer's renewal fee and during the same year may reinstate the holder's contractor's certificate and license upon payment of the difference between the installer and contractor renewal fee.

History: Effective January 1, 1992.
General Authority: NDCC 43-18.2-02
Law Implemented: NDCC 43-18.2-09

62-03-01-01. Definitions. For the purpose of this article, the following terms shall have the meaning indicated in this section. No attempt is made to define ordinary words which are used in accordance with their established dictionary meaning except where it is necessary to define their meaning as used in this article to avoid misunderstanding.

1. "A.B.S." means acrylonitrile-butadiene-styrene.

2. "Accessible" means having access thereto but which first may require the removal of an access panel, door, or similar obstruction. "Readily accessible" means direct access without the necessity of removing or moving any panel, door, or similar obstruction.

3. "Acid waste" means corrosive waste.

4. "Administrative authority" means the individual official, board, department, or agency established and authorized by a state, county, city, or other political subdivision created by

law to administer and enforce the provisions of the plumbing code as adopted or amended.

5. "A.G.A." means American gas association.

6. "Air break (drainage system)" means a piping arrangement in which a drain from a fixture, appliance, or device discharges indirectly into a fixture, receptacle, or interceptor at a point below the flood level rim of the receptacle so installed as to prevent backflow or siphonage.

7. "Air chamber" means a pressure surge absorbing device operating through the compressibility of air.

8. "Airgap (drainage systems)" means the unobstructed vertical distance through the free atmosphere between the outlet of waste pipe and the flood level rim of the receptacle into which it is discharging.

9. "Airgap (water distribution system)" means the unobstructed vertical distance through the free atmosphere between the lowest opening from any pipe or faucet supplying water to a tank, plumbing fixture, or other device and the flood level rim of the receptacle.

9.1. "Alkali waste" means waste having a pH factor more than seven.

10. "Anchors" means supports.

11. "A.N.S.I." means the American national standards institute.

12. "Antiscald valve" - see "water temperature control valve".

13. "Approved" means accepted or acceptable under an applicable standard stated or cited in this article, or accepted as suitable for the proposed use under procedures and powers of the administrative authority.

14. "Area drain" means a receptacle designed to collect surface or storm water from an open area.

15. "A.S.M.E." means the American society of mechanical engineers.

16. "Aspirator" means a fitting or device supplied with water or other fluid under positive pressure which passes through an integral orifice or "constriction" causing a vacuum.

17. "Autopsy table" means a fixture or table used for the postmortem examination of a body.

18. "B and S" means Brown and Sharpe.

19. "Backflow" means the flow of water or other liquids, mixtures, or substances into the distributing pipes of a potable supply of water from any source or sources other than its intended source. Backsiphonage is one type of backflow.

20. "Backflow connection" means any arrangement whereby backflow can occur.

21. "Backflow drainage" means a reversal of flow in the drainage system.

22. "Backflow preventer" means a device or means to prevent backflow.

23. "Backflow preventer, reduced pressure zone type" means an assembly of differential valves and check valves including an automatically opened spillage port to the atmosphere.

24. "Backflow, water distribution" means the flow of water or other liquids, mixtures, or substances into the distributing pipes of a potable supply of water from any source or sources other than its intended source. Backsiphonage is one type of backflow.

25. "Back pressure backflow" means a condition, which may occur in the potable water distribution system, whereby a higher pressure than the supply pressure is created which causes a reversal of flow into the potable water piping.

26. "Backsiphonage" means the flowing back of used, contaminated, or polluted water from a plumbing fixture or vessel or other sources into a potable water supply pipe due to a negative pressure in the pipe.

27. "Back vent" means individual vent.

28. "Backwater valve" means a device installed in a drain or pipe to prevent backflow.

29. "Bathroom group" means, unless specifically cited in the body of the code, a water closet, a lavatory, and a bathtub or shower stall or both.

30. "Battery of fixtures" means any group of two or more similar adjacent fixtures which discharge into a common horizontal waste or soil branch.

31. "Bedpan steamer" means a fixture used for scalding bedpans or urinals by direct application of steam.

32. "Bedpan washer" means a fixture designed to wash bedpans and to flush the contents into the soil drainage system. It may

also provide for steaming the utensils with steam or hot water.

33. "Bedpan washer hose" means a device supplied with hot and cold water and located adjacent to a water closet or clinic sink to be used for cleansing bedpans.

34. "Boiler blowoff" means an outlet on a boiler to permit emptying or discharge of sediment.

35. "Boiler blowoff tank" means a vessel designed to receive the discharge from a boiler blowoff outlet and to cool the discharge to a temperature which permits its safe discharge to the drainage system.

36. "Branch" means any part of the piping system other than a riser, main, or stack.

37. "Branch, fixture" means fixture branch.

38. "Branch, horizontal" means horizontal branch.

39. "Branch interval" means a distance along a soil or waste stack corresponding in general to a story height, but in no case less than eight feet [2.44 meters], within which the horizontal branches from one floor or story of a building are connected to the stack.

40. "Branch vent" means a vent connecting one or more individual vents with a vent stack or stack vent.

41. "Building" means a structure having walls and a roof designed and used for the housing, shelter, enclosure, or support of persons, animals, or property.

42. "Building classification" means the arrangement adopted by the administrative authority for the designation of buildings in classes according to occupancy.

43. "Building drain" means that part of the lowest piping of a drainage system which receives the discharge from soil, waste, and other drainage pipes inside the walls of the building and conveys it to the building sewer beginning three feet [91.44 centimeters] outside the building wall.

44. "Building drain - combined" means a building drain which conveys both sewage and storm water or other drainage.

45. "Building drain - sanitary" means a building drain which conveys sewage only.

46. "Building drain - storm" means a building drain which conveys storm water or other drainage but no sewage.

47. "Building sewer" means that part of the drainage system which extends from the end of the building drain and conveys its discharge to a public sewer, private sewer, individual sewage-disposal system, or other point of disposal.

48. "Building sewer - combined" means a building sewer which conveys both sewage and storm water or other drainage.

49. "Building sewer - sanitary" means a building sewer which conveys sewage only.

50. "Building sewer - storm" means a building sewer which conveys storm water or other drainage but no sewage.

51. "Building subdrain" means that portion of a drainage system which does not drain by gravity into the building sewer.

52. "Building trap" means a device, fitting, or assembly of fittings installed in the building drain to prevent circulation of air between the drainage system of the building and the building sewer.

53. "Cesspool" means a lined and covered excavation in the ground which receives the discharge of domestic sewage or other organic waste from a drainage system, so designed as to retain the organic matter and solids, but permitting the liquids to seep through the bottom and sides.

54. "Chemical waste" means special wastes such as, but not limited to, corrosive wastes or industrial wastes containing chemicals.

55. "Circuit vent" means a branch vent that serves two or more traps and extends from the downstream side of the highest fixture connection of a horizontal branch to the vent stack.

56. "Clear water waste" means cooling water and condensate drainage from refrigeration, and air-conditioning equipment; cooled condensate from steam heating systems; cooled boiler blowdown water; wastewater drainage from equipment rooms and other areas where water is used without an appreciable addition of oil, gasoline, solvent, acid, etc., and treated effluent in which impurities have been reduced below a minimum concentration considered harmful.

57. "Clinic sink (bedpan hopper)" means a sink designed primarily to receive wastes from bedpans provided with a flush rim, integral trap with a visible trap seal, having the same flushing and cleansing characteristics as a water closet.

58. "Code" means this article, subsequent amendments thereto, or any emergency rule or regulation which the administrative authority having jurisdiction may lawfully adopt.

59. "Combination fixture" means a fixture combining one sink and laundry tray or a two- or three-compartment sink or laundry tray in one unit.

60. "Combination waste and vent system" means a specially designed system of waste piping embodying the horizontal wet venting of one or more sinks or floor drains by means of a common waste and vent pipe adequately sized to provide free movement of air above the flow line of the drain.

61. "Combined building drain" means building drain - combined.

62. "Combined building sewer" means building sewer - combined.

63. "Commercial" means public or public use.

64. "Common vent" means a vent connected at a common connection of two fixture drains and serving as a vent for both fixtures.

65. "Conductor" means the water conductor from the roof to the building storm drain, combined building sewer, or other means of disposal and located inside of the building.

66. "Continuous vent" means a vertical vent that is a continuation of the drain to which it connects.

67. "Continuous waste" means a drain from two or more fixtures connected to a single trap.

68. "Corrosive waste" means waste derived from laboratories or classrooms used for laboratory or demonstration purposes, or from industrial or commercial processes, or from any sink or fixture made to receive discarded chemicals, whereby acid or other harmful chemicals are disposed of, which may destroy or cause damage to the materials and equipment of a plumbing installation, if such materials and equipment are not of a type selected, manufactured, or installed for such special use.

69. "Critical level" on a backflow prevention device or vacuum breaker means a point established by the manufacturer and usually stamped on the device by the manufacturer which determines the minimum elevation above the flood level rim of the fixture or receptacle served at which the device may be installed. When a backflow prevention device does not bear a critical level marking, the bottom of the vacuum breaker, combination valve, or the bottom of any approved device shall constitute the critical level.

70. "Cross-connection" means any connection or arrangement between two otherwise separate piping systems, one of which contains potable water and the other either water of unknown or questionable safety or steam, gas, or chemical whereby there

may be a flow from one system to the other, the direction of flow depending on the pressure differential between the two systems. (See backflow and backsiphonage.)

71. "Dead end" means a branch leading from a soil, waste, or vent pipe, building drain, or building sewer, and terminating at a developed length of two feet [60.96 centimeters] or more by means of a plug, cap, or other closed fitting.

72. "Department having jurisdiction" means administrative authority.

73. "Developed length" means the length of a pipeline measured along the centerline of the pipe and fittings.

74. "Diameter" means the nominal diameter as designated commercially.

75. "Double check valve assembly" means a backflow prevention device consisting of two independently acting check valves, internally force loaded to a normally closed position between two tightly closing shutoff valves, and with means of testing for tightness.

76. "Double offset" means two changes of direction installed in succession or series in a continuous pipe.

77. "Downspout" means the rainleader from the roof to the building storm drain, combined building sewer, or other means of disposal and located outside of the building.

78. "Domestic sewage" means the water-borne wastes derived from ordinary living processes.

79. "Drain" means any pipe which carries wastewater or water-borne wastes in a building drainage system.

80. "Drainage pipe" means drainage system.

81. "Drainage system" means all the piping, within public or private premises, which conveys sewage, rainwater, or other liquid wastes to a point of disposal. It does not include the mains of a public sewer system or private or public sewage-treatment or disposal plant.

82. "Drainage system, building gravity" means a drainage system which drains by gravity into the building sewer.

83. "Drainage system, sub-building" means building subdrain.

84. "Dry well" means leaching well.

85. "Dual vent" means common vent.

86. "Durham system" means a soil, waste, or vent pipe system where all piping is of threaded pipe using recessed drainage fittings.

87. "Dwelling unit - multiple" means a room or group of rooms forming a single habitable unit with facilities which are used or intended to be used for living, sleeping, cooking, and eating; and whose sewer connections and water supply within its own premise are shared with one or more other dwelling units.

88. "Dwelling unit - single" means a room or group of rooms forming a single habitable unit with facilities which are used or intended to be used for living, sleeping, cooking, and eating; and whose sewer connections and water supply are within its own premise separate from and completely independent of any other dwelling.

89. "D.W.V." means drainage, waste, and venting.

90. "Effective opening" means the minimum cross-sectional area at the point of water supply discharge, measured or expressed in terms of (a) diameter of a circle, or (b) if the opening is not circular, the diameter of a circle of equivalent cross-sectional area.

91. "Existing work" means a plumbing system or any part thereof installed prior to the effective date of this article.

92. "Family" means one or more individuals living together and sharing the same facilities.

93. "Fixture" means plumbing fixture.

94. "Fixture branch" means a water supply pipe between the fixture supply and water distributing pipe.

95. "Fixture branch - drainage" means a drain serving one or more fixtures which discharges into another drain.

96. "Fixture drain" means the drain from the trap of a fixture to the junction of that drain with any other drainpipe.

97. "Fixture supply" means the water supply pipe connecting a fixture to a branch water supply pipe or directly to a main water supply pipe.

98. "Fixture unit (drainage - d.f.u.)" means a measure of the probable discharge into the drainage system by various types of plumbing fixtures. The drainage fixture-unit value for a particular fixture depends on its volume rate of drainage discharge, on the time duration of a single drainage

operation, and on the average time between successive operations.

99. "Fixture unit (supply - s.f.u.)" means a measure of the probable hydraulic demand on the water supply by various types of plumbing fixtures. The supply fixture-unit value for a particular fixture depends on its volume rate of supply, on the time duration of a single supply operation, and on the average time between successive operations.

100. "Flood level" means flood level rim.

101. "Flood level rim" means the edge of the receptacle from which water overflows.

102. "Flooded" means the condition which results when the liquid in a container or receptacle rises to the flood-level rim.

103. "Flow pressure" means the pressure in the water supply pipe near the faucet or water outlet while the faucet or water outlet is wide-open and flowing.

104. "Flushing type floor drain" means a floor drain which is equipped with an integral water supply, enabling flushing of the drain receptor and trap.

105. "Flush valve" means a device located at the bottom of a tank for flushing water closets and similar fixtures.

105.1. "Flushometer tank" means a device integrated within an air accumulator vessel which is designed to discharge a predetermined quantity of water to fixtures for flushing purposes.

106. "Flushometer valve" means a device which discharges a predetermined quantity of water to fixtures for flushing purposes and is closed by direct water pressure.

107. "Frostproof closet" means a hopper with no water in the bowl and with the trap and water supply control valve located below frostline.

108. "F.U." means fixture units.

109. "Funnel drain" means a funnel-shaped receptor for receiving the discharge of an indirect waste pipe.

110. "G.P.M." means gallons per minute.

111. "Grade" means the fall (slope) of a line of pipe in reference to a horizontal plane. In drainage it is usually expressed as the fall in a fraction of an inch per foot length of pipe.

112. "Grease interceptor" means interceptor.

113. "Grease trap" means interceptor.

114. "Ground water" means subsurface water occupying the zone of saturation.

a. "Confined ground water" is a body of ground water overlain by material sufficiently impervious to sever free hydraulic connection with overlying ground water.

b. "Free ground water" is ground water in the zone of saturation extending down to the first impervious barrier.

115. "Hangers" means supports.

116. "Health authority" means the state department of health or a county, city, or multi or combined county or city health unit.

117. "Horizontal branch drain" means a drain branch pipe extending laterally from a soil or waste stack or building drain, with or without vertical sections or branches, which receives the discharge from one or more fixture drains and conducts it to the soil or waste stack or to the building drain.

118. "Horizontal pipe" means any pipe or fitting which makes an angle of less than forty-five degrees with the horizontal.

119. "Hot water" means water supplied to plumbing fixtures at a temperature of not less than one hundred ten degrees Fahrenheit [-12.22 degrees Celsius], and not more than one hundred forty degrees Fahrenheit [60 degrees Celsius], except that commercial dishwashing machines and similar equipment shall be provided with water one hundred eighty degrees Fahrenheit [82.22 degrees Celsius] for sterilization purposes.

120. "House drain" means building drain.

121. "House sewer" means building sewer.

122. "House trap" means building trap.

123. "Individual sewage disposal system" means a system for disposal of domestic sewage by means of a septic tank, cesspool, or mechanical treatment, designed for use apart from a public sewer to serve a single establishment or building.

124. "Indirect waste pipe" means a waste pipe which does not connect directly with the drainage system, but which discharges into the drainage system through an air break or airgap into a trap, fixture, receptor, or interceptor.

125. "Individual vent" means a pipe installed to vent a fixture drain. It connects with the vent system above the fixture served or terminates outside the building into the open air.

126. "Individual water supply" means a supply other than an approved public water supply which serves one or more families.

127. "Industrial wastes" means liquid or liquid-borne wastes resulting from the processes employed in industrial and commercial establishments.

128. "Insanitary" means contrary to sanitary principles - injurious to health.

129. "Interceptor" means a device designed and installed so as to separate and retain deleterious, hazardous, or undesirable matter from normal wastes while permitting normal sewage or liquid wastes to discharge into the drainage system by gravity.

130. "Installed" means altered, changed, or a new installation.

131. "Interval" means branch interval.

132. "Invert" means the lowest portion of the inside of a horizontal pipe.

133. "Leaching well or pit" means a pit or receptacle having porous walls which permit the contents to seep into the ground.

134. "Leader" means an exterior vertical drainage pipe for conveying storm water from roof or gutter drains.

135. "Liquid waste" means the discharge from any fixture, appliance, area, or appurtenance, which does not contain human or animal waste matter.

136. "Load factor" means the percentage of the total connected fixture until flow which is likely to occur at any point in the drainage system.

137. "Local ventilating pipe" means a pipe on the fixture side of the trap through which vapor or foul air is removed from a room or a fixture.

138. "Loop vent" means a circuit vent which loops back to connect with a stack vent instead of a vent stack.

139. "Main" means the principal pipe artery to which branches may be connected.

140. "Main sewer" means public sewer.

141. "Main vent" means the principal artery of the venting system to which vent branches may be connected.

142. "May" is permissive.

143. "Multiple dwelling" means a building containing two or more dwelling units.

144. "Nonpotable water" means water not safe for drinking or for personal or culinary use.

145. "Nuisance" means public nuisance at common law or in equity jurisprudence; whatever is dangerous to human life or detrimental to health; whatever building, structure, or premise is not sufficiently ventilated, sewered, drained, cleaned, or lighted, in reference to its intended or actual use; and whatever renders the air or human food or drink or water supply unwholesome.

146. "Offset" means a combination of elbows or bends which brings one section of the pipe out of line but into a line parallel with the other section.

147. "Oil interceptor" means interceptor.

148. "P.E." means polyethylene.

149. "Person" means a natural person, the natural person's heirs, executors, administrators or assigns, and includes a firm, partnership, or corporation, its or their successors or assigns. Singular includes plural and male includes female.

150. "Pitch" means grade.

151. "Plumbing" means the installation, maintenance, extension, alteration, and removal of all piping, plumbing fixtures, plumbing appliances, and other appurtenances in connection with bringing water into, and using the water in buildings, and for removing liquids and water-carried wastes therefrom. Maintenance does not include making repairs to faucets, valves, appliances, and fixtures, or removal of stoppages in waste or drainage pipes.

152. "Plumbing appliance" means any one of a special class of plumbing fixture which is intended to perform a special plumbing function. Its operation or control may be dependent upon one or more energized components, such as motors, controls, heating elements, or pressure or temperature-sensing elements. Such fixtures may operate automatically through one or more of the following actions: a time cycle, a temperature range, a pressure range, a measured volume or weight; or the fixture may be manually adjusted or controlled by the user or operator.

153. "Plumbing appurtenance" means a manufactured device, or a prefabricated assembly, or an on-the-job assembly of component parts, and which is an adjunct to the basic piping system and plumbing fixtures. An appurtenance demands no additional water supply, nor does it add any discharge load to a fixture or the drainage system. It is presumed that it performs some useful function in the operation, maintenance, servicing, economy, or safety of the plumbing system.

154. "Plumbing fixture" means a receptacle or device which is either permanently or temporarily connected to the water distribution system of the premises, and demands a supply of water therefrom, or it discharges used water, liquid-borne waste materials, or sewage either directly or indirectly to the drainage system of the premises, or which requires both a water supply connection and a discharge to the drainage system of the premises. Plumbing appliances as a special class of fixture are further defined.

155. "Plumbing fixture" - private or private use" means in the classification of plumbing fixtures, fixtures in residences, apartments, or condominiums, or single fixtures for the intended use of a family or individual.

156. "Plumbing fixture - public or public use" means in the classification of plumbing fixtures, every fixture not defined under private use and includes all installations where a number of fixtures are installed and their use may be restricted or unrestricted.

157. "Plumbing inspector" means administrative authority.

158. "Plumbing system" includes the water supply and distribution pipes, plumbing fixture, and traps; soil, waste, and vent pipes; sanitary and storm drains and building sewers, including their respective connections, devices, and appurtenances to an approved point of disposal.

159. "Pollution" means the addition of sewage, industrial wastes, or other harmful or objectionable material to water. Sources of sewage pollution may be privies, septic tanks, subsurface irrigation fields, seepage pits, sink drains, barnyard wastes, etc.

160. "Pool" means swimming pool.

161. "Potable water" means water free from impurities present in amounts sufficient to cause disease or harmful physiological effects and conforming in its bacteriological and chemical quality to the requirements of the public health service drinking water standards or the regulations of the public health authority having jurisdiction.

161.1. "Pressure gradient monitor" means a device used to protect the quality of potable water, fail-safe by design, protecting the water system by isolating the heat exchangers when the positive pressure differential is less than the set point.

162. "Private or private use" means in the classification of plumbing fixtures, fixtures in residences ~~and~~, apartments, private bathrooms of hotels and motels, and similar installations where the fixtures are intended for use by a family or an individual to the exclusion of all others.

163. "Private sewage disposal system" means a system for disposal of domestic sewage by means of a septic tank or mechanical treatment, designed for use apart from a public sewer to serve a single establishment or building.

164. "Private sewer" means a sewer not directly controlled by public authority.

165. "P.S.I." means pounds per square inch.

166. "Public or public use" means, in the classification of plumbing fixtures, every fixture not defined under private use, and public includes all installations where a number of fixtures are installed and their use may be restricted or unrestricted.

167. "Public sewer" means a common sewer directly controlled by public authority.

168. "Public toilet room means an unrestricted toilet facility that serves the public.

169. "Public water main" means a water supply pipe for public use controlled by public authority.

169.1. "Public water system" means a system for the provision to the public of piped water for human consumption, if such system has at least fifteen service connections, or regularly serves an average of at least twenty-five individuals daily at least sixty days out of the year.

170. "P.V.C." means polyvinyl chloride.

171. "Receptor" means a fixture or device which receives the discharge from indirect waste pipes.

172. "Relief vent" means an auxiliary vent which permits additional circulation of air in or between drainage and vent systems.

173. "Return offset" means a double offset installed so as to return the pipe to its original alignment.

174. "Revent pipe" means individual vent.

175. "Rim" means an unobstructed open edge of a fixture.

176. "Riser" means a water supply pipe which extends vertically one full story or more to convey water to branches or to a group of fixtures.

177. "Roof drain" means a drain installed to receive water collecting on the surface of a roof and to discharge it into a leader or a conductor.

178. "Roughing-in" means the installation of all parts of the plumbing system which can be completed prior to the installation of fixtures. This includes drainage, water supply, and vent piping, and the necessary fixture supports, or any fixtures that are built into the structure.

179. "Safe waste" means indirect waste.

180. "Sand filter" means a treatment device or structure, constructed above or below the surface of the ground, for removing solid or colloidal material of a type that cannot be removed by sedimentation, from septic tank effluent.

181. "Sand interceptor" means interceptor.

182. "Sand trap" means interceptor.

183. "Sanitary sewer" means a sewer which carries sewage and excludes storm, surface and ground water.

184. "Scavenger" means any person engaged in the business of cleaning and emptying septic tanks, seepage pits, privies, or any other sewage disposal facility.

185. "Seepage well or pit" means leaching well.

186. "Separator" means interceptor.

187. "Septic tank" means a watertight receptacle which receives the discharge of a building sanitary drainage system or part thereof, and is designed and constructed so as to separate solids from the liquid, digest organic matter through a period of detention, and allow the liquids to discharge into the soil outside of the tank through a system of open joint or perforated piping, or a seepage pit.

188. "Sewage" means any liquid waste containing animal or vegetable matter in suspension or solution, and may include liquids containing chemicals in solution.

189. "Sewage ejectors" means a device for lifting sewage by entraining it in a high velocity jet of steam, air, or water.

190. "Sewage pump" means a permanently installed mechanical device other than an ejector for removing sewage or liquid waste from a sump.

191. "Shall" is mandatory.

192. "Shock arrestor (mechanical device)" means a device used to absorb the pressure surge (water hammer) that occurs when water flow is suddenly stopped.

193. "Side vent" means a vent connecting to the drainpipe through a fitting at an angle not greater than forty-five degrees to the vertical.

194. "Siphon" means an arrangement of plumbing piping, fittings, or device that will allow liquid to flow from a higher level to a lower level over an intervening level at a velocity sufficient to break the water seal of a trap.

195. "Size of pipe and tubing" means diameter.

196. "Slope" means grade.

197. "Soil pipe" means a pipe which conveys sewage containing human or animal waste to the building drain or building sewer.

198. "Soil vent" means stack vent.

199. "Special waste pipe" means a pipe which conveys special wastes.

200. "Special wastes" means wastes which require special treatment before entry into the normal plumbing system.

201. "S.P.S." means standard pipe size.

202. "Stack" means any vertical line of soil, waste, vent, or inside conductor piping extending through one or more stories.

203. "Stack group" means a group of fixtures located adjacent to the stack so that by means of proper fittings, vents may be reduced to a minimum.

204. "Stack vent" means the extension of a soil or waste stack above the highest horizontal drain connected to the stack.

205. "Stack venting" means a method of venting a fixture or fixtures through the soil or waste stack.

206. "Static line pressure" means the pressure existence without any flow.

207. "Sterilizer, boiling type" means a fixture (nonpressure type) used for boiling instruments, utensils, or other equipment (used for disinfection) and may be portable or connected to the plumbing system.

208. "Sterilizer instrument" means a sterilizer, boiling type.

209. "Sterilizer, pressure, instrument washer" means a fixture (pressure vessel) designed to both wash and sterilize instruments during the operating cycle of the fixture.

210. "Sterilizer, pressure (autoclave)" means a fixture (pressure vessel) designed to use steam under pressure for sterilizing. See Sterilizer, boiling type.

211. "Sterilizer vent" means a separate pipe or stack, indirectly connected to the building drainage system at the lower terminal, which receives the vapors from nonpressure sterilizers, or the exhaust vapors from pressure sterilizers, and conducts the vapors directly to the outer air. Sometimes called a vapor, steam, atmosphere, or exhaust vent.

212. "Sterilizer, water" means a device for sterilizing water and storing sterile water.

213. "Still" means a device used in distilling liquids.

214. "Storm drain" means building storm drain.

215. "Storm sewer" means a sewer used for conveying rainwater, surface water, condensate, cooling water, or similar liquid wastes.

216. "Subsoil drain" means a drain which collects subsurface or seepage water and conveys it to a place of disposal.

217. "Sump" means a tank or pit, which receives sewage or liquid waste, located below the normal grade of the gravity system and which must be emptied by mechanical means.

218. "Sump drainage" means a liquid and airtight tank that receives sewage or liquid waste, or both, located below the elevation of the gravity system, and is emptied by pumping.

219. "Sump pump" means a permanently installed mechanical device other than an ejector for removing sewage or liquid waste from a sump.

220. "Supports" means devices for supporting and securing pipe, fixtures, and equipment.

221. "Swimming pool" means any structure, basin, chamber, or tank containing an artificial body of water for swimming, diving, wading, or recreational bathing.

222. "Tailpiece" means a connection used from outlet of fixture strainer to trap connection.

223. "Tempered water" means water at a temperature of not less than ninety degrees Fahrenheit [32.22 degrees Celsius] and not more than one hundred five degrees Fahrenheit [40.56 degrees Celsius].

224. "Trap" means a fitting or device which provides a liquid seal to prevent the emission of sewer gases without materially affecting the flow of sewage or wastewater through it.

225. "Trap arm" means that portion of a fixture drain between a trap and its vent.

226. "Trap primer" means a device or system of piping to maintain a water seal in a trap.

227. "Trap seal" means the vertical distance between the crown weir and the top of the dip of the trap.

228. "Vacuum" means any pressure less than that exerted by the atmosphere.

229. "Vacuum breaker" means backflow preventer.

230. "Vacuum breaker, nonpressure type (atmospheric)" means a vacuum breaker which is not designed to be subject to static line pressure.

231. "Vacuum breaker, pressure type" means a vacuum breaker designed to operate under conditions of static line pressure.

232. "Vacuum relief valve" means a device to prevent excessive vacuum in a pressure vessel.

233. "Vent pipe" means part of the vent system.

234. "Vent stack" means a vertical vent pipe installed to provide circulation of air to and from the drainage system and which extends through one or more stories.

235. "Vent system" means a pipe or pipes installed to provide a flow of air to or from a drainage system or to provide a circulation of air within such system to protect trap seals from siphonage and back pressure.

236. "Vertical pipe" means any pipe or fitting which makes an angle of forty-five degrees or less with the vertical.

237. "Wall hung water closet" means a water closet installed in such a way that no part of the water closet touches the floor.

238. "Waste" means liquid waste and industrial waste.

239. "Waste pipe" means a pipe which conveys only waste.

240. "Water distributing pipe" means a pipe within the building or on the premises which conveys water from the water-service pipe to the point of usage.

241. "Water lifts" means sewage ejector.

242. "Water main" means a water supply pipe for public use.

243. "Water outlet" means a discharge opening through which water is supplied to a fixture, into the atmosphere (except into an open tank which is part of the water supply system), to a boiler or heating system, to any devices or equipment requiring water to operate but which are not part of the plumbing system.

244. "Water riser pipe" means riser.

245. "Water service pipe" means the pipe from the water main or other source of potable water supply to the water distributing system of the building served.

246. "Water supply system" means the water service pipe, the water-distributing pipes, and the necessary connecting pipes, fittings, control valves, and all appurtenances in or adjacent to the building or premises.

246.1. "Water temperature control valve" means a valve of the pressure balancing, thermostatic mixing, or combination pressure balance thermostatic mixing type, which is designed to control water temperature to reduce the risk of scalding.

247. "Wet vent" means a vent which receives the discharge of wastes other than from water closets and kitchen sinks.

247.1. "Whirlpool bathtub" means a bathtub fixture which is equipped and fitted with a circulation piping system, pump, and other appurtenances and is so designed to accept, circulate, and discharge bathtub water upon each use.

248. "Yoke vent" means a pipe connecting upward from a soil or waste stack to a vent stack for the purpose of preventing pressure changes in the stack.

History: Amended effective July 1, 1985; October 1, 1989; September 1, 1990; January 1, 1992.
General Authority: NDCC 43-18-09

Law Implemented: NDCC 43-18-09

62-03-02-01. Conformance with code. All plumbing materials, and plumbing ~~systems~~ system installations or parts thereof installed hereafter, including additions, extensions, alterations, and replacements in existing buildings, shall meet or exceed the minimum provisions of this article.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-03.1-01. Materials.

1. Standards. The standards cited in this chapter control all materials, systems, and equipment used in the construction, installation, alteration, repair, or replacement of any plumbing or drainage system or part thereof, except:

   a. The administrative authority shall allow the extension, addition to, or relocation of, existing water, soil, waste vent pipes with materials of like grade or quality as permitted in subsection 2 of section 62-03-03.1-12.

   b. Materials not covered by the standards cited in this chapter may be used with the approval of the administrative authority as permitted in subsection 2 of section 62-03-03.1-12.

   2. General requirements. All materials, fixtures, or equipment used in the installation, repair, or alteration of any plumbing system must conform at least to the standards listed in this chapter except as otherwise approved by the administrative authority under the authority contained in section 62-03-03.1-12.

   All materials installed in plumbing systems must be so handled and installed as to avoid damage so that the quality of the material will not be impaired.

   No defective or damaged materials, equipment, or apparatus may be installed or maintained. (Sections 62-03-02-14 and 62-03-02-15).

   All materials used must be installed in strict accordance with the standards under which the materials are accepted and approved, including the appendices of the standards, and in strict accordance with the manufacturer's instructions.

3. Standards applicable to plumbing materials. A material is considered approved if it meets one or more of the standards

cited in Table 62-03-03.1, Standards for Approved Plumbing Materials and Equipment; and in the case of plastic pipe, also the listed standard of the national sanitation foundation. Materials not listed in Table 62-03-03.1 may be used only as provided for in subsection 2 of section 62-03-03.1-12 or as permitted elsewhere in this article.

Note: Abbreviations in Table 62-03-03.1 refer to the following organizations:

ANSI American National Standards Institute
1430 Broadway
New York, New York 10018

ARI Air Conditioning and Refrigeration Institute
1815 North Fort Myer Drive
Arlington, Virginia 22209

ASSE American Society of Sanitary Engineering
P.O. Box 9712
Bay Village, Ohio 44140

ASTM American Society for Testing and Materials
1916 Race Street
Philadelphia, Pennsylvania 19103

AWWA American Water Works Association
~~521 Fifth Avenue~~ 6666 West Quincy Avenue
~~New York, New York 10017~~ Denver, Colorado 80235

CISPI Cast Iron Soil Pipe Institute
~~1499 Chain Bridge Road~~ 5959 Shallowford Road, Suite 419
~~McLean, Virginia 22101~~ Chattanooga, Tennessee 37421

CMI Cultured Marble Institute
435 North Michigan Avenue
Chicago, Illinois 60611

CS Commercial Standards
Commodity Standards Division
Office of Industry and Commerce
Washington, D.C. 20230

CSA Canadian Standards Association
178 Rexdale Boulevard, Rexdale
Toronto, Ontario, Canada M9W1R3

FS Federal Supply Service
Standards Division
General Services Administration
Washington, D.C. 20405

IAPMO International Association of Plumbing and Mechanical Officials
~~5032 Alhambra Avenue~~ 20001 South Walnut Drive
~~Los Angeles, California 90032~~ Walnut, California 91789

MSS Manufacturing Standardization Society
5203 Leesburg Pike, Suite 502
Falls Church, Virginia 22041

NSF National Sanitation Foundation
Ann Arbor, Michigan 48106

PDI Plumbing and Drainage Institute
5342 Boulevard Place
Indianapolis, Indiana 46208

UL Underwriters Laboratories
333 Pfingsten Road
Northbrook, Illinois 60062

WQA Water Quality Association
4151 Naperville Road
Lisle, Illinois 60532

4. Identification of materials. Materials must be identified as provided in the standard to which they conform.

History: Effective July 1, 1985; amended effective October 1, 1989; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-03.1-03. Fittings, fixtures, appliances, and appurtenances.

1. Cleanout plugs and cap.

   a. Cleanout plugs must be of brass, plastic, stainless steel, or other approved materials and must be raised or countersunk square heads, except that where raised heads will cause a tripping hazard, countersunk heads must be used.

   b. Cleanout caps must be of brass, plastic, reinforced neoprene, cast iron, or other approved material and shall be readily removable.

2. Fixtures.

   a. Plumbing fixtures must be constructed from approved materials having smooth, nonabsorbent surfaces and be free from defects, and except as permitted elsewhere in this

article, must conform to the standards cited in Table 62-03-03.1-01.3.

b. Materials for special use fixtures not otherwise covered in this article must be constructed of materials especially suited to the use for which the fixture is intended.

3. Floor flanges and mounting bolts.

a. Floor flanges for water closets or similar fixtures may not be less than one-eighth inch [3.18 millimeter] thick for brass, one-fourth inch [6.35 millimeter] thick and not less than one and one-half inches [38.1 millimeters] caulking depth for cast iron or galvanized malleable iron. Approved copper and plastic flanges may be used.

b. If of hard lead, they must weigh not less than one pound nine ounces [70.87 decigrams] and be composed of lead alloy with not less than seven and seventy-five hundredths percent antimony by weight. Flanges must be soldered to lead bends, or shall be caulked, soldered, or threaded into other metal.

c. All plastic flanges shall conform to current national sanitation foundation standards.

d. Closet screws and bolts shall be brass.

e. The top of the closet flange must be installed above the finished floor not to exceed more than one-fourth inch [6.35 millimeters].

4. Flush pipes and fittings. Flush pipes and fittings must be of nonferrous material. When of brass or copper tube, the material must be at least three hundred thirteen ten-thousandths of an inch [.795 millimeter] in thickness [No. 20 U.S. gauge].

5. Hangers and supports. Hangers, anchors, and supports must be of metal or other material of sufficient strength to support the piping and its contents. Piers may be of concrete, brick, or other approved material.

6. Interceptors. Interceptors must comply, in all respects, with the type or model of each size thereof approved by the administrative authority.

7. Pressure tanks and vessels.

a. Hot water storage tanks must meet construction requirements of American society of mechanical engineers,

American gas association, or underwriter's laboratory as appropriate (see standards Table 62-03-03.1).

b. Storage tanks less in volume than those requirements specified by American society of mechanical engineers shall be of durable materials and constructed to withstand one hundred twenty-five pounds per square inch [56.70 kilograms per 6.45 square centimeters] with a safety factor of two.

8. Roof drains. Roof drains must be of cast iron, copper, lead, or other approved corrosion-resistant materials.

9. Safety devices for pressure tanks. Safety devices must meet the requirements of the American national standards institute, the American society of mechanical engineers, or the underwriters laboratories. Listing by underwriters laboratories, American gas association, or national board of boiler and pressure vessel inspectors constitutes evidence of conformance with these standards. Where a device is not listed by any of these, it must have certification by an approved laboratory as having met these requirements.

10. Septic tank.

a. Plans for all septic tanks must be submitted to the approving authority for approval. The plans must show all dimensions, reinforcing, structural calculations, and such other pertinent data as may be required.

b. Septic tanks must be constructed of sound durable materials, not subject to excessive corrosion or decay, and must be watertight. (See ~~subsections 4 and 5~~ subsection 2 of section 62-03-16-06).

History: Effective July 1, 1985; amended effective October 1, 1989; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

TABLE 62-03-03.1
STANDARDS FOR APPROVED PLUMBING MATERIALS AND EQUIPMENT

DESCRIPTION	ANSI	ASTM	FS	OTHER
Socket-Type Chlorinated Poly Vinyl Chloride (CPVC) Plastic Pipe Fittings, Schedule 80	None	F439-77	None	NSF 14
** Poly (Vinyl Chloride) (PVC) Plastic Pipe, Schedules 40, 80 and 120	B72.7-1971	* D1785-83	L-P-1035A-74	NSF 14 See ASTM D2774 for underground installation procedures See ASTM D2855
Making Solvent-Cemented joints with Poly (Vinyl Chloride) (PVC) Pipe and Fittings	None	D2855-83	None	None
** Poly (Vinyl Chloride) (PVC) Plastic Pipe (SDR-Series)	None	D2241-84	None	NSF 14 See ASTM D2774 for underground installation procedures See ASTM D2855
** Chlorinated Poly (Vinyl Chloride) (CPVC) Plastic Pipe (SDR-PR)	None	F442-82	None	None
** Chlorinated Poly (Vinyl Chloride) (CPVC) Plastic Pipe, Schedules 40 and 80	None	F441-84	None	NSF 14 See ASTM D2846 Appendix X2 for installation procedures
Coextruded Poly (Vinyl Chloride) (PVC) Plastic Pipe with a Cellular Core Schedule 40	None	F891-88A	None	NSF 14 See ASTM Appendixes XI, X2, and X3 for Storage, joining and Installation procedures

TABLE 62-03-03.1

STANDARDS FOR APPROVED PLUMBING MATERIALS AND EQUIPMENT

DESCRIPTION	ANSI	ASTM	FS	OTHER
Plumbing Appliances				
Dishwashing Machines, Commercial	A197.3-1973	None	Qo-D-431c (2)-70	UL 921-78 ASSE 1004-67
Dishwashing Machines, Household	C33.69-1971 A197.1-1973	None	None	* UL 749-78 ASSE-1006-86
Drinking Water Coolers, Self Contained Mechanically Refrigerated	A112.11.1-1973	None	None	* ARL-1010-78 * UL399-79 ASSE 1009-70
Food Waste Disposals, Commercial	None	None	None	
Food Waste Disposal Units, Household	C33.59-1970 A197.3-1973	None	QQ-G-001513-68	* UL430-78 ASSE 1008-86
Home Laundry Equipment	C33.13-1972 A197.2-1973	None	None	* UL 560-78 * ASSE 1007-86
Hot Water Dispenser Household Storage Type, Electrical	None	None	None	* ASSE 1023-79
Tanks for Domestic Use, Procelain Enameled	None	None	None	CS 115-60
Water Heaters, Automatic Storage Type	Z21.10.1a-1975	None	None	None
Water Heaters, Circulating Tank	Z21.10.3a-1975	None	None	None
Water Heaters, Electric Storage Tank	None	None	W-H-196j(j)-71	*UL 174-77
Water Heaters, Instantaneous	None	None	WW-H-191b-70	~~None~~ UL 499

TABLE 62-03-03.1
STANDARDS FOR APPROVED PLUMBING MATERIALS AND EQUIPMENT

DESCRIPTION	ANSI	ASTM	FS	OTHER
Water Heaters, Oil Fired Storage Type	None	None	None	*UL 732-75 CSA B140.12-76
Water Heaters, Side Arm Type	Z21.10.1-1975	None	None	None
Plumbing Fixtures and Appurtenances				
Accessories (Land Use)	None	None	WW-P-541/8B-81	None
Bathtubs	A112.19.1M-1979	None	WW-P-541/3B-81	None
Plastic Bathtub Units	Z124.1-1980	None	WW-P-541/3B-81	None
Drinking Fountains	A112.18.1M-1979	None	WW-P-541/6a-71	None
Fittings, Plumbing Fixtures, Finished and Rough Brass	A112.18.1M-1979 (R1974)	None	WW-P-541/ALL-81	None
Hand Held Showers, Performance Requirements	None	None	None	*ASSE 1014-79
Individual Shower Control Valves, Anti-Scald Type	None	None	None	*ASSE 1016-79
Lavatories	None	None	WW-P-541/4B-81	None
Lavatory, Cultured Marble	Z124.3-86	None	None	CMI LS-2
Lavatories, Plastic	Z124.3-86	None	None	None
Plumbing Fixtures, General Specification	None	None	WW-P-541-GEN-81	None
Plumbing Fixtures, Enameled Cast Iron	A112.19.1M-87	None	WW-P-541/3B + 5B-81	None
Plumbing Fixtures, Stainless Steel	A112.193M-1987	None	WW-P-541/5B-81	None
Plumbing Fixtures, Vitreous China	A112.19.2-1982	None	WW-P-541/1B, 2B, 4B, 6B - 81	None
Plumbing Fixtures, Enameled Steel	A112.19.4M-84	None	WW-P-541/3B,4B, 6B-81	None
Pressurized Flushing Devices Plumbing Fixtures (Flushometers)	None	None	None	ASSE 1037-86
Shower Baths, Heads and Water Control Valves	A112.181M-1979	None	WW-P-541/7B-81	None

TABLE 62-03-03.1
STANDARDS FOR APPROVED PLUMBING MATERIALS AND EQUIPMENT

DESCRIPTION	ANSI	ASTM	FS	OTHER
Plastic Shower Receptors and Shower Stalls	Z124.2-1980	None	None	None
Sinks, Kitchen and Service, and Laundry Tub	A112.19.2M-1982 A112.19.3-1976	None	WW-P-541/5B-81	None
Supports for Off-the-Floor Plumbing Fixtures for Public Use	A112.6.1-1979	None	None	None
Thermostatic Mixing Valves, Self Actuated for Primary Domestic Use	None	None	None	*ASSE 1017-86
Urinals	A112.19.2M-1982	None	WW-P-541/2B-81	None
WaterClosets	A112.19-2M-1982	None	WW-P-541/1B-81	None
Water Closet Plastic Bowls and Tanks	Z124.4-1986	None	None	None
Whirlpool Bathtub Appliances	A112.19.7-1987	None	None	None
Suction Fittings for Use in Whirlpool Bathtub Appliances	A112.19.8-1987	None	None	None
Backflow Preventors				
Air Gap Standards	A112.1.2-1942 (R1979)	None	None	None
Air Gap Drains for Domestic Dishwashers	None	None	None	ASSE 1021-76
Vavcuum Breakers, Anti-Siphon	A112.1.1-1971	None	None	BSR/ASSE 1001-80
Vavcuum Breakers, Hose Connection	A112.1.3-1976	None	None	*ASSE 1011-81
Double Check with Atmospheric Vent	None	None	None	ASSE 1012-78
Reduced Pressure Principle Back Pressure, Backflow Preventer	None	None	None	ASSE 1013-80
Double Check Valve, Back Pressure, Backflow Assembly	None	None	None	ASSE 1015-80
Dual Check Valve Type	None	None	None	ASSE 1024-1988
Wall Hydrants, Freezeless, Automatic Draining Anti-Backflow Type	None	None	None	*ASSE 1019-78

TABLE 62-03-03.1
STANDARDS FOR APPROVED PLUMBING MATERIALS AND EQUIPMENT

DESCRIPTION	ANSI	ASTM	FS	OTHER
Drain, Roof	A112.21.2-1971	None	None	None
Interceptors, Grease	None	None	None	PDI G 101
Laboratory Faucet Vacuum Breakers	None	None	None	ASSE 1035-81
Lead , Sheet, Grade A	None	None	QQ-L-201f (2)-70	None
Liquid & Paste Fluxes for Soldering	None	B-813-91	None	None
Installation of Thermoplastic Pipe and Corrugated Tubing in Septic Tank Leach Fields	None	F481-76 (1981)	None	None
Plugs, Metallic Cleanout	A112.36.2-1975	None	None	None
Relief Valves, Automatic	Z21.22-1979	None	None	None
Recomended Practice for Making Solvent Cemented Joints with Polyvinyl Chloride (PVC) Plastic Pipe and Fittings	None	* D2855-78	None	None
Reducing Valves, Water Pressure for Domestic Water Supply System	A112.26.2-1975	None	None	BSR/ASSE 1003-81 IAPMO PS-15-77
Safe Handling of Solvent Cements Used for Joining Thermoplastic Pipe and Fittings	None	F402-80	None	None
Solder, Soft	None	None	QQ-S-571d-63	None
Septic Tank, metal, bituminous-coated	A162.1-1970	None	None	UL70-74
Septic Tank, Steel	None	None	None	CSI77-62
Tape, Pipe Coating, Pressure Sensitive Polyethylene	None	None	L-T-0075 (1)-66	None
Tee, Diversion and Twin Waste Elbow	None	None	None	IAPMO PS-9-77
Thermoplastic Accessible and Replaceable Plastic Tube and Tubular Fittings	None	* F409-81	None	NSF 14

62-03-04-02. Types of joints for piping materials.

1. Caulked.

   a. Cast iron soil pipe. Every lead caulked joint for cast iron hub and spigot soil pipe shall be firmly packed with oakum or hemp and filled with molten lead not less than one inch [2.54 centimeters] deep and not to extend more than one-eighth inch [3.18 millimeters] below the rim of the hub. No paint, varnish, or other coatings shall be permitted on the jointing material until after the joint has been tested and approved. Lead shall be run in one pouring and shall be caulked tight.

   b. Cast iron water pipe. Every lead caulked joint for cast iron bell and spigot water pipe shall be firmly packed with clean, sound asbestos rope or treated paper rope. The remaining space in the hub shall be filled with molten lead according to the following schedule:

Pipe Size	Depth of Lead
Up to twenty inches	Two and one-fourth inches
Twenty-four, thirty, thirty-six inches	Two and one-half inches
Larger than thirty-six inches	Three inches

   Lead shall be run in one pouring and shall be caulked tight.

2. Threaded. Every threaded joint shall conform to the American National Taper Pipe Thread, ANSI B2.1-1960. All burrs shall be removed. Pipe ends shall be reamed or filed out to size of bore, and all chips shall be removed. Pipe joint compound shall be used only on male threads.

3. Wiped. Every joint in lead pipe or fittings, or between lead pipe or fittings and brass or copper pipe, ferrules, solder nipples, or traps, shall be full-wiped joints. Wiped joints shall have an exposed surface on each side of a joint not less than three-fourths inch [19.05 millimeters] and at least as thick as the material being jointed. Wall or floor flange lead-wiped joints shall be made by using a lead ring or flange placed behind the joints at wall or floor. Joints between lead pipe and cast iron, steel, or wrought iron shall be made by means of a caulking ferrule, soldering nipple, or bushing.

4. Soldered. Joints in copper tubing shall be made by the appropriate use of approved brass or copper fittings. The surface to be joined by soldering shall be cleaned bright by manual or mechanical means. The joints shall be properly fluxed with an approved noncorrosive paste type flux and made

up with approved solder. Joints for potable water used in copper, brass, or wrought copper fittings must be made with a solder and flux containing not more than 0.2 percent lead. Soldered joints shall not be used for tube installed underground.

5. Flared. Every flared joint for annealed-temper copper water tube shall be made with fittings meeting approved standards. The tube shall be reamed and then expanded with a proper flaring tool.

6. Precast. Every precast collar shall be formed in both the spigot and bell of the pipe in advance of use. Collar surfaces shall be conical with side slopes of three degrees with the axis of the pipe and the length shall be equal to the depth of the socket. Prior to making joint contact, surfaces shall be cleaned and coated with solvents and adhesives as recommended in the standard. When the spigot end is inserted in the collar, it shall bind before contacting the base of the socket. Material shall be inert and resistant to both acids and alkalies.

7. Brazed joints and extracted mechanical joints.

   a. Brazed joints must be made by first cleaning the surface to be joined down to the base metal, applying flux approved for such joints and for the filler metal to be used, and making the joint by heating to a temperature sufficient to melt the approved brazing filler metal on contact.

   b. An extracted mechanical joint may be made in copper tube. It must be produced with an appropriate tool and joined by brazing. To prevent the branch tube from being inserted beyond the depth of the extracted joint, depth stops must be provided. The brazed joint must be made according to subdivision a.

8. Cement. Except for repairs and connections to existing lines constructed with such joints, cement mortar joints are prohibited. Where permitted, cement mortar joints shall be made in the following manner: A layer of jute or hemp shall be inserted into the base of the annular joint space and packed tightly to prevent mortar from entering the interior of the pipe or fitting. Not more than twenty-five percent of the annular space shall be used for jute or hemp. The remaining space shall be filled in one continuous operation with a thoroughly mixed mortar composed of one part cement and two parts sand, with only sufficient water to make the mixture workable by hand. Additional mortar of the same composition shall then be applied to form a one to one slope with the barrel of the pipe. The bell or hub of the pipe shall be left exposed and when necessary the interior of the pipe shall be

swabbed to remove any mortar or other material which may have found its way into such pipe.

9. **Burned lead (welded).** Every burned (welded) joint shall be made in such manner that the two or more sections to be joined shall be uniformly fused together into one continuous piece. The thickness of the weld shall be at least as thick as the lead being joined.

10. Mechanical (flexible or slip joint).

    a. Cast iron pipe.

        (1) Mechanical joint. Every mechanical joint in cast iron pipe shall be made with a flanged collar, rubber ring gasket, and appropriate number of securing bolts.

        (2) Hubless pipe. Joints for hubless cast iron soil pipe and fittings shall be made with an approved elastomeric sealing sleeve and stainless steel clamp, clamping screw, and housing.

        (3) Bell and spigot pipe. Joints for bell and spigot cast iron soil pipe and fittings may be made by caulking with lead and oakum or by use of a compression gasket that is compressed when the spigot is inserted into the hub of the pipe.

    b. Clay pipe. Flexible joints between lengths of clay pipe may be made using approved resilient materials both on the spigot end and in the bell end of the pipe.

    c. Concrete pipe. Flexible joints between lengths of concrete pipe may be made using approved elastomeric materials both on the spigot end and in the bell end of the pipe. For plain end pipe, see American society for testing and materials C-594; for bell and spigot, see American society for testing and materials C-425.

11. **Tapered couplings.** Every joint in bituminized fiber pipe shall be made with tapered type couplings of the same material as the pipe. Joints between bituminized fiber pipe and metal pipe shall be made by means of an adapter coupling caulked as required in subsection 1.

12. Plastic.

    a. Every joint in plastic piping shall be made with approved fittings by either solvent-cemented or heat-joined connections, approved elastomeric gaskets, metal clamps and screws of corrosion-resistant materials, approved insert fittings, approved mechanical fittings, or threaded

joints according to approved standards. The commingling of acrylonitrile-butadiene-styrene and polyvinyl chloride material is prohibited.

b. An approved ~~purple color~~ primer which is of contrasting color to the pipe and solvent cement ~~not purple in color shall~~ must be used in joining P.V.C. and C.P.V.C. pipe and fittings. A mechanical method of preparing P.V.C. or C.P.V.C. pipe for solvent cement is not acceptable in lieu of using primer. Solvent-cemented plastic joints may not be installed when the temperature in the installation area is less than forty degrees Fahrenheit [4.4 degrees Celsius] or more than ninety degrees Fahrenheit [32.22 degrees Celsius].

13. **Slip.** Every slip joint shall be made using approved packing or gasket material, or approved ground joint brass compression rings. Ground joint brass connections which allow adjustment of tubing but provide a rigid joint when made up shall not be considered as slip joints.

14. **Expansion.** Every expansion joint shall be of approved type and its material shall conform with the type of piping in which it is installed.

15. **Split couplings.** Couplings made in two or more parts and designed for use with plain end or grooved pipe or approved fittings and with compression gaskets may be used for hot and cold water piping and conductors and leaders. Each manufacturer must have the manufacturer's complete joining assembly approved for the intended use by one of the organizations listed in chapter 62-03-03 or by the administrative authority.

History: Amended effective April 1, 1984; July 1, 1985; January 1, 1988; December 1, 1988; October 1, 1989; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-04-03. Types of joints between different piping materials.

1. **Vitrified clay to other material.** Every joint between vitrified clay and other piping materials should be specially formed to vitrified clay and resilient material to meet the test conditions of American society for testing and materials C-425. All adapters must meet requirements of positive jointing and smooth flow line.

2. **Cast iron to vitrified clay.** Every joint between cast iron piping and vitrified clay piping shall be made either of hot poured bitumastic compound or by a preformed elastomeric ring.

This ring shall, after ramming, completely fill the annular space between the cast iron spigot and the vitrified clay hub.

3. **Threaded pipe to cast iron.** Every joint between wrought iron, steel, or brass, and cast iron pipe shall be either caulked or threaded or shall be made with approved adapter fittings.

4. **Lead to cast iron, wrought iron, or steel.** Every joint between lead and cast iron, wrought iron, or steel pipe shall be made by means of wiped joints to a caulking ferrule, soldering nipple, bushing, or by means of a mechanical adapter.

5. **Cast iron to copper tube.** Every joint between cast iron and copper tube shall be made by using an approved brass or copper caulking ferrule and properly soldering the copper tube to the ferrule.

6. **Copper tube to threaded pipe joints.** Every joint from copper tube to threaded pipe shall be made by the use of brass or copper converter fittings. The joint between the copper pipe and the fitting shall be properly soldered, and the connection between the threaded pipe and the fitting shall be made with a standard pipe size screw joint.

7. **Special joints for drainage piping.** Different types of drainage piping materials shall be jointed either by adapter fittings or by means of an acceptable prefabricated sealing ring or sleeve as specifically approved by the administrative authority. <u>For aboveground installations an exterior corrosion-resistant shield to prevent outward expansion of the coupling must be included.</u>

8. **Acrylonitrile-butadiene-styrene or polyvinyl plastic drainage, waste, and venting to other material.**

   a. Threaded joints. Acrylonitrile-butadiene-styrene or polyvinyl drainage, waste, and venting joints when threaded shall use the proper male or female threaded adapter. Use only approved thread tape or lubricant seal or other approved material as recommended by the manufacturer.

      Threaded joints shall not be overtightened. After hand tightening the joint, one-half to one full turn with a strap wrench will be sufficient.

   b. Cast iron hub joints. Joints may be made by caulking with lead and oakum or by use of a compression gasket that is compressed when the plastic pipe is inserted into the cast iron hub end of the pipe. No adapters are required for this connection.

c. Cast iron spigot ends or schedule 40 steel pipe-copper drainage, waste, and venting tube. Joints where the outside diameter of the two pipes or fittings to be joined are the same may be joined with an approved elastomeric sealing sleeve and stainless steel clamp, clamping screw, and housing.

History: Amended effective October 1, 1989; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-06-01. Interceptors and separators.

1. Interceptors and separators required. ~~Interceptors (including grease, oil, and sand interceptors, etc.)~~ All necessary floor drains, sand interceptors, catch basins, oil and flammable liquids separators, and grease interceptors shall be provided when, in the opinion of the administrative authority, they are necessary for the proper handling of liquid wastes containing grease, flammable wastes, sand, solids, and other ingredients harmful to the building drainage system, the public sewer, or sewage-treatment plant or processes.

2. Approval of interceptors and separators. The size, type, and location of each interceptor and of each separator shall be approved by the administrative authority and no wastes other than those requiring treatment or separation shall be discharged into any interceptor or separator.

3. All interceptors to follow type approved. No interceptor shall be hereinafter installed which does not comply, in all respects, with the type or model of each size thereof approved by the administrative authority.

4. Separation of liquids. A mixture of light and heavy liquids having various specific gravities may be treated and then separated in a receptacle as approved by the administrative authority.

5. Venting of interceptors and separators. Interceptors and separators shall be so designed that they will not become airbound if tight covers are used. Each interceptor or separator shall be properly vented if loss of trap seal is possible.

6. Interceptors and separators to be accessible. Each interceptor and separator shall be so installed that it is readily accessible for removal of cover, servicing, and maintenance. Need for use of ladders or moving of bulky objects in order to service interceptors shall constitute a violation of accessibility.

7. Maintenance of interceptors and separators. Interceptors and separators shall be maintained in efficient operating condition by periodic removal of accumulated grease, scum, oil, or other floating substances, and solids deposited in the interceptor or separator.

8. Discharge. The waste pipe from oil and sand interceptors shall discharge into the storm sewer, or as otherwise approved by the administrative authority.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-06-02. Grease interceptors.

1. Commercial buildings. A grease interceptor shall not be required in restaurants, hotel kitchens, bars, factory cafeterias or restaurants, clubs, or other similar establishments (except in special cases as may be determined by the administrative authority).

   Food-waste grinders or dishwashing machines shall not discharge to the building drainage system through a grease interceptor.

2. Water-cooled grease interceptors. The installation of water-cooled grease interceptors shall be prohibited.

3. Grease interceptors capacity. Grease interceptors, if installed, shall have a grease retention capacity of not less than two pounds [90.72 centigrams] for each gallon [3.79 liters] per minute.

Grease Interceptor Capacity		
Total Number of Fixtures	Maximum Rate of Flow per Minute, Gallons	Grease Retention Capacity Pounds
1	20	40
2	25	50
3	35	70
4	50	100

   Note: Multiple compartments sinks may be considered one fixture.

4. Rate of flow controls. Grease interceptors shall be equipped with devices to control the rate of waterflow through the interceptors so that it does not exceed the rated flow of the interceptors.

5. Interceptors not required. A grease interceptor is not required for individual dwelling units or any private living quarters.

6. Trap equivalent. Each fixture discharging into a grease interceptor must be individually trapped and vented in an approved manner. An approved type grease interceptor may be used as a fixture trap for a single fixture when the horizontal distance between the fixture outlet and the grease interceptor does not exceed four feet [1.22 meters] and the vertical tailpipe or drain does not exceed two and one-half feet [.762 meters]. Where the interceptor inlet is above the static water level in the interceptor, a separate trap is required.

History: Amended effective October 1, 1989; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-06-03. Oil and flammable liquids separator.

1. Separators required. All commercial, ~~storage, or~~ repair garages; gasoline stations with grease racks, grease pits, work or wash racks; all motor vehicle laundries with degreasing provisions; and all ~~factories which have~~ buildings where oily or flammable wastes ~~as a result of manufacturing storage, maintenance, repair, or testing processes~~ are produced shall be provided with ~~all necessary floor drains, sand interceptors, catch basins, and~~ oil ~~interceptors properly vented through the roof on the sewer side of the interceptor when, in the opinion of~~ and flammable liquids separator. When a hazard exists, the administrative authority~~, a hazard exists. The waste line shall not be less than three inches [7.62 centimeters] in diameter with a full size cleanout to grade and the vent pipe not less than two inches [5.08 centimeters].~~ ~~The~~ may require the oil ~~interceptor shall~~ separator be provided with an overflow line to a waste oil tank, underwriters' laboratories approved, of adequate size, ~~minimum capacity five hundred fifty gallons [2081.98 liters],~~ and such tank shall be vented with a minimum ~~one and one-half inch [3.81 centimeter]~~ two-inch [5.08-centimeter] vent terminating in the open air at an approved location at least twelve feet [3.66 meters] above grade and with a minimum two-inch [5.08-centimeter] pumpout opening at grade.

2. Design of separators.

   a. Overall requirements. ~~Oil separators~~ Each separator shall be of watertight construction and have a depth of not less than two feet [60.96 centimeters] below the invert of the discharge drain. The outlet opening of the separator shall have not less than an eighteen-inch

[45.72-centimeter] water seal. The minimum size of the inlet and outlet drain must be three inches [7.62 centimeters] with a full size cleanout to grade on the discharge drain. Whenever the outlet branch drain serving a separator is more than twenty-five feet [7.62 meters] from a vented drain, the branch drain must be provided with a two-inch [5.08-centimeter] vent pipe.

~~b. Motor vehicle garages. On each floor of garages where not more than three motor vehicles are serviced and stored, separators shall have a minimum capacity of six cubic feet [.17 cubic meters] and one cubic foot [.03 cubic meter] capacity shall be added for each vehicle up to ten vehicles. Above ten vehicles the administrative authority shall determine the size of the separator required.~~

~~c.~~ b. ~~Service stations and repair shops. Where vehicles are serviced only and not stored, separator~~ Construction and size. Separators must be constructed of monolithic poured reinforced concrete with a minimum floor and wall thickness of four inches [10.16 centimeters], or of a prefabricated cast iron or other watertight material approved by the administrative authority. A nonperforated iron or steel cover and ring of not less than twenty-four inches [60.96 centimeters] in diameter shall be provided. Separator capacity shall be based on a net capacity of one cubic foot [.03 cubic meter] for each one hundred square feet [9.29 square meters] of surface to be drained into the separator with a minimum of six cubic feet [.17 cubic meters].

3. Vapor venting. Oil ~~interceptors~~ separators shall have a minimum size two-inch [5.08-centimeter] vapor vent ~~extending~~ from the air space in the top of the separator ~~and terminating in~~ extending separately to the open air at an approved location at least twelve feet [3.66 meters] above grade.

4. ~~Private garages. Private garages housing not more than three motor vehicles are not required to have a garage drain or oil interceptor. However, if floor drain is provided, a catch basin and oil interceptor must be provided as specified in subsection 1 of section 62-03-06-03.~~

~~5.~~ Combination oil and sand interceptor. A combination oil and sand interceptor may be installed when the design is approved ~~in writing~~ by the administrative authority.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-06-04. Sand interceptors.

1. Where required.

   a. Wherever a floor drain discharges through an oil ~~interceptor~~ separator, it must first discharge through a sand interceptor. Multiple floor drains may discharge into one sand interceptor.

   b. Whenever the discharge of a floor drain may contain solids, or semisolids that would be harmful to a drainage system, or tend to choke the system, the discharge must be through a sand interceptor.

   c. Wherever the administrative authority deems it advisable to have a sand interceptor to protect the drainage system.

2. Construction and size. Sand interceptors ~~shall~~ must be ~~built~~ constructed of ~~brick or concrete and be watertight~~ monolithic poured reinforced concrete with a minimum floor and wall thickness of four inches [10.16 centimters], or of a prefabricated cast iron or other watertight material approved by the administrative authority. The interceptor shall have an interior brick or concrete baffle for the full separation of the interceptor into two sections. The outlet pipe shall be the same size as the inlet size of the oil ~~interceptor~~ separator, the minimum being three inches [7.62 centimeters], and the baffle must have two openings of the same diameter as the outlet pipe and at the same invert as the outlet pipe. These openings must be staggered so that there cannot be a straight line of flow between any inlet pipe and the outlet pipe. The invert of the inlet pipes must be no lower than the invert of the outlet pipe.

   The sand interceptor shall have a minimum dimension of two feet [60.96 centimeters] square for the net free opening of the inlet section and a minimum depth under the invert of the outlet pipe of two feet [60.96 centimeters].

   For each five gallons [18.93 liters] per minute flow or fraction thereof over twenty gallons [75.71 liters] per minute, the area of the sand interceptor inlet section is to be increased by one square foot [929.03 square centimeters]. The outlet section shall at all times have a minimum area of fifty percent of the inlet section.

   The outlet section must be covered by a solid removable cover set flush with the finished floor, and the inlet section shall have an open grating set flush with the finished floor and suitable for the traffic in the area in which it is located.

3. Separate use. When a sand interceptor is used by itself without also discharging through an oil ~~interceptor~~ separator, the outlet pipe must be turned down inside the interceptor under the water level to provide a six-inch [15.24-centimeter]

water seal. A cleanout shall be installed to provide access to the outlet line.

4. **Alternate design.** Alternate designs for construction or baffling of sand interceptors complying with the intent of this code may be submitted to the administrative authority for approval.

5. Residential garages. Residential garages housing motor vehicles are not required to have a garage drain or oil separator. If a floor drain is provided, a catch basin or other means of sand separation approved by the administrative authority must be provided as specified in subsection 1 of section 62-03-06-03.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-07-04. Installation of fixtures.

1. **Access for cleaning.** Plumbing fixtures shall be so installed as to afford easy access for cleaning both the fixture and the area about it. Where practical, all pipes from fixtures shall be run to the nearest wall.

2. **Watertight joints.** Joints formed where fixtures come in contact with walls or floors shall be sealed.

3. **Securing floor-mounted fixtures.** Floor-mounted fixtures shall be rigidly secured to the structure and to their mounting flanges by screws or bolts.

4. **Securing wall-hung water closet bowls.** Wall-hung water closet bowls shall be rigidly supported by a concealed metal hanger which is attached to the building structural members so that no strain is transmitted to the closet connector or any other part of the plumbing system.

5. **Convenient and accessible.** Fixtures shall be set level and in proper alignment with reference to adjacent walls. See Diagram 62-03-07.

6. **Access to concealed connections.** Fixtures having concealed slip joint connections shall be provided with an access panel or utility space or other convenient access so arranged as to make the slip connections accessible for inspection and repair. ~~However, where all joints are soldered, screwed, or solvent welded to form a solid connection, access panels or doors may be eliminated.~~

History: Amended effective July 1, 1985; January 1, 1992.

General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-07-24. Minimum plumbing facilities.

1. Minimum number of fixtures. Plumbing fixtures shall be provided for the type of building occupancy and in the minimum number shown in Table 62-03-07.1. Types of building occupancy not shown in Table 62-03-07.1 will be considered individually by the administrative authority.

2. Separate facilities. In other than residential installations where toilet and bathing facilities are provided to serve members of both sexes and are designed for use by more than one person at a time, separate facilities shall be installed for each sex, except as allowed in table 62-03-07.

History: Amended effective April 1, 1984; July 1, 1985; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-07-25. Facilities for the handicapped.

1. In ~~new~~ newly constructed or remodeled buildings and facilities used by the public, toilet rooms shall be made accessible to, and usable by, the physically handicapped.

2. It is essential that an appropriate number (note 5) of toilet rooms, in accordance with the nature and use of a specific building or facility, be made accessible to, and usable by, the physically handicapped.

3. Toilet rooms for the handicapped shall ~~have space to allow traffic of individuals in wheelchairs~~ conform to the requirements of the administrative authority.

4. Toilet rooms shall have at least one toilet stall that:

   a. Is ~~three feet [91.44 centimeters]~~ forty-two inches [106.68 centimeters] wide.

   b. Is at least ~~four feet eight inches [142.24 centimters], preferably~~ five feet [152.4 centimeters] deep.

   c. Has a door (where doors are used) ~~that is~~ with thirty-two inches [81.28 centimeters] ~~wide~~ clear space and swings out.

d. Has two handrails ~~on each side~~, thirty-three to thirty-six inches [83.82 to 91.44 centimeters] high and parallel to the floor, one and one-half inches [38.1 millimeters] in outside diameter, with one and one-half inches [38.1 millimeters] clearance between rail and wall, and fastened securely ~~at ends and center~~.

e. Has a water closet with the seat ~~eighteen~~ seventeen to ~~twenty inches [45.72 to 50.8 centimeters]~~ nineteen inches [43.18 to 45.72 centimeters] from the floor (standard height bowls with seat that raise bowl height are permissible).

Note: The design and mounting of the water closet is of considerable importance. A wall-mounted water closet with a narrow understructure that recedes sharply is most desirable. If a floor-mounted water closet must be used, it should not have a front that is wide and perpendicular to the floor at the front of the seat. The bowl should be shallow at the front of the seat and turn backward more than downward to allow the individual in a wheelchair to get close to the water closet with the seat of the wheelchair.

5. Toilet rooms shall have ~~lavatories~~ at least one lavatory with ~~narrow aprons~~ twenty-nine-inch [73.66-centimeter] clearance below apron, which when mounted at standard height ~~are~~ is usable by individuals in wheelchairs~~,~~ or shall have lavatories mounted higher, when particular designs demand, so that they are usable by individuals in wheelchairs.

Note: It is important that drainpipes and hot water pipes under a lavatory be covered or insulated so that a wheelchair individual without sensation will not burn oneself.

6. ~~Some mirrors~~ Mirrors and shelves shall be provided above lavatories at a height as low as possible and no higher than forty inches [101.6 centimeters] above the floor, measured from the top of the shelf and the bottom of the mirror.

7. Toilet rooms ~~for men~~ in which more than one urinal is provided shall have one wall-mounted ~~urinals~~ urinal with the opening of the basin ~~nineteen inches [48.26 centimeters]~~ seventeen inches [43.18 centimeters] from the floor.

8. Toilet rooms shall have an appropriate number (note 5) of towel racks, towel dispensers, and other dispensers and disposal units mounted no higher than forty inches [101.6 centimeters] from the floor.

9. Water fountains. An appropriate number (note 5) of water fountains or other water dispensing means shall be accessible to, and usable by, the physically disabled.

10. Water fountains or coolers shall have up-front spouts and controls.

11. Water fountains or coolers shall be hand-operated or hand-and-foot operated. (See also American Standard Specifications for Drinking Fountains, Z4.2-1942.)

Note 1. Conventional floor-mounted water coolers can be serviceable to individuals in wheelchairs if a small fountain is mounted on the side of the cooler thirty inches [76.2 centimeters] above the floor.

Note 2. Wall-mounted, hand-operated coolers of the latest design, manufactured by many companies, can serve the able-bodied and the physically disabled equally well when the cooler is mounted with the basin thirty-six inches [91.44 centimeters] from the floor.

Note 3. Fully recessed water fountains are not recommended.

Note 4. Water fountains should not be set into an alcove unless the alcove is wider than a wheelchair.

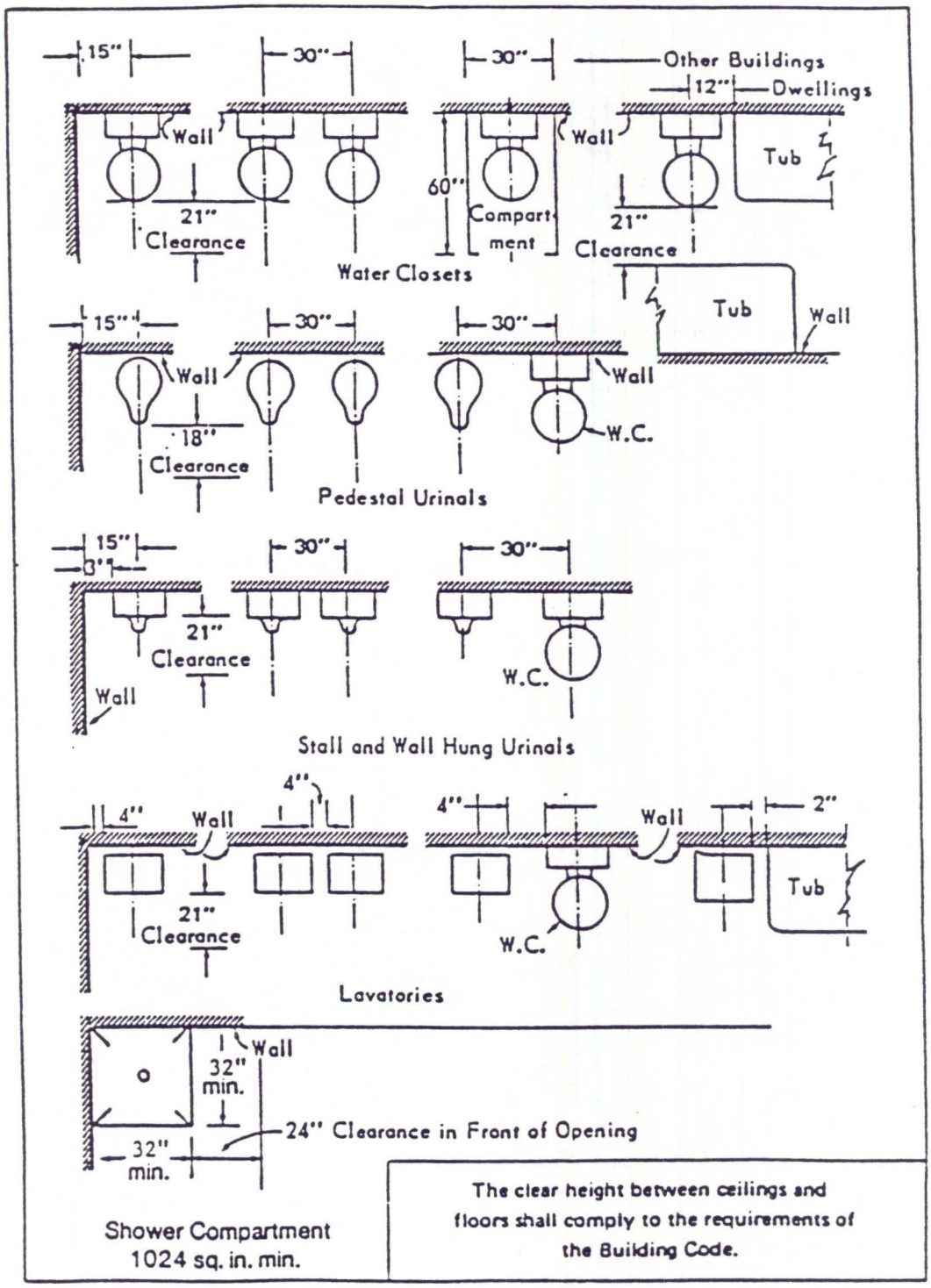
Note 5. As used in this section, appropriate number means the number of a specific item that would be necessary, in accord with the purpose and function of a building or facility, to accommodate individuals with specific disabilities in proportion to the anticipated number of individuals with disabilities who would use a particular building or facility.

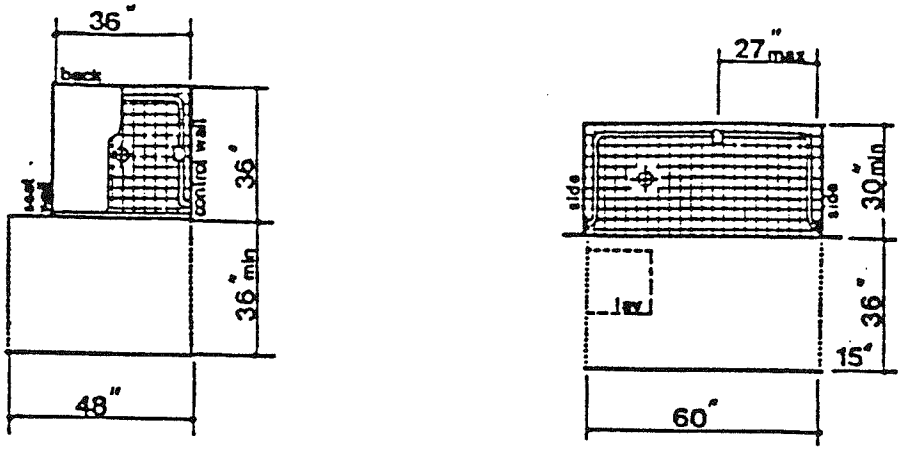
Example: Although these specifications shall apply to all buildings and facilities used by the public, the numerical need for a specific item would differ, for example, between a major transportation terminal, where many individuals with diverse disabilities would be continually coming and going, an office building or factory, where varying numbers of individuals with disabilities of varying manifestations (in many instances, very large numbers) might be employed or have reason for frequent visits, a school or church, where the number of individuals may be fixed and activities more definitive, and many other buildings and facilities dedicated to specific functions and purposes.

Note. Disabilities are specific and where the individual has been properly evaluated and properly oriented and where architectural barriers have been eliminated, a specific disability does not constitute a handicap. It should be emphasized that more and more of those physically disabled are becoming participants, rather than spectators, in the fullest meaning of the word.

History: Amended effective April 1, 1984; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

Diagram 62-03-07 Minimum Fixture Clearances

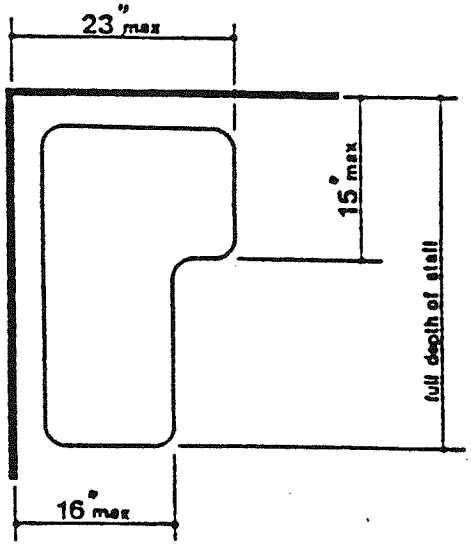




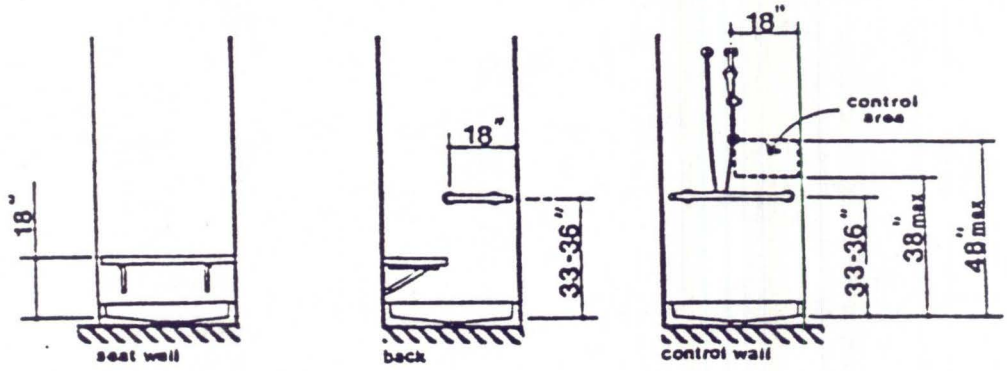
(a)
36-in by 36-in

(b)
30-in by 60-in

Shower Size and Clearances

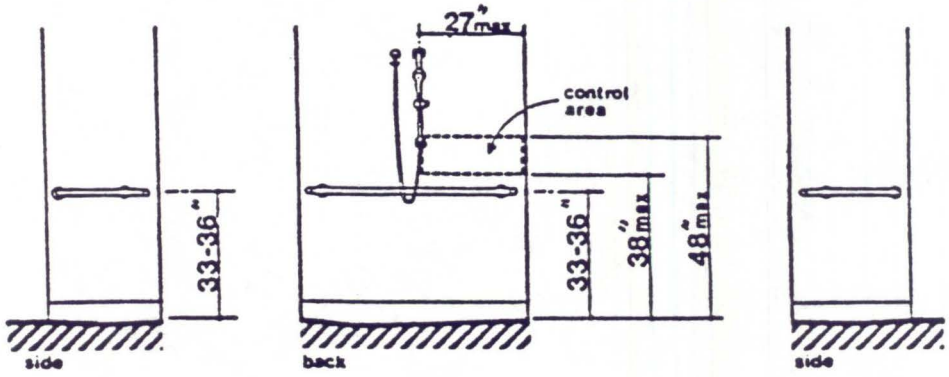


Shower Seat Design



(a)

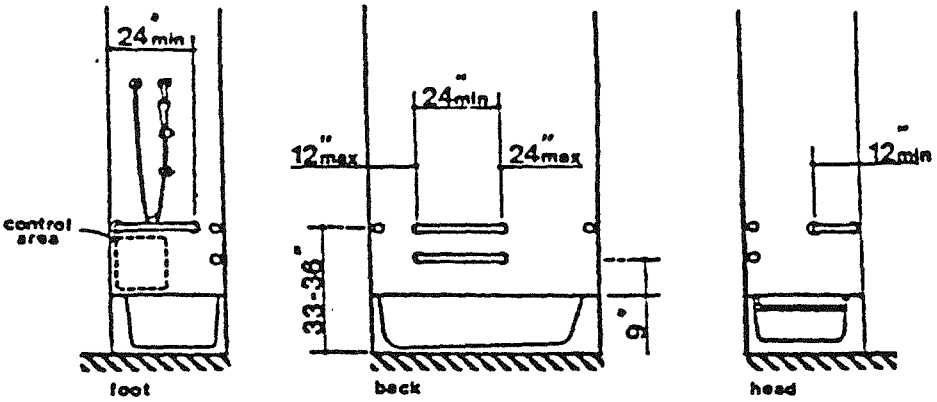
36-in by 36-in



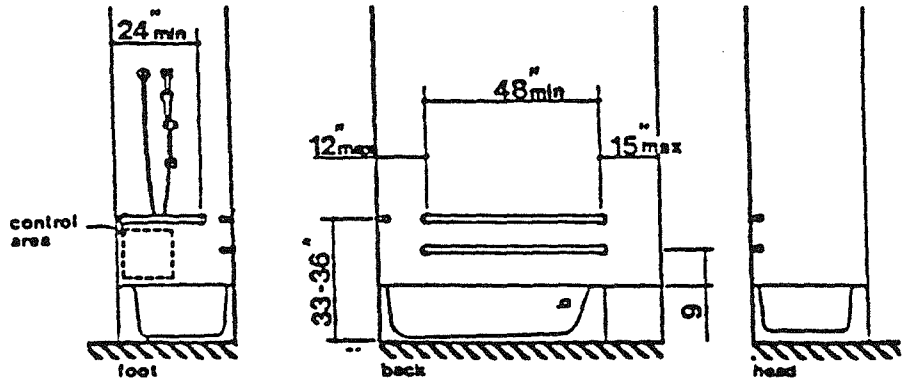
(b)

30-in by 60-in

Grab Bars at Shower Stalls

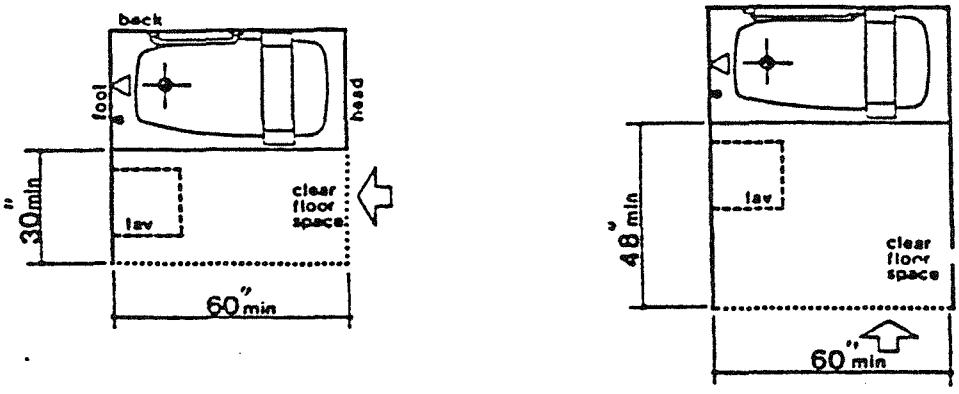


(a)
With Seat in Tub

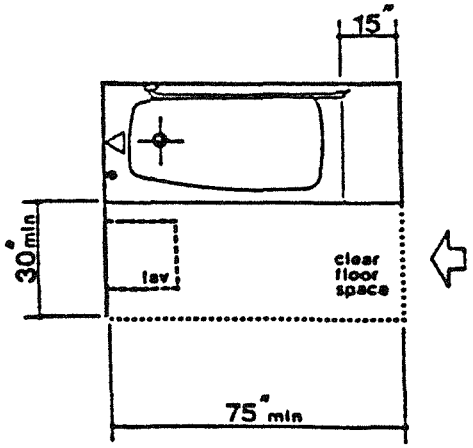


(b)
With Seat at Head of Tub

Grab Bars at Bathtubs



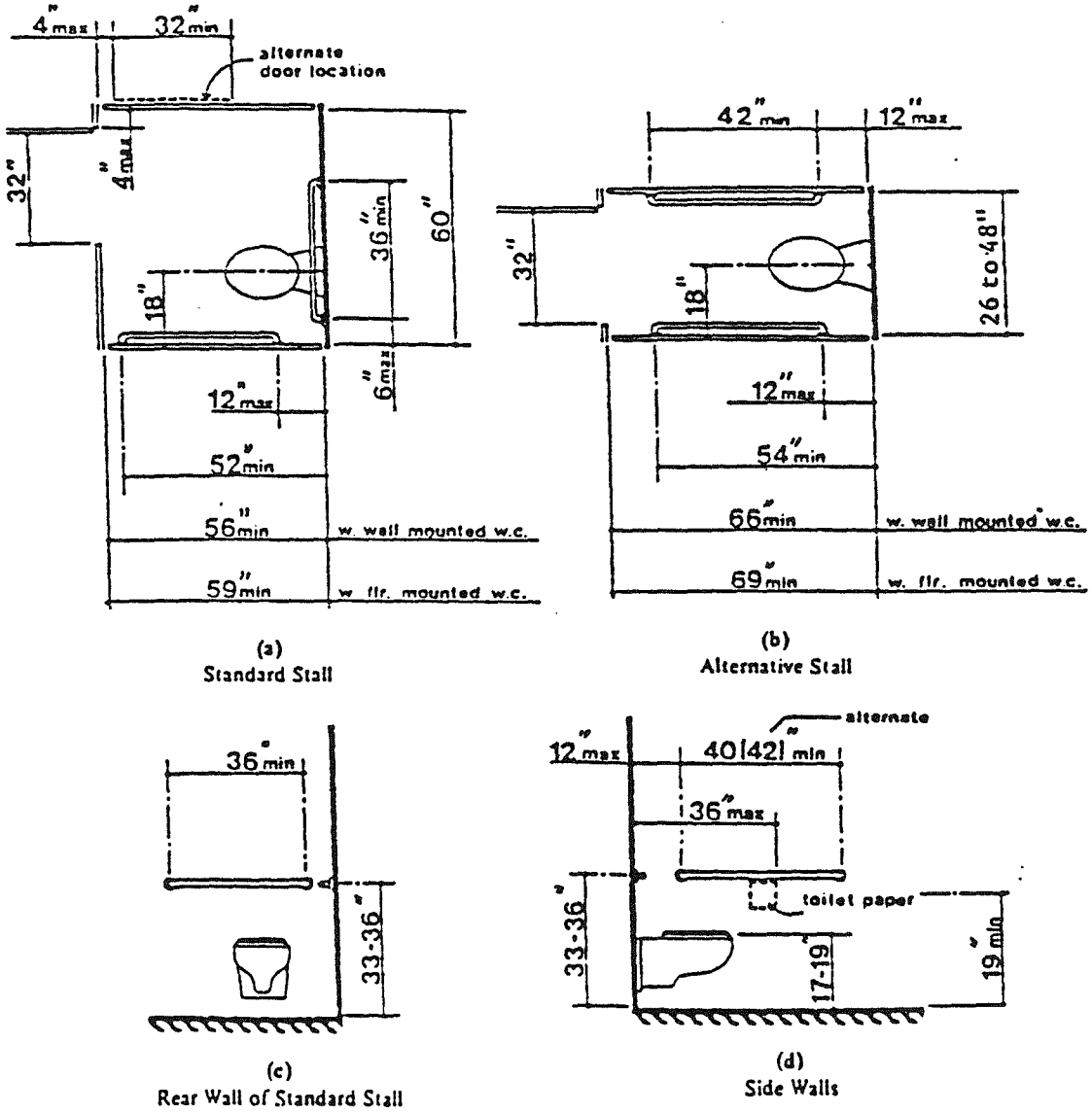
(a)
With Seat in Tub



SYMBOL KEY:
- Shower controls
- Shower head
- Drain

(b)
With Seat at Head of Tub

Clear Floor Space at Bathtubs



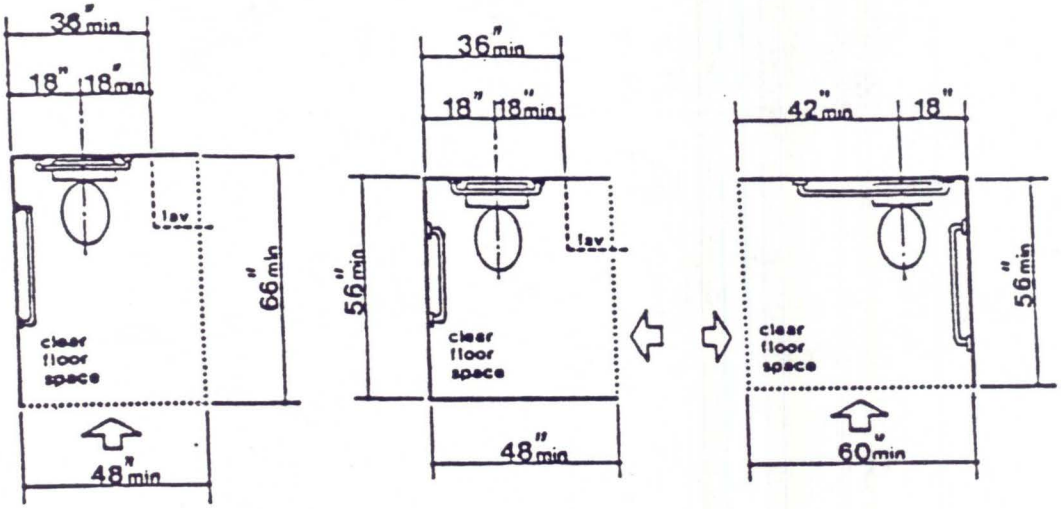
(a)
Standard Stall

(b)
Alternative Stall

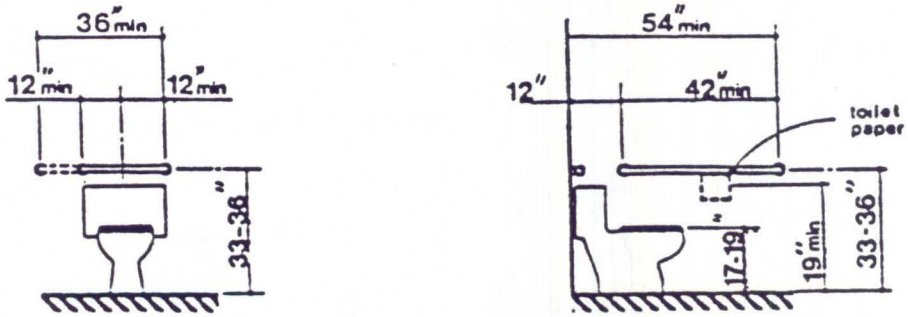
(c)
Rear Wall of Standard Stall

(d)
Side Walls

Toilet Stalls



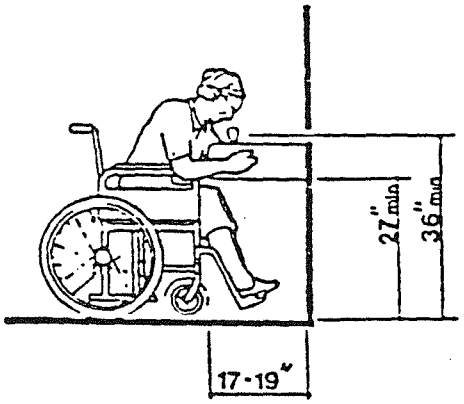
Clear Floor Space at Water Closets



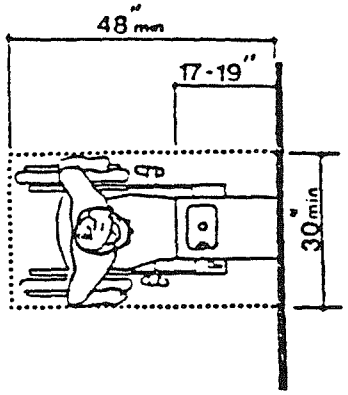
(a)
Back Wall

(b)
Side Wall

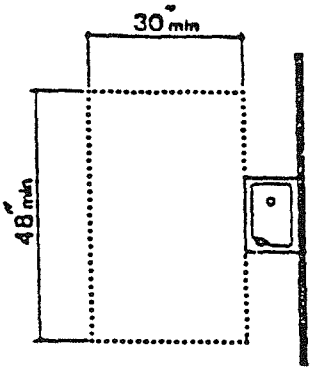
Grab Bars at Water Closets



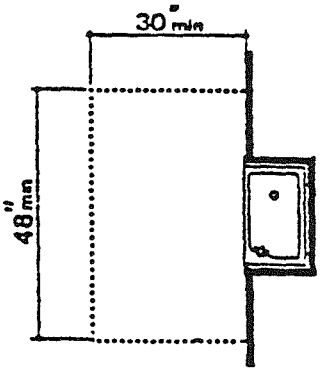
(a)
Spout Height and



(b)
Clear Floor Space

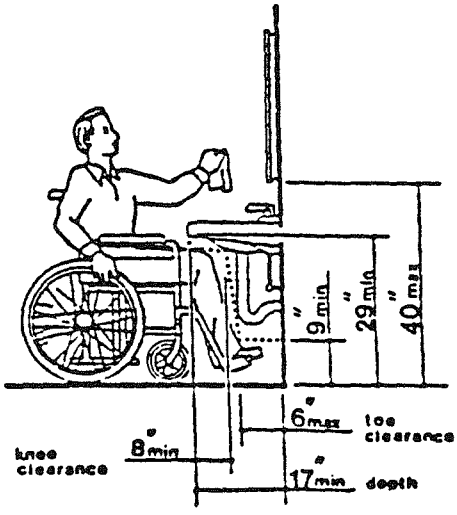


(c)
Free-Standing
Fountain or Cooler

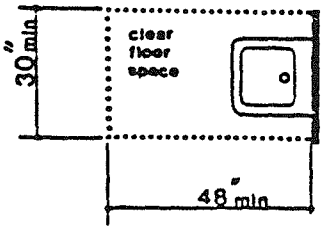


(d)
Built-In
Fountain or Cooler

Drinking Fountains and Water Coolers



Lavatory Clearances



Clear Floor Space at Lavatories

TABLE 62-03-07
MINIMUM NUMBER OF PLUMBING FIXTURES

Use Group or Type of Bldg.	Water Closets (Urinals - See Note 4) No. of Persons Per Sex	Water Closets (Urinals - See Note 4) No. of Fixtures	Lavatories	Fountains	Bathtubs or Showers	Other	Note Reference
I. Assembly							
A. Assembly "Quiet" or "Brief" includes churches, auditoriums, museums, theatres, waiting rooms, day rooms, libraries, and other similar uses.	1-50 51-300 each add'n 300	1 2 add 1	1/2 no. of water closets	1/1000 people	—	—	3,5,8,10
B. Assembly - where food and drinks are served. Includes arenas, stadiums, ball parks, passenger terminals, convention halls and other similar uses.	1-50 51-100 101-200 201-400 each add'n 300	1 2 3 4 add 1	1/2 no. of water closets	1/1000 people	—	—	2,3,5,8
C. Assembly - Restaurants, bars, and nightclubs where seating is provided.	1-30 31-80 81-150 151-300 each add'n 200	1 2 3 4 add 1	1/2 no. of water closets		—	1 service sink/floor	2,3,5,8
D. Assembly - Recreational facilities includes health spas, country clubs, public swimming pools and other similar uses.	1-40 each add'n 40	1 add 1	1/2 no. of water closets	1/100 people	1 shower/ 40 people	1 service sink/floor (where applicable)	3,5,8,10

TABLE 62-03-07
MINIMUM NUMBER OF PLUMBING FIXTURES

Use Group or Type of Bldg.	Water Closets (Urinals - See Note 4) No. of Persons Per Sex	Water Closets (Urinals - See Note 4) No. of Fixtures	Lavatories	Fountains	Bathtubs or Showers	Other	Note Reference
E. Assembly - Schools,							
1. Preschool	1-15 each add'n 15	1 add 1	1/2 no. of water closets	1/100 people	—	1 service sink/floor	3,5,8,10
2. Elemetary	1-25 each add'n 25	1 add 1	1/2 no. of water closets	1/100 people	—	1 service sink/floor	3,5,8,10
3. Secondary	1-30 each add'n 30	1 add 1	1/2 no. of water closets	1/100 people	—	1 service sink/floor	3,5,8,10
II. Workplaces							
A. Industrial - Service when a locker room is provided and used mainly at shift change.	1-10 11-25 26-50 51-75 76-100 each add'n 50	1 2 3 4 5 add 1	1/2 no. of water closets	1/100 people	1 shower/ sink/floor when exposed to extreme heat or skin contamination	1 service sink/floor	3,5,8
B. Employees - all occupancies except industrial/service such as in stores shopping centers, banks, office buildings, and light industrial/service uses without locker rooms.	1-8 9-40 41-75 each add'n 60	1 2 3 add 1	1/2 no. of water closets	1/100 people	—	1 service sink/floor	3,5,8,10

TABLE 62-03-07
MINIMUM NUMBER OF PLUMBING FIXTURES

Use Group or Type of Bldg.	Water Closets (Urinals - See Note 4) No. of Persons Per Sex	Water Closets (Urinals - See Note 4) No. of Fixtures	Lavatories	Drinking Fountains	Bathtubs or Showers	Other	Note Reference
III. Mercantile/Business							
A. Customers in stores, shopping centers, banks, office buildings and carry-out food establishments where seating is not provided.	1-50 51-300 each add'n 300	1 2 add 1	1/2 no. of water closets	1/1000 people			2,3,5,6, 8,10,11
IV. Dwelling Units							
A. Single	—	1	1	—	1	1 kitchen sink 1 laundry tray or 1 auto/ washer standpipe	
B. Multiple	—	1/unit	1/unit	—	—	1 kitchen sink/unit 1 laundry tray, or auto/washer standpipe/ per 4 units up to 12	9

TABLE 62-03-07
MINIMUM NUMBER OF PLUMBING FIXTURES

Use Group or Type of Bldg.	Water Closets (Urinals - See Note 4) No. of Persons Per Sex	Water Closets (Urinals - See Note 4) No. of Fixtures	Lavatories	Fountains	Bathtubs or Showers	Other	Note Reference
C. Dormitories, Boarding Houses	1-20 each add'n 20	2 add 1	1/2 no. of water closets	1/100 people or 1/floor	1-20 people 2 fixtures each add'n 20 add 1	1 service sink/floor 1 laundry tray, or auto/washer standpipe/ 10 people	3
D. Hotel/Motel	—	1/unit	1/unit	—	1/unit	1 service sink/floor	
V. Institutional							
A. Hospital	1-8 patients each add'n 8	1 add 1	1/2 no. of water closets	—	1/20 patients	1 service sink/floor	
B. Hospital - Private or semi-private rooms	—	1	1	—	1	—	
C. Penal short term detention	1/cell or 1/4 inmates	— —	1/cell or 1/4 inmates	—	1/6 inmates	1 service sink/floor	Water closet and lavatory may be a combination fixture. All showers and lav. in penal institutions to have thermostatic control and timing devices
Long term correctional	1/cell or 1/8 inmates	— —	1/15 inmates 1/8 inmates	—	1/15 inmates	1 service sink/floor	

NOTES:

1. This table shall be used in the absence of local building code requirements. Fire codes may also be consulted for assembly values. For handicap requirements see local, state and national ordinances. Additional fixtures may be required where environmental conditions or special activities may be encountered.
2. In food preparation areas, fixture requirements may be dictated by local health codes.
3. Whenever both sexes are present in approximately equal numbers, multiply the total census by 50 percent to determine the number of persons for each sex to be provided for. This regulation only applies when specific information, which would otherwise affect the fixture count, is not provided.
4. Not more than 50 percent of the required number of water closets may be urinals. When additional water closets or urinals are provided the appropriate number of lavatories must also be provided.
5. In buildings constructed with multiple floors, accessibility to the fixtures shall not exceed one vertical story.
6. Fixtures for public uses as required by this section may be met by providing a centrally located facility accessible to several stores. The maximum distance from entry to any store to this facility shall not exceed 500 feet.
7. In stores with floor area of 150 square feet or less, the requirements of this section to provide facilities for uses by employees may be met by providing a centrally located facility accessible to several stores. The maximum distance from entry to any store to this facility shall not exceed 300 feet.
8. Fixtures accessible only to private offices shall not be counted to determine compliance with this section.
9. Multiple dwelling units or boarding houses without public laundry rooms, shall have one laundry tray or one automatic washer standpipe for each dwelling unit. When public laundry rooms are provided, one laundry tray or automatic washer standpipe shall be required for each four apartments. For multiple dwelling units over twelve, add one laundry tray or one automatic washer standpipe for each additional eight units.
10. Where the total number of persons do not exceed eight, one toilet facility with one water closet and one urinal with a lockable door is permitted.
11. Requirements for employees and customers may be met with a single set of restrooms. The required number of fixtures shall be the greater of the required number for employees, or the required number for customers.

History: Effective July 1, 1985; amended effective October 1, 1989; January 1, 1992.

62-03-09-01. Indirect wastes.

1. Airgap or air break required. All indirect waste piping shall discharge into the building drainage system through an airgap or air break, as set forth in this article.

2. Food handling establishments.

   a. In the case of food handling establishments engaged in the storage, preparation, selling, serving, processing, or otherwise handling foods, indirect waste piping shall be provided for refrigerator coils, walk-in freezers, walk-in coolers, ice boxes, ice making machines, steam kettles, steam tables, potato peelers, egg boilers, coffee urns, and similar types of enclosed equipment, and sinks that are used for soaking or washing ~~ready-to-serve~~ food.

   b. Subdivision a does not apply to any dishwashing or culinary sink in any food preparation room, unless such receptacle is used for soaking or washing ready-to-serve food.

   c. The indirect waste shall discharge through an airgap or air break into a trapped and vented receptor except that an airgap is required where the indirect waste pipe may be under vacuum (less than atmospheric pressure).

   d. The waste from a dishwashing machine shall be indirectly connected through an airgap or air break, or be directly connected to the sewer side of a floor drain trap located adjacent to the dishwashing machine.

   e. This subsection does not apply to private living quarters or dwelling units.

3. Bar and fountain sink traps. When sinks in bars, soda fountains, and counters are so located that the traps serving such sinks cannot be vented, a combination waste and vent system (section 62-03-12-17) three inches [7.62 centimeters] in diameter shall connect to the sewer side of a floor drain located adjacent to the sink. Sink compartments used for storing ice shall be connected with an airgap or air break to the drainage system.

4. Connections from water distribution system. Indirect waste connections shall be provided for drains, overflows, or relief pipes from the water distribution system by means of an airgap.

5. Sterilizers. Appliances, devices, or apparatus such as stills, sterilizers, and similar equipment requiring waste connections and used for sterile materials shall be indirectly connected by means of airgap.

6. Drips or drainage outlets. Appliances, devices, or apparatus not regularly classed as plumbing fixtures but which have drips or drainage outlets may be drained by indirect waste pipes discharging into an open receptacle through either an airgap or air break as shall be determined by the administrative authority.

7. Pressure tanks, boilers, and relief valves. The drains from pressure tanks, boilers, relief valves, and similar equipment may discharge indirectly to the drainage system by means of an airgap and without any traps or vents on the indirect piping.

8. Air-conditioning equipment. No evaporative cooler, air washer, air handling, or similar air-conditioning equipment shall have any drain pipe in connection therewith directly connected to any soil, waste, or vent pipe. Such equipment shall be drained by means of indirect waste pipe. The indirect waste shall discharge through an airgap or air break into an open floor sink, floor drain, or other approved type receptor which is properly connected to the drainage system, except that an airgap is required where the indirect waste pipe may be under vacuum.

History: Amended effective July 1, 1985; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-10-05. Protection against backflow and backsiphonage.

1. Water outlets. A potable water system shall be protected against backflow and backsiphonage by providing at each outlet by the following:

   a. An airgap as specified herein between the potable water outlet and the flood level rim of the fixture it supplies or between the outlet and any other source of contamination.

   b. Where an airgap is impracticable, a backflow preventer device or vacuum breaker approved as hereinafter provided.

2. Minimum required airgap.

   a. How measured. The minimum required airgap shall be measured vertically from the lowest end of a potable water outlet to the flood rim or line of the fixture or receptacle into which it discharges.

   b. Size. The minimum required airgap shall be twice the effective opening of a potable water outlet unless the outlet is a distance less than three times the effective opening away from a wall or similar vertical surface in

which cases the minimum required airgap shall be three times the effective opening of the outlet. In no case shall the minimum required airgap be less than shown in the following table:

MINIMUM AIRGAPS FOR PLUMBING FIXTURES

Fixture	Minimum Airgap	
	When Not Affected By Near Wall * (Inches)	When Affected By Near Wall ** (Inches)
Lavatories and other fixtures with effective opening not greater than 1/2 inch diameter	1	1 1/2
Sink, laundry trays, gooseneck bath faucets and other fixtures with effective openings not greater than 3/4 inch diameter	1 1/2	2 1/4
Over rim bath fillers and other fixtures with effective openings not greater than 1 inch diameter	2	3
Drinking water fountains - single orifice not greater than 7/16 (0.437) inch diameter or multiple orifices having total area of 0.150 square inches (area of circle 7/16 inch diameter)	1	1 1/2
Effective openings greater than one inch	2X Diameter of effective opening	3X Diameter of effective opening

* Side walls, ribs, or similar obstructions do not affect airgaps when spaced from inside edge of spout opening a distance greater than three times the diameter of the effective opening for a single wall, or a distance greater than four times the diameter of the effective opening for two intersecting walls.

** Vertical walls, ribs, or similar obstructions extending from the water surface to or above the horizontal plane of the spout opening require a greater airgap when spaced closer to the nearest inside edge of spout opening than specified in Note 1, above. The effect of three or more such vertical walls or ribs has not been determined. In such cases, the airgap shall be measured from the top of the wall.

3. Devices for the protection of the potable water supply. When plumbing fixtures and equipment are subject to backflow conditions, approved backflow preventers or vacuum breakers must be used. Connection to the potable water supply system, for the following fixtures or equipment, must be protected against backflow with any one or more of the devices as indicated.

   a. Low inlet to receptacles containing toxic substances (vats, storage containers, plumbing fixtures).

      (1) An approved airgap.

      (2) Reduced pressure principle backflow preventer.

      (3) Pressure vacuum breaker unit.

      (4) Atmospheric vacuum breaker unit.

   b. Low inlet to receptors containing nontoxic substances (steam, air, food, beverages, etc.)

      (1) An approved airgap.

      (2) Reduced pressure principle backflow preventer.

      (3) Pressure vacuum breaker unit.

      (4) Atmospheric vacuum breaker unit.

      (5) Approved doublecheck valve assembly.

   c. Outlets with hose attachments which may constitute a cross connection.

      (1) An approved airgap.

      (2) Reduced pressure principle backflow preventer.

      (3) Pressure vacuum breaker unit.

      (4) Atmospheric vacuum breaker unit.

   d. Coils or jackets used as heat exchangers in compressors, degreasers, and other such equipment involving toxic substances.

      (1) An approved airgap.

      (2) Reduced pressure principle backflow preventer.

      (3) Pressure vacuum breaker unit.

e. Heat exchangers for ~~systems used for~~ potable hot water supply which utilize heat recovery or solar ~~systems~~ recovery.

(1) Heat exchangers with a pressure on the transfer fluid side above the potable hot water side must be separated from the potable water by a double wall construction. A space open to atmosphere must be provided between the two walls.

(2) Exception:

~~(a) Heat exchangers using a potable water transfer fluid may be of single wall construction.~~

~~(b)~~ Heat exchangers with a pressure on the transfer fluid side ~~a minimum of ten pounds per square inch~~ lower than the pressure on the potable water side and ~~protected with a pressure gradient monitor~~ the heating system is equipped with an approved pressure relief valve set at a minimum of ten pounds per square inch lower than the potable water operating pressure may be of single wall construction. ~~The pressure gradient monitor must be maintained as per subsection 4.~~

f. Systems subject to back pressure.

(1) Nontoxic substances.

(a) An approved airgap.

(b) Reduced pressure principle backflow preventer.

(c) Approved doublecheck valve assembly.

(2) Toxic substances.

(a) An approved airgap.

(b) Reduced pressure principle backflow preventer.

(3) Sewage. An approved airgap.

g. Lawn sprinkler or irrigation systems.

(1) Systems without pumps or connections for fertilizer or chemical attachments.

(a) Reduced pressure principle backflow preventer.

(b) Approved double check valve assembly.

(c) Pressure vacuum breaker.

(d) Atmospheric vacuum breaker.

(2) Systems with connections for fertilizer or chemical attachments. Reduced pressure principle backflow preventer.

h. Fire protection systems.

(1) Systems with piping connected to potable water.

(a) Reduced pressure principle backflow preventer.

(b) Approved double check valve assembly,

(2) Systems with direct connections to nonpotable sources or with toxic chemical additives or antifreeze. Reduced pressure principle backflow preventer.

4. Approval of devices. Before any device for the prevention of backflow or backsiphonage is installed, it shall have first been certified by a recognized testing laboratory acceptable to the administrative authority. Devices installed in a building potable water supply distribution system for protection against backflow shall be maintained in good working condition by the person or persons responsible for the maintenance of the system.

5. Installation of backflow preventers.

a. Atmospheric vacuum breakers. Atmospheric vacuum breakers shall be installed with the critical level at least six inches [15.24 centimeters] above the flood level rim of the fixture they serve and on the discharge side of the last control valve to the fixture. No shutoff valve or faucet shall be installed beyond the vacuum breaker. Where C-L mark is not shown on the preventer, the bottom of the device shall be the C-L reference.

b. Pressure type vacuum breakers. Pressure type vacuum breakers must be installed at a height of at least twelve inches [30.48 centimeters] above the flood level rim of the fixture, tank, or similar device.

c. Doublecheck valves and reduced pressure principle valves. Such devices must be installed at not less than twelve inches [30.48 centimeters] above the floor. A reduced pressure zone type backflow preventer must be installed where there is a high potential health hazard.

d. Devices of all types. Backflow and backsiphonage prevention devices shall be accessibly located. Backflow

prevention devices may not be installed in pits or similar potentially submerged locations. All devices with a vent to atmosphere may not be located within a fuel hood.

6. Tanks and vats - Below rim supply.

   a. Where a potable water outlet terminates below the rim of a tank or vat and the tank or vat has an overflow of diameter not less than given in the table in subsection 3 of section 62-03-10-08, the overflow pipe shall be provided with an airgap as close to the tank as possible.

   b. The potable water outlet to the tank or vat shall terminate a distance not less than one and one-half times the height to which water can rise in the tank above the top of the overflow. This level shall be established at the maximum flow rate of the supply to the tank or vat and with all outlets closed except the airgapped overflow outlet.

   c. The distance from the outlet to the high water level shall be measured from the critical point of the potable water supply outlet.

7. Connections to boilers. Potable water connections to boiler feed water systems must be made through an airgap or provided with an approved doublecheck backflow preventer with atmospheric vent and appropriate testing arrangements. If toxic materials are to be used in the boiler, additional protection must be installed.

8. Refrigeration unit condensers and cooling jackets. Except where potable water provided for a refrigeration condenser or cooling jacket is entirely outside the piping or tank containing a toxic or flammable refrigerant as listed in American national standards institute B9.1-1964 Par. 5.1.2 and 5.1.3 or with two separate thicknessess of metal separating the refrigerant from the potable water supply, inlet connection must be provided with an approved doublecheck valve assembly. Also, adjacent to and at the outlet side of the doublecheck valve, an approved pressure relief valve set to relieve at five pounds per square inch [2.27 kilograms per 6.45 square centimeters] above the maximum water pressure at the point of installation must be provided if the refrigeration units contain more than twenty pounds [9.07 kilograms] of refrigerants.

9. Connections to carbonated beverage dispensers.

   a. Water supply connections to a carbonated beverage dispenser must be made with a doublecheck valve with atmospheric vent or equivalent protection. The doublecheck valve with atmospheric vent devices must be

located within twelve inches [30.48 centimeters] of the equipment.

b. The piping downstream of this backflow preventer shall not be affected by carbon dioxide gas.

10. Barometric loop. Water connections not subject to back pressure where an actual or potential backflow or backsiphonage hazard exists may in lieu of devices specified in subsection 5 be provided with a barometric loop. Barometric loops shall precede the point of connection.

11. Lawn sprinklers. Lawn sprinkler systems when connected to a potable water system shall be installed in accordance with this section. Adequate and proper provision shall be made for control and drainage, and to prevent backsiphonage. The water supply lines may be laid at a depth less than three and one-half feet [106.68 centimeters], if and when approved by the administrative authority. Detailed plans of lawn sprinkler systems shall be submitted with the application for a permit to make the installation. Water shall not be turned on to any lawn sprinkler system until it has been inspected and approved. The administrative authority shall give approval on the materials used in the installation of lawn sprinkler systems.

History: Amended effective October 1, 1989; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-10-09. Disinfection of potable water system. New or repaired potable water systems shall be disinfected prior to use whenever required by the authority having jurisdiction. The method to be followed shall be that prescribed by the health authority or, in case no method is prescribed by the health authority, the following:

1. The pipe system shall be flushed with clean, potable water until no dirty water appears at the points of outlet.

2. The system or part thereof shall be filled with a water-chlorine solution containing at least fifty parts per million of chlorine and the system or part thereof shall be valved off and allowed to stand for twenty-four hours~~.~~ , or

~~3.~~ ~~The~~ the system or part thereof shall be filled with a water-chlorine solution containing at least two hundred parts per million of chlorine and allowed to stand for three hours.

~~4.~~ 3. Following the allowed standing time the system shall be flushed with clean potable water until no chlorine remains in the water coming from the system.

~~5.~~ 4. The procedure shall be repeated if it is shown by a bacteriological examination made by the authority that contamination still persists in the system.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-10-12. Water supply control valves.

1. Curb valve. On each water service from a street main to a building, an approved gate valve or ground key stopcock or ball valve shall be installed near the curbline between the property line and the curb. This valve or stopcock shall be provided with an approved curb valve box and may not be under a driveway.

2. Building valve. Each building water service up to two inches [5.08 centimeters] shall be provided with a ~~gate valve or~~ ball valve of same nominal size. For water service over two inches [5.08 centimeters], a gate valve of same nominal size may be used. The valve must be located inside the building near the point where the water service enters. Where there are two or more water services serving one building, a check valve shall be installed on each service in addition to the above valves.

3. Tank controls. Supply lines from pressure or gravity tanks shall be valved at or near the tanks.

4. Valves in dwelling units. All water closets and kitchen sinks shall have individual fixture valves installed. Valves must also be installed for each bath, shower, powder room, or fixture group. A group of fixtures means two or more fixtures adjacent to each other in the same family unit, but not necessarily in the same room. In a one family unit, one or two bathrooms back to back or one over the other may be considered a group. However, in each dwelling unit with two or more bathroom groups not adjacent to each other, one or more control valves or individual fixture valves shall be provided so that each group may be isolated from the other.

   In more than single family dwelling units, one or more control valves shall be provided so that the water to any plumbing fixture or group of fixtures in any one dwelling unit may be shut off without stopping flow of water to fixtures in other dwelling units. These valves shall be accessible inside the building unit controlled.

5. Riser valves. Except in single family dwellings, a valve shall be installed at the foot of each water supply riser. In multistory buildings, a valve shall be installed at the top of

each water supply downfeed pipe and also at the base where required to isolate this riser for servicing.

6. **Individual fixture valves.** In occupied buildings other than dwellings, the water distribution line to each fixture or other piece of equipment shall be provided with a valve or fixture stop to shut off the water to the fixture or the room in which it is located. Except in single family dwellings, sill cocks and wall hydrants shall be separately controlled within eight feet [2.438 meters] by an accessible valve inside the building.

7. **Water heating equipment valve.** The cold water branch to each hot water storage tank or water heater shall be provided with a valve located near the equipment and only serving this equipment. The hot water line from each hot water storage tank or water heater shall be provided with a valve when the line is one inch [2.54 centimeters] or larger. Each tank or heater shall be equipped with an approved automatic relief valve as specified in subsection 1 of section 62-03-10-16.

8. **Meter valve.** A gate valve or ball valve shall be installed in the line on the discharge side of each water meter.

9. **Valves to be accessible.** All water supply control valves shall be placed so as to be accessible for service and maintenance.

10. **Control valve design.** Except to single fixtures, control valves on all waterlines shall, when fully opened, have a cross-sectional area not less than eighty-five percent of the cross-sectional area of the line in which they are installed.

11. Wall hydrants. Wall hydrants subject to freezing must be of the frostproof type with integral backflow protection and automatic draining with hose attached.

History: Amended effective November 1, 1979; July 1, 1985; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-10-14. Procedure in sizing the water distribution system.

1. **Design of building water distribution system.** Water piping systems shall be designed and installed so that the maximum velocity at any time shall not exceed eight feet [2.44 meters] per second. If a manufacturer's recommendations, or an industry's standards, limits the recommended velocities in any particular piping material to a value lower than eight feet [2.44 meters] per second, then the reduced velocity limit shall be the maximum design.

2. Size of fixture supply. The minimum sizes of a fixture supply pipe shall be as shown in the table contained in this subsection. The fixture supply pipe shall be extended to within at least thirty inches [76.2 centimeters] of the point of connection to the fixture, and be within the same area and physical space as the point of connection to the fixture. Not more than two fixtures shall be supplied by a one-half-inch [12.7-millimeter] pipe. All future fixture connections must be considered in sizing pipe at the time of initial installation.

MINIMUM SIZES OF FIXTURE WATER SUPPLY PIPES

Type of Fixture or Device	Nominal Pipe Size (Inches)	Type of Fixture or Device	Nominal Pipe Size (Inches)
Bathtubs	1/2	Shower (single head)	1/2
Combination sink and tray	1/2	Sinks (service)	1/2
Drinking fountain	3/8	Sinks (flushing rim)	3/4
Dishwasher (domestic)	1/2	Urinal (flush tank)	1/2
Electric drinking water cooler	3/8	Urinal (direct flush valve)	3/4
Kitchen sink, residential	1/2	Water closet (tank type)	3/8
Kitchen sink, commercial	3/4	Water closet (flush valve type)	1
Lavatory	3/8	Hose bibb	1/2
Laundry tray 1, 2, or 3 compartments	1/2	Wall hydrant	1/2

3. Flow rates.

   a. Minimum flow rates and pressures required in water distribution system. Based on the minimum static pressure available, pipe sizes shall be selected so that under conditions of peak demand a minimum flow pressure at the point of discharge shall be not less than required to maintain minimum flow rates listed in the table contained in this subsection. Pipe sizes for flush valve water closets and urinals shall be adequate to maintain flow pressures of twenty-five pounds per square inch [11.34 kilograms per 6.45 square centimeters] for blowout action and fifteen pounds per square inch [6.80 kilograms per 6.45 square centimeters] for jet action fixtures or as required by the manufacturer.

b. Maximum flow rates. Flow rates for fixtures in commercial and public buildings shall be regulated at the fixture to prevent flow rates from exceeding maximum rates listed in the table contained in this subsection for either hot or cold water.

MINIMUM AND MAXIMUM FLOW RATES PER OUTLET

Fixture	Flow Rate Minimum	~~GPM~~ Flow Rate Maximum
Lavatory	~~2~~	~~4~~ 3.0
Sink	~~4~~	~~8~~ 3.0
Bathtub	~~6~~ 4	-
Laundry tray	~~5~~	- 3.0
Shower	~~4~~	~~8~~ 3.0
~~Water closets~~		
~~Tank type .....~~	~~3~~	~~6~~
~~Blowout action~~		
~~→ ..~~	~~Depends on Flow Pressure~~	
~~Jet action →~~		
Drinking fountain ..	0.75	2.0
Wall hydrant	5	-

4. Inadequate water pressure. Whenever water pressure from the street main or other sources of supply is insufficient to provide flow pressures at fixture outlets as required under subsection 3, a booster pump and pressure tank or other approved means shall be installed on the building water supply system.

5. Variable street pressures. Where street water main pressures fluctuate, the building water distribution system shall be designed for the minimum pressure available.

6. Excessive pressures. When street main pressure exceeds eighty pounds per square inch [36.29 kilograms per 6.45 square centimeters], an approved pressure reducing valve shall be installed in the water service pipe near its entrance to the building to reduce the water pressure to eighty pounds per square inch [36.29 kilograms per 6.45 square centimeters] or lower except where the water service pipe supplies water directly to a water pressure booster system, an elevated water gravity tank, or to pumps provided in connection with a hydropneumatic or elevated gravity water supply tank system. Pressure at any fixture shall be limited to no more than eighty pounds per square inch [36.29 kilograms per 6.45 square centimeters] under no-flow conditions.

7. Water hammer. All building water supply systems in which quick acting valves are installed shall be provided with devices to absorb high pressures resulting from the quick closing of these valves. These pressure absorbing devices shall be either air chambers or approved mechanical devices. Water pressure absorbers shall be placed as close as possible to the quick acting valves or installed also at the ends of long pipe runs or near batteries of fixtures.

   a. Air chambers. Where air chambers are installed, they shall be in an accessible place and each air chamber shall be provided with an accessible means for restoring the air in event the chamber becomes waterlogged.

   b. Mechanical devices. Where mechanical devices are used, the manufacturer's specifications shall be followed as to location and method of installation.

History: Amended effective July 1, 1985; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-10-15. Hot water distribution.

1. Hot water supply system. In residences and buildings intended for human occupancy, hot water shall be supplied to all plumbing fixtures and equipment used for bathing, washing, culinary purpose, cleansing, laundry, or building maintenance, at a minimum temperature of one hundred ten degrees Fahrenheit [43 degrees Celsius] and a maximum leaving temperature of one hundred forty degrees Fahrenheit [60 degrees Celsius].

2. Return circulation - where required. Hot water supply systems in buildings four or more stories high or in buildings where developed length of hot water piping from the source of hot water supply to the farthest fixture supplied exceeds one hundred feet [30.48 meters] shall be of the return circulation type.

3. Minimum requirements for hot water storage tanks. Hot water storage tanks shall be adequate in size, when combined with the British thermal unit input of the water heating equipment to provide the rise in temperature necessary.

   The water heater and storage tank shall be sized to provide sufficient hot water to provide both daily requirements and hourly peak loads of the occupants of the building.

   Hot water storage tanks shall meet construction requirements of the American society of mechanical engineers, American gas association, or underwriters' laboratories as appropriate.

Storage tanks less in volume than those requirements specified by the American society of mechanical engineers shall be of durable materials and constructed to withstand one hundred twenty-five pounds per square inch [56.70 kilograms per 6.45 square centimeters] with a safety factor of two.

The water inlets and outlets of a hot water storage tank shall be not less than the hot water distribution pipe served.

All storage tanks shall be protected against excessive temperatures and pressure conditions as specified in this article.

4. Drain cocks or valves for hot water storage tanks. Drain cocks or valves for emptying shall be installed at the lowest point of each hot water storage tank.

5. Mixed water temperature control.

   a. The temperature of mixed water to multiple or gang showers must be controlled by a master thermostatic blender or such showers may be individually regulated by balanced pressure mixing valves.

   b. Showers and bathtub/shower combinations in buildings other than single dwelling units must be protected with water temperature control valves of the balanced pressure mixing type or the thermostatic mixing valve type, or the combination pressure balance, thermostatic type.

6. Thermal expansion control. Whenever a check valve or backflow prevention device is installed, which prevents the expansion of water from a water heater to the building water service, a device for controlling thermal expansion must be installed.

History: Amended effective April 1, 1984; July 1, 1985; October 1, 1989; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-10-16. Safety devices.

1. Pressure relief valves and temperature relief valves required. Equipment used for heating water or storing hot water shall be protected by approved safety devices in accordance with one of the following methods:

   a. A separate pressure relief valve and a separate temperature relief valve.

   b. A combination pressure and temperature relief valve.

c. A combination of either subdivision a or b and an energy cutoff device.

d. Nonstorage instantaneous water heaters conforming to a listed standard approved for use without a relief valve, and the space containing the heating element is less than three inches [7.6 centimeters] in diameter, may be installed without a pressure relief valve.

Safety devices shall meet the requirements of the American national standards institute, American society of mechanical engineers, or the underwriters' laboratories. Listing by underwriters' laboratories, American gas association, or national board of boiler and pressure vessel inspectors shall constitute evidence of conformance with these standards.

Where a device is not listed by any of these, it must have certification by an approved laboratory as having met these requirements.

2. Pressure relief valves. Pressure relief valves shall meet the American national standards institute standards and the American society of mechanical engineers standards when required by the administrative authority. The valves shall have a relief rating adequate to meet the pressure conditions in the equipment served. They shall be installed either directly in a top tank tapping or in the hot or cold outlet line close to the tank. There shall be no shutoff valve between the pressure relief valve and tank. The pressure relief valve must be set to open at not less than twenty-five pounds per square inch [11.34 kilograms per 6.45 square centimeters] above the street main pressure or not less than twenty-five pounds per square inch [11.34 kilograms per 6.45 square centimeters] above the setting of any house water pressure regulating valve. The setting shall not exceed the tank rated working pressure.

3. Temperature relief valves. Temperature relief valves shall be of adequate relief rating, expressed in British thermal unit per hour, for the equipment served. They shall be installed so that the temperature sensing element is immersed in the hottest water within the top six inches [15.24 centimeters] of the tank. The valve shall be set to open when the stored water temperature is two hundred ten degrees Fahrenheit [98.89 degrees Celsius] (or less).

These valves must be approved by an appropriate standard or by the administrative authority for the intended use, and shall be sized so that when the valve opens, the water temperature cannot exceed two hundred ten degrees Fahrenheit [98.89 degrees Celsius] with the water heating equipment operating at maximum input.

4. Combination pressure-temperature relief valves. Combination pressure-temperature relief valves shall comply with all the requirements of the separate pressure and temperature relief valves.

5. Energy cutoff devices. Energy cutoff devices shall be of adequate performance rating for the equipment served. Immersion type energy cutoff devices shall be located so that the temperature sensing element is immersed in the water within the tank and controls the temperature of the water within the top six inches [15.24 centimeters] of the tank. When approved by the administrative authority, contact types shall be installed so that the sensing element is responsive to the highest water temperature within the equipment served and is securely fastened in place. Such devices shall meet the requirements of applicable American national standards institute standards. When an energy cutoff device is used, it shall be factory applied by the heater manufacturer, and comply fully with the appropriate standards of the American national standards institute and underwriters' laboratories. They shall be installed in a manner that will isolate them from ambient, flue gas temperatures and other conditions not indicative of the temperature of the water within the heater.

6. Installation of relief valves. No check valve or shutoff valve shall be installed between any safety device and the hot water equipment used, nor shall there be any shutoff valve or traps or dips in the discharge pipe from the relief valve. The discharge pipe shall not be smaller than the relief valve outlet and it shall be an indirect connection into a plumbing fixture, floor drain, sump pit, or other approved point of discharge. Relief outlets when connected to the building drainage system shall be indirectly connected.

   The terminal end of a discharge pipe must not be threaded.

   In addition to all other requirements, if the relief outlet discharge piping is installed so that it leaves the room or enclosure in which the water heater and relief valve are located, there must be an airgap installed before or at this point of leaving the room or enclosure.

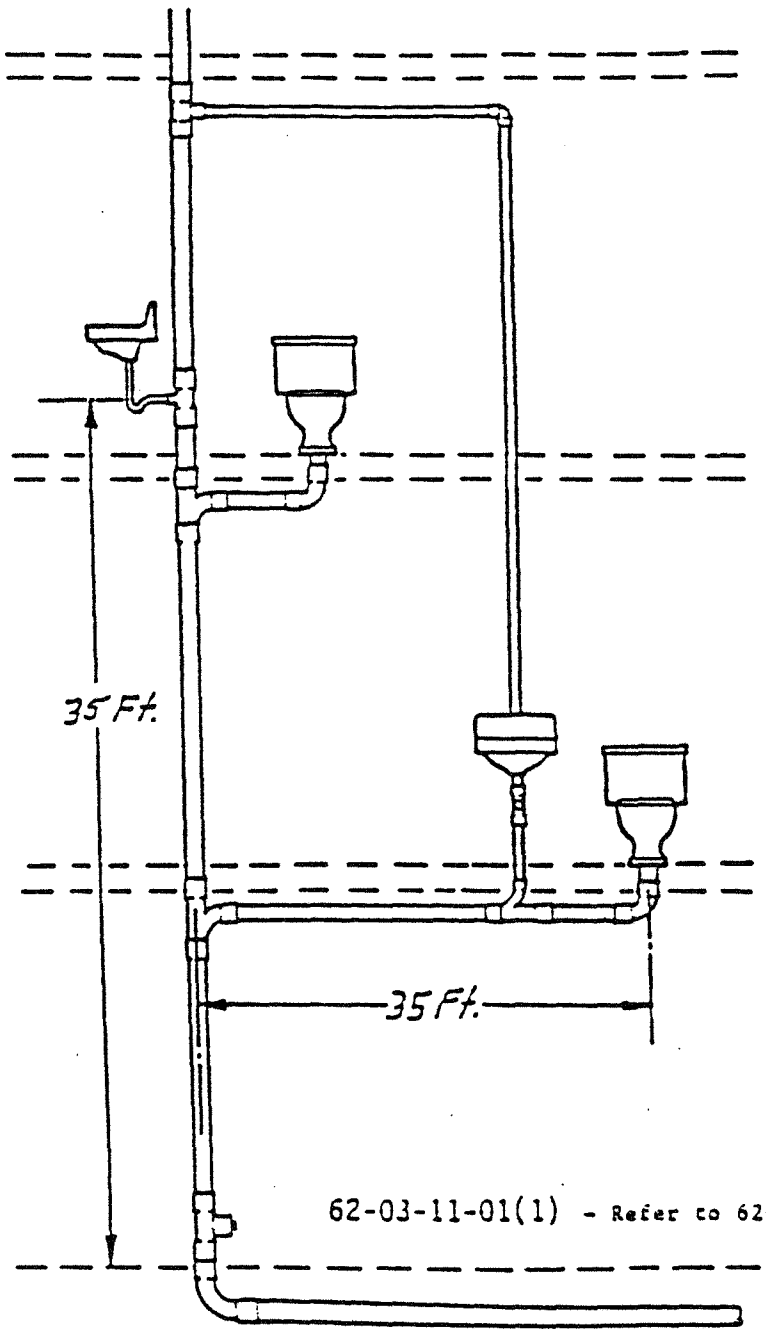
   This airgap may be the same one used to comply with other provisions of this section. All piping after the airgap or indirect connection must be sized as a gravity drain using subsection 2 of section 62-03-11-04 to determine equivalent fixture unit load and the tables contained in section 62-03-11-05 to determine drain sizes, and such other tables and regulations as may be applicable. These provisions as to airgap and drain sizing apply to single and multiple relief valve piping installations.

When water heaters are replaced, the temperature relief valve and the pressure relief valve, or the combination temperature and pressure relief valve must also be replaced. The safety device may not be reused.

7. Pressure marking of hot water storage tank. Hot water storage tanks shall be permanently marked in an accessible place with the maximum allowable working pressure, in accordance with the applicable standard.

8. Water heaters on wood. Water heaters which are located in areas that have floors of wood construction shall be provided with a watertight pan. Such pans shall turn upon all sides at least two inches [5.08 centimeters]. The pan drain shall be indirectly connected with an air break to the buildings drainage system and shall be a minimum of one inch [2.54 centimeters] in diameter.

History: Amended effective August 1, 1981; July 1, 1985; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09



62-03-11-01(1) - Refer to 62-03-03.1-06

62-03-11-04. Fixture units.

1. Load on drainage piping. The load on drainage system piping shall be computed in terms of drainage fixture unit values in accordance with the table in this subsection and with subsection 2.

DRAINAGE FIXTURE UNIT VALUES FOR VARIOUS PLUMBING FIXTURES

Type of Fixture or Group of Fixtures	Drainage Fixture Unit Value (d.f.u.)
Automatic clothes washer (two-inch standpipe)	3
Bathroom group consisting of a water closet, lavatory and bathtub or shower stall:	
Flushometer valve closet	8
Tank type closet	6
Bathtub * (with or without overhead shower)	2
Bidet	4
Clinic sink	6
Combination sink-and-tray with food-waste grinder	4
Combination sink-and-tray with one one and one-half-inch trap	2
Combination sink-and-tray with separate one and one-half-inch traps	3
Dental unit or cuspidor	1
Dental lavatory	1
Drinking fountain	1/2
Dishwasher, domestic	2
Floor drains with two-inch waste	3
Kitchen sink, domestic, with one one and one-half-inch trap	2
Kitchen sink, domestic, with food-waste grinder	2
Kitchen sink, domestic, with food-waste grinder and dishwasher ~~two inch trap~~ one and one-half-inch trap	3
Kitchen sink, domestic, with dishwasher one and one-half-inch trap	3
Lavatory with one and one-fourth-inch waste	1
Laundry tray (one or two compartments)	2
Shower stall, domestic	2
Showers (group) per head **	2
Sinks:	
Surgeon's	3
Flushing rim (with valve)	6
Service (trap standard)	3
Service (P trap)	2
Pot, scullery etc. **	4
Urinal, wall hung blowout	6

Urinal, wall hung syphon jet	4
Urinal trough (each six-foot section)	2
Wash sink (circular or multiple) each set of faucets	2
Water closet, tank-operated	4
Water closet, valve-operated	6
Fixtures not listed above:	
Trap size one and one-fourth inch or less	1
Trap size one and one-half inch	2
Trap size two inches	3
Trap size two and one-half inches	4
Trap size three inches	5
Trap size four inches	6

* A shower head over a bathtub does not increase the fixture unit value.

** See subsection 2 of section 62-03-11-04 for method of computing equivalent fixture unit values for devices or equipment which discharge continuous or semicontinuous flows into sanitary drainage systems.

2. Values for continuous flow. For a continuous or semicontinuous flow into a drainage system, such as from a pump, ejector, air-conditioning equipment, or similar device, two fixture units shall be allowed for each gallon-per-minute of flow.

3. Diversity factors. In certain structures such as hospitals, laboratory buildings, and other special use or occupancy buildings where the ratio of plumbing fixtures to occupants is proportionally more than required by building occupancy and in excess of one thousand fixture units, the administrative authority may permit the use of a diversity factor for sizing branches, stacks, and building sewers.

History: Amended effective July 1, 1985; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-03-11-05. Determining size of drainage system.

1. Selecting size of drainage piping. Pipe sizes shall be determined from the tables contained in this subsection on the basis of drainage load computed from the table contained in subsection 1 of section 62-03-11-04 and from subsection 2 of section 62-03-11-04.

BUILDING DRAINS AND SEWERS

Maximum number of fixture units that may be connected

to any portion of the building drain or the building sewer including branches of the building drain.

Diameter of Pipe Inches	Fall per Foot			
	One-sixteenth Inch	One-eighth Inch	One-fourth Inch	One-half Inch
2			21	26
2 1/2			24	31
3			42 *	50 *
4		180	216	250
5		390	480	575
6		700	840	1,000
8	1,400	1,600	1,920	2,300
10	2,500	2,900	3,500	4,200
12	3,900	4,600	5,600	6,700
15	7,000	8,300	10,000	12,000

* Not over two water closets or two bathroom groups, except that in single family dwellings, not over three water closets or three bathroom groups may be installed.

HORIZONTAL FIXTURE BRANCHES AND STACKS

Maximum number of fixture units that may be connected to:

Diameter of Pipe Inches	Any Horizontal Fixture Branch *	Stack Sizing for Three Stories in Height or Three Intervals	Stack Sizing For More Than Three Stories In Height	
			Total for Stack	Total at One Story or Branch Interval
1 1/2	3 ***	4 ***	8 ***	2 ***
2	6	12	24	6
2 1/2	12	20	42	9
3	20 **	48 **	72 **	20 **
4	160	240	500	90
5	360	540	1,100	200
6	620	960	1,900	350
8	1,400	2,200	3,600	600
10	2,500	3,800	5,600	1,000

12	3,900	6,000	8,400	1,500
15	7,000			

* Does not include branches of the building drain.

** Not more than two water closets or bathroom groups within each branch interval nor more than six water closets or bathroom groups on the stack. Stacks must be sized according to the total accumulated connected load at each story or branch interval and may be reduced in size as this load decreases to a minimum diameter of one-half of the largest size required.

*** Does not include kitchen sink.

2. Minimum size of soil and waste stacks. No soil or waste stack shall be smaller than the largest horizontal branch connected thereto, except that:

   a. A four-inch by three-inch [10.16-centimeter by 7.62-centimeter] water closet connection shall not be considered as reduction in pipe size.

   b. A four-inch [10.16-centimeter] horizontal drain to a three-inch [7.62-centimeter] soil stack by means of a three-inch by four-inch [7.62-centimeter by 10.16-centimeter] tee-wye, or to above the centerline of a three-inch [7.62-centimeter] horizontal drain by means of a three-inch by four-inch [7.62-centimeter by 10.16-centimeter] wye shall be acceptable; provided that the four-inch [10.16-centimeter] drain does not receive the discharge of any stack and that it receives only the discharge of fixtures located on the floor or wall immediately above the four-inch [10.16-centimeter] drain. All such four-inch [10.16-centimeter] horizontal drain lines shall be sized, graded, and vented as if the four-inch [10.16-centimeter] drain were a three-inch [7.62-centimeter] horizontal drain.

3. Minimum size of stack vent or vent stack. Any structure in which a building drain is installed shall have at least one stack vent or vent stack sized in accordance with subsection 6 of section 62-03-12-16.

4. Provision for future fixtures. When provision is made for the future installation of fixtures, those provided for shall be considered in determining the required size of drain and vent pipes. Construction to provide for such future installations shall be terminated with a plugged fitting or fittings.

5. Minimum size of underground drainage piping. No portion of the drainage system installed underground or below a basement

or cellar shall be less than two inches [5.08 centimeters] in diameter.

This does not apply when used for condensate wastes or a relief valve discharge line which shall not be less than one and one-fourth inches [31.75 millimeters] in diameter.

~~Underground waste lines serving kitchen sinks shall not be less than three inches [7.62 centimeters] in diameter if the developed length exceeds ten feet [3.05 meters].~~

6. Minimum size for aboveground drainage piping. No portion of the drainage system installed aboveground shall be less than one and one-half inches [38.1 millimeters].

History: Amended effective April 1, 1984; July 1, 1985; January 1, 1992.
General Authority: NDCC 43-18-09
Law Implemented: NDCC 43-18-09

62-04-02-01. Conformance with code. All plumbing materials and water conditioning systems or parts thereof installed hereafter shall meet or exceed the minimum provisions of this article and ~~article 62-03~~ conform to national sanitation foundation, underwriters laboratories, or water quality association listed standards.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-18.1-03
Law Implemented: NDCC 43-18.1-04

62-04-07-09. Water supply distribution.

1. Supply demand. The supply demand in gallons per minute in the building water distributing system shall be determined on the basis of the load in terms of supply fixture units and of the relationship between load and supply demand as shown in the tables contained in subsection 2 of section 62-03-10-13.

2. Size of fixture supply. The minimum sizes of a fixture supply pipe shall be as shown in the table contained in subsection 2 of section 62-03-10-14. The fixture supply pipe shall be extended to within at least thirty inches [76.2 centimeters] of the point of connection to the fixture, and be within the same area and physical space as the point of connection to the fixture. Not more than two fixtures shall be supplied by a one-half inch [12.7 millimeter] pipe. All future fixture connections must be considered in sizing pipe at the time of initial installation.

3. Existing installations. Pipe sizes in existing installations may be increased but shall not be decreased.

4. Minimum size inlet and outlet. The minimum size inlet and outlet piping to water softeners and water filters ~~shall~~ must be ~~the same size as the water service to the building~~ not less than the distribution pipe served. Control valves ~~shall~~ must be installed in the inlet and outlet lines. A bypass valve ~~shall~~ must be installed between the inlet and outlet line valves.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-18.1-03
Law Implemented: NDCC 43-18.1-04

62-04-08-07. Installation.

1. Drainage. Drainage from the softener in regenerating shall discharge to the building drain through an air break or air gap, to a laundry tray, floor drain, or similar properly trapped and vented fixture or stand pipe. If a fixture is not accessible it shall be the duty of the water conditioning contractor to obtain the services of a licensed ~~master~~ plumber to install a trapped and vented outlet.

2. Brine rinse. Installations requiring rinsing of brine through building water distribution piping shall not be acceptable.

3. Piping. Pipe used in installations shall not create a corrosive condition because of dissimilarity of metals, and shall not create more than a ten percent pressure drop in system when system operates at forty pounds per square inch [18.14 kilograms per 6.45 square centimeters] or less, and shall not create a pressure drop of more than twenty percent when system operates at a pressure of forty-one pounds per square inch [18.60 kilograms per 6.45 square centimeters] or more (when softener is operating at manufacturer's specified softening flow rate).

4. Disinfection. Disinfection of all installations shall comply with the manufacturer's instructions or the water conditioning equipment manufacturer's association's instruction.

5. Operating instructions. The manufacturer or installer shall provide and attach to, or near, the softening equipment a set of instructions for use of the owner, detailing the method of operation, regeneration, and maintenance required.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-18.1-03
Law Implemented: NDCC 43-18.1-04

TITLE 63

Board of Podiatric Medicine

DECEMBER 1991

63-01-01-01. Organization and function of board of ~~registry in podiatry~~ podiatric medicine.

1. History. In 1929 the legislative assembly enacted the Podiatry Practice Act, which is codified as North Dakota Century Code chapter 43-05. The chapter provides for a board of ~~registry in podiatry~~ podiatric medicine.

2. Function. The function and responsibility of the board is to examine and license qualified applicants for licensure, ensure the continuing qualifications and general educational background of ~~podiatry practitioners~~ podiatrists, determine discipline for podiatrists who violate general statute or this title, regulate the practice of podiatric medicine in North Dakota, and perform such other duties as may be required by general statute or this title.

3. Board membership. The board consists of ~~four~~ five members appointed by the governor. ~~Three~~ Four of the members are doctors of podiatric medicine. One member is a doctor of medicine. The board members annually elect by majority vote from the board membership the president, vice president, and secretary-treasurer and such other officers as are established by the board. Members of the board who are doctors of podiatric medicine shall serve four-year terms arranged so that one term expires each year.

History: Amended effective October 1, 1982; December 1, 1991.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-02.1, 43-05-03

63-01-02-02. Duties of vice president. The vice president shall assume all duties of the president in the event of the president's

inability to perform the duties of the office because of absence or ill health. The vice president shall assume the office of president should that office be vacated. Further, the vice president shall perform any other duty assigned by the president.

History: Effective October 1, 1982.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 28-32-02.1, 43-05-04, 43-05-08

63-01-02-03. Duties of secretary-treasurer. The secretary-treasurer shall be in charge of the books, records, property, and money of the board and is responsible for administration of the board's activities. The secretary-treasurer shall conduct the board's correspondence, keep and preserve all applications and records for at least six years beyond the disposition of the application or record or the last annual registration of the licensee, whichever is longer, keep a complete and accurate record of the business transactions at all meetings, and of all fees received and expenses paid under the rules, and shall report the same to the board annually or as otherwise required by the board or the members thereof. The secretary-treasurer shall also:

1. Keep a complete record listing of the names and addresses of all persons to whom licenses have been granted with the number and date of issue of each license.

2. Collect application and licensing fees and license renewals, giving a receipt therefor, and deposit to the account of the North Dakota state board of ~~registry in podiatry~~ podiatric medicine all money received not later than the first day of the calendar month following the receipt of the money.

3. Receive and submit to the board for approval all applications for licenses and temporary permits.

4. Notify the members of the board in writing of the dates and places of all regular and special meetings of the board. No agenda or purpose for any meeting needs to be stated in the written notice of any meeting.

5. ~~Provide~~ At the specific direction of the board, provide notice to all ~~practitioners~~ podiatrists and the public of regular and special meetings ~~as may be required by law or by this title~~ of the board.

6. Notify applicants for licensure of the dates, times, and places of examination and the personal appearance.

7. Keep a confidential file of all forfeited, revoked, or suspended licenses and the reasons for the board action with respect to these licenses. Such information will be kept confidential, but may be released to any other state board

inquiring about a candidate for licensure in that state, or as required by state law or as in the discretion of the board.

8. Such other duties as are assigned by the board.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 28-32-02.1, 43-05-04, 43-05-07

63-01-02-04. Other duties. The officers and members of the board shall perform such other duties as are required by law. The board shall have the authority to create additional offices and appoint such additional officers from the board and specify the duties pertaining thereto or create such committees composed of members of the board and specify the duties of such committees as the board shall determine.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-02, 43-05-03, 43-05-04, 43-05-08

63-01-03-01. Inquiries and communications. Any inquiries, communications, or complaints concerning the board of ~~registry in podiatry~~ podiatric medicine should be sent to:

~~Aaron Olson, D.P.M.~~
~~President, North Dakota Podiatry Examiners~~
~~Medical Arts Building~~
~~810 East Rosser~~
~~Bismarck, North Dakota 58501~~

Secretary-Treasurer
North Dakota Board of Podiatric Medicine
525 North 9th Street
Bismarck, ND 58501

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-02.1, 43-05-03, 43-05-08

63-01-04-01. Procedure of board.

1. North Dakota Century Code chapter 28-32 is adopted as the rules of procedure of the board of ~~registry in podiatry~~ podiatric medicine and is controlling except as otherwise required by statute or provided in this title.

2. The board shall hold an annual meeting at the call of the president, or at the call of two board members if the president has failed to call for the annual meeting. Attendance without objection to the lack of prior written

notice by a board member constitutes waiver of notice of the annual meeting.

3. The president or any two members of the board may call a special meeting of the board and attendance at any special meeting without objection to the lack of prior written notice by a board member shall constitute waiver of notice of any special meeting. Special meetings may take place by use of telephone conference or other like modes of communication as determined by the person or persons calling the meeting.

4. If a member of the board is absent from two consecutive regular or special meetings or two consecutive meetings, the board may declare that member's position to be vacant, provided that the absent board member is given notice and an opportunity to be heard before the board prior to the board's determination that a vacancy exists.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 28-32-02.2, 43-05-04

STAFF COMMENT: Chapter 63-01-05 contains all new material but is not underscored so as to improve readability.

CHAPTER 63-01-05
DEFINITIONS

Section
63-01-05-01 Definitions

63-01-05-01. Definitions. For purposes of this title, unless the context or subject matter otherwise requires:

1. "Board" means the North Dakota board of podiatric medicine.

2. "Clinical residency" means a formal, structured postdoctoral training program sponsored by and conducted in an accredited institution such as a hospital or ambulatory health care facility or conducted by a college of podiatric medicine accredited by the council on podiatric medical education or the American podiatric medical association. The residency must:

   a. Provide the podiatric medical graduate with a well-rounded exposure in preparation for management of podiatric conditions and diseases as they are related to systemic diseases;

b. Develop the podiatric medical graduate in the art of preventing and controlling podiatric conditions and diseases and in the promotion of foot health principally through mechanical and rehabilitative methods;

c. Provide the podiatric medical graduate with clinical experience necessary to refine competency in the podiatric medical and surgical care of the foot as defined by the statutory scope of practice; or

d. Provide the podiatric medical graduate with clinical experience necessary to become competent in the full scope of advanced podiatric medicine and surgery.

3. "Podiatric medicine" means the profession of the health services concerned with the diagnosis and treatment of conditions affecting the human foot and ankle and their governing and related structures including local manifestations of systemic conditions by all appropriate systems and means and includes the prescribing or administering of drugs or medications necessary or helpful to that profession.

4. "Podiatrist" means a person who is qualified or authorized to practice podiatric medicine in North Dakota.

5. "Preceptorship" means a formal, structured postdoctoral training program, with written objectives appropriate to all aspects of the program and a written evaluation process, conducted by a podiatrist primarily in an office-based setting and controlled and supervised by a college of podiatric medicine accredited by the council on podiatric medical education or the American podiatric medical association. The preceptorship must provide the recent podiatric medical graduate sufficient experiences to have further patient care exposure, to improve clinical management and communication skills, and to obtain increased self-confidence. Preceptor requirements must include the following:

   a. Provide training in the care of children and adults that offers experience as defined by the statutory scope of practice including drug therapy, radiology, local anesthesia, analgesia, biomechanics, physical medicine, rehabilitation, and the following surgeries:

      (1) Nail;

      (2) Digital;

      (3) Soft tissue;

      (4) Forefoot;

(5) Metatarsal;

(6) Midfoot; and

(7) Rearfoot or ankle and related and governing structures.

b. Hold a clinical appointment at a podiatric medical school or be a member of the teaching staff of a hospital sponsoring a residency program.

c. Have a hospital staff appointment with podiatric surgical privileges; however, the granting of staff privileges is solely within the discretion of individual institutions; and

d. Not have been the subject of disciplinary action concerning professional conduct or practice.

6. "Title" or "this title" means title 63 of the North Dakota Administrative Code.

History: Effective December 1, 1991.
General Authority: NDCC 43-05-08
Law Implemented: NDCC 43-05-01, 43-05-11

63-02-01-01. Application requirements. Every person applying for ~~a regular~~ an annual license to practice ~~podiatry~~ podiatric medicine shall submit the following materials not later than thirty days preceding the date of the oral-practical examination or personal appearance:

1. A completed application form provided by the board.

2. A certified copy of a diploma from an approved ~~podiatry college~~ or recognized school of podiatric medicine, or its equivalent as determined by the board, granted to the applicant by such school.

3. A certified transcript from ~~the podiatry school~~ a recognized or approved school of podiatric medicine which contains the date of graduation, degree granted, and the original seal of the school.

4. Three reference letters regarding the character of the applicant; no more than two from teachers or doctors of ~~podiatry~~ podiatric medicine, and none from relatives.

5. An unmounted photograph of approximately three by four inches [7.62 by 10.16 centimeters] of the applicant, taken within one hundred twenty days of the date of the application, and signed across the front by the applicant.

6. An application fee and annual licensing fee.

7. For applicants graduating from and after July 1, 1991, evidence of satisfactory completion of a program of clinical residency. A preceptorship program qualifies as a clinical residency only until January 1, 1995.

8. Evidence of satisfactory completion of the national board of podiatric medical examiners licensing examination as provided herein.

History: Amended effective October 1, 1982; December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-01(2), 43-05-10, 43-05-11, 43-05-12, 43-05-15

63-02-01-02. Recognized school. A recognized or approved school of ~~podiatry~~ podiatric medicine means one accredited by the council on podiatric medical education of the American ~~podiatry~~ podiatric medical association. The board, however, reserves the right to add to or take from the accredited list of American schools of ~~podiatry~~ podiatric medicine by a majority vote of the board. Foreign schools not approved by the council on podiatric medical education of the American ~~podiatry~~ podiatric medical association shall be evaluated from curriculum, catalogs, professors, and other data furnished by the applicant to the board, and translated into English, and such translations certified to the board by the United States counsel or other qualified persons approved by the board.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-10, 43-05-11

63-02-01-03. Application refunds. ~~Applicants who are found to be unqualified for examination by the board will receive a refund of one half of the examination fee. An applicant who fails to take an examination will receive a refund of one half of the examination fee if the applicant provides written notice at least ten days in advance that the applicant is unable to take the examination; or if the applicant who fails to provide written notice later submits a written explanation satisfactory to the board that the applicant's failure to take the examination resulted from extreme personal hardship.~~ Repealed effective December 1, 1991.

History: ~~Effective October 1, 1982.~~
General Authority: ~~NDCC 28-32-02, 43-05-08~~
Law Implemented: ~~NDCC 43-05-10, 43-05-11~~

63-02-02-01. Examination contents. Examinations shall have two parts: written and oral-practical. The written and oral-practical

examinations are scored separately and an applicant must achieve a passing grade ~~of seventy five percent~~ on each examination to become qualified for license.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-12

63-02-02-02. Written examination. The board utilizes the examination given by the national board of ~~podiatry~~ podiatric medical examiners licensing examination as its written examination, and requires a ~~cumulative~~ passing score ~~of seventy five percent or better~~ in all sections in part one and part two, recorded by the national board of ~~podiatry~~ podiatric medical examiners as a passing score. An applicant is responsible for arranging one's own examination with the national board of ~~podiatry~~ podiatric medical examiners, and with providing a verified copy of the score to the board which must contain an original seal of the national board.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-12

63-02-02-03. Oral-practical examination. All oral-practical examinations will be conducted by the board annually in the months of May through July unless otherwise ~~provided~~ arranged by the board.

1. Every applicant who has demonstrated passage of the written portion of the examination will be eligible to take the oral-practical examination.

2. The board will notify each applicant found eligible to take the oral-practical examination of the time and place scheduled for that applicant's oral-practical examination not less than thirty days in advance.

3. The subjects covered on the practical portion of the examination are diagnosis, surgery, biomechanics, emergencies, patient care, ethics, and theory in practice.

4. Failure of an applicant to appear for examination as scheduled will void the application, and will require the applicant to reapply for licensure, unless prior scheduling arrangements have been made with the board.

5. An applicant failing the oral-practical ~~exam~~ examination may be reexamined at the next regularly scheduled ~~exam~~ examination period for an additional reapplication fee, if the applicant completes an application within one year.

History: Effective October 1, 1982; amended effective December 1, 1991.

General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC ~~43-05-13~~ 43-05-12

63-02-02-04. Personal appearance. In addition to the oral-practical examination, all applicants for license or permit must be scheduled for and attend a personal appearance before one or more members of the board when the other requirements for licensure have been met. The board may require the applicant, at the personal appearance, to respond satisfactorily to questions regarding ethics of practice, the applicant's familiarity with North Dakota Century Code chapter 43-05 and this title, and questions derived from the oral-practical examination. The board may combine the oral-practical examination and the personal appearance.

History: Effective December 1, 1991.
General Authority: NDCC 43-05-08
Law Implemented: NDCC 43-05-12

63-02-02-05. Application nullification.

1. The board will nullify an application for licensure if the applicant fails to complete the application process within twenty-four months after submission of the application or notification by the board of a deficiency, whichever is later, unless a different action is agreed upon during a disciplinary proceeding or pursuant to a reinstatement of license proceeding.

2. For a nullified application, the fees are forfeited and the application and other documents have no further force or effect. If the applicant later desires licensure, a new application and documentation must be submitted and the applicable requirements met.

History: Effective December 1, 1991.
General Authority: NDCC 43-05-08
Law Implemented: NDCC 43-05-08, 43-05-12

63-02-03-01. License issuance. Every applicant who passes the board examination and satisfies the requirements for licensure or whose reciprocity has been accepted by the board shall be issued an official annual license to practice ~~podiatry~~ podiatric medicine in North Dakota.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-09

63-02-03-02. License display. Every ~~practitioner~~ podiatrist to whom ~~a~~ an annual license has been issued shall keep the license

conspicuously in one's office or place of business, and shall whenever required exhibit the license to any member or representative of the board. If a licensee has more than one office or place of business, official ~~copies~~ duplicates of the current annual license must be obtained and prominently displayed in each office. A fee of ten dollars for each such duplicate must be paid by the podiatrist.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-09

63-02-03-03. Notification of address. Every licensed ~~practitioner~~ podiatrist must notify the board's secretary-treasurer of one's business address within thirty days of opening one's first office, all other offices, or moving of offices.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-09

63-02-04-01. Temporary license. A ~~practitioner~~ podiatrist holding a valid license to practice ~~podiatry~~ podiatric medicine issued from another licensing jurisdiction of the United States may apply to the board for a temporary license to practice podiatry in North Dakota. The applicant shall submit all materials required for ~~a regular~~ an annual license and license by reciprocity and pay the required application fee and temporary licensing fee. The application and documentary evidence submitted by the applicant shall be reviewed by the ~~officers~~ board, and upon their finding that the applicant is qualified, the board may issue a temporary license to practice ~~podiatry~~ podiatric medicine in North Dakota to the applicant until the next regular examination date. If the applicant is unable to take the ~~exam~~ examination for reason of illness or personal hardship, the applicant must reapply for a temporary license and must again pay the application fee. The applicant shall make a personal appearance before the board or a member thereof as arranged by the board.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-08

63-02-04-02. Temporary permit.

1. An applicant for a temporary permit to practice podiatric medicine in North Dakota must submit a complete acceptable application for an annual license and pay the required fee for a temporary permit and the application fee. The oral-practical examination may be completed during the permit period. The applicant must submit written evidence that the applicant has been accepted as a resident in a clinical

residency program and that the clinical residency program meets the standards set forth in this title.

2. A granted temporary permit is valid for the period of clinical residency training and is not to exceed twelve months beginning with the first day of clinical residency training. A temporary permit may be reissued once if the applicant submits acceptable evidence that the clinical residency training was interrupted by circumstances beyond the control of the applicant and that the sponsor of the program agrees to the extension and the applicant pays the temporary permit fee.

3. The temporary permit is automatically revoked if an applicant has engaged in conduct that constitutes grounds for denial of licensure or disciplinary action, discontinues training, or moves out of North Dakota under the procedures of automatic revocation as set forth in North Dakota Century Code section 43-05-16.2.

4. The scope of practice of the temporary permitholder is limited to the performance of podiatric medicine within the structure of the clinical residency program within which the temporary permitholder is enrolled and is not authorization for independent practice.

History: Effective December 1, 1991.
General Authority: NDCC 43-05-08
Law Implemented: NDCC 43-05-12, 43-05-16.2

63-02-05-01. License by reciprocity.

1. All applications for license by reciprocal agreement must be made on the official form supplied by the board and must be filed with the secretary-treasurer of the board. The application must be accompanied by the required application fee and annual licensing fee as well as other documents required for a standard application for licensure. An applicant must also submit a photocopy of the license upon which reciprocity is based and a statement from that licensure board verifying that the applicant has a valid license, is in good standing with that board, and has engaged in the practice of podiatry for the two immediately preceding years. If the applicant is licensed in one or more other states or Canadian provinces, the applicant must cause a form supplied by the board to be submitted from the licensure board of each other state or Canadian province in which the applicant is licensed during the five years immediately preceding application. Reciprocity can be granted only with those states or Canadian provinces honoring reciprocity with North Dakota.

2. Such licenses by reciprocity may be granted without examination as is otherwise required in this title. The

applicant must not have had the applicant's license to practice podiatric medicine suspended or revoked or engaged in conduct warranting or which would have warranted disciplinary action against a licensee if the conduct was committed in North Dakota, the licensing state or Canadian province, or elsewhere.

3. Such applicant for a license by reciprocity must not have been subjected to disciplinary action in any licensing state or Canadian province.

4. The applicant must also submit, with the application, for the five-year period immediately preceding the date of filing of the application, the name and address of the applicant's professional liability insurance carrier in each other state or Canadian province where licensed and the number, date, and disposition of any podiatric medical malpractice settlement or award made to a plaintiff relating to the quality of podiatric medical treatment by the applicant.

5. If such an applicant does not satisfy all the requirements set forth herein, the board shall not license such an applicant unless the board determines that the public will be protected through issuance of a license with such conditions or limitations, for such a period as determined by the board, that will guard the public health, safety, and welfare.

6. All applicants for license by reciprocity must be scheduled for and attend a personal appearance before one or more members of the board when the other requirements for licensure by reciprocity have been met. The board may require the applicant for license by reciprocity, at the personal appearance, to respond satisfactorily to questions regarding ethics of practice, the applicant's familiarity with North Dakota Century Code chapter 43-05 and this title, and questions derived from the oral-practical examination.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-14

63-02-07-01. Reinstatement of license.

1. ~~Any practitioner~~ Except as is otherwise provided for reinstatement of licenses for delinquency in renewals, any podiatrist whose license or permit to practice ~~podiatry~~ podiatric medicine has been properly revoked, suspended, or placed on probation by the board may apply for reinstatement after the time set forth in the disciplinary ruling. The application must be in writing, must set forth why the license should be reinstated, and must be accompanied by the appropriate relicensure fee and license fee. At its first

regular meeting after receiving the application for reinstatement, the board shall make an inquiry, and shall render a decision with reference to any application for reinstatement, in accordance with North Dakota Century Code chapter 43-05 and this title.

2. Except as is otherwise provided for reinstatement of licenses for delinquency in renewal, upon a podiatrist's compliance with the requirements of this section, the podiatrist's license or permit may be reinstated. The podiatrist requesting reinstatement of a license or permit shall submit the following materials:

   a. An application form and relicensure fee and license fee;

   b. Verification of licensure status from each state in which the podiatrist has held an active license during the five years preceding application;

   c. If the license or permit has been inactive for five years or less, evidence of participation in fifteen hours of acceptable continuing education for each year that the license was expired or terminated up to seventy-five hours;

   d. If the license or permit has been inactive for more than five years, evidence of continuing competency as shown by submission of seventy-five hours of acceptable continuing education obtained during the five years immediately before application; and

   e. Other evidence as the board may reasonably require.

3. No license or permit that has been suspended or revoked by the board will be reinstated unless the former licensee or permittee provides evidence of full rehabilitation from the cause or causes for which the license was suspended or revoked and complies with the other reasonable conditions imposed by the board for the purpose of establishing the extent of rehabilitation. In addition, if the disciplinary action was based in part on failure to meet continuing education requirements, the license or permit will not be reinstated until the former licensee or permittee has successfully completed the requirements. The board may require the licensee or permittee to pay the costs of the proceedings resulting in the suspension or revocation of a license or permit under its disciplinary authority and the reinstatement or issuance of a new license or permit. A licensee or permittee who has been disciplined by the board in a manner other than by suspension or revocation may be required by the board to pay the costs of the proceedings resulting in the disciplinary action.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-08, 43-05-16.2

63-02-08-01. Fees. All remittances must be made payable to the North Dakota board of ~~registry in podiatry~~ podiatric medicine and must be paid in United States money and are not refundable except as otherwise provided in section 63-02-08-02. The ~~types~~ type of ~~fee~~ fees and amounts are:

1.	Application fee	$150
2.	Application fee based on reciprocity	150
3.	Temporary license fee	150
4.	Delinquent renewal fee	~~150~~ 25
5.	~~Reinstatement~~ Relicensure fee	150
6.	Annual license fee or annual license renewal fee	200
	~~a. 1 to 5 years of practice~~	~~50~~
	~~b. 5 to 10 years of practice~~	~~100~~
	~~c. Over 10 years of practice~~	~~150~~
	~~d. Out-of-state practitioner shall pay one-half of the corresponding fees above~~	
7.	Temporary ~~license~~ permit fee	~~150~~ 200
8.	Reexamination license fee	~~10~~ 300
9.	Duplicate ~~license~~/replacement fee	10 for each

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-08, 43-05-10, 43-05-12, 43-05-13, 43-05-14, 43-05-15

63-02-08-02. Proration of licensing or permit fees. All applicants for an initial annual, temporary, or reciprocal license or temporary permit shall pay the prorated amount of the license or permit fee as established in section 63-02-08-01 calculated upon a calendar month basis based upon the date of issuance of the license or permit. There may be no proration of any application fee or relicensure fee, and

any application fee or relicensure fee must be construed as a separate and distinct fee and is not refundable.

History: Effective December 1, 1991.
General Authority: NDCC 43-05-08
Law Implemented: NDCC 43-05-08

63-03-01-01. General administration. Each licensed ~~practitioner~~ podiatrist shall annually register and renew the podiatrist's license with the board and pay such renewal fee as is set forth in this title. On or before December first of each year, the board shall mail to each licenseholder, at the holder's last known address as it appears in the records of the board, an application form on which to apply for renewal of the license. Each ~~practitioner~~ podiatrist shall complete the application form and return it, together with the required renewal fee, along with satisfactory evidence of completion of continuing education requirements, to the office of the board prior to the next succeeding January first. Upon receipt of the renewal application and fee, the board shall provide each practitioner with a renewal license specifying the period of time covered. The license renewal term is twelve months beginning January first and ending December thirty-first. Applications received and postmarked after January first of the year for which the license is being renewed will be returned for addition of the delinquent renewal fee. A podiatrist must maintain at all times with the board a correct mailing address for each of their offices to receive board communications and notices. A podiatrist who has changed addresses must notify the board in writing immediately of each new address. A licensee or permittee who has changed names must notify the board in writing as soon as possible and request a revised renewal certificate and pay the replacement fee. The board may require substantiation of the name change by requiring official documentation. Placing a notice in first-class United States mail, postage prepaid and addressed to the licensee or permittee at the licensee's or permittee's last known address, constitutes valid service.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-09, 43-05-15

63-03-02-01. Continuing education requirements. A licensed podiatrist shall at the time of submitting the annual renewal application and as a condition of renewal submit to the board satisfactory evidence of having completed a minimum of twenty hours of study in the continuing education courses approved by the ~~North Dakota~~ board ~~of registry in podiatry~~ and completed during the ~~twelve~~ eighteen months preceding ~~reregistration~~ renewal.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-10, 43-05-11

63-03-02-02. First-year licensure satisfies requirement. Passing the licensure examination completes the continuing education requirement for that license year or the successful enrollment in a clinical residency program for any person holding a temporary permit completes the continuing education requirement for that temporary permit year.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-08, 43-05-11

63-03-02-03. Satisfactory evidence of course attendance. Satisfactory evidence of attendance must be attached to the statement demonstrating sufficient continuing education. The evidence must consist of a copy of a certification of attendance including the dates, title, and sponsors of the course. However, the board in its discretion may accept a letter from the applicant listing the above information if a certificate is not available.

History: Effective October 1, 1982.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-08, 43-05-11

63-03-02-04. Self-study. A licensed podiatrist may receive a maximum of eight hours of credits of continuing education annually through self-study, including television viewing, video or sound recorded programs, correspondence work, research, preparation and publication of scholarly works, or by other similar methods. However, ~~practitioners~~ podiatrists using these methods must receive prior approval of the board by means of a letter specifying the education methods and contents and assurances they are of value to the applicant together with any other information requested by the board.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-08, 43-05-11

63-03-02-05. Waiver. The continuing education requirement may be waived by the board acting on an application for waiver by the ~~practitioner~~ podiatrist, satisfactorily explaining the ~~practitioner's~~ podiatrist's basis for seeking such a waiver.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC ~~43-05-10~~ 43-05-11

63-03-02-06. Approved courses.

1. In order for a continuing education program to be approved by the board, the program must meet the following criteria:

a. The content must be directly related to the practice of podiatric medicine. Subjects such as practice management, risk management, or those not of a scientific nature are not acceptable.

b. The speaker must be a licensed podiatrist, other credentialed health care professional, or person especially qualified to address the subject.

c. The sponsor must provide the attendee a written statement of attendance that includes the name and dates of the program, the name and address of the sponsor, the number of continuing education clock hours granted by the sponsor and approved by the board if prior approval has been sought, the name of the attendee and a signature of the sponsor or designee, or upon completion of the program, the sponsor must send the board a list of attendees.

2. Either the sponsor of a continuing education program or a licensee may submit the program for approval by the board. The following information about the program is required:

a. Name and address of program sponsor;

b. Dates and times of the program;

c. Subject or content matter of each item on the program together with the amount of time devoted to each subject;

d. Name of and identifying information about the speakers or instructors; or

e. Assurance that a written statement of attendance will be given to the podiatrist or that a list of attendees will be sent to the board.

3. The board shall approve each continuing education program for a specific number of clock hours of continuing education. One clock hour is sixty minutes. Partial hours will not be granted. Lunch breaks, rest periods, and other noneducational time will not be included.

History: Effective December 1, 1991.
General Authority: NDCC 43-05-08
Law Implemented: NDCC 43-05-11

63-03-03-01. ~~Issuance of show cause order~~ Automatic revocation. If the license renewal is not completed on or before ~~May~~ June first of any given year, the board shall send the ~~practitioner an order to show cause why the license should not be revoked. The show cause order shall specifically advise the respondent of the violation and of the time and place of the hearing on the order~~ written notice to the podiatrist's

last known address, as it appears in the records of the board, that the license is revoked as of June first. This issuance of this written notice constitutes the commencement of revocation.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-08, 43-05-15, 43-05-16.2

63-03-03-02. ~~Show cause hearing~~ Hearing after revocation. ~~The~~ A hearing after revocation shall be held in compliance with North Dakota Century Code chapter 28-32 and shall be held within sixty days of the service of the notice of revocation upon the podiatrist, subject to the podiatrist's right to waive this hearing upon agreement of the podiatrist and the board.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 28-32-02.1, 43-05-15, 43-05-16.2

63-03-03-03. Revocation. ~~If, after the hearing, the board decides the delinquent practitioner has not shown "good cause" the practitioner's license shall be revoked.~~ Repealed effective December 1, 1991.

History: ~~Effective October 1, 1982.~~
General Authority: ~~NDCC 28-32-02, 43-05-08~~
Law Implemented: ~~NDCC 43-05-08, 43-05-15~~

63-03-03-04. Reinstatement. Any practitioner whose license has been revoked for delinquency in renewal must reapply for licensure and must submit the regular application for license and the application fee and renewal fee and a delinquency fee of twenty-five dollars and must pay the costs of the ~~show cause~~ hearing.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-08, 43-05-15, 43-05-16.2

63-04-01-01. Complaint and reports. Any person, public officer, association, or the board may register a complaint against a licensed podiatrist. The complaint must be in writing and must be submitted to the board. Mandatory reporting may be made on forms provided by the board. Any entity or person mandated to report to the board shall provide any further, supplemental, or additional information as may be reasonably requested by the board. Insurers required to submit reports to the board shall send the reports to the board by the first day of the months of February, May, August, and November of each year.

History: Effective October 1, 1982; amended effective December 1, 1991.

General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-08, 43-05-16.5

63-04-01-02. Preliminary investigation. All complaints alleging or implying violations of North Dakota Century Code chapter 43-05 or this title shall be referred to the board's counsel with instructions to investigate.

1. Upon the initial investigation, the board's counsel will recommend to the board what action, if any, the board shall take.

2. Complaints involving minor or routine issues may, at the discretion of the board, be assigned to a member of the board. Typically, such assignment will be a written inquiry, explanation, or warning to the person or persons accused, with copies of all correspondence to the other members.

3. The board may hold a preliminary hearing to determine whether a formal administrative hearing is necessary.

4. The board shall cause the board's counsel or secretary-treasurer to immediately serve or send written notice of suspension or revocation to the affected podiatrist for any ex parte suspension or ex parte revocation, allowed by law, that is approved by the board after preliminary investigation.

History: Effective October 1, 1982; amended effective December 1,1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-08, 43-05-16.2

63-04-01-03. Administrative hearing. If the board decides that the complaint requires a formal administrative hearing, the hearing shall be in accordance with North Dakota Century Code chapter 28-32.

1. Upon the conclusion of the hearing, the board shall make findings of fact and conclusions of law and accordingly may ~~revoke the license of the accused, or suspend the license for a fixed period, or reprimand, or take such other disciplinary action, or dismiss the charges~~ take such disciplinary action as is allowed by law.

2. An order of suspension made by the board may contain such provisions as to reinstatement of the license as the board shall direct and as are authorized by law.

3. The board upon good cause may direct a rehearing.

4. Any appeal may be taken in the manner provided in North Dakota Century Code chapter 28-32.

History: Effective October 1, 1982; amended effective December 1, 1991.
General Authority: NDCC 28-32-02, 43-05-08
Law Implemented: NDCC 43-05-08, 43-05-16.1, 43-05-16.2

STAFF COMMENT: Article 63-05 contains all new material but is not underscored so as to improve readability.

ARTICLE 63-05

WAIVERS AND VARIANCES

CHAPTER 63-05-01
WAIVERS AND VARIANCES

63-05-01-01. Waivers and variances.

1. Waivers - Application. A licensee or applicant for licensure may petition the board for a time limited waiver of any rule except for any part of a rule which incorporates a statutory requirement. The waiver must be granted if:

   a. The rule in question does not address a problem of significance to the public in relation to the practice or application of the petitioner;

   b. Adherence to the rule would impose an undue burden on the petitioner; and

   c. The granting of a waiver will not adversely affect the public welfare.

2. Waivers - Renewal, reporting, and revocation. A waiver must be renewed upon reapplication according to the procedure described in subsection 1 if the circumstances justifying its granting continue to exist. Any petitioner who is granted a waiver shall immediately notify the board in writing of any material change in the circumstances which justify its granting. A waiver must be revoked if a material change in the circumstances which justify its granting occurs.

3. **Variances - Application.** A licensee or applicant may petition the board for a time limited variance from any rule except for any part of a rule which incorporates a statutory requirement. A variance must be granted if the petitioner specifies alternative practices or measures equivalent to or superior to those prescribed in the rule in question and provides evidence that:

   a. The rationale for the rule in question can be met or exceeded by the specified alternative practices or measures;

   b. Adherence to the rule would impose an undue burden on the petitioner; and

   c. The granting of the variance will not adversely affect the public welfare.

4. **Variances - Compliance.** Any petitioner who is granted a variance shall comply with the alternative practices or measures specified in the application for the variance.

5. **Variance - Renewal, reporting, and revocation.** A variance must be renewed upon reapplication according to the procedure described in subsection 3 if the circumstances justifying its granting continue to exist. Any petitioner who has been granted a variance shall immediately notify the board of any material change in circumstances which justify the granting of the variance. A variance shall be revoked if a material change in the circumstances which justify its granting occurs.

6. **Burden of proof.** The burden of proof is upon the petitioner to demonstrate to the board that the requirements in subsections 1 and 3 have been met.

7. **Statement of reasons.** The minutes of any meeting at which a waiver or variance is granted, denied, renewed, or revoked must include the reason for the action.

History: Effective December 1, 1991.
General Authority: NDCC 43-05-08
Law Implemented: NDCC 43-05-08

TITLE 67

Public Instruction, Superintendent of

OCTOBER 1991

STAFF COMMENT: Article 67-07 contains all new material but is not underscored so as to improve readability.

ARTICLE 67-07

SCHOOL DISTRICT EDUCATIONAL SERVICES AGREEMENTS

CHAPTER 67-07-01
DEFINITIONS

67-07-01-01. Definitions. In this article:

1. "Assistance" means the assistance that the superintendent will provide school districts in developing and implementing an educational services plan.

2. "Contiguous" means school districts that have a border or part of a border that is common to a border or part of a border of another school district in an educational services agreement.

3. "Educational services plan" means the proposal submitted to the superintendent, on behalf of the state board, describing the services to be purchased and the manner in which they are to be initiated and continued.

4. "Full funding" means payments of one hundred fifty dollars or more per full-time equivalent pupil enrolled in the purchasing district.

5. "Provider" means any qualified school district that provides educational services to another school district.

6. "Purchased services" means those additional educational services that one school district purchases from another school district.

7. "Purchaser" means any qualified school district that purchases educational services from another school district.

8. "State board" means the state board of public school education provided for by North Dakota Century Code section 15-21-17.

9. "Superintendent" means the superintendent of public instruction provided for by North Dakota Century Code section 15-21-01.

10. "Supplemental payments" means payments, not to exceed three years duration, to a school district that enters into a qualified cooperative arrangement to purchase services from another school district.

11. Vote" means a determination by the eligible voters in a purchaser school district to determine if it should reorganize with or annex to the provider district.

History: Effective October 1, 1991.
General Authority: NDCC 15-27.7-01
Law Implemented: NDCC 15-27.7

CHAPTER 67-07-02
QUALIFICATIONS OF PARTICIPANTS

67-07-02-01. Qualifications. In order to qualify as a participant in the program:

1. A provider district:

   a. Must qualify under North Dakota Century Code section 15-27.7-01 as a provider district.

   b. Must agree to provide the services for up to three years.

2. A purchaser district:

   a. Must qualify under North Dakota Century Code section 15-27.7-01 as a purchaser district.

   b. Must purchase services from a contiguous district if that contiguous district can provide adequate and appropriate services.

   c. May not be receiving payments from any other sources, other than the state foundation aid program, for the same services.

   d. Desiring to receive full funding, must agree to purchase the services for three years and must commit to a vote by the end of the third year of the program to determine if it should join the provider district if it is contiguous.

3. Districts having the option under North Dakota Century Code section 15-27.7-01 of providing services or purchasing services may not do both.

History: Effective October 1, 1991.
General Authority: NDCC 15-27.7-01
Law Implemented: NDCC 15-27.7

CHAPTER 67-07-03
THE PROGRAM APPLICATION

67-07-03-01. The program application. Qualifying school districts may apply for purchased services supplemental payments by submitting an application to the superintendent which must include:

1. Documentation of the date and vote by which participating school boards approved the plan and agreed to submit an application to the department, by submission of a completed school board resolution form provided by the superintendent.

2. A detailed description of the educational services to be purchased for up to three years.

3. A description of how the purchased services will increase the educational opportunities for students.

4. A detailed time schedule for the implementation and maintenance of the educational services program including, if appropriate, the third-year election process.

5. A detailed cost description of the services to be purchased and implemented.

In order to be eligible to receive payments for the entire school year, applications must be submitted to the superintendent by July thirty-first of the school year for which payments are desired or at a later date with prior approval of the superintendent.

History: Effective October 1, 1991.
General Authority: NDCC 15-27.7-01
Law Implemented: NDCC 15-27.7

CHAPTER 67-07-04
THE APPROVAL PROCESS

Section
67-07-04-01 The Approval Process

67-07-04-01. The approval process. The application must be reviewed by the superintendent or the superintendent's designee.

1. The superintendent shall make a recommendation to the state board to either approve or disapprove the plan based on the following criteria:

   a. Appropriate documentation of participating school boards' actions by completion of a school board resolution form provided by the superintendent.

   b. The extent to which the plan describes the educational services to be purchased.

c. The extent to which the plan includes time lines for the implementation of the educational services plan.

d. The extent to which the plan details the cost of the purchased services.

e. The extent to which the plan describes how students will benefit from implementation of the educational services plan.

f. Whether the district is receiving payments for the same services from other sources.

2. The superintendent shall make a recommendation to the state board regarding the level of funding for the educational services plan based on the following criteria:

a. The exclusion of any costs for buildings and sites, equipment, or debt service.

b. The availability of program money from legislative appropriations.

c. The cost of the plan.

d. Other criteria the superintendent deems necessary for proper administration of the program.

3. Funding for an approved plan will be on an annual basis. School districts must reapply for continued annual funding.

History: Effective October 1, 1991.
General Authority: NDCC 15-27.7-01, 15-27.7-02
Law Implemented: NDCC 15-27.7

CHAPTER 67-07-05
IMPLEMENTATION AND REPORTING

67-07-05-01. Implementation and reporting. After approval of the plan by the state board:

1. The superintendent shall distribute the supplemental payments to the purchasing district as provided in North Dakota Century Code section 15-40.1-05.

2. Applicants must submit any proposed changes in the agreement to the superintendent for approval before implementation.

3. All districts receiving supplemental payments for this program must complete and return an annual report form provided by the superintendent.

4. Renewal applications for second and third year funding must be submitted to the superintendent and must meet the same qualifications as first-year applicants.

5. The plan will be reviewed annually by the superintendent or the superintendent's designee.

History: Effective October 1, 1991.
General Authority: NDCC 15-27.7-01
Law Implemented: NDCC 15-27.7

TITLE 69

Public Service Commission

AUGUST 1991

69-09-05-04. Rules for resale of telecommunications services.

1. Definitions.

   a. "End user" means a person who uses telecommunications service for his own use.

   b. "Premise cable" means telecommunications cable or channels on the reseller's side of the point of connection to the local exchange company (demarcation point).

   c. "Prepayment" means payments made by customers of a reseller in advance of receiving service.

   d. "Resale" means the subscription to local or long distance telecommunications services and facilities by one entity, and reoffered for profit or with markup to others with or without enhancements. Where reoffered service is part of a package, and the package is offered for profit or markup, it is resale.

   e. "Reseller" means a person reselling local or long distance telecommunications services. The definition does not include ~~coin operated~~ pay telephone providers, but does include cellular services.

   f. "Same continuous property" is contiguous real estate owned by the same individual, group of individuals, or other legal entity having title to the property. The property may be traversed by streets, ditches, or other similar manmade or natural terrain features provided that, but for terrain features, the property would be contiguous and provided that such terrain features are of a nature and

dimension that it is reasonable to treat the property as contiguous.

g. "Shared tenant service provider" means a person reselling telecommunications services to the tenants of a building complex on the same continuous property or to parties with a community of interest.

2. Resellers shall:

a. Obtain a certificate of registration from the commission authorizing the provision of local resale or long-distance resale services in the state of North Dakota.

b. If they require prepayment for service:

(1) Submit a performance bond in an amount specified by the commission; or

(2) Establish an escrow account in a North Dakota bank containing an amount equal to the prepayments collected at any given time, and file monthly reports showing escrow account activities and call completion data.

c. File annual reports.

3. Resale of local exchange service, except cellular service, is restricted to provision of service to a building complex on the same continuous property, or to other parties having a community of interest with the reseller.

4. The commission will analyze each local exchange reseller's application to determine if the reseller serves parties having a community of interest.

5. Except for residents of dormitories or residence halls of schools, colleges, or universities, the end user has the unrestricted right to choose service from the local exchange.

6. Shared tenant service providers shall allow the tenant to use the shared tenant service providers premise cable and wire in the event an end user wants to receive service from the local exchange company.

7. The reseller is responsible for the charges incurred for telecommunications services to which it subscribes for serving its end users.

History: Effective March 1, 1989; amended effective August 1, 1991.
General Authority: NDCC ~~28-32-04~~ 28-32-02, 49-02-11
Law Implemented: NDCC 49-02-11, 49-21

69-09-05-05. Rules for the provision of operator services.

1. Definitions.

   a. "End user" means the person to whom operator service is provided.

   b. "Operator service" means service provided to assist in the completion or billing of telephone calls through the use of a live operator or automated equipment. "Operator service" does not include the automated operator services provided by pay telephone sets with built-in automated operator messages.

   c. "Operator service provider" means the person providing operator service.

2. Operator service providers shall:

   a. Obtain a certificate of registration from the commission authorizing the provision of operator services in the state of North Dakota.

   b. File tariffs containing rates, charges, and rules for operator services, as well as for any associated intrastate long-distance resale services, with the commission. This filing is for informational purposes.

   c. File service quality standards relating to operator response, including emergency calls, and call processing time with the commission for informational purposes.

   d. Provide written material for use in disclosing to the end user the name and toll free telephone number of the operator service provider. This material must be provided to all coin telephone operators, motels, hospitals, and any other locations where end users may use telephone service not billable to their home or business phones without operator service.

   e. Require operators to clearly identify the operator service provider to all end users and when requested, provide rate information.

   f. Provide emergency call service that is equal to that provided by the local exchange telephone company and, if unable to meet this requirement, provide emergency call service by immediate transfer of such calls to the local exchange company.

   g. For billing purposes, itemize, identify, and rate calls from the point of origination to the point of termination. No call may be transferred to another carrier by an

operator service provider which cannot or will not complete the call, unless the call can be billed in accordance with this subsection.

h. Not charge for incompleted calls.

i. Bill for their services only and at the rates contained in their filed tariffs.

j. Disclose their names on bills which include charges for services they provided.

History: Effective March 1, 1989; amended effective August 1, 1991.
General Authority: NDCC ~~28-32-04~~ 28-32-02, 49-02-11
Law Implemented: NDCC 49-02-11, 49-21

69-09-05-06. Rules for pay telephones.

1. "Pay telephone" means a telephone available for use by the public, generally on the payment of a fee.

2. All pay telephones must allow the completion of both local and long distance calls, except for 1+900 calls. Coin-operated pay telephones, however, need not be equipped to handle cash transactions ("0-plus") for long distance. Access to toll free, "800" numbers must be provided without cost to the caller.

3. For customer-owned pay telephones, the charges for local exchange area calls must not exceed twenty-five cents per call. The time allowed for a local exchange area call must not be limited.

4. Pay telephones which require payment before the call is answered at the terminating end must be equipped to return payment if there is no answer.

5. A local exchange telephone directory for the local exchange in which the pay telephone is located must be provided and maintained at each pay telephone. In the alternative, the pay telephone must provide access to local directory assistance without charge and without using a coin.

6. Pay telephones must be registered in accordance with part 68 of the federal communications commission's rules and regulations, or connected behind a registered coupler.

7. Pay telephones must enable their users to reach the 911 emergency number, where available, without charge and without using a coin. Where the 911 emergency number is not available, the pay telephone must enable its users to reach the operator without charge and without using a coin.

8. Each pay telephone must prominently display:

   a. The name and toll free telephone number of the operator or provider of that telephone.

   b. The charges for local service.

9. The subscriber to the access line to which a privately owned pay telephone is connected is responsible for the billing for all calls originated from or accepted at the line.

10. All pay telephones must meet any federal, state, or local requirements for hearing aid compatibility and must be mounted in accordance with height regulations for disabled persons.

11. Operators and providers of pay telephones are not required to register with the commission.

History: Effective August 1, 1991.
General Authority: NDCC 28-32-02, 49-02-11
Law Implemented: NDCC 49-02-11, 49-21

69-09-05-07. Customer trouble reports. When a customer's service is found to be out of order or a customer reports trouble, the telecommunications company shall test its facilities to determine if the problem is with the local exchange company's facilities. If it is, the local exchange company shall correct the trouble promptly. There may be no charge to the customer for testing or correcting a problem found on the local exchange company's facilities.

History: Effective August 1, 1991.
General Authority: NDCC 28-32-02, 49-02-11
Law Implemented: NDCC 49-02-11, 49-21

OCTOBER 1991

OBJECTION

THE LEGISLATIVE COUNCIL'S COMMITTEE ON ADMINISTRATIVE RULES OBJECTS TO CHANGES TO NORTH DAKOTA ADMINISTRATIVE CODE SECTION 69-09-07-09 ADOPTED BY THE PUBLIC SERVICE COMMISSION EFFECTIVE MAY 1991 RELATING TO THE RATES THAT ELECTRIC UTILITIES MUST PAY FOR POWER PURCHASED FROM QUALIFYING FACILITIES.

The committee objects to this rule because:

1. North Dakota Administrative Code section 69-09-07-09 establishes rates that investor-owned utilities must pay for power purchased from qualified facilities and requires net energy billing.

2. 1991 Senate Bill No. 2463, which would have required net energy billing for sales involving investor-owned utilities and rural cooperatives, failed to pass the Senate on a vote of 6 to 43.

3. It is clearly a violation of legislative intent for the Public Service Commission to adopt rules requiring net energy billing by investor-owned utilities when the 1991 Legislative Assembly defeated a bill that would have required the same.

Section 28-32-03.3 provides that after the filing of a committee objection, the burden of persuasion is upon the agency in any action for judicial review or for enforcement of the rule to establish that the whole or portion thereof objected to is within the procedural and substantive authority delegated to the agency. If the agency fails to meet its burden of persuasion, the court shall declare the whole or portion of the rule objected to invalid and judgment shall be rendered against the agency for court costs.

History: Effective August 9, 1991.
General Authority: NDCC 28-32-03.3

TITLE 70

Real Estate Commission

JANUARY 1992

70-01-02-01. Place of hearing. All hearings shall be held in the county where the applicant or ~~salesman~~ salesperson resides or has the place of business, unless the applicant, broker, or ~~salesman~~ salesperson, by written waiver, consents to a change of place of hearing. In such case the commission may, in its discretion, designate another place of hearing.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(3)
Law Implemented: NDCC 43-23-11.1(3)

70-02-01-01. Application and purpose of title.

1. This title applies in all proceedings and hearings had before the commission in matters within its jurisdiction, except in cases where the statute involved provides a procedure inconsistent with this title, and in such case the statute shall govern to the extent of such inconsistency.

2. It is the purpose of this commission, acting under the provisions of the law creating it, to safeguard the public interest in real estate transactions, to regulate the licensing of real estate brokers and ~~salesmen~~ salespersons, to encourage and require the maintenance of high standards in ethical practices by all real estate licensees doing business in North Dakota, and to seek out and prosecute those persons who unlawfully engage in dishonest, fraudulent, or criminal activities in connection therewith.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(3)
Law Implemented: NDCC 43-23-02

70-02-01-02. Application for license.

1. No application for either a broker or ~~salesman's~~ salesperson's license will be accepted from a person under the age of eighteen years.

2. All applications must be filed with the commission at least twenty days before an examination date complete in every detail and every question answered and correct fees sent with the application before the deadline date.

3. It shall be incumbent upon the applicant for a real estate broker's license to submit the applicant's proofs of qualification pursuant to subsection 2 of North Dakota Century Code section 43-23-08. Broker applicants wishing to qualify under the two-year experience requirement shall be required to submit to the commission a letter from said applicant's broker or brokers that the applicant has been actively engaged in the real estate business as a ~~salesman~~ salesperson for at least two years.

   "Actively engaged" means that the applicant must have devoted the applicant's full time as a licensed real estate ~~salesman~~ salesperson. The foregoing shall be certified by a licensed real estate broker.

4. Each application for license shall be made on application forms provided by the real estate commission and are to be filled in personally by, or under the supervision of, the applicant.

5. After an application is filed and examination scheduled, no refund of application fee will be made to any applicant in the event of withdrawal.

6. The commission may deny any application for license when one or more of the following conditions are present:

   a. The application contains any false statement.

   b. An investigation fails to show affirmatively that the applicant possesses in every instance the necessary qualifications.

   c. The applicant has acted or attempted to act in violation of North Dakota Century Code chapter 43-23 or this title.

   d. The applicant has had a license suspended or revoked in another state.

   e. The check used in paying an examination or license fee shall not, for any reason, be honored by the financial institution upon which it is written.

f. The applicant has issued one or more checks or drafts which have been dishonored by a payor bank because:

(1) No account exists;

(2) The account was closed; or

(3) The account did not contain sufficient funds to pay the check or draft in full upon its presentment.

g. The applicant's credit history shows the existence of unpaid and overdue judgments, liens, or other debt obligations which, for the protection of the public, requires that the application be denied.

7. If the application and supporting documents on their face show that the applicant is qualified, but from complaints and information received or from investigation it shall appear to the commission at any time before the initial license is delivered, that there may be cause to deny a license, the commission may order a hearing to be held to consider such complaints or information.

8. The commission may require such other proof as may be deemed advisable of the honesty, truthfulness, and good reputation of any applicant, including the officers and directors of any corporation, or the members of any copartnership or association making such application, before accepting an application for license.

9. Inquiry and investigation may be made by the commission as to the financial responsibility of each applicant.

10. When a corporation submits its application for a broker's license, the application must be accompanied by a copy of the articles of incorporation and a certificate of authority issued by the secretary of state.

11. When a partnership submits its application for a broker's license, the application must be accompanied by a copy of the partnership agreement.

12. An applicant for licensure in another state may request the commission to certify to such other state that the applicant is a licensee of this state. A fee of ten dollars shall accompany the request.

History: Amended effective August 1, 1981; May 1, 1986; January 1, 1992.
General Authority: NDCC 28-32-02, 43-23-08(7)
Law Implemented: NDCC 43-23-05, 43-23-08, 43-23-09, 43-23-11.1

70-02-01-03. Examinations.

1. All examinations for real estate broker's and ~~salesman's~~ salesperson's licenses will be given periodically as designated by the commission and the applicant will be notified of the scheduled dates and places upon receipt of the application. This notification to all applicants will be accompanied with an identification card and such card must be in the applicant's possession and surrendered to a representative of the commission when appearing for the written examination.

2. An applicant will not be permitted to take the written examination until and unless the applicant has been authorized in writing to appear for the examination.

3. Neither broker nor ~~salesman~~ salesperson examinations will be given during the month of December of any year unless the commission determines that it is practicable to do so.

4. If an applicant should fail to appear for examination within four months after notification by the commission that the applicant is qualified to take the examination, an applicant must reapply for examination as in the first instance and pay the required fee.

5. Broker or ~~salesman~~ salesperson applicants who fail an examination and wish to rewrite the examination must submit a rewrite application and fee. Each rewrite of an examination will be permitted only upon submission of a notice of intention to rewrite and submission of an examination rewrite fee on or before twenty days prior to the next examination.

6. During the examination the use or possession of any unfair methods or notes, the giving or receiving of aid of any kind, or the failure to obey instructions will result in a denial of the application and license.

7. If the broker or ~~salesman~~ salesperson applicant fails the third examination, no subsequent examination will be given the applicant for at least twelve months after failure of the third examination and applicant must submit a new application in complete detail together with the statutory fees.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(3)
Law Implemented: NDCC 43-23-08(1), 43-23-13(9)

70-02-01-05. Inactive licenses.

1. A qualified licensed ~~salesman~~ salesperson desiring to place the ~~salesman's~~ salesperson's license on an inactive status may

do so by having the broker with whom the ~~salesman~~ salesperson is associated surrender the ~~salesman's~~ salesperson's license and pocket card to the commission, with a written request from the ~~salesman~~ salesperson that the ~~salesman's~~ salesperson's license be placed on an inactive status. The ~~salesman~~ salesperson may keep the ~~salesman's~~ salesperson's license on an inactive status for an indefinite period from the date the license is surrendered. The ~~salesman~~ salesperson placing the ~~salesman's~~ salesperson's license on inactive status shall pay the required fee for such ~~salesman's~~ salesperson's license each year. A ~~salesman~~ salesperson whose license is in an inactive status shall not engage in any manner in any of the activities described under North Dakota Century Code chapters 43-23 and 43-23.1, until the ~~salesman~~ salesperson shall first request that the ~~salesman's~~ salesperson's license be reactivated by the commission. During the time that a ~~salesman's~~ salesperson's license is on an inactive status educational requirements do not need to be met. However, if any applicable education requirements are unsatisfied, proof of fulfillment must be submitted before the license can be reissued on an active status.

2. A qualified licensed broker who withdraws from the real estate business entirely and who desires to place the broker's license on an inactive status may do so by surrendering the broker's license and pocket card to the commission, with a written request that the license be placed on an inactive status. The broker may keep the broker's license on an inactive status for an indefinite period from the date of expiration of the license surrendered. The broker placing the broker's license on inactive status shall pay the required fee for such broker's license each year. During the time that a broker's license is on an inactive status educational requirements do not need to be met. However, if any applicable education requirements are unsatisfied, proof of fulfillment must be submitted before the license can be reissued on an active status.

3. While a license is on inactive status it is not necessary, in the case of a broker, to maintain an active trust account.

4. Applicable education requirements shall consist of the requirements of subsection 5 of North Dakota Century Code section 43-23-08 and eight hours for each year of inactive status, but not to exceed twenty-four hours as required by North Dakota Century Code section 43-23-08.2. The requirements of North Dakota Century Code section 43-23-08.2 must have been fulfilled within the three years immediately preceding the return to active status.

History: Amended effective May 1, 1986; January 1, 1992.
General Authority: NDCC 28-32-02, 43-23-08(7)
Law Implemented: NDCC 43-23-08, 43-23-08.2

70-02-01-06. Nonresident brokers and ~~salesmen~~ salesperson.

1. Any person who becomes an applicant for a nonresident license shall become subject to the same rules required of an applicant whose residence is in North Dakota.

2. An applicant for nonresident broker's or ~~salesman's~~ salesperson's license shall hold a currently valid broker's or ~~saleman's~~ salesperson's license in the state of the applicant's domicile and that state shall certify that the applicant is in good standing and no complaints are pending.

3. A nonresident broker must maintain an active place of business as a real estate broker in the state of the broker's residence. The nonresident broker shall furnish proof of maintaining an active place of business by submitting a photostatic copy of the broker's license and any further information deemed necessary by the commission.

4. North Dakota will not recognize the licensee from another state unless an agreement granting reciprocal privileges to North Dakota licensees has been made by the commission with the proper regulatory authorities of that state. The agreement shall set out the terms and the regulations to be followed.

History: Amended effective May 1, 1986; January 1, 1992.
General Authority: NDCC 28-32-02, 43-23-08(7)
Law Implemented: NDCC 43-23-10

70-02-01-07. Licensee's duties upon surrender, suspension, or revocation of license. A broker or ~~salesman~~ salesperson, upon surrendering the broker's or ~~salesman's~~ salesperson's license or upon notice of suspension or revocation of the broker's or ~~salesman's~~ salesperson's license, shall forward the same, together with the pocket card, at once to the commission. If the license is that of a broker, the broker shall also forward to the commission with the broker's license and pocket card all ~~salesman's~~ salesperson's licenses and pocket cards in the broker's possession or in the broker's office and shall be responsible for all missing licenses of the broker's ~~salesmen~~ salesperson. No refund will be made upon any license when surrendered, suspended, or revoked.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(3)
Law Implemented: NDCC 43-23-11.1

70-02-01-08. ~~Salesmen~~ Salesperson transfer or release. The real estate broker shall retain in the broker's possession the license of all real estate ~~salesmen~~ salespersons licensed under the broker and shall relinquish possession of the licenses only to the real estate

commission. When for any reason a ~~salesman~~ salesperson severs connection with the ~~salesman's~~ salesperson's broker and desires to transfer to another broker, the ~~salesman~~ salesperson must secure a transfer and release form provided by the commission, to be executed by the ~~salesman~~ salesperson, the ~~salesman's~~ salesperson's former broker, and the ~~salesman's~~ salesperson's new employing broker. Should the ~~salesman's~~ salesperson's former broker not be agreeable to the transfer or release, the broker then shall have the right to state the broker's reasons for refusal. Unless there is sufficient justification, the license will be transferred pending the receipt of the transfer form and fee.

History: Amended effective May 1, 1986; January 1, 1992.
General Authority: NDCC 28-32-02, 43-23-08(7), 43-23-11.1(3)
Law Implemented: NDCC 43-23-12(2), 43-23-13(6), 43-23-13(7)

70-02-01-09. Broker associates. A real estate broker regularly licensed who does not conduct an office under the broker's own name, but is employed by another licensed broker or affiliated with another licensed broker on a fee division basis and performs service similar to that of a ~~salesman~~ salesperson, must not at any time act independently as a broker, and shall not perform any real estate service without full consent and knowledge of the broker's employing or supervising broker. The employing or supervising broker shall at all times be responsible for the action of the employed or affiliated broker to the same extent as though the employed or affiliated broker were an employed ~~salesman~~ salesperson.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(3)
Law Implemented: NDCC 43-23-06.1(5)

70-02-01-10. ~~Salesman~~ Salesperson. A ~~salesman~~ salesperson shall not commence work until the ~~salesman~~ salesperson receives the ~~salesman's~~ salesperson's pocket card (identification card) from the ~~salesman's~~ salesperson's employing broker, either on original application or transfer. Any ~~salesman~~ salesperson leaving the employment of a broker shall not take nor use any listings of properties secured through the office or through ~~salesmen~~ salespersons of the former employing broker unless specifically authorized by the broker. All plats of property, "for sale" signs, notebooks, listing cards, or records of any kind that have been used in connection with the listing or selling of property shall be returned to the former broker in person by the departing ~~salesman~~ salesperson.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(3)
Law Implemented: NDCC 43-23-12(2)

70-02-01-14. ~~Salesmen~~ Salesperson closing. A ~~salesman~~ salesperson shall not handle the closing of any real estate transaction (unless authorized by the ~~salesman's~~ salesperson's employer broker), except under the direct supervision of the broker, a licensed officer, or a licensed partner of the corporation or partnership under whom the ~~salesman~~ salesperson is licensed.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(3)
Law Implemented: NDCC 43-23-11.1(1)

70-02-01-15. Trust account requirements - Handling of funds - Records.

1. All moneys belonging to others and accepted by the broker while acting in the capacity as a broker shall be deposited in a federally insured financial institution in this state in an account separate from money belonging to the broker. Clients' funds shall be retained in the depository until the transaction involved is consummated or terminated, at which time the broker shall account for the full amounts received.

   a. Name of account. The name of such separate account shall be identified by the words "trust account" or "escrow account".

   b. Notification. Each broker shall notify the commission of the name of the institution in which the trust account or accounts are maintained and also the name of the accounts on forms provided therefore. A trust account card shall be filed with the commission by each new applicant for a real estate broker's license. A new form shall be filed with the commission each time a broker changes the real estate trust account in any manner whatsoever including, but not limited to, change of depository, change of account number, change of business name, or change of method of doing business. The form shall be filed with the commission within ten days after the aforementioned change takes place.

   c. Authorization. Each broker shall authorize the commission to examine and audit the trust account and shall complete an authorization form attesting to the trust account and consenting to the examination and audit of the account by a duly authorized representative of the commission.

   d. Commingling prohibited. Each broker shall only deposit trust funds received on real estate transactions in the broker's trust account and shall not commingle the broker's personal funds or other funds in the trust account with the exception that a broker may deposit and keep a sum not to exceed one hundred dollars in the

account from the broker's personal funds which sum shall be specifically identified and deposited to cover service charges relating to the trust account.

e. Number of accounts. A broker may maintain more than one trust account provided the commission is advised of the account.

f. Time of deposit. Each broker shall deposit all real estate trust money received by the broker or the broker's ~~salesmen~~ salespersons in the trust account within twenty-four hours of receipt of the money by the broker or the ~~salesman~~ salesperson unless otherwise provided in the purchase contract. In the event the trust money is received on a day prior to a holiday or other day the depository is closed, the money shall then be deposited on the next business day of the depository.

g. Responsibility. When a broker is registered in the office of the real estate commission as in the employ of another broker, the responsibility for the maintenance of a separate account shall be the responsibility of the employing broker.

h. Interest-bearing accounts. Trust deposits may also be made in an interest-bearing account in a federally insured bank, trust company, savings and loan association, or credit union, if all persons having an interest in the funds have so agreed to the deposit in writing and a copy of the agreement is maintained by the broker for inspection by the commission. All requirements of this section with respect to trust accounts, including but not limited to identification of the account, authorization to audit, prohibition of commingling, time within which funds must be deposited and responsibility of the broker for the deposit shall apply to interest-bearing accounts; provided, that it shall not be necessary that trust account cards be filed with the commission for each interest-bearing deposit or when such account is terminated or redeposited. All records relating to the interest-bearing deposit shall be maintained on file by the broker and open to inspection by the commission for examination and audit.

2. Brokers are responsible at all times for deposits and earnest money accepted by them or their salespersons.

a. Personal payments. No payments of personal indebtedness of the broker shall be made from the separate account other than a withdrawal of earned commissions payable to the broker or withdrawals made on behalf of the beneficiaries of the separate account.

b. Withdrawals. Money held in the separate account which is due and payable to the broker should be withdrawn promptly.

c. Earnest money. A broker shall not be entitled to any part of the earnest money or other moneys paid to the broker in connection with any real estate transaction as part or all of the broker's commission or fee until the transaction has been consummated or terminated. The earnest money contract shall include a provision for division of moneys taken in earnest, when the transaction is not consummated and such moneys retained as forfeiture payment.

3. A broker shall maintain in the broker's office a complete record of all moneys received or escrowed on real estate transactions, in the following manner:

a. Bank deposit slips. A bank deposit slip showing the date of deposit, amount, source of the money, and where deposited.

b. Bank statements. Monthly bank statements are to be retained and kept on file.

c. Trust account checks. Trust account checks should be numbered and all voided checks retained. The checks should denote the broker's business name, address, and should be designated as "real estate trust account".

d. Journal. A permanently bound record book called a journal which shows the chronological sequence in which funds are received and disbursed:

(1) For funds received, the journal must include the date, the name of the party who is giving the money, the name of the principal, and the amount.

(2) For disbursements, the journal must include the date, the payee, and the amount.

(3) A running balance must be shown after each entry (receipt or disbursement).

e. Ledger. This record book will show the receipt and the disbursements as they affect a single, particular transaction as between buyer and seller, etc. The ledger must include the names of both parties to a transaction, the dates and the amounts received. When disbursing funds, the date, payee, and amount must be shown.

f. Reconciliation. The trust account must be reconciled monthly except in the case where there had been no activity during that month.

g. Maintain records. Every broker shall keep permanent records of all funds and property of others received by the broker for not less than six years from date of receipt of any such funds or property.

History: Amended effective August 1, 1981; January 1, 1992.
General Authority: NDCC 43-23-11.1(3)
Law Implemented: NDCC 43-23-11.1(1)

70-02-01-16. Complaints - Answer - Dismissal - Hearing.

1. All complaints to be investigated by the real estate commission, as required by North Dakota Century Code section 43-23-11.1, must be in writing and filed in triplicate on forms furnished by the commission. The complaint shall be verified and shall include: the full name and address of the person making the complaint, hereinafter referred to as the complainant; the full name and address of the person against whom the complaint is made, hereinafter referred to as the respondent; an allegation that respondent is either a licensed broker or ~~salesman~~ salesperson, and if the respondent is a ~~salesman~~ salesperson, then the full name and address of the broker employer; and a clear and concise statement of the facts constituting the alleged complaint including the time and place of occurrence of particular acts and the names of persons involved.

2. The licensee against whom a complaint, or complaints, has been filed must, within twenty days from receipt of copy or copies of complaints, file the licensee's answer in triplicate on forms furnished by the commission. This answer must be in written affidavit form in triplicate, properly certified, and contain a factual response to the allegations set out in the complaint.

3. If the investigation reveals that the complaint does not involve a violation of the laws, rules, or code of ethics regulating licensees, the complaint shall be dismissed without a formal hearing, and the complainant so informed in writing.

4. If the investigation reveals that the acts of the respondent may be such as to justify disciplinary action against the respondent, a formal hearing will be held on the complaint. Notice of such hearing shall be given at least twenty days in advance by serving upon the respondent a copy of the complaint against the respondent and the date and place of hearing.

History: Amended effective May 1, 1986; January 1, 1992.
General Authority: NDCC 28-32-02, 43-23-11.1(3)
Law Implemented: NDCC 43-23-11.1

70-02-01-17. Disputes between licensees. The real estate commission is not authorized by law nor will it consider or conduct hearings involving disputes over fees or commissions between cooperating brokers or brokers and ~~salesmen~~ salespersons.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(3)
Law Implemented: NDCC 43-23-11.1(1)

70-02-02-02. Application for approval of classroom instruction or correspondence course. In order for any course to be approved by the real estate commission an application for approval shall be filed with the commission not less than forty-five days prior to the contemplated date of opening. The application, in addition to the name and address of the school or person offering the course as well as any other identifying criteria which the commission may require, must be accompanied by a nonrefundable fee of fifty dollars, and must set forth the following:

1. A proposed course outline, in reasonable detail, with hours spent on each subject area to be covered by the course. Each outline shall make reference to the textbook used and other material related to the course or subject matter, and shall substantially conform to the approved curricula outlines prepared by the commission.

2. A resume on all instructors and subject to be taught must accompany the application.

3. A schedule of course offerings for the year for which approval is sought must accompany the application. Each schedule must include the name, date, time, and place of any course offering. The schedule of offerings must be arranged so as to allow reasonable time for either home study or in class preparation for each classroom session.

4. A fee schedule for all course offerings must accompany the application.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-08(7)
Law Implemented: NDCC 43-23-08

70-02-03-01. Application of code of ethics. The commission shall have the power to investigate and to suspend or revoke a broker's or ~~salesman's~~ salesperson's license upon violation by a licensee of any provisions of the code of ethics.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(1)
Law Implemented: NDCC 43-23-11.1(1)

70-02-03-02. Advertising. ~~A broker shall not advertise to sell, buy, exchange, or lease real estate in any manner indicating that the offer to sell, buy, exchange, or lease such real estate is being made by a private party not engaged in the real estate business, and no advertisement shall be inserted in any publication where only a post office box number, telephone number, or street address appears. Every broker, when advertising real estate, shall use the name under which the broker is licensed or the broker's regular trade name as registered with the real estate commission and shall affirmatively and unmistakingly indicate that the party advertising is a real estate broker and not a private party. Every real estate salesman is prohibited from advertising under the salesman's own name to sell, buy, exchange, or lease real estate. All advertising shall be under the direct supervision and in the name of the broker. The preceding also applies to real property owned by the broker or salesman. No licensee shall be allowed to advertise "For Sale By Owner". Disclosures of the individual's status as a real estate licensee is required in all advertising and promotional material.~~ Repealed effective January 1, 1992.

General Authority: ~~NDCC 43-23-11.1(1)~~
Law Implemented: ~~NDCC 43-23-11.1(1)~~

70-02-03-02.1. Advertising.

1. All advertising of real property, or any interest therein, for sale, purchase, trade, lease, exchange, or mortgage for which a fee, commission, or other consideration is expected to be received by a real estate broker must be advertised only under the exact name of the broker as licensed or under the broker's trade name as registered with the commission. No advertisement may be permitted which sets forth only a post-office box number, telephone number, or street address, or any combination thereof. A real estate broker may advertise, in the licensee's own name, property which is owned by the licensee, provided that immediately following the licensee's name where it appears in the advertisement, the words "Owner/Licensed Broker" must also appear. The provisions of this subsection apply both to active broker licensees and licensees whose license is on an inactive status. Disclosure of the individual's status as a broker is required on all promotional and advertising materials in which the licensee's name appears.

2. A real estate salesperson may not advertise under the licensee's own name any real property, or any interest therein, for which that person expects to receive a fee, commission, or other consideration for the sale, purchase, trade, lease, exchange, or mortgage of such real property. A real estate salesperson may advertise in that person's own name property which is owned by the salesperson, provided that immediately following the name where it appears in the

advertisement, the words "Owner/Licensed Salesperson" must also appear. The provisions of this subsection apply both to active salesperson licensees and licensees whose license is on an inactive status. Disclosure of the individual's status as a salesperson is required on all promotional and advertising material in which that person's name appears.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 43-23-11.1(1)

70-02-03-06. Offer to purchase. A broker or ~~salesman~~ salesperson shall promptly tender to the seller every written offer to purchase obtained on the property involved and, upon obtaining a proper acceptance of the offer to purchase, shall promptly deliver true executed copies of same, signed by the seller and purchaser, to both seller and purchaser. All brokers and ~~salesmen~~ salespersons shall make certain that all of the terms and conditions of the real estate transaction are included in the offer to purchase. Brokers and ~~salesmen~~ salespersons shall also make certain that any changes in the text of the offer made by the seller are agreed to and initiated by the offeror in the first place before proceeding with the transaction. If any changes made are material or extensive, the entire offer or contract should be rewritten.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(1)
Law Implemented: NDCC 43-23-11.1(1)

70-02-03-09. Use of false or misleading documents. Any broker or ~~salesman~~ salesperson licensed by the commission who uses, proposes the use of, agrees to the use of, or knowingly permits the use of any contract of sale, earnest money agreement, loan application, mortgage, note, or other document, which is not made known to the prospective lender or the loan guarantor, to enable the purchaser to obtain a larger loan than the true sales price would allow, or to enable the purchaser to qualify for a loan which the purchaser otherwise could not obtain, shall be deemed to have engaged in a course of misconduct permitting suspension or revocation of the broker's or ~~salesman's~~ salesperson's license as a broker or ~~salesman~~ salesperson.

History: Amended effective August 1, 1981; January 1, 1992.
General Authority: NDCC 43-23-11.1(1)
Law Implemented: NDCC 43-23-11.1(1)

70-02-03-13. Personal interest.

1. A broker shall not, either directly or indirectly, buy for oneself property listed with the broker or as to which the broker has been approached by the owner to act as broker, nor

shall the broker acquire interest in any other property therein, either directly or indirectly, without first making the broker's true position clearly known to the owner. Satisfactory written proof of this fact must be produced by the broker upon a request.

2. A broker shall not take an option to oneself, either directly or indirectly, upon property for the sale of which the broker has been approached by the owner to act as a broker, without first making the broker's true position clearly known that the broker is now acting as a prospective buyer and is no longer acting as a broker or agent for the owner. Satisfactory proof of this must be produced by the broker upon request.

3. A ~~salesman~~ salesperson shall not buy for oneself, either directly or indirectly, property listed with the ~~salesman's~~ salesperson's employer broker, nor shall the ~~salesman~~ salesperson acquire interest in any other property, either directly or indirectly, without first making the ~~salesman's~~ salesperson's true position clearly known to the owner, nor shall the ~~salesman~~ salesperson take an option unto oneself from any such owner or to anyone on the ~~salesman's~~ salesperson's behalf upon any property without first making the ~~salesman's~~ salesperson's position known. Satisfactory written proof of these facts must be produced by the ~~salesman~~ salesperson on request.

4. A real estate broker or ~~salesman~~ salesperson who sells property in which the broker or ~~salesman~~ salesperson owns an interest must make such interest known to the purchaser.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(1)
Law Implemented: NDCC 43-23-11.1(1)

70-02-03-14. Accepting nonnegotiable instruments. A broker or ~~salesman~~ salesperson shall not accept any note or any nonnegotiable instrument or anything of value not readily negotiable as a deposit on a contract or offer to purchase without the knowledge and permission of the broker's or ~~salesman's~~ salesperson's principal.

History: Amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(1)
Law Implemented: NDCC 43-23-11.1(1)

70-02-03-16. Licensee acting in own behalf to set forth terms and conditions and make disclosure. A broker or ~~salesman~~ salesperson acting in his own behalf shall disclose his licensed status in writing to any person with whom he purchases, sells, exchanges, or options real property. All the terms and conditions of the transaction as agreed upon must be in writing, properly executed, and a copy furnished to such

person. Copies of the disclosure of his licensed status and of the documents containing the terms and conditions of the transaction must be retained by the broker or ~~salesman~~ salesperson and made available to the commission upon request.

History: Effective September 6, 1989; amended effective January 1, 1992.
General Authority: NDCC 43-23-11.1(1)
Law Implemented: NDCC 43-23-11.1(1)

70-02-04-02. Hours required. To qualify for the renewal of a real estate license, each broker or ~~salesman~~ salesperson must complete twenty-four hours of continuing education before January 1, 1984, and every three years thereafter.

History: Effective August 1, 1981; amended effective January 1, 1992.
General Authority: NDCC 43-23-08.2
Law Implemented: NDCC 43-23-08.2

70-02-04-05. Nonqualifying courses. The following course offerings will not be considered as qualifying for continuing education purposes:

1. "Cram courses" for examinations.
2. Offerings in mechanical office and business skills such as typing, speed reading, memory improvement, language, and report writing.
3. Sales promotion or other meetings held in conjunction with the general business of the attendee or the attendee's employer.
4. Time devoted to breakfast, luncheons, or dinners.
5. Any course certified by the use of a challenge examination. All students must complete the required number of classroom hours in order to receive certification.
6. Any course hours in excess of twelve obtained by correspondence within the three-year certification period.

The listing of the above offerings does not limit the commission's authority to disapprove any application which fails to meet the standards for course approval.

History: Effective August 1, 1981; amended effective January 1, 1992.
General Authority: NDCC 43-23-08.2
Law Implemented: NDCC 43-23-08.2

70-02-04-12. Correspondence programs. The amount of credit to be allowed for correspondence programs shall be recommended by the program sponsor based upon the average completion time calculated by the sponsor after it has conducted "field tests". Although the program sponsor must make recommendations concerning the number of credit hours that should be granted, the number of credit hours that will be granted shall be determined by the commission.

Credit earned for correspondence coursework is subject to the limitation expressed in subsection 6 of section 70-02-04-05.

History: Effective August 1, 1981; amended effective January 1, 1992.
General Authority: NDCC 43-23-08.2
Law Implemented: NDCC 43-23-08.2

70-02-04-15. Exemptions from continuing education requirement. Any ~~salesman~~ salesperson applicant, upon successful completion of the real estate licensing examination, shall be exempt from the twenty-four hour continuing education requirement for only the three-year period during which the applicant successfully completed such examination. Any broker applicant, upon successful completion of the real estate licensing examination, and the successful completion of a minimum of thirty classroom hours of prelicensing education earned within the same three-year period in which the applicant has written the licensing examination, shall be exempt from the twenty-four hour continuing education requirement only for such three-year period.

History: Effective August 1, 1981; amended effective January 1, 1992.
General Authority: NDCC 43-23-08.2
Law Implemented: NDCC 43-23-08.2

TITLE 71

Retirement Board

SEPTEMBER 1991

71-02-01-01. Definitions. As used in North Dakota Century Code chapter 54-52 and this article:

1. "Accumulated contributions" means the total of all of the following:

   a. The employee account fund balance accumulated under the prior plan as of June 30, 1977.

   b. The vested portion of the employee's "vesting fund" accumulated under the prior plan as of June 30, 1977.

   c. The member's mandatory contributions made after July 1, 1977.

   d. The interest on the sums determined under subdivisions a, b, and c, compounded annually at the rate of five percent from July 1, 1977, to June 30, 1981, six percent from July 1, 1981, through June 30, 1986, and one-half of one percent less than the actuarial interest assumption from July 1, 1986, to the member's termination of employment or retirement.

   e. The sum of any employee purchase or repurchase payments.

2. "Actuarial equivalent" means a benefit calculated to be of equal value to the benefit otherwise payable when computed on the basis of assumptions and methods adopted for this purpose by the board.

3. "Alternative retirement system" means the teachers' fund for retirement, the highway patrolmen's retirement system, and the teachers' insurance and annuity association of America.

4. "Annual enrollment period" is the period of time between May fifteenth and June fifteenth when temporary or part-time employees can enroll in the public employees retirement system.

5. "Beneficiary" means any person in receipt of a benefit provided by this plan or any person designated by a participating member to receive benefits.

6. "Claim" means the right to receive a monthly retirement allowance, the receiving of a retirement allowance, or the receiving of a disability benefit.

7. "Continuously employed" means any period of employment uninterrupted by voluntary or involuntary termination or discharge. A member who has taken a leave of absence approved by the member's employer, not to exceed a year unless approved by the executive director, and returns to employment shall be regarded as continuously employed for the period.

8. "Contribution" means the payment into the fund of nine and twelve-hundredths percent of the salary of a member.

9. "Interruption of employment" is when an individual is inducted (enlists or is ordered or called to active duty into the armed forces of the United States) and leaves an employment position with a state agency or political subdivision, other than a temporary position. The individual must have left employment to enter active duty and must make application for reemployment within ninety days of discharge under honorable conditions.

10. "Leave of absence" means the period of time up to one year for which an individual may be absent from covered employment without being terminated. At the executive director's discretion, the leave of absence may be extended not to exceed two years.

~~10.~~ 11. "Office" means the administrative office of the public employees retirement system.

12. "Participating employer" means an employer who contributes to the North Dakota public employees retirement system.

~~11.~~ 13. "Pay status" means a member is receiving a retirement allowance from the fund.

~~12.~~ 14. "Plan year" means the twelve consecutive months commencing July first of the calendar year and ending June thirtieth of the subsequent calendar year.

~~13.~~ 15. "Prior plan" means the state employees' retirement system which existed from July 1, 1966, to June 30, 1977.

~~14.~~ 16. "Retiree" means an individual receiving a monthly allowance pursuant to chapter 54-52.

~~15.~~ 17. "Termination of employment" means a severance of employment by not being on the payroll of a covered employer for a minimum of one month. Approved leave of absence does not constitute termination of employment.

History: Amended effective September 1, 1982; November 1, 1990; September 1, 1991.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52

STAFF COMMENT: Chapter 71-02-11 contains all new material but is not underscored so as to improve readability.

CHAPTER 71-02-11
VETERANS' REEMPLOYMENT RIGHTS ACT

71-02-11-01. Eligibility requirements. To be eligible to receive service credit with North Dakota public employees retirement system for military time under this chapter, a veteran must have had an interruption of the veteran's employment and been discharged under honorable conditions.

History: Effective September 1, 1991.
General Authority: NDCC 54-52-04
Law Implemented: 38 USC 2021-2026

71-02-11-02. Award of service credit.

1. An individual with eligible time may receive up to sixty months credit upon proper application for the following time periods. A veteran eligible to receive service credit for military time must apply for and purchase that time prior to receiving credit for retirement purposes. Service credit will not be awarded until all required documentation is received by the North Dakota public employees retirement system, and payment of both the employer and the employee contributions is made in full.

a. For periods of time between June 24, 1948, through August 1, 1961, up to four years of credited service for military time may be awarded.

b. For periods of time after August 1, 1961, up to five years of service credit for military time may be awarded.

c. Service credit for military time which exceeds the maximums listed above may be awarded if served at the request of the federal government or imposed pursuant to law. The member must provide proof that the extended service was not voluntary.

d. Purchase maximums will be determined from the documentation provided by the member.

2. For persons employed by a political subdivision who will or have returned from an interruption of employment, the following applies:

a. If the employing political subdivision is not a participating employer in the North Dakota public employees retirement system and does not become one, no credit will be granted.

b. If the employing political subdivision joins the North Dakota public employees retirement system at a date later than the interruption of employment, and purchases prior service credit for its employees while the applicant is still employed, service will be granted as provided in subsection 1 of section 71-02-11-02.

c. If the employing political subdivision joins the North Dakota public employees retirement system while the applicant is still employed, and prior service is not purchased on behalf of the employees, no credit will be given.

d. If a political subdivision joins the North Dakota public employees retirement system after an employee has terminated, no credit may be granted to said employee for interruption of employment.

History: Effective September 1, 1991.
General Authority: NDCC 54-52-04
Law Implemented: 38 USC 2021-2026

71-02-11-03. Documentation requirements. The burden of proof will be on the member for providing documentation necessary to determine what military time is eligible for service credit. At a minimum, the following documentation is required before service credit will be awarded:

1. The member must provide a legible copy of military discharge papers (DD214, DD215, or NGB22).

2. The member must provide proof of the last day of employment prior to reporting for active duty and the first day of employment following the return from active duty. This information must be certified by the authorized agent of the employing agency using a "record of previous service" (SFN17028) or notice of change (SFN10766) if returning from leave of absence.

3. The members requesting service credit for extended military terms discussed under subdivision c of subsection 1 of section 71-02-11-02 must provide a legible copy of the appropriate military papers (DD214).

4. Members who elect to purchase military time must submit a completed purchase agreement (SFN17758).

History: Effective September 1, 1991.
General Authority: NDCC 54-52-04
Law Implemented: 38 USC 2021-2026

71-02-11-04. Payment. The cost for purchase of eligible military service in the North Dakota public employees retirement system and the North Dakota highway patrolmen's retirement system is as follows:

1. Employee contributions pertaining to the North Dakota public employees retirement system.

   a. June 24, 1948 - June 30, 1966 - Military time which meets the eligibility requirements will be credited to the member's account at no cost.

   b. July 1, 1966, and after - Military time which meets the eligibility requirements must be purchased at a cost of four percent times the monthly salary in the month in which the employee elects to purchase the military service, times the number of months being purchased.

   c. The cost determined above may be paid in a lump sum or in installments pursuant to the rules established for purchase or repurchase payment under section 71-02-03-02.2. If retirement occurs before purchase is complete, service being purchased will not be credited to the account for retirement purposes until the payment is complete. If no payments have been made, no credit will be awarded. To prevent any delay in issuing the employee's first retirement check, purchase must be completed at least thirty days prior to retirement date.

2. Employee contributions pertaining to the North Dakota highway patrolmen's retirement system.

   a. Military time which meets the eligibility requirements must be purchased using the amount appropriate to the date military service was earned as specified below, times the monthly salary in the month in which the employee elects to purchase the military service, times the number of months being purchased.

      (1) July 1, 1949 - June 30, 1951 3.5%
      (2) July 1, 1951 - June 30, 1965 6% not to exceed $ 18.00
      (3) July 1, 1965 - June 30, 1971 6% not to exceed $ 24.00
      (4) July 1, 1971 - June 30, 1975 9% not to exceed $ 67.50
      (5) July 1, 1975 - June 30, 1977 9% not to exceed $ 76.50
      (6) July 1, 1977 - June 30, 1979 9% not to exceed $112.50
      (7) July 1, 1979 - June 30, 1981 9% not to exceed $135.00
      (8) July 1, 1981 - June 30, 1985 7% not to exceed $133.00
      (9) July 1, 1985 to present 10.3%

   b. The cost determined above may be paid in a lump sum or in installments pursuant to the rules established for purchase or repurchase payment under section 71-02-03-02.2. If retirement occurs before purchase is complete, service being purchased will not be credited to the account for retirement purposes until the payment is complete. If no payments have been made, no credit will be awarded. To prevent any delay in issuing the employee's first retirement check, purchase must be completed at least thirty days prior to retirement date.

3. Employer contributions pertaining to the North Dakota public employees retirement system.

   a. June 24, 1948 - June 30, 1966 - Military time which meets the eligibility requirements will be credited to the member's account at no cost.

   b. July 1, 1966, and after - Military time which meets the eligibility requirements must be purchased at a cost of five and twelve-hundredths percent times the monthly salary in the month in which the employee elects to purchase the military service, times the number of months being purchased.

   c. The employer cost, determined above, will be assessed to the member's most recent participating employer. Upon being billed by the North Dakota public employees retirement system, the participating employer will have thirty days in which to make payment in full. If, after sixty days, the employer has not made payment in full, a civil penalty on fifty dollars will be assessed, and, as

interest, one percent of the amount due for each month of delay or fraction thereof after the payment became due.

d. In the event the most recent participating employer no longer exists, the board shall review each biennium the outstanding obligation and determine whether sufficient actuarial margins exist to absorb this cost. If sufficient margins do not exist, the board shall seek legislative remedy through an appropriations bill.

4. Employer contributions pertaining to the North Dakota highway patrolmen's retirement system.

a. Military time which meets the eligibility requirements must be purchased based on the amount appropriate to the date military service was earned as specified below, times the monthly salary in the month in which the employee elects to purchase the military service, times the number of months being purchased.

(1) July 1, 1949 - June 30, 1951	3.5%
(2) July 1, 1951 - June 30, 1965	6% not to exceed $ 18.00
(3) July 1, 1965 - June 30, 1971	One and one-fourth of employees contribution
(4) July 1, 1971 - June 30, 1975	9% not to exceed $ 67.50
(5) July 1, 1975 - June 30, 1977	9% not to exceed $ 76.50
(6) July 1, 1977 - June 30, 1979	9% not to exceed $112.50
(7) July 1, 1979 - June 30, 1981	9% not to exceed $135.00
(8) July 1, 1981 - June 30, 1985	12% not to exceed $228.00
(9) July 1, 1985 to present	17.70%

b. The employer cost will be assessed to the North Dakota highway patrol. Upon being billed by the North Dakota public employees retirement system, payment must be received in full within thirty days. If, after sixty days, the employer has not made payment in full, a civil penalty of fifty dollars will be assessed, and, as interest, one percent of the amount due for each month of delay or fraction thereof after payment became due.

History: Effective September 1, 1991.
General Authority: NDCC 39-03.1-06, 54-52-04
Law Implemented: NDCC 39-03.1-10, 54-52-06; 38 USC 2021-2026

71-02-11-05. Retired members. Retired receiving members of the North Dakota public employees retirement system may be eligible for service as established in section 71-02-11-01. However, the following exceptions apply:

1. Cost.

a. When calculating the cost of purchasing the employee's contribution for military time, the retiree's final average salary will be multiplied by four percent times the months of eligible military time if pertaining to the North Dakota public employees retirement system or as set forth in subdivision a of subsection 2 of section 71-02-11-04 if pertaining to the North Dakota highway patrolmen's retirement system. This amount may be paid as a lump sum, be deducted from the retroactive payment, or a combination of both.

b. The employer's contribution shall be calculated by multiplying the retiree's final average salary by five and twelve-hundredths percent times the months of eligible military time if pertaining to the North Dakota public employees retirement system or as set forth in subdivision a of subsection 4 of section 71-02-11-04 if pertaining to the North Dakota highway patrolmen's retirement system. Payment of the employer contribution shall follow section 71-02-11-04.

2. The retiree's monthly benefit amount will be recalculated to reflect the service credit for eligible military time only after the proper application has been completed and payment in full has been received, if applicable. This benefit increase will be applied retroactively. The retroactive payment will be processed and paid to the retiree within twelve months. Interest will not be paid on the retroactive payment.

3. A retiree's monthly benefit will only be recalculated if there is an increase in service credit. The North Dakota public employees retirement system will not take away any erroneous service credit that may be discovered in this process.

History: Effective September 1, 1991.
General Authority: NDCC 54-52-04
Law Implemented: 38 USC 2021-2026

71-02-11-06. Deceased retirees or members.

1. A deceased retiree or member, for which no benefits are currently being paid to beneficiaries, will not qualify for a retroactive adjustment.

2. A beneficiary who is currently receiving public employees retirement system benefits, has the option to apply for service credit for military time on behalf of the deceased retiree or member. The only military time eligible for credited service is military time prior to July 1, 1966. To receive credit for military time, the beneficiary must follow the general eligibility requirements and procedures, as stated in section 71-02-11-02.

3. If a retiree or member dies after completing the application requirements for service credit for military time, but prior to receiving a retroactive adjustment, the retroactive payment would be payable to the retiree's stated beneficiary.

History: Effective September 1, 1991.
General Authority: NDCC 54-52-04
Law Implemented: 38 USC 2021-2026

71-02-11-07. Refund of overpayments. In the event an employee or retiree purchased military service pursuant to North Dakota Century Code section 54-52-17.4, at a cost higher than determined above, overpayments may be refunded. Upon verification that the previously purchased military service meets the general eligibility requirements under section 71-02-11-01, a refund may be issued according to the following guidelines:

1. For a purchase paid in a lump sum:

   a. If eligible military time was pre-July 1, 1966, nine and twelve-hundredths percent times the salary which purchase was computed on, times months of eligible military time, will be refunded.

   b. If eligible military time was July 1966 or after, five and twelve-hundredths percent times the salary which purchase was computed on, times months of eligible military time, will be refunded.

   c. Interest on the refund amount will be paid at an annual rate of seven and five-tenths percent compounded monthly. Interest will be calculated from the month the public employees retirement system received the lump sum payment to the month in which the refund is made.

   d. The refund will be calculated and issued within one hundred eighty days of receiving all necessary documentation.

2. For a purchase paid in installments:

   a. If employee is currently making installment payments, the purchase amount will be recalculated using four percent of salary times eligible months of military time being purchased. Any excess funds resulting from the recalculation will be applied towards the outstanding amount due. Should the payments made to date exceed the new contract amount, a refund of the difference will be issued within one hundred eighty days.

   b. If an eligible employee or retiree has paid the installment contract in full, the purchase amount will be

recalculated using four percent of salary times eligible months of military time being purchased. A refund of the difference between the payments actually made and what the payments should have been on the new contract amount will be made within one hundred eighty days of receiving the necessary documentation. Interest on the refund amount will be calculated at an annual rate of seven and five-tenths percent, compounded monthly, from the month in which the purchase was paid in full to the month in which the refund is issued.

History: Effective September 1, 1991.
General Authority: NDCC 54-52-04
Law Implemented: 38 USC 2021-2026

OCTOBER 1991

71-05-01-01. Definitions. As used in North Dakota Century Code chapter 39-03.1:

1. "Covered employment" means employment with the North Dakota highway patrol.

2. "Medical examination" means an examination conducted by a doctor licensed to practice in North Dakota that includes a diagnosis of the disability, the treatment being provided for the disability, the prognosis and classification of the disability, and a statement indicating how the disability prevents the individual from performing the duties of a highway patrolman.

3. "Office" means the administrative office of the public employees retirement system.

4. "Permanent and total disability" means any medically determinable physical or mental impairment which is static or deteriorating, and the prognosis does not indicate an anticipated recovery from the disability, and results in the individual's inability to be engaged in any gainful occupation for which the person is, or could become, reasonably fitted by education, training, or experience.

~~4~~ 5. "Plan administrator" means the executive director of the North Dakota public employees retirement system.

History: Effective November 1, 1990; amended effective October 1, 1991.
General Authority: NDCC 39-03.1-06~~, 39-03.1-11~~
Law Implemented: NDCC ~~39-03.1~~ 39-03.1-07

STAFF COMMENT: Chapters 71-05-03, 71-05-04, 71-05-05, 71-05-06, 71-05-07, and 71-05-08 contain all new material but are not underscored so as to improve readability.

CHAPTER 71-05-03
MEMBERSHIP

71-05-03-01. Membership - General rule. Each eligible member of the highway patrol shall become a member of the North Dakota highway patrolmen's retirement system upon filing a membership form with the office, and the beginning of contributions to the fund.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-07

CHAPTER 71-05-04
SERVICE CREDIT

71-05-04-01. Service credit - General rule. A member receives credit for each month a contribution is made except if the enrollment date is after the fifteenth of the month. If the enrollment date is after the fifteenth, then the member's enrollment date will automatically be the following month.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-11

71-05-04-02. Military credit. Eligible service credit may be granted as it pertains to the North Dakota highway patrol retirement system as established in chapter 71-02-11.

History: Effective October 1, 1991.

General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 38 USC 2021-2026

71-05-04-03. Repurchase of service credit and purchase of additional service credit.

1. A contributor may purchase service credit for time spent serving as a member of the legislative assembly. An eligible contributor must submit a completed purchase application (SFN 17758) along with purchase amount within one year after the adjournment of that legislative session.

2. Upon reemployment, a contributor who previously received a refund may repurchase service credit. A completed repurchase agreement (SFN 17758) must be submitted to the board within ninety days of reemployment.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-08.1; 38 USC 2021-2026

71-05-04-04. Payment. The total dollar amount for repurchase or purchase may be paid on a monthly, quarterly, semiannual, or annual basis.

1. The cost of legislative service credit must be calculated using twenty-eight percent of current monthly salary at time of election to purchase multiplied by the number of months to be purchased.

2. Payment of repurchase of service must be calculated using twenty-eight percent of current monthly salary at time of election to purchase multiplied by the number of months to be purchased.

3. If payment is made on an installment basis, amount is subject to an interest rate established by the board. The following conditions also apply:

   a. Simple interest at the actuarial rate of return will accrue monthly on the unpaid balance.

   b. A minimum payment of fifty dollars per month is required.

   c. The installment schedule can be a maximum term of five years.

   d. There is no penalty for early payoff.

   e. Installment payments can be made by a payroll deduction where available. However, it is the responsibility of the

member to initiate and terminate the payroll reduction. The first payment is due within ninety days of notice by the public employees retirement system of the total amount due or the amount due pursuant to the installment method selected. Payments are due by the fifteenth of the month to be credited for the month.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-08.1; 38 USC 2021-2026

71-05-04-05. Delinquent payment. If a payment to be made pursuant to section 71-05-04-04 is not received within thirty days of the due date, the plan administrator shall send a letter to the participating member or member of an alternative retirement system advising them of the delinquency. If no payment is received within sixty days after the due date, the account must be closed. Payments received on any closed account will be returned to the member.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-08.1; 38 USC 2021-2026

71-05-04-06. Crediting repurchased service. Service repurchased will be credited in the following manner:

1. The employee's record will be updated with the benefit credit once the account is paid in full.

2. If the member or member of an alternative retirement system terminates, retires, or the member's account is closed due to delinquency, service credit will be granted in proportion to the actual payments.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-10.1; 38 USC 2021-2026

71-05-04-07. Cancellation of credits. If a member terminates service and receives a return of the member's accumulated contributions, service credit for the years of such contributions must be canceled.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-10.1, 39-03.1-14.1

CHAPTER 71-05-05
NORMAL AND EARLY RETIREMENT BENEFITS

71-05-05-01. Normal and early retirement benefits - Application. Except as provided in section 71-05-05-02 for retirement options, a member shall file an application with the office for normal or early retirement benefits at least thirty days before normal retirement date or before the commencement of early retirement.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-11

71-05-05-02. Special retirement options - Application.

1. A member may elect a retirement option by filing an application with the office no less than thirty days prior to the beginning date of benefit payments.

2. A member may revoke the election of an optional benefit as provided in subsection 1 and make a new election if such revocation is received in writing before the first retirement check is cashed but no later than fifteen days after the first retirement check has been issued. If the member changes the member's election less than fifteen days prior to the named beginning date of benefits, the first retirement payment may be delayed up to two months. Any delayed payment must be adjusted to include any deferred retirement payments.

3. A member may not revoke the elected benefit after receiving and cashing the first benefit check, unless the member can provide sufficient evidence to the executive director that the factual basis by which the election was made later proved to

be incorrect and such was due in part to representation or misrepresentations made by the employer or the retirement office.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-11

71-05-05-03. Payment date - Regular early and normal retirement benefits. Except for the retirement options provided in section 71-05-05-02, a member's normal or early retirement benefit must commence on the first day of the month which follows the member's eligibility for the benefit and which is at least thirty days after the date on which the member filed an application with the office.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-11

71-05-05-04. Optional benefits. A member may elect, as provided in section 71-05-05-02, to receive one of the following optional benefits in lieu of the regular early or normal retirement benefit.

1. One hundred percent joint and survivor benefit. A member may receive an actuarially reduced retirement benefit during the member's lifetime and after the member's death the same amount will be continued to the member's surviving spouse during the spouse's lifetime. The designated beneficiary is limited to the member's spouse. Should the member remarry and wish to change such designation, a new actuarial retirement benefit will be calculated. Payments of benefits to a member's surviving spouse must be made on the first day of each month, commencing on the first day of the month following the member's death, providing the beneficiary has supplied a marriage certificate, death certificate, birth certificate verifying age, and is still living. Benefits must terminate in the month in which the death of the beneficiary occurs.

2. Five-year or ten-year term certain. A member may elect an option which is the actuarial equivalent of the member's normal, early, or deferred vested retirement pension payable for life with a five-year or ten-year certain feature, as designated by the member.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-11

71-05-05-05. Designation of beneficiary. A member may designate a beneficiary or beneficiaries by filing such designation with the office. A member shall have the right to change the member's

designation of beneficiary without the consent of the beneficiary, but no such change is effective or binding unless it is received by the office prior to the death of the member.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-11(7)(8)

71-05-05-06. Lack of a designated beneficiary. If no beneficiary is designated by a member, any benefits due and payable must be paid to the estate. If the member has elected the one hundred percent joint and survivor option, and the designated beneficiary predeceases the member, the option must be canceled and the member's benefits must be returned to its unreduced amount.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-11

71-05-05-07. Amount of early retirement benefit. The early retirement benefit must be an amount actuarially reduced from the normal retirement benefit by one-half of one percent for each month (six percent per year), that the member is younger than age fifty-five on the date the member's early retirement benefit commences.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-11

71-05-05-08. Retirement - Dual membership. In the event a member elects to begin drawing monthly benefits while continuing to participate in North Dakota public employees retirement system or teachers' fund for retirement, retirement calculations must be based upon salary earned in the employ of the highway patrol as a patrolman.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-14.1(1)(c)
Law Implemented: NDCC 39-03.1-14.1

CHAPTER 71-05-06
RETURN OF CONTRIBUTIONS

71-05-06-01. Return of contributions - Conditions for return. The accumulated contributions of a member who terminates permanent employment:

1. Before accumulating ten years of service credit must be automatically refunded unless the member elects to remain in an inactive status.

2. After accumulating ten years of service credit, accumulated contributions must be refunded upon application filed with the retirement office.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-10.1

71-05-06-02. Effect of return. Refund of accumulated contributions cancels all service credit accumulated prior to the refund and extinguishes the right to any benefits provided by North Dakota Century Code chapter 39-03. Any former member returning their refund, with interest at the actuarial rate of return, within sixty days from withdrawal must be reinstated.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-10.1

CHAPTER 71-05-07
RETURN TO SERVICE

71-05-07-01. Return to service - Retired member. The benefits of a retired member who returns to permanent employment must be suspended. Upon final retirement, the member's benefit must be recalculated as follows:

1. If the period of subsequent employment is less than two years, the member may elect:

   a. A return of the member's contributions made after reemployment, and the suspended benefit restored, adjusted for the member's age at final retirement and for benefit payments received prior to reemployment; or

   b. A recalculation of the member's benefit based on the benefit provisions in effect at the member's initial

retirement, but adjusted to take account of age at final retirement, benefit payments received prior to reemployment, and salary and service credits accrued during the period of subsequent employment.

2. If the period of subsequent employment is more than two years, the member's benefit must be based on the benefit provisions in effect at final retirement and shall include the member's age and salary earned during the period of reemployment together with total service earned before and after reemployment, adjusted to take account of benefit payments received prior to reemployment. If a different option is selected at the second retirement date, the member and office will submit information as required to make an actuarial determination of the elected benefit and the related payment of such.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-11

71-05-07-02. Return to service - Disabled member. If the recipient of a disability benefit returns to work, said member is responsible for reporting employment to the public employees retirement system.

1. If a member is working in a permanent full-time position and is eligible to participate in the North Dakota highway patrolmen's retirement system, monthly benefits from the North Dakota highway patrolmen's retirement system must be suspended. If an individual is not able to continue employment for at least nine months, said member may resume disability status with the North Dakota highway patrolmen's retirement system.

2. If a member is receiving disability benefits from the North Dakota highway patrolmen's retirement system, and returns to employment not covered under the highway patrolmen's retirement system, disability benefits may continue for up to nine months.

3. If a member becomes ineligible for a disability benefit from the North Dakota highway patrolmen's retirement system, the disability benefit will be discontinued on the date the member becomes ineligible for disability status.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-11

CHAPTER 71-05-08
QUALIFIED DOMESTIC RELATIONS ORDERS

71-05-08-01. Payment in accordance with qualified domestic relations orders. Retirement benefits must be paid in accordance with any qualified domestic relations order (QDRO) issued in compliance with subsection 4 of North Dakota Century Code section 39-03.1-11.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-14.2
Law Implemented: NDCC 39-03.1-14.2

71-05-08-02. Qualified domestic relations orders procedures.

1. Upon receipt of a domestic relations order, the board shall send an initial notice to each person named therein, including the member and the alternate payee named in the order, together with an explanation of the procedures followed by the fund.

2. Upon receipt of a domestic relations order, the board shall, if the account is in pay status or begins pay status during the review, segregate in a separate account of the fund or in an escrow account amounts which the alternate payee would be entitled to by direction of the order, if any.

3. Upon receipt of a domestic relations order, the board shall review the domestic relations order to determine if it is a qualified order.

4. If the order becomes qualified within eighteen months of the initial receipt, the executive director shall:

   a. Send notice to all persons named in the order and any representatives designated in writing by such person that a determination has been made that the order is a qualified domestic relations order.

   b. Comply with the terms of the order.

   c. If a segregated account or an escrow account has been established for an alternate payee, distribute the amount, plus interest at a rate determined by the board, to the alternate payee.

5. In the event the order is determined not to be a qualified domestic relations order or a determination cannot be made as to whether the order is qualified or not qualified within eighteen months or receipt of such order, the board shall:

   a. Send written notification of such to all parties.

   b. If a segregated account or an escrow account has been established for an alternate payee, distribute the amounts in the segregated account or escrow account, plus interest at a rate determined by the board, to the person or persons who would be entitled to receive such amount in the absence of an order.

   c. If determined after the expiration of the eighteen-month period the order (as modified, if applicable) is a qualified domestic relations order, the qualified domestic relations order must be applied prospectively only.

History: Effective October 1, 1991.
General Authority: NDCC 39-03.1-06
Law Implemented: NDCC 39-03.1-14.2

JANUARY 1992

71-02-01-01. Definitions. As used in North Dakota Century Code chapter 54-52 and this article:

1. "Accumulated contributions" means the total of all of the following:

   a. The employee account fund balance accumulated under the prior plan as of June 30, 1977.

   b. The vested portion of the employee's "vesting fund" accumulated under the prior plan as of June 30, 1977.

   c. The member's mandatory contributions made after July 1, 1977.

   d. The interest on the sums determined under subdivisions a, b, and c, compounded annually at the rate of five percent from July 1, 1977, to June 30, 1981, six percent from July 1, 1981, through June 30, 1986, and one-half of one percent less than the actuarial interest assumption from July 1, 1986, to the member's termination of employment or retirement.

   e. The sum of any employee purchase or repurchase payments.

2. "Actuarial equivalent" means a benefit calculated to be of equal value to the benefit otherwise payable when computed on the basis of assumptions and methods adopted for this purpose by the board.

3. "Alternative retirement system" means the teachers' fund for retirement, the highway patrolmen's retirement system, and the teachers' insurance and annuity association of America.

4. "Annual enrollment period" is the period of time between May fifteenth and June fifteenth when temporary or part-time employees can enroll in the public employees retirement system.

5. "Beneficiary" means any person in receipt of a benefit provided by this plan or any person designated by a participating member to receive benefits.

6. "Claim" means the right to receive a monthly retirement allowance, the receiving of a retirement allowance, or the receiving of a disability benefit.

7. "Continuously employed" means any period of employment uninterrupted by voluntary or involuntary termination or discharge. A member who has taken a leave of absence approved by the member's employer, not to exceed a year unless approved by the executive director, and returns to employment shall be regarded as continuously employed for the period.

8. "Contribution" means the payment into the fund of nine and twelve-hundredths percent of the salary of a member.

9. "Interruption of employment" is when an individual is inducted (enlists or is ordered or called to active duty into the armed forces of the United States) and leaves an employment position with a state agency or political subdivision, other than a temporary position. The individual must have left employment to enter active duty and must make application for reemployment within ninety days of discharge under honorable conditions.

10. "Leave of absence" means the period of time up to one year for which an individual may be absent from covered employment without being terminated. At the executive director's discretion, the leave of absence may be extended not to exceed two years.

11. "Office" means the administrative office of the public employees retirement system.

12. "Participating employer" means an employer who contributes to the North Dakota public employees retirement system.

13. "Pay status" means a member is receiving a retirement allowance from the fund.

14. <u>"Permanent and total disability" means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months.</u>

15. "Plan administrator" means the executive director of the North Dakota public employees retirement system or such other person or committee as may be appointed by the board of the North Dakota public employees retirement system from time to time.

16. "Plan year" means the twelve consecutive months commencing July first of the calendar year and ending June thirtieth of the subsequent calendar year.

~~15.~~ 17. "Prior plan" means the state employees' retirement system which existed from July 1, 1966, to June 30, 1977.

~~16.~~ 18. "Retiree" means an individual receiving a monthly allowance pursuant to chapter 54-52.

19. "Service credit" means increments of time to be used in the calculation of retirement benefits. Service credit may be earned as stated in section 71-02-03-01 or may be purchased or repurchased according to section 71-02-03-02.1.

20. "Substantial gainful activity" is to be based upon the totality of the circumstances including: consideration of an individual's training, education, experience, their potential for earning at least seventy percent of their predisability earnings; and other items deemed significant on a case-by-case basis. Eligibility is based on an individual's employability and not actual employment status.

~~17.~~ 21. "Termination of employment" means a severance of employment by not being on the payroll of a covered employer for a minimum of one month. Approved leave of absence does not constitute termination of employment.

History: Amended effective September 1, 1982; November 1, 1990; September 1, 1991; January 1, 1992.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52

71-02-05-01. Eligibility. ~~A member shall be entitled to a disability retirement benefit provided all of the following occur:~~

~~1. The member retires from active employment with the employer and files a written application for a disability retirement benefit with the office on a form prescribed for that purpose by the board.~~

~~2. The member has been approved for a disability benefit under the federal Social Security Act.~~

~~3. The member has executed a release of information form authorizing the social security administration to furnish the~~

~~board with evidence of continued disability when requested by the board.~~

~~4. The member is not eligible for normal retirement benefits.~~ Repealed effective January 1, 1992.

History: ~~Amended effective September 1, 1982; November 1, 1990.~~
General Authority: ~~NDCC 54-52-04~~
Law Implemented: ~~NDCC 54-52-17, 54-52-17(3)(d)~~

71-02-05-02. Commencement of benefit. ~~If the application is filed within sixty days of the date of the determination that the member is entitled to a social security disability benefit, the state disability benefit shall be payable beginning the first of the month coincident with or following the effective date of the social security award or date of last retirement contribution, whichever is the later date. If the application is not filed within sixty days of the social security determination, the benefit shall commence on the first day of the month which follows such determination.~~ Repealed effective January 1, 1992.

History: ~~Amended effective September 1, 1982; November 1, 1990.~~
General Authority: ~~NDCC 54-52-04~~
Law Implemented: ~~NDCC 54-52-17~~

71-02-05-03. ~~Continuation or cancellation~~ Cancellation of disability benefit.

~~1. A~~ If a member ~~who receives~~ receiving a disability ~~retirement benefits shall continue to receive such benefits only so long as the member's total and permanent disability shall continue. The board shall have the right to verify the continued existence of the member's total disability at reasonable times prior to the member's normal retirement date. Should the member refuse to submit to medical examination, the disability benefit shall be discontinued until the member submits to such examination~~ benefit ceases to be eligible for disability benefits prior to the attainment of normal retirement age, that member is eligible to draw retirement benefits as specified in North Dakota Century Code section 54-52-17.

~~2. If a member receiving a disability benefit ceases to be eligible for social security disability prior to attainment of age sixty-five, such fact shall be reported in writing to the board within twenty-one days of the date the member receives notice from the social security administration of such loss. If such written report is not provided, the member will, upon the member's subsequent retirement, not be eligible for benefits for a period of six months following the date of the member's retirement, in addition to the months which may have elapsed since the member received notice of the termination of~~

~~social security disability and in which the member received a disability benefit under this plan.~~

History: Amended effective January 1, 1992.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-17

71-02-05-05. Conditions for changing to a disability retirement benefit from an early reduced retirement benefit. A member may elect to start receiving an early reduced retirement benefit, should the member be eligible to do so, pending a disability determination ~~by the federal social security office~~ or appeal. Upon ~~receipt of the~~ receiving a disability determination ~~letter, the member or retiree may apply for a disability retirement benefit. The~~, the disability benefit will be calculated and a differential payment made retroactive ~~from the date of the first early reduced benefit payment if the application is filed within sixty days of the social security determination. If the application is not filed within sixty days of the social security determination, the benefit commences on the first day of the month following such determination~~ to the first day of the month following the member's termination from covered employment.

History: Effective September 1, 1982; amended effective November 1, 1990; January 1, 1992.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-17

71-02-05-06. Determination of disability - Procedures.

1. Application.

   a. If the member is unable or unwilling to file an application, the member's legal representative may file the member's disability application.

   b. The application must explain the cause of the disability, the limitations caused by the disability, the treatment being followed, and the effect of the disability on the individual's ability to be engaged in any gainful occupation for which the person is, or could become, reasonably fitted by education, training, or experience.

   c. The application must be filed with the executive director.

2. Plan administrator.

   a. The board may retain a plan administrator to evaluate and make recommendations on disability retirement applications.

b. The plan administrator shall review all medical information provided by the applicant.

c. The plan administrator is responsible to determine eligibility for disability benefits and advise the executive director of the decision in writing.

d. The executive director shall notify the applicant in writing of the decision. If the applicant is determined not to be eligible for disability benefits, the executive director shall advise the applicant of the appeal procedure. If the applicant is deemed eligible for disability benefits, benefits must be paid pursuant to subsection 5.

3. Medical examination.

a. The applicant for disability retirement shall provide the plan administrator with medical examination reports as requested.

b. The member is liable for any costs incurred by the member in undergoing medical examinations and completing and submitting the necessary medical examination reports, medical reports, and hospital reports.

4. Appeal.

a. The applicant may appeal an adverse determination to the board by providing a written notice of appeal within sixty days of the date that the plan administrator mailed the decision.

b. The board shall consider all appeals at regularly scheduled board meetings. The applicant must be notified of the time and date of the meeting and may attend or be represented by legal counsel. The executive director shall provide to the board for its consideration a case history brief that includes membership history, medical examination summary, and the plan administrator's conclusions and recommendations. The board shall make the determination for eligibility at the meeting unless additional evidence or information is needed. The discussion concerning disability applications must be confidential and closed to the general public.

5. Payment of annuity. If awarded, the disability annuity is payable on, or retroactive to, the first day of the month following the member's termination from covered employment minus any early retirement benefits that have been paid.

6. Redetermination and recertification.

a. A disabled annuitant's eligibility must be recertified as specified by the plan administrator. The plan administrator may waive the necessity for a recertification, if the facts warrant this action.

b. The plan administrator will send a recertification form by certified mail with return receipt to the disabled annuitant to be completed and sent back to the fund. If completed recertification has not been received by the recertification date set in subdivision a, benefits will be suspended effective the first of the month following that date. Benefits will be reinstated the first of the month following recertification by the plan administrator.

c. The plan administrator may require the disabled annuitant to be reexamined by a doctor at the annuitant's own expense. The submission of medical reports by the annuitant, and the review of those reports by the board's medical consultant, may satisfy the reexamination requirement. Upon recertification, the disabled annuitant must be reimbursed up to four hundred dollars for the cost of the required reexamination.

d. The plan administrator will make the recertification decision. The decision may be appealed to the board within ninety days of receiving the written recertification decision.

e. If it is determined that the disability annuitant was not eligible for benefits during any time period when benefits were provided, the executive director may do all things necessary to recover the erroneously paid benefits.

History: Effective January 1, 1992.
General Authority: NDCC 54-52-17
Law Implemented: NDCC 54-52-17, 54-52-26

71-02-05-07. Optional benefits. An individual deemed eligible for a disability benefit may elect, as provided in this section, to receive one of the following optional benefits in lieu of the regular disability benefit. Under no circumstances is an option available if the calculation of the optional benefit to which the member is entitled results in an amount which is less than one hundred dollars.

1. One hundred percent joint and survivor benefit. A member shall receive an actuarially reduced retirement benefit during the member's lifetime and after the member's death the same amount will be continued to the member's surviving spouse during the spouse's lifetime. The designated beneficiary is limited to the member's spouse. Should the member remarry and wish to change such designation, a new actuarial retirement benefit will be calculated. Payments of benefits to a

member's surviving spouse must be made on the first day of each month commencing on the first day of the month following the member's death, provided the beneficiary has supplied a marriage certificate, death certificate, and is still living. Benefits terminate in the month in which the death of the beneficiary occurs.

2. Fifty percent joint and survivor benefit. A member shall receive an actuarially reduced benefit during the member's lifetime and after the member's death one-half the rate of the reduced benefit will be continued to the member's spouse during the spouse's lifetime, and terminates in the month the death of the beneficiary occurs.

3. Five-year or ten-year certain option. A member may elect an option which is the actuarial equivalent of the member's normal, early, or deferred vested retirement pension payable for life with a five-year or ten-year certain feature, as designated by the member.

History: Effective January 1, 1992.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-17

71-02-05-08. Transitional period. For purposes of providing a transition period during the twelve-month application period provided under previous law, amendments to chapter 71-02-05 dated January 1, 1992, apply to disabled employees who terminated on or after July 1, 1991. However, the previous rules will continue in effect for disabled employees who terminated before July 1, 1991.

History: Effective January 1, 1992.
General Authority: NDCC 54-52-04
Law Implemented: NDCC 54-52-17

TITLE 74

Seed Commission

AUGUST 1991

74-03-01-11. Seed sampling and laboratory inspection.

1. Identification in storage. Field inspected seed must be positively identified by lot number (field inspection number) at all times. Bins of bulk lots of uncleaned or cleaned seed should be marked. Bags should be identified by a stenciled lot number or an identification tag securely sewn or fastened to the bag.

2. Germination sample. To speed up tagging and determine suitability of seed prior to conditioning a representative sample of seed from each field which has passed field inspection may be submitted to the state seed department soon after the crop is harvested. A special seed envelope for this sample is furnished the grower. This sample should be cleaned on a small mill or hand sieve to correspond as nearly as possible to the condition of the entire lot after cleaning or conditioning. Only a germination test and embryo test in the case of susceptible barley varieties is made on this sample. This germination test and embryo test (in the case of barley) can be used in the final tagging of the lot and all sublots. A grower may, however, request a new test on each lot after final conditioning or delay the germination test and embryo test until after conditioning. The labeler is responsible for the germination stated on the seed label.

3. Sampling procedures.

   a. All seed lots for final certification should be sampled during conditioning by taking samples from the mills at periodic intervals.

   b. Specific instruction to samplers are found on the reverse side of the report.

4. Maximum lot size and numbering.

   a. ~~The maximum size of lot for sampling of cereals and flax is five hundred bushels [176.20 dekaliters] for bagged seed; with no maximum size for bulk seed. For grasses and legumes, the maximum size of lot for sampling shall be two thousand pounds [907.18 kilograms]. When desired, sublot samples can be combined under one lot number. Field inspection numbers should not be changed. The maximum size for any bagged lot is two thousand bushels [704.78 dekaliters]. Bulk certified lots do not have a maximum limit except bin capacity. Bulk registered class seed requires one sample per two thousand bushels [704.78 dekaliters] while bulk certified class seed requires one sample per bin~~ The maximum lot size for bagged cereal grain and flax is two thousand bushels [704.78 dekaliters]. The maximum lot size for all bagged other crops is five hundred bags. For all crops, one sample for each lot is required, except small seeded legumes and grasses. Small seeded legumes and grasses, one sample for fifteen thousand pounds [6803.85 kilograms] is required. Bulk certified and registered class lots do not have a maximum size limit except bin capacity. Bulk certified class requires one sample per lot. Bulk registered class requires one sample per two thousand bushels [704.78 dekaliters].

   b. The lot number should be preceded by the initials of both the variety and kind of seed. When large lots of seed are broken up into smaller lots and conditioned at different times, a sublot number should be used. For example, the seed from a field of Larker barley, which has field inspection number eight hundred ninety-seven, will be designated as lot lb 897. If only a part of the entire lot is conditioned at one time, the sublot will be designated lb 897-1. When another portion of the lot is conditioned, this sublot will be designated lb 897-2.

5. Bulking seed lots. Seed from different fields of the same kind and variety, which have passed field inspection, may be bulked if the seed is of the same class, generation, or general quality. If the seed of different classes or generations is bulked, the seed becomes eligible for the lowest class only.

6. Conditioning.

   a. All field inspected seed which is to be tagged and sealed must be conditioned and must meet the minimum seed standards and conditioning requirements for the crop and class.

b. Field inspected seed may be conditioned either by the grower or at an approved seed conditioning plant.

7. Conditioning by farmer/grower - Procedure.

a. Condition the seed. A farmer/grower does not need an approved conditioning plant permit if the farmer/grower conditions seed on the farmer's/grower's premises.

b. Meets farmer/grower requirements for equipment and management.

c. Complete section A of the grower's declaration, and sampler's report, sign, and mail to the state seed department at Fargo.

8. Conditioning at an approved plant.

a. Growers must fill in grower's declaration - section B or C.

b. The completed grower's declaration should be presented to the manager of the approved conditioning plant when the seed is delivered for conditioning.

c. After conditioning, all seed is sampled by the authorized sampler in the plant.

9. Regulatory sampling. The state seed department may resample any lot of seed either before final certification or after the seed is tagged and sealed.

10. Laboratory analysis.

a. All laboratory testing shall be done by qualified personnel of the state seed department. Analysis and tests of seed samples and definition of analysis terms shall be in accordance with the rules of the association of official seed analysis.

b. If more than one sample of seed is tested from the same lot without additional conditioning, an average shall be taken of all tests made.

History: Amended effective May 1, 1986; May 1, 1988; December 18, 1989; August 1, 1991.
General Authority: NDCC 4-09-03, 4-09-05, 4-09-16
Law Implemented: NDCC 4-09-16, 4-09-17, 4-09-18

74-03-02-04. Seed standards (wheat - oats - barley - rye - triticale).

Seed count required on wheat, barley, and durum.

Factor	Standards for Each Class		
	Foundation	Registered	Certified
Pure seed (minimum) *.....	99.0 percent	99.0 percent	99.0 percent
Total weed seeds (maximum)	2 per pound	5 per pound	10 per pound
Other varieties ** ..	1 per 2 pounds	1 per pound	3 per pound
Other crop seeds (maximum)	1 per 2 pounds	1 per pound	3 per pound
Inert matter (maximum) ***	1.0 percent	1.0 percent	1.0 percent
Prohibited noxious weed seeds + ...	none	none	none
Objectionable weed seeds (maximum) ++	1 per 4 pounds	1 per 2 pounds	1 per pound
Germination +++	85.0 percent	85.0 percent	85.0 percent

* The standard for durum and rye shall be 98.0 percent minimum.

** Other varieties shall not include variations which are characteristic of the variety.

*** For all crops foreign matter other than broken seed shall not exceed 0.2 percent. Durum and rye may contain 2.0 percent maximum inert matter.

\+ Prohibited noxious weed seed including the seeds of quackgrass.

++ Objectionable weed seeds shall include the following: dodder, wild mustard, wild oats, hedge bindweed (wild morning glory), field pennycress (frenchweed), giant ragweed (kinghead), falseflax, and dragonhead.

+++ Winter wheat and rye minimum 80.0 percent.

Note: ~~The loose smut content of any class of certified seed of barley shall not exceed four percent unless a special seed treatment has been applied. The percentage of loose smut as determined by the embryo test will be printed on the certification tag or labeled with an approved seed treatment. The foundation class of barley has a zero tolerance for barley stripe mosaic virus~~ A barley grower is responsible for having a loose smut test, by an official lab, on the harvested seed of each field of barley. If seed from more than one field is blended without having a test for each field, a loose smut test must be made on each seed lot or sublot. The percentage of loose smut will be printed on the

certification certificate or labeled with an approved seed treatment. Any seed lot that exceeds two percent loose smut, that is not treated with an approved seed treatment must carry a statement on the certification certificate that seed is recommended to be treated. The foundation class of barley has a zero tolerance for barley stripe mosaic virus.

History: Amended effective May 1, 1986; May 1, 1988; December 18, 1989; August 1, 1991.
General Authority: NDCC 4-09-03, 4-09-05, 4-09-16
Law Implemented: NDCC 4-09-16, 4-09-17, 4-09-18

74-03-12-03. Field standards.

1. Isolation. A strip at least five feet [1.52 meters] wide which is either mowed, uncropped, or planted to some other separable crop shall constitute a field boundary for the purpose of isolation.

2. Specific requirements (soybean).

Factor	Maximum Tolerance Foundation	Registered	Certified
Other varieties * ...	0.1 percent	0.2 percent	0.2 percent
Corn and sunflower plants bearing seed ..	none	none	none
Prohibited noxious weeds **	none	none	none
Objectionable weeds ***	none	none	none

* Other varieties shall not include variations which are characteristic of the variety inspected.

** Prohibited noxious weeds include only field bindweed, leafy spurge, and Russian knapweed. The tolerance for other noxious and common weeds will be determined by the inspector based on the amount and separability of the seed from the crop being considered and the development of the crop and the weed.

*** Objectionable weeds include nightshade species and cocklebur.

3. Specific requirements (field peas).

Factor	Maximum Tolerance Foundation	Registered	Certified
Other varieties *.	0.01 percent	0.01 percent	0.01 percent
Other crops (inseparable)	none	none	none
Prohibited noxious weeds **	none	none	none

* Other varieties shall not include variations which are characteristic of the variety inspected.

** Prohibited noxious weeds include only field bindweed, leafy spurge, and Russian knapweed. The tolerance for other noxious and common weeds will be determined by the inspector based on the amount and separability of the seed from the crop being considered and the stage development of the crop and the weed.

History: Amended effective May 1, 1986; August 1, 1991.
General Authority: NDCC 4-09-03, 4-09-05, 4-09-16
Law Implemented: NDCC 4-09-16, 4-09-17, 4-09-18

74-03-13-03. Specific field standards (dry field beans).

Factor	Maximum Tolerance Foundation	Registered	Certified
Other varieties or classes *	0.03 percent	0.05 percent	0.1 percent
Inseparable other crops ...	none	none	none
Prohibited noxious weeds **	none	none	none
Objectionable weeds *** ...	none	none	none
Bacterial bean blights (leaves)	.005 percent	.005 percent	.005 percent
(pods) ~~**~~ ****	none	none	none
Anthracnose	none	none	none
Wilt	none	none	none
Common bean mosaic	none	0.5 percent	1.0 percent

* Other varieties shall not include variations which are characteristic of variety.

** ~~During second inspection, the inspector will stake (flag) any area found with a bacterial blighted pod. The grower shall isolate and~~

~~not harvest within a one hundred foot [30.5 meter] radius of all staked (flagged) areas. One blight infected pod or staked area is allowed per ten acres [4 hectares] of production. If any staked areas are harvested with the production field, the entire field is rejected.~~ Prohibited noxious weeds include only field bindweed.

*** Objectionable weeds include nightshade species and cocklebur.

**** During second inspection, the inspector will use the following procedures to isolate bacterial blighted area of a field. Using these procedures will allow the inspector to try to save as much of the field as possible. It is understood that when blighted spots are found throughout the field, it becomes impractical to try to isolate and save portions of the field. This decision to isolate or not in such cases will be made by the inspector.

1. The grower shall isolate and not thresh within a one hundred foot [30.5 meter] radius of all staked (flagged) plants. Leave flag by plants with blight infected pods.

2. Blight infected areas of field should be isolated. Each corner of the area to be left isolated and unthreshed should be marked by flags. Isolated area should not be threshed within one hundred feet [30.5 meters] of flags.

3. Areas to be isolated must be mapped out on field inspection report.

4. In any case, it is important that blighted areas be clearly defined by flags. These blighted areas must be left unthreshed while the rest of the field is threshed. The inspector may recheck the field to ensure that these blighted areas were indeed left. Failure to leave the rejected area will result in total field being rejected.

History: Amended effective May 1, 1986; May 1, 1988; December 18, 1989; August 1, 1991.
General Authority: NDCC 4-09-03, 4-09-05, 4-09-16
Law Implemented: NDCC 4-09-16, 4-09-17, 4-09-18

74-03-13-04. Seed standards (dry field beans) - Seed count required on dry field beans.

Factor	Standards for Each Class		
	Foundation	Registered	Certified
Pure seed (minimum) * .	98.5 percent	98.5 percent	98.5 percent
Inert matter (maximum) **	1.5 percent	1.5 percent	1.5 percent

Total weed seeds (maximum)	none	none	2 per pound
Other varieties or classes	0.01 percent	0.05 percent	0.1 percent
Other crops (maximum)	none	none	1 per 2 pounds
Prohibited noxious weed seeds	none	none	none
Objectionable weed seeds ***	none	none	none
Germination (minimum)	no standard	85.0 percent	85.0 percent
Bacterial blight test ****	pass	pass	pass

* Foreign matter other than broken seed may not exceed 0.50 percent.

** Splits and cracks cannot exceed 1.0 percent.

*** Objectionable weed seeds include those of buckhorn, dodder, hedge bindweed (wild morning glory), field pennycress, (frenchweed), hoary alyssum, horsenettle, quackgrass, wild oats, wild mustard, wild vetch species, giant foxtail, wild radish, nightshade species, and cocklebur.

**** The grower shall be responsible for having a bacterial blight test on the harvested seed of each field of dry field beans.

A seed treatment to reduce surface bacterial contamination of the seed coat is recommended.

History: Amended effective May 1, 1986; December 18, 1989; August 1, 1991.
General Authority: NDCC 4-09-03, 4-09-05, 4-09-16
Law Implemented: NDCC 4-09-16, 4-09-17, 4-09-18

TITLE 75

Department of Human Services

OCTOBER 1991

OBJECTION

THE LEGISLATIVE COUNCIL'S COMMITTEE ON ADMINISTRATIVE RULES OBJECTS TO NORTH DAKOTA ADMINISTRATIVE CODE CHAPTER 75-02-04.1 RELATING TO CHILD SUPPORT GUIDELINES.

The committee objects to this rule because:

1. Both parents have a legal duty to support their children.

2. Any guidelines adopted to ensure proper child support amounts are paid upon divorce must be based on the best interests of the child.

3. The obligor model adopted by the Department of Human Services establishes child support amounts by using a percentage of the obligor's income and does not take into consideration the income of the custodial parent.

4. The income shares model considered, but not adopted, by the department combines the income of both parents and requires the parties to contribute child support in proportion to the income each receives.

5. Public opinion expressed by the parties directly affected (the parents) strongly supports the income shares model over the obligor model because of the inherent fairness of that proposal. The best interests of the child would be better served by adoption of the income shares model as it would provide not only sufficient financial resources for the child but should provide for more harmonious relationships due to the fairness of the income shares model.

Section 28-32-03.3 provides that after the filing of a committee objection, the burden of persuasion is upon the agency in any action for judicial review or for enforcement of the rule to establish that the whole or portion thereof objected to is within the procedural and substantive authority delegated to the agency. If the agency fails to meet its burden of persuasion, the court shall declare the whole or portion of the rule objected to invalid and judgment shall be rendered against the agency for court costs.

History: Effective August 9, 1991.
General Authority: NDCC 28-32-03.3

NOVEMBER 1991

AGENCY SYNOPSIS: Regarding proposed amendments to North Dakota Administrative Code section 75-02-06-16(2). Rate determinations ratesetting for nursing home care.

The proposed amendments increase incentives payable to nursing facilities with an acutal rate below the limit rate for indirect care costs in an amount equal to 70% times the difference between the actual rate, exclusive of inflation indices, and the limit rate, exclusive of current inflation indices. The existing rules set a maximum incentive of $1.85. The amendment increases the maximum to $2.60.

The amendment also establishes an operating margin of three percent based upon the lesser of actual direct care and other direct care rates, or the limit rate.

Both of these amendments have the effect of increasing nursing rates. The proposed amendments are intended to allow the department to conform to the requirements of Senate Bill No. 2021. Senate Bill No. 2021 conditions the appropriation of general funds to the Medicaid program, for the purpose of paying increased rates in nursing facilities, upon the approval of necessary state plan amendments by the Health Care Financing Administration. The proposed rule was adopted as an interim final rule, effective April 1, 1991.

75-02-06-16. Rate determinations.

1. Each cost category actual rate is calculated using the allowable historical operating costs and adjustment factors provided for in subsection 4 divided by standardized resident's days for the direct care cost category and resident days for other direct care, indirect care, and property cost categories. The actual rate as calculated is compared to the limit rate for each cost category to determine the lesser of the actual rate or the limit rate. The lesser rate for direct

care is then multiplied times the weight for each classification in subsection 5 of section 75-02-06-17 to establish the direct care rate for that classification. The lesser of the actual rate or the limit rate for other direct care, indirect care, and property costs, and the adjustments provided for in subsections 2 and 3 are then added to the direct care rate for each classification to arrive at the established rate for a given classification.

2. a. Incentives. For a facility with an acutal rate below the limit rate for indirect care costs, an amount equal to seventy percent times the difference between the actual rate, exclusive of inflation indices, and the limit rate, exclusive of current inflation indices, up to a maximum of ~~one dollar and eighty five~~ two dollars and sixty cents will be included as part of the indirect care cost rate.

   b. Operating margins. A facility will receive an operating margin of three percent based on the lesser of the actual direct care and other direct care rates or the limit rate exclusive of current inflation indices. The three percent operating margin will then be added to the rate for the direct care and other direct care cost categories.

3. Limitations.

   a. The department shall accumulate and analyze statistics on costs incurred by the nursing facilities. These statistics may be used to establish reasonable ceiling limitations and incentives for efficiency and economy based on reasonable determination of standards of operations necessary for efficient delivery of needed services. These limitations and incentives may be established on the basis of cost of comparable facilities and services and may be applied as ceilings on the overall costs of providing services or on specific areas of operations. It shall be the option of the department to implement the ceilings so mentioned at any time based upon the information available and under guidelines required within the regulations of title XIX.

   b. The department will review, on an ongoing basis, aggregate payments to nursing facilities to determine that payments do not exceed an amount that can reasonably be estimated would have been paid for those services under medicare payment principles. If aggregate payments to nursing facilities exceed estimated payments under medicare, the department may make adjustments to rates to establish the upper limitations so that aggregate payments do not exceed an amount that can be estimated would have been paid under medicare payment principles.

c. Limits. All facilities except those facilities described in North Dakota Century Code section 50-24.4-13 will be used to establish a limit rate for the direct care, other direct care, and indirect care cost categories. This limit rate will be established using allowable historical operating costs for the report year ended June 30, 1988, and adjustment factors for the rate year as set forth in subsection 4. These limit rates may not be rebased prior to the rate periods beginning January 1, 1993. The department will review economic trends and factors affecting nursing facilities to determine when rebasing of the limits will occur.

(1) The limit rate for each of the cost categories will be established using the median rate for the appropriate cost category plus a fixed percentage of the median rate. The fixed percentage is to be determined as follows:

(a) Historical costs for June 30, 1988, as adjusted, will be used to set rates for all facilities in the direct care, other direct care, and indirect care cost categories.

(b) The rates for each cost category will be ranked from low to high. The ninetieth percentile ranking will be determined for the direct care and other direct care cost categories, and the seventy-fifth percentile ranking will be determined for the indirect care cost category.

(c) The fixed percentage will be determined by subtracting the median rate from the percentile ranking rate and dividing the difference by the median rate.

(d) The fixed percentage established under subparagraph c of this paragraph will be used to determine limits if and when rebasing of the limit year occurs.

(2) A facility who has an actual rate that exceeds the limit rate for a cost category will receive the limit rate.

(3) For the rate years beginning January 1, 1990, and ending December 31, 1992, a facility whose actual rate exceeds the limit rate for a cost category will receive a percentage of the difference between the actual rate and the limit rate as follows:

(a) For the rate year beginning January 1, 1990, forty-five percent of the difference will be included in the facility's rate.

(b) For the rate year beginning January 1, 1991, forty-five percent of the difference will be included in the facility's rate.

(c) For the rate year beginning January 1, 1992, twenty-five percent of the difference will be included in the facility's rate.

4. Adjustment factors for direct care, other direct care, and indirect care costs.

   a. The department will utilize an independent economic forecast method of predicting the factors to be used to adjust historical allowable costs. Where possible, adjustment factors specific to North Dakota will be used to establish the adjustment for each rate year. If specific North Dakota data is not available, regional-specific or national data will be used to establish adjustment factors for each rate year. Individual adjustment factors for the cost components included in this subdivision will be calculated for each rate year.

      (1) Salaries.

      (2) Employment benefits.

      (3) Foods.

      (4) Utilities.

      (5) Drugs and nursing supplies.

      (6) Other costs.

      An adjustment factor will be separately calculated for direct care, other direct care, and indirect care costs based on the forecasted increase or decrease in the cost components for the eighteen months from the end of the report year to the end of the next rate year.

   b. The same methodology will be used to adjust the previous year's established limit rates for direct care, other direct care, and indirect care costs.

5. Rate adjustments.

   a. Desk audit rate.

(1) The cost report will be reviewed taking into consideration the prior year's adjustments. The facility will be notified by telephone or mail of any adjustments based on the desk review. Within seven working days after notification, the facility may submit information to explain why the desk adjustment should not be made. The department will review the information and make adjustments which are determined to be appropriate.

(2) The desk audit rate will be effective January first of each rate year and will continue in effect until a final rate is established.

(3) Until a final rate is effective, pursuant to paragraph 3 of subdivision b of this subsection, private-pay rates may not exceed the desk audit rate except as provided for in North Dakota Century Code section 50-24.4-19.

(4) No reconsideration will be given by the department for the desk rate unless the facility has been notified that the desk rate is the final rate.

b. Final rate.

(1) The cost report may be field audited to establish a final rate. If no field audit is performed, the desk audit rate will become the final rate.

(2) The final rate will include any adjustments for nonallowable costs, errors, or omissions that result in a change from the desk audit rate of five cents per day or an aggregate of one thousand dollars for the facility, whichever is less, that are found during a field audit or are reported by the facility within twelve months of the rate yearend.

(3) The private-pay rate must be adjusted to the final rate in the second month following receipt of notification by the department of the final rate and is not retroactive except as provided for in subdivision c of this subsection.

(4) If adjustments, errors, or omissions are found after a final rate has been established, the following procedures will be used:

(a) Adjustments, errors, or omissions found within twelve months of establishment of the final rate and resulting in a change of at least five cents per day will result in a change to the final

rate. The change will be applied retroactively as provided for in this section.

(b) Adjustments, errors, or omissions in excess of one thousand dollars for the facility found later than twelve months after the establishment of the final rate will be included as an adjustment in the report year that the adjustment, error, or omission was found.

c. Adjustment of the total payment rate. The final rate as established will be retroactive to January first of the rate year, except with respect to rates paid by private-paying residents. Rates paid by private-pay residents must be retroactively adjusted and the difference refunded to the resident, if the desk audit rate exceeds the final rate by at least twenty-five cents per day.

6. Rate payments.

a. The rate as established shall be considered as payment for all accommodations and includes all items designated as routinely provided. No payments may be solicited or received from the resident or any other person to supplement the rate as established.

b. The rate as established shall be paid by the department only if the rate charged to private-pay residents for semiprivate accommodations equals the established rate. If at any time the facility discounts the private pay rate for those periods of time that the resident is not in the facility, the discounted rate will be the maximum chargeable to the department for the same service, i.e., hospital or leave days.

c. If the established rate exceeds the private pay rate, on any given date, the facility shall immediately report that fact to the department and charge the department at the lower rate. If payments were received at the higher rate, the facility shall, within thirty days, refund the overpayment. The refund will be the difference between the established rate and the rate charged the private-pay resident times the number of medical assistance resident days paid during the period in which the established rate exceeded the rate charged to private-pay residents, plus interest calculated at two percent over the Bank of North Dakota prime rate on any amount not repaid within thirty days. The refund provision will also apply to all duplicate billings involving the department. Interest charges on these refunds are not allowable costs.

d. Peer groupings, limitations, or adjustments which are based upon data received from or relating to more than one facility will be effective for a rate period. Any change in the data used to establish peer groupings, limitations, or adjustments will not be used to change such peer groupings, limitations, or adjustments during the rate period, except with respect to the specific facility or facilities to which the data change relates.

7. Partial year.

a. For facilities changing ownership during the rate period, the rate established for the previous owner will be retained. The rate for the next rate period following the change in ownership will be established as follows:

(1) For a facility with four or more months of operation under the new ownership during the report year, a cost report for the period will be used.

(2) For a facility with less than four months of operations under the new ownership during the report year, the rate established for the previous owner will be indexed forward using the adjustment factors as set forth in subsection 4.

b. For an existing facility with a capacity increase and for a new facility, the department will establish an interim rate equal to one hundred ten percent of the sixtieth percentile of the direct care, other direct care, and indirect care rates not to exceed the limit rate, plus an amount calculated using paragraph 3 of subdivision c of subsection 3 of this section, plus the property rate. The property rate will be calculated using projected property costs and certificate of need projected census. The interim rate will be in effect for no less than four months and no more than fifteen months. Costs for the period in which the interim rate is effective will be used to establish a final rate, which will be limited to the lesser of the interim or actual rate. If the final rate for direct care, other direct care, and indirect care costs is less than the interim rate for those costs, a retroactive adjustment as provided for in subsection 5 will be made. No retroactive adjustments will be made for property costs. For the rate period following submission of any partial year cost report by a facility, census used to establish rates for property and indirect care costs will be the greater of actual census or certificate of need projected census.

c. For a facility with renovations or replacements in excess of one hundred thousand dollars, and excluding capacity increases, the rate established will be the direct care,

other care direct, and indirect care rates based on the last report year, plus a property rate calculated based on projected property costs and census from the last report year. The projected property rate will be effective at the time the project is completed and placed into service.

d. For a facility terminating its participation in the medical assistance program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until medical assistance residents can be relocated to facilities participating in the medical assistance program.

8. One-time adjustments.

a. Adjustments to meet certification standards.

(1) The department may provide for an increase in the established rate for additional costs that are incurred to meet certification standards. The survey conducted by the state department of health and consolidated laboratories must clearly require that the facility take steps to correct deficiencies dealing with resident care. The plan of correction must identify the salary and other costs that will be increased to correct the deficiencies cited in the survey process.

(2) The facility must submit a written request to the medical services division within thirty days of submitting the plan of correction to the state department of health and consolidated laboratories. The request must contain the following information:

(a) A statement that costs or staff numbers have not been reduced for the report year immediately preceding the state department of health and consolidated laboratories' certification survey.

(b) The number of new staff or additional staff hours and the associated costs that will be required to meet the certification standards.

(c) A detailed list and implementation of any other costs necessary to meet survey standards.

(3) The department will review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate will be adjusted upward not to exceed the limit rate.

(4) Any additional funds provided must be used in accordance with the facility's written request to the department and are subject to audit. If the department determines that the funds were not utilized for the intended purpose, an adjustment will be made in accordance with subsection 5.

b. Adjustments for unforeseeable expenses.

(1) The department may provide for an increase in the established rate for additional costs that are incurred to meet major unforeseeable expenses. Such expenses must be resident related and must be beyond the control of those responsible for the management of the facility.

(2) The facility must submit a written request containing the following information to the medical services division within sixty days after first incurring the unforeseeable expense:

(a) An explanation as to why the facility believes the expense was unforeseeable.

(b) An explanation as to why the facility's management believes the expense was beyond the managerial control of the facility.

(c) A detailed breakdown of the unforeseeable expenses by expense line item.

(3) The department will base its decision on whether the request clearly demonstrates that the economic or other factors that caused the expense were unexpected and arose because of conditions that could not have been anticipated by management based on their background and knowledge of nursing care industry and business trends.

(4) The department will review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate will be adjusted upward not to exceed the limit rate.

(5) Any additional funds provided must be used to meet the unforeseeable expenses outlined in the facility's request to the department and are subject to audit. If the department determines that the funds were not utilized for the intended purpose, an adjustment will be made in accordance with subsection 5.

c. Adjustment to historical operating costs.

(1) A facility may receive a one-time adjustment to historical operating costs when the facility has been found to be significantly below care-related minimum standards described in subparagraph a of paragraph 2 of this subdivision and when it has been determined that the facility cannot meet the minimum standards through reallocation of costs and efficiency incentives.

(2) The following conditions must be met before a facility can receive the adjustment:

(a) The facility shall document that based on nursing hours and standardized resident days, the facility cannot provide a minimum of one and two-tenths nursing hours per standardized resident day.

(b) The facility shall document that all available resources, including efficiency incentives, if used to increase nursing hours, are not sufficient to meet the minimum standards.

(c) The facility shall submit a written plan describing how the facility will meet the minimum standard if the adjustment is received. The plan must include the number and type of staff to be added to the current staff and the projected cost for salary and fringe benefits for the additional staff.

(3) The adjustment will be calculated based on the costs necessary to increase nursing hours to the minimum standards less any operating margins and incentives included when calculating the established rate. The net increase will be divided by standardized resident days and the amount calculated will be added to the actual rate. This rate will then be subject to any rate limitations that may apply.

(4) If the facility fails to implement the plan to increase nursing hours to one and two-tenths hours per standardized resident day, the amount included as the adjustment will be adjusted in accordance with the methodologies set forth in subsection 5.

(5) If the actual cost of implementing the plan exceeds the amount included as the adjustment, no retroactive settlement will be made.

History: Effective September 1, 1980; amended effective July 1, 1981; December 1, 1983; July 1, 1984; September 1, 1987; January 1, 1990; November 1, 1991.

General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

DECEMBER 1991

75-02-02-01. Purpose. ~~The purpose of the medical assistance program is to provide medical care and services to persons whose income and resources are insufficient to meet such costs, and further to provide preventive, rehabilitative, and other services to help families and individuals to retain or attain capability for independent care or self care.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

General Authority: ~~NDCC 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-01~~

75-02-02-03.1. Definitions. ~~For the purposes of this chapter:~~

~~1. "Blind" has the same meaning as the term has when used by the social security administration in the supplemental security income program.~~

~~2. "Disabled" has the same meaning as the term has when used by the social security administration in the supplemental security income program.~~

~~3. "Good faith offer to sell" means an honest offer to sell in a manner which is reasonably calculated to induce a willing buyer to believe that the property offered for sale is actually for sale at a fair price. A good faith offer to sell includes, at a minimum, making the offer at a stated minimum price equal to seventy-five percent of fair market value, in the following manner:~~

~~a. To the regular market for such property, if any regular market exists and, if no buyer is thereby secured;~~

b. To any coowner, joint owner, possessor, or occupier of the property and, if no buyer is thereby secured,

c. By public advertisement for sale in a newspaper of general circulation, the circulation area of which includes the location of any property resource offered for sale, which advertisement was published successively for two weeks if the newspaper is a weekly publication, and for one week if the newspaper is a daily publication, and which includes a plain and accurate description of the property and the name, address, and telephone number of a person who will answer inquiries and receive offers.

4. "Home" means, when used in the phrase "the home occupied by the medical assistance unit," the residence occupied by the medical assistance unit including the land on which it is located, provided that the acreage [hectarage] does not exceed one hundred sixty contiguous acres [64.75 hectares] if rural or two acres [.81 hectares] if located within the established boundaries of a city.

5. "Medical assistance unit" means an individual, a married couple, or a family with children under twenty-one years of age, whose income and resources are considered in determining eligibility for any member of that unit, without regard to whether the members of the unit all physically reside in the same location.

6. "Occupied" means, when used in the phrase "the home occupied by the medical assistance unit," the home the medical assistance unit is living in, or if temporarily absent from, possessed with an intention to return and the capability of returning within a reasonable length of time. Property is not occupied if the right to occupy has been given up through a rental or lease agreement whether or not that rental or lease agreement is written. Property is not occupied by an individual in long-term care or the state hospital, with no spouse or child who is under age twenty-one or blind or disabled, at home, unless a physician has certified that the individual is likely to return home within six months.

7. "Persons deemed to be receiving aid to families with dependent children" means those persons who are not receiving an aid to families with dependent children money payment, but who must be treated as recipients of such benefits because federal law or regulations so provides.

8. "Property which is essential to earning a livelihood" means property which the applicant or recipient owns, and which the applicant or recipient is actively engaged in using to earn income and where the total benefit of such income is derived for the applicant or recipient's needs. An applicant or recipient is actively engaged in using the property if that

~~individual contributes significant current personal labor in using the property for income-producing purposes. The payment of social security taxes on the income from such current personal labor is an indicator of the active use of the property. Property from which an applicant or recipient is merely receiving rental or lease income is not essential to earning a livelihood.~~

~~9. "Property resource" includes any kind of property or property interest, whether real, personal, or mixed, and whether or not presently vested with possessory rights.~~

~~10. "Property which is not salable without working an undue hardship" means property which the owner has made a good faith offer to sell which has produced no buyer willing to pay an amount equaling or exceeding seventy-five percent of the property's fair market value, and which is continuously for sale.~~

~~11. "Specialized facility" means a residential facility which provides remedial services.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: ~~Effective May 1, 1986.~~
General Authority: ~~NDCC 50-06-16, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02~~

75-02-02-04. Application and decision.

~~1.~~ Application.

~~a. All individuals wishing to make application for medical assistance under the medical assistance program shall have the opportunity to do so, without delay.~~

~~b. An application is a written request made to a county social service board by a person desiring assistance under the medical assistance program or by a proper person seeking such assistance on behalf of another person. A proper person means any person of sufficient maturity and understanding to act responsibly on behalf of the applicant.~~

~~c. An application must be in writing and signed on the prescribed application form.~~

~~d. The prescribed application form must be signed by each applicant if the applicant is physically and mentally able to do so. For those applicants adjudged incompetent by a court, it shall be signed on behalf of the applicant by a legally appointed guardian.~~

~~e. Information concerning eligibility requirements, available services, and the rights and responsibilities of applicants and recipients shall be furnished to all who require it.~~

~~f. A relative or other interested party may file an application in behalf of a deceased person to cover medical costs incurred prior to the deceased person's death.~~

~~2. xDecision.~~

~~a. A decision as to eligibility will be made promptly on applications, within forty-five days, or sixty days in disability cases, except in unusual situations.~~

~~b. Immediately upon determination of eligibility, applicants for medical assistance will be notified by the county social service board.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: Amended effective February 1, 1981; May 1, 1986.
General Authority: ~~NDCC 50-06-05.1, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02, 42 CFR 435.905, 42 CFR 435.906, 42 CFR 435.907, 42 CFR 435.908, 42 CFR 435.909, 42 CFR 435.910, 42 CFR 435.911, 42 CFR 435.912, 42 CFR 435.914~~

75-02-02-05. Furnishing assistance.

~~1. Individuals found eligible for medical assistance will qualify for assistance, beginning at least with the date of application, and if determined eligible, eligibility may begin in or after the third month prior to the month of application provided that eligibility existed at the time medical services prior to application were received.~~

~~2. The medical care and services covered by the plan will be furnished promptly to eligible individuals without any delay attributable to the agency's administrative processes, which will be efficient and in the best interests of the recipient.~~

~~3. Where an individual has been determined to be eligible, eligibility will be reconsidered or redetermined: (a) when required on the basis of information the agency had obtained previously about anticipated changes in the individual's situation; (b) promptly, within thirty days, after a report is obtained which indicates that changes in the individual's circumstances may affect the amount of assistance to which the individual is entitled or may make the individual eligible; and (c) periodically, no less often than every twelve months.~~

Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

General Authority: ~~NDCC 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-04, 42 CFR 435.914, 42 CFR 435.916, 42 CFR 435.930~~

75-02-02-15. Groups covered.

~~1. Categorically needy. Within the limit of legislative appropriation, and subject to any waiver granted by the United States department of health and human services, medical assistance will be made available to individuals described in the title XIX state plan for medical assistance as "categorically needy", with medical care and services available in the same amount, duration, and scope for all eligible individuals.~~

~~2. Medically needy. Within the limits of legislative appropriations, and subject to any waiver granted by the United States department of health and human services, medical assistance may be made available to individuals described in the title XIX state plan for medical assistance as "medically needy", with medical care and services available in the same amount, duration, and scope for all eligible individuals.~~

~~3. Aliens. Aliens shall not be eligible for medical assistance except as specifically allowed by federal law and regulation.~~

~~4. Inmates. Inmates of public institutions shall not be eligible for medical assistance except as specifically allowed by federal law and regulation.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: ~~Effective May 1, 1986.~~
General Authority: ~~NDCC 50-06-16, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02, 50-24.1-06, 42 CFR Part 435~~

75-02-02-16. Basic eligibility factors.

~~1. It is the responsibility of the applicant for medical assistance benefits to establish the eligibility of each individual for whom medical assistance is requested including, but not limited to, the furnishing of a social security number, and, the establishment of age, identity, residence, citizenship, blindness, disability, and financial eligibility. The applicant and each individual for whom assistance is requested must, as a condition of eligibility, execute all necessary documents to protect his, or the agency's, rights to~~

~~subsequent reimbursement from any third parties, for medical care and services included under this plan, the need for which arises out of injury, disease, or disability of the applicant or recipient for medical assistance.~~

~~2. No age, residence, citizenship, or other requirement that is prohibited by title XIX of the Social Security Act will be imposed as a condition of eligibility.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: ~~Effective May 1, 1986.~~
General Authority: ~~NDCC 50-06-16, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02, 42 CFR Part 435~~

75-02-02-17. Blindness and disability.

~~1. In any instance in which a determination is to be made as to whether any individual is disabled, each medical report form and social history will be reviewed by technically competent persons, not less than a physician and a social worker qualified by professional training and pertinent experience, acting cooperatively, who are responsible for the department's decision that the applicant does or does not meet the appropriate definitions of disability.~~

~~2. In any instance in which a determination is to be made whether an individual is blind, there will be an examination by a physician skilled in the diseases of the eye, or by an optometrist, whichever the individual may select. Each eye examination report will be reviewed by state supervising ophthalmologist who is responsible for comparing that report with the state's definition of blindness and for determining:~~

~~a. Whether the individual meets the definition of blindness; and~~

~~b. Whether and when reexaminations are necessary for periodic redeterminations of eligibility.~~

~~3. The agency shall decline to determine blindness or disability when such a determination can be made pursuant to the processing of a supplemental security income benefit application or an old-age and survivors' insurance benefit payments application by the social security administration, or its contractee, for that purpose.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: ~~Effective May 1, 1986.~~

General Authority: ~~NDCC 50-06-16, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02, 42 CFR Part 435~~

75-02-02-18. Financial eligibility.

~~1. Persons receiving or deemed to be receiving aid to families with dependent children benefits are eligible for medical assistance benefits.~~

~~2. Persons receiving supplemental security income program benefits are eligible for medical assistance benefits only if they also meet all income and resource requirements of this chapter.~~

~~3. Essential spouses of, or persons essential to, individuals receiving benefits, in December 1973, under the state's approved plan for title XVI, aid to the aged, blind or disabled, who were grandfathered into the supplemental security income program, and who have continuously received benefits under the supplemental security income program since its inception, but only if the "essential spouse" or "person essential to" continues to live with the individual.~~

~~4. Any individual not described in subsection 1, 2, or 3 may be made eligible for medical assistance benefits only if the individual meets all eligibility requirements of this chapter.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: ~~Effective May 1, 1986.~~
General Authority: ~~NDCC 50-06-16, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02~~

75-02-02-19. Income and resource considerations.

~~1. All income and resources will be considered in establishing eligibility and in the flexible application of income to medical costs not in the state plan, and payment toward the medical assistance costs.~~

~~2. Only such income and resources as are actually available will be considered; income and resources will be reasonably evaluated.~~

~~3. The financial responsibility of any individual for any applicant or recipient of medical assistance will be limited to the responsibility of spouse for spouse, and parents for a child under age twenty-one. Such responsibility is imposed upon applicants or recipients as a condition of eligibility under the state plan. Except as otherwise provided in this~~

section, the income and resources of the spouse, and of the parents of a child under age twenty-one, will be considered available to the applicant or recipient even if they are not actually contributed.

4. Except as otherwise provided in this subsection, one hundred percent of the income of the ineligible medical assistance unit in the home, which exceeds the appropriate medical assistance income level, will be deemed to be available to all individuals residing in the home. Individuals residing in the home include individuals who are physically present as well as individuals who are temporarily absent, including individuals receiving educational services, acute medical care and service in a specialized facility. Only twenty-five percent of the income of that ineligible medical assistance unit which exceeds the appropriate medical assistance income level will be deemed available to an eligible individual receiving services in a specialized facility. None of the income of the medical assistance unit in the home will be deemed available to an eligible individual who resides, or is treated as residing, outside of the home of the medical assistance unit on other than a temporary basis. Individuals who reside in a facility which provides to them skilled nursing home services or intermediate nursing care are residing outside the home on other than a temporary basis. Individuals receiving home and community-based services are treated as residing outside the home on other than a temporary basis.

5. Applicants and recipients must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include, but are not limited to, veterans' compensation and pensions, old age, survivors, and disability insurance benefits, railroad retirement benefits, and unemployment compensation.

6. It is presumed that all spousal resources are actually available to aged, blind, or disabled individuals where financial responsibility is imposed pursuant to subsection 3. In order to rebut this presumption, the applicant or recipient must demonstrate that the spousal resources are unavailable despite reasonable and diligent efforts to access such resources. The rebuttal of this presumption does not preclude the department from exercising the powers granted to it by North Dakota Century Code section 50-24.1-02.1. Except as provided in subdivisions a, b, and c, no applicant or recipient who has a statutory or common law cause of action for support out of the resources of a spouse, but who has failed to diligently pursue that cause of action, may rebut the presumption. Any applicant or recipient who documents any of the following circumstances will have rebutted the presumption without further proof:

~~a. A court order, entered following a contested case, determines the amounts of support that a spouse must pay to the applicant or recipient.~~

~~b. The spouse from whom support could ordinarily be sought, and the property of such spouse, is outside the jurisdiction of the courts of the United States or any of the United States.~~

~~c. The applicant or recipient has been subject to marital separation, with or without court order, for at least two years prior to making application for medical assistance benefits, and there has been no contact whatever between the applicant or recipient and his or her spouse for the same two-year period.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: ~~Effective May 1, 1986.~~
General Authority: ~~NDCC 50-06-16, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02~~

75-02-02-20. Income levels and application.

~~1. Levels of income for maintenance, in total dollar amounts, will be used as a basis for establishing financial eligibility for medical assistance. The income levels applicable to families of various sizes will be established by the department of human services.~~

~~2. There shall be a flexible measurement of available income which will be applied as follows:~~

~~a. First, for maintenance, so that any income in an amount at or below the established income level will be protected for maintenance;~~

~~b. Payments made for noncovered necessary current medical and remedial care;~~

~~c. Reasonable work-related expenses for producing any earned income as determined by the department;~~

~~d. Payments made for necessary health insurance coverage; and~~

~~e. Appropriate income deductions and disregards as determined by the department.~~

~~All the remaining income will be applied to costs of medical care included in the state plan.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed

pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: ~~Effective May 1, 1986.~~
General Authority: ~~NDCC 50-06-16, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02~~

75-02-02-21. Property resource limits. ~~The following property provisions will be applied in determining eligibility for medical assistance. In all instances, including determinations of equity, property must be realistically evaluated in accord with current market value. Any reasonable costs which may be associated with liquidation of excess property must be taken into account. Except for those persons found eligible for medical assistance benefits pursuant to section 75-02-02-26, no person may be found eligible for medical assistance benefits unless the total value of the medical assistance unit's resources, in addition to resources exempted pursuant to section 75-02-02-22 or excluded pursuant to section 75-02-02-23, does not exceed:~~

1. ~~Three thousand dollars for a one-person unit;~~

2. ~~Six thousand dollars for a two-person unit; and~~

3. ~~An additional amount of twenty-five dollars for each member of the unit in excess of two.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: ~~Effective May 1, 1986.~~
General Authority: ~~NDCC 50-06-16, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02~~

75-02-02-22. Exempt property resources. ~~The following resources shall be exempt from consideration in determining eligibility for medical assistance:~~

1. ~~The home occupied by the medical assistance unit, including trailer homes being used as living quarters;~~

2. ~~Personal effects, wearing apparel, household goods, and furniture;~~

3. ~~Term insurance;~~

4. ~~Burial insurance, the terms of which specifically provide that the proceeds can be used only to pay the burial expenses of the insured; and~~

~~5. One motor vehicle.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: ~~Effective May 1, 1986.~~
General Authority: ~~NDCC 50-06-16, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02~~

75-02-02-23. Excluded property resources. ~~The following types of property interests will be excluded in determining if the available resources of an applicant or recipient exceed resource limits:~~

~~1. Property which is essential to earning a livelihood;~~

~~2. Property which is not salable without working an undue hardship;~~

~~3. Any prepayments or deposits which total three thousand dollars or less made under a pre-need funeral service contract for each applicant or recipient in the medical assistance unit; and~~

~~4. Property with a fair market value which does not exceed twenty-five thousand dollars and which is separately owned by a noninstitutionalized spouse of an institutionalized applicant or recipient who has lived separately and apart from that spouse for at least six months.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: ~~Effective May 1, 1986.~~
General Authority: ~~NDCC 50-06-16, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02, 50-24.1-02.2, 50-24.1-02.3~~

75-02-02-24. Contractual rights to receive money payments. ~~There is a presumption that the holder's interest in contractual rights to receive money payments, including, but not limited to, the seller's interest in a long-term contract for the sale of real or personal property, promissory notes, trust deeds, mortgages, and accounts receivable, is salable without working an undue hardship. This presumption may be rebutted by evidence demonstrating a good faith offer to sell the contractual rights to receive money payments and the sworn statement of the applicant, recipient, or the applicant's or recipient's representative, that no offers were received which equaled or exceeded the stated minimum price. The stated minimum price may not exceed seventy-five percent of the determined discounted value of the holder's interest, or thirty thousand dollars, whichever is less.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: ~~Effective May 1, 1986.~~
General Authority: ~~NDCC 50-06-16, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02~~

75-02-02-25. Disqualifying transfers.

~~1. An assignment or transfer of a nonexempt property, for less than adequate consideration, whenever made with the intent to render the assignor or transferor, or a family member, eligible for medical assistance benefits, produces ineligibility. An amount equal to the fair market value of the property transferred will be treated as though the assignor or transferor had retained the property. An individual found ineligible as a result of a disqualifying assignment or transfer will remain ineligible until he becomes obligated for medical expenses equal to the difference between the fair market value of the property and the amount of compensation actually received. The return of an assigned or transferred resource to the assignor or transferor will nullify the disqualifying assignment or transfer, and the returned resource is thereafter treated as any other property resource.~~

~~2. There are legitimate instances when a property assignment or transfer may be valid. The applicant or recipient should be given full opportunity to state the reasons for having made the property assignment or transfer, and these statements should be considered in relation to the following questions:~~

~~a. Was adequate consideration received?~~

~~b. How recent was the assignment or transfer? (Caution on this point is advised since very recent assignments or transfers may in some instances be entirely acceptable.)~~

~~c. Is the applicant's or recipient's stated purpose reasonable in view of the circumstances prevailing at the time of the assignment or transfer?~~

~~d. Would it have been reasonable to anticipate that the assignment or transfer of property at the time it occurred would result in an earlier need for assistance?~~

~~e. Was there some consideration other than cash? For instance, were benefits available to the applicant or recipient, from the assignee or transferee, that were contingent upon the assignment or transfer of the property?~~

~~f. Did the transferee have a legal or equitable interest in the property transferred?~~

3. Where the assignee or transferee is a relative of the assignor or transferor, services or assistance furnished by the assignee or transferee to the assignor or transferor may not be treated as consideration for the property unless provided pursuant to a valid contract entered into prior to the rendering of the service or assistance.

4. An assignment or transfer of property for less than adequate consideration, made at any time after two years prior to the first date of application or inquiry for medical assistance, or after a previous application for medical assistance has been made and denied because of excess property resources, shall be presumed to have been made for the purpose of rendering the applicant eligible for medical assistance. This presumption may be rebutted by substantial evidence of an intent which is inconsistent with the presumed intent.
Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: Effective May 1, 1986.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02-26. Eligibility under 1972 state plan. No individual may be determined to be ineligible for medical assistance benefits for any month if, had the approved state plan for medical assistance in effect on January 1, 1972, been in effect in such month, that individual would be eligible. The following income and resource standards were a part of the approved state plan in effect on January 1, 1972, and may not be exceeded by any individual who claims eligibility under this section:

1. The income level for a family of one is one hundred fifty dollars per month. The income level for a family of two is two hundred dollars per month. The income level for a family of three is two hundred fifty dollars per month. The income level for a family of four is three hundred dollars per month. The income level for a family of five is three hundred forty-two dollars per month. The income level for a family of six is three hundred eighty-four dollars per month. The income level for a family of seven is four hundred twenty-five dollars per month. An additional thirty-four dollars per month will be added for each family member beyond seven to establish the income level for families with more than seven members. The income level for a person residing in a long-term care facility is eight dollars per month.

2. The home occupied by the medical assistance unit will be exempted in determining eligibility for medical assistance.

3. Real property other than the home may not exceed an equity of two thousand five hundred dollars, except that real property which is essential to earning a livelihood shall be exempt from the limitation, if the liquidation of such assets would cause undue hardship. Liquidation of income-producing real property, which would result in reducing annual income below the established income levels, would be considered undue hardship. If undue hardship is not a consideration, equity in excess of the two thousand five hundred dollars would be considered available for meeting medical costs, providing the property is salable. The person would have the option of liquidating the excess property or borrowing funds on it.

4. For the purposes of subsections 5, 6, and 7, personal property includes cash, savings, and redeemable stocks and bonds, vehicles, machinery, livestock, et cetera, but does not include personal effects, wearing apparel, household goods, furniture, or trailer homes being used for living quarters. Cash surrender value of life insurance policies will be considered personal property but will not be considered cash.

5. Personal property may not exceed an equity of twenty-five hundred dollars except that such property which is essential to the earning of a livelihood shall be exempt from the limitation if the liquidation of such excess assets would cause undue hardship. Liquidation of income-producing personal property which would result in reducing annual income below the established income levels would be considered undue hardship. If undue hardship is not found to be a consideration, equity in excess of the twenty-five hundred dollars would be considered available for meeting medical costs providing the property is salable. The person would have the option of liquidating the excess property or borrowing funds on it.

6. In all instances, real and personal property must be realistically evaluated in accord with current market value, and in considering net equity, any possible costs which may be associated with liquidation of the excess property must be taken into account.

7. With respect to cash, savings, redeemable stocks and bonds, and other liquid assets, the following levels will be applicable to families of various sizes:

   a. Three hundred fifty dollars for one person;

   b. Seven hundred dollars for two persons;

   c. Fifty dollars for each family member through ten; and

   d. Twenty-five dollars for each additional family member.

~~These amounts will not be considered as being available for medical expenses.~~ Repealed effective December 1, 1991, unless chapter 75-02-02.1 is appealed pursuant to section 27 of 1991 House Bill No. 1194 and is not affirmed.

History: ~~Effective May 1, 1986.~~
General Authority: ~~NDCC 50-06-16, 50-24.1-04~~
Law Implemented: ~~NDCC 50-24.1-02~~

AGENCY SYNOPSIS: Regarding proposed new North Dakota Administrative Code chapter 75-02-02.1, Eligibility for Medicaid.

The Department of Human Services is responsible for the administration of the Medical Assistance (Medicaid) Program pursuant to N.D.C.C. chapter 50-24.1. The department is the "single state agency" responsible to administer the program in conformance with the requirements for Medical Assistance state plans imposed under federal law. 42 U.S.C. section 1396(a) et seq. The department has heretofore established rules governing various aspects of the Medical Assistance Program. North Dakota Administrative Code chapter 75-02-02, Medical Services. The proposed new administrative code chapter describes the requirements for establishing eligibility for Medicaid benefits. The existing provisions of North Dakota Administrative Code chapter 75-02-02, medical services, which presently govern Medicaid eligibility, would be repealed.

The proposed new chapter establishes, in detail, the principles for determination of eligibility for Medicaid benefits. This program is extraordinarily complex as a consequence of the state's efforts to conform all aspects of the program to federal requirements. A failure to conform to the federal requirements would preclude the receipt of federal moneys which currently pay approximately 70% of the costs of Medicaid benefits furnished under the program.

The proposed rules are laid out in the order in which each section would ordinarily be applied in making a determination for Medicaid eligibility. This practice has been followed to remain consistent with existing Department of Human Services' manual provisions concerning eligibility determinations in the Medicaid program. Administration of the program requires the use of many terms which have special limitations and definitions. A general definition section is found in proposed new section 75-02-02.1-01. However, throughout the proposed new chapter, definitions particular to specific sections or subsections of the chapter may be found within the section or subsection to which those definitions pertain.

The proposed rules are intended to conform eligibility determinations in the Medicaid program, in all respects, to applicable federal and state laws. For the most part, the rules do not contain or describe significant departures from existing departmental policies concerning determinations of eligibility for Medicaid benefits. However, significant new policy would be created under proposed North Dakota

Administrative Code section 75-02-02.1-36, Budgeting. This new section would alter the current practice of "retrospective" budgeting and substitute the practice of "prospective" budgeting, or determining financial eligibility based on the best estimate of the circumstances of the Medicaid unit during the month in which eligibility is to be determined.

North Dakota Administrative Code chapter 75-02-02.1 contains 42 sections. They are:

75-02-02.1-01 - Definitions: Defines 37 terms used in the chapter.

75-02-02.1-02 - Application and redetermination: Sets forth requirements concerning the manner of making applications, and the responsibilities of recipients in periodic redeterminations of eligibility.

75-02-02.1-03 - Decision and notice: Sets forth requirements concerning actions taken on applications.

75-02-02.1-04 - Screening of recipients of certain services: Requires a specific determination that persons who seek nursing home care, or similar services, undergo a determination as to their need for such care.

75-02-02.1-05 - Covered groups: Describes the several categories of persons who may be eligible for medicaid benefits of some type.

75-02-02.1-06 - Applicant's choice of aid category or coverage group: States the applicant's right to choose a category or coverage group which is of greatest benefit to the applicant.

75-02-02.1-07 - Applicant's duty to establish eligibility: Describes the applicant's responsibility to show that all eligibility factors are met.

75-02-02.1-08 - Selecting medicaid unit members: Allows a medicaid unit to determine, in some circumstances, which household members will become a part of the medicaid unit.

75-02-02.1-09 - Assignment of rights to recover medical costs: Requires an applicant to assign rights to recover medicaid benefits from third parties, and establishes exceptions.

75-02-02.1-10 - Eligibility - Current and retroactive: Describes the times at which medicaid eligibility can begin.

75-02-02.1-11 - Need: Requires that persons seeking medicaid benefits actually have a need for the medical care sought.

75-02-02.1-12 - Limitation on conditions of eligibility: Sets forth the federal requirements concerning conditions of eligibility.

75-02-02.1-13 - Social security numbers: Requires applicants and recipients to furnish social security numbers, and provides for exceptions.

75-02-02.1-14 - Blindness and disability: Describes the standard to be applied in determining if an applicant is blind or disabled.

75-02-02.1-15 - Incapacity of a parent: Describes the standard for determining if a parent is incapacitated.

75-02-02.1-16 - State of residence: Describes the method of determining an applicant's state of residence for medicaid purposes.

75-02-02.1-17 - Application for other benefits: Requires a medicaid applicant to seek other benefits which may be available.

75-02-02.1-18 - Coverage for aliens: Describes the circumstances in which aliens can become recipients of medicaid benefits.

75-02-02.1-19 - Inmates of public institutions not covered - Exceptions: Describes the general rule that limits the availability of medicaid benefits to inmates of public institutions, and describes exceptions.

75-02-02.1-20 - Extended medicaid benefits to certain former recipients of AFDC benefits: Provides for continued medicaid benefits to AFDC recipients who lose AFDC eligibility because of specified factors.

75-02-02.1-21 - Continuous eligibility for pregnant women: Provides that in described circumstances pregnant women, once eligible, continue eligible for medicaid benefits until after the child is born.

75-02-02.1-22 - Eligibility for qualified medicare beneficiaries: Describes limited benefits available to certain low income beneficiaries.

75-02-02.1-23 - Eligibility for qualified disabled and working individuals: Describes limited medicaid benefits available to certain disabled persons with earned income.

75-02-02.1-24 - Spousal impoverishment prevention: Describes provisions for consideration of income and assets owned by a married couple where one member of the couple is receiving care in a nursing facility, all for the purpose of permitting the spouse in the community to retain substantial assets and income.

75-02-02.1-25 - Asset considerations: States general requirements concerning the consideration of assets in determinations of eligibility.

75-02-02.1-26 - Asset limits: Describes asset limits which, if exceeded, preclude eligibility for medicaid benefits.

75-02-02.1-27 - Exempt assets: Identifies assets which are exempted in considering asset limits.

75-02-02.1-28 - Excluded assets: Describes assets which are not treated as available in determining the application of asset limits.

75-02-02.1-29 - Forms of asset ownership: Describes the various ways in which assets can be owned, singly or in combination, and describes the implications of each type of asset ownership.

75-02-02.1-30 - Contract for rights to receive money payments: Established a presumption that contracts for rights to receive money payments are available assets, and provides a mechanism for rebutting that presumption.

75-02-02.1-31 - Trusts: Categorizes various types of trusts and describes the treatment of each type for medicaid eligibility purposes.

75-02-02.1-32 - Valuation of assets: Describes methods of determining the value of assets for medicaid eligibility purposes.

75-02-02.1-33 - Disqualifying transfers: Describes the circumstances in which a transfer for less than adequate consideration can lead to the loss of medicaid benefits for the transferor or the transferor's family.

75-02-02.1-34 - Income considerations: Describes general considerations used in determining income available to meet medical needs.

75-02-02.1-35 - Budgeting: Describes the method of determining how much available income will be treated as being available to meet medical needs, and of determining the amount of medicaid benefits to which an individual or medicaid unit may be entitled.

75-02-02.1-36 - Disregarded income: Identifies types of income which are not counted in determining medicaid eligibility.

75-02-02.1-37 - Unearned income: Identifies special policies with respect to the consideration of unearned income.

75-02-02.1-38 - Earned income: Identifies special policies with respect to the earned income.

75-02-02.1-39 - Income deductions: Describes amounts of income which are deducted in determining income available to meet medical needs.

75-02-02.1-40 - Income levels: Identifies the level of income below which no income is treated as being available to meet medical needs.

75-02-02.1-41 - Deeming of income: Describes circumstances where income will be treated as being available to an applicant or recipient of medicaid benefits.

75-02-02.1-42 - Eligibility under 1972 state plan: Describes requirements imposed on persons who assert they are eligible under the state's 1972 state plan.

STAFF COMMENT: Chapter 75-02-02.1 contains all new material but is not underscored so as to improve readability.

CHAPTER 75-02-02.1
ELIGIBILITY FOR MEDICAID

75-02-02.1-01. Definitions. For the purposes of this chapter:

1. "Agency" means the North Dakota department of human services.

2. "Aid to families with dependent children" means aid to families with dependent children, a program administered under North Dakota Century Code chapter 50-09 and title IV-A of the Social Security Act [42 U.S.C. 601 et seq.].

3. "Asset" means any kind of property or property interest, whether real, personal, or mixed, whether liquid or illiquid, and whether or not presently vested with possessory rights.

4. "Blind" has the same meaning as the term has when used by the social security administration in the supplemental security income program.

5. "Child" means a person, under twenty-one, who is not living independently.

6. "County agency" means the county social service board.

7. "Department" means the North Dakota department of human services.

8. "Disabled" has the same meaning as the term has when used by the social security administration in the supplemental security income program.

9. "Disabled adult child" means a disabled or blind person over the age of twenty-one who became blind or disabled before age twenty-two.

10. "Earned income" means income which is currently received as wages, salaries, commissions, or profits from activities in which an individual or family is engaged through either employment or self-employment. There must be an appreciable amount of personal involvement and effort, on the part of the individual or family, for income to be considered "earned".

11. "Full calendar month" means the period which begins at midnight on the last day of the previous month and ends at midnight on the last day of the month under consideration.

12. "Good faith effort to sell" means an honest effort to sell in a manner which is reasonably calculated to induce a willing

buyer to believe that the property offered for sale is actually for sale at a fair price. A good faith effort to sell includes, at a minimum, making the offer at a stated minimum price equal to seventy-five percent of fair market value (sixty-six and two-thirds percent of fair market value with respect to determination of qualified disabled and working individual benefits under section 75-02-02.1-08), in the following manner:

a. To any coowner, joint owner, possessor, or occupier of the property, and, if no buyer is thereby secured.

b. To the regular market for such property, if any regular market exists, and, if no buyer is thereby secured.

c. By public advertisement for sale in a newspaper of general circulation, the circulation area of which includes the location of any property resource offered for sale, which advertisement was published successively for two weeks if the newspaper is a weekly publication and for one week if the newspaper is a daily publication, and which includes a plain and accurate description of the property and the name, address, and telephone number of a person who will answer inquiries and receive offers.

13. "Home" means, when used in the phrase "the home occupied by the medical assistance unit", the residence occupied by the medical assistance unit, including the land on which it is located, provided that the acreage [hectarage] does not exceed one hundred sixty contiguous acres [64.75 hectares] if rural or two acres [.81 hectares] if located within the established boundaries of a city.

14. "Institutionalized person" means a person who is an inpatient in a nursing facility or a swing bed facility, or who receives home or community-based services and with respect to whom there has been a determination that, but for the provision of home or community-based services, the person would require the level of care provided in a nursing facility.

15. "Living independently" means, in references to a child under the age of twenty-one, a status which arises in any of the following circumstances:

a. The applicant or recipient has served a tour of active duty with the armed services of the United States and lives separately and apart from the parent.

b. The applicant or recipient has married, even though that marriage may have been dissolved or annulled in a court of law.

c. The applicant or recipient has lived separately and apart from both parents for at least six months prior to making application for medicaid benefits, and has received no support or assistance from either parent during that period. For purposes of this subdivision, periods when the applicant or recipient is attending an educational or training facility are deemed to be periods when the applicant or recipient was living with a parent, whether or not the place of abode during school terms was with either parent.

d. Both parents from whom support could ordinarily be sought, and the property of such parents, is outside the jurisdiction of the courts of the United States or any of the United States.

16. "Medicaid" means a program implemented pursuant to North Dakota Century Code chapter 50-24.1 and 42 U.S.C. 1396 et seq. to furnish medical assistance, as defined in 42 U.S.C. 1396d(a), to persons determined eligible for medically necessary, covered medical, and remedial services.

17. "Medicaid unit" means an individual, a married couple, or a family with children under twenty-one years of age, whose income and assets are considered in determining eligibility for any member of that unit, without regard to whether the members of the unit all physically reside in the same location.

18. "Medicare cost sharing" means the following costs:

a. (1) Medicare part A premiums; and

(2) Medicare part B premiums;

b. Medicare coinsurance;

c. Medicare deductibles; and

d. Twenty percent of the allowed cost for medicare covered services where medicare covers only eighty percent of the allowed costs.

19. "Occupied" means, when used in the phrase "the home occupied by the medicaid unit", the home the medicaid unit is living in or, if temporarily absent from, possessed with an intention to return and the capability of returning within a reasonable length of time. Property is not occupied if the right to occupy has been given up through a rental or lease agreement, whether or not that rental or lease agreement is written. Property is not occupied by an individual in long-term care or the state hospital, with no spouse, disabled adult child, or child under age twenty-one at home, unless a physician has

certified that the individual is likely to return home within six months.

20. "Persons deemed to be receiving aid to families with dependent children" means those persons who are not receiving an aid to families with dependent children money payment, but who must be treated as recipients of such benefits because federal law or regulations so provides.

21. "Pre-need funeral service contract" has the same meaning provided for in subsection 2 of North Dakota Century Code section 43-10.1-01.

22. "Property which is essential to earning a livelihood" means property which the applicant or recipient owns, and which the applicant or recipient is actively engaged in using to earn income, and where the total benefit of such income is derived for the applicant or recipient's needs. An applicant or recipient is actively engaged in using the property of that individual contributes significant current personal labor in using the property for income-producing purposes. The payment of social security taxes on the income from such current personal labor is an indicator of the active use of the property. Property from which an applicant or recipient is merely receiving rental or lease income is not essential to earning a livelihood.

23. "Property which is not saleable without working an undue hardship" means property which the owner has made a good faith effort to sell which has produced no buyer willing to pay an amount equaling or exceeding seventy-five percent of the property's fair market value (sixty-six and two-thirds percent of the property's fair market value with respect to determination of qualified disabled and working individual benefits under section 75-02-02.1-08), and which is continuously for sale. Property may not be included within this definition at any time earlier than the first day of the first month in which a good faith effort to sell is begun.

24. "Regulation", as used in 42 CFR 431.210, 431.244, and 435.912, includes any written statement of federal or state law or policy, including, but not limited to, federal and state constitutions, statutes, regulations, rules, policy manuals or directives, policy letters or instructions, and relevant controlling decisions of federal or state courts.

25. "Specialized facility" means a residential facility, including a basic care, a licensed family foster care home for children or adults, a licensed group foster care home for children or adults, a transitional living facility, a facility established to provide quarters to clients of a sheltered workshop, and any other facility determined by the department to be a

provider of remedial services, but does not mean an acute care facility or a nursing facility.

26. "State agency" means the North Dakota department of human services.

27. "Supplemental security income" means supplemental security income, a program administered under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

28. "The act" means the Social Security Act [42 U.S.C. 301 et seq.].

29. "Title II" means title II of the Social Security Act [42 U.S.C. 401 et seq.].

30. "Title IV-A" means title IV-A of the Social Security Act [42 U.S.C. 601 et seq.].

31. "Title IV-D" means title IV-D of the Social Security Act [42 U.S.C. 651 et seq.].

32. "Title IV-E" means title IV-E of the Social Security Act [42 U.S.C. 670 et seq.].

33. Title XVI" means title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

34. "Unearned income" means income which is not earned income.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-02. Application and redetermination.

1. Application.

   a. All individuals wishing to make application for medicaid must have the opportunity to do so, without delay.

   b. An application is a written request made by a person desiring assistance under the medicaid program, or by a proper person seeking such assistance on behalf of another person, to a county social service board, a disproportionate share hospital, as defined in section 1923(a)(3)(A) of the Act [42 U.S.C. 1396r-4(a)(1)(A)], or a federally qualified health center, as described in section 1905(1)(2)(B) of the Act [42 U.S.C. 1396d(1)(2)(B)]. A proper person means any person of sufficient maturity and understanding to act responsibly on behalf of the applicant.

c. An application must be in writing and signed on a prescribed application form.

d. A prescribed application form must be signed by the applicant if the applicant is physically and mentally able to do so. An application made on behalf of an applicant adjudged incompetent by a court must be signed by the guardian.

e. Information concerning eligibility requirements, available services, and the rights and responsibilities of applicant and recipients must be furnished to all who require it.

f. A relative or other interested party may file an application in behalf of a deceased person to cover medical costs incurred prior to the deceased person's death.

g. The date of application is the date an application, signed by an appropriate person, is received at a county social service board office, a disproportionate share hospital, or a federally qualified health center.

2. Redetermination. A redetermination must be made within thirty days after a county agency has received information indicating a possible change in eligibility status, when a recipient enters a nursing facility, and in any event, no less than annually. A recipient has the same responsibility to furnish information during a redetermination as an applicant has during an application.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-03. Decision and notice.

1. A decision as to eligibility will be made promptly on applications, within forty-five days, or within ninety days in disability cases, except in unusual circumstances.

2. A decision as to eligibility on redeterminations will be made within thirty days.

3. Immediately upon an eligibility determination, whether eligibility can be found, ineligibility can be found, or eligibility cannot be determined, medicaid applicants or recipients must be notified by the county agency. A notice must be sent in advance of any decision terminating or reducing medicaid benefits.

4. Notice must be sent at the time, and in the manner, required by 42 CFR 431.210 through 431.214.

5. Errors made by public officials and delays caused by the actions of public officials do not create eligibility or additional benefits for an applicant or recipient who is adversely affected.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-04. Screening of recipients of certain services. All applicants or recipients who seek services in nursing facilities (including swing bed facilities) or intermediate care facilities for the mentally retarded, or who seek home and community-based services, must demonstrate a medical necessity for the service sought on or prior to admission to a facility, upon application for medicaid while in a facility, or upon request for home and community-based services.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-05. Covered groups. Within the limits of legislative appropriation, four broad coverage groups are included under the medicaid program. Within each coverage group, one or more aid categories is established. These coverage groups do not define eligibility for medicaid benefits. Any person who is within a coverage group must also demonstrate that all other eligibility criteria are met.

1. Categorically needy groups include:

   a. Persons who are receiving cash assistance payments through aid to families with dependent children.

   b. Persons who are deemed to be recipients of aid to families with dependent children including:

      (1) Individuals denied an aid to families with dependent children payment solely because the amount would be less than ten dollars;

      (2) Individuals whose aid to families with dependent children payments are reduced to zero by reason of recovery of overpayment of aid to families with dependent children funds;

      (3) Families who were receiving aid to families with dependent children cash assistance payments in at least three of the six months immediately preceding

the month in which they became ineligible as a result (wholly or partly) of the collection or increased collection of child or spousal support and are deemed to be recipients of aid to families with dependent children, and continue eligible for medicaid for four calendar months following the month for which the final cash payment was made;

(4) Children for whom adoption assistance maintenance payments are made under title IV-E;

(5) Children for whom foster care maintenance payments are made under title IV-E;

(6) Children who are living in North Dakota and are receiving title IV-E adoption assistance payments from another state; and

(7) Children in a foster care placement in North Dakota and receiving a title IV-E foster care payment from another state.

c. Families which received aid to families with dependent children payments in at least three of the six months immediately preceding the month in which the family became ineligible for aid to families with dependent children solely because of increased hours of, or income from, employment of the caretaker relative; or which became ineligible for aid to families with dependent children solely because a member of the family lost one of the time-limited aid to families with dependent children earned income disregards (the thirty dollar earned income disregard and the disregard of one-third of earned income).

d. Pregnant women whose pregnancy has been medically verified and who would be eligible for an aid to families with dependent children cash payment on the basis of the income and asset requirements of the state-approved aid to families with dependent children plan.

e. Women who, while pregnant, apply for and are found eligible for medicaid, continue to be eligible, as though they were pregnant, for sixty days after the day each pregnancy ends, and for the remaining days of the month in which the sixtieth day falls.

f. Children born to women who have applied for and been found eligible for medicaid on or before the day of the child's birth, with respect to the day of the child's birth.

g. Aged, blind, or disabled individuals who are receiving supplemental security income payments or who appear on the

state data exchange as zero payment as a result of supplemental security income's recovery of an overpayment or who are suspended because the individuals do not have a protective payee, provided that the more restrictive medicaid criteria is met.

h. Individuals who meet the more restrictive requirements of the medicaid program and qualify for supplemental security income benefits under section 1619(a) or 1619(b) of the Act [42 U.S.C. 1382h(a) or 1382h(b)].

i. Essential spouses of, or persons essential to, individuals who received benefits, in December 1973 under the state's approved plan for title XVI of the Social Security Act (repealed), who were grandfathered into the supplemental security income program and who have continuously received benefits under the supplemental security income program and the medicaid program since the inception of the supplemental security income program, but only if the essential spouse of, or person essential to, the individual continues to reside with the individual.

2. Optional categorically needy groups include:

a. All individuals under age twenty-one who are not receiving aid to families with dependent children, but whose income and assets are at or below the aid to families with dependent children program limits.

b. All individuals under age twenty-one who are residing in adoptive homes and who have been determined under the state-subsidized adoption program to be eligible as provided in state law and in accordance with the requirements of the department.

c. All individuals under age twenty-one who qualify on the basis of financial eligibility for medicaid and who are residing in foster homes or private child care institutions licensed or approved by the department, irrespective of financial arrangements, including children in a "free" foster home placement.

3. Medically needy groups include:

a. Eligible caretaker relatives and individuals under age twenty-one in aid to families with dependent children families who do not meet financial or certain technical aid to families with dependent children requirements (i.e., work requirements) for a cash payment, but meet medically needy income and asset standards.

b. All individuals under the age of twenty-one who qualify for and require medical services on the basis of

insufficient income and assets, but who do not qualify as categorically needy, including children in stepparent families who are ineligible for aid to families with dependent children or children in non-IV-E foster care.

c. Pregnant women whose pregnancy has been medically verified and who, except for income and assets, would be eligible as categorically needy.

d. Pregnant women whose pregnancy has been medically verified and who qualify on the basis of financial eligibility.

e. Eligible pregnant women who applied for medicaid during their pregnancies, and for whom recipient liability for the month was met no later than on the date the pregnancy ends, continue to be eligible, as though they were pregnant, for sixty days after the day each pregnancy ends, and for the remaining days of the month in which the sixtieth day falls.

f. Aged, blind, or disabled individuals who would be eligible for supplemental security income benefits or certain state supplemental payments, but who have not applied for cash assistance or have sufficient income or assets to meet their maintenance needs.

g. Individuals under age twenty-one or age sixty-five and over in the state hospital who qualify on the basis of financial eligibility.

4. Poverty level groups include:

a. Pregnant women whose pregnancy has been medically verified and who meet the nonfinancial and asset requirements of the medicaid program and whose family income is at or below one hundred thirty-three percent of the poverty level.

b. Eligible pregnant women who applied for medicaid during their pregnancy who continue to be eligible for sixty days after the day each pregnancy ends, and for the remaining days of the month in which the sixtieth day falls.

c. Children under the age of six who meet the nonfinancial and asset requirements of the medicaid program and whose family income is at or below one hundred thirty-three percent of the poverty level.

d. Children, age six or older, born after September 30, 1983, who meet the nonfinancial and asset requirements of the medicaid program and whose family income is at or below one hundred percent of the poverty level.

e. Qualified medicare beneficiaries are aged, blind, or disabled individuals who are entitled to medicare part A benefits, meet the medically needy nonfinancial criteria, have assets no greater than twice the supplemental security income resource standards, and have income at or below one hundred percent of the poverty level.

f. Qualified disabled and working individuals are individuals entitled to enroll in medicare part A under section 1818a of the Social Security Act [42 U.S.C. 1395i-2(a)], have income no greater than two hundred percent of the federal poverty level, have assets no greater than twice the supplemental security income resource standard, and are not eligible for medicaid under any other provision. The supplemental security income program income and asset methodologies must be used and none of the more restrictive 209b criteria may be applied.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-06. Applicant's choice of aid category or coverage group. A person who could establish eligibility under more than one aid category or coverage group may have eligibility determined under the aid category or coverage group the person selects. Except with respect to qualified medicare beneficiaries, who may also establish eligibility as categorically needy or medically needy, a person may establish eligibility under only one aid category and only one coverage group.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-07. Applicant's duty to establish eligibility. It is the responsibility of the applicant for medicaid to establish the eligibility of each individual for whom assistance is requested, including, but not limited to, the furnishing of a social security number, and the establishment of age, identity, residence, citizenship, blindness, disability, and financial eligibility in each of the months in which medicaid benefits are sought.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-08. Selecting medicaid unit members. An applicant or recipient who is also a caretaker of children under twenty-two years of age may select the children who will be included in the medicaid unit. Anyone whose needs are included in the unit for any month is subject to

all medicaid requirements which may affect the unit. The financial responsibility of relatives must be considered with respect to all members of the assistance unit.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-09. Assignment of rights to recover medical costs.

1. The applicant and each individual for whom assistance is requested must, as a condition of eligibility, execute all necessary documents to protect his or the agency's rights to payment from any third party or private insurer, including, but not limited to, the execution of assignments provided for under North Dakota Century Code sections 50-24.1-02 and 50-24.1-02.1, for medical care and services included under this plan, the need for which arises out of injury, disease, or disability of the applicant or recipient for medicaid; assign rights to medical support from any absent parent when a child is deprived of parental support or care due to the absence of one or both parents; and cooperate with the department and county agency in obtaining payment and medical support and establishing paternity of a child in the medicaid unit with respect to whom paternity has not been established. The requirement for the assignment of rights to medical support from absent parents continues through the month in which the child reaches the age of nineteen years or completes high school (or its equivalent), whichever comes first.

2. For purposes of this section:

   a. "Cooperate in obtaining payment and medical support" includes:

      (1) Appearing at a state or local office designated by the department or county agency to provide information or evidence relevant to the case;

      (2) Appearing as a witness at a court or other proceeding;

      (3) Providing information, or attesting to lack of information, under penalty of perjury;

      (4) Paying to the department any support or medical care funds received that are covered by the assignment of rights; and

      (5) Taking any other reasonable steps to assist in establishing paternity and securing medical support and payments.

b. "Deprived of parental support or care due to the absence of one or both parents" means a situation which occurs when all of the following factors are present:

(1) The parent is physically absent from the home;

(2) The nature of the parent's absence is such as to interrupt or terminate the parent's functioning as a provider of maintenance, physical care, or guidance for the child; and

(3) The known or indefinite duration of the absence precludes relying on the parent to perform the parent's functions in planning for the present support or care of the child.

c. "Private insurer" includes any commercial insurance company offering health or casualty insurance to individuals or groups, including both experience-related insurance contract and indemnity contracts; any profit or nonprofit prepaid plan offering either medical services or full or partial payment for services covered by the medicaid program; and any organization administering health or casualty insurance plans for professional associations, employer-employee benefit plans, or any similar organization offering these payments or services, including self-insured and self-funded plans.

d. "Third party" means any individual, entity, or program that is or may be liable to pay all or a part of the expenditures for services furnished under medicaid, including a parent or other person who owes a duty to provide medical support to or on behalf of a child for whom medicaid benefits are sought.

3. The department or the county agency may take any action or impose any requirement upon an applicant or recipient as may be reasonably necessary to determine the liability of third parties and private insurers. Any action which may be taken, and any requirement which may be imposed under 42 CFR 433.138, as necessary to determine such liability, may be required of an applicant or recipient as a condition of eligibility.

4. The assignment of rights to benefits, except medical support benefits, is automatic under North Dakota Century Code section 50-24.1-02.1. However, as a condition of eligibility, the applicant or recipient may be required to execute a written assignment whenever appropriate to facilitate establishment of liability of a third party or private insurer.

5. An individual must cooperate in establishing paternity of a child born out of wedlock for whom he or she can legally assign rights, and obtaining medical care support and payments

for himself, herself, and any other individual for whom he or she can legally assign rights, unless:

a. The individual is a pregnant woman whose pregnancy has been medically verified and who meets the nonfinancial and asset requirements of the medicaid program and whose family income is at or below one hundred and thirty-three percent of the poverty level;

b. The individual is an eligible pregnant woman who applied for medicaid during her pregnancy who continues to be eligible for sixty days after her pregnancy ends, and for the remaining days of the month in which the sixtieth day falls; or

c. Cooperation is waived by the county agency for good cause.

6. The county agency may waive the requirements of subsection 5 for good cause if it determines that cooperation is against the best interests of the child. A county agency may determine that cooperation required under subsection 5 is against the best interests of the child only if:

a. The applicant's or recipient's cooperation in establishing paternity or securing medical support is reasonably anticipated to result in:

(1) Physical harm to the child for whom support is to be sought;

(2) Emotional harm to the child for whom support is to be sought;

(3) Physical harm to the parent or caretaker relative with whom the child is living which reduces such person's capacity to care for the child adequately;

(4) Emotional harm to the parent or caretaker relative with whom the child is living, of such nature or degree that it reduces such person's capacity to care for the child adequately; or

b. At least one of the following circumstances exists, and the county agency believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure medical support would be detrimental to the child for whom support would be sought.

(1) The child for whom support is sought was conceived as a result of incest or forcible rape;

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

(3) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep or relinquish the child for adoption, and the discussions have not gone on for more than three months.

7. Physical harm and emotional harm must be of a serious nature in order to justify a waiver under subsection 6.

8. A waiver under subsection 6 due to emotional harm may only be based on a demonstration of an emotional impairment that substantially impairs the individual's functioning. In determining a waiver under subsection 6, based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the caretaker relative, the county agency must consider:

   a. The present emotional state of the individual subject to emotional harm;

   b. The emotional health history of the individual subject to emotional harm;

   c. Intensity and probable duration of the emotional impairment;

   d. The degree of cooperation to be required; and

   e. The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

9. A determination to grant a waiver under subsection 6 must be reviewed no less frequently than every six months to determine if the circumstances which led to the waiver continue to exist.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-10. Eligibility - Current and retroactive.

1. Except for qualified medicare beneficiaries, current eligibility may be established from the first day of the month in which the application was received, and for periods after that day until a redetermination is required, based upon information in the completed application and any necessary verification.

2. Except for qualified medicare beneficiaries, retroactive eligibility may be established for as many as three calendar months prior to the month in which the application was received, if eligibility can be established in each of those months for which benefits are sought and all factors of eligibility are met during each month of retroactive benefits sought, except that the assets which would have been allowed for an ineligible community spouse are not treated as exceeding the asset limit of an institutionalized spouse. If a previous application has been taken and denied in the same month, eligibility for that entire month may be established based on the current application. Retroactive eligibility may be established even if there is no eligibility in the month of application.

3. An applicant or recipient determined eligible for part of a month is eligible for the entire calendar month unless a specific factor prevents eligibility during part of that month. Examples of specific factors include:

   a. An applicant is born in the month, in which case the date of birth is the first date of eligibility;

   b. An individual enters the state, in which case the date of entry is the first date of eligibility unless the individual was receiving medicaid benefits from another state, in which case the later of the date of entry or the day after the last day of eligibility under the other state's medicaid program is the first date of eligibility; and

   c. An individual discharged from a public institution, in which case the date of eligibility is the date of discharge.

4. Eligibility for qualified medicare beneficiaries begins in the month following the month in which the eligibility determination is made.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-11. Need. For a medically needy applicant or recipient, need is established when there is no recipient liability or when medical expenses exceed the recipient liability. If there is no need, there is no eligibility, and the application must be denied or the case must be closed.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-12. Limitation on conditions of eligibility. No age, residence, citizenship, or other requirement that is prohibited by title XIX of the Social Security Act will be imposed as a condition of eligibility.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-13. Social security numbers. A social security number must be furnished as a condition of eligibility, for each individual for whom medicaid benefits are sought, except:

1. A newborn child for the first sixty days after the date of birth; and

2. With respect to emergency benefits provided to aliens who are not lawfully admitted.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-14. Blindness and disability.

1. In any instance in which a determination is to be made as to whether any individual is disabled, each medical report form and social history will be reviewed by technically competent persons, not less than a physician and a social worker qualified by professional training and pertinent experience, acting cooperatively, who are responsible for the department's decision that the applicant does or does not meet the appropriate definitions of disability.

2. In any instance in which a determination is to be made whether an individual is blind, there will be an examination by a physician skilled in the diseases of the eye, or by an optometrist, whichever the individual may select. Each eye examination report will be reviewed by the state supervising ophthalmologist who is responsible for comparing that report with the state's definition of blindness and for determining:

   a. Whether the individual meets the definition of blindness; and

   b. Whether and when reexaminations are necessary for periodic redeterminations of eligibility.

3. The agency shall decline to determine blindness or disability when such a determination is made pursuant to the processing of a supplemental security income benefit application or an

old-age and survivors' insurance benefit payments application by the social security administration, or its contractee, for that purpose.

4. The agency may not make an independent determination of disability if the social security administration has made a disability determination within ninety days after the date of application.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 CFR Part 435

75-02-02.1-15. Incapacity of a parent.

1. A child, if otherwise eligible for medicaid benefits, is "deprived of parental support or care" when the child's parent has a physical or mental defect which significantly interferes with his or her capacity to earn a livelihood (breadwinner) or to discharge his or her responsibilities as a homemaker and provider of child care (homemaker) for a period of thirty days or more.

2. If the incapacitated parent is a breadwinner, the incapacity must be such that it substantially precludes employment in his or her usual occupation or another occupation to which he or she may be able to adapt. The fact that a breadwinner may have to change occupation or work location does not establish incapacity. A breadwinner may establish incapacity by demonstrating that he or she has reached age sixty-five.

3. If the incapacitated parent is a homemaker, the incapacity must be such that it substantially precludes the performance of usual homemaking tasks and the furnishing of necessary care to children.

4. If, prior to onset of the incapacitating condition, a parent was gainfully employed, was usually engaged in that employment for one hundred or more hours per month, the parent is regarded as a breadwinner. Any parent not regarded as a breadwinner is regarded as a homemaker.

5. A determination that a parent is disabled or blind, made by the social security administration, constitutes adequate substantiation of incapacity for purposes of this section.

6. A parent continues to be incapacitated, for purposes of this section, if the incapacity is not reasonably subject to remediation, or if the parent makes reasonable progress towards remediation of the incapacity. For purposes of this section, "reasonable progress towards remediation of the incapacity" means:

a. In the case of an incapacitated homemaker, cooperation with medical practitioners who prescribe a course of treatment intended to remediate or limit the effect of the incapacity, including, but not limited to, physical therapy, counseling, use of prosthesis, drug therapy and weight loss; and

b. In the case of an incapacitated breadwinner, cooperation which is required of an incapacitated homemaker, cooperation with vocational practitioners, cooperation with vocational and functional capacity evaluations and reasonable progress in a course of training or education intended to qualify the parent to perform an occupation which, with that training or education, the parent would have the capacity to perform.

7. A parent who engages in activities which are inconsistent with the claimed incapacity may be determined to not be incapacitated based upon those activities.

8. The department may require a parent to demonstrate reasonable progress towards remediation of the incapacity, and may set reasonable deadlines for such demonstrations.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-16. State of residence. A resident of the state is a person who is living in the state voluntarily and not for a temporary purpose. Temporary absences from the state with subsequent returns to the state, or intent to return when the purpose of the absence has been accomplished, do not interrupt continuity of residence. Residence is retained until abandoned or established in another state.

1. For persons entering the state, the earliest date of eligibility is the date of entry. Residence may not be established for persons who are receiving medicaid benefits from another state.

2. Individuals under age twenty-one.

a. For any individual under age twenty-one who is living independently from his or her parents or who is married and capable of indicating intent, the state of residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period.

b. For any individual who is receiving foster care or adoption assistance payments, under title IV-E, from

another state and are living in North Dakota, North Dakota is the state of residence for medicaid purposes.

c. For any individual under age twenty-one not residing in an institution, whose medicaid eligibility is based on blindness or disability, the state of residence is the state in which the individual is living.

d. For any other noninstitutionalized individual under age twenty-one, the state of residence is determined by the rules governing residence under the aid to families with dependent children program.

e. For any institutionalized individual, under age twenty-one, who is neither married nor living independently, residence is that of the parents or legal guardian at the time of placement. Only if the parental rights have been terminated, and a guardian or custodian appointed, may the residence of the guardian or custodian be used. If the individual has been abandoned by his or her parents and does not have a guardian, the individual is a resident of the state in which he or she lives.

3. Individuals age twenty-one and over:

a. For any individual not residing in an institution, the state of residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period or is entering the state with a job commitment or seeking employment.

b. Institutionalized individuals age twenty-one and older.

(1) Except as provided in paragraph 2, the state of residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period.

(2) For an institutionalized individual who became incapable of indicating intent before age twenty-one, the state of residence is that of the parent or guardian making application, at the time of placement or, if the individual is institutionalized in that state, at the time of application. If the individual has no guardian, the application is not made by either parent, and the placement was not made by another state, the state of residence is the state in which the individual is physically present.

4. Terms used in this subsection have the meaning given in subsection 3 of section 75-02-02.1-19 and, for purposes of this subsection, a "person incapable of indicating intent" means one who:

a. Has an intelligence quotient of forty-nine or less, or a mental age of seven or less, based upon tests acceptable to the division of mental health of the department of human services;

b. Has been found by a court of competent jurisdiction to be an incapacitated person as defined in subsection 1 of North Dakota Century Code section 30.1-20-01;

c. Has been found by a court of competent jurisdiction to be legally incompetent; or

d. Is found incapable of indicating intent based on medical documentation obtained from a physician or surgeon, clinical psychologist, or other person licensed by the state in the field of mental retardation.

5. Notwithstanding any other provision of this section except subsections 6 through 9, individuals placed in out-of-state institutions by a state retain residence in that state regardless of the individual's indicated intent or ability to indicate intent. The application of this subsection ends when a person capable of indicating intent leaves an institution in which the person was placed by this state. Providing information about another state's medicaid program or about the availability of health care services and facilities in another state, or assisting an individual in locating an institution in another state, does not constitute a state placement.

6. For any individual receiving a state supplemental payment, the state of residence is the state making the payment.

7. For any individual on whose behalf payments for regular foster care or state adoption assistance are made, the state of residence is the state making the payment.

8. If an interstate reciprocal residency agreement has been entered into between this state and another state pursuant to 42 CFR 435.403(k), the state of residence of an affected individual is the state determined under that agreement.

9. When two or more states cannot agree which state is the individual's state of residence, the state of residence is the state in which the individual is physically present.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 CFR Part 435

75-02-02.1-17. Application for other benefits. Applicants and recipients must take all necessary steps to obtain any annuities,

pensions, retirement, and disability benefits to which they are entitled, unless they can show good cause for not doing so. Annuities, pensions, retirement, and disability benefits include, but are not limited to, veterans' compensation and pensions; old age, survivors, and disability insurance benefits; railroad retirement benefits; and unemployment compensation. Good cause under this subsection exists if:

1. Receipt of the annuity, pension, retirement, or disability benefit would result in a net loss of cash income; or

2. The benefit is supplemental security income or aid to families with dependent children.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-18. Coverage for aliens. An alien is eligible for medicaid:

1. If lawfully admitted for permanent residence; or

2. If all of the following conditions are met:

   a. The alien is not lawfully admitted;

   b. The alien has a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

      (1) Placing health in serious jeopardy;

      (2) Serious impairment to bodily functions; or

      (3) Serious dysfunction of any bodily organ or part;

   c. The alien who meets the medical criteria in subdivision b must also meet all other eligibility requirements for medicaid except the requirements concerning furnishing social security numbers and verification of alien status; and

   d. The alien's need for the emergency service continues.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-19. Inmates of public institutions not covered - Exceptions. An inmate of a public institution is not eligible for medicaid unless the inmate is over age sixty-five and a patient in an institution for mental diseases or under age twenty-one (or, with respect to a patient who is eligible for medicaid and is receiving services in the institution when the patient reaches age twenty-one, inpatient psychiatric services under 42 CFR 440.160 may continue until age twenty-two), a patient in an institution for mental diseases, and receiving inpatient psychiatric services consistent with the requirements of 42 CFR 440.160 and 42 CFR part 441, subpart D.

1. The period of ineligibility under this section begins the day after the day of entry of the individual as an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases, and ends the day before the day of discharge of the individual from such an institution.

2. An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age twenty-two and has been receiving inpatient psychiatric services under 42 CFR 440.160 is considered to be a patient in the institution until unconditionally released or, if earlier, the last day of the month in which the patient reaches age twenty-two.

3. For purposes of this section:

   a. "Child-care institution" means a nonprofit, private child-care institution or a public child-care institution that accommodates no more than twenty-five children, which is licensed by the state in which it is situated, or has been approved by the agency of the state responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing. The term does not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children who are determined to be delinquent.

   b. "In an institution" refers to an individual who is admitted to live there and receive treatment or services provided there that are appropriate to his requirements.

   c. "Definite leave", as used by the state hospital, means conditional release.

   d. "Inmate of a public institution" means a person who is living in a public institution. An individual is not considered an inmate if:

(1) The individual is in a public educational or vocational training institution for purposes of securing education or vocational training;

(2) The individual is in a public institution for a temporary period pending other arrangements appropriate to his needs; or

(3) The individual has been unconditionally released from the institution.

e. "Inpatient" means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who receives room, board, and professional services in the institution for a twenty-four-hour period or longer.

f. "Institution" means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

g. "Institution for mental diseases" means an institution that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the mentally retarded is not an institution for mental diseases.

h. "Institution for the mentally retarded or persons with related conditions" means an institution (or distinct part of an institution) that:

(1) Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions; and

(2) Provides, in a protected residential setting, ongoing evaluation, planning, twenty-four-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.

i. "Living in a public institution" refers to an individual who has been sentenced, placed, committed, admitted, or otherwise required or allowed to live in the institution, and who has not subsequently been unconditionally released or discharged from the institution.

j. "Patient" means an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

k. "Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term "public institution" does not include:

(1) A medical institution as defined in 42 CFR 43.1009;

(2) A nursing facility as defined in 42 U.S.C. 1396r(a);

(3) A publicly operated community residence that serves no more than sixteen residents, as defined in 20 CFR 416.231(b)(6)(i); or

(4) A child-care institution as defined in this section with respect to:

(a) Children for whom foster care maintenance payments are made under title IV-E of the Act; and

(b) Children receiving aid to families with dependent children-foster care under title IV-A of the Act.

l. "Publicly operated community residence that serves no more than sixteen residents" has the same meaning given in 20 CFR 416.231(b)(6)(i). A summary of that definition follows:

(1) In general, a publicly operated community residence means:

(a) It is publicly operated as defined in 20 CFR 416.231(b)(2).

(b) It is designed or has been changed to serve no more than sixteen residents and it is serving no more than sixteen; and

(c) It provides some services beyond food and shelter such as social services, help with personal living activities, or training in socialization and life skills. Occasional medical or remedial care may also be provided as defined in 45 CFR 228.1; and

(2) A publicly operated community residence does not include the following facilities, even though they accommodate sixteen or fewer residents:

(a) Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex.

(b) Educational or vocational training institutions that primarily provide an approved, accredited, or recognized program to individuals residing there.

(c) Correctional or holding facilities for individuals who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

(d) Hospitals and nursing facilities.

m. "Unconditionally released" means released, discharged, or otherwise allowed or required to leave the institution under circumstances where a return to the institution cannot be required by the operator of the institution.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-06; 42 CFR 435.1008, 42 CFR 1009

75-02-02.1-20. Extended medicaid benefits to certain former recipients of aid to families with dependent children benefits. Former recipients of aid to families with dependent children benefits, who continue to cooperate in obtaining payment and medical support, continue to be eligible for medicaid benefits without making further application for medicaid benefits in certain circumstances.

1. In the case of former recipients of aid to families with dependent children benefits who received aid to families with dependent children benefits in at least three of the six-month immediately preceding the month in which the former recipients became ineligible solely because of the hours of, or income from, employment of the caretaker relative in the aid to families with dependent children unit; or because a member of the aid to families with dependent children unit loses the aid to families with dependent children disregard of thirty dollars of earned income; or the aid to families with dependent children disregard of one-third of earned income, medicaid benefits may continue for up to twelve months if:

a. In the first six-month period, the caretaker relative:

(1) Has a dependent child living in the home; and

(2) Remains a resident of the state; or

b. In the second six-month period, the caretaker relative:

(1) Has a dependent child living in the home;

(2) Remains a resident of the state;

(3) Remains employed (in cases where aid to families with dependent children ineligibility resulted from increases in hours of, or income from, employment of the caretaker relative); and

(4) Has gross earned income, less child care expenses the caretaker relative is responsible for, which, in either of the three month periods consisting of the fourth, fifth, and sixth months or the seventh, eighth, and ninth months, when totaled and divided by three, do not exceed one hundred and eighty-five percent of the poverty level.

2. A recipient who seeks eligibility under subsection 1 of this section must report and verify income and child care expenses for the fourth, fifth, and sixth months by the twenty-first day of the seventh month, and for the seventh, eighth, and ninth months by the twenty-first day of the tenth month. Failure to report income and child care expenses in the seventh month and the tenth month, or receipt of income in excess of one hundred and eighty-five percent of the poverty level, causes ineligibility effective on the last day, respectively, of the seventh month or the tenth month. No ten-day advance notice of closing need be furnished if a case is ineligible due to this subsection; however, a notice of closing must be sent before the effective date of the closing.

3. In the case of former recipients of aid to families with dependent children benefits who received aid to families with dependent children benefits in at least three of the six months immediately preceding the month in which the former recipients become ineligible solely or partly as a result of the collection or increased collection of child or spousal support, medicaid benefits may continue for four calendar months following the month for which the final aid to families with dependent children benefit was paid if the caretaker relative:

(a) Has a dependent child living in the home; and

(b) Remains a resident of the state.

4. A former recipient of aid to families with dependent children benefits, who seeks to demonstrate the receipt of aid to families with dependent children benefits in at least three of the six months immediately preceding the month in which the former aid to families with dependent children recipient became ineligible, must have been receiving aid to families with dependent children benefits in this state in the month immediately preceding the month in which the former aid to families with dependent children recipient became ineligible.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-21. Continuous eligibility for pregnant women. Notwithstanding the coverage group, if a pregnant woman, whose pregnancy has been medically verified, becomes eligible for medicaid, she continues eligible, without regard to any increase in income of the medicaid unit, for sixty days after the day her pregnancy ends, and for the remaining days of the month in which the sixtieth day fell.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-22. Eligibility of qualified medicare beneficiaries.

1. Qualified medicare beneficiaries are entitled only to medicare cost sharing benefits described in subsection 18 of section 75-02-02.1-01.

2. Asset limits. The following asset limits apply to qualified medicare beneficiaries eligibility determinations. No person may be found to be a qualified medicare beneficiary unless the total value of all assets, not described in subsection 4, does not exceed:

   a. Four thousand dollars for a one-person unit; or

   b. Six thousand dollars for a two-person unit.

3. Provision of this chapter governing asset considerations (75-02-02.1-25), valuation of assets (75-02-02.1-32), and forms of asset ownership (75-02-02.1-29) apply to qualified medicare beneficiary eligibility determinations except:

   a. Half of a liquid asset held in common with another qualified medicare beneficiary is presumed available;

   b. Assets owned by a child, under age twenty-one, in the unit are not considered available in determining qualified

medicare beneficiary eligibility for the child's parent, except that all liquid assets held in common by the child and the parent are considered available to the parent; and

c. Assets owned by a spouse who is not residing with an applicant for or recipient of qualified medicare beneficiary benefits are not considered available in determining qualified medicare beneficiary eligibility unless they are liquid assets held in common.

4. Excluded assets for purposes of this section:

a. The assets described in subsections 2 through 5 of section 75-02-02.1-27 and a residence occupied by the person, the person's spouse, or the person's dependent relative are excluded. Terms used in this section have the following meanings:

(1) "Residence" includes all contiguous lands, including mineral interests, upon which it is located. The residence may include a mobile home suitable for use, and being used, as a principal place of residence. Rural property contiguous to the residence is excluded, even if rented or leased to a third party. The residence is excluded during the temporary institutionalization or other absence of the individual from the residence, so long as the individual intends to return. However, a six-month absence due to institutionalization ends the exclusion.

(2) "Relative" means a child, stepchild, grandchild, parent, stepparent, grandparent, aunt, uncle, niece, nephew, brother, sister, stepbrother, stepsister, half brother, half sister, first cousin, or in-law.

(3) "Dependency" includes financial, medical, and other forms of dependency. Financial dependency exists with respect to someone whom a taxpayer is able to claim a deduction on a federal income tax return.

b. Property which is excluded under subsections 1, 2, and 4 through 9 of section 75-02-02.1-28 is excluded for purposes of this section.

c. Burial funds of up to one thousand five hundred dollars each, plus earnings on excluded funds in and after the month of application, held for the individual and for the individual's spouse are excluded. Burial funds may consist of revocable burial contracts; revocable burial trusts; other revocable burial arrangements, including the value of installment sales contracts for burial spaces; cash; financial accounts such as savings or checking

accounts; or other financial instruments with a definite cash value, such as stocks, bonds, and certificates of deposit. The fund must be unencumbered and available for conversion to cash on very short notice. The fund may not be commingled with nonburial-related assets and must be identified as a burial fund by title of account or a signed statement. Burial insurance, irrevocable trusts, or any other irrevocable arrangement for burial must be considered at face value for meeting the burial fund exclusion. Combined face value of an individual's life insurance policies with a total face value of one thousand five hundred dollars or less must be considered toward this exclusion. Cash values of an individual's life insurance with a total face value in excess of one thousand five hundred dollars may be applied towards the burial fund exclusion.

d. A burial space or agreement which represents the purchase of a burial space held for the individual, the individual's spouse, or any other member of the individual's immediate family is excluded. The burial space exclusion is in addition to the burial fund exclusion set forth in subdivision c. Only one item intended to serve a particular burial purpose, per individual, may be excluded. For purposes of this subdivision:

(1) "Burial space" means a burial plot, granite, crypt, or mausoleum; a casket, urn, niche, or other repository customarily and traditionally used for a deceased's bodily remains; a vault or burial container; a headstone, marker, or plaque; and prepaid arrangements for the opening and closing of the gravesite or for care and maintenance of the gravesite.

(2) "Held for" means the individual currently has title to or possesses a burial space intended for the individual's use or has a contract with a funeral service company for specified burial spaces for the individual's burial, such as an agreement which represents the individual's current right to use of the items at the amount shown; but does not mean any arrangement where the individual does not currently own the space, or does not currently have the right to use the space, or where the seller is not currently obligated to provide the space.

(3) "Other member of the individual's immediate family" means the individual's parents, minor or adult children, siblings, and the spouses of those persons, whether the relationship is established by birth,

adoption, or marriage, except that a relationship established by marriage ends if the marriage ends.

e. Property essential to self-support is excluded.

(1) "Property essential to self-support" means:

(a) Property which the applicant or recipient owns, up to an equity value of six thousand dollars, which produces annual income at least equal to six percent of the excluded amount, and with respect to which the applicant or recipient is not actively engaged in using to produce income.

(b) Nonbusiness property which the applicant or recipient owns, up to an equity value of six thousand dollars, when used to produce goods or services essential to daily activities, or, for instance, when used to grow produce or livestock solely for consumption in the individual's households.

(2) Two or more properties of the type described in subparagraph a of paragraph 1 may be excluded if each such property produces at least a six percent return and if the combined equity value of such properties does not exceed six thousand dollars.

(3) Equity in property of the type described in subparagraph a of paragraph 1 is a countable asset to the extent that equity exceeds six thousand dollars and is a countable asset if it produces an annual return of less than six percent of equity.

(4) Equity in property of the type described in subparagraph b of paragraph 1 is a countable asset to the extent that equity exceeds six thousand dollars.

(5) Assets excluded under this subdivision must be in current use in the type of activity described, or, if not in current use, the assets must have been in such use and there must be a reasonable expectation that the use will resume, and, with respect to property of the type described in subparagraph a of paragraph 1, the annual return test will be met:

(a) Within twelve months of the last use; or

(b) If the nonuse is due to the disabling condition of the applicant or recipient, within twenty-four months of the last use.

(6) Liquid assets are not property essential to self-support except when used as part of a trade or business.

f. Lump sum payments of title II or supplemental security income benefits for six consecutive months following the month of receipt.

g. Real property, the sale of which would cause undue hardship to a coowner, is excluded for so long as the coowner uses the property as a principal residence, would have to move if the property were sold, and has no other readily available housing.

h. Life insurance that generates a cash surrender value if the face value of all life insurance policies on the life of that person total one thousand five hundred dollars or less.

i. Assets set aside, by a blind or disabled (but not an aged) person, as a part of a plan to achieve self-support which has been approved, if the person is a supplemental security income recipient, or would be approved, if the person were a supplemental security income recipient, are excluded.

5. Assets excluded under subsection 4 must be identifiable to be excluded:

6. a. Income calculation to determine qualified medicare beneficiary eligibility must consider income in the manner provided for in section 75-02-02.1-34, income considerations; section 75-02-02.1-36, disregarded income; section 75-02-02.1-37, unearned income; 75-02-02.1-38, earned income; and section 75-02-02.1-39, income deductions; except:

(1) Supplemental security income lump sum payments are not treated as income in the six months following the months in which the benefit is received.

(2) Married individuals living separate and apart from a spouse are treated as single individuals.

(3) The deductions described in subdivisions a, b, d, and h of subsection 1 of section 75-02-02.1-39, income deductions, are not allowed.

(4) The deductions described in subdivision i of subsection 1 and subdivision e of subsection 2 of section 75-02-02.1-39, income deductions, are allowed even if the person resides in a nursing facility, the state hospital, or the Anne Carlsen school-hospital.

(5) The deduction described in subdivision f of subsection 2 of section 75-01-02.1-39, income deductions, is not allowed.

b. A qualified medicare beneficiary applicant is eligible if countable income is equal to or less than one hundred percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved, and if he or she meets all of the requirements described in this section; but is otherwise ineligible.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-23. Eligibility of qualified disabled and working individuals.

1. Qualified disabled and working individuals are entitled only to medicare cost-sharing benefits described in paragraph 1 of subdivision a of subsection 18 of section 75-02-02.1-01.

2. Asset limits. The following asset limits apply to qualified disabled and working individual eligibility determinations. No person may be found to be a qualified disabled and working individual unless the total value of all assets not described in subsection 4 does not exceed:

   a. Four thousand dollars for a one-person unit; or

   b. Six thousand dollars for a two-person unit.

3. Provisions of this chapter governing asset considerations (75-02-02.1-25), valuation of assets (75-02-02.1-32), and forms of asset ownership (75-02-02.1-29) apply to qualified disabled and working individual eligibility determinations except:

   a. Half of a liquid asset held in common with another qualified disabled and working individual is presumed available;

   b. Assets owned by a child, under age twenty-one, in the unit are not considered available in determining qualified disabled and working individual eligibility for the child's parent except that all liquid assets held in common by the child and the parent are considered available to the parent; and

c. Assets owned by a spouse who is not residing with an applicant for or recipient of qualified disabled and working individual benefits are not considered available in determining qualified disabled and working individual eligibility unless they are liquid assets held in common.

4. Excluded assets for purposes of this section.

a. The assets described in subsections 2 through 5 of section 75-02-02.1-27 and a residence occupied by the person, the person's spouse, or the person's dependent relative are excluded from consideration in determining qualified disabled and working individual eligibility. Terms used in this section have the following meaning:

(1) "Residence" includes all contiguous lands, including mineral interests, upon which it is located. The residence may include a mobile home suitable for use, and being used, as a principal place of residence. Rural property contiguous to the residence is exempt, even if rented or leased to a third party. The residence remains exempt during the temporary institutionalization or other absence of the individual from the residence, so long as the individual intends to return. However, a six-month absence due to institutionalization ends the exemption.

(2) "Relative" means a child, stepchild, grandchild, parent, stepparent, grandparent, aunt, uncle, niece, nephew, brother, sister, stepbrother, stepsister, half brother, half sister, first cousin, or in-law.

(3) "Dependency" includes financial, medical, and other forms of dependency. Financial dependency exists with respect to someone whom a taxpayer is able to claim a deduction on a federal income tax return.

b. Property which is excluded under subsections 1, 2, and 4 through 9 of section 75-02-02.1-28 is excluded for purposes of this section.

c. Burial funds of up to one thousand five hundred dollars each, plus earnings on excluded funds in and after the month of application, held for the individual and the individual's spouse are excluded. Burial funds may consist of revocable burial contracts; revocable burial trusts; other revocable burial arrangements, including the value of installment sales contracts for burial spaces; cash; financial accounts such as savings or checking accounts; or other financial instruments with a definite cash value, such as stocks, bonds, and certificates of deposit. The fund must be unencumbered and available for

conversion to cash on very short notice. The fund may not be commingled with nonburial-related assets and must be identified as a burial fund by title of account or by a signed statement. Burial insurance, irrevocable trusts, or any other irrevocable arrangement for burial must be considered at face value for meeting the burial fund exclusion. Combined face value of an individual's life insurance policies with a total face value of one thousand five hundred dollars or less must be considered toward this exclusion. Cash values of an individual's life insurance with a total face value in excess of one thousand five hundred dollars may be applied towards the burial fund exclusion.

d. A burial space or agreement which represents the purchase of a burial space held for the individual, the individual's spouse, or any other member of the individual's immediate family is excluded. The burial space exclusion is in addition to the burial fund exclusion set forth in subdivision c. Only one item intended to serve a burial particular purpose, per individual, may be excluded. For purposes of this subdivision:

(1) "Burial space" means a burial plot, granite, crypt, or mausoleum; a casket, urn, niche, or other repository customarily and traditionally used for a deceased's bodily remains; a vault or burial container; a headstone, marker, or plaque; and prepaid arrangements for the opening and closing of the gravesite or for care and maintenance of the gravesite.

(2) "Held for" means the individual currently has title to or possesses a burial space intended for the individual's use or has a contract with a funeral service company for specified burial spaces for the individual's burial, such as an agreement which represents the individual's current right to use of the items at the amount shown; but does not mean any arrangement where the individual does not currently own the space, or does not currently have the right to use the space, or where the seller is not currently obligated to provide the space.

e. Property essential to self-support is excluded.

(1) "Property essential to self-support" means:

(a) Property which the applicant or recipient owns, up to an equity value of six thousand dollars, which produces annual income at least equal to six percent of the excluded amount, and with

respect to which the applicant or recipient is not actively engaged in using to produce income.

(b) Nonbusiness property which the applicant or recipient owns, up to an equity value of six thousand dollars, when used to produce goods or services essential to daily activities, or, for instance, when used to grow produce or livestock solely for consumption in the individual's households.

(2) Two or more properties of the type described in subparagraph a of paragraph 1 may be excluded if each such property produces at least a six percent return and if the combined equity value of such properties does not exceed six thousand dollars.

(3) Equity in property of the type described in subparagraph a of paragraph 1 is a countable asset to the extent that equity exceeds six thousand dollars and is a countable asset if it produces an annual return of less than six percent of equity.

(4) Equity in property of the type described in subparagraph b of paragraph 1 is a countable asset to the extent that equity exceeds six thousand dollars.

(5) Assets excluded under this subdivision must be in current use in the type of activity described, or, if not in current use, the asset must have been in such use and there must be a reasonable expectation that the use will resume, and, with respect to property of the type described in subparagraph a of paragraph 1, the annual return test will be met:

(a) Within twelve months of the last use; or

(b) If the nonuse is due to the disabling condition of the applicant or recipient, within twenty-four months of the last use.

(6) Liquid assets are not property essential to self-support except when used as part of a trade or business.

f. Lump sum payments of title II or supplemental security income benefits are excluded for six consecutive months following the month of receipt.

g. Real property, the sale of which would cause undue hardship to a coowner, is excluded for so long as the coowner uses the property as a principal residence, would

have to move if the property were sold, and has no other readily available housing.

h. Life insurance that generates a cash surrender value is excluded if the face value of all life insurance policies of that person total one thousand five hundred dollars or less.

i. Assets set aside, by a blind or disabled (but not an aged) person, as a part of a plan to achieve self-support which has been approved, if the person is a supplemental security income recipient, or would be approved if the person were a supplemental security income recipient, are excluded.

5. Assets excluded under subsection 4 must be identifiable to be excluded.

6. a. Income calculation to determine qualified disabled and working individual eligibility must consider income in the manner provided for in section 75-02-02.1-34, income considerations; section 75-02-02.1-36, disregarded income; section 75-02-02.1-37, unearned income; 75-02-02.1-38, earned income, and section 75-02-02.1-39, income deductions, except:

(1) Supplemental security income lump sum payments are not treated as income in the six months following the month in which the benefit is received;

(2) Married individuals living separate and apart from a spouse are treated as single individuals; and

(3) The deductions described in subdivisions a, b, d, and h of subsection 1 of section 75-02-02.1-39, income deductions, are not allowed.

b. A qualified disabled and working individual applicant is eligible if countable income is equal to or less than two hundred percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved, and if he or she meets all of the requirements described in this section; but is otherwise ineligible.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: 50-24.1-02

75-02-02.1-24. Spousal impoverishment prevention.

1. Definitions. For purposes of this section:

   a. "Community spouse" means the spouse of an institutionalized spouse.

   b. "Community spouse countable asset allowance" means:

      (1) With respect to applicants who began a continuous period of institutionalization before September 30, 1989, all countable assets of the applicant and the community spouse up to a maximum of twenty-five thousand dollars.

      (2) With respect to applicants who began a continuous period of institutionalization on or after September 30, 1989, one-half of all countable assets of the applicant and the community spouse up to the maximum amount permitted under 42 U.S.C. 1396r-5(f)(2)(A)(ii)(II), as adjusted pursuant to 42 U.S.C. 1396r-5(g), plus:

         (a) Any additional amount transferred under a court order in the manner and for the purpose described in subdivision c of subsection 4; or

         (b) Any additional amount established through a fair hearing conducted under subsection 4;

      (3) Notwithstanding the provisions of paragraph 2, the community spouse countable asset allowance include all countable assets of the applicant and the community spouse up to a maximum of twenty-five thousand dollars.

   c. "Community spouse monthly income allowance" means the greater of:

      (1) An amount by which the monthly needs allowance exceeds the amount of monthly income otherwise available to the community spouse; or

      (2) If a court has entered an order against an institutionalized spouse for monthly payments for the support of the community spouse, the amount of the monthly payment so ordered.

   d. "Countable assets" includes all assets except those listed in paragraphs 1 through 14.

      (1) A residence and all contiguous lands, including mineral interests, upon which it is located. A

residence may include a mobile home suitable for, and being used as, a principal place of residence. Rural property contiguous to the residence is within this exception, even though the property is rented or leased to a third party.

(2) Household goods, personal effects, and an automobile or other vehicle primarily used for personal transportation.

(3) A burial fund of up to one thousand five hundred dollars, plus earnings on excluded funds in and after the month of application. Burial funds may consist of revocable burial contracts; revocable burial trusts; other revocable burial arrangements, including the value of installment sales contracts for burial spaces; cash; financial accounts such as savings or checking accounts; or other financial instruments with a definite cash value, such as stocks, bonds, and certificates of deposit. The fund must be unencumbered and available for conversion to cash on very short notice. The fund may not be commingled with nonburial-related assets and must be identified as a burial fund by title of account or written statement. Burial insurance, irrevocable trusts, or any other irrevocable arrangement for burial must be considered at face value for meeting the burial fund exclusion. Combined face value of an individual's life insurance with a total face value of one thousand five hundred dollars or less must be considered toward this exclusion. Cash values of an individual's life insurance with a total face value in excess of one thousand five hundred dollars may be applied towards the burial fund exclusion.

(4) A burial space or agreement which represents the purchase of a burial space held for the individual, the individual's spouse, or any other member of the individual's immediate family. The burial space exclusion is in addition to the burial fund exclusion set forth in paragraph 3. Only one item intended to serve a particular burial purpose, per individual, may be excluded. For purposes of this paragraph:

(a) "Burial space" means a burial plot, granite, crypt, or mausoleum; a casket, urn, niche, or other repository customarily and traditionally used for a deceased's bodily remains; a vault or burial container; a headstone, marker, or plaque; and prepaid arrangements for the opening and closing of the gravesite or for care and maintenance of the gravesite.

(b) "Held for" means the individual currently has title to or possesses a burial space intended for the individual's use or has a contract with a funeral service company for specified burial spaces for the individual's burial, such as an agreement which represents the individual's current right to use of the items at the amount shown; but does not mean any arrangement where the individual does not currently own the space, or does not currently have the right to use the space, or where the seller is not currently obligated to provide the space.

(5) Property essential to self-support.

(a) "Property essential to self-support" means:

[1] Property which the applicant or recipient owns, with an equity value not exceeding six thousand dollars, which produces annual income at least equal to six percent of equity value, and which the applicant or recipient is not actively engaged in using to produce income; and

[2] Nonbusiness property which the applicant or recipient owns, up to an equity value of six thousand dollars, when used to produce goods or services essential to daily activities, or, for instance, when used to grow produce or livestock solely for consumption in the individual's household.

(b) Two or more properties with a combined equity value totaling six thousand dollars or less may be excepted if each such property produces at least a six percent annual return on equity and if the combined equity value of such properties does not exceed six thousand dollars.

(c) Equity in property which produces an annual return on equity of at least six percent is a countable asset to the extent that equity exceeds six thousand dollars.

(d) Equity in property which produces an annual return on equity of less than six percent is a countable asset.

(e) Assets excluded under this paragraph must be in current use in the type of activity described, or, if not in current use, the asset must have been in such use and there must be a reasonable

expectation that the use will resume, and, with respect to property of the type described in item 1 of subparagraph a, the annual return test will be met:

[1] Within twelve months of the last use; or

[2] If the nonuse is due to the disabling condition of the applicant or recipient, within twenty-four months of the last use.

(f) Liquid assets are not property essential to self-support except when used as part of a trade or business.

(6) Assets set aside, by a blind or disabled (but not an aged) individual, as a part of a plan, approved by the social security administration, for the individual to achieve self-support.

(7) Stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act [43 U.S.C. 1606(h) and 1607(c)].

(8) Assistance received under the Disaster Relief and Emergency Assistance Act [42 U.S.C. 5121 et seq.] or other assistance provided pursuant to a federal statute on account of a catastrophe which is declared to be a major disaster by the president, and interest received on such assistance for a nine-month period beginning on the date such funds are received.

(9) Any amounts received from the United States which are attributable to underpayments of benefits due for one or more prior months, under title II or title XVI of the Act [42 U.S.C. 401 et seq. and 1381 et seq.] for a six-month period beginning on the date such amounts are received.

(10) The value of assistance, paid with respect to a dwelling unit occupied by the community spouse, under the United States Housing Act of 1937, [42 U.S.C. 1437 et seq.], the National Housing Act [12 U.S.C. 1701 et seq.], section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949 [42 U.S.C. 1471 et seq.], or section 202(h) of the Housing Act of 1959 [12 U.S.C. 1701q(h)].

(11) For the nine-month period beginning with the month in which received, any amount received by the applicant or recipient, or the community spouse, from a fund

established by a state to aid victims of crime, to the extent that the applicant or recipient, or the community spouse demonstrates that such amount was paid in compensation for expenses incurred or losses suffered as a result of a crime.

(12) For the nine-month period beginning after the month in which received, relocation assistance provided by a state or local government to an applicant or recipient, or to a community spouse, comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 [42 U.S.C. 4621 et seq.] which is subject to the treatment required by section 216 of such Act [42 U.S.C. 4636].

(13) For the month of receipt and the following month, any refund of federal income taxes made to an applicant or recipient, or to the community spouse, by reason of section 32 of the Internal Revenue Code of 1986 (relating to earned income tax credit) and any payment made to an applicant or recipient, or to the community spouse, by an employer under section 3507 of the Internal Revenue Code of 1986 (relating to advance payment of earned income credit).

(14) Cash surrender value of a life insurance policy owned by the applicant or recipient, or the community spouse, if the total cash surrender value of all such policies is less than one thousand five hundred dollars.

e. "Family member" means only minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

f. "Institutionalized spouse" means an individual who:

(1) Is in a swing bed or nursing facility and is likely to be in a swing bed or nursing facility for at least thirty days; and

(2) Is married to a spouse who is not in a swing bed or nursing facility.

g. "Monthly maintenance needs allowance" means for a community spouse, the maximum amount permitted under 42 U.S.C. 1396r-5(d)(3)(C), as adjusted pursuant to 42 U.S.C. 1396r-5(g).

2. Treatment of income.

a. No income of the community spouse may be deemed available to the institutionalized spouse during any month in which an institutionalized spouse is in the institution.

b. After an institutionalized spouse is determined or redetermined to be eligible for medicaid, in determining the amount of the institutionalized spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the institutionalized spouse's monthly income the following amounts in the following order:

(1) A personal needs allowance.

(2) A community spouse monthly income allowance, but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

(3) A family allowance, for each family member, equal to one-third of an amount, determined in accordance with 42 U.S.C. 1396r-5(d)(3)(A)(i), less the monthly income of that family member.

(4) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse.

c. In determining the amount of income of an eligible institutionalized spouse or a community spouse:

(1) In the case of income from a trust, except as provided in paragraph 2, income must be attributed in accordance with this chapter, including section 75-02-02.1-31.

(2) Income must be considered available to each spouse as provided in the trust or in the absence of a specific provision in the trust:

(a) If payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(b) If payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(c) If payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered

available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

d. Unless the institutionalized spouse can establish that the ownership interests in income are otherwise:

(1) In the case of income for which there is no instrument establishing ownership, one-half of the income must be considered available to each spouse; or

(2) Unless the instrument providing the income otherwise specifically provides:

(a) If payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(b) If payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(c) If payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

e. Veterans administration aid and attendance payments and veterans administration reimbursements for unusual medical expenses are not income, and must be treated as received in the months in which the increased medical need or unusual medical expense was incurred and expended in such months for such increased medical need or unusual medical expense.

3. Treatment of countable assets.

a. Assessment. At the request of an institutionalized spouse or community spouse, at the beginning of the first continuous period of institutionalization of the institutionalized spouse which begins on or after September 30, 1989, and upon receipt of relevant

documentation of resources, the total value described in subdivision b shall be assessed and documented.

b. Total joint countable assets. There shall be computed, as of the beginning of the first continuous period of institutionalization of the institutionalized spouse which begins on or after September 30, 1989:

(1) The total value of the countable assets to the extent either the institutionalized spouse or the community spouse has an ownership interest; and

(2) A spousal share which is equal to one-half of such total value.

c. In determining the assets of the institutionalized spouse at the time of application, all countable assets held by the institutionalized spouse, the community spouse, or both, must be considered available to the institutionalized spouse to the extent they exceed the community spouse countable asset allowance.

d. During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this chapter, no countable assets of the community spouse may be deemed available to the institutionalized spouse.

e. The institutionalized spouse is not ineligible by reason of assets determined under subdivision c to be available for the cost of care where:

(1) The institutionalized spouse has assigned to the state any rights to support from the community spouse;

(2) The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without such assignment; or

(3) It is determined that a denial of eligibility would work an undue hardship because the presumption described in subsection 4 of section 75-02-02.1-25 has been rebutted.

4. Notice and fair hearing.

a. Notice must be provided of the amount of the community spouse income allowance, of the amount of any family allowances, of the method of computing the amount of the

community spouse countable asset allowance, and of the right to a fair hearing respecting ownership or availability of income and assets, and the determination of the community spouse monthly income or countable asset allowance. The notice must be provided, upon a determination of medicaid eligibility of an institutionalized spouse, to both spouses, and upon a request by either spouse or a representative acting on behalf of either spouse, to the spouse making the request.

b. Fair hearing. A community spouse or an institutionalized spouse is entitled to a fair hearing under chapter 75-01-03 if application for medicaid has been made on behalf of the institutionalized spouse and either spouse is dissatisfied with a determination of:

(1) The community spouse monthly income allowance;

(2) The amount of monthly income otherwise available to the community spouse as determined in calculating the community spouse monthly income allowance;

(3) The computation of the spousal share of countable assets under subdivision b of subsection 3;

(4) The attribution of countable assets under subdivision c of subsection 3; or

(5) The determination of the community spouse countable asset allowance.

c. Any hearing respecting the determination of the community spouse countable asset allowance must be held within thirty days of the request for the hearing.

d. If either spouse establishes that the community spouse needs income, above the level provided by the monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, the monthly maintenance needs allowance for that spouse must be increased to an amount adequate to provide necessary additional income.

e. If either spouse establishes that the assets included within the community spouse countable asset allowance generate an amount of income inadequate to raise the community spouse's income to the monthly needs allowance, to the extent that total assets permit the community spouse countable asset allowance for that spouse must be increased to an amount adequate to provide such a monthly maintenance needs allowance.

5. Permitting transfer of assets to community spouse.

a. An institutionalized spouse may transfer an amount equal to the community spouse countable asset allowance, but only to the extent the assets of the institutionalized spouse are transferred to, or for the sole benefit of, the community spouse.

b. A transfer under subdivision a must be made within sixty days after the date of the institutionalized spouse's application for medicaid, and within the remaining days of the month in which the sixtieth day falls.

c. If a court has entered an order against an institutionalized spouse for the support of a community spouse, a transfer of assets required by such order to be transferred, by the institutionalized spouse to the community spouse, may not produce a period of ineligibility for the institutionalized spouse.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: 50-24.1-02; 42 USC 1396r-5

75-02-02.1-25. Asset considerations.

1. All assets must be considered in establishing eligibility for medicaid.

2. Only such assets as are actually available will be considered. Assets are actually available when at the disposal of an applicant, recipient, or responsible relative; when the applicant, recipient, or responsible relative has a legal interest in a liquidated sum and has the legal ability to make the sum available for support, maintenance, or medical care; or when the applicant, recipient, or responsible relative has the lawful power to make the asset available, or to cause the asset to be made available. Assets will be reasonably evaluated. A determination that an asset is deemed available is a determination that the asset is actually available. An asset may be sold or exchanged for another asset. An asset acquired in an exchange or with the proceeds from a sale continues to be treated as an asset subject to the asset limits, exemptions, and exclusions applicable to the type of asset which was acquired. This subsection does not supersede other provisions of this chapter which describe or require specific treatment of assets, or which describe specific circumstances which require a particular treatment of assets.

3. The financial responsibility of any individual for any applicant or recipient of medicaid is limited to the responsibility of spouse for spouse and parents for a child under age twenty-one or, if blind or disabled, under age eighteen. Such responsibility is imposed upon applicants or

recipients as a condition of eligibility for medicaid. Except as otherwise provided in this section, the assets of the spouse and of the parents of a child under age twenty-one or, if blind or disabled, under age eighteen, are deemed available to an applicant or recipient, even if those assets are not actually contributed. For purposes of this subsection, biological and adoptive parents, but not stepparents, are treated as parents.

4. It is presumed that all spousal assets are actually available to aged, blind, or disabled individuals where financial responsibility is imposed pursuant to subsection 3. In order to rebut this presumption, the applicant or recipient must demonstrate that the spousal assets are unavailable despite reasonable and diligent efforts to access such assets. The rebuttal of this presumption does not preclude the department from exercising the powers granted to it by North Dakota Century section 50-24.1-02.1. Except as provided in subdivisions a, b, and c, no applicant or recipient who has a statutory or common law cause of action for support out of the assets of a spouse, but who has failed to diligently pursue that cause of action, may rebut the presumption. Any applicant or recipient who documents any of the following circumstances will have rebutted the presumption without further proof:

   a. A court order, entered following a contested case, determines the amounts of support that a spouse must pay to the applicant or recipient.

   b. The spouse from whom support could ordinarily be sought, and the property of such spouse, is outside the jurisdiction of the courts of the United States or any of the United States.

   c. The applicant or recipient has been subject to marital separation, with or without court order, for at least two years prior to making application for medical assistance benefits, and there has been no contact whatever between the applicant or recipient and his or her spouse for the same two-year period.

5. It is presumed that all parental assets are actually available to a child under age twenty-one where financial responsibility is imposed pursuant to subsection 3. This presumption may be rebutted by a showing that the child under age twenty-one is living independently.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-26. Asset limits. The following property provisions must be applied in determining medicaid eligibility. In all instances, including determinations of equity, property must be realistically evaluated in accord with current market value. Any reasonable costs which may be associated with liquidation of excess property must be taken into account. Except for those persons found eligible for medicare cost sharing as qualified medicare beneficiaries pursuant to section 75-02-02.1-22 or as qualified disabled and working individuals pursuant to section 75-02-02.1-23, no person may be found eligible for medicaid unless the total value of the medicaid unit's assets, in addition to assets exempted pursuant to section 75-02-02.1-27 or excluded pursuant to section 75-02-02.1-28, do not exceed:

1. Three thousand dollars for a one-person unit;

2. Six thousand dollars for a two-person unit; and

3. An additional amount of twenty-five dollars for each member of the unit in excess of two.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-27. Exempt assets. Except as provided in sections 75-02-02.1-22 and 75-02-02.1-23, the following assets are exempt from consideration in determining medicaid eligibility:

1. The home occupied by the medicaid unit, including trailer homes being used as living quarters;

2. Personal effects, wearing apparel, household goods, and furniture;

3. One motor vehicle;

4. Indian trust or restricted lands; and

5. Indian per capita funds and judgments funds awarded by either the Indian claims commission or the court of claims after October 19, 1973, interest and investment income accrued on such Indian per capita or judgment funds while held in trust, and purchases made using interest or investment income accrued on such funds while held in trust. The funds must be identifiable and distinguishable from other funds. Commingling of per capita funds, judgment funds, and interest and investment income earned on those funds, with other funds, results in loss of the exemption.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-28. Excluded assets. Except as provided in sections 75-02-02.1-22 and 75-02-02.1-23, the following types of property interests will be excluded in determining if the available assets of an applicant or recipient exceed asset limits:

1. Property which is essential to earning a livelihood. Such property may be excluded only during months in which the applicant or recipient is actively engaged in using the asset to earn a livelihood. Assets which are used seasonably are excluded as long as continued seasonal use is reasonably anticipated.

2. Property which is not saleable without working an undue hardship. Such property may not be excluded earlier than the first day of the month in which good faith attempts to sell are begun, and continues to be excluded only for so long as the asset continues to be for sale. Persons seeking to establish retroactive eligibility must demonstrate that good faith attempts to sell were begun and continued in each of the months for which retroactive eligibility is sought. Information concerning attempts to sell, which demonstrate that an asset is not saleable without working an undue hardship, are relevant to establishing eligibility in the month in which the good faith attempts to sell are begun, but are not relevant to months prior to that month and do not relate back to prior months.

3. Any prepayments or deposits which total three thousand dollars or less, and the interest accrued thereon after July 1, 1987, made under a pre-need funeral service contract for each applicant or recipient in the medicaid unit. The applicant or recipient must verify that the deposit is made in a manner such that the applicant or recipient may obtain the deposit within five days after making a request directly to the financial institution, and without furnishing documents maintained by the funeral establishment or waiting for the financial institution to secure permission from the funeral establishment.

4. Home replacement funds, derived from the sale of an excluded home, and if intended for the purchase of another excluded home, until the last day of the third month following the month in which the proceeds from the sale are received.

5. Unspent assistance, and interest earned on unspent assistance, received under the Disaster Relief and Emergency Assistance Act of 1974 [Pub. L. 93-288] or some other federal statute, because of a presidentially declared major disaster, for nine months after receipt, and for up to an additional nine months, if circumstances beyond the person's control prevent the repair or replacement of the damaged, or destroyed property, and keep the person from contracting for such repair or replacement.

6. Payments, interest earned on the payments, and in-kind items received for the repair or replacement of lost, damaged, or stolen excluded assets are excluded for nine months after receipt, and for up to an additional nine months, if circumstances beyond the person's control prevent the repair or replacement of the lost, damaged, or stolen assets, and keep the person from contracting for such repair or replacement.

7. Agent orange payments.

8. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act [Pub. L. 100-383].

9. German reparation payments to survivors of the holocaust, and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act, which have been retained and not commingled with other assets.

10. Unspent financial assistance provided for attendance costs to undergraduate and graduate students under programs in title IV of the Higher Education Act or for attendance costs under bureau of Indian affairs student assistance programs.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02, 50-24.1-02.3

75-02-02.1-29. Forms of asset ownership.

1. Ownership of real or personal property or accounts can take various forms. The first basic consideration is the distinction between real and personal property. Real property relates to land and those things, such as houses, barns, and office buildings, which are more or less permanently attached to it. Personal property describes all other things which are subject to individual rights. The distinction is really between movable objects, generally created by man, and the immovable earth. It is the permanency of the land, and the need for a permanent frame of reference governing the ownership of that land, that has led to most of the legal distinctions between real and personal property.

2. The owner of property is not always an individual or a married couple. Since the various types of property ownership may affect the valuation of the applicant's or recipient's assets, it is important to carefully record information relating to such property.

a. "Fee" or "fee simple" ownership is a term applied to real property in which the "owner" has the sole ownership interest. A fee simple interest will, in theory, last as long as the land. Even though one owner dies, that owner has the power to sell or to "will" the property. The resulting series of owners each has a fee simple. A fee simple ownership interest is not changed when the property is mortgaged. The mortgage merely secures the owner's promise to repay a debt. If the debt is not paid, the owner may be obliged to forfeit the property. Fee simple ownership may be individual or may be shared.

b. Shared ownership means that the ownership interest in the property is vested in more than one person. Shared ownership may be by "joint tenancy" or by "tenancy in common". Shared ownership occurs both with real property and with valuable personal property of a semipermanent nature (such as accounts, motor vehicles, and mobile homes).

(1) In joint tenancy, each of two or more joint tenants has an equal interest in the whole property. On the death of one of two joint tenants, the survivor becomes the sole owner. On the death of one of three or more joint tenants, the survivors remain joint tenants in the entire interest. It is possible for any joint tenant, acting independently, to convert the joint tenancy to a tenancy in common by selling his interest to a person who was not one of the original joint tenants.

(2) In tenancy in common, two or more persons have an undivided fractional interest in the whole property. There is no "right of survivorship" in a tenancy in common. On the death of one of the tenants in a tenancy in common, the surviving tenants gain nothing, and the estate of the deceased tenant thereafter owns the deceased tenant's share.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-30. Contractual rights to receive money payments. There is a presumption that the holder's interest in contractual rights to receive money payments, including, but not limited to, the seller's interest in a long-term contract for the sale of real or personal property, promissory notes, trust deeds, mortgages, and accounts receivable, is saleable without working an undue hardship. This

presumption may be rebutted by evidence demonstrating that the contractual rights are not saleable without working an undue hardship.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-31. **Trusts.** A trust is an arrangement whereby a person (the "grantor" or "trustor") gives property to another (the "trustee") with instructions to use the property for the benefit of a third person (the "beneficiary"). The property placed in trust is called the "principal" or "corpus". The positions of grantor, trustee, and beneficiary occur in all trusts, but it is not uncommon for a single trust to involve more than one grantor, trustee, or beneficiary. It is also not uncommon for a grantor to establish a trust where the grantor is also a beneficiary or where the trustee is also a beneficiary. Trusts are often very individualized arrangements, and generalizations about them can prove inaccurate. However, the trust may have an effect on eligibility whether the applicant is a grantor, trustee, or beneficiary.

1. **Revocable - irrevocable.** Trusts may be categorized in many ways, but the revocability of a trust is a fundamental one. A revocable trust is one where someone, usually the grantor, has the power to remove the property from the trust, or otherwise end the trust. An irrevocable trust is one where that power does not exist. The determination of trust revocability is not based solely on a trust declaration of irrevocability. Even a trust which, on its face, appears clearly to be irrevocable, may be revoked with the consent of the grantor and the beneficiaries.

   a. If the grantor of a trust is also the sole beneficiary, trust assets are treated as the grantor's assets for medicaid purposes.

   b. If the grantor of a trust and all trust beneficiaries are part of a medicaid unit, trust assets are treated as the grantor's assets for medicaid purposes.

   c. Trust assets of a revocable trust are treated as the grantor's assets for medicaid purposes.

2. **Medicaid-qualifying trusts.**

   a. For purposes of this subsection, "medicaid-qualifying trust" means a trust established, other than by will, by an individual or the individual's spouse, under which the individual may be the beneficiary of all or part of the payments from the trust, and the distribution of such payments is determined by one or more trustees who are

permitted to exercise any discretion with respect to the distribution to the individual.

b. The amount from a medicaid-qualifying trust deemed available to the grantor or the grantor's spouse is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the grantor. For purposes of this subdivision, "grantor" means the individual referred to in subdivision a.

c. This subsection applies without regard to:

(1) Whether or not the medicaid-qualifying trust is irrevocable or is established for purposes other than to enable a grantor to qualify for medicaid; or

(2) Whether or not the discretion described in subdivision a is actually exercised.

3. Support trust.

a. For purposes of this subsection, "support trust" means a trust which has, as a purpose, the provision of support or care to a beneficiary. The purpose of a support trust is indicated by language such as "to provide for the care, support, and maintenance of . . ."; "to provide as necessary for the support of . . ."; or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort, and general welfare". No particular language is necessary, but words such as "care", "maintenance", "medical needs", or "support" are usually present. The term includes trusts which may also be called "discretionary support trusts" or "discretionary trusts", so long as support is a trust purpose. This subsection applies without regard to:

(1) Whether or not the support trust is irrevocable or is established for purposes other than to enable a beneficiary to qualify for medicaid or any other benefit program where availability of benefits requires the establishment of financial need; or

(2) Whether or not the discretion described in subdivision a is actually exercised.

b. Except as provided in subdivisions c and d, the amount from a support trust deemed available to the beneficiary, the beneficiary's spouse, and the beneficiary's children is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by

the trustee or trustees for the distribution of the maximum amount to the beneficiary.

c. A beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise any discretion with respect to that distribution, may show that the amounts deemed available under subdivision b are not actually available by:

(1) Commencing proceedings against the trustee or trustees in a court of competent jurisdiction;

(2) Diligently and in good faith asserted in the proceeding that the trustee or trustees is required to provide support out of the trust; and

(3) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount determined under subdivision b.

d. If the beneficiary makes the showing described in subdivision c, the amount deemed available from the trust is the amount determined by the court.

e. Any action by a beneficiary or the beneficiary's representative, in attempting a showing under subdivision c, to make the department, the state of North Dakota, or a county agency a party to the proceeding, or to show to the court that medicaid benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required under subdivision c.

4. Discretionary trusts.

a. For purposes of this subsection, "discretionary trust" means any trust in which one or more trustees is permitted to exercise any discretion with respect to distribution to the beneficiary, but does not mean a "support trust", as that term is defined in subsection 3.

b. The amounts from a discretionary trust deemed available to a beneficiary are the amounts actually distributed by the trustee or trustees. Distribution from a discretionary trust is treated as income in the month received and an asset thereafter.

5. Other trusts.

a. For purposes of this subsection, "other trusts" means any trust which is not an "irrevocable trust", as that term is

explained in subsection 1; a "medicaid-qualifying trust", as that term is defined in subsection 2; a "support trust", as that term is defined in subsection 3; or a "discretionary trust", as that term is defined in subsection 4.

b. The amount from an "other trust" deemed available to a beneficiary of that trust is the greater of the amount which must be distributed to that beneficiary under the terms of the trust, whether or not that amount is actually distributed, and the amount which is actually distributed.

6. Applicant as trustee. An applicant or recipient who is a trustee has the legal ownership of trust property and the legal powers to distribute income or trust assets which are described in the trust. However, those powers may be exercised only on behalf of trust beneficiaries. If the trustee or other members of the medicaid unit are not also beneficiaries or grantors to whom trust income or assets are treated as available under subsection 1, 2, 3, 4, or 5, trust assets are not available to the trustee.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396a(k)

75-02-02.1-32. Valuation of assets. It is not always possible to determine the value of assets with absolute certainty, but it is necessary to determine a value in order to determine eligibility. The valuation must be based on reasonably reliable information. It is the responsibility of the applicant or recipient, or the persons acting on behalf of the applicant or recipient, to furnish reasonably reliable information. However, because an applicant or recipient may not be knowledgeable of asset values, and particularly because that person may have a strong interest in the establishment of a particular value, whether or not that value is accurate, some verification of value must be obtained. Useful sources of verification include, but are not limited to:

1. With respect to liquid assets: account records maintained by banking facilities.

2. With respect to personal property other than liquid assets:

   a. Publicly traded stocks, bonds and securities: stock brokers.

   b. Autos, trucks, mobile homes, boats, or any other property listed in published valuation guides accepted in the trade: the valuation guide.

c. With respect to harvested grains or produce: grain buyers, grain elevator operators, produce buyers; and, for crops grown on contract: the contract.

d. With respect to stock in corporations not publicly traded: appraisers, accountants.

e. With respect to other personal property: dealers and buyers of that property.

3. Real property.

a. With respect to surface interests: market value or "true and full" value from tax records, whichever represents an approximation of fair market value; real estate agents; appraisers; loan officers in local banking institutions. If a valuation from a source offered by the applicant or recipient is greatly different from fair market value established by tax records, an explanation for the difference must be made, particularly if the applicant or recipient may be able to influence the person furnishing the valuation.

b. With respect to mineral interests: appraisers, specializing in minerals, mineral buyers, geologists.

4. Divided or partial interests. Divided or partial interests include assets held by the applicant or recipients; jointly or in common with persons who are not in the medicaid unit; assets where the applicant or recipient or other persons within the medicaid unit own only a partial share of what is usually regarded as the entire asset; and interests where the applicant or recipient owns only a life estate or remainder interest in the asset.

a. Liquid assets. The value of a partial or shared interest in a liquid asset is equal to the total value of that asset.

b. Personal property other than liquid assets and real property other than life estates and remainder interests. The value of a partial or shared interest is a proportionate share of the total value of the asset equal to the proportionate share of the asset owned by the applicant or recipient.

c. Life estates and remainder interests.

(1) Real property interests may be divided in terms of the time when the owner of the interest is entitled to possession of the property. The owner of a life estate (life tenant) is entitled to possession of the real property for a period measured by the lifetime

of a specific person or persons. A life tenant has the right to use the property and is entitled to any rents or profits from the property. A life tenant may sell the life estate, but such a sale does not change the identity of the person or persons whose lifetimes measure the duration of the life estate. A life estate may be referred to as a "life lease".

(2) When a life estate is created, a right to possess the property, after the death of the life tenant, must also be created. That right is called a "remainder interest", and the owner of that right is called a "remainderman". Upon the death of the life tenant, the remainderman owns the property. The remainderman is not entitled to possess or use the property until the death of the life tenant. The remainderman does have the right to sell the remainder interest.

(3) A life estate may be created where the right to possess the property returns, upon the death of the life tenant, to the person or entity which created the life estate. This rare form of ownership may arise when a legal entity which does not die a natural death (i.e., a trust or corporation) creates a life estate. The right to have possession of property returned after the end of a life estate is properly called a "reversion", but is treated as a remainder interest for purposes of valuation.

(4) Life estate and remainder interest tables. These tables must be used to determine the value of a life estate or remainder interest. In order to use the table, it is necessary to first know the age of the life tenant or, if there are more than one life tenants, the age of the youngest life tenant; and the fair market value of the property which is subject to the life estate or remainder interest. The value of a life estate is found by selecting the appropriate age in the table and multiplying the corresponding life estate decimal fraction times the fair market value of the property. The value of a remainder interest is found by selecting the appropriate age of the life tenant in the table and multiplying the corresponding remainder interest decimal fraction times the fair market value of the property.

Life Estate and Remainder Interest Table

Age	Life Estate	Remainder Interest
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983

3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137

47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951
79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.40295	.59705
83	.38642	.61358
84	.36998	.63002
85	.35359	.64641
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779

91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

(5) In some cases, the life tenant may suffer from a condition which is likely to cause death at an unusually early age. That circumstance decreases the value of the life estate and increases the value of the remainder interest. The existence of such a condition must be verified by a medical statement which estimates the remaining duration of life in years. The estimated remaining duration of life may be used, in conjunction with a mortability table, to determine the comparable age for application of the life estate and remainder interest table.

5. Contractual rights to receive money payments:

a. For various reasons, but usually because an applicant or recipient has sold property with a contract to receive a series of payments, rather than one payment, an applicant or recipient may own contractual rights to receive money payments. Such contractual rights are available assets subject to the asset limits. If the applicant or recipient has sold real property or a mobile home, and received in return a promise of payments of money at a later date, usually to be made periodically, and an attendant promise to return the property if the payments are not made, the arrangement is usually called a "contract for deed". The essential feature of the contract for deed is the right to receive future payments, usually coupled with a right to get the property back if the payments are not made. Contractual rights to receive money payments also arise out of other types of

transactions. The valuable contract document may be called a note, accounts receivable, mortgage, or by some other name.

b. Because such contracts may have been entered into when interest rates were lower, or because a low interest rate or no interest may have been charged in a transaction between relatives, the contract may not be saleable or negotiable at face value. That is not to say that such contractual rights have no value. A proper valuation may be made by a process called "discounting", which will take into account the changes in the interest rates. The discounted value may be determined by the applicant or recipient through the application of paragraph 1 or by the legal services division of the state agency under paragraph 2.

(1) The discounting process requires estimating the present value of the money payments described in the contract. The formula for present value is:

$$PV = S \frac{1}{(1+i)n} \text{ or } \frac{S}{(1+i)n} \text{ or } S(1+1)^{-n} \text{ where}$$

PV = present value of future sum of money
S = future sum of money
i = earnings rate for each compounding period
n = number of periods

The information to apply the formula is derived from the contract except for the factor "i". The earnings rate to be used for the factor "i" is the posted yields of the federal national mortgage association (Fannie Mae), as posted for standard conventional fixed rate mortgages, as published in the Wall Street Journal at its most recent publication of posted yields. The application of this formula will produce the highest reasonable determination of fair market value of the contractual rights to receive money payments. In the event the contract is in default, and there is no reasonable expectation that payments on the contract will be brought current within one year's time, the factor "S" is equal to the total of all outstanding principal and interest due on the contract and the factor "n" equals one.

(2) A request for the discounted value, accompanied by the contract documents, may be sent to the legal services division. The request must indicate if the payments on the contract are current. If the payments are not current, the request must indicate

the amount of each payment made and time each such payment was made.

c. In some cases, the price and terms of a contract for deed may, in combination, be extremely favorable to the buyer. If the sale is made with a minimal downpayment, low interest rates, a long payment period, or a combination of any of those factors, the effect may be a transfer for less than adequate consideration. In such cases, the valuation must also indicate the fair market value of the property sold as of the date of sale and the value of the contractual rights immediately after the sale.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-33. Disqualifying transfers.

1. a. Except as provided in subsections 2 and 3, a person is ineligible for nursing facility services, swing bed services, and medicaid waivered services for a period of time, determined under this subsection, following the disposal of any asset by the person or the person's spouse for less than fair market value.

b. The period of ineligibility begins with the month in which such assets were transferred, and the number of months in the period is equal to the lesser of:

(1) Thirty months; or

(2) The total uncompensated value of the assets so transferred, divided by the average monthly cost of nursing facility care in North Dakota in the year of application.

c. A person is not ineligible because of subdivision a to the extent that the asset was the person's home and the home was transferred to:

(1) The person's spouse;

(2) The person's son or daughter who is under age twenty-one or blind or disabled;

(3) The person's brother or sister who has an equity interest in the home and who was residing in the home for a period of at least one year immediately before the date the person became an institutionalized person;

(4) The person's son or daughter (other than a child described in paragraph 2) who was residing in the person's home for a period of at least two years immediately before the date the person became an institutionalized person, and who provided care to the person which permitted the person to reside in the person's home, rather than in an institution or facility.

d. A person is not ineligible because of subdivision a to the extent that the assets were transferred in trust for the sole benefit of the person, the person's spouse, or the person's child described in paragraph 2 of subdivision c.

e. A person is not ineligible because of subdivision a to the extent that the person shows that:

(1) He or she intended to dispose of the assets either at fair market value or other valuable consideration, and makes a satisfactory showing that he or she had an objectively reasonable belief that adequate consideration was received;

(2) The assets were transferred exclusively for a purpose other than to qualify for medicaid; or

(3) With respect to periods after the asset is returned, the assigned or transferred asset has been returned to the assignor or transferor.

f. A person is not ineligible because of subdivision a to the extent that the asset transferred was:

(1) Household goods, personal effects, or an automobile with an equity value of four thousand five hundred dollars or less.

(2) A burial fund of up to one thousand five hundred dollars, plus earnings on the burial fund.

(3) A burial space or agreement which represents the purchase of a burial space held for the transferor, the transferor's spouse, or any other member for the transferor's immediate family.

(4) Property essential to self-support, which means:

(a) Property which the transferor owns, with an equity value not exceeding six thousand dollars, which produces annual income at least equal to six percent of equity value, and which the transferor is not actively engaged in using to produce income;

(b) Nonbusiness property which the transferor owns, up to an equity value of six thousand dollars when used to produce goods or services essential to daily activities or, for instance, when used to grow produce or livestock solely for consumption in the transferor's household; and

(c) Property which is essential to self-support.

(5) Assets set aside, by a blind or disabled (but not an aged) transferor, as a part of a plan approved by the social security administration, for the transferor to achieve self-support.

(6) Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 [Pub. L. 93-288], or other assistance provided pursuant to a federal statute on account of a catastrophe which is declared to be a major disaster by the president, and interest earned on that assistance, but only for nine months following receipt of that assistance.

(7) Any amounts received from the United States which are attributable to underpayments of benefits due from one or more prior months, under title II or title XVI of the Act [42 U.S.C. 401 et seq. and 1381 et seq.], but only for six months following receipt of those amounts.

(8) The value of assistance, paid with respect to a dwelling unit occupied by the transferer, under the United States Housing Act of 1937 [42 U.S.C. 1437 et seq.], the National Housing Act [12 U.S.C. 1701 et seq.], section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949 [42 U.S.C. 1471 et seq.], or section 202(h) of the Housing Act of 1959 [12 U.S.C. 1701q(h)].

(9) Any amounts received by the transferor from a fund established by a state to aid victims of crime, to the extent that the transferor demonstrates that the amount was paid in compensation for expenses incurred or losses suffered as a result of a crime, but only for nine months following receipt of the amount.

(10) Relocation assistance amounts provided by a state or local government to the transferor, comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 [42 U.S.C. 4621 et seq.], which is subject to the treatment required by section 216 of such Act [42 U.S.C. 4636], but only for nine months following receipt of the amounts.

(11) Transferred to the transferor's spouse before the transferor was determined eligible for medicaid.

(12) Transferred to the transferor's community spouse, by a transferor who is an institutionalized person, within sixty days after the date of the transferor's application for medicaid benefits, and within the remaining days of the month in which the sixtieth day falls, but only to the extent necessary to provide the community spouse with assets which do not exceed the community spouse resource allowance in effect on the date initial medicaid eligibility was determined.

g. There is a presumption that a transfer for less than adequate consideration was made for purposes which include the purpose of qualifying for medicaid:

(1) In any case in which the person's assets remaining after the transfer produce income which, when added to other income available to the person, totals an amount insufficient to meet all living expenses and medical costs reasonably anticipated to be incurred in the month of transfer and in the twenty-nine months following the month of the transfer;

(2) In any case in which an application or inquiry about medicaid benefits was made by or on behalf of the person and the person making inquiry was informed of medicaid asset limits; or

(3) In any case in which the person was an applicant for or recipient of medicaid at the time the transfer was made.

h. An applicant or recipient who claims that an asset was transferred exclusively for a purpose other than to qualify for medicaid must show that a desire to receive medicaid benefits played no part in the decision to make the transfer and must rebut any presumption arising under subdivision g.

i. For purposes of this subsection, "adequate consideration" means:

(1) In the case of an asset which is not subject to reasonable dispute concerning its value, such as cash, bank deposits, stocks, and fungible commodities, one hundred percent of fair market value; and

(2) In the case of an asset which is subject to reasonable dispute concerning its value, seventy-five

percent of fair market value established before the sale.

2. a. Except as provided in subsection 3, assignment or transfer of a nonexempt property for less than adequate consideration, made prior to July 1, 1988, whenever made with the intent to render the assignor or transferor, or a family member eligible for medicaid benefits, produces ineligibility. An amount equal to the fair market value of the property transferred will be treated as though the assignor or transferor had retained the property. An individual found ineligible as a result of a disqualifying assignment or transfer will remain ineligible until the individual becomes legally obligated to pay for medical expenses, not paid for by any other third party, equal to the difference between the fair market value of the property and the amount of compensation actually received. The return of an assigned or transferred asset to the assignor or transferor will nullify the disqualifying assignment or transfer, and the returned asset is thereafter treated as any other asset.

b. There are legitimate instances when a property assignment or transfer may be valid. The applicant or recipient should be given full opportunity to state the reasons for having made the property assignment or transfer, and the statements should be considered in relation to the following questions:

(1) Was adequate consideration received?

(2) How recent was the assignment or transfer?

(3) Is the applicant's or recipient's stated purpose reasonable in view of the circumstances prevailing at the time of the assignment or transfer?

(4) Would it have been reasonable to anticipate that the assignment or transfer of property at the time it occurred would result in an earlier need for assistance?

(5) Was there some consideration other than cash?

(6) Did the transferee have a legal or equitable interest in the property transferred?

c. An assignment or transfer of property for less than adequate consideration, made at any time after two years prior to the first date of application or inquiry for medicaid or after a previous application for medicaid has been made and denied because of excess property resources, shall be presumed to have been made for the purpose of

rendering the applicant eligible for medicaid. This presumption may be rebutted by substantial evidence of an intent which is inconsistent with the presumed intent.

3. The provisions of subsections 1 and 2 may not be applied to deny, to qualified medicare beneficiaries and to qualified disabled and working individuals, benefits available solely due to their status as qualified medicare beneficiaries and qualified disabled and working individuals.

4. Where the assignee or transferee is a relative of the assignor or transferor, services or assistance furnished by the assignee or transferee to the assignor or transferor may not be treated as consideration for the transferred property unless provided pursuant to a valid contract entered into prior to the rendering of the service or assistance.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02; 42 USC 1396p(c)

75-02-02.1-34. Income considerations.

1. All income must be considered in establishing eligibility, in the flexible application of income to medical costs not in the state plan, and in determining recipient's liability toward the medical costs.

2. Only such income as is actually available will be considered. Income is actually available when it is at the disposal of an applicant, recipient, or responsible relative; when the applicant, recipient, or responsible relative has a legal interest in a liquidated sum and has the legal ability to make the sum available for support, maintenance, or medical care; or when the applicant, recipient, or responsible relative has the lawful power to make the income available or to cause the income to be made available. Income will be reasonably evaluated. A determination that income is deemed available is a determination that the income is actually available. This subsection does not supersede other provisions of this chapter which describe or require specific treatment of income, or which describe specific circumstances which require a particular treatment of income.

3. The financial responsibility of any individual for any applicant or recipient of medicaid will be limited to the responsibility of spouse for spouse and parents for a child under age twenty-one or, if blind or disabled, under age eighteen. Such responsibility is imposed upon applicants or recipients as a condition of eligibility for medicaid. Except as otherwise provided in this section, the income of the spouse and of the parents of a child under age twenty-one or,

if blind or disabled, under age eighteen are deemed available to the applicant or recipient, even if that income is not actually contributed. For purposes of this subsection, biological and adoptive parents, but not stepparents, are treated as parents.

a. It is presumed that all spousal income is actually available to aged, blind, or disabled individuals where financial responsibility is imposed pursuant to this subsection. In order to rebut this presumption, the applicant or recipient must demonstrate that the spousal income is unavailable despite reasonable and diligent efforts to access such income. The rebuttal of this presumption does not preclude the department from exercising the powers granted to it by North Dakota Century Code section 50-24.1-02.1. Except as provided in paragraphs 1, 2, and 3, no applicant or recipient who has a statutory or common law cause of action for support from a spouse, but who has failed to diligently pursue that cause of action, may rebut the presumption. Any applicant or recipient who documents any of the following circumstances will have rebutted the presumption without further proof:

   (1) A court order, entered following a contested case, determines the amounts of support that a spouse must pay to the applicant or recipient.

   (2) The spouse from whom support could ordinarily be sought, and the property of such spouse, is outside the jurisdiction of the courts of the United States or any of the United States.

   (3) The applicant or recipient has been subject to marital separation, with or without court order, for at least two years prior to making application for medical assistance benefits, and there has been no contact whatever between the applicant or recipient and his or her spouse for the same two-year period.

b. It is presumed that all parental assets are actually available to a child under age twenty-one where financial responsibility is imposed pursuant to this subsection. This presumption may be rebutted by a showing that the child is living independently.

4. Income may be received weekly, biweekly, monthly, intermittently, or annually. However income is received, a monthly income amount must be computed. Lump-sum income will be attributed to an appropriate month as provided for in sections 75-02-02.1-37 and 75-02-02.1-38. All other income must be treated as received in the month in which it is normally received. Payments from any source, which are or may

be received as a result of a medical expense or increased medical need (such as veterans administration aid and attendance or indemnity insurance payments), are not income. Such payments must be treated as received in the months in which the medical expense or increased medical need was incurred and expended in such month for such medical expense or increased medical need.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-35. Budgeting.

1. Definitions. For purposes of this section:

   a. "Base month" means the calendar month prior to the processing month.

   b. "Best estimate" means an income, expense, or circumstance prediction based on past amounts of income and expense and known factual information concerning future circumstances which affect eligibility, expenses to be incurred, or income to be received in the recipient liability month. A prediction based on past circumstances and income and expense amounts uses those circumstances and income and expense amounts which occurred in the base month. Factual information concerning future circumstances must be based on information by which the applicant or recipient demonstrates known changes or highly probable changes to the income, expense, or circumstances which offset eligibility, from the base month to the recipient liability month.

   c. "Processing month" means the month between the base month and the recipient liability month.

   d. "Prospective budgeting" means computation of a household's eligibility and recipient liability based on the best estimate of income, expenses, and circumstances for a recipient liability month.

   e. "Recipient liability month" means the calendar month for which eligibility and recipient liability is being computed.

2. Computing recipient liability for previous month. Compute the amount of recipient liability by use of actual verified information, rather than best estimate, in each of the previous months for which eligibility is sought.

3. Computing recipient liability for the current month and next month at time of approval of the application. Compute the amount of the recipient liability prospectively for the current month and the next month. The income received or best estimate of income to be received during the current month must be used to compute the recipient liability for the current month. The best estimates of income to be received during the next month must be used to compute the recipient liability for the next month.

4. Computing recipient liability for ongoing cases.

   a. For cases with fluctuating income, compute the recipient liability using verified income, expenses, and circumstances which existed during the base month, unless factual information concerning future circumstances is available. Recipients must report their income, expenses, and other circumstances on a monthly basis to determine continued eligibility.

   b. For cases with stable income, compute the recipient liability using the best estimate of income, expenses, and circumstances. Recipients with stable income must report changes in income, expenses, and other circumstances within ten days of the day they became aware of the change. A determination of continued eligibility, after a change is reported and demonstrated, is based on a revised best estimate which takes the changes into consideration.

5. Budgeting procedures used when adding individuals to an eligible unit. Individuals may be added to an eligible unit up to one year prior to the current month, provided the individual meets all eligibility criteria for medicaid; provided that, the eligible unit was eligible in all of the months in which eligibility for the individual is established; and provided that, the individual was in the unit in the months with respect to which eligibility for that individual is sought. Recipient liability will be based on the unit's actual income and circumstances when adding each individual for retroactive periods. Recipient liability must be based on the unit's income and circumstances from the base month, plus the best estimate of each individual's income and circumstances when adding each individual to the current or next month.

6. Budgeting procedures when deleting individuals from a case. When a member of an existing unit is expected to leave the unit during the recipient liability month, that person is considered to be a member of the unit until the end of the recipient liability month.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-36. Disregarded income. The following types of income must be disregarded in determining medicaid eligibility:

1. Money payments made by the department in connection with foster care or the subsidized adoption program;

2. Occasional small gifts;

3. County general assistance that may be issued on an intermittent basis to cover emergency type situations;

4. Income received as a housing allowance by programs sponsored by the United States department of housing and urban development and rent supplements or utility payments provided through the housing assistance program;

5. Income of an individual living in the parental home if the individual is not included in the medicaid unit;

6. Mandatory and optional supplementation payments;

7. Educational loans, scholarships, grants, awards, and work study received by an undergraduate student, educational assistance provided for attendance costs to undergraduate and graduate students under programs in title IV of the Higher Education Act, and for attendance costs under bureau of Indian affairs student assistance programs;

8. In-kind income except in-kind income received in lieu of wages;

9. Per capita judgment funds paid to members of any Indian tribe under Pub. L. 92-254 or Pub. L. 93-134;

10. Compensation received by volunteers participating in the action program as stipulated in the Domestic Volunteer Service Act of 1973 [Pub. L. 93-113], including foster grandparents, older American community service program, retired senior volunteer program, service corps of retired executives, volunteers in service to America, and university year for action;

11. Benefits received through the low income home energy assistance program;

12. Training funds received from vocational rehabilitation;

13. Training allowances of up to thirty dollars per week provided through the tribal work experience program, community work experience program, job assistance program, or job search. Funds in excess of thirty dollars per week are treated as unearned income;

14. Income tax refunds and earned income credits;

15. Needs-based payments, support services, and relocation expenses provided through the Job Training Partnership Act;

16. Income derived from submarginal lands, conveyed to Indian tribes and held in trust by the United States, as required by Pub. L. 94-114;

17. Income earned by an eligible child, including income received through volunteers in service to America and Job Training Partnership Act; provided that, the child is a full-time student or a part-time student who is not employed one hundred hours or more per month. A child retains status as a student during summer vacation if the child intends to return to school in the fall;

18. Payments from the family subsidy program, except payments which are made to reimburse the cost of medical services furnished by medicaid;

19. The first fifty dollars per month of current child support received on behalf of children in the medicaid unit;

20. Interest earned on checking accounts;

21. Payments made to recipients under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 [Pub. L. 91-646];

22. Tax-exempt portions of payments made as a result of the Alaska Native Claims Settlement Act [Pub. L. 92-203];

23. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act [Pub. L. 100-383];

24. Agent orange payments;

25. A loan for any source that is subject to a written agreement requiring repayment by the recipient;

26. Supplemental medical insurance benefit, the medicare part B premium refunded by Social Security Administration;

27. Crime Victims Reparation Act payments;

28. Lump-sum supplemental security income benefits in the month in which the benefit is received;

29. Income used to determine an aid to families with dependent children benefit;

30. German reparation payments made to survivors of the holocaust, and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

31. For so long as 38 U.S.C. 3203(f) remains effective, forty-five dollars of veterans administration improved pensions paid to a veteran who has neither spouse nor child and who resides in a medicaid-approved nursing facility;

32. Supplemental security income lump-sum payments, which are disregarded in the month received and treated as assets thereafter; and

33. Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 [Pub. L. 93-288] or some other federal statute, because of a presidentially declared major disaster, and interest earned on that assistance.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-37. Unearned income.

1. Gross income includes unearned income which is received in a fixed amount each month, and unearned income received in a lump-sum.

2. Recurring unearned lump-sum payments are prorated over the number of months the payment is intended to cover.

3. All nonrecurring unearned lump-sum payments, except supplemental security income, veterans administration aid and attendance, veterans administration reimbursements for unusual medical expenses, and major disaster relief payments must be considered as income in the month received and assets thereafter.

   a. Supplemental security income lump-sum payments must be disregarded as income in the month received and treated as assets thereafter;

b. Veterans administration aid and attendance benefits must be considered as payments received in the months the benefit was intended to cover and must be applied to the medical expense incurred in such months;

c. Veterans administration reimbursements for unusual medical expenses must be considered as payments received in the months in which the increased medical expense occurred and must be applied to the medical expense incurred in such months; and

d. Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 [Pub. L. 93-288] or some other federal statute, because of a presidentially declared major disaster, and interest earned on that assistance treated as an asset.

4. Interest and dividend income paid directly to the applicant or recipient is income in the month received. Interest accrued but not paid is an asset.

5. One-twelfth of the annual amount of lease payments deposited in individual Indian moneys accounts by the bureau of Indian affairs is income in each month and may be determined:

a. By totaling all payments in the most recent full calendar year and dividing by twelve;

b. By totaling all payments in the twelve-month period ending with the previous month and dividing by twelve; or

c. If the applicant or recipient demonstrates, by furnishing lease documents or reports, that the deposit amount will be substantially different than the annual amount which would be determined under subdivision a or b, by totaling all payments likely to be made in the twelve-month period beginning with the month in which the lease arrangement changed and dividing by twelve.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-38. Earned income.

1. Net earned income is determined by adding monthly net income from self-employment to other monthly earned income and subtracting the applicable deductions.

2. "Monthly net income from self-employment" means:

a. In the case of self-employed persons whose business does not require the purchase of goods for sale or resale, seventy-five percent of gross monthly earnings from self-employment.

b. In the case of self-employed persons whose business requires the purchase of goods for sale or resale, seventy-five percent of the result determined by subtracting cost of goods purchased from gross receipts, determined monthly.

c. In the case of a business which furnishes room and board, monthly gross receipts less one hundred dollars per room and board client.

d. In the case of self-employed persons in a service business which requires the purchase of goods or parts for repair or replacement, twenty-five percent of gross monthly earnings from self-employment.

e. In the case of self-employed persons who receive income other than monthly, the amount determined under paragraph 1 is the monthly net income from self-employment unless any of the circumstances described in paragraph 2 are demonstrated.

(1) Twenty-five percent of gross annual income, plus the gain or minus the loss resulting from the sale of capital items, plus ordinary gains or minus ordinary losses, divided by twelve; or

(2) If the most recent available federal income tax return reports income for a fiscal year which ended more than eighteen months before the month for which eligibility is being determined, if the business has been terminated or subject to severe reversal, if the applicant or recipient makes a convincing showing that actual net income is substantially less than net income as determined under paragraph 1, or if the county agency determines for any reason that actual net profits are substantially greater than annual net income as determined under paragraph 1, an amount determined by the county agency to represent the best estimate of annual net income for the calendar year within which the eligibility month occurs, divided by twelve, is the monthly net income from self-employment.

3. If earnings from more than one month are received in a lump-sum payment, the payment must be divided by the number of months in which the income was earned, and the resulting monthly amounts are attributed to each of the months with respect to which the earnings were received.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-39. Income deductions.

1. The deductions described in this subsection must be allowed on either earned income or unearned income.

   a. The cost of premiums for health insurance carried by an individual or family. This cost may be deducted from income in the month the premium is incurred or may be prorated over the months for which the premium affords coverage. If the individual or family carries health insurance policies with duplicate coverage, the individual may choose the policy for which the premium is deducted. This deduction may not be made in determining qualified medicare beneficiary and qualified disabled and working individual eligibility. For purposes of this deduction, premiums for health insurance include payments made for insurance, health care plans, or nonprofit health service plan contracts which provide benefits for hospital, surgical, and medical care, but do not include payments made for coverage which is:

      (1) Limited to disability or income protection coverage;

      (2) Automobile medical payment coverage;

      (3) Supplemental to liability insurance;

      (4) Designed solely to provide payments on a per diem basis, daily indemnity, or nonexpense-incurred basis; or

      (5) Credit accident and health insurance.

   b. Medical expenses incurred and claimed by ineligible members of the medicaid unit. Each expense claimed for deduction must be documented by the applicant or recipient in a manner which describes the service, the date of the service, the amount of cost incurred, the amount of the cost remaining unpaid, the amount of the cost previously applied in determining medicaid benefits for any medicaid recipient, and the name of the service provider. This deduction may not be made in determining qualified

medicare beneficiary and qualified disabled and working individual eligibility.

c. Court-ordered child and spousal support payments actually paid by a member of the medicaid unit on behalf of a person who is not a member of the medicaid unit.

d. The cost of premiums for a nursing insurance policy carried by an individual or the individual's spouse. This cost may be deducted from income in the month the premium is paid or may be prorated over the months for which the premium affords coverage. If the individual or family carries nursing insurance policies with duplicate coverage, the individual may choose the policy for which the premium is deducted. This deduction may not be made in determining qualified medicare beneficiary and qualified disabled and working individual eligibility.

e. Reasonable child care expenses necessary to engage in employment or training.

f. With respect to each individual in the medicaid unit who is employed or in training, but who is not aged, blind, disabled, or a child, thirty dollars as a work or training allowance.

g. Transportation expenses necessary to secure medical care provided for a member of the medicaid unit.

h. The cost of remedial care for an individual residing in a specialized facility. This deduction is limited to the difference between the facility rate and the regular medically needy income level. This deduction may not be made in determining qualified medicare beneficiary and qualified disabled and working individual eligibility.

i. For all aged, blind, and disabled applicants or recipients other than those residing in a nursing facility, the state hospital, or the Anne Carlsen school-hospital, twenty dollars, provided that when more than one aged, blind, or disabled persons live together, no more than a total of twenty dollars may be deducted.

2. The deductions described in this subsection may be allowed only on earned income.

a. For all applicants or recipients except for aged, blind, or disabled applicants or recipients, mandatory payroll deductions and union dues actually paid or withheld, or ninety dollars, whichever is greater;

b. Mandatory retirement plan deductions;

c. Expenses of a blind person, reasonably attributable to earning income, if the blind person is:

(1) Under age sixty-five; or

(2) Age sixty-five or older, who received supplemental security income payments due to blindness for the month before the person attained age sixty-five;

d. Expenses for items or services which are directly related to enabling an impaired person to work and which are necessarily incurred by that person because of a physical or mental impairment, in any month in which the individual meets all supplemental security income nonincome criteria and meets the supplemental security income test; and in any continuous subsequent month in which the person meets all supplemental security income nonincome criteria and meets the supplemental security income test after deductions made under this subdivision.

e. For all aged, blind, or disabled applicants or recipients other than those residing in a nursing facility, the state hospital or the Anne Carlsen school-hospital, sixty-five dollars plus one-half of the remaining monthly gross earned income; provided that, when more than one aged, blind, or disabled person lives together, no more than sixty-five dollars, plus one-half of the remaining combined earned income, may be deducted; and

f. For all aged, blind, or disabled applicants or recipients residing in a nursing facility, the state hospital, or the Anne Carlsen school-hospital, mandatory payroll deductions actually withheld.

3. A deduction of actual payments made for services of a guardian or conservator may be made, up to a maximum deduction equal to the greater of:

a. Five percent of gross monthly income from benefit programs (i.e., supplemental security income, social security administration, veterans benefits and railroad retirement), but excluding lump-sum payments of such benefits; or

b. An amount specifically approved as a reasonable fee in an order of a court with jurisdiction over the guardianship or conservatorship.

4. For purposes of this section:

a. "Full-time student" means a person who attends school on a schedule equal to a full curriculum.

b. "Student" means a child under the age of twenty-one years who regularly attends and makes satisfactory progress in a course of elementary or secondary school, college, university, or vocational training.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-40. Income levels.

1. Levels of income for maintenance, in total dollar amounts, will be used as a basis for establishing financial eligibility for medicaid. The income levels applicable to individuals and units are:

   a. Categorically needy income levels.

      (1) Categorically needy aid to families with dependent children recipients - The income level which establishes aid to families with dependent children eligibility. Eligibility for medicaid exists as a result of aid to families with dependent children eligibility.

      (2) Categorically needy aged, blind, and disabled recipients - The income level which establishes supplemental security income eligibility.

   b. Medically needy income levels.

      (1) Regular income levels. Regular income levels are applied when a medicaid individual or unit resides in their own home or in a specialized facility, and when a medicaid individual has been screened as requiring nursing facility care, but elects to receive home and community based services. The family size is increased for each unborn when determining the appropriate family size.

Number of Persons	Income Level Monthly	Yearly
1	$345	$4140
2	400	4800
3	435	5220
4	530	6360
5	600	7200
6	665	7980
7	705	8460

8	740	8880
9	770	9240
10	795	9540

For each person in the medicaid unit above ten, add twenty-one dollars to the monthly amount and two hundred and fifty-two dollars to the yearly amount.

(2) Nursing home income level. The nursing home income level must be applied to residents receiving care in nursing facilities, swing bed hospital facilities, intermediate care facilities for the developmentally disabled, the state hospital, and the Anne Carlsen school-hospital. This income level is forty-five dollars monthly and five hundred and forty dollars yearly. This income level is effective for all full calendar months of nursing care for single individuals and for individuals with eligible family members at home. For institutionalized individuals with an ineligible community spouse, this income level is effective in the month of entry, during full calendar months, and in the month of discharge.

(3) Community spouse income level. The community spouse income level for a community spouse who is eligible for medicaid is subject to subdivision a, paragraph 1 of subdivision b, or subdivision c. The level for an ineligible community spouse is the maximum amount permitted under 41 U.S.C. 1396 r-5(d)(3)(C), as adjusted pursuant to 42 U.S.C. 1396r-5(g), plus an amount, for each additional family member living with the community spouse, equal to one-third of an amount determined in accordance with 42 U.S.C. 1396r-5(d)(3)(A)(i), less the monthly income of that family member.

c. Poverty income level.

(1) Pregnant women and children under age six. The income level is equal to one hundred and thirty-three percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved. The family size is increased for each unborn when determining the appropriate family size.

(2) Qualified medicare beneficiaries. Income levels will be applied to individuals or family members living together whose family includes a member who is aged, blind, or disabled and who is entitled to part A benefit under medicare. These income levels apply regardless of living arrangements. Individuals

living apart from other family members are allowed separate income levels. The income level is equal to one hundred percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to the family of the size involved.

(3) Children born after September 30, 1983. The income level is equal to one hundred percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved, with respect to individuals and families including individuals born after September 30, 1983, who have attained at least the age of six years. The family size is increased for each unborn when determining the appropriate family size.

(4) Extended medicaid benefits. The income level is equal to one hundred and eighty-five percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved.

(5) Qualified disabled and working individuals. Income levels will be applied to individuals or family members living together whose family includes a member who is disabled and who is entitled to part A benefits under medicare. The income levels apply regardless of living arrangements. Individuals living apart from other family members are allowed separate income levels. The income level is equal to two hundred percent of the official poverty line, as defined by the United States office of management and budget, and as revised annually in accordance with 42 U.S.C. 9902(2), applicable to the family of the size involved.

2. There shall be a flexible measurement of available income which will be applied in the following order:

a. Reasonable work-related expenses for producing any earned income as determined by the department;

b. Payments made for necessary health insurance coverage;

c. Appropriate income deductions and disregards as determined by the department;

d. For maintenance, so that any income in an amount at or below the established income level will be protected for maintenance; and

e. Payments made for noncovered necessary medical and remedial care prescribed or ordered by a medical practitioner acting within the scope of practice permitted under state law.

3. All the remaining income will be applied to costs of medical care included in the state plan.

4. Determining the appropriate income level in special circumstances.

a. A child who is temporarily living out of the home of the child's parents, for the purpose of attending school, is not treated as living independently, but is allowed the regular income level for a family of one in addition to the income level applicable for the family unit remaining at home.

b. During a month in which an individual with an eligible community spouse at home enters a nursing facility or leaves a nursing facility to return home, a month in which an individual enters a specialized facility or leaves a specialized facility to return home, or a month in which an individual elects to receive home and community-based services or terminates that election, the individual will be included in a family unit which also includes persons remaining at home for the purpose of determining the family size and the application of the appropriate medically needy income level.

c. In the case of an individual without family members remaining at home, whose physician certifies that the individual is likely to return home within six months after entry into a nursing facility, a medically needy income level for a family of one is allowed for the first six calendar months that the individual remains in the nursing facility, or until the physician determines that the individual is no longer likely to return home within six months after entry into the nursing facility, whichever occurs first.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

75-02-02.1-41. Deeming of income. Except as otherwise provided in this section, one hundred percent of the income of the ineligible medicaid unit in the home which exceeds the appropriate medicaid income

level will be deemed to be available to all individuals residing in the home. "Individuals residing in the home" include individuals who are physically present, individuals who are temporarily absent, individuals attending educational facilities, individuals receiving acute medical care, and individuals receiving service in a specialized facility. Only twenty-five percent of the income of that ineligible medicaid unit which exceeds the appropriate medicaid income level will be deemed available to an eligible individual receiving services in a specialized facility. None of the income of the medicaid unit in the home will be deemed available to an eligible individual who resides, or is treated as residing, outside of the home of the medicaid unit on other than a temporary basis; or to an eligible child under the age of twenty-one who is living independently. Individuals who reside in a facility which provides nursing care services to them are residing outside the home on other than a temporary basis. Individuals receiving home and community-based services are treated as residing outside the home on other than a temporary basis.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-02.1-42. Eligibility under 1972 state plan. No individual may be determined to be ineligible for medicaid for any month if, had the approved state plan for medical assistance in effect on January 1, 1972, been in effect in such month, that individual would be eligible. The following income and resource standards were a part of the approved state plan in effect on January 1, 1972, and may not be exceeded by any individual who claims eligibility under this section:

1. The income level for a family of one is one hundred fifty dollars per month. The income level for a family of two is two hundred dollars per month. The income level for a family of three is two hundred fifty dollars per month. The income level for a family of four is three hundred dollars per month. The income level for a family of five is three hundred forty-two dollars per month. The income level for a family of six is three hundred eighty-four dollars per month. The income level for a family of seven is four hundred twenty-five dollars per month. An additional thirty-four dollars per month will be added for each family member beyond seven to establish the income level for families with more than seven members. The income level for a person residing in a long-term care facility is eight dollars per month.

2. The home occupied by the medicaid unit will be exempted in determining medicaid eligibility.

3. Real property other than the home may not exceed an equity of two thousand five hundred dollars, except that real property which is essential to earning a livelihood shall be exempt from the limitation, if the liquidation of such assets would

cause undue hardship. Liquidation of income-producing real property, which would result in reducing annual income below the established income levels, would be considered undue hardship. If undue hardship is not a consideration, equity in excess of the two thousand five hundred dollars would be considered available for meeting medical costs, providing the property is saleable. The person would have the option of liquidating the excess property or borrowing funds on it.

4. For the purposes of subsections 5, 6, and 7, personal property includes cash, savings, redeemable stocks and bonds, vehicles, machinery, or livestock, but does not include personal effects, wearing apparel, household goods, furniture, or trailer homes being used for living quarters. Cash surrender value of life insurance policies will be considered personal property, but will not be considered cash.

5. Personal property may not exceed an equity of two thousand five hundred dollars except that such property which is essential to the earning of a livelihood shall be exempt from the limitation if the liquidation of such excess assets would cause undue hardship. Liquidation of income-producing personal property which would result in reducing annual income below the established income levels would be considered undue hardship. If undue hardship is not found to be a consideration, equity in excess of the two thousand five hundred dollars would be considered available for meeting medical costs providing the property is saleable. The person would have the option of liquidating the excess property or borrowing funds on it.

6. In all instances, real and personal property must be realistically evaluated in accord with current market value and, in considering net equity, any possible costs which may be associated with liquidation of the excess property must be taken into account.

7. With respect to cash, savings, redeemable stocks and bonds, and other liquid assets, the following levels will be applicable to families of various sizes:

   a. Three hundred fifty dollars for one person;

   b. Seven hundred dollars for two persons;

   c. Fifty dollars for each family member through ten; and

d. Twenty-five dollars for each additional family member. These amounts will not be considered as being available for medical expenses.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-16, 50-24.1-04
Law Implemented: NDCC 50-24.1-02

AGENCY SYNOPSIS: Regarding new North Dakota Administrative Code chapter 75-03-20 Ratesetting for Residential Treatment Centers for Children.

The establishment rate for residential treatment centers for children is based on prospective ratesetting procedures. The established rate begins with a historical cost. Adjustments are then made for claimed costs which are not includable in allowable costs. Adjustment factors are then applied to allowable costs. Allowable costs of administration for maintenance and rehabilitation rates are the lesser of actual costs of administration or 15% of allowable costs. No retroactive settlement for actual costs incurred during the rate year which exceed the final rate will be made unless provided for in the rules. Provision is made for resolution of disputes concerning the final rate. There are detailed reporting requirements which identify those costs which are properly included in the rate. The proposed rates also require specific classifications of costs and provide direction for the allocation of costs within the classifications.

STAFF COMMENT: Chapter 75-03-20 contains all new material but is not underscored so as to improve readability.

CHAPTER 75-03-20
RATESETTING FOR RESIDENTIAL
TREATMENT CENTERS FOR CHILDREN

75-03-20-01. Definitions.

1. "Accrual basis" means the recording of revenue in the period when it is earned, regardless of when it is collected, and the recording of expenses in the period when incurred, regardless of when they are paid.

2. "Addiction evaluation" means an assessment by an addiction counselor to determine the nature or extent of possible alcohol abuse, drug abuse, or chemical dependency.

3. "Adjustment factors" means indices used to adjust reported costs for inflation or deflation based on economic forecasts for the rate year.

4. "Administration" means the cost of activities performed by the center staff in which the direct recipient of the activity is the organization itself. These include, but are not limited to, fiscal activities, statistical reporting, recruiting, and general office management which are indirectly related to reimbursable services provided.

5. "Allowable cost" means the center's actual and reasonable cost after adjustments required by department rules.

6. "Case management" means services which may assist individuals to gain access to needed medical, social, educational, and other services. Case management includes case-related paper work, contacts with significant others and agencies, phone contacts, case-related travel, and consultation with other staff, supervisors, and peers.

7. "Center" means the residential treatment center for children.

8. "Client day" means a day for which service is provided or for which payment is ordinarily sought and includes in-house, trial placement, approved leave, or hospital days.

9. "Clinical consultation" means services provided by psychiatrists, clinical psychologist, psychiatric nurses, social workers, addiction counselors, occupational therapists, and other mental health professionals to center staff to develop or increase their skills in providing mental health services.

10. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting and the determination of cost limitations and rates. For the purposes of this chapter, the cost categories of administration, education, maintenance, and rehabilitation will be used.

11. "Cost report" means the department-approved form for reporting costs, statistical data, and other relevant information to the department.

12. "Department" means the department of human services.

13. "Depreciation" means an allocation of the cost of an asset over its estimated useful life.

14. "Education" means the cost of activities related to academic and vocational training generally provided by a school district.

15. "Family counseling or therapy" means treatment in which a counselor or a therapist works with various combinations of family members.

16. "Final rate" means the rate established after any adjustments by the department, including, but not limited to, adjustments resulting from cost report reviews and audits.

17. "Fringe benefits" means workers compensation insurance, group health, dental or vision insurance, group life insurance, payment towards retirement plans, accrued compensation for absences, uniform allowances, employer's share of Federal Insurance Contributions Act and unemployment compensation taxes.

18. "Group counseling" or "group therapy" means a form of treatment in which a group of clients, with similar problems, meet with a counselor or a therapist to discuss difficulties, provide support for each other, gain insight into problems, and develop better methods of meeting their problems.

19. "Individual counseling" or individual therapy" means a form of treatment in which a counselor or therapist works with a client on an individual basis.

20 "Interest" means cost incurred for the use of borrowed funds.

21. "Maintenance" means room and board and includes all costs associated with the preparation and serving of food, the provision of shelter and the maintenance thereof, including depreciation and interest or lease payments, and operating expenses of a vehicle used for transportation of clients.

22. "Medication review" means prescription monitoring and consultation to a client regarding the client's use of medication performed by a psychiatrist or a physician, or a registered nurse or a licensed practical nurse under the medical direction and supervision of a psychiatrist or physician.

23. "Other clinical evaluation" means the evaluation of the client's environmental and personal situation. This includes, but is not limited to, developmental, social, and independent living evaluations.

24. "Partial care" means center or community-based rehabilitative services provided to mentally ill persons to maintain and promote social, emotional, and physical well-being through opportunities for socialization, therapy, work participation, education, and other self-enhancement activities.

25. "Plant operations costs" means the costs for repairing and maintaining the physical plant of the center. These costs include utilities, repairs, and compensation for housekeepers, janitors, engineers, caretakers, and all personnel performing tasks related to repairing and maintaining the physical plant.

26. "Program consultation" means services provided to center staff for development of program design and planning for mental health services to the center.

27. "Property costs" means depreciation, interest on capital debt, property taxes, and rental expense.

28. "Psychiatric evaluation" means the assessment or evaluation of a client by a psychiatrist.

29. "Psychological evaluation" means the assessment or evaluation of a client by or under the supervision of a licensed psychologist.

30. "Rate year" means the twelve-month period beginning the seventh month after the end of a center's fiscal year.

31. "Reasonable cost" means the cost that must be incurred by an efficiently and economically operated center to provide services in conformity with applicable state and federal laws, rules, and quality and safety standards. Reasonable cost takes into account that the center seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or services.

32. "Rehabilitation" means services provided for maximum reduction of physical or mental disability and restoration of a client to the best possible functional level. Services can include any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of the practitioner's practice under state law.

33. "Related organization" means an organization which a center is, to a significant extent, associated with, affiliated with, able to control, or controlled by; and which furnishes services, facilities, or supplies to the center. Control

exists where an individual or organization has the power, directly or indirectly, to significantly influence or direct the policies of an organization or center.

34. "Report year" means the center's fiscal year.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-02. Financial reporting requirements.

1. Records.

   a. The center will maintain on the premises census records and financial information which will be sufficient to provide for a proper audit or review. For any cost being claimed on the cost report, sufficient data must be available as of the audit date to fully support the report item.

   b. Where several centers are associated with a group and their accounting and reports are centrally prepared, added information must be submitted for those items known to be lacking support at the reporting center prior to the audit or review of the center. Accounting or financial information regarding related organizations must be readily available to substantiate cost.

   c. Each center shall maintain, for a period of not less than five years following the date of submission of the cost report to the state agency, financial and statistical records of the period covered by such cost report which are accurate and in sufficient detail to substantiate the cost data reported. Each center shall make such records available upon reasonable demand to representatives of the department.

2. Accounting and reporting requirements.

   a. The accrual basis of accounting, in accordance with generally accepted accounting principles, must be used for cost reporting purposes. However, if conflicts occur between ratesetting procedures and generally accepted accounting principles, ratesetting procedures will prevail. A center may maintain its accounting records on a cash basis during the year, but adjustments must be made to reflect proper accrual accounting procedures at yearend and when subsequently reported.

   b. To properly facilitate auditing, the accounting system should be maintained in such a manner that cost accounts

will be grouped by cost category and be readily traceable to the cost report.

c. The cost report must be submitted on or before the last day of the third month following the center's report year. The report must contain all actual costs of the provider, adjustments for nonallowable costs, and client days.

d. Upon request, the following information must be made available.

(1) A statement of ownership including the name, address, and proportion of ownership of each owner.

(2) Copies of leases, purchase agreements, appraisals, financing arrangements, and other documents related to the lease or purchase of the center or a certification that the content of any such document remains unchanged since the most recent statement given pursuant to this subsection.

(3) Supplemental information reconciling the costs on the financial statements with costs on the cost report.

(4) Copies of leases, purchase agreements, and other documents related to the acquisition of equipment, goods, and services which are claimed as allowable costs.

e. If the center fails to file the cost report on or before the due date, the department may impose a nonrefundable penalty of ten percent of any amount claimed for reimbursement. The penalty may be imposed after the last day of the first month following the due date and continues through the month in which the statement or report is received.

f. The center will make all adjustments and allocations necessary to arrive at allowable costs. The department may reject any cost report when the information which has been filed is incomplete or inaccurate. In the event that a cost report is rejected, the department may impose the penalties described in subdivision e.

g. The department may grant an extension of the reporting deadline to a center. To receive such an extension, a center must submit a written request to the division of mental health services.

3. The department will perform an audit of the latest available report year of each center at least once every six years and retain for at least three years all audit-related documents, including cost reports, working papers, and internal reports

on rate calculations which are utilized and generated by audit staff in performance of audits and in establishing rates. Audits will meet generally accepted governmental auditing standards.

4. Penalties for false reports.

   a. A false report is one wherein a center knowingly supplies inaccurate or false information in a required report that results in an overpayment. If a false report is received, the department may:

      (1) Immediately adjust the center's payment rate to recover the entire overpayment within the rate year;

      (2) Terminate the department's agreement with the center;

      (3) Prosecute under applicable state or federal law; or

      (4) Use any combination of the foregoing actions.

   b. If a center claims as an allowable cost costs which have been previously adjusted, the department may determine that the report is a false report. Previously adjusted costs which are being appealed must be identified as unallowable costs. The center may indicate that the costs are under appeal and not claimed under protest to perfect a claim should the appeal be successful.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2, 25-03.2-08(3)

75-03-20-03. General cost principles.

1. For ratesetting purposes, a cost must:

   a. Be ordinary, necessary, and related to client care;

   b. Be no more than an amount which a prudent and cost-conscious business person would pay for the specific good or service in the open market in an arm's length transaction; and

   c. Be for goods or services actually provided in the center.

2. The cost effects of transactions which circumvent these rules are not allowable under the principle that the substance of the transaction prevails over the form.

3. Reasonable client-related costs will be determined in accordance with the ratesetting procedures set forth in this chapter and instructions issued by the department.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-04. Ratesetting.

1. The established rate is based on prospective ratesetting procedures. The establishment of a rate begins with historical costs. Adjustments are then made for claimed costs which are not includable in allowable costs. Adjustment factors are then applied to allowable costs. No retroactive settlements for actual costs incurred during the rate year which exceed the final rate will be made unless specifically provided for in this chapter.

2. Desk audit rate.

   a. The department will establish desk rates for maintenance and rehabilitation, based on the cost report, which will be effective the first day of the seventh month following the center's fiscal yearend.

   b. The desk rates will continue in effect until final rates are established.

   c. The cost report will be reviewed taking into consideration the prior year's adjustments. Centers will be notified by telephone or mail of any desk adjustments based on the desk review. Within seven working days after notification, the center may submit information to explain why a desk adjustment should not be made. The department will review the submitted information, make appropriate adjustments, including adjustment factors, and issue the desk rates.

   d. No reconsideration will be given by the department for the desk rates unless the center has been notified that the desk rates are the final rates.

3. Final rate.

   a. The cost report may be field audited to establish final rates. If no field audit is performed, the desk rates will become the final rates upon notification to the center from the department.

b. The final rate for rehabilitation will be effective beginning the first day of the seventh month following the center's fiscal yearend.

c. The final rate for maintenance will be effective beginning the first day of the month in which notification of the rate is given to the center. There will be no retroactive adjustments to the beginning of the rate year for any increase or decrease in the maintenance rate.

d. The final rate will include any adjustments for nonallowable costs, errors, or omissions that result in a change from the desk rate of at least five cents per day.

e. Adjustments, errors, or omissions which are found after a final rate has been established will be included as an adjustment in the report year that the adjustments, errors, or omissions are found.

4. Special rates.

a. Centers providing services for the first time.

(1) Rates for a center which is providing services which are purchased by the department will be established using the following methodology for the first two fiscal years of the center if such period is less than twenty-four months.

(a) The center must submit a budget for the first twelve months of operation. A final rate will be established for a rate period which begins on the first of the month in which the center begins operation. This rate will remain in effect for eighteen months. No adjustment factors will be included in the first year final rate.

(b) Upon completion of the first twelve months of operation, the center must submit a cost report for the twelve-month period regardless of the fiscal yearend of the center.

[1] The twelve-month cost report is due on or before the last day of the third month following the end of the twelve-month period.

[2] The twelve-month cost report will be used to establish a rate for the remainder of the second rate year. Appropriate adjustment factors will be used to establish the rate.

(2) The center must submit a cost report which will be used to establish rates in accordance with subsections 2 and 3 after the center has been in operation for the entire twelve months of the center's fiscal year.

b. Centers changing ownership.

(1) For centers changing ownership, the rate established for the previous owner will be retained until the end of the rate year in which the change occurred.

(2) The rate for the second rate year after a change in ownership occurs will be established as follows:

(a) For a center with four or more months of operation under the new ownership during the report year, a cost report for the period since the ownership change occurred will be used to establish the rate for the next rate year.

(b) For a center with less than four months of operation under the new ownership in the reporting year, the prior report year's costs as adjusted for the previous owner will be indexed forward using appropriate adjustments.

c. Centers having a capacity increase or major renovation or construction.

(1) For centers which increase licensed capacity by twenty percent or more or have renovation or construction projects in excess of fifty thousand dollars, the rate established for the rate year in which the licensed increase occurs or the construction or renovation is complete may be adjusted to include projected property costs. The adjusted rate will be calculated based on a rate for historical costs, exclusive of property costs, as adjusted, divided by historical census, plus a rate for property costs based on projected property costs divided by projected census. The established rate for rehabilitation, including projected property costs, will be effective on the first day of the month in which the renovation or construction is complete or when the capacity increase is approved if no construction or renovation is necessary. The established rate for maintenance including projected property costs will be effective on the first of the month in which notification of the rate is given to the center.

(2) For the rate year immediately following the rate year in which the capacity increase occurred or construction and renovation was completed, a rate will be established based on historical costs, exclusive of property costs, as adjusted for the report year, divided by reported census plus a rate for property costs, based on projected property costs, divided by projected census.

d. Centers that have changes in services or staff.

(1) The department may provide for an increase in the established rate for additional costs that are necessary to add services or staff to the existing program.

(2) The center must submit information to the division of mental health services supporting the request for the increase in the rate. Information must include a detailed listing of new or additional staff or costs associated with the increase in services.

(3) The department will review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate will be adjusted. The effective date of the rate increase will be on the first of the month following approval by the department. The adjustment will not be retroactive to the beginning of the rate year.

(4) For the rate year immediately following a rate year in which a rate was adjusted under paragraph 3 of this subdivision, the center may request that consideration be given to additional costs. The center must demonstrate to the department's satisfaction that historical costs do not reflect twelve months of actual costs of the additional staff or added services in order to adjust the rate for the second rate year. The additional costs would be based on a projection of costs for the remainder of a twelve-month period.

5. The final rate must be considered as payment for all accommodations which include items identified in section 75-03-20-06. For any client whose rate is paid in whole or in part by the department, no payment may be solicited or received from the client or any other person to supplement the rate as established.

6. For a center terminating its participation in the program, whether voluntarily or involuntarily, the department may

authorize the center to receive continued payment until clients can be relocated.

7. Limitations.

   a. The department may accumulate and analyze statistics on costs incurred by the centers. These statistics may be used to establish reasonable ceiling limitations and incentives for efficiency and economy based on reasonable determination of standards of operations necessary for efficient delivery of needed services. These limitations and incentives may be established on the basis of cost of comparable centers and services and may be applied as ceilings on the overall costs of providing services or on specific areas of operations. Limitations and incentives are effective upon notification of a center by the department.

   b. Allowable administration costs to be included in the maintenance and rehabilitation rates are the lesser of the actual cost of administration as allocated to the cost category or an amount equal to fifteen percent of the allowable costs for the cost category.

8. Adjustment factors. The department will use an independent economic forecast method of predicting the adjustment factors to be used to adjust historical allowable costs. The department will use the independent economic forecaster used by the office of management and budget at the time the rate is established. Adjustment factors will be based on the forecasted increase or decrease in cost components for the eighteen-month period from the end of the report year to the end of the rate year. The following cost components will have individual adjustment factors calculated for each rate year:

   a. Salaries and fringe benefits;

   b. Food;

   c. Utilities; and

   d. Other costs exclusive of property costs.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-05. Client census.

1. A daily census record must be maintained by the center. Any day for which services are provided or payment is ordinarily sought for an available bed must be counted as a client day.

The day of admission or death will be counted. The day of discharge will be counted if payment is sought for that day.

2. The daily census records must include:

   a. Identification of the client;

   b. Entries for all days. Entries cannot be made just by exception; and

   c. Identification of type of day, i.e., in-house or hospital day.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-06. Cost categories.

1. Administration. Costs for administration include only those allowable costs for administering the overall activities of the center identified as follows:

   a. Compensation for administrators, regional directors, program directors, accounting personnel, clerical personnel, secretaries, receptionists, data processing personnel, purchasing personnel, and security personnel.

   b. Office supplies and forms.

   c. Insurance, except property insurance directly identified to other cost categories, and insurance included as a fringe benefit.

   d. The cost of telephone service not specifically included in other cost categories.

   e. Postage and freight.

   f. Professional fees for services such as legal, accounting, and data processing.

   g. Central or home office costs.

   h. Personnel recruitment costs.

   i. Management consultants and fees.

   j. Dues, license fees, and subscriptions.

   k. Travel and training not specifically included in other cost categories.

l. Utilities. The cost of heating and cooling, electricity, and water, sewer, and garbage for space used to provide administration.

m. Repairs. The cost of routine repairs and maintenance of property and equipment used to provide administration.

n. Plant and housekeeping salaries. The cost of plant operation and housekeeping salaries and fringe benefits associated with the space used to provide administration.

o. Property costs. Depreciation, interest, taxes, and lease costs on equipment and buildings for space used to provide administration.

p. Interest on funds borrowed for working capital.

q. Startup costs.

r. Any costs which cannot be specifically classified or assigned as a direct cost to other cost categories.

2. **Maintenance.** Costs for maintenance include only those allowable costs identified as follows:

a. Compensation for community home counselors when performing functions other than rehabilitation, houseparents, dietary personnel, cooks, and laundry personnel.

b. Plant and housekeeping salaries. The cost of plant operation and housekeeping salaries and fringe benefits associated with the space used to provide maintenance.

c. Food. The cost of consumable food products consumed by clients, houseparents, or community home counselors when performing functions other than rehabilitation.

d. Operating supplies. The cost of supplies necessary to maintain the household for clients. Costs include such items as cleaning supplies, paper products, and hardware goods.

e. Personal supplies. The cost of supplies used by an individual client for his or her personal needs.

f. Clothing. The cost of clothing to maintain a client's wardrobe.

g. Personal allowances. The cost of moneys given periodically to clients for personal use. The cost does not include payment, whether in cash or in kind, for work performed by the client or for bonuses or rewards based on behavior.

h. School supplies. The cost of school supplies and activity fees, when not provided by or at the expense of the school.

i. Recreation expenses. Costs incurred for providing recreation to the clients including subscriptions, sports equipment, dues for clubs, and admission fees to sporting, recreation, and social events.

j. Utilities. The cost of heating and cooling, electricity, water, sewer, and garbage, and cable television for space which would normally be included in a single-family dwelling.

k. Telephone. The cost of local telephone service to the living quarters.

l. Repairs. The cost of routine repairs and maintenance of property and equipment used for the maintenance of the clients.

m. Travel. All costs related to transporting clients exclusive of transportation costs involved with active treatment. Transportation costs may include actual expenses of center-owned vehicles or mileage paid to employees for use of personal vehicles.

n. Property costs. Depreciation, interest, taxes, and lease costs on equipment and buildings for space associated with the provision of shelter.

o. Property insurance. The cost of insuring property and equipment used in the maintenance of clients.

3. **Rehabilitation.** Costs for rehabilitation include only those allowable costs identified as follows:

a. Compensation for social workers, human relations counselors, community home counselors, clinical psychologists, psychiatrists, physicians, nurses or other individuals who provide ongoing rehabilitative services in order to reduce the mental disability of the clients and restore them to their best possible functional level. Rehabilitative services include family, group, and individual counseling or therapy, and case and program consultation.

b. The cost of services purchased and not provided at the center which include: case management; addiction, psychiatric, psychological, and other clinical evaluations; medication review; and partial care or day treatment.

c. Utilities. The cost of heating and cooling, electricity, and water, sewer, and garbage for space used to provide rehabilitation.

d. Telephone. The cost of long distance telephone service directly related to providing rehabilitation.

e. Repairs. The cost of routine repairs and maintenance of property and equipment used to provide rehabilitation.

f. Plant and housekeeping salaries. The cost of plant operation and housekeeping salaries and fringe benefits associated with the space used to provide rehabilitation.

g. Property costs. Depreciation, interest, taxes, and lease costs on equipment and buildings for space used to provide rehabilitation.

h. Property insurance. The cost of insuring property and equipment used to provide rehabilitation.

i. Travel. Costs related to transporting clients for rehabilitation. Transportation costs may include actual expenses of center-owned vehicles or mileage paid to employees for use of personal vehicles.

j. Training. The cost of training which is necessary to maintain licensure, certification, or professional standards for rehabilitation personnel and the related travel costs.

4. **Education.** Costs for education include only those allowable costs identified as follows:

a. Compensation for teachers and teacher aides who provide academic training to clients in-house.

b. Property and plant operation expenses for space used to provide in-house academic training to clients.

c. The cost of supplies and equipment used in a classroom that are normally provided by a school district as part of the academic training.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-07. Cost allocation.

1. Direct costing of allowable costs will be used whenever possible. If direct costing is not possible and the center

has more than one license or has services which are jointly used for administration, education, maintenance, rehabilitation, or nonclient activities, the following allocation methods will be used:

a. Salaries which cannot be reported based on direct costs are to be allocated using time studies. Time studies must be conducted at least semiannually for a two-week period or quarterly for a one-week period. The time study must represent a typical period of time when employees are performing normal work activities in each of their assigned areas of responsibility. Allocation percentages based on the time studies are to be used starting with the next pay period following completion of the time study or averaged for the report year. The methodology used by the center may not be changed without approval by the department.

b. Salaries of direct care supervisory personnel may be allocated based on full-time equivalents of the employees supervised or on a ratio of salaries.

c. Fringe benefits must be allocated based on the ratio of salaries to total salaries.

d. Plant operation expenses must be allocated based on square footage.

e. Property costs must be allocated based on square footage.

f. Administration cost must be allocated on the basis of the percentage of total costs, excluding administration and property costs, in each cost center.

g. Dietary costs and food must be allocated based on meals served.

h. Vehicle expenses must be allocated based on mileage logs. Mileage logs must include documentation for all miles driven and purpose of travel. If sufficient documentation is not available to determine which cost category vehicle expenses are to be allocated to, vehicle expenses will be allocated in total to administration.

i. Costs not direct costed or allocable using methods identified in subdivisions a through h must be included as administration costs.

2. If any of the above allocation methods cannot be used by the center, a waiver request may be submitted to the division of mental health services. The request must include an adequate explanation as to why the referenced allocation method cannot be used by the center. The center must also provide a

rationale for the proposed allocation method. Based on the information provided, the department will determine the allocation method that will be used to report costs.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-08. Nonallowable costs. Nonallowable costs include, but are not limited to:

1. Promotional, publicity, and advertising expenses, exclusive of personnel procurement;
2. Political contributions;
3. Salaries or expenses of a lobbyist;
4. Basic research;
5. Fines or penalties including interest charges on the penalty, bank overdraft charges, and late payment charges;
6. Bad debts;
7. Compensation and expenses for officers, directors, or stockholders;
8. Contributions or charitable donations;
9. Costs incurred for activities directly related to influencing employees with respect to unionization;
10. Costs of membership or participation in health, fraternal, or social organizations such as eagles, country clubs, knights of columbus;
11. Corporate costs such as organization costs, reorganization costs, costs associated with acquisition of capital stock, costs relating to the issuance and sale of capital stock or other securities, and other costs not related to client services;
12. Home office costs which would be unallowable if incurred directly by the center;
13. Stockholder servicing costs incurred primarily for the benefit of stockholders or other investors. Such costs include, but are not limited to, annual meetings, annual reports and newsletters, accounting and legal fees for consolidating statements, stock transfer agent fees, and stockbroker and investment analysis;

14. The cost of any equipment, whether owned or leased, not exclusively used by the center except to the extent that the center demonstrates to the satisfaction of the department that any particular use of equipment was related to client care;

15. Costs, including by way of illustration and not by way of limitation, for legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, attributed to the negotiation or settlement of the sale or purchase of any capital assets, whether by sale or merger, when the cost of the asset has been previously reported and included in the rate paid to any center;

16. Depreciation expense for center assets which are not related to client care;

17. Personal expenses of owners and employees for items or activities including, but not limited to, vacations, boats, airplanes, personal travel or vehicles, and entertainment;

18. Costs which are not adequately documented. Adequate documentation includes written documentation, date of purchase, vendor name, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or centers;

19. The following taxes, when levied on providers:

    a. Federal income and excess profit taxes, including any interest or penalties paid thereon;

    b. State or local income and excess profit taxes;

    c. Taxes in connection with financing, refinancing, or refunding operations such as taxes in the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense;

    d. Taxes such as real estate and sales tax for which exemptions are available to the center;

    e. Taxes on property which is not used in the provision of covered services; and

    f. Taxes such as sales taxes, levied, collected, and remitted by the center;

20. The unvested portion of a center's accrual for sick or annual leave;

21. Expense or liabilities established through or under threat of litigation against the state of North Dakota or any of its agencies; provided, that reasonable insurance expense may not be limited by this subsection;

22. Fringe benefits, exclusive of the Federal Insurance Contributions Act, unemployment compensation, health, dental and vision insurance, life insurance, workers compensation insurance, payments toward retirement plans, accrued compensation for absences, and uniform allowances which have not received written prior approval of the department;

23. Fundraising costs including salaries, advertising, promotional, or publicity costs incurred for such a purpose;

24. Funeral and cemetery expenses;

25. Travel not directly related to professional conferences, state or federally sponsored activities, or client services;

26. Items or services such as telephone, television, and radio which are located in a client's room and which are furnished solely for the convenience of the clients;

27. Value of donated goods and services except as provided for in subsection 5 of section 75-03-20-09;

28. Religious salaries, space, and supplies;

29. Miscellaneous expenses not related to client services;

30. Premiums for top management personnel life insurance policies, except that such premiums shall be allowed if the policy is included within a group policy provided for all employees, or if such a policy is required as a condition of a mortgage or loan and the mortgagee or lending institution is listed as the beneficiary;

31. Travel costs involving the use of vehicles not exclusively used by the center are allowable only within the limits of this subsection:

    a. Vehicle travel costs may not exceed the amount established by the internal revenue service.

    b. The center must support vehicle costs related to client care with sufficient documentation. Documentation includes mileage logs for all miles, purpose of travel, and receipts for purchases.

    c. The center must document all costs associated with a vehicle not exclusively used by the center;

32. Vehicle and aircraft costs not directly related to center business or client services;

33. Nonclient-related operations and the associated administrative costs;

34. Costs related to income-producing activities regardless of the profitability of the activity;

35. Costs which are incurred by the center's subcontractors or by the lessor of property which the center leases, and which become an element in the subcontractor's or lessor's charge to the center, if such costs would not have been allowable had they been incurred by a center directly furnishing the subcontracted services or owning the leased property;

36. All costs for services paid directly by the department to an outside provider;

37. Depreciation on assets acquired with federal or state grants;

38. Costs that are incurred due to management inefficiency, unnecessary care or services, agreements not to compete, or activities not commonly accepted in the industry;

39. The cost of consumable food products, in excess of income from employees, guests, and nonclients offset in accordance with section 75-03-20-16.1, consumed by persons other than clients or maintenance personnel identified in subdivision c of subsection 2 of section 75-03-20-06; and

40. Payments to clients, whether in cash or in kind, for work performed or for bonuses or rewards based on behavior.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-09. Depreciation.

1. Ratesetting principles require that payment for services should include depreciation on all depreciable type assets that are used to provide necessary services. This includes assets that may have been fully or partially depreciated on the books of the center, but are in use at the time the center enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on the revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity. If any depreciated personal property asset is sold or disposed of for an amount different than its undepreciated value, the difference

represents an incorrect allocation of the cost of the asset to the center and must be included as a gain or loss on the cost report.

2. Depreciation methods.

   a. The straight-line method of depreciation must be used. All accelerated methods of depreciation including depreciation options made available for income tax purposes, such as those offered under the asset depreciation range system, are unacceptable. The method and procedure for computing depreciation must be applied on a basis consistent from year to year, and detailed schedules of individual assets must be maintained. If the books of account reflect depreciation different than that submitted on the cost report, a reconciliation must be prepared by the center.

   b. Centers must use a composite useful life of ten years for all equipment and land improvements, and four years for vehicles. Buildings and improvements to buildings are to be depreciated over the length of the mortgage or a minimum of twenty-five years, whichever is greater.

3. Acquisitions.

   a. If a depreciable asset has at the time of its acquisition historical cost of at least one thousand dollars for each item, its cost must be capitalized and depreciated over the estimated useful life of the asset except as provided for in subsection 3 of section 75-03-20-11. Costs, such as architectural, consulting and legal fees, and interest, incurred during the construction of an asset must be capitalized as a part of the cost of the asset.

   b. All repair or maintenance costs in excess of five thousand dollars per project on equipment or buildings must be capitalized and depreciated over the remaining useful life of the equipment or building or one-half of the original estimated useful life, whichever is greater.

4. Proper records must provide accountability for the fixed assets and also provide adequate means by which depreciation can be computed and established as an allowable client-related cost. Tagging of major equipment items is not mandatory, but alternate records must exist to satisfy audit verification of the existence and location of the assets.

5. For purposes of this chapter, donated assets may be recorded and depreciated based on their fair market value. In the case where the center's records do not contain the fair market value of the donated asset as of the date of the donation, an appraisal must be made. The appraisal will be made by a

recognized appraisal expert and will be accepted for depreciation purposes. The center may elect to forego depreciation on donated assets thereby negating the need for a fair market value determination.

6. Basis for depreciation.

   a. Determination of the cost basis of a center and its depreciable assets, which have not been involved in any programs which are funded in whole or in part by the department, depends on whether or not the transaction is a bona fide sale. Should the issue arise, the purchaser has the burden of proving that the transaction was a bona fide sale. Purchases where the buyer and seller are related organizations are not bona fide.

      (1) If the sale is bona fide, the cost basis will be the actual cost of the buyer.

      (2) If the sale is not bona fide, the cost basis will be the seller's cost basis less accumulated depreciation.

   b. Cost basis of a center and its depreciable assets which are purchased as an ongoing operation will be the seller's cost basis less accumulated depreciation.

   c. Cost basis of a center and its depreciable assets which have been used in any programs which are funded in whole or in part by the department will be the cost basis used by the other program less accumulated depreciation.

   d. Sale and leaseback transactions will be considered a related party transaction. The cost basis of a center and its depreciable assets purchased and subsequently leased to a provider who will operate the center will be the seller's cost basis less accumulated depreciation.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-10. Interest expense. To be allowable under the program, interest must be:

1. Supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required. Repayment of operating loans must be made within two years of the borrowing.

2. Identifiable in the center's accounting records.

3. Related to the reporting period in which the costs are incurred.

4. Necessary and proper for the operation, maintenance, or acquisition of the center. Necessary means that the interest be incurred on a loan made to satisfy a financial need of the center and for a purpose reasonable related to client care. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in an arm's-length transaction. In addition, the interest must be paid to a lender not related to the center through common ownership or control.

5. Unrelated to funds borrowed to finance costs of assets in excess of the depreciable cost of the asset as recognized in "depreciation".

6. In such cases where it is necessary to issue bonds for financing, any bond premium or discount will be amortized on a straight-line basis over the life of the bond issue.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-11. Taxes.

1. Taxes assessed against the center in accordance with the levying enactments of the several states and lower levels of government and for which the center is liable for payment are allowable costs except for those taxes identified as unallowable in section 75-30-20-08.

2. Whenever exemptions to taxes are legally available, the center is to take advantage of them. If the center does not take advantage of available exemptions, the expense incurred for such taxes is not recognized as an allowable cost under the program.

3. Special assessments in excess of one thousand dollars which are paid in a lump sum must be capitalized and depreciated. Special assessments not paid in a lump sum may be expensed as they are billed by the taxing authority.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-12. Home office costs.

1. Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to their member facilities. Although the home office of a chain is normally not a center in itself, it may furnish to the individual center central administration or other services such as centralized accounting, purchasing, personnel, or management services. Only the home office's actual costs of providing such services is includable in the center's allowable costs under the program.

2. Costs which are not allowed in the center will not be allowed as home office costs which are allocated to the center.

3. Any service provided by the home office which is included in costs as payments by the center to an outside vendor or which duplicates costs for services provided by the center will be considered a duplication of costs and will not be allowed.

4. Where the home office makes a loan to or borrows money from one of the components of a chain organization, the interest paid is not an allowable cost and interest income is not used to offset interest expense.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-13. Related organizations.

1. Costs applicable to services, facilities, and supplies furnished to a center by a related organization may not exceed the lower of the costs to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere primarily in the local market. Centers must identify such related organizations and costs, and allocations must be submitted with the cost report.

2. A center may lease buildings or equipment from a related organization within the meaning of ratesetting principles. In such case, rent or lease expense paid to the lessor is allowable in an amount not to exceed the actual costs associated with the asset if the rental of the buildings or equipment is necessary to provide programs and services to clients. the actual costs associated with the asset are limited to depreciation, interest, real estate taxes, property insurance, and plant operation expenses incurred by the lessor.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-14. Startup costs. In the first stages of operation, a new center incurs certain costs in developing its ability to care for clients prior to their admission. Staff is obtained and organized, and other operating costs are incurred during this time of preparation which cannot be allocated to client care during that period because there are no clients receiving services. Such costs are commonly referred to as startup costs. The startup costs are to be capitalized and will be recognized as allowable administration costs amortized over sixty consecutive months starting with the month in which the first client is admitted.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-15. Compensation.

1. Reasonable compensation for a person with a minimum of five percent ownership, persons on the governing board, or any person related within the third degree of kinship to top management personnel must be considered an allowable cost if services are actually performed and required to be performed. The amount allowed must be in an amount not to exceed the average of salaries paid to individuals in like positions in all centers which are nonprofit organizations and which have no top management personnel who have a minimum of five percent ownership or are on the governing board. Salaries used to determine the average will be based on the latest information available to the department. Reasonableness also requires that functions performed be necessary in that, had the services not been rendered, the center would have to employ another person to perform them.

2. Items which are considered compensation include, but are not limited to, the following:

   a. Salary.

   b. Amounts paid by the center for the personal benefit of the person, e.g., housing or automobile allowance.

   c. The cost of assets, services, or supplies provided by the center for the personal use of the person.

   d. Pension, retirement benefits, annuities, or deferred compensation.

   e. Insurance premiums.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-16. Revenue offsets. Centers must identify income to offset costs where applicable in order that state financial participation not supplant or duplicate other funding sources. Any income whether in cash or in any other form which is received by the center, with the exception of the established rate and income from payment made under the Job Training Partnership Act, will be offset up to the total of the appropriate actual costs. If actual costs are not identifiable, income will be offset in total to the appropriate cost category. If costs relating to income are reported in more than one cost category, the income must be offset in the ratio of the costs in each of the cost categories. These sources of income include, but are not limited to:

1. Food income. Centers receiving reimbursement for food and related costs from other programs such as the United States department of agriculture or the department of public instruction or amounts from or paid on behalf of employees, guests, or other nonclients for meals or snacks must reduce allowable food costs by the revenue received.

2. Vending income. Income from the sale of beverages, candy, or other items will be offset to the cost of the vending items or, if the cost is not identified, all vending income will be offset to maintenance costs.

3. Insurance recovery. Any amount received from insurance for a loss incurred must be offset against the appropriate cost category regardless of when the cost was incurred if the center did not adjust the basis for depreciable assets.

4. Refunds and rebates. Any refund or rebate received for a reported cost must be offset against the appropriate cost.

5. Transportation income. Any amount received for use of the center's vehicles must be offset to transportation costs.

6. Gain on the sale of assets. Revenue from the sale of an asset will be offset against depreciation expense.

7. Rental income. Revenue received from outside sources for the use of center buildings or equipment will be offset to property expenses.

8. Interest income. Revenue from investments will be offset against interest expense.

9. Grant income. Grants, gifts, and awards from the federal, state, or philanthropic agencies will be offset to the costs which are allowed under the grant.

10. Restricted gifts and income from endowments. Gifts or endowment income designated by a donor for paying specific operating costs incurred in providing contract services must

be offset to costs in the year the cost is incurred regardless of when the gift or endowment is received.

11. Other cost-related income. Miscellaneous income including amounts generated through the sale of a previously expensed item, e.g., supplies or equipment, must be offset to the cost category where the item was expensed.

12. Other income to the center from local, state, or federal units of government may be determined by the department to be an offset to costs.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

75-03-20-17. Private pay rates.

1. The department's rate will not exceed the full rate charged to nondepartmental or private pay clients for the same service. The rate being charged nondepartmental or private pay clients at the time the services were provided will govern. In cases where the clients are not charged a daily rate, a daily rate will be computed by dividing the total nondepartmental or private pay charges for each month by the total nondepartmental or private pay census for each month. If at any time the center discounts any rates for those periods of time that a client is not in the facility and the discount creates a situation in which the rate is less than the established rate paid by the department, then the discounted rate will be the maximum chargeable for departmental clients and the department will be afforded a discount in the amount of the difference between the discounted rate and the established rate.

2. If the established rate exceeds the rate charged to nondepartmental or private pay clients for a service, on any given date, the center shall immediately report that fact to the department and charge the department at the lower rate. If payments were received at the higher rate, the center shall, within thirty days, refund the overpayment. The refund will be the difference between the established rate and the rate charged to nondepartmental or private pay clients times the number of department client days paid during the period in which the established rate exceeded the nondepartmental or private rate plus interest calculated at two percent over the Bank of North Dakota prime rate on any amount not repaid within thirty days. Interest charges on these refunds are not allowable costs.

History: Effective December 1, 1991.
General Authority: NDCC 25-03.2-10, 50-06-16

Law Implemented: NDCC 25-03.2

75-03-20-18. Reconsiderations and appeals.

1. Reconsiderations.

   a. A center dissatisfied with the final rate established must request a reconsideration of the final rate before a formal appeal can be made. Any requests for reconsideration must be filed with the department's division of mental health services for administrative consideration within thirty days of the date of the rate notification.

   b. The department's division of mental health services will make a determination regarding the reconsideration within forty-five days of receiving the reconsideration filing and any requested documentation.

2. Appeals.

   a. A center dissatisfied with the final rate established may appeal upon completion of the reconsideration process as provided for in subsection 1. This appeal must be filed with the department within thirty days of the date of the written notice of the determination by the division of mental health services with respect to the request for reconsideration.

   b. An appeal under this section is timely perfected only if accompanied by written documents including the following information:

      (1) A copy of the letter received from the division of mental health services advising of that division's decision on the request for reconsideration.

      (2) A statement of each disputed item and the reason or basis for the dispute.

      (3) A computation and the dollar amount which reflects the appealing party's claim as to the correct computation and dollar amount for each disputed item.

      (4) The authority in statute or rule upon which the appealing party relies for each disputed item.

      (5) The name, address, and telephone number of the person upon whom all notices will be served regarding the appeal.

History: Effective December 1, 1991.

General Authority: NDCC 25-03.2-10, 50-06-16
Law Implemented: NDCC 25-03.2

AGENCY SYNOPSIS: Regarding proposed amendments to North Dakota Administrative Code Article 75-05 Human Service Center Licensure Standards.

Section 75-05-01-01 - Definitions: Deletes some definitions, revises some, and defines new terms.

Section 75-05-01-02 - Administration: Redefines the duties of a regional director in more general terms and provides for contracting for services according to the department's policies.

Section 75-05-01-04 - Fiscal management: States the responsibilities of a business manager to be designated by the regional director.

Section 75-05-01-05 - Personnel policies and procedures: Deletes this section with respect to adherence to personnel policies of the department covered elsewhere.

Section 75-05-01-06 - Staff orientation and inservice training: Redefines on-the-job training as orientation and inservice training.

Section 75-05-01-07 - Quality assurance: Redefines the elements of a quality assurance plan as applied to clients, staff, and visitors.

Section 75-05-01-08 - Data collection: Requires a center to comply with the department's data collection system.

Section 75-05-01-09 - Emergency management: Redesignates a disaster plan as an emergency management plan and provides that drills must be conducted annually at human service centers and at least every six months at residential facilities operated by centers.

Section 75-05-01-10 - Clients' rights: Defines intake as admissions and requires that a written statement regarding the exercise and protection of a client's civil rights must include the assurances to clients with respect to the Americans With Disabilities Act of 1990. Limitations of rights are governed by N.D.C.C. section 25-03.1-14.

75-05-01-01. Definitions. As used in this article:

1. "Acute treatment ~~and care~~ services" means ~~the process of providing treatment services to clients on a regularly scheduled basis with arrangements made for nonscheduled visits during times of increased stress or crisis~~ a group of core services designed to address the needs of vulnerable children, adolescents, adults, elderly, and families who have problems.

2. "Addiction evaluation" means an assessment by an addiction counselor to determine the nature or extent of possible

alcohol abuse, drug abuse, or ~~addictive illness~~ chemical dependency.

3. "Admission process" means an initial face-to-face contact with the client intended to define and evaluate the presenting problem and make disposition for appropriate services.

4. "Aftercare services" means activities provided to ~~persons which~~ individuals with serious mental illnesses and who are in an inpatient facility and ready for discharge. These services assist them in gaining access to needed social, psychiatric, psychological, medical, vocational, housing, and other services in the community.

~~4. "Case closure summary" means a document prepared by the client's case manager and filed in the client's record which contains a summary of the intake data, course of treatment or training, final diagnosis, and recommendations for care and treatment outside the human service center.~~

5. "Case management and aftercare for individuals with serious mental illnesses" means services which will provide or assist individuals with serious mental illnesses in gaining access to needed medical, psychological, social, educational, vocational, housing, and other services.

6. "Client" means a person who receives services from the human service center and for whom an individualized service record is maintained.

~~6.~~ 7. "Clinical services" means a variety of services, including acute treatment ~~and care~~ services, emergency services, ~~psychosocial rehabilitation~~ extended care services, ~~and medication review~~ medications, medical services, community consultation and education, psychological services, and regional intervention services to meet the care and treatment needs of clients.

~~52.~~ 8. "~~Staff~~ Clinical staff privileges" means approval by ~~the quality assurance committee~~ center staff, who have been identified in the written quality assurance plan, to render client care and treatment services within well-defined limits, based on the individual's professional qualifications, experiences, competence, ability, and judgment.

~~7. "Community correction aftercare program" means supervision and treatment services provided to appropriately referred unruly and delinquent youth committed to the legal custody of the superintendent of the North Dakota state industrial school by the juvenile courts through a contractual agreement between the director of institutions and the department.~~

~~8. "Community correction prevention program" means supervision, prevention, and treatment services provided to youth having, or potentially having, conflicts with the law and families experiencing parent-child conflict but who have not been adjudicated unruly or delinquent by the juvenile court.~~

~~9. "Community correction program" means a program which consists of four major components: state youth authority, aftercare, prevention, and interstate compact on juveniles. This program provides rehabilitative services to predelinquent, delinquent, and unruly youth.~~

~~10.~~ 9. "Community home counselor" means a person who provides care, supervision, and training for ~~chronically mentally ill clients~~ individuals with serious mental illnesses in a community residential care facility, assists residents in reorientation to the community, and is responsible for the upkeep and maintenance of the facility.

~~11.~~ 10. "Community living supervisor" means a professional who is responsible for the planning and implementation of training and treatment in a community residential care facility for ~~chronically mentally ill clients~~ individuals with serious mental illnesses.

~~12.~~ 11. "Community residential service" means a ~~service for the chronically mentally ill that provides twenty-four-hour supervision, seven days a week, in transitional living and long-term care facilities which provide room, board, and training in daily living skills. This service also includes supportive living, which provides human service center staff to be available twenty-four hours in supportive care. On an individual basis, the supportive living program can provide room, board, and training in daily living skills~~ variety of residential options which may include transitional living, supported living, crisis residential, in-home residential services, and other residential services to assist an individual in becoming successful and satisfied in their living environment.

~~13.~~ 12. "Community supportive care service" means ~~a volunteer program~~ the use of noncenter staff to assist ~~the chronically mentally ill person~~ individuals with serious mental illnesses to remain in the community.

13. "Crisis residential services" means temporary housing to provide crisis intervention, treatment, and other supportive services to achieve stabilization and crisis resolution.

14. "DSM ~~III~~ III-R" means the ~~third edition~~ third edition-revised of the diagnostic and statistical manual of mental disorders of the American psychiatric association.

15. "Department" means the department of human services.

~~16. "Developmental disabilities case management" means activities provided to persons with developmental disabilities which will assist them in gaining access to needed social, medical, educational, vocational, residential, and other services in the community.~~

~~17. "Developmental disabilities case manager" means a professional in the field of developmental disabilities who provides professional case coordination aimed at accessing the necessary community and institutional services for developmentally disabled individuals, which includes the coordination of vocational, psychological, and medical assessments to plan for individual needs, the establishment of individual service plans, placement of individuals with appropriate service providers, and monitoring and reviewing services provided.~~

~~18.~~ 16. "Diagnosis" means the process of identifying specific mental or physical disorders based on DSM ~~III (Axes I, II, III, IV, V)~~ III-R and ~~ICD-9CM~~ ICD-9-CM.

~~19.~~ 17. "Educational programs" means planned, time-limited educational programs such as child management or parenting courses.

~~20.~~ 18. "Emergency services" means a service that is available at all times to handle crisis situations.

19. "Extended care services" means services provided to individuals to maintain or promote social, emotional, and physical well-being through opportunities for socialization, work participation, education, and other self-enhancement activities. Extended care services include partial care, community residential services, work skills development, community supportive care services, seriously mentally ill case management and aftercare services, and psychosocial rehabilitation centers.

20. "Extended services" means a federally mandated [34 CFR part 363.50(a)(2)] component designed to provide employment-related, ongoing support for individuals in supported employment upon completion of training. This may include job development, replacement in the event job loss occurs, and, except for those individuals with serious mental illness, must include a minimum of two onsite job skills training contacts per month and other support services as needed to maintain employment. It may also mean providing other support services at or away from the worksite.

21. "Group counseling" or "group therapy" means a form of treatment in which a group of clients, with similar problems, meet with a counselor or therapist to discuss difficulties,

provide support for each other, gain insight into problems, and develop better methods of meeting their problems.

22. "Human service center" means a facility which was established in accordance with the provisions of North Dakota Century Code section 50-06-05.3.

23. "Human service council" means a group appointed in accordance with the provisions of North Dakota Century Code section 50-06-05.3.

24. "~~ICD-9CM~~ ICD-9-CM" means the 1990 international classification of diseases (ninth revision, seventh edition) clinical modification.

25. "Individual counseling" or "individual therapy" means a form of treatment in which a counselor or therapist works with a client on a one-to-one basis.

26. "Individual service plan (ISP)" means a document ~~which describes service needs of the developmentally disabled person and the scope of services to be provided. The individual service plan, in conjunction with an individual program plan (IPP) prepared by each provider, provides a comprehensive plan of care. This comprehensive plan of care identifies the services to be provided, the persons who will provide services, the time period of service provision, and the frequency of the service~~ that identifies the services to be provided to mental retardation-developmental disabilities case management clients.

27. "Individual treatment plan (ITP)" means a document which describes an individual plan of treatment or service for each client, including a description of the client's problems, goals, and objectives for treatment and of individuals responsible for developing and implementing the plan. ~~The individual program plan of a developmentally disabled person constitutes that person's individual treatment plan. The youth service plan of a person committed to the state youth authority constitutes that person's individual treatment plan.~~

28. "Individual with a serious mental illness" means a chronically mentally ill individual as defined in subsection 0.1 of North Dakota Century Code section 57-38-01.

29. "Individualized written rehabilitation program (IWRP)" means a statement of the client's rehabilitation goal and a detailed outline of the program to be followed in achieving the goal. The individualized written rehabilitation program is not a contract, but is rather a tool in the rehabilitation process used for information, planning, and assessment purposes. It requires participatory planning by the counselor and the

client to establish communication and a mutual understanding of the goals and the objectives.

~~29. "Intake" means an initial contact with the client intended to define and evaluate the presenting problem and make disposition for appropriate services.~~

~~30. "Interstate compact on juveniles" means an administrative responsibility established pursuant to North Dakota Century Code chapter 27-22 and the statutes of other states, to provide procedures for protection of juveniles who are on probation, parole, or runaway status and are in need of placement, supervision, and return home services.~~

~~31.~~ 30. "Medication review" means prescription monitoring and consultation to a client regarding the client's use of medication performed by a psychiatrist or medical doctor, or by a registered nurse or a licensed practical nurse under the direction and supervision of a psychiatrist or ~~medical doctor~~ physician.

31. "Mental retardation-developmental disabilities case management" means activities provided to eligible persons with mental retardation-developmental disabilities which will assist them in gaining access to needed social, medical, educational, vocational, residential, and other services in the community.

32. "Mental retardation-developmental disabilities case manager" means a qualified mental retardation professional who is responsible for providing a single point of entry, program coordination, and monitoring and review for assigned clients.

~~32.~~ 33. "Multidisciplinary team" means at least ~~two clinical~~ three staff members representing two different professions, disciplines, or services. At least one of the three must be a psychiatrist or psychologist.

~~33.~~ 34. "Outreach" means the process of reaching into a community systematically for the purposes of identifying persons in need of services, alerting and referring persons and their families to the availability of services, locating needed services, and enabling persons to enter and accept the service delivery system.

~~34.~~ 35. "Partial care" means ~~services, provided in or based at a human service center, to individuals~~ center or community-based rehabilitative services provided to mentally ill persons to maintain and promote social, emotional, and physical well-being through opportunities for socialization, therapy, work participation, education, and other self-enhancement activities.

~~35.~~ 36. "Program" means an organized ~~written~~ system of services designed to meet the service needs of clients.

~~36.~~ 37. "Progress notes" means the documentation in the client's record which describes the client's progress or lack of progress in treatment.

~~37.~~ 38. "Psychiatric evaluation" means the assessment or evaluation of a client by a psychiatrist.

~~38.~~ 39. "Psychiatrist" means a physician, with three years of approved residency training in psychiatry, who is American board of psychiatry and neurology eligible, and who is licensed to practice medicine in the state of North Dakota.

~~39.~~ 40. "Psychological evaluation" means the assessment or evaluation of a client by or under the supervision of a licensed psychologist.

~~40.~~ 41. "Psychologist" means a professional who holds a doctor's degree in psychology and who is licensed by the state of North Dakota or who qualifies as a psychologist under North Dakota Century Code section 43-32-30.

42. "Psychosocial rehabilitation center" means a facility whose staff provide socialization, social skill building, information and referral, and community awareness for the purpose of enhancing the ability of individuals with serious mental illnesses to live in the community.

~~41. "Psychosocial rehabilitation services" means services provided to individuals to maintain or promote social, emotional, and physical well-being through opportunities for socialization, work participation, education, and other self-enhancement activities. Psychosocial rehabilitation services include partial care, community residential services, employment services, community supportive care program, and aftercare program.~~

~~42.~~ 43. "Quality assurance" means ~~a facility-wide ongoing objective and systematic series of activities for which monitor and evaluate~~ an ongoing process which systematically monitors and evaluates the quality and appropriateness of client care and other agency services, ~~provide~~ provides a method problem identification, ~~provide~~ provides corrective action if needed, and ~~monitor~~ monitors outcomes.

~~43.~~ 44. "Regional aging services coordinator" means a person assigned responsibility to plan, develop, implement, and assess programs under the Older Americans Act.

~~44.~~ 45. "Regional ~~developmental~~ mental retardation-developmental disabilities program administrator" means a professional ~~in~~

~~the field of developmental disabilities who is responsible for the development, monitoring, and coordination of services to developmentally disabled individuals of all ages. Specifically, this position is responsible to manage and supervise the case management system, authorize payments for service programs, provide technical assistance and consultation to service providers, assist in the development of new provider facilities and services, coordinate the regional deinstitutionalization plan, and monitor the effectiveness of services~~ designated by the regional director who is responsible for the overall management and administration of the mental retardation-developmental disabilities case management system.

~~45.~~ 46. "Regional director" means the human service professional who is appointed by the executive director of the department to be responsible for the overall management and administration of the human service center.

47. "Regional intervention service" means a service unit within a human service center which provides crisis intervention and support services in a community's as an alternative to state hospital admission.

~~46. "Regional ombudsman" means a person assigned the responsibility to plan, develop, and maintain the North Dakota long-term care ombudsman program.~~

~~47.~~ 48. "Regional representative of county social services programs" means a person, designated by the regional director of the human service center, to whom is delegated the responsibility for supervising and assisting with county social service board programs as assigned.

~~48. "Residential care" means services provided on a twenty-four-hour per day basis, including room and board, to unwed pregnant women who are unable to remain in their own homes and who are in need of instruction and counseling to cope with the problems associated with unwed pregnancy.~~

49. "Residential treatment team" means multidisciplinary staff who make decisions regarding admissions, treatment, training, and disposition of clients in the community residential service.

50. "Risk management" means an ongoing process of systematically reviewing the activities which monitor and evaluate the quality and appropriateness of clients', staff, and visitors' safety and protection.

~~50.~~ 51. "Service record" means a compilation of those events and processes that describe and document the evaluation, care, treatment, and service of the client.

~~51.~~ 52. "Staff ~~growth and development~~ orientation and inservice training" means ~~professional growth activities~~ orientation of new employees and inservice training of staff provided or approved by the department~~, and approved professional growth activities of individual staff persons seeking to advance their own career goals and professional expertise~~.

~~53. "State youth authority" means an administrative function of the department authorized by North Dakota Century Code chapter 27-21 to provide treatment and rehabilitation services to delinquent and unruly youth and their families when the youth are committed to it by juvenile courts of North Dakota.~~

~~54.~~ 53. "Supervision of county social services" means the activities of supervision, consultation, evaluation, licensure, certification of various county social service programs, program planning, implementation, monitoring, receiving and reviewing reports, generation of statistical reports, staff development, and inservice training of county social service board staff and board members.

54. "Supported living services" means services which are provided to individuals with serious mental illnesses in their chosen environment to assist and enhance their abilities to be successful and satisfied in their living environment. Services may include assessment, education and training, monitoring, financial assistance, advocacy, or other supported activities.

55. "Transitional living" means the provision of meals and lodging-related services to an individual in a twenty-four-hour per day community-based living environment established for individuals who do not need the protection offered in an institutional setting, but are not yet ready for independent living.

56. "Utilization review" means a program designed to ensure optimal ~~allocation~~ use of ~~financial and clinical~~ center resources to determine if ~~generally accepted guidelines for service utilization and duration~~ professionally recognized standards are being practiced for service utilization.

57. "Vocational adjustment counseling" means assisting the individual and family to understand and accept any physical or mental limitations placed on activities because of a disability. This includes working with the client, teacher, trainer, and employer to help the client learn adaptive behavior or techniques to attain the vocational objective and function appropriately in the family and community.

58. "Vocational assessment (diagnosis and evaluation)" means acquisition and analysis of medical, psychological, vocational, educational, and social information to determine

the effect of a handicapping condition on preparing for or obtaining employment. This also includes the medical and psychological consultations, as well as consultations with social workers, teachers, and employers, on behalf of a specific client.

59. "Vocational rehabilitation administrator" means the professional responsible for the overall management and implementation of all vocational rehabilitation services within a region.

60. "Vocational rehabilitation counselor" means the professional who provides vocational counseling and guidance, placement services, and assists physically and mentally handicapped persons to become vocationally competent.

61. ~~"Work activity" means therapeutic training in community survival and prevocational skills, but does not mean "developmental work activity" as that term is defined in section 75-04-01-01.~~ "Work skills development" means a range of services designed to assess clients' vocational strengths and weaknesses, provide prevocational skills training, job exploration, and followup.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-01-02. Administration.

1. The regional director shall have direct responsibility for the overall management and implementation of services and programs of the human service center and must be a full-time employee.

2. The regional director shall employ personnel who shall meet applicable federal and state laws, ~~applicable~~ rules, and ~~applicable~~ court orders. The employed personnel shall meet the criteria for employment as set forth by state merit system standards and the central personnel division. All human service center employees are department employees.

3. The regional director shall develop an organizational chart which reflects the line of authority of staff.

~~4. The regional director shall develop and implement a written plan for the essential services the center provides, the goals and objectives of the services, staff positions designated to provide the services, authority and responsibility of positions, and coordination of the services with other services of the center.~~

~~5.~~ 4. Where necessary, the regional director may contract for services with nonemployees ~~with the permission of the executive director of the department~~ according to the department's policies.

~~6. The regional director shall employ or contract with a psychiatrist to be the medical director in accordance with the policies of the department. The medical director shall provide consultation, treatment, and psychiatric evaluations for clients at the human service center and shall provide input in program planning and development of services.~~

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-01-04. Fiscal management.

1. The regional director shall designate a business manager who shall oversee the financial management of the center. ~~The business office shall abide by the policies and procedures of the department and by state and federal laws, rules, and regulations.~~

2. ~~The center shall have a formal system of internal control in the handling of the center's fiscal affairs.~~ The business manager, or the business manager's delegate, shall:

   a. Prepare the biennial budget;

   b. Collect data for ratesetting purposes;

   c. Maintain the departmental data collection systems;

   d. Close audit recommendations;

   e. Timely and accurately respond to information requests;

   f. Supervise all assets, inventories, and receivables under the control of the human service center; and

   g. Manage day-to-day business affairs of the human service center including collection and payment of bills consistent with the departmental manuals.

~~3. The center shall follow manuals or have guidelines for the following:~~

   ~~a. Budget preparation and development, which is the result of a team effort, which includes active participation of professional staff.~~

~~b. Fee for services schedule, including rates and charges, which is available to any person upon request.~~

~~c. Authorizations and approvals for purchasing supplies, services, and equipment, and an equipment inventory control program.~~

~~d. Fiscal reports which are prepared as needed or requested.~~

~~e. Accounts receivable policies, procedures, and reports.~~

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-01-05. Personnel policies and procedures. ~~All personnel employed at the human service center shall abide by the personnel policies and procedures established by the department and the central personnel division.~~ Repealed effective December 1, 1991.

History: ~~Effective November 1, 1987.~~
General Authority: ~~NDCC 50-06-05.2~~
Law Implemented: ~~NDCC 50-06-05.2~~

75-05-01-06. Staff ~~growth and development~~ orientation and inservice training.

1. There must be a written plan for the orientation and ~~on the job~~ inservice training of all new employees.

   a. The orientation program must be initiated upon employment and completed within thirty working days.

   b. The orientation program must include policies and procedures of the department and operations of the human service center, and any other information deemed necessary by the regional director and the supervisor of the person being employed.

2. Employees of the human service center shall attend inservice training programs at the human service center as it pertains to their program and clients.

3. All ~~on the job~~ orientation training and inservice training must be documented.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-01-07. Quality assurance.

1. The regional director shall appoint a committee or an individual who is responsible for coordinating and monitoring the activities for the quality assurance program at the human service center.

2. The committee's or individual's functions shall be to develop a written quality assurance plan which ~~must include~~ is updated at least every two years and shall provide for, as a minimum, the following components:

   a. Client ~~and~~, staff, and visitor safety and protection (risk management)~~.~~, including, at least:

      (1) Infection control;

      (2) Compliance with the life safety code of the national fire protection association applicable to buildings under the center's control;

      (3) Protection of clients' rights as required by section 75-05-01-09;

      (4) Internal and external disaster controls; and

      (5) Management of episodes of aggressive and violent client behavior in facilities operated by the center.

   b. ~~Specifications for the~~ Use of appropriate methods for the performance evaluation ~~and utilization~~ of personnel.

   c. A system for credentialing and granting or withholding clinical staff privileges.

   d. A utilization review program to ~~ensure~~ assure quality client care, which reviews appropriateness of admissions, services provided, duration of service, and underutilization and overutilization of personnel and financial resources and outcome or followup studies.

   e. A plan for the review of individual treatment and ~~service plans~~ services provided.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-01-08. Data collection. ~~There must be a data collection system which provides statistics to comply with the policies of the department and state and federal laws, rules, and regulations which must~~

~~show, at a minimum, the number of clients served, type of services, and reasons for termination of services.~~ The centers must comply with the requirements of the department's data collection system which includes, but is not limited to, data concerning the number of clients served and the types of services received.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-01-09. ~~Disaster plan~~ Emergency management.

1. The regional director shall adopt and maintain a written ~~disaster~~ emergency management plan which ~~must provide~~ provides crisis counseling for disaster emergencies in ~~the~~ counties ~~and coordination with the North Dakota division of emergency management~~ within the center's catchment area.

2. The regional director shall adopt and maintain a written ~~disaster~~ emergency management plan ~~which must provide for disaster emergencies~~ within the human service center and other facilities which are operated by the center.

3. The emergency management plan must be available on the premises and clients must be instructed in its implementation when appropriate.

4. Evacuation drills at the human service center ~~and other~~ must be conducted and documented yearly. Evacuation drills at the residential facilities which are operated by the center must be conducted and documented at least every six months.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-01-10. Clients' rights.

1. The persons responsible for ~~intake~~ admissions shall provide all human service center clients, and families or guardians, as appropriate, with a written statement regarding the exercise and protection of the clients' civil rights. This statement must include the assurance of civil rights for all clients of the human service center regardless of the clients' race, color, religion, national origin, sex, age, political beliefs, or handicap in accordance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act, the Americans with

Disabilities Act of 1990, and the North Dakota Human Rights Act (North Dakota Century Code chapter 14-02.4).

2. The clients, and families or guardians, as appropriate, must receive written information concerning their rights under each program within the human service center from which the client is receiving services.

3. Each client, and family or guardian, as appropriate, will receive written information describing:

   a. The conditions under which a decision, action, or inaction may be appealed;

   b. The method of filing the appeal;

   c. The various steps in the appeal; and

   d. The assistance which can be furnished in the preparation and submission of the appeal.

4. The human service center shall provide assistance in obtaining protective or advocacy services, if needed and appropriate.

5. Clients' rights will not be limited unless the limitation is essential to protect the clients' safety, the safety of others, or is determined to be of therapeutic value. The restriction will ~~be implemented and documented~~ follow the limitations and restrictions of the patient's rights according ~~to the policies of the department~~ to North Dakota Century Code section 25-03.1-41.

6. This article may not be construed as creating, for the benefit of a client, or a client's family or guardian, any civil right or other right.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

AGENCY SYNOPSIS: Regarding proposed amendments to North Dakota Administrative Code Article 75-05 Human Service Center Licensure Standards.

Section 75-05-02-02 - Physical environment: Provides for handicapped parking and that all buildings under control of a human service center must meet minimum requirements in accordance with the Americans With Disabilities Act of 1990. Public restrooms and public telephones must be accessible to persons with disabilities. One telecommunication device for the deaf must be available. Drinking units must comply with the 1986 American National Standards Institute standards.

Section 75-05-02-04 - Motor vehicles: Requires that a vehicle be usable by staff who require special equipment in the operation of a motor vehicle for purposes of conducting center business.

75-05-02-02. ~~Therapeutic~~ Physical environment. The human service center shall establish and maintain an environment that enhances the positive self-image of clients and preserves their human dignity.

1. There must be outside parking which must be well marked with lighting for safety. There must be designated handicapped parking space available for staff, clients, and public usage.

2. The human service center and all buildings under the control of the center shall meet the minimum requirements of North Dakota Century Code section 48-02-19 and shall provide accessibility to services in accordance with the accessibility requirements of section 504 of the Rehabilitation Act of 1973, as amended, and in accordance with the Americans With Disabilities Act of 1990.

3. Waiting room and reception areas must be comfortable in their design, location, and furnishings, and must accommodate the client's and staff's needs.

   a. ~~Restrooms which are handicapped~~ Public restrooms must be accessible ~~must be~~ to persons with disabilities, and available for clients, visitors, and staff.

   b. ~~A telephone for local calls must be available for client use.~~ A public telephone must be available for client use. In addition, a telephone must be available for handicapped clients which must not exceed forty-eight inches [1219.20 millimeters] at the highest working part and must include amplification. One telecommunication device for the deaf must be available for hearing handicapped.

   c. Drinking units must be accessible ~~either by the physical location or by the availability of drinking cups~~ to persons with disabilities and must not present a hazard to visually impaired persons, according to 1986 American national standards institute standards section 4.15.

4. Direct outside air ventilation must be provided to all rooms by forced ventilation, air-conditioning, or operable windows.

5. All furnishings must be clean, in good repair, and appropriate to the age and ~~handicap~~ disabling condition of clients ~~or~~, staff, and visitors.

6. Offices and group therapy or counseling rooms must be appropriately decorated, and furniture and equipment must be in good usable repair and must meet the needs of the clients and staff. The offices and group therapy or counseling rooms

must have ample room and furniture must be fully accessible to accommodate the client, family members, and guardian.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-02-04. Motor vehicles. The human service center shall assure the availability of a motor vehicle accessible to and usable by staff with disabilities who require special equipment in the operation of a motor vehicle and who are required to conduct center business in a motor vehicle.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

AGENCY SYNOPSIS: Regarding proposed amendments to North Dakota Administrative Code Article 75-05 Human Service Center Licensure Standards.

Section 75-05-03-01 - Acute treatment services: Requires the human service center to define and provide general outpatient services and implement programs for vulnerable children, adolescents, adults, and families who have problems. The section also provides that the human service center have an addiction service.

Section 75-05-03-02 - Emergency services: With respect to emergency services, a complete list of community resources is required to be available to emergency service personnel and information about available resources and treatment services must be given to individuals receiving emergency services.

Section 75-05-03-03 - Extended care services: Psychosocial rehabilitation services are redesignated as extended care services. Care includes individual and group therapy. Attendance and crisis situations are required to be documented in a client's record. With respect to community residential services, a human service center shall provide at a minimum two of the following options as delineated in this section: (1) transitional living services; (2) supported living services; (3) work skills development; (4) case management and aftercare services for individuals with serious mental illnesses; (5) community supportive care services; and (6) psychological rehabilitation centers.

Section 75-05-03-04 - Medications: This section recognizes that medication orders may be written not only by a physician, but also by some other professional licensed by the state and permitted by such license to write medication orders. Physicians orders must be signed and a record of the administration of the medication kept. An assessment to detect tardive dyskinesia must be administered to all

clients taking antipsychotic medication where required. Human service centers are to have written policies and procedures for self-administered medication programs and document training received by the client.

Section 75-05-03-05 - Medical services: Outreach is redefined as medical services. The medical director must be a psychiatrist who is to provide consultation, treatment, and psychiatric evaluation for clients. Psychiatric services are to be available at a minimum of 160 hours per month.

Section 75-05-03-06 - Community consultation and education: Requires a written plan for providing information to the public and local agencies concerning human service center services. A human service center is also required to respond to requests for educational presentations and inservice training for public and private agencies and to provide technical assistance to communities in assessing mental health needs and services.

Section 75-05-03-07 - Psychological services: Requires the regional director to employ psychologists and describes psychological services.

Section 75-05-03-08 - Regional intervention service: Requires the administration of a regional intervention system to assess all persons who are considering voluntary admission to the State Hospital and refer them to community-based treatment when available.

75-05-03-01. Acute treatment ~~and care~~ services.

1. ~~There must be an acute treatment and care service in the human service center~~ Outpatient services.

2. ~~Treatment modalities that must be offered to clients include, but are limited to, the following: individual counseling and psychotherapy; group counseling and psychotherapy; family therapy; marital therapy; and chemotherapy.~~

3. ~~All treatment provided must be documented in the client's record.~~

4. ~~The regional director shall employ clinical staff to provide the acute treatment and care service.~~

5. ~~Acute treatment and care services must be available to clients during the day and on designated evenings.~~

6. ~~When appropriate, access to acute treatment and care services must be made available to clients in settings outside the human service center, such as the client's home and outreach offices.~~

~~7. When appropriate, services provided by the acute treatment and care service must be coordinated with other private and public agencies.~~

a. Each human service center will define and provide general outpatient services to vulnerable children, adolescents, adults, elderly, and families who have problems as outlined in the document entitled, "Essential Services and Functions - Regional Human Service Centers, revised August 19, 1990".

b. Each human service center shall develop policies and procedures for implementation of each program provided by the center.

c. Outpatient services must be available to clients during the day and on designated evenings.

d. All significant client contacts and treatment provided must be documented in the client's record.

e. When appropriate, outpatient services provided by acute treatment service must be coordinated with other private and public agencies.

2. Addiction service. The human service center shall have an addiction service which meets the requirements of article 33-08, chapters 33-08-01 through 33-08-08, article 75-05, and North Dakota Century Code section 23-01-03.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-03-02. Emergency services.

1. The human service center shall maintain or contract for a twenty-four-hour emergency service. As a minimum, telephone or face-to-face contact must be part of this service. All contacts must be documented.

2. Emergency service personnel must be trained to handle crisis situations. Training must include, but not be limited to: suicide intervention; violent behavior of clients; and crisis telephone calls. This training must be documented.

3. ~~In situations where face to face~~ Face-to-face crisis counseling ~~is~~ must be provided~~, it must be~~ in an environment which is conducive to treatment and control of the client in ~~case~~ the event of suicide or violent behavior.

4. ~~When appropriate, emergency services personnel shall be responsible for notifying the client's family of the emergency and of the arrangements made for delivery of the service.~~ A complete list of community resources must be available to emergency service personnel and updated on an annual basis.

5. ~~Emergency service personnel must be fully informed and aware of all agencies and organizations which provide services and emergency service to people, including hospitals, clergy, inpatient programs, law enforcement personnel, and ambulance~~ Any individual receiving emergency services must be given information about available resources and treatment services.

~~6. If additional services are needed after emergency services have been delivered, the human service center shall make available any treatment which is needed by the client and which the center normally provides.~~

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-03-03. ~~Psychosocial rehabilitation services~~ Extended care services.

1. Partial care.

   a. The regional director shall designate a person who shall ~~coordinate, administer, and~~ supervise the partial care service.

   ~~b. The partial care service must be a full-time program with a minimum of thirty programmed hours per week offered during the day and designated evening hours.~~

   ~~c.~~ b. Treatment and training modalities offered to clients must include, but are not limited to: individual ~~counseling and psychotherapy~~ therapy; group ~~counseling and psychotherapy~~ therapy; daily living skills training; and prevocational skills training~~, work activity, vocational counseling, occupational therapy, and training in the appropriate use of leisure time~~.

   ~~d.~~ c. An evaluation of the client's progress in partial care must be documented in the client's record on at least a monthly basis ~~or when a significant life event occurs.~~ Attendance must be documented as it occurs. Crisis situations will be documented in the client's record at the first opportunity following the crisis.

~~e. The center shall employ staff to carry out the functions of a partial care program.~~

2. Community residential services.

a. The regional director shall designate a community living supervisor to supervise the community residential services.

~~b. When ordered by the client's physician, special diets must be made available to all clients of the community residential service.~~

~~c. The community residential service facility must:~~

~~(1) Be physically integrated into the community with interior and exterior features that are comparable and compatible to other residences in the nearby neighborhood;~~

~~(2) Be readily accessible to an outdoor recreational area;~~

~~(3) Have bedrooms which are outside rooms and must accommodate one or two clients. Each client must be provided with a bed appropriate for his size and weight, a clean, comfortable mattress, bedding appropriate for weather and climate, and furniture; and~~

~~(4) Have an area where the client can go for quiet or private times.~~

~~d. The transitional living environment must:~~

~~(1) Not house more than eight clients;~~

~~(2) Have the ability to house both male and female clients, while being maintained to accommodate privacy for individuals;~~

~~(3) Have bedrooms on or above grade level with a minimum of eighty square feet [7.43 square meters] per client for multiple sleeping rooms and at least one hundred square feet [9.29 square meters] in single bedrooms unless a variance has been granted by the department; and~~

~~(4) Provide at least one full bathroom for every four clients.~~

~~e. The staff of the community residential service shall have the following duties and responsibilities:~~

(1) The client's individual treatment plan shall include input from the community home counselors as well as the residential treatment team.

(2) An activity schedule for each client must be available to the community home counselors and must be implemented daily and posted when appropriate.

(3) The community home counselor is responsible for maintaining an inventory of the client's personal effects.

(4) The community living supervisor shall appoint a community home counselor who is responsible for food purchasing, food storage, and sanitary conditions for food preparation.

(5) Make arrangements so that the privacy and individual rights of the clients are not infringed upon by other clients.

f. The transitional living facility shall comply with the most recent provisions of chapter 20 "Lodging Rooming Houses" of the life safety code.

g. Clients in the community residential service must be allowed home visits when appropriate and as documented in the client's individual treatment plan.

h. The client's family may visit the community residential facility during visiting hours except as contraindicated by the individual treatment plan.

3. Work evaluation, job training, and placement.

a. Work evaluation, job training, and placement must be provided to or arranged for clients determined to be ready for and in need of such services.

b. Services offered to clients must include, but are not limited to: assessment of clients' strengths and weaknesses as related to employment; vocational counseling; prevocational training; job development; job placement; and followup.

c. All clients who have been placed on a job must be provided followup services.

4. Aftercare services.

a. The regional director shall designate an aftercare coordinator.

~~b. The aftercare coordinator shall maintain close contact with the North Dakota state hospital in whatever fashion is appropriate to serve the clients as part of the continuum of care of clients.~~

~~5. Community supportive care services.~~

~~a. The regional director shall designate a community supportive care supervisor.~~

~~b. The community supportive care supervisor is responsible for the recruitment and training of all community supportive caregivers.~~

~~c. Community supportive caregivers shall meet monthly with a designated clinical staff person for case consultation and related matters.~~

b. The human service center shall provide or contract for, as a minimum, two of the following options:

(1) Transitional living services.

(a) Transitional living service facilities must:

[1] Comply with the provisions of the chapter entitled "Lodging Rooming Houses" of the 1985 life safety code. The community living supervisor shall assure that the appropriate officials provide onsite review and documentation of review once every two years;

[2] House no more than fourteen clients;

[3] Have the ability to house both male and female clients while accommodating privacy for individuals;

[4] Provide at least one full bathroom for every four clients; and

[5] Have bedrooms which are outside rooms, accommodate one or two clients, provide each client with a bed appropriate for his or her size and weight, with a clean and comfortable mattress, bedding appropriate for weather and climate, and provide other appropriate bedroom furniture.

(b) The staff of the transitional living service facility shall:

[1] Assure that the client's individual treatment plan includes input from the community home counselors as well as the residential treatment team.

[2] Maintain an inventory of the client's personal belongings when the client enters the transitional living facility.

(c) A brochure of client's rights according to section 75-05-01-10 must be given to all new residents of the transitional facility upon admission.

(2) Supported living services.

(a) The human service center shall develop policies and procedures that will include, at a minimum, assurance that all local building and fire safety codes are conformed to and safe and sanitary conditions are maintained.

(b) Human service center staff shall develop policies and procedures to assure that supportive living services are being provided in the client's residence.

(c) An evaluation of the client's progress in supportive living services must be documented in the client's record at least on a monthly basis.

(3) Crisis residential services.

(a) Human service center staff shall develop policies and procedures to assure that safe and effective crisis residential services are provided.

(b) Documentation of the individual's progress shall occur daily.

3. Work skills development.

a. The human service center shall either provide or contract for:

(1) Methods to assess the abilities of individuals with serious mental illnesses as related to employment;

(2) Prevocational skills development;

(3) Job exploration; and

(4) Followup.

b. The client's progress in work skills development must be documented at least monthly.

4. Case management and aftercare services for individuals with serious mental illnesses.

a. Case management must be available to all eligible individuals with serious mental illnesses throughout the human service center's catchment area.

b. Case management for individuals with serious mental illnesses will be identified on the client's individual treatment plan and will be documented in the progress notes when it occurs.

c. Aftercare services will be made available to all individuals with serious mental illnesses in an inpatient facility who are returning to the region after discharge. The regional director shall designate one or more staff members to provide aftercare services.

d. The human service center will, through case management services, assure that extended services are provided for individuals with serious mental illnesses who have completed the training and stabilization components of the supported employment program and continue to require ongoing support services to maintain competitive employment.

5. Community supportive care services. The human service center shall provide or contract with a private, nonprofit group to provide a community supportive care program. This program must include:

a. Designation of an individual to serve as the community supportive care supervisor.

b. Assignment of responsibility to the community supportive care supervisor for the recruitment, scheduling, and training of all community supportive caregivers.

c. Provision of companionship services for individuals with serious mental illnesses who have been referred by a multidisciplinary team. These services may include, but are not limited to: transportation; assisting in meal preparation; leisure activities; and assisting in shopping for food, clothes, and other essential items by community supportive caregivers.

6. Psychosocial rehabilitation centers.

a. The human service center shall provide or contract for the operation of a psychosocial rehabilitation center.

b. The psychosocial rehabilitation center shall:

(1) Provide evening and weekend activities;

(2) Be open seven days a week; and

(3) Provide a minimum of forty hours of programming a week.

c. The psychosocial rehabilitation center shall have an advisory council composed of client members.

d. The regional director shall appoint a human service center staff member as a liaison between the human service center and the psychosocial rehabilitation center.

e. The psychosocial rehabilitation center shall provide written monthly activity reports to the human service center.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-03-04. Medication review Medications.

1. The human service center shall have written policies and procedures designed to ~~ensure~~ assure that all medications are administered safely and properly in accordance with state laws.

2. Medication orders must be written only by ~~physicians~~ a physician or other professional licensed by law and permitted by such license to write medication orders and who are in direct care and treatment of clients.

~~3. Administration of medications must be in accordance with state laws.~~

~~4.~~ 3. ~~There must be maintained a record~~ All prescribed medications must be recorded in the client's record ~~of medication administered and prescriptions written~~.

4. When medications are prescribed and administered by human service center staff, the physician's orders must be signed and a record of the administration kept.

5. There must be a system of checking to detect unhealthy side effects or toxic reactions.

6. Medication storage areas must be well lighted, safely secured, and maintained in accordance with the security requirements of federal, state, and local laws.

7. Each client who receives ~~medication~~ medications prescribed at a human service center must be informed of the benefits, risks, side effects, and ~~potential effects if medications are not accepted~~ consequences of medication noncompliance. At a minimum, ~~this informed consent~~ a record that such information was provided must be made in a progress note written by the person prescribing ~~physician~~ the medication. A signed informed consent statement by the client is acceptable in addition to the progress note, but not in lieu of the progress note. The progress note must include:

   a. A statement that a discussion regarding medications prescribed ~~was given~~ has occurred.

   b. ~~A statement~~ Documentation that a specific discussion of tardive dyskinesia ~~was had, if the medication is an~~ has occurred, if that is a potential side effect of the antipsychotic medication.

   c. ~~A statement that the person appears to be not competent to understand the discussion regarding medications if that is the case.~~ If the client, in the opinion of the ~~physician, is not competent to~~ person prescribing the medication, does not appear to understand the discussion ~~and gives consent~~, the progress note in the client's service record must document discussions with the client's guardian, the client's family, or other responsible individuals.

8. ~~When clients of community residential services are not capable of the competent self-administration of medication, a self-administration program will be designed. When a client has received training in self-medication, this will be documented in the client's clinical record.~~ An assessment instrument to detect signs of tardive dyskinesia must be administered to all clients every six months or as medically indicated to clients every six months or as medically indicated to clients on antipsychotic medications for which tardive dyskinesia is a potential side effect.

9. Each human service center shall have written policies and procedures for self-administered medication programs. Documentation of training received must be entered in the client's record.

History: Effective November 1, 1987; amended effective December 1, 1991.

General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-03-05. ~~Outreach.~~ Medical services. The regional director shall employ or contract with a psychiatrist to be the medical director. The medical director should provide consultation, treatment, and psychiatric evaluations for clients at the human service center and shall provide input in program planning and development of services. Psychiatric services must be available at a minimum of one hundred sixty hours per month.

~~1. The outreach service shall assist the people who have problems or handicaps in obtaining those services by making referrals to local providers or by developing programs to meet those needs.~~

~~2. If services are developed in the outreach program, the services shall meet the standards of chapters 75-05-03 and 75-05-04.~~

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-03-06. ~~Consultation.~~ Community consultation and education. The human service center shall:

1. ~~The human service center shall maintain a consultation service.~~ Maintain a written plan for providing information to the general public and local agencies regarding center services.

2. ~~A list of qualified staff who can provide consultation to the various community groups or agencies must be maintained.~~ Have a systematic approach for informing clients and agencies about center services and how to access those services.

3. Respond to requests for educational presentations and inservice training for public and private agencies as staff time allows or refer the requests to other community resources.

4. Provide technical assistance to communities in assessing mental health needs and service options.

5. Document the number of hours, clients, and type of activity spent on community consultation and education.

History: Effective November 1, 1987; amended effective December 1, 1991.

General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-03-07. ~~Community education~~ Psychological services.

1. ~~The human service center shall maintain a community education service~~ The regional director shall employ one or more psychologists who meet the requirements of North Dakota Century Code chapter 43-32.

2. ~~The general public must be informed of the services of the human service center.~~ Psychological services include: psychological evaluations, psychological consultations, and psychotherapy services.

~~3. The human service center shall document the number, type, and time spent on community educational services.~~

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-03-08. Regional intervention service.

1. The regional director shall designate staff to coordinate, administer, and supervise the regional intervention system.

2. The regional intervention service must assess all individuals who are under consideration for voluntary admission to the North Dakota state hospital.

3. The regional intervention service must refer clients to appropriate community-based treatment in lieu of state hospital admission when available.

History: Effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

AGENCY SYNOPSIS: Regarding proposed amendments to North Dakota Administrative Code Article 75-05 Human Service Center Licensure Standards.

Section 75-05-04-01 - Admission process: Redefines intake as admission process. Requires a signed application for services to be completed at the time of admission and outlines the admission process.

Section 75-05-04-02 - Admission: Repeals a section previously dealing with the admission process.

Section 75-05-04-03 - Individual treatment plans: Redefines treatment and service plans as individual treatment plans.

Section 75-05-04-04 - Progress notes: Requires that progress notes must include the client's progress towards meeting the goals of the individual treatment plan.

Section 75-05-04-05 - Individual treatment plan review: Requires review of individual treatment plans at least every six months except for chronic cases which must be reviewed at least every 12 months.

Section 75-05-04-06 - Completion of treatment or services: Redefines case closure as completion of treatment or service and requires a treatment or service completion statement to be entered in a client's progress notes.

Section 75-05-04-08 - Records maintenance: Client's record is available not only to the client but to any person designated by the client in writing.

75-05-04-01. ~~Intake~~ Admission process.

1. The regional director shall designate ~~intake~~ admission personnel who are responsible for the initial contact with the ~~client~~ individual and family to define and evaluate the presenting problems and make disposition for appropriate services.

2. If, in the judgment of the ~~intake~~ admission personnel, the contact which has been made is of an emergency nature, the ~~intake~~ admission personnel shall comply with emergency service procedures.

3. If, in the judgment of the ~~intake~~ admission personnel, the contact which has been made is not of an emergency nature, the ~~intake~~ admission personnel shall determine if the treatment or services required by the ~~client~~ individual and family can be appropriately provided by the center. Upon such determination, the ~~intake~~ admission personnel shall assure an appointment is scheduled ~~with an appropriate staff member~~.

4. A signed application for services must be completed at the time of admission.

5. The initial admission process must involve a face-to-face interview with the clients and include the following:

   a. Statement of the presenting problems.

   b. Social history to include, when appropriate, family background, developmental history, educational history, and employment.

c. Medical history to include any relevant findings of previous physical or psychiatric evaluations, a list of the client's current medications and allergies, and additional evaluations as deemed necessary. If the client is being considered for community residential services, a physical examination must have been completed within the last three months.

d. Signed release of information form from the client and client's parent or guardian when deemed necessary.

6. Upon completion of the admission process, a provisional diagnosis must be made and a treatment plan developed.

7. Within ten working days from date of admission, which is the time when the client and the staff member first meet to begin the admission process, a case staffing must be held with a multidisciplinary team to confirm or revise the diagnosis and treatment plan, or reassign the client to an appropriate member of the professional staff.

8. If the client is being referred for community residential services, the client shall, if possible, visit the residential facility. If arrangements can be made, an overnight stay must be considered.

9. If the human service center cannot provide appropriate services, the professional staff person shall document, in writing in the individual's admission file, the reasons why he or she is not provided services. A professional staff person will, with the individual's approval, assist him or her in referral to appropriate services.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-04-02. Admission.

~~1. The initial admission process shall involve a face to face interview with the client. The admission process must include the following:~~

~~a. Social history to include, when appropriate, presenting problems, family background, developmental history, educational history, and employment.~~

~~b. Medical history to include any relevant findings of previous physical or psychiatric evaluations, a list of the client's current medications and allergies, and additional evaluations as deemed necessary. If the client~~

~~is being considered for community residential services, a physical examination must have been completed within the last three months.~~

~~c. A psychological evaluation, if appropriate.~~

~~d. An addiction evaluation, if appropriate.~~

~~e. A vocational assessment, if the client has been employed, and if appropriate.~~

~~f. Signed release of information form from the client and client's parent or guardian when deemed necessary.~~

~~2. Upon completion of the admission process, a diagnosis must be made and a treatment or service plan developed.~~

~~3. A case staffing must be held with a multidisciplinary team to confirm or revise the diagnosis and the treatment or service plan or reassign the client to an appropriate member of the professional staff based on the client's needs.~~

~~4. If the client is being referred for community residential services, the client shall, if possible, visit the residential facility. If arrangements can be made, an overnight stay must be considered.~~

~~5. If the human service center cannot provide appropriate services, the professional staff person shall document, in writing, in the client's admission file, the reasons why the client is not eligible. The professional staff person will contact the client within seventy-two hours and assist the client in referral to appropriate services.~~ Repealed effective December 1, 1991.

History: ~~Effective November 1, 1987.~~
General Authority: ~~NDCC 50-06-05.2~~
Law Implemented: ~~NDCC 50-06-05.2~~

75-05-04-03. ~~Treatment and service~~ Individual treatment plans.

1. Each client who has been admitted for service to the human service center shall have an ~~individualized~~ individual treatment ~~or service~~ plan that is based on the admission data and needs of the client.

2. Overall development and implementation of the individual treatment ~~or service~~ plan are the responsibility of the professional staff assigned the client.

3. The individual treatment ~~or service~~ plan must be developed in accordance with the following time lines:

a. Clients whose ~~preliminary~~ diagnosis indicates a mental disorder (based on ~~DSM III or ICD-9CM~~ DSM III-R or ICD-9-CM classification) or ~~alcohol and drug abuse~~ psychoactive substance use disorder or individual and family dysfunction shall have an ~~individualized~~ individual treatment plan (ITP) developed within ~~twenty~~ ten working days from the ~~day~~ date of case ~~assignment~~ admission.

b. Clients who are eligible for vocational rehabilitation services shall have an ~~individualized~~ individual written rehabilitation program (IWRP).

~~c. Clients who are admitted for state youth authority services shall have a youth service plan (YSP) developed within sixty working days of admission.~~

~~d. Clients who are admitted for developmental disabilities services shall have an individual service plan (ISP) within thirty calendar days of admission. If additional developmental disability services are provided by the center, an individual program plan (IPP) must be developed within thirty calendar days.~~

4. The individual treatment ~~or service~~ plan shall contain the name of the client, problems of the client, service strategies to resolve problems, goals and planned outcomes, ~~service strategies, expected achievement dates of goals and outcomes,~~ staff responsible for service strategies, and signature of the case manager. In the case of clients who are eligible for medical assistance benefits, and receiving clinic service, there must be documentation of physician approval.

5. The professional staff member assigned the client shall review the individual treatment ~~or service~~ plan with the client and shall document such review in the client's record.

~~6. The treatment or service plan shall include, if appropriate, involving the family and significant others in the treatment or service of the client.~~

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-04-04. Progress notes. Progress notes must be entered into the client's service record and must include, after each visit, the client's progress towards meeting the goals of the individual treatment ~~or service~~ plan. Partial care activities must be documented in the individual client's service record at least monthly. Group therapy progress notes must be documented in the individual client's service

record at least weekly. The date, signature, and title of the staff member making an entry must be included with each entry.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-04-05. ~~Treatment and service~~ Individual treatment plan review. Individual treatment plans ~~and youth service plans must be reviewed and evaluated by the professional staff member assigned the client and that staff member's supervisor at least every six months after the development of the individual treatment plan and youth service plan. If it is determined that a client will receive long-term services, the individual treatment plan must be reviewed and evaluated at least every twelve months by the case manager and the case manager's supervisor~~ must be reviewed at least every six months, except for chronic cases which must be reviewed at least every twelve months. The individual written rehabilitation program must be reviewed and evaluated at least every twelve months by the vocational rehabilitation counselor and the ~~counselor's supervisor. The individual program plan must be reviewed and evaluated at least every twelve months by the case manager and the case manager's supervisor~~ client.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-04-06. ~~Case closure~~ Completion of treatment or service. ~~A case closure summary must be entered in the client's record within fifteen working days following the client's completion of treatment or training as outlined in the client's record. The summary must include a brief statement of the presenting problems, a summary of the course of treatment or training, diagnosis or clinical impressions at time of closure, reason for closure, and an aftercare or followup plan or referral, if appropriate. Case closure of vocational rehabilitation records shall be subject to federal law.~~

1. A treatment or service completion statement must be entered in the client's progress notes when clients have not received treatment in six months or when termination is mutually agreed upon by client and service provider, or when it has been determined by a multidisciplinary team that a client no longer needs treatment or that treatment is inappropriate.

2. When the service completion statement has been finalized, the closure must be entered on the data collection system.

History: Effective November 1, 1987; amended effective December 1, 1991.

General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-04-08. Records maintenance.

1. The regional director shall designate a staff person who is responsible for the safekeeping of each client's record.

2. All data and information in the client's record is confidential.

   a. Records must be maintained in accordance with federal and state confidentiality requirements.

   b. Upon written request, the client's record is available to the client, or to any person designated by the client, for review unless a legally sufficient basis for denying the client access to the record has been established. The center shall establish policies which encourage clients to seek professional assistance while undertaking a review of records, and which prevent the alteration of any record during a review.

3. The human service center shall comply with department policies and procedures concerning records management.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

AGENCY SYNOPSIS: Regarding proposed amendments to North Dakota Administrative Code Article 75-05 Human Service Center Licensure Standards.

Section 75-05-05-01 - Mental retardation - Developmental disabilities program - Case management: Redefines the developmental disabilities program as mental retardation - Developmental disabilities program - Case management. Provides for designation of a regional mental retardation-developmental disabilities program administrator. Requires that case management services be provided in accordance with chapter 75-04-06 and outlines written procedures to be maintained.

Section 75-05-05-02 - Vocational rehabilitation: Provides that a report of at least 10% of the vocational rehabilitation client files must be available to the regional director. Further requires that all activities be conducted in compliance with 34 CFR part 361.

Section 75-05-05-03 - Supervision and direction of county social services: Requires that all reports of suspected child abuse and neglect in a region be reviewed for compliance with North Dakota

Administrative Code chapter 75-03-19. Requires a regional representative of county social services programs to assure county access to a multidisciplinary child protection team and that child abuse and neglect information be entered into a data base. Specifies that the regional representative monitor all foster care placements for children in accordance with federal law. Requires that the representative review all foster care placements with the appropriate permanency planning committee and issue approvals for placements. Specifies other duties of the regional representative including providing for regular inservice training with respect to foster care and deletes certain other duties of the regional representative. Requires the regional representative to review each adult family foster care licensing study; to approve or deny a license and, where appropriate, revoke a license; and to provide technical assistance and interpretation of policies, procedures, rules, and law related to adult family foster care licensure standards.

Section 75-05-05-04 - Community correction program: Repeals this section relating to the community correction program.

Section 75-05-05-05 - Aging services: Specifies federal law applicable to aging services. Requires community education in gerontology.

Section 75-05-05-06 - Long-term care ombudsman program: Repeals this section concerning the employment of a regional ombudsman for long-term care facilities and requirements of the ombudsman program and staff.

75-05-05-01. Mental retardation- ~~Developmental~~ developmental disabilities program - Case management.

~~1. If the human service center operates developmental disability programs subject to licensure under chapter 75-04-01, the center must be accredited by the accreditation council for developmentally disabled persons using the most recent standards applicable at the time of survey by the council.~~

~~2. The regional director shall designate a regional developmental disabilities program administrator.~~

~~3. The human service center shall provide case management services to eligible developmentally disabled persons.~~

~~a. There must be written procedures to provide for opportunities for the individual or the individual's family to request a change of the person responsible for coordinating the individual's service plan.~~

~~b. The average caseload of the developmental disabilities case management unit must be no greater than sixty clients per case manager.~~

~~c. The developmental disabilities case manager assigned to an individual will be responsible for coordinating the~~

~~individual's overall individual service plan. The developmental disabilities case manager:~~

~~(1) Attends to the total spectrum of the individual's needs including, but not limited to, housing, family relationships, social activities, education, finance, employment, health (including special health needs), recreation, mobility, protective services, and records;~~

~~(2) Locates, obtains, and coordinates services as needed by the individual;~~

~~(3) Secures relevant data from other agencies providing services, to maintain a current individual service plan;~~

~~(4) Provides documentation concerning coordination of the individual service plan;~~

~~(5) Visits each of the persons on the case manager's caseload at their residences and day programs as required by department policies and procedures;~~

~~(6) Reviews the individual program plan prepared by each provider to assure that the resulting comprehensive plan of care identifies services to be provided, the service provider, the time of service provision, and the frequency of the service;~~

~~(7) Intervenes, when necessary, to assure implementation of the individual service plan;~~

~~(8) Requests, when necessary, review of the individual service plan by the individual's interagency team;~~

~~(9) Requests, when necessary, review of the individual program plan by the individual's interdisciplinary team; and~~

~~(10) Initiates the transfer of the individual to another service or agency, when such transfer is appropriate to meet the individual's needs.~~

1. The regional director shall designate a regional mental retardation-developmental disabilities program administrator.

2. The average caseload of the mental retardation-developmental disabilities case management unit must be no more than sixty clients per case manager.

3. Mental retardation-developmental disabilities case management services will be provided in accordance with chapter 75-04-06.

4. The center will maintain written procedures to provide for:

   a. Client admission.

   b. Assignment of a mental retardation-developmental disabilities case manager.

   c. A client or a client's legal representative to request a change in case manager.

   d. Development of an individual service plan.

   e. The completion of program reviews.

   f. A regional referral committee to coordinate adult referrals.

   g. A regional review team to review out-of-home placement options for children.

   h. Interregional transfers.

   i. Case closings.

5. A human service center that operates programs subject to licensure under chapter 75-04-01 must maintain a current license from the division of developmental disabilities for those programs. Programs in compliance with chapter 75-04-01 will not be subject to human service center licensure standards.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-05-02. Vocational rehabilitation.

1. The regional director shall designate a full-time vocational rehabilitation administrator.

2. The vocational rehabilitation administrator shall establish annual goals and objectives identifying, as a minimum, the following:

   a. Number of clients to be served and rehabilitated;

   b. Major regional initiatives in service delivery; and

   c. Job placement activities.

3. The vocational rehabilitation administrator shall follow the appeals procedures outlined in chapter 75-01-03 and shall inform all clients or potential clients of the client assistance program.

4. Client files must be monitored to assure appropriateness of services using the status life guidelines.

   a. At least ten percent of the client files will be reviewed annually using the case review schedule. A report of the results and recommendations of the review ~~will~~ must be ~~submitted~~ available to the regional director~~, if requested~~.

   b. ~~There must be a recorded contact with or on behalf of the client within the past ninety days unless the previous recording explains why a contact is not necessary~~ All activities from referral status to closure will be conducted in compliance with federal regulations [34 CFR part 361].

5. The vocational rehabilitation administrator monitors the ~~encumbrance~~ obligation of funds and bills paid to ~~ensure~~ assure that ~~obligations of available~~ funds are appropriately expended or canceled.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-05-03. Supervision and direction of county social services.

1. The regional director shall designate a regional representative of county social ~~service~~ services programs.

2. With respect to child protective services, the regional representative shall:

   a. Review all reports of suspected child abuse and neglect in the region and determine if they are investigated in accordance with North Dakota Century Code chapter 50-25.1 and ~~department policy~~ chapter 75-03-19;

   b. Determine if the investigative completion time frames and appropriate child protective services are provided in accordance with chapter 75-03-19;

   c. Provide technical assistance in child abuse and neglect services;

d. Provide final determinations of probable cause or no probable cause for all child abuse and neglect cases in the region;

~~e. Refer all child abuse and neglect cases where there is a probable cause determination to the appropriate juvenile court;~~

~~f.~~ e. Provide investigative services for reports of institutional child abuse or neglect in the region;

~~g.~~ f. ~~Establish and chair all county or multicounty child protection teams in the region and assure that they meet at least monthly~~ Assure county access to a multidisciplinary child protection term;

g. Assure that child abuse and neglect information is entered into date base;

~~h. Maintain a regional log concerning all child abuse and neglect reports and the disposition of those reports; and~~

~~i.~~ h. Provide or arrange for an orientation in children's services for counties for appropriate county social service board staff.

3. With respect to foster care services for children, the regional representative shall:

a. Monitor all placements and review all court orders for compliance with the provisions of ~~Public Law 96-272~~ title I of the Adoption Assistance and Child Welfare Act of 1980 [Pub. L. 96-272, 42 U.S.C. 670 et seq.] and section 427 of title IV-B of the Social Security Act [42 U.S.C. 627];

~~g.~~ b. Chair each county or multicounty permanency planning committee in the region and assure they meet in conformance with section 75-03-14-06;

c. Review all foster care placements and pending placements with the appropriate permanency planning committee;

d. Issue approvals for group and residential foster care placements for the region;

~~b.~~ e. Review all foster care grievances in the region to determine if they are carried out in compliance with state law and policy;

~~c.~~ f. Maintain a regional log of all children in foster care;

~~d.~~ g. Approve and arrange for specialized ~~foster care service payments program~~ therapeutic and shelter foster care service payments for all appropriate cases in the region;

h. ~~Approve all referrals for group or residential foster care placements for the region and review with the permanency planning committee; and~~ Develop and supervise special projects in the region;

~~e.~~ i. Conduct an annual licensing study of each group home or residential child care facility in the region and forward the study and recommendation to the department;

~~f.~~ j. Review each family foster care licensing study conducted in the region and approve, and issue the license, or deny the license and provide appropriate notice to applicant;

k. Where appropriate, revoke foster care licenses and provide notice to the licensee;

~~i.~~ l. Provide technical assistance and interpretation of policies, procedures, rules, and laws related to foster care services~~.~~; and

m. Provide or arrange for regular inservice training related to foster care issues for county social workers, division of juvenile services staff, and private agencies.

~~4. With respect to homemaker-home health aid services, the regional representative shall:~~

~~a. Conduct an annual audit on the certification of each county homemaker-home health aid service and send such report to the department no later than December thirty-first of the year previous to the effective date of the license;~~

~~b. Provide technical assistance to counties regarding aspects of the homemaker-home health aid services;~~

~~c. Provide or arrange for training to new homemaker supervisors in the region; and~~

~~d. Serve on the county interviewing panel for the selection of all new homemaker and home health aides in the region.~~

~~5.~~ 4. With respect to early childhood services (day care services), the regional representative shall:

a. Approve, deny, or revoke all early childhood home, group, and center license applications, as well as license applications for preschool educational facilities, and provide formal notification to all applicants;

b. Provide technical assistance regarding policies, procedures, rules, and laws for early childhood services in the region; and

c. Provide or arrange for inservice training for early childhood licensing staff regionwide.

~~6.~~ 5. With respect to unmarried minor parent services, the regional representative shall provide technical assistance for services to unmarried minor parents.

~~7. With respect to work incentive program (WIN) services, the regional representative shall provide technical assistance for the work incentive program.~~

~~8. With respect to home and community-based services (HCBS) for aged and disabled, the regional representative shall:~~

~~a. Arrange for or conduct training related to home and community-based services;~~

~~b. Provide technical assistance and interpretation of policies, procedures, rules, and laws related to home and community-based services;~~

~~c. Monitor services provided and reimbursements claimed under the home and community-based services program;~~

~~d. Resolve compliance discrepancies for services and reimbursements under the home and community-based services program; and~~

~~e. Act on individual care plans submitted for services to be provided under the medicaid waiver program for aged and disabled.~~

~~9.~~ 6. With respect to crippled children's services, the regional representative shall:

a. Provide technical assistance to county social service staff in the administration of crippled children's services; and

b. ~~Provide regional supervision~~ Cooperate and coordinate with the department's division of crippled children's services and the county social service boards for the provision of all crippled children field clinics.

7. With respect to adult family foster care licensure services, the regional representative shall:

a. Review each adult family foster care licensing study conducted in the region and approve and issue the license,

or deny the license and provide appropriate notice to applicant;

b. Where appropriate, revoke adult family foster care licenses and provide notice to the licensee; and

c. Provide technical assistance and interpretation of policies, procedures, rules, and laws related to adult family foster care licensure standards.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-05-04. Community correction program. ~~The regional director shall designate a person who is responsible for the community correction program, which must include the following four major components:~~ Repealed effective December 1, 1991.

~~1. State youth authority (SYA).~~

~~a. All youth committed to state youth authority shall have a valid court order from the originating juvenile court of jurisdiction.~~

~~b. All client management services shall include the following:~~

~~(1) The admission process must involve a face to face interview with the youth and the youth's family when possible.~~

~~(2) The admission process must include obtaining an appropriate release of information form from the parents, guardian, or legal custodian.~~

~~(3) There must be a diagnostic testing and evaluation process for all youth committed to state youth authority by professional staff within sixty days of referral as may be necessary.~~

~~(4) The diagnostic testing and evaluation process must include a report which must be sent to the committing juvenile court within ten days after the completion of the evaluation.~~

~~(5) There must be a written youth service plan based on the diagnostic testing and evaluation process and completed within sixty working days of admission.~~

(6) The youth service plan must include a placement choice which is in the least restrictive environment appropriate for treatment or rehabilitation, the name of the youth, case status, legal status, presenting problems, treatment plan goals and objectives, treatment program progress during past quarter to include action or steps taken, state youth authority worker's recommendations, and appropriate signatures to include supervisor.

(7) The youth service plan must be reviewed at least every three months; however, this plan may be reviewed and revised to reflect the ongoing treatment and rehabilitation needs of the youth.

(8) A written quarterly report must be sent to the committing court on the current status and progress of each youth committed to state youth authority.

(9) A written community placement agreement must be completed and revised as necessary for all youth committed to state youth authority.

(10) A signed release of information form from the parents, guardian, or legal custodian shall be included in the referral process for all youth committed to state youth authority who need treatment or therapy which the human service center does not provide.

c. The human service center shall provide case management and treatment or rehabilitation services to all youth committed to state youth authority.

d. State youth authority staff shall make at least one face-to-face and one additional contact every month for each youth and family residing within the regional service area and one contact each month for each youth and family residing outside the regional service area.

e. A state youth authority staff person shall serve on the permanency planning committee for all youth committed to state youth authority and to be placed in foster care.

f. There must be documentation that all youth have been informed of their civil rights and provided an explanation as to why out-of-home placement is in the youth's best interest.

g. Documentation in the youth's case file must include correspondence to youth, parents, court of jurisdiction, and other coordinating agencies as appropriate.

~~2. Upon receipt of a request from the state industrial school, which is in compliance with the current interagency contract, community correction program staff will provide aftercare services to all youth who are committed directly to the state industrial school by the court.~~

~~3. Upon referral of all youth who have, or who are likely to have, conflicts with the law, community correction program staff shall provide or arrange for the provision of supervision, counseling, and treatment.~~

~~4. Community correction program staff shall complete a placement and investigation report, and shall provide case management or supervision, counseling, and treatment services for any youth who is referred through an interstate compact from another state.~~

History: ~~Effective November 1, 1987.~~
General Authority: ~~NDCC 50-06-05.2~~
Law Implemented: ~~NDCC 50-06-05.2~~

75-05-05-05. Aging services. The regional director shall designate a regional aging services coordinator. The regional aging service coordinator, or a designee, shall:

1. Develop a plan of advocacy for services to older persons in the region.

2. Conduct public hearings:

   a. Concerning the state plan on aging; and

   b. Concerning the state funding plan for title III of the Older Americans ~~Act~~ Comprehensive Service Amendments of 1973 [Pub. L. 93-29, 42 U.S.C. 3021 et seq.].

3. Publish and distribute information to older persons.

4. Provide and document technical assistance to service providers on:

   a. Senior organizations' development and operation;

   b. Program and service development and implementation;

   c. Resource development;

   d. Funding requests under title III of the Older Americans ~~Act~~ Comprehensive Service Amendments of 1973 [Pub. L. 93-29, 42 U.S.C. 3021 et seq.];

   e. Title III audit resolution; and

f. ~~Senior center acquisition, renovation, and construction.~~ Program and service accessiblity.

5. Review and evaluate title III funding requests and grant or contract revisions for fiscal and programmatic accuracy and compliance with grant application and contracting requirements.

6. Conduct and document formal onsite ~~fiscal and~~ programmatic assessments of all title III funded service providers.

~~7. Monitor the service and fiscal performance data of each title III funded service provider.~~

~~8.~~ 7. Provide ~~financial and~~ or arrange for program training for title III funded service providers as appropriate.

~~9.~~ 8. ~~Promote~~ Provide or arrange for community education ~~and training~~ in areas of gerontology.

~~10.~~ 9. Implement ~~and evaluate outcomes of~~ selected federal and state aging program initiatives included in the state plan on aging and evaluate the results of such initiatives.

History: Effective November 1, 1987; amended effective December 1, 1991.
General Authority: NDCC 50-06-05.2
Law Implemented: NDCC 50-06-05.2

75-05-05-06. Long-term care ombudsman program. ~~The regional director of the human service center shall employ a regional ombudsman for long-term care facilities designated by the executive director of the department and maintain a staff who shall:~~ Repealed effective December 1, 1991.

~~1. Carry out the responsibilities assigned by the state long-term care ombudsman in accordance with North Dakota Century Code chapter 50-10.1.~~

~~2. Visit each long-term care facility in the region.~~

~~3. In the investigation and resolution of complaints made by or on behalf of long-term care facility residents:~~

~~a. Follow departmental procedures established for the statewide uniform reporting system.~~

~~b. File a copy of the final case closure report with the statewide uniform reporting system.~~

~~c. Maintain a filing system for the purpose of documenting pertinent information concerning the case.~~

~~4. Identify and document issues affecting long-term care residents, and where within the authority of the regional ombudsman, act on those issues.~~

~~5. Provide to the public, information and education on long-term care issues.~~

~~6. Recruit, select, train, and certify community volunteer ombudsmen, and provide technical assistance and supervision to them.~~

History: ~~Effective November 1, 1987.~~
General Authority: ~~NDCC 50-06-05.2~~
Law Implemented: ~~NDCC 50-06-05.2~~

JANUARY 1992

75-02-06-01. Definitions. In this chapter, unless the context or subject matter requires otherwise:

1. "Accrual basis" means the recording of revenue in the period when it is earned, regardless of when it is collected, and the recording of expenses in the period when incurred, regardless of when they are paid.

2. "Actual rate" means the facility rate for each cost category calculated using allowable historical operating costs and adjustment factors.

3. "Adjustment factors" means indices used to adjust reported costs for inflation or deflation based on forecasts for the rate year.

4. "Admission" means any time a resident is admitted to the facility from an outside location, including readmission resulting from a resident being hospitalized.

5. "Allowable cost" means the facility's actual cost after appropriate adjustments as required by medical assistance regulations.

6. "Chain organization" means a group of two or more health care facilities which are owned, leased, or, through any other device, controlled by one business entity. This includes not only proprietary chains, but also chains operated by various religious and other charitable organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care.

7. "Community contribution" means contributions to civic organizations and sponsorship of community activities. It does not include donations to charities.

8. "Cost category" means the classification or grouping of similar or related costs for purposes of reporting, the determination of cost limitations, and determination of rates.

9. "Cost center" means a division, department, or subdivision thereof, group of services or employees or both, or any unit or type of activity into which functions of a facility are divided for purposes of cost assignment and allocations.

10. "Cost report" means the department approved form for reporting costs, statistical data, and other relevant information of the facility.

11. "Department" means the department of human services.

12. "Depreciation" means an allocation of the cost of an asset over its estimated useful life.

13. "Desk audit rate" means the rate established by the department based upon a review of the cost report submission prior to an actual audit of the cost report.

14. "Direct costing" means identification of actual costs directly to a facility or cost category without use of any means of allocation.

15. ~~"Direct care costs" means the cost category for allowable nursing and therapy costs.~~

~~16.~~ "Employment benefits" means fringe benefits and payroll taxes.

~~17.~~ 16. "Established rate" means the rate paid for services.

~~18.~~ 17. "Facility" means a nursing facility not owned or administered by state government. It does not mean an intermediate care facility for the mentally retarded.

~~19.~~ 18. "Fair market value" means value at which an asset could be sold in the open market in a transaction between informed, unrelated parties.

~~20.~~ 19. "Freestanding facility" means a nursing facility which does not share basic services with a hospital-based provider.

~~21.~~ 20. "Highest market driven compensation" means the highest compensation given to an employee of a freestanding facility who is not an owner of the facility or is not a member of the governing board of the facility.

~~22. "Indirect care costs" means the cost category for allowable administration, plant, housekeeping, medical records, chaplain, pharmacy, and dietary, exclusive of food costs.~~

21. "Hospital leave day" means any day that a resident is not in the facility, but is in an acute care setting as an inpatient.

~~23.~~ 22. "In-house resident day" for nursing facilities means a day that a resident was actually residing in the facility and was not on therapeutic leave or in the hospital. "In-house resident day" for hospitals means an inpatient day.

~~24.~~ 23. "Limit rate" means the rate established as the maximum allowable rate for a cost category.

~~25.~~ 24. "Lobbyist" means any person who in any manner, directly or indirectly, attempts to secure the passage, amendment, defeat, approval, or veto of any legislation, attempts to influence decisions made by the legislative council, and is required to register as a lobbyist.

~~26.~~ 25. "Medical assistance program" means the program which pays the cost of health care provided to eligible recipients pursuant to North Dakota Century Code chapter 50-24.1.

~~27.~~ 26. "Medical records costs" means costs associated with the determination that medical record standards are met and with the maintenance of records for individuals who have been discharged from the facility. It does not include maintenance of medical records for in-house residents.

~~28. "Other direct care costs" means the cost category for allowable activities, social services, laundry, and food costs.~~

~~29.~~ 27. "Private room" means a room which is equipped for use by only one resident.

~~30.~~ 28. "Property costs" means the cost category for allowable real property costs and other costs which are passed through.

~~31.~~ 29. "Provider" means the organization or individual who has executed the provider agreement with the department.

~~32.~~ 30. "Reasonable resident-related cost" means the cost that must be incurred by an efficiently and economically operated facility to provide services in conformity with applicable state and federal laws, regulations, and quality and safety standards. Reasonable resident-related cost takes into account that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost-conscious buyer pays for a given item or services.

~~33.~~ 31. "Related organization" means an organization which a provider is, to a significant extent, associated with, affiliated with, able to control, or controlled by, and which furnishes services, facilities, or supplies to the provider. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the policies of an organization or provider.

32. "Resident" means a person who has been admitted to the facility, but not discharged.

~~34.~~ 33. "Resident day" in a nursing facility means all days for which service is provided or for which payment is ordinarily sought, including hospital~~,~~ ~~leave, and hold~~ and leave days. The day of admission will be counted. The day of death will be counted, but not the day of discharge. "Resident day" in a hospital means all inpatient days for which payment is ordinarily sought.

34. "Significant capacity increase" means an increase of fifty percent or more in the number of licensed beds or an increase of twenty beds, whichever is greater; but does not mean such an increase by a facility which reduces the number of its licensed beds and thereafter relicenses those beds, and does not mean an increase in a nursing facility's licensed capacity resulting from converting beds formerly licensed as basic care beds.

35. "Standardized resident day" means a resident day times the classification weight for the resident.

36. "Therapeutic leave day" means any day that a resident is not in the facility or in a hospital.

History: Effective September 1, 1980; amended effective December 1, 1983; June 1, 1985; September 1, 1987; January 1, 1990; January 1, 1992.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-02.2. Direct care costs. Direct care costs include only those costs identified in this section.

1. Therapies:

   a. Salary and employment benefits for speech, occupational, and physical therapists, or for personnel, who are not reported in subsection 2, performing therapy under the direction of a licensed therapist.

   b. The cost of noncapitalized therapy equipment or supplies used to directly provide therapy, not including office supplies.

c. Training which is required to maintain licensure, certification, or professional standards, and the related travel costs.

2. Nursing:

a. Salary and employment benefits for the director of nursing, nursing supervisors, inservice trainers for nursing staff, registered nurses, licensed practical nurses, quality assurance personnel, nurse aides, orderlies, and ward clerks.

b. Routine nursing care supplies ~~which are:~~

~~(1)~~ ~~Items~~ including items that are furnished routinely and relatively uniformly to all residents; ~~e.g., gowns, water pitchers, basins, bedpans, etc.~~

~~(2)~~ ~~Items~~ items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually in small quantities; ~~e.g., alcohol, applicators, cotton balls, incontinent supplies, bandaids, antacids, aspirins, nonlegend drugs ordinarily kept on hand, suppositories, tongue depressors, shampoo, deodorants, mouthwashes, kleenex, toothpaste, denture cleaner, etc.~~

~~(3)~~ ~~Items~~ and items utilized by individual residents which are reusable, vary by the needs of an individual, and are expected to be available in the facility~~, e.g., ice bags, bedrails, canes, crutches, walkers, traction equipment, other durable medical equipment and wheelchairs,~~ except for motorized, heavy-duty, specialized wheelchairs purchased at a cost in excess of one thousand dollars, and wheelchairs other than the type normally provided by the facility.

~~(4) Items which come within the definitions set forth in the personal needs guidelines of the guidelines for routine drugs, supplies, and equipment for nursing facilities as issued by the medical services division.~~

c. Training which is required to maintain licensure, certification, or professional standards requirements, and the related travel costs.

d. Routine hair care, including grooming, shampooing, and cutting.

History: Effective January 1, 1990; amended effective January 1, 1992.
General Authority: NDCC 50-24.1-04, 50-24.4-02

Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-02.6. Cost allocations.

1. Direct costing of allowable costs will be used whenever possible. For facilities which cannot direct cost, the following allocation methods are to be used:

   a. For nursing facilities that are combined with a hospital or have more than one license (including basic care), the following allocation methods must be used:

      (1) Nursing salaries which cannot be reported based on actual costs are to be allocated using time studies. Time studies must be conducted at least semiannually for a two-week period or quarterly for a one-week period. The time study must represent a typical period of time when employees are performing normal work activities in each of their assigned areas of responsibilities. Allocation percentages based on the time studies are to be used starting with the next pay period following completion of the time study or averaged for the report year. The methodology used by the facility may not be changed without approval by the department. If time studies are not completed, nursing salaries will be allocated based on revenues for resident services.

      (2) Salaries for a director of nursing or nursing supervisors which cannot be reported based on actual costs or time studies must be allocated based on nursing salaries or full-time equivalents (FTEs) of nursing staff.

      (3) Staff development or inservice trainer salaries must be allocated ~~based on salaries~~ to nursing and therapies based on the ratio of nursing and therapy salaries to total salaries, to non-long term care based on the ratio of non-long term care salaries to total salaries, and to administration based on the ratio of total salaries less nursing salaries, therapy salaries, and non-long term care salaries to total salaries.

      (4) Other nursing costs must be allocated based on resident days.

      (5) Therapy costs, other than therapy salaries and purchased services, must be allocated based on the ratio of therapy salaries and purchased services in the nursing facility to total therapy salaries and purchased services.

(6) Dietary and food costs must be allocated based on number of meals served or in-house resident days.

(7) Laundry costs must be allocated on the basis of pounds of laundry.

(8) Activity costs must be allocated based on in-house resident days.

(9) Social service costs must be allocated based on resident days.

(10) Housekeeping costs must be allocated based on ~~usable~~ weighted square footage.

(11) Plant operation costs must be allocated based on ~~usable~~ weighted square footage.

(12) Medical records costs must be allocated based on the number of admissions or discharges and deaths.

(13) Pharmacy costs for consultants must be allocated based on in-house resident days.

(14) Administration costs must be allocated on the basis of the percentage of total adjusted cost, excluding property, administration, and chaplain, in each facility.

(15) Property costs must be allocated first to a cost center based on square footage. The property costs allocated to a given cost center will then be allocated using the methodologies set forth in this section for that particular cost center.

(16) Chaplain costs must be allocated based on the percentage of total costs, excluding property, administration, and chaplain.

(17) Employment benefits must be allocated based on the ratio of salaries to total salaries.

b. If any of the allocation methods in subdivision a cannot be used by a facility, a waiver request may be submitted to the medical services division. The request must include an adequate explanation as to why the referenced allocation method cannot be used by the facility. The facility must also provide a rationale for the proposed allocation method. Based on the information provided, the department will determine the allocation method that will be used to report costs.

c. Malpractice ~~and~~, professional liability insurance ~~and~~, therapy salaries, and purchased therapy services must be direct costed.

d. The costs of operating a pharmacy must be included as non-long term care costs.

e. For purposes of this subsection, "weighted square footage" means the allocation of the facility's total square footage, excluding common areas, identified first to a cost category and then allocated based on the allocation method described in this subsection for that cost category.

2. For nursing facilities that cannot directly identify salaries and employment benefits to a cost category, the following cost allocation methods must be used:

a. Salaries, excluding staff development and inservice trainer salaries, must be allocated using time studies. Time studies must be conducted semiannually for a two-week period or quarterly for a one-week period. The time study must represent a typical period of time when employees are performing normal work activities in each of their assigned areas of responsibilities. Allocation percentages based on the time studies are to be used starting with the next pay period following completion of time study or averaged for the reporting year. The methodology used by the facility may not be changed without approval by the department. If time studies are not completed, salaries and employment benefits will be allocated entirely to the indirect care costs, if any of the employee's job duties are included in this cost category. Otherwise, salaries and employment benefits will be other direct care costs.

b. Staff development and inservice trainer salaries must be allocated to nursing and therapies based on the ratio of nursing and therapy salaries to total salaries and to administration based on the ratio of total salaries less nursing and therapy salaries to total salaries.

c. Employment benefits must be allocated based on the ratio of salaries in the cost category to total salaries.

3. Nursing facilities which operate or are associated with nonresident-related activities, i.e., apartment complexes, shall allocate administration costs as follows:

a. If the costs of the nonresident-related activities exceed five percent of total nursing facility cost, exclusive of property, administration, and chaplain costs, administration costs must be allocated on the basis of the

percentage of total cost, excluding property, administration, and chaplain.

b. If the costs of the nonresident-related activities are less than five percent of total nursing facility costs, exclusive of property, administration, and chaplain costs, administration costs must be allocated to each such activity based on the percent gross revenues for the activity is of total gross revenues; provided, however, that the allocation will not be based on a percentage exceeding two percent for each activity.

c. If the provider can document, to the satisfaction of the department, that none of the nursing facility resources or services are used in connection with the nonresident-related activities, no allocation need be made.

d. The provisions of this subsection do not apply to the activities of hospital and basic care facilities associated with a nursing facility.

History: Effective January 1, 1990; amended effective January 1, 1992.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-03. Depreciation.

1. Ratesetting principles require that payment for services should include depreciation on all depreciable type assets that are used to provide necessary services. This includes assets that may have been fully (or partially) depreciated on the books of the provider, but are in use at the time the provider enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on the revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity. If any depreciated personal property asset is sold or disposed of for an amount different than its undepreciated value, the difference represents an incorrect allocation of the cost of the asset to the facility and must be included as a gain or loss on the cost report.

2. Depreciation methods.

   a. The straight-line method of depreciation must be used. All accelerated methods of depreciation, including depreciation options made available for income tax purposes, are unacceptable. The method and procedure for computing depreciation must be applied on a basis consistent from year to year and detailed schedules of

individual assets shall be maintained. If the books of account reflect depreciation different than that submitted on the cost report, a reconciliation must be prepared by the facility.

b. Providers shall project a useful life at least as long as the useful life guidelines published by the American hospital association. The provider may choose to use a composite useful life of ten years for all equipment and four years for vehicles. With the exception of assets purchased prior to July 1, 1989, all assets must be depreciated using the same methodology.

3. Acquisitions.

a. If a depreciable asset or special assessment has, at the time of its acquisition, a historical cost of at least one thousand dollars, its cost must be capitalized and depreciated over the estimated useful life of the asset. Cost during the construction of an asset, such as architectural, consulting and legal fees, interest, etc., should be capitalized as a part of the cost of the asset.

b. All repair or maintenance costs in excess of five thousand dollars per project on equipment or buildings must be capitalized and depreciated over the remaining useful life of the equipment or building repaired or maintained, or one-half of the original estimated useful life, whichever is greater.

4. Proper records will provide accountability for the fixed assets and also provide adequate means by which depreciation can be computed and established as an allowable resident-related cost. Tagging of major equipment items is not mandatory, but alternate records must exist to satisfy audit verification of the existence and location of the assets.

5. For purposes of this chapter, donated assets may be recorded and depreciated based on their fair market value. In the case where the provider's records do not contain the fair market value of the donated asset, as of the date of the donation, an appraisal must be made. The appraisal will be made by a recognized appraisal expert and will be accepted for depreciation purposes. The facility may elect to forego depreciation on donated assets thereby negating the need for a fair market value determination.

6. Purchase of a facility and its depreciable assets as an ongoing operation.

a. Determination of the cost basis of a facility and its depreciable assets of an ongoing operation depends on

whether or not the transaction is a bona fide sale. Should the issue arise, the purchaser has the burden of proving that the transaction was a bona fide sale. Purchases where the buyer and seller are related organizations are not bona fide. The cost basis of a facility and its depreciable assets acquired as an ongoing operation is limited to the lowest of the following:

(1) Current reproduction cost of the assets, depreciated on a straight-line basis over its useful life to the time of the sale;

(2) Price paid by the purchaser (actual cost);

(3) Fair market value of the facility or asset at the time of the sale;

(4) In a sale not bona fide, the seller's cost basis, less accumulated depreciation; or

(5) With respect to sales made on or after July 18, 1984, the seller's cost basis less accumulated depreciation, plus recaptured depreciation.

(6) In the case of assets which have been previously owned by a hospital, or facility, and for which such hospital or facility has received payment, for services provided to recipients of benefits under title XVIII (medicare) or XIX (medicaid) of the Social Security Act, at a rate which reflects depreciation expense concerning those assets, the allowable acquisition cost of such assets to the first owner on or after July 18, 1984.

b. The seller shall always use the sale price in computing the gain or loss on the disposition of assets.

c. Appraisal guidelines. To properly provide for costs or valuations of fixed assets, an appraisal will be required if the provider:

(1) Has no historical cost records or has incomplete records of depreciable fixed assets; or

(2) Prior to July 18, 1984, purchases a facility without designation of purchase price for the classification of assets acquired. Prior to having an appraisal made, the provider must inform the state that it intends to have the appraisal made. At this time the provider shall also set forth the reasons for the appraisal and will make available to the department the agreement between the provider and the appraiser. The appraisal agreement should contain the appraisal

date, the estimated date of completion, the scope of the appraisal, and the statement that the appraisal will conform to the current medicare regulation on principles of reimbursement for provider cost.

(3) Limitation. With respect to purchases occurring before July 18, 1984, the department will recognize appraised value not to exceed cost basis for tax purposes. In all cases of major change, proper authority for expenditure shall be obtained.

7. For rate years beginning on or after January 1, 1990, the department will recognize for depreciation purposes the difference of the actual purchase price of building and equipment for nonrelated party purchases finalized before July 1, 1987, and the cost basis established at the time of purchase. The department will continue to use the useful life and the cost basis established at the time the purchases were made in determining the basis of depreciation for a facility purchased as an ongoing operation on or after July 1, 1987. No adjustments will be allowed for any depreciable costs that exceeded the basis in effect for rate periods prior to January 1, 1990.

8. Recapture of depreciation.

a. At any time that the operators of a facility sell an asset, or otherwise remove that asset from service in or to the facility, any depreciation costs asserted after June 1, 1984, with respect to that asset, are subject to recapture to the extent that the sale or disposal price exceeds the undepreciated value. If the department determines that a sale or disposal was made to a related party, or if a facility terminates participation as a provider of services in the medicaid program, any depreciation costs asserted after June 1, 1984, with respect to that asset or facility, are subject to recapture to the extent that the fair market value of the asset or facility exceeds the depreciated value.

b. The seller and the purchaser may, by agreement, determine which shall pay the recaptured depreciation. If the ~~parties to the sale do not inform the department of their agreement~~ depreciation recapture amount is not paid in full to the department within thirty days after the date of the sale, the department will offset the amount of depreciation to be recaptured against any amounts owed, or to be owed, by the department to the seller and buyer. The department will first exercise the offset against the seller, and shall only exercise the offset against the buyer to the extent that the seller has failed to repay the amount of the recaptured depreciation, plus interest. If the depreciation recapture amount is not paid in full

to the department within thirty days of the date of the sale, interest on the depreciation recapture amount from the date of sale is due to the department in addition to the depreciation recapture amount. The interest accrues at the rate at which interest accrues against the state of North Dakota, under the Cash Management Improvement Act of 1990, [Pub. L. 101-453; 31 U.S.C. 6501 et seq.] for refunds of federal medicaid funds received by the state, but not repaid to the federal agency, or six percent per annum, whichever is greater. Depreciation recapture amounts and interest payments made thereon to the department and the cost of borrowing for the purpose of repaying recaptured depreciation and interest on recaptured depreciation are not costs which are related to resident care.

History: Effective September 1, 1980; amended effective December 1, 1983; October 1, 1984; September 1, 1987; January 1, 1990; January 1, 1992.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-12. Offsets to cost.

1. Several items of income, whether in cash or in any other form, will be considered as offsets against various costs as recorded in the books of the facility. Any income which is received by the facility, with the exception of the established rate, income from payments made under the Job Training Partnership Act, and income from charges to private pay residents for private rooms or special services, will be offset up to the total of the appropriate actual cost. If actual costs are not identifiable, income will be offset up to the total of costs described in this section. If costs relating to income are reported in more than one cost category, the income must be offset in the ratio of the costs in each cost category. These sources of income include, but are not limited to:

   a. "Activities income". Income from the activities department and the gift shop will be offset to activity costs.

   b. "Dietary income". Amounts received from or on behalf of employees, guests, or other nonresidents for lunches, meals, or snacks will be offset to dietary costs.

   c. "Drugs or supplies income". Amounts received from employees, doctors, or others not admitted as residents will be offset to nursing supplies.

d. "Insurance recoveries income". Any amount received from insurance for a loss incurred shall be offset against the appropriate cost category, regardless of when the cost was incurred, if the facility did not adjust the basis for depreciable assets.

e. "Interest or investment income". Interest received on investments, except amounts earned on funded depreciation or from earnings on gifts where the identity remains intact, shall be offset to interest expense.

f. "Laundry income". All amounts received for services rendered to or on behalf of employees, doctors, or others will be offset to laundry costs.

g. "Private duty nurse income". Income received for the providing of a private duty nurse will be offset to nursing salaries.

h. "Rentals of facility space income". Income received from outside sources for the use of facility space and equipment will be offset to property costs.

i. "Telegraph and telephone income". Income received from residents, guests, or employees will be offset to indirect costs. Income from emergency answering services need not be offset.

j. "Therapy income". Income from ~~medicare part B and outpatient~~ all therapy services will be offset to therapy costs. ~~If therapy income is not identified by source, all therapy income will be offset.~~

k. "Vending income". Income from the sale of beverages, candy, or other items will be offset to the cost of the vending items or, if the cost is not identified, all vending income will be offset to administrative costs.

l. "Bad debt recovery". Income for bad debts which have been previously claimed shall be offset to administrative costs in the year of recovery.

m. "Other cost-related income". Miscellaneous income, including amounts generated through the sale of a previously expensed or depreciated item, e.g., supplies or equipment, must be offset to the cost category where the item was expensed or depreciated.

2. Payments to a provider by its vendor will ordinarily be treated as purchase discounts, allowances, refunds, or rebates in determining allowable costs even though these payments may be treated as "contributions" or "unrestricted grants" by the provider and the vendor. However, such payments may represent

a true donation or grant. Examples include, but are not limited to, when: (1) they are made by a vendor in response to building or other fundraising campaigns in which communitywide contributions are solicited; or (2) the volume or value of purchases is so nominal that no relationship to the contribution can be inferred. The provider must provide verification, satisfactory to the department, to support a claim that a payment represents a true donation.

3. Where an owner or other official of a provider directly receives from a vendor monetary payments or goods or services for the owner's or official's own personal use as a result of the provider's purchases from the vendor, the value of such payments, goods, or services constitutes a type of refund or rebate and must be applied as a reduction of the provider's costs for goods or services purchased from the vendor.

4. Where the purchasing function for a provider is performed by a central unit or organization, all discounts, allowances, refunds, and rebates must be credited to the costs of the provider in accordance with the instructions above. These should not be treated as income of the central purchasing function or used to reduce the administrative costs of that function. Such administrative costs are, however, properly allocable to the facilities serviced by the central purchasing function.

5. Purchase discounts, allowances, refunds, and rebates are reductions of the cost of whatever was purchased.

History: Effective September 1, 1980; amended effective December 1, 1983; October 1, 1984; September 1, 1987; June 1, 1988; January 1, 1990; January 1, 1992.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-12.1. Nonallowable costs. Nonallowable costs include, but are not limited to:

1. Costs described as nonallowable under North Dakota Century Code section 50-24.4-07.

2. Interest charges on fines or penalties, bank overdraft charges, and late payment charges.

3. Assessments made by or the portion of dues charged by associations or professional organizations for lobbying costs, contributions to political action committees or campaigns, or litigation, except for successful challenges to decisions made by governmental agencies. Where the breakdown of dues charged to a facility is not provided, the entire cost is nonallowable.

4. Community contributions, employer sponsorship of sports teams, and dues to civic and business organizations, i.e., Lions, Chamber of Commerce, or Kiwanis, in excess of fifteen hundred dollars per cost reporting period.

5. Home office costs which would be nonallowable if incurred by a facility.

6. Stockholder servicing costs, including, but not limited to, annual meetings, annual reports and newsletters, accounting and legal fees for consolidating statements for security exchange commission proposes, stock transfer agent fees, and stockholder and investment analysis.

7. Corporate costs which are not related to resident care, including reorganization costs, costs associated with acquisition of capital stock, and costs relating to the issuance and sale of capital stock or other securities.

8. The full cost of items or services such as telephone, radio, and television, including cable hookups or satellite dishes, located in resident accommodations, excluding common areas, which are furnished solely for the personal comfort of the residents.

9. Fundraising costs, including salaries, advertising, promotional, or publicity costs incurred for such a purpose.

10. The cost of any equipment, whether owned or leased, not exclusively used by the facility except to the extent that the facility demonstrates, to the satisfaction of the department, that any particular use of equipment was related to resident care.

11. Costs, including, by way of illustration and not by way of limitation, legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, attributed to the negotiation or settlement of the sale or purchase of any capital assets, whether by sale or merger, when the cost of the asset has been previously reported and included in the rate paid to any hospital or facility.

12. Costs which are incurred by the provider's subcontractors, or by the lessor of property which the provider leases, and which become an element in the subcontractor's or lessor's charge to the provider, if such costs would not have been allowable had they been incurred by a provider directly furnishing the subcontracted services, or owning the leased property; provided, however, that no provider shall have a particular item of cost disallowed under this subsection if that cost arises out of a transaction which was completed before July 18, 1984.

13. The cost, in excess of charges, of providing meals and lodging to facility personnel living on premises.

14. Depreciation expense for facility assets which are not related to resident care.

15. Nonnursing facility operations and associated administrative costs.

16. Direct costs or any amount claimed to medicare for medicare utilization review costs.

17. All costs for services paid directly by the department to an outside provider.

18. Travel costs involving the use of vehicles not exclusively used by the facility are allowable only within the limits of this subsection.

    a. Vehicle travel costs may not exceed the amount established by the internal revenue service.

    b. The facility shall support vehicle travel costs with sufficient documentation to establish that the purpose of the travel is related to resident care.

    c. The facility shall document all costs associated with a vehicle not exclusively used by the facility.

19. Travel costs other than vehicle-related costs are allowable provided they are supported, reasonable, and related to resident care.

20. The fees paid to members of a board of directors for meetings attended must be allowed in an amount not to exceed the compensation paid, per day, to members of the legislative council, pursuant to North Dakota Century Code section 54-35-10. No additional compensation will be allowed for service of employees on the board of directors. Travel costs associated with meetings of boards of directors are allowable to the extent such meetings are held in a location where the organization has a nursing facility.

21. The costs of deferred compensation and pension plans that discriminate in favor of certain employees, excluding the portion of the cost which relates to costs that benefits all eligible employees.

22. Premiums for top management personnel life insurance policies, except that such premiums must be allowed if the policy is included within a group policy provided for all employees, or if such a policy is required as a condition of mortgage or

loan and the mortgagee or lending institution is listed as the beneficiary.

23. Personal expenses of owners and employees, such as vacations, boats, airplanes, personal travel or vehicles, and entertainment.

24. Costs which are not adequately documented. Adequate documentation includes written documentation, date of purchase, vendor name, listing of items or services purchased, cost of items purchased, account number to which the cost is posted, and a breakdown of any allocation of costs between accounts or facilities.

25. The following taxes:

    a. Federal income and excess profit taxes, including any interest or penalties paid thereon.

    b. State or local income and excess profit taxes.

    c. Taxes in connection with financing, refinancing, or refunding operation, such as taxes in the issuance of bonds, property transfers, issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.

    d. Taxes such as real estate and sales tax for which exemptions are available to the provider.

    e. Taxes on property which is not used in the provision of covered services.

    f. Taxes, such as sales taxes, levied against the residents and collected and remitted by the provider.

    g. Self-employment (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, etc.

26. The unvested portion of a facility's accrual for sick or annual leave.

27. The cost, including depreciation, of equipment which was purchased with funds received from a local or state agency, exclusive of any federal funds.

28. Hair care, other than routine hair care, when requested by a resident.

29. The ~~direct costs of operating a pharmacy~~ cost of education unless:

a. The education was provided by an accredited academic or technical educational facility;

b. The expenses were for materials, books, or tuition;

c. The employee was enrolled in a course of study intended to prepare the employee for a position at the facility, and is in that position; and

d. The facility claims the cost of the education at a rate which does not exceed one dollar per hour of work performed by the employee in the position for which the employee received education at the facility's expense, provided that the amount claimed per employee may not exceed two thousand dollars per year, or an aggregate of eight thousand dollars, and in any event may not exceed the cost to the facility of the employee's education.

History: Effective January 1, 1990; amended effective January 1, 1992.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

75-02-06-16. Rate determinations.

1. Each cost category actual rate is calculated using the allowable historical operating costs and adjustment factors provided for in subsection 4 divided by standardized resident's days for the direct care cost category and resident days for other direct care, indirect care, and property cost categories. The actual rate as calculated is compared to the limit rate for each cost category to determine the lesser of the actual rate or the limit rate. The lesser rate for direct care is then multiplied times the weight for each classification in subsection 5 of section 75-02-06-17 to establish the direct care rate for that classification. The lesser of the actual rate or the limit rate for other direct care, indirect care, and property costs, and the adjustments provided for in subsections 2 and 3 are then added to the direct care rate for each classification to arrive at the established rate for a given classification.

2. a. Incentives. For a facility with an acutal rate below the limit rate for indirect care costs, an amount equal to seventy percent times the difference between the actual rate, exclusive of inflation indices, and the limit rate, exclusive of ~~current~~ inflation indices for periods after the report year, up to a maximum of two dollars and sixty cents will be included as part of the indirect care cost rate.

b. Operating margins. A facility will receive an operating margin of three percent based on the lesser of the actual

direct care and other direct care rates or the limit rate exclusive of current inflation indices. The three percent operating margin will then be added to the rate for the direct care and other direct care cost categories.

3. Limitations.

   a. The department shall accumulate and analyze statistics on costs incurred by the nursing facilities. These statistics may be used to establish reasonable ceiling limitations and incentives for efficiency and economy based on reasonable determination of standards of operations necessary for efficient delivery of needed services. These limitations and incentives may be established on the basis of cost of comparable facilities and services and may be applied as ceilings on the overall costs of providing services or on specific areas of operations. It shall be the option of the department to implement the ceilings so mentioned at any time based upon the information available and under guidelines required within the regulations of title XIX.

   b. The department will review, on an ongoing basis, aggregate payments to nursing facilities to determine that payments do not exceed an amount that can reasonably be estimated would have been paid for those services under medicare payment principles. If aggregate payments to nursing facilities exceed estimated payments under medicare, the department may make adjustments to rates to establish the upper limitations so that aggregate payments do not exceed an amount that can be estimated would have been paid under medicare payment principles.

   c. Limits. All facilities except those facilities described in North Dakota Century Code section 50-24.4-13 will be used to establish a limit rate for the direct care, other direct care, and indirect care cost categories. This limit rate will be established using allowable historical operating costs for the ~~report year ended June 30, 1988~~ base year, and adjustment factors for the rate year as set forth in ~~subsection 4~~ this subsection. The initial base year is the report year ended June 30, 1988. These limit rates may not be rebased prior to the rate periods beginning January 1, 1993. The department will review economic trends and factors affecting nursing facilities to determine when rebasing of the limits will occur. Base year costs may not be adjusted in any manner or for any reason not provided for in this subsection.

      (1) The limit rate for each of the cost categories will be established using the median rate for the appropriate cost category plus a fixed percentage of

the median rate. The fixed percentage is to be determined as follows:

(a) Historical costs for June 30, 1988, as adjusted, will be used to set rates for all facilities in the direct care, other direct care, and indirect care cost categories.

(b) The rates for each cost category will be ranked from low to high. The ninetieth percentile ranking will be determined for the direct care and other direct care cost categories, and the seventy-fifth percentile ranking will be determined for the indirect care cost category.

(c) The fixed percentage will be determined by subtracting the median rate from the percentile ranking rate and dividing the difference by the median rate.

(d) The fixed percentage established under subparagraph c of this paragraph will be used to determine limits if and when rebasing of the limit year occurs.

(2) A facility who has an actual rate that exceeds the limit rate for a cost category will receive the limit rate.

(3) For the rate years beginning January 1, 1990, and ending December 31, 1992, a facility whose actual rate exceeds the limit rate for a cost category will receive a percentage of the difference between the actual rate and the limit rate as follows:

(a) For the rate year beginning January 1, 1990, forty-five percent of the difference will be included in the facility's rate.

(b) For the rate year beginning January 1, 1991, forty-five percent of the difference will be included in the facility's rate.

(c) For the rate year beginning January 1, 1992, twenty-five percent of the difference will be included in the facility's rate.

(4) The limit rates will be adjusted each year to reflect the latest available index of nursing facility costs, prepared by an independent economic forecaster, which is, to the extent reasonably possible, based on the actual historical increase or decrease in base year costs, and which is further adjusted to reflect the

forecasted increase or decrease in base year costs to the end of the rate year.

4. Adjustment factors for direct care, other direct care, and indirect care costs.

   a. The department will utilize an independent economic forecast method of predicting the factors to be used to adjust historical allowable costs. Where possible, adjustment factors specific to North Dakota will be used to establish the adjustment for each rate year. If specific North Dakota data is not available, regional-specific or national data will be used to establish adjustment factors for each rate year. Individual adjustment factors for the cost components included in this subdivision will be calculated for each rate year.

      (1) Salaries.

      (2) Employment benefits.

      (3) Foods.

      (4) Utilities.

      (5) Drugs and nursing supplies.

      (6) Other costs.

   b. An adjustment factor will be separately calculated for direct care, other direct care, and indirect care costs based on the forecasted increase or decrease in the cost components for the eighteen months from the end of the report year to the end of the next rate year.

   ~~b. The same methodology will be used to adjust the previous year's established limit rates for direct care, other direct care, and indirect care costs.~~

5. Rate adjustments.

   a. Desk audit rate.

      (1) The cost report will be reviewed taking into consideration the prior year's adjustments. The facility will be notified by telephone or mail of any adjustments based on the desk review. Within seven working days after notification, the facility may submit information to explain why the desk adjustment should not be made. The department will review the information and make adjustments which are determined to be appropriate.

(2) The desk audit rate will be effective January first of each rate year and will continue in effect until a final rate is established.

(3) Until a final rate is effective, pursuant to paragraph 3 of subdivision b of this subsection, private-pay rates may not exceed the desk audit rate except as provided for in North Dakota Century Code section 50-24.4-19.

(4) No reconsideration will be given by the department for the desk rate unless the facility has been notified that the desk rate is the final rate.

b. Final rate.

(1) The cost report may be field audited to establish a final rate. If no field audit is performed, the desk audit rate will become the final rate.

(2) The final rate will include any adjustments for nonallowable costs, errors, or omissions that result in a change from the desk audit rate of five cents per day or an aggregate of one thousand dollars for the facility, whichever is less, that are found during a field audit or are reported by the facility within twelve months of the rate yearend.

(3) The private-pay rate must be adjusted to the final rate ~~in~~ no later than the first day of the second month following receipt of notification by the department of the final rate and is not retroactive except as provided for in subdivision c of this subsection.

(4) If adjustments, errors, or omissions are found after a final rate has been established, the following procedures will be used:

(a) Adjustments, errors, or omissions found within twelve months of establishment of the final rate and resulting in a change of at least five cents per day will result in a change to the final rate. The change will be applied retroactively as provided for in this section.

(b) Adjustments, errors, or omissions in excess of one thousand dollars for the facility found later than twelve months after the establishment of the final rate will be included as an adjustment in the report year that the adjustment, error, or omission was found.

c. Adjustment of the total payment rate. The final rate as established will be retroactive to January first of the rate year, except with respect to rates paid by private-paying residents. Rates paid by private-pay residents must be retroactively adjusted and the difference refunded to the resident, if the desk audit rate exceeds the final rate by at least twenty-five cents per day.

6. Rate payments.

a. The rate as established shall be considered as payment for all accommodations and includes all items designated as routinely provided. No payments may be solicited or received from the resident or any other person to supplement the rate as established.

b. The rate as established shall be paid by the department only if the rate charged to private-pay residents for semiprivate accommodations equals the established rate. If at any time the facility discounts the private pay rate for those periods of time that the resident is not in the facility, the discounted rate will be the maximum chargeable to the department for the same service, i.e., hospital or leave days.

c. If the established rate exceeds the private pay rate, on any given date, the facility shall immediately report that fact to the department and charge the department at the lower rate. If payments were received at the higher rate, the facility shall, within thirty days, refund the overpayment. The refund will be the difference between the established rate and the rate charged the private-pay resident times the number of medical assistance resident days paid during the period in which the established rate exceeded the rate charged to private-pay residents, plus interest calculated at two percent over the Bank of North Dakota prime rate on any amount not repaid within thirty days. The refund provision will also apply to all duplicate billings involving the department. Interest charges on these refunds are not allowable costs.

d. Peer groupings, limitations, or adjustments which are based upon data received from or relating to more than one facility will be effective for a rate period. Any change in the data used to establish peer groupings, limitations, or adjustments will not be used to change such peer groupings, limitations, or adjustments during the rate period, except with respect to the specific facility or facilities to which the data change relates.

7. Partial year.

a. For facilities changing ownership during the rate period, the rate established for the previous owner will be retained. The rate for the next rate period following the change in ownership will be established as follows:

(1) For a facility with four or more months of operation under the new ownership during the report year, a cost report for the period will be used.

(2) For a facility with less than four months of operations under the new ownership during the report year, the rate established for the previous owner will be indexed forward using the adjustment factors as set forth in subsection 4.

b. For ~~an existing facility with a capacity increase and for~~ a new facility, the department will establish ~~an~~ interim ~~rate equal to one hundred ten percent of the sixtieth percentile of the~~ rates equal to the limit rates for direct care, other direct care, and indirect care ~~rates not to exceed the limit rate, plus an amount calculated using paragraph 3 of subdivision c of subsection 3 of this section~~ in effect for the rate year in which the facility begins operation, plus the property rate. The property rate will be calculated using projected property costs and certificate of need projected census. The interim rate will be in effect for no less than ~~four~~ ten months and no more than ~~fifteen~~ eighteen months. Costs for the period in which the interim ~~rate is~~ rates are effective will be used to establish ~~a~~ final ~~rate~~ rates, which will be limited to the lesser of the interim or actual ~~rate~~ rates. If the final ~~rate~~ rates for direct care, other direct care, and indirect care costs ~~is~~ are less than the interim ~~rate~~ rates for those costs, a retroactive adjustment as provided for in subsection 5 will be made. ~~No~~ A retroactive ~~adjustments~~ adjustment to the property rate will be made ~~for~~ to adjust projected property costs to actual property costs. For the rate period following submission of any partial year cost report by a facility, census used to establish rates for property and indirect care costs will be the greater of actual census or certificate of need projected census.

(1) If the effective date of the interim rates is on or after the first day of March and on or before June thirtieth, the interim rates will be effective for the remainder of that rate year and will continue through June thirtieth of the subsequent rate year. The facility must file an interim cost report for the period ending December thirty-first of the year in which the facility first provides services. The interim cost report is due March first and is used to establish actual rates which will be effective July

first of the subsequent rate year. The partial year rates established based on the interim cost report will include applicable incentives, margins, phase-ins, and adjustment factors and will not be subject to any cost settle-up. The cost reports for the report year ending June thirtieth of the current and subsequent rate years will be used to determine the final rates for the period that the interim rates were in effect.

(2) If the effective date of the interim rates is on or after July first and on or before December thirty-first, the interim rates will remain in effect through the end of the subsequent rate year. The facility must file a cost report for the partial report year ending June thirtieth of the subsequent rate year. This cost report will be used to establish the rates for the next subsequent rate year. The facility must file an interim cost report for the period July first through December thirty-first of the subsequent rate year. The interim cost report is due on March first and is used, along with the report year cost report, to determine the final rates for the period that the interim rates were in effect.

(3) If the effective date of the interim rate is on or after January first and on or before February twenty-ninth, the interim rates will remain in effect through the end of the rate year in which the interim rates become effective. The facility must file a cost report for the period ending June thirtieth of the current rate year. This cost report will be used to establish the rates for the subsequent rate year. The facility must file an interim cost report for the period July first through December thirty-first of the current rate year. The interim cost report is due on March first and is used, along with the report year cost report, to determine the final rates for the period that the interim rates were in effect. The final rates will be limited to the lesser of the limit rates for the current rate year or the actual rates.

c. For a facility with renovations or replacements in excess of one hundred thousand dollars, and ~~excluding~~ without a significant capacity ~~increases~~ increase, the ~~rate~~ rates established ~~will be the~~ for direct care, other ~~care~~ direct care, and indirect care ~~rates,~~ based on the last report year, plus a property rate calculated based on projected property costs and census from the last report year, must be applied to all licensed beds. The projected property rate will be effective at the time the project is

completed and placed into service. The property rate for the subsequent rate year will be based on projected property costs and census imputed based on actual census on all licensed beds existing before the renovation, plus ninety-five percent occupancy of the increase in licensed bed capacity, rather than on property costs actually incurred in the report year.

d. For a facility with a significant capacity increase, the rates established for direct care, other direct care, and indirect care, based on the last report year, must be applied to all licensed beds. An interim property rate will be established based on projected property costs and projected census. The interim property rate will be effective from the first day of the month beginning after the date in which the increase in licensed beds is issued by the department of health and consolidated laboratories through the end of the rate year. The facility must file an interim property cost report following the rate year. The interim cost report is due March first and is used to determine the final rate for property and to establish the amount for a retroactive cost settle-up. The final rate for property is limited to the lesser of the interim property rate or a rate based upon actual property costs. The property rate for the subsequent rate year will be based on projected property costs and census imputed as ninety-five percent of licensed beds, rather than on property costs actually incurred during the report year, and will not be subject to retroactive cost settle-up.

e. For a facility which has no significant capacity increase and no renovations or replacements in excess of one hundred thousand dollars, the rates based on the report year will be applied throughout the rate year for all licensed beds.

f. For a facility with a capacity increase occurring on or after January 1, 1990, but before July 1, 1991, and for a facility with a capacity increase which is not a significant capacity increase, occurring on or after July 1, 1991, but before January 1, 1992, a settle-up for property costs will be made. The settle-up will be based on property costs, actually incurred after the capacity increase was available for use, as reported in the cost report for the report year in which the costs were incurred. No settle-up will be made for costs incurred after December 31, 1991. Settle-up will occur within sixty days after both the cost report and a request for settle-up are received by the department. Any settle-up made before audit is subject to audit. The department may determine and make a settle-up after audit.

~~d.~~ g. For a facility terminating its participation in the medical assistance program, whether voluntarily or involuntarily, the department may authorize the facility to receive continued payment until medical assistance residents can be relocated to facilities participating in the medical assistance program.

8. One-time adjustments.

a. Adjustments to meet certification standards.

(1) The department may provide for an increase in the established rate for additional costs that are incurred to meet certification standards. The survey conducted by the state department of health and consolidated laboratories must clearly require that the facility take steps to correct deficiencies dealing with resident care. The plan of correction must identify the salary and other costs that will be increased to correct the deficiencies cited in the survey process.

(2) The facility must submit a written request to the medical services division within thirty days of submitting the plan of correction to the state department of health and consolidated laboratories. The request must contain the following information:

(a) A statement that costs or staff numbers have not been reduced for the report year immediately preceding the state department of health and consolidated laboratories' certification survey.

(b) The number of new staff or additional staff hours and the associated costs that will be required to meet the certification standards.

(c) A detailed list and implementation of any other costs necessary to meet survey standards.

(3) The department will review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate will be adjusted upward not to exceed the limit rate.

(4) Any additional funds provided must be used in accordance with the facility's written request to the department and are subject to audit. If the department determines that the funds were not utilized for the intended purpose, an adjustment will be made in accordance with subsection 5.

b. Adjustments for unforeseeable expenses.

(1) The department may provide for an increase in the established rate for additional costs that are incurred to meet major unforeseeable expenses. Such expenses must be resident related and must be beyond the control of those responsible for the management of the facility.

(2) The facility must submit a written request containing the following information to the medical services division within sixty days after first incurring the unforeseeable expense:

(a) An explanation as to why the facility believes the expense was unforeseeable.

(b) An explanation as to why the facility's management believes the expense was beyond the managerial control of the facility.

(c) A detailed breakdown of the unforeseeable expenses by expense line item.

(3) The department will base its decision on whether the request clearly demonstrates that the economic or other factors that caused the expense were unexpected and arose because of conditions that could not have been anticipated by management based on their background and knowledge of nursing care industry and business trends.

(4) The department will review the submitted information and may request additional documentation or conduct onsite visits. If an increase in costs is approved, the established rate will be adjusted upward not to exceed the limit rate.

(5) Any additional funds provided must be used to meet the unforeseeable expenses outlined in the facility's request to the department and are subject to audit. If the department determines that the funds were not utilized for the intended purpose, an adjustment will be made in accordance with subsection 5.

c. Adjustment to historical operating costs.

(1) A facility may receive a one-time adjustment to historical operating costs when the facility has been found to be significantly below care-related minimum standards described in subparagraph a of paragraph 2 of this subdivision and when it has been determined that the facility cannot meet the minimum standards

through reallocation of costs and efficiency incentives.

(2) The following conditions must be met before a facility can receive the adjustment:

(a) The facility shall document that based on nursing hours and standardized resident days, the facility cannot provide a minimum of one and two-tenths nursing hours per standardized resident day.

(b) The facility shall document that all available resources, including efficiency incentives, if used to increase nursing hours, are not sufficient to meet the minimum standards.

(c) The facility shall submit a written plan describing how the facility will meet the minimum standard if the adjustment is received. The plan must include the number and type of staff to be added to the current staff and the projected cost for salary and fringe benefits for the additional staff.

(3) The adjustment will be calculated based on the costs necessary to increase nursing hours to the minimum standards less any operating margins and incentives included when calculating the established rate. The net increase will be divided by standardized resident days and the amount calculated will be added to the actual rate. This rate will then be subject to any rate limitations that may apply.

(4) If the facility fails to implement the plan to increase nursing hours to one and two-tenths hours per standardized resident day, the amount included as the adjustment will be adjusted in accordance with the methodologies set forth in subsection 5.

(5) If the actual cost of implementing the plan exceeds the amount included as the adjustment, no retroactive settlement will be made.

History: Effective September 1, 1980; amended effective July 1, 1981; December 1, 1983; July 1, 1984; September 1, 1987; January 1, 1990; April 1, 1991; January 1, 1992.
General Authority: NDCC 50-24.1-04, 50-24.4-02
Law Implemented: NDCC 50-24.4; 42 USC 1396a(a)(13)

TITLE 81

Tax Commissioner

NOVEMBER 1991

81-01.1-01-04. Audit requests - Enforcement.

1. When the tax commissioner requests audit information be sent to the tax commissioner's office, such request must be in writing and the taxpayer has thirty days to respond.

2. If, within thirty days, a taxpayer fails to respond, or fails to request and receive a written extension, the tax commissioner shall issue another written request, second notice, and allow the taxpayer thirty days to respond. If an extension has been granted, no second notice is required.

3. If, within thirty days, the taxpayer fails to respond to the second notice, or fails to respond within the extension deadline, the tax commissioner shall issue a final notice. The final notice must inform the taxpayer that if the taxpayer fails to respond within thirty days, the tax commissioner may serve the taxpayer with a subpoena, issue a notice of determination based on the best information available, or, in the case of income tax, issue a nonreviewable determination. The notice must also specify that the taxpayer may, within thirty days after the final notice, request in writing that the tax commissioner issue a subpoena for the audit information. If the taxpayer requests a subpoena ~~and the taxpayer has signed an extension of time for making an assessment~~, the tax commissioner shall issue the subpoena in lieu of issuing a notice of determination.

History: Effective May 1, 1991; amended effective November 1, 1991.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 57-01-02, 57-01-11

81-01.1-01-05. Time for completion of an audit.

1. The tax commissioner shall notify the taxpayer in writing if the tax commissioner is unable to complete a field or office audit within twelve months of the commencement of such audit. For purposes of this section, an office audit is commenced on the date the tax commissioner first makes written request for information. A field audit is commenced on the date the auditor begins the review of taxpayer's records at the taxpayer's place of business.

2. If the tax commissioner issues a notice of determination later than twelve months after the commencement of a field or office audit, subsection 2 of section 81-01.1-01-09 applies. The twelve-month period is extended by any agreed upon extensions of time and by the time expended after the second notice provided for in section 81-01.1-01-04.

3. Audits conducted by the multistate tax commission are not subject to the time deadlines set forth in subsection 1 or 2.

History: Effective May 1, 1991; amended effective November 1, 1991.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 57-01-02

81-01.1-01-13. Reaudit.

1. Provided the statute of limitations remains open, the tax commissioner may reaudit years that were previously audited. Such reaudit is limited to issues and facts not previously audited. Documents previously supplied by the taxpayer may not be requested in future audits of the same year unless the taxpayer utilizes those documents as relevant to the new audit or the tax commissioner and taxpayer have otherwise agreed.

2. The tax commissioner may not audit tax years previously audited if the purpose of ~~that~~ the reaudit is to examine issues which were assessed and subsequently resolved in the previous audit.

History: Effective May 1, 1991; amended effective November 1, 1991.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 57-01-02

81-01.1-02-02.1. Complaint - Time for filing - Extensions granted.

1. When a taxpayer is required to file an administrative complaint in response to a notice of reconsideration, the taxpayer shall file the complaint within thirty days of the notice. The taxpayer will be granted an automatic extension of thirty days to file a complaint, provided the taxpayer makes a request for extension within thirty days of the

notice. Further extensions are available at the discretion of the tax commissioner.

2. When a representative of the tax commissioner files an administrative complaint pursuant to North Dakota Century Code section 57-39.2-15, ~~the tax commissioner shall file~~ the administrative complaint must be filed within nine months of the statement of grounds, plus mutually agreed extensions.

History: Effective May 1, 1991; amended effective November 1, 1991.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-05

81-01.1-02-03. Notice of intent to proceed to hearing - Answer - Time for filing.

1. When a taxpayer files a complaint and requests a hearing, the tax commissioner must serve a notice of intent to proceed to hearing upon the taxpayer and upon a designated representative of the tax commissioner within thirty days from the date of service of the complaint. The designated representative of the tax commissioner must file an answer to the complaint within twenty days of receipt of the complaint and the notice ~~of hearing~~.

2. When a representative of the tax commissioner elects to file a complaint and requests a hearing, the tax commissioner must serve a notice of intent to proceed to hearing together with a copy of the complaint upon the taxpayer. The taxpayer must file an answer to the complaint within twenty days of service of the notice ~~of hearing~~ and complaint.

History: Effective July 1, 1985; amended effective May 1, 1991; November 1, 1991.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 28-32-05, 57-01-02

81-01.1-02-03.1. Rules governing administrative proceedings. The North Dakota Rules of Civil Procedure apply to all proceedings before the commissioner unless otherwise provided by a specific statute.

History: Effective November 1, 1991.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 57-01-02

81-01.1-02-04. Place of formal hearing. All formal hearings, regardless of the taxpayer's residence, must be held at the office of the tax commissioner or any other location in the State Capitol, Bismarck, North Dakota, as designated by the hearing officer.

History: Effective July 1, 1985; amended effective November 1, 1991.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 57-01-02

81-01.1-02-05. Appointment of hearing officer - Powers. ~~A taxpayer may, within thirty days of the filing of a complaint, request that the tax commissioner appoint an independent hearing officer. Upon receipt of such request, the tax commissioner shall appoint an independent hearing officer and shall so notify the taxpayer and a representative of the tax commissioner. If the request is made after thirty days of the filing of the complaint, appointment of an independent hearing officer is discretionary with the tax commissioner.~~

1. If a taxpayer requests an independent hearing officer within thirty days of the filing of a complaint, the tax commissioner shall appoint an independent hearing officer and shall notify the taxpayer and a representative of the tax commissioner. If no answer is filed, the tax commissioner may appoint an independent hearing officer or consider the matter a default matter and proceed accordingly. After the filing of a complaint, the service of a notice of intent to proceed to hearing, and the filing of an answer, the tax commissioner shall appoint an independent hearing officer no later than forty-five days before the hearing and shall notify the taxpayer and representative of the tax commissioner.

2. A person appointed as a hearing officer may:

~~1. Issue notice of hearing and specifications of issues.~~

~~2.~~ a. Issue subpoenas.

~~3.~~ b. Administer oaths.

~~4.~~ c. Regulate the course of the hearing to assure that it proceeds in an orderly fashion.

~~5.~~ d. Rule on offers of proof and receive relevant evidence.

~~6.~~ e. Elicit all facts necessary to clearly present the issues. The hearing officer may examine or cross-examine witnesses in order to develop and clarify the facts and issues.

~~7.~~ f. Exclude evidence which is cumulative or repetitious.

~~8.~~ g. Order or allow discovery proceedings and set and regulate time limits for obtaining and exchanging information.

~~9.~~ h. Hold appropriate conferences before or during hearing. A summary of the conference must be made by the hearing officer either in writing or orally as part of the hearing record.

~~10.~~ i. Dispose of procedural matters and rule upon procedural motions.

~~11.~~ j. Authorize any party to furnish and serve designated late filed exhibits within thirty days after the hearing is adjourned.

~~12.~~ k. Request or allow the filing of briefs by the parties and set a time limit during which the briefs must be filed.

~~a.~~ (1) The hearing officer, at that officer's discretion, may extend the due date of the briefs for good cause. An extension must be requested and responded to in writing.

~~b.~~ (2) Any party who does not file a brief on or before the initial or extended due date forfeits the right to do so.

~~13.~~ l. Allow any party to the proceedings to file proposed findings of fact, conclusions of law, and decision. The proposal must be filed with the tax commissioner within a reasonable time after the date of the formal hearing.

~~14.~~ m. Grant or deny continuances or postponements.

~~15.~~ n. Take any other action necessary to discharge the duties vested in the tax commissioner and the appointed hearing officer and which is consistent with the statutes and rules under which the tax commissioner operates.

3. A person appointed as a hearing officer shall:

a. Issue a notice of hearing and specification of issues. If the tax commissioner has already issued a specification of issues, the hearing officer may amend it.

~~16.~~ b. Issue ~~proposed~~ recommended findings of fact and conclusions of law, and a recommended order.

History: Effective July 1, 1985; amended effective May 1, 1991; November 1, 1991.
General Authority: NDCC 28-32-02
Law Implemented: NDCC 57-01-02

81-03-01.1-09. Requirement to report federal changes.

1. The following provisions are applicable for purposes of interpreting subsection 1 of North Dakota Century Code section 57-38-34.4:

a. If a change or correction to federal taxable income or federal income tax liability is initiated by the United States internal revenue service, the change or correction must be reported to the commissioner even if it does not result in an underpayment or an overpayment of federal income tax.

b. "Final determination" means a decision, action, or date from which no further action is taken by the taxpayer or the United States internal revenue service to resolve any dispute relating to the change or correction which was made to the taxpayer's federal taxable income or federal income tax liability. A final determination has occurred if any of the following circumstances apply:

(1) A taxpayer receives a notice or other correspondence from the United States internal revenue service which makes an adjustment to the taxpayer's federal taxable income based on:

(a) A mathematical or clerical error.

(b) Any other change or correction where the taxpayer has paid or arranged to pay the underpayment of federal income tax, or where the United States internal revenue service has credited or refunded to the taxpayer an overpayment of federal income tax. A final determination does not occur, however, if a taxpayer pays the tax and then files a claim for credit or refund with the United States internal revenue service.

(2) A taxpayer waives the restrictions on assessment and collection of all or any part of an underpayment of federal income tax by signing a federal form 870 or any other form prescribed for this purpose by the United States internal revenue service. A final determination does not occur with respect to any part of the underpayment which is not covered by the waiver. Where the signature of an authorized representative of the United States internal revenue service is required to execute this waiver, the date of final determination is when the taxpayer receives notice of the signing. A final determination does not occur, however, if a taxpayer pays the tax and then files a claim for credit or refund with the United States internal revenue service.

(3) A taxpayer receives a federal statutory notice of deficiency and does not timely file a petition with the United States tax court for redetermination of the assessed underpayment of federal income tax. The

date of final determination is when the time period within which to file the petition expires. A final determination does not occur, however, if a taxpayer pays the tax and then files a claim for credit or refund with the United States internal revenue service.

(4) A closing agreement is executed pursuant to United States Internal Revenue Code section 7121 [26 U.S.C. 7121]. The date of final determination is when the taxpayer receives notice of the signing of the closing agreement by an authorized representative of the United States commissioner of internal revenue.

(5) A federal court of law issues a decision which is not appealed or is not subject to appeal.

(6) A federal court of law approves a voluntary agreement stipulating final disposition of a case.

(7) If a taxpayer files a claim for credit or refund of all or any part of an underpayment of federal income tax, as described in paragraphs 1, 2, or 3 of this subdivision, a final determination has occurred if any of the following circumstances apply:

(a) The taxpayer receives notice of the disallowance of the claim for credit or refund from the United States internal revenue service and the taxpayer does not appeal the disallowance or file a suit for refund.

(b) The taxpayer receives notice of the allowance of the claim for credit or refund from the United states internal revenue service.

(c) Receipt of the refund from the United States internal revenue service, if no prior notice is received.

(d) The provisions of paragraphs 4, 5, or 6 of this subdivision apply.

2. The following provisions are applicable for purposes of interpreting subsection 2 of North Dakota Century Code section 57-38-34.4:

a. If a taxpayer initiates the filing of the amended federal income tax return, the taxpayer must also file an amended state income tax return even if it does not result in payment of additional tax.

b. To request a credit or refund of tax, a taxpayer must file an amended state income tax return either within the time period prescribed in subsection 1 of North Dakota Century Code section 57-38-40 or within the ninety-day time period prescribed in subsection 2 of North Dakota Century Code section 57-38-34.4.

History: Effective November 1, 1991.
General Authority: NDCC 57-38-56
Law Implemented: NDCC 57-38-34.4

81-03-04-01. Corporation required to report and pay estimated tax, penalty, and interest - Refund of overpayment.

1. Any corporation may elect to file a declaration of estimated income tax with the tax commissioner.

2. A corporation shall file a declaration of estimated tax with the tax commissioner if:

   a. The corporation's previous year's state income tax liability exceeded five thousand dollars; and

   b. The corporation reasonably expects the current state income tax liability to be in excess of five thousand dollars.

3. For the purpose of this section, tax liability is defined as the amount of North Dakota tax due computed after the application of allowable credits and before the application of estimated payments.

4. When making the declaration, a corporation has the option of basing the estimation on the tax liability for the previous year or on an estimate of the liability for the current tax year.

5. The declaration of estimated tax must be filed on or before the fifteenth day of the fourth month of the current corporate tax year. The original declaration may be amended by filing an amended declaration any time before the fifteenth day of the first month of the tax year following the current tax year.

6. A corporation shall pay the estimated tax liability in four equal installments payable on the fifteenth day of the fourth, sixth, and ninth month of the current tax year and the fifteenth day of the first month of the following tax year. As an alternative to paying in quarterly installments, a corporation may pay the entire estimated amount on the fifteenth day of the fourth month of the current tax year.

7. For taxable years beginning after December 31, 1986, the provisions for recurring seasonal income as provided in section 6655(e) of the Internal Revenue Code ~~is~~ are recognized for state income tax purposes.

8. For taxable years beginning after December 31, 1990, the provisions for the annualized or adjusted seasonal method of determining estimated income under section 6655 of the Internal Revenue Code are recognized for state income tax purposes.

9. Penalty and interest apply in the following conditions:

   a. A corporation did not timely file a declaration of estimated tax.

   b. A corporation did not pay the estimated tax on or before the quarterly due date.

   c. The quarterly estimated payments were underpaid by more than ten percent of the actual tax liability for the current tax year divided by four. However, no penalty or interest will apply if the quarterly estimated payments equaled the previous year's total tax divided by four.

~~9.~~ 10. Interest is computed from the due date of the quarterly installment to the date of actual payment. Estimated tax payments, received as a result of an amended declaration of estimated tax, will have interest computed from the date paid to the date due in the related quarters.

~~10.~~ 11. If the total amount of estimated tax payments exceed the total amount of tax required to be paid for the current tax year, the overpayment will be refunded. Interest will be paid on any overpayment of tax if the overpayment is not refunded within sixty days after the due date of the income tax return or within sixty days after the date the income tax return was filed, whichever comes later.

~~11.~~ 12. a. If the total amount of estimated tax payments exceeds the anticipated tax liability for the tax year by more than five hundred dollars, a quick refund may be requested. The request for refund must be filed on forms provided by the tax commissioner. In addition, the request must be filed after the close of the tax year and before the original due date of the tax return. No interest will be paid on a quick refund.

   b. If a quick refund of estimated income tax results in a corporation's failure to meet the requirements of North Dakota Century Code section 57-38-62, penalty and interest provisions will apply.

History: Effective July 1, 1985; amended effective November 1, 1987; November 1, 1991.
General Authority: NDCC 57-38-56
Law Implemented: NDCC 57-38-62

81-03-04-02. Payments of estimated taxes by individuals, estates, and trusts.

1. Except as otherwise provided, an individual, estate, or trust subject to section 6654 of the Internal Revenue Code, relating to failure to pay estimated income taxes, shall make payments of estimated state income tax. ~~The form filed with each payment of estimated income tax constitutes a declaration.~~

2. Penalty and interest for failure to make payments of estimated state income tax must be waived by the tax commissioner in the following situations:

   a. When an individual derives over two-thirds of gross income from farming, files a federal income tax return by March first of the following tax year, and pays the federal tax in full by that same date, but does not make payments of estimated state income tax. The individual does not have to file a state income tax return or pay any state income tax due on or before March first of the following tax year to qualify for this waiver of penalty and interest.

   b. When an individual derives over two-thirds of gross income from farming, makes the one required estimated federal tax installment on January fifteenth of the following tax year, files a federal income tax return after March first of the following tax year, and pays the estimated state income tax due on January fifteenth of the following tax year. The first three payments due on April fifteenth, June fifteenth, and September fifteenth of the current tax year are not required to qualify for this waiver of penalty and interest.

   c. When an individual, estate, or trust utilizes the annualized income installment method as provided in section 6654 of the Internal Revenue Code, and makes the required estimated state income tax payment based thereon.

   d. When an individual, estate, or trust has a current year tax liability which exceeds the taxpayer's withholding by less than two hundred dollars, and the taxpayer does not make payments of estimated state income tax. The two hundred dollar limitation applies per return.

3. To determine tax liability for the immediately preceding year, married taxpayers who filed separate returns in the prior year, but who plan to file a joint return for the current

year, shall combine the tax liabilities reflected on their prior year returns. Joint estimated tax payments for the current year must equal or exceed one hundred percent of the couple's total tax liability for the prior year if the prior year test is applicable.

History: Effective November 1, 1987; amended effective July 1, 1989; March 1, 1990; November 1, 1991.
General Authority: NDCC 57-38-56
Law Implemented: NDCC 57-38-45, 57-38-62, 57-38-63, 57-38-64

81-03-05.4-01. Definitions. The following definitions are only applicable in computing a taxpayer's federal income tax deduction pursuant to subdivision c of subsection 1 of North Dakota Century Code section 57-38-01.3:

1. "Apportionment factor" means a fraction, computed pursuant to North Dakota Century Code chapter 57-38 ~~or~~, 57-38.1, or 57-59, used to divide business income of a multistate taxpayer among states.

2. "Federal" means the United States.

3. "Federal income tax deduction" means the adjustment provided for in subdivision c of subsection 1 of North Dakota Century Code section 57-38-01.3.

4. "Federal income tax ~~paid~~ liability" means the amount of federal income tax ~~that was either paid or accrued~~, excluding any federal alternative minimum tax, computed under chapter 1 of the Internal Revenue Code of 1986, as amended.

5. "Federal income tax ratio" means North Dakota taxable income divided by income relating to federal income tax ~~paid~~ accrued.

6. "Income relating to federal income tax paid" means total income less income relating to foreign tax credit.

7. "Income relating to foreign tax credit" means income directly attributable to either the foreign tax credit or the possessions credit.

8. "North Dakota taxable income" means income which has been apportioned to North Dakota pursuant to North Dakota Century Code chapters 57-38, 57-38.1, and 57-59; provided, however, that no adjustment should be made for the federal income tax deduction.

9. "Taxpayer" means a corporation that is required to file an income tax return in North Dakota.

10. "Total income" means the federal taxable income of those entities in the unitary group that are required to file a federal income tax return during the period in question, plus or minus the adjustments provided for in North Dakota Century Code section 57-38-01.3, with the exception of subdivisions c and f of subsection 1 of North Dakota Century Code section 57-38-01.3.

History: Effective July 1, 1989; amended effective May 1, 1991; November 1, 1991.
General Authority: NDCC 57-38-57
Law Implemented: NDCC 57-38-01.3

81-03-05.4-03. Computation - Part I. Any taxpayer claiming a federal income tax deduction shall compute federal income tax ~~paid~~ liability on income which is taxable in North Dakota in the following manner:

1.	Consolidated federal income tax ~~paid~~ liability.		XXX
2.	Separate company pro forma federal income tax liability for all of the profit companies that are on the consolidated return and included in the unitary group. Use the method described in Internal Revenue Code section 1.1552-1(a)(2).	XXX	
3.	Separate company pro forma federal income tax liability for all of the profit companies that are included on the consolidated return.	XXX	
4.	Line 2 divided by line 3.		XXX
5.	Unitary companies' share of consolidated federal income tax ~~paid~~ liability (line 1 multiplied by line 4).		XXX
6.	Federal taxable income of the unitary companies which are included on the consolidated return.	XXX	
7.	Amount of federal taxable income reported on line 6 that is not taxable in North Dakota.	XXX	
8.	Federal taxable income attributable to North Dakota (line 6 minus line 7).	XXX	
9.	Line 8 divided by line 6.		XXX

10. Consolidated federal income tax ~~paid~~ liability on income which is taxable in North Dakota (line 5 multiplied by line 9). XXX

History: Effective July 1, 1989; amended effective May 1, 1991; November 1, 1991.
General Authority: NDCC 57-38-57
Law Implemented: NDCC 57-38-01.3

81-03-05.4-05. Additional provisions.

1. If members of a unitary group filed more than one federal income tax return, subsections 1 through 10 in section 81-03-05.4-03 must be repeated for each federal income tax return and the result totalled before application of the income tax ratio or apportionment factor in 81-03-05.4-04.

2. A taxpayer may exclude subsections 1 through 4 in section 81-03-05.4-03 when:

   a. A North Dakota return is filed using the combined report method and all corporations included in the federal consolidated return are included in the combined report.

   b. A corporation does not file a federal consolidated return.

3. If federal alternative minimum tax is ~~paid~~ accrued and state alternative minimum tax is not, the federal minimum tax must be excluded from subsections 1 through 5 of section 81-03-05.4-03.

~~4. If a taxpayer elects to compute its federal income tax deduction on the cash basis, it must do so on the return as originally filed. The cash basis election is not available to a taxpayer that files as a member of a federal consolidated return.~~

History: Effective May 1, 1991; amended effective November 1, 1991.
General Authority: NDCC 57-38-57
Law Implemented: NDCC 57-38-01.3

STAFF COMMENT: Chapter 81-03-05.5 contains all new material but is not underscored so as to improve readability.

CHAPTER 81-03-05.5
DEDUCTION AND CREDIT FOR ALTERNATIVE MINIMUM INCOME TAX

Minimum Tax
81-03-05.5-02 Deduction for Federal Alternative Minimum Tax

81-03-05.5-01. Credit for North Dakota alternative minimum tax. The following provisions are applicable for purposes of interpreting subsection 2 of North Dakota Century Code section 57-38-30:

1. For purposes of this section, alternative minimum tax means North Dakota alternative minimum tax.

2. To be eligible for a credit on its state income tax return for the years 1991, 1992, 1993, or 1994, a corporation must have paid state alternative minimum tax on its 1989 or 1990 tax return.

3. The amount available for credit is equal to the state alternative minimum tax paid for the years 1989 and 1990, less any credit previously taken by the corporation. However, the amount of credit taken in any year may not exceed the corporation's income tax liability for that year.

History: Effective November 1, 1991.
General Authority: NDCC 57-38-56
Law Implemented: NDCC 57-38-01.3, 57-38-30

81-03-05.5-02. Deduction for federal alternative minimum tax. The following provisions are applicable for purposes of interpreting subdivision c of subsection 1 of North Dakota Century Code section 57-38-01.3:

1. Definitions. The following definitions are applicable in computing a taxpayer's federal alternative minimum tax deduction:

   a. "Apportionment factor" means a fraction, computed pursuant to North Dakota Century Code chapter 57-38, 57-38.1, or 57-59, used to divide business income of a multistate taxpayer among states.

   b. "Disallowed federal alternative minimum tax" means the amount of federal alternative minimum tax for which a taxpayer did not receive a state income tax deduction pursuant to subdivision c of subsection 1 of North Dakota Century Code section 57-38-01.3.

   c. "Federal" means the United States.

   d. "Federal alternative minimum tax" means the amount of federal alternative minimum tax computed under chapter 1 of the Internal Revenue Code of 1986, as amended.

e. "Federal income tax ratio" means North Dakota taxable income divided by income relating to federal income tax accrued.

f. "State alternative minimum tax deduction" means the amount of disallowed federal alternative minimum tax which a taxpayer is allowed to claim as a deduction for purposes of determining North Dakota taxable income.

g. "Taxpayer" means a corporation that is required to file an income tax return in North Dakota.

2. **Requirements to claim a state alternative minimum tax deduction.** A taxpayer is entitled to claim a state alternative minimum tax deduction for any federal alternative minimum tax accrued subsequent to December 31, 1986, if the following conditions are met:

a. The taxpayer filed a North Dakota corporate income tax return for the same year in which the federal alternative minimum tax was accrued.

b. The deduction is taken in a taxable year beginning after December 31, 1990.

c. The deduction is taken in the same taxable year for which the taxpayer took a credit for federal alternative minimum tax.

3. **Computation of state alternative minimum tax deduction.** A deduction for alternative minimum tax must be computed in the following manner:

a.	Disallowed federal alternative minimum tax.		xxx
b.	Separate company pro forma income tax liability for all the profit companies that are on the consolidated return and included in the unitary group. Use the method described in Internal Revenue Code section 1.1552-1(a)(2).	xxx	
c.	Separate company pro forma federal income tax liability for all of the profit companies that are included on the consolidated return.	xxx	
d.	Line b divided by line c.		xxx
e.	Unitary companies' share of consolidated disallowed federal alternative minimum tax (line a multiplied by line d).		xxx

f.	Federal taxable income of the unitary companies which are included on the consolidated return.	xxx	
g.	Amount of federal taxable income reported on line f that is not taxable in North Dakota.	xxx	
h.	Federal taxable income attributable to North Dakota (line f minus line g).	xxx	
i.	Line h divided by line f.		xxx
j.	Line i multiplied by line e.		xxx
k.	The federal income tax ratio or the apportionment factor for the taxable year in which the federal alternative minimum tax was accrued, whichever is applicable.		xxx
l.	State alternative minimum tax deduction (line j multiplied by line k).		xxx

4. **Limitation on amount of state alternative minimum tax deduction.** The amount claimed for a state alternative minimum tax deduction cannot exceed the taxpayer's North Dakota taxable income before any state net operating loss. Any excess deduction may be carried forward and used in a year which meets the requirements of subsection 2.

5. Additional provisions.

   a. If members of a unitary group filed more than one federal income tax return, subdivisions a through j in subsection 3 must be repeated for each federal income tax return and the result totaled before application of the income tax ratio or apportionment factor.

   b. A taxpayer may exclude subdivisions b through d in subsection 3 when:

      (1) A North Dakota return is filed using the combined report method and all corporations included in the federal consolidated return are included in the combined report.

      (2) A corporation does not file a federal consolidated return.

History: Effective November 1, 1991.
General Authority: NDCC 57-38-56

Law Implemented: NDCC 57-38-01.3, 57-38-30

81-03-09-03. Business and nonbusiness income defined. Subsection 1 of North Dakota Century Code section 57-38.1-01 and article IV(1)(a) of North Dakota Century Code section 57-59-01 define "business income" as income arising from transactions and activity in the regular course of the taxpayer's trade or business and includes income from tangible and intangible property if the acquisition, management, and disposition of the property constitute integral parts of the taxpayer's regular trade or business operations. In essence, all income which arises from the conduct of trade or business operations of a taxpayer is business income. For purposes of administration of North Dakota Century Code chapter 57-38.1, and North Dakota Century Code chapter 57-59, the income of the taxpayer is business income unless clearly classifiable as nonbusiness income. Nonbusiness income means all income other than business income.

The classification of income by the labels occasionally used, such as manufacturing income, compensation for services, sales income, interest, dividends, rents, royalties, gains, operating income, nonoperating income, and so forth, is of no aid in determining whether income is business or nonbusiness income. Income of any type or class and from any source is business income if it arises from transactions and activity occurring in the regular course of a trade or business. Accordingly, the critical element in determining whether income is "business income" or "nonbusiness income" is the identification of the transactions and activity which are the elements of a particular trade or business. In general, all transactions and activities of the taxpayer which are dependent upon or contribute to the operations of the taxpayer's economic enterprise as a whole constitute the taxpayer's trade or business and will be transactions and activity arising in the regular course of and will constitute integral parts of a trade or business. See ~~section 81-03-09-05 for more specific examples of the classification of income as business or nonbusiness income; see~~ sections 81-03-09-04 and 81-03-09-08 for further explanation of a trade or business.

History: Amended effective November 1, 1991.
General Authority: NDCC 57-38-56
Law Implemented: NDCC 57-38.1-01(1), 57-59-01 (art.IV(1)(a))

81-03-09-04. Two or more businesses of a single taxpayer. A taxpayer may have more than one "trade or business". In such cases, it is necessary to determine the business income attributable to each separate trade or business. The income of each business is then apportioned by an apportionment formula which takes into consideration the instate and outstate factors which relate to the trade or business the income of which is being apportioned.

~~Example: The taxpayer is a conglomerate with three operating divisions. One division is engaged in manufacturing aerospace items for~~

~~the federal government. Another division is engaged in growing tobacco products. The third division produces and distributes motion pictures for theaters and television. Each division operates independently; there is no strong central management. Each division operates in this state as well as in other states. In this case, it is fair to conclude that the taxpayer is engaged in three separate "trades or businesses". Accordingly, the amount of business income attributable to the taxpayer's trade or business activities in this state is determined by applying an appropriate apportionment formula to the business income of each business.~~

The determination of whether the activities of the taxpayer constitute a single trade or business or more than one trade or business will turn on the facts in each case. In general, the activities of the taxpayer will be considered a single business if there is evidence to indicate that the segments under consideration are integrated with, dependent upon, or contribute to each other and the operations of the taxpayer as a whole. The following factors are considered to be good indicia of a single trade or business, and the presence of any of these factors creates a strong presumption that the activities of the taxpayer constitute a single trade or business:

1. Same type of business. A taxpayer is generally engaged in a single trade or business when all of its activities are in the same general line. For example, a taxpayer which operates a chain of retail grocery stores will almost always be engaged in a single trade or business.

2. Steps in a vertical process. A taxpayer is almost always engaged in a single trade or business when its various divisions or segments are engaged in different steps in a large, vertically structured enterprise. For example, a taxpayer which explores for and mines copper ores; concentrates, smelts, and refines the copper ores; and fabricates the refined copper into consumer products is engaged in a single trade or business, regardless of the fact that the various steps in the process are operated substantially independent of each other with only general supervision from the taxpayer's executive offices.

3. Strong centralized management. A taxpayer which might otherwise be considered as engaged in more than one trade or business is properly considered as engaged in one trade or business when there is a strong central management, coupled with the existence of centralized departments for such functions as financing, advertising, research, or purchasing. Thus, ~~some conglomerates~~ a corporation may properly be considered as engaged in only one trade or business when the central executive officers are normally involved in the operations of the various divisions and there are centralized offices which perform for the divisions the normal matters which a truly independent business would perform for itself,

such as accounting, personnel, insurance, legal, purchasing, advertising, or financing.

History: Amended effective November 1, 1991.
General Authority: NDCC 57-38-56
Law Implemented: NDCC 57-38.1-01(1), 57-59-01 (art.IV(1)(a))

81-03-09-05. Business and nonbusiness income - Application of definitions. ~~The following are rules and examples for determining whether particular income is business or nonbusiness income. The examples used throughout these sections are illustrative only and do not purport to set forth all pertinent facts.~~

~~1.~~ ~~Rents from real and tangible personal property. Rental income from real and tangible property is business income if the property with respect to which the rental income was received is used in the taxpayer's trade or business or is incidental thereto and therefore is includable in the property factor under sections 81-03-09-15 through 81-03-09-21.~~

~~Example a. The taxpayer operates a multistate car rental business. The income from care rentals is business income.~~

~~Example b. The taxpayer is engaged in the heavy construction business in which it uses equipment such as cranes, tractors, and earth-moving vehicles. The taxpayer makes short-term leases of the equipment when particular pieces of equipment are not needed on any particular project. The rental income is business income.~~

~~Example c. The taxpayer operated a multistate chain of men's clothing stores. The taxpayer purchases a five-story office building for use in connection with its trade or business. It uses the street floor as one of its retail stores and the second and third floors for its general corporate headquarters. The remaining two floors are leased to others. The rental of the two floors is incidental to the operation of the taxpayer's trade or business. The rental income is business income.~~

~~Example d. The taxpayer operates a multistate chain of grocery stores. It purchases as an investment an office building in another state with surplus funds and leases the entire building to others. The net rental income is not business income of the grocery store trade or business. Therefore, the net rental income is nonbusiness income.~~

~~Example e. The taxpayer operates a multistate chain of men's clothing stores. The taxpayer invests in a twenty-story office building and uses the street floor as one of its retail stores and the second floor for its general corporate headquarters. The remaining eighteen floors are leased to~~

~~others. The rental of the eighteen floors is not incidental to but rather is separate from the operation of the taxpayer's trade or business. The net rental income is not business income of the clothing store trade or business. Therefore, the net rental income is nonbusiness income.~~

~~Example f: The taxpayer constructed a plant for use in its multistate manufacturing business and twenty years later the plant was closed and put up for sale. The plant was rented for a temporary period from the time it was closed by the taxpayer until it was sold eighteen months later. The rental income is business income and the gain on the sale of the plant is business income.~~

~~Example g: The taxpayer operates a multistate chain of grocery stores. It owned an office building which it occupied as its corporate headquarters. Because of inadequate space, taxpayer acquired a new and larger building elsewhere for its corporate headquarters. The old building was rented to an investment company under a five-year lease. Upon expiration of the lease, taxpayer sold the building at a gain or loss. The net rental income received over the lease period is nonbusiness income and the gain or loss on the sale of the building is nonbusiness income.~~

~~2. Gains or losses from sales of assets. Gain or loss from the sale, exchange, or other disposition of real or tangible or intangible personal property constitutes business income if the property while owned by the taxpayer was used in the taxpayer's trade or business. However, if such property was utilized for the production of nonbusiness income or otherwise was removed from the property factor before its sale, exchange, or other disposition, the gain or loss will constitute nonbusiness income. See sections 81-03-09-15 through 81-03-09-21.~~

~~Example a: In conducting its multistate manufacturing business, the taxpayer systematically replaces automobiles, machines, and other equipment used in the business. The gains or losses resulting from those sales constitute business income.~~

~~Example b: The taxpayer constructed a plant for use in its multistate manufacturing business and twenty years later sold the property at a gain while it was in operation by the taxpayer. The gain is business income.~~

~~Example c: Same as example b except that the plant was closed and put up for sale but was not in fact sold until a buyer was found eighteen months later. The gain is business income.~~

Example d: Same as example b except that the plant was rented while being held for sale. The rental income is business income and the gain on the sale of the plant is business income.

Example e: The taxpayer operates a multistate chain of grocery stores. It owned an office building which it occupied as its corporate headquarters. Because of inadequate space, taxpayer acquired a new and larger building elsewhere for its corporate headquarters. The old building was rented to an unrelated investment company under a five-year lease. Upon expiration of the lease, taxpayer sold the building at a gain or loss. The gain or loss on the sale is nonbusiness income and the rental income received over the lease period is nonbusiness income.

3. Interest. Interest income is business income where the intangible with respect to which the interest was received arises out of or was created in the regular course of the taxpayer's trade or business operations or where the purpose for acquiring and holding the intangible is related to or incidental to such trade or business operations.

Example a: The taxpayer operates a multistate chain of department stores, selling for cash and on credit. Service charges, interest, or time-price differentials and the like are received with respect to installment sales and revolving charge accounts. These amounts are business income.

Example b: The taxpayer conducts a multistate manufacturing business. During the year the taxpayer receives a federal income tax refund and collects a judgment against a debtor of the business. Both the tax refund and the judgment bore interest. The interest income is business income.

Example c: The taxpayer is engaged in a multistate manufacturing and wholesaling business. In connection with that business, the taxpayer maintains special accounts to cover such items as workmen's compensation claims, rain and storm damage, machinery, replacement, and so forth. The moneys in those accounts are invested at interest. Similarly, the taxpayer temporarily invests funds intended for payment of federal, state, and local tax obligations. The interest income is business income.

Example d: The taxpayer is engaged in a multistate money order and traveler's checks business. In addition to the fees received in connection with the sale of the money orders and traveler's checks, the taxpayer earns interest income by the investment of the funds pending their redemption. The interest income is business income.

Example e: The taxpayer is engaged in a multistate manufacturing and selling business. The taxpayer usually has working capital and extra cash totaling two hundred thousand dollars which it regularly invests in short-term interest bearing securities. The interest income is business income.

Example f: In January the taxpayer sold all the stock of a subsidiary for twenty million dollars. The funds are placed in an interest-bearing account pending a decision by management as to how the funds are to be utilized. The interest income is nonbusiness income.

4. Dividends. Dividends are business income where the stock with respect to which the dividends are received arises out of or was acquired in the regular course of the taxpayer's trade or business operations or where the purpose for acquiring and holding the stock is related to or incidental to such trade or business operations.

Example a: The taxpayer operates a multistate chain of stock brokerage houses. During the year the taxpayer receives dividends on stock it owns. The dividends are business income.

Example b: The taxpayer is engaged in a multistate manufacturing and wholesaling business. In connection with that business the taxpayer maintains special accounts to cover such items as workmen's compensation claims, and so forth. A portion of the moneys in those accounts is invested in interest-bearing bonds. The remainder is invested in various common stocks listed on national stock exchanges. Both the interest income and any dividends are business income.

Example c: The taxpayer and several unrelated corporations own all of the stock of a corporation whose business operations consist solely of acquiring and processing materials for delivery to the corporate owners. The taxpayer acquired the stock in order to obtain a source of supply of materials used in its manufacturing business. The dividends are business income.

Example d: The taxpayer is engaged in a multistate heavy construction business. Much of its construction work is performed for agencies of the federal government and various state governments. Under state and federal laws applicable to contracts for these agencies, a contractor must have adequate bonding capacity, as measured by the ratio of its current assets, cash, and marketable securities, to current liabilities. In order to maintain an adequate bonding capacity the taxpayer holds various stocks and interest-bearing securities. Both the interest income and any dividends received are business income.

~~Example e: The taxpayer receives dividends from the stock of its subsidiary or affiliate which acts as the marketing agency for products manufactured by the taxpayer. The dividends are business income.~~

~~Example f: The taxpayer is engaged in a multistate glass manufacturing business. It also holds a portfolio of stock and interest-bearing securities, the acquisition and holding of which are unrelated to the manufacturing business. The dividends and interest income received are nonbusiness income.~~

~~5. Patent and copyright royalties. Patent and copyright royalties are business income where the patent or copyright with respect to which the royalties were received arises out of or was created in the regular course of the taxpayer's trade or business operations or where the purpose for acquiring and holding the patent or copyright is related to or incidental to such trade or business operations.~~

~~Example a: The taxpayer is engaged in the multistate business of manufacturing and selling industrial chemicals. In connection with that business the taxpayer obtained patents on certain of its products. The taxpayer licensed the production of the chemicals in foreign countries, in return for which the taxpayer receives royalties. The royalties received by the taxpayer are business income.~~

~~Example b: The taxpayer is engaged in the music publishing business and holds copyrights on numerous songs. The taxpayer acquires the assets of a smaller publishing company, including music copyrights. These acquired copyrights are thereafter used by the taxpayer in its business. Any royalties received on these copyrights are business income.~~

~~Example c: Same as example b, except that the acquired company also held the patent on a type of phonograph needle. The taxpayer does not manufacture or sell phonographs or phonograph equipment. Any royalties received on the patent would be nonbusiness income.~~ Repealed effective November 1, 1991.

General Authority: ~~NDCC 57-38-56~~
Law Implemented: ~~NDCC 57-38.1-01(1), 57-59-01 (art.IV(1)(a))~~

81-03-10-01. Designation of overpayment amount. ~~North Dakota taxpayers~~ An individual income taxpayer with an available ~~overpayments~~ overpayment of tax of at least five dollars may designate a portion of ~~their~~ the overpayment, as a voluntary contribution, a minimum of one dollar to either or both of the following:

1. The nongame wildlife ~~management~~ fund.

2. The centennial tree program trust fund.

History: Effective July 1, 1989; amended effective November 1, 1991.
General Authority: NDCC 57-38-56
Law Implemented: NDCC 57-38-34.3, 57-38-35.1

81-04.1-01-02. Confidential information. A return includes all the business records and information of a retailer which reflect or record sales or use tax data which are used to calculate sales or use tax obligations for purposes of North Dakota Century Code section 57-39.2-23.

The tax commissioner is authorized to release name and mailing address information on sales and use tax permitholders to any North Dakota state government agency for the limited purpose of distributing state government publications or information. Permitholder information that can be released is restricted to the business name and mailing address used to mail sales and use tax returns to permitholders. Other permitholder information, including filing schedule, starting date, payment history, ownership status, and standard industrial classification, is confidential and may not be released by the tax commissioner.

The tax commissioner may not release any information regarding a sales and use tax permitholder to any agency, entity, or representative of the federal government, of any other state government, of any local government, or of any foreign government. Information regarding a North Dakota sales and use tax permitholder may not be released to a private entity for any purpose, including fundraising or other sales solicitation, except for name and mailing address information provided to a private entity to facilitate the publication and distribution of state government publications or information.

History: Effective June 1, 1984; amended effective November 1, 1991.
General Authority: NDCC 57-39.2-19
Law Implemented: NDCC 57-39.2-01, 57-39.2-23

81-04.1-01-03.1. Definitions. Any person having nexus in North Dakota and making taxable sales in or making taxable sales having a destination in North Dakota must obtain a North Dakota sales and use tax permit from the tax commissioner and collect and remit tax on these sales.

For purposes of implementing subsection 8 of North Dakota Century Code section 57-39.2-01 and subsection ~~5~~ 6 of North Dakota Century Code section 57-40.2-01, unless the context otherwise requires:

1. "Advertisement" means any message by which a retailer solicits retail sales of tangible personal property. It includes but is not limited to:

a. Each transmittance, by United States mail, common carrier or otherwise, of a printed sales solicitation message in the form of a bulk mailing or bulk delivery, a sales catalog, brochure, advertising flier, billing or package insert, or similar publication or device.

b. Each transmittance of a sales solicitation message by space advertising in a newspaper, magazine, or other publication, which is local, regional, or national in nature.

c. Each transmittance of a sales solicitation message by radio, television, telephone, telegraph, computer data base, or by cable, optic, microwave or other electronic means, or by any other communications means.

2. "Destination" means the location to which the delivery of tangible personal property is made by a retailer or the retailer's agent.

3. "Regular or systematic solicitation" means three or more separate transmittances of any advertisement or advertisements during a testing period.

4. "Separate transmittance" means any transmittance of an advertisement during any twenty-four-hour period.

5. "Solicitation" means:

a. Offering, by advertisement, to make a taxable sale with a destination in North Dakota.

b. Inviting offers to purchase tangible personal property for delivery in North Dakota.

6. "Taxable sale" means a sale made by a retailer or a retailer maintaining a place of business in this state to purchasers for final use or consumption and not for resale or processing.

7. "Testing period", with respect to the determination of whether a person is required to obtain a permit and collect use tax as a retailer for tax periods commencing on or after the effective date of this section, means the twelve-month period ending on September thirtieth of the preceding calendar year.

History: Effective November 1, 1987; amended effective March 1, 1988; November 1, 1991.
General Authority: NDCC 57-39.2-19, 57-40.2-13
Law Implemented: NDCC 57-39.2-19, 57-40.2-01

81-04.1-01-23. Manufacturers. ~~For purposes of implementing chapter 716 of the 1989 Session Laws, manufacturing~~ Manufacturing or

agricultural processing is a process which produces a new article with a different form, use, and name. The modification of articles of tangible personal property is not manufacturing or processing. For example, the creation of steel ducts or I-beams is manufacturing whereas the modification of steel ducts or I-beams to meet the specifications of a particular real property construction contract is not manufacturing or processing. To be considered manufacturing or processing, the raw materials must be materially altered.

By way of illustration and not of limitation, the following are manufacturers or agricultural processors: food, beverage, confectionary plants; grain mills; bakeries; textile mills; apparel makers; wood and lumber plants; furniture and fixture makers; paper product makers; printers and publishers (includes newspapers); chemical producers; leather good plants; stone, clay, glass, concrete product makers; cement and asphalt plants; metal ware makers; auto/aircraft makers; dairy processors (not producers); photo finishers (not photographers); and dental, medical, ophthalmolic labs.

By way of illustration and not of limitation, the following are not manufacturers or agricultural processors: farmers or ranchers, construction contractors, refining companies, artists, utilities, nurseries, restaurants, pharmacists, drycleaners, photographers, advertisement agencies, secretarial services, computer programmers, auto body shops, repair shops, radio and television stations, architects, jewelers, grain elevators, and tire retreaders or recappers.

Machinery and equipment used directly in the manufacturing process includes molds and dies that determine the physical characteristics of the finished product or its packaging material, and computers and related peripheral equipment that directly control or measure the manufacturing process.

Items which are consumed or destroyed in the manufacturing process but which do not become a part of the finished product cannot be considered machinery and equipment and consequently are subject to the general sales and use tax. Purchase of these items by a manufacturer is taxable, and suppliers shall charge sales or use tax on these consumable items. If the items are purchased from an out-of-state supplier or if a North Dakota supplier fails to charge the tax, the North Dakota manufacturer shall report the sales or use tax directly to the North Dakota tax commissioner.

Machinery and equipment not used directly in the manufacturing process or in agricultural processing include repair parts, equipment used for storage, delivery to and from the plant, repairing or maintaining facilities, research and development, or environmental control equipment required to maintain certain levels of humidity ~~and~~, temperature, or air quality in a manufacturing or agricultural processing plant.

~~For purposes of administering chapter 716 of the 1989 Session Laws, requests~~ Requests for approval to buy goods ~~at the reduced rate~~

without paying tax or for refunds of tax paid on goods which qualify for ~~the reduced rate~~ exemption must be made ~~on forms prescribed or approved by~~ in writing to the tax commissioner. The tax commissioner reserves the right to make an onsite inspection prior to granting permission to purchase qualifying goods without paying tax or to receiving a refund. The tax commissioner's approval to purchase goods ~~at a reduced rate~~ without paying tax or to grant a refund is binding unless a further review or additional information indicates that the decision was made upon misrepresentation by the applicant. An onsite inspection by the tax commissioner does not preclude an audit of the taxpayer's books and records.

History: Effective June 1, 1984; amended effective March 1, 1990; November 1, 1991.
General Authority: NDCC 57-39.2-19
Law Implemented: NDCC 57-39.2-01, 57-39.2-02.1, ~~57-39.2-03.5,~~ 57-39.2-04, 57-39.2-04.3, 57-39.2-07, 57-40.2-02.1, ~~57-40.2-03.4~~ 57-40.2-04

81-04.1-04-26. ~~Hotels, restaurants~~ Hotel, restaurant, and lodging. The sale of ~~meals~~ a meal by ~~hotels, restaurants, and~~ a hotel, restaurant, or other eating ~~places are sales~~ place is a sale of tangible personal property and is subject to sales tax. ~~Sales~~ A sale of food supplies and beverage products to an eating ~~places~~ place for use in preparing and serving meals ~~are sales~~ is a sale for processing or resale and is not subject to tax.

When ~~hotels, restaurants~~ a hotel, restaurant, or other eating ~~places furnish~~ place furnishes meals to ~~their~~ its employees as part compensation, ~~they are~~ it is liable for the tax upon the cost of the meals furnished. If records to substantiate the cost of meals to employees are not available, the tax commissioner will accept figures from records kept by competing hotels, restaurants, and other eating places, as a basis on which to compute the tax.

~~Cover charges~~ A cover charge made exclusively for the privilege of occupying space within an eating ~~places are~~ place is included in the gross receipts.

A hotel, motel, or lodging accommodation used for residential housing for thirty or more consecutive days is exempt only when the accommodation includes continuous residency by at least one specific individual for thirty or more consecutive days. Any break in the continuous occupancy of the room by that individual which results in a continuous occupancy of less than thirty consecutive days subjects the accommodation to tax. In a case where an occupancy break results in one continuous occupancy period of thirty or more consecutive days and one continuous occupancy period of less than thirty consecutive days, the exemption applies only to the occupancy period of thirty or more consecutive days.

A business which rents a lodging accommodation is not exempt from tax unless the same worker or workers occupy the accommodation for thirty or more consecutive days.

History: Effective June 1, 1984; amended effective November 1, 1991.
General Authority: NDCC 57-39.2-19
Law Implemented: NDCC 57-39.2-01, 57-39.2-02.1, 57-39.2-03.2, 57-39.2-04, 57-39.2-21

81-06.1-02-05. Tax deductions allowed to dealers.

1. A motor vehicle fuel dealer is allowed to deduct two percent of the amount of the tax due to cover the cost of collecting the tax and remitting it to the tax commissioner.

2. A motor vehicle fuel dealer and a special fuels dealer, other than a dealer of liquefied petroleum gas, is allowed to deduct the actual shrinkage of the total gallonage of the motor fuel received each calendar month, if that allowance does not exceed one percent of the total received by the dealer during that month.

   a. The motor vehicle fuel dealer must file reports on gross purchases unless a temperature adjusted method is agreed to between the dealer and the supplier. A reporting method must be used for a full reporting year, and any change in the reporting method must have prior approval by the tax commissioner.

   b. It is presumed that all motor vehicle fuel and special fuels received by a dealer over and above the one percent shrinkage allowance has been sold, delivered, or used, and the dealer is liable for the appropriate tax on each gallon [3.79 liters] of fuel not accounted for.

   c. ~~In consideration of shrinkage losses and a retailer's cost of collecting and transmitting taxes, a wholesale dealer making a sale of motor vehicle fuels must credit the retail dealer with one percent of the gallons [liters] sold.~~ For purposes of administering North Dakota Century Code section 57-43.1-27, the following procedures apply:

      (1) On a sale made to a retail outlet or other entity not licensed by the tax commissioner, a dealer must credit the outlet or other entity with a one percent shrinkage and tax collection allowance. The allowance must be documented on the face of the delivery invoice, and the dealer shall deduct the allowance from taxable gallons on the dealer's tax return.

(2) On a transfer of product to a dealer's retail storage facility or pump, a credit may be allowed for a one percent shrinkage and tax collection allowance, provided:

(a) The transfer is treated as a sale documented by a sales invoice.

(b) The per gallon tax is reported and paid on the monthly report for the month in which the product is transferred.

(c) The product transferred is deducted from the dealer's inventory as sold or used. The allowance must be documented on the face of the delivery invoice, and the dealer shall deduct the allowance from taxable gallons on the dealer's tax return.

(3) On a sale of fuel made by a dealer to a fuel user, including a person who uses fuel for agricultural purposes, the one percent shrinkage and tax collection allowance credit may not be taken on the dealer's tax return.

d. The special fuels dealer of liquefied petroleum gas may deduct the actual shrinkage of the total gallonage received each month not to exceed two percent of the gallonage received during that month.

History: Effective June 1, 1984; amended effective November 1, 1991.
General Authority: NDCC 57-43.1-30, 57-43.2-22
Law Implemented: NDCC 57-43.1-24, 57-43.1-26, 57-43.1-27, 57-43.2-21

81-06.1-02-06. Tax reduction, exemption, credit, or refund on gasoline containing alcohol. ~~In order for a motor vehicle fuel dealer to receive a reduction from the motor vehicle fuel tax pursuant to North Dakota Century Code section 57-43.1-02, the dealer must receive a certificate from the alcohol plant which produced anhydrous alcohol for use in the gasoline blending process. The certificate must state the following:~~

~~1. The anhydrous alcohol for gasoline blending was produced from wet alcohol manufactured or distilled from agricultural products produced in the United States or from coal.~~

~~2. The anhydrous alcohol for gasoline blending was at least ninety-nine percent alcohol.~~

~~3. The name of the state in which the wet alcohol, used to produce the anhydrous alcohol, was manufactured or distilled.~~

~~The certificate must also contain a written statement that all the information provided is accurate and must be signed by an authorized representative of the alcohol plant.~~

~~In making the certification to the dealer, the following restrictions apply. If wet alcohol manufactured or distilled in one state is upgraded to anhydrous alcohol in another state, the tax reduction, exemption, credit, or refund allowed when the anhydrous alcohol is blended with gasoline and sold in North Dakota is based upon the qualification of the state where the wet alcohol was manufactured or distilled.~~

~~If an alcohol plant manufactures or distills wet alcohol from coal or agricultural products and upgrades that wet alcohol to anhydrous alcohol and also upgrades wet alcohol manufactured or distilled in another state to anhydrous alcohol, the tax reduction, exemption, credit, or refund allowed on the gasohol blend containing the anhydrous alcohol produced in that plant is dependent on the qualification of the state where the wet alcohol was manufactured or distilled. When the plant is producing anhydrous alcohol from two separate processes and commingling the production, the plant shall maintain separate book inventories from the two processes. Where only a part of the anhydrous alcohol produced in the plant is sold to North Dakota dealers, the alcohol plant shall provide the purchaser of the anhydrous alcohol with a breakdown of the gallons sold to North Dakota dealers according to the percentage of the anhydrous alcohol produced from each process.~~

~~Example No. 1: If a plant located in Iowa manufactures or distills wet alcohol and transports the wet alcohol to Minnesota where it is upgraded to anhydrous alcohol, the tax reduction as applied to gasoline blended with that anhydrous alcohol and sold in North Dakota, is the qualifying Iowa state reduction.~~

~~Example No. 2: If a Minnesota plant produces one hundred thousand gallons of anhydrous alcohol by upgrading Iowa wet alcohol and produces one hundred thousand gallons of anhydrous alcohol by upgrading wet alcohol manufactured or distilled from coal or agricultural products and the anhydrous alcohol from each process is commingled, the gasoline blended with anhydrous alcohol sold from the Minnesota plant will be taxed at two rates, fifty percent at the Minnesota reduction and fifty percent at the Iowa reduction. When the anhydrous alcohol is sold in North Dakota, the alcohol plant shall indicate to the purchaser the portion which was produced from Iowa wet alcohol and the portion which was produced from Minnesota wet alcohol. When the anhydrous alcohol is so commingled, the plant will not be allowed to claim that all the anhydrous alcohol produced from Minnesota wet alcohol was sold in North Dakota while the anhydrous alcohol produced from Iowa wet alcohol was consigned to another state.~~ Repealed effective November 1, 1991.

History: ~~Effective December 3, 1985~~
General Authority: NDCC ~~57-43.3-05~~
Law Implemented: NDCC ~~57-43.3-02~~

81-06.1-03-01. Motor vehicle fuel tax refunds. ~~Motor~~ A motor vehicle fuel tax ~~refunds~~ refund may be obtained upon application to and approval by the tax commissioner. ~~Refunds~~ A refund may be issued for:

1. Tax paid by any person on motor vehicle fuel used for an agricultural ~~or privately funded industrial purposes~~ purpose, except fuel used in motor vehicles operated or intended to be operated on public highways in this state.

   Five cents per gallon [3.79 liters] is withheld from the refund. The tax withheld is distributed as follows: one cent per gallon [3.79 liters] to the township highway aid fund, two cents per gallon [3.79 liters] to the agriculturally derived fuel tax fund, and two cents per gallon [3.79 liters] to the highway distribution fund.

2. Tax paid by any person on motor vehicle fuel used for a privately funded industrial purpose, except fuel used in motor vehicles operated or intended to be operated on public highways in this state.

   One and one-half cents per gallon [3.79 liters] is withheld from the refund. The tax withheld is distributed as follows: one cent per gallon [3.79 liters] to the township highway aid fund, and one-half cent per gallon [3.79 liters] to the agriculturally derived fuel tax fund.

3. Motor vehicle fuel tax paid by the state of North Dakota or any of its political subdivisions on fuel used in publicly owned vehicles for construction, reconstruction, or maintenance of any public road, highway, street, or airport. The tax imposed may be fully refunded.

~~3.~~ 4. Motor vehicle fuel tax imposed on fuel used in the operation of auxiliary equipment which is fueled from the same supply tank as the vehicle itself, provided:

   a. The user keeps complete and accurate daily records of the time during which the equipment is operated.

   b. The records reflect miles [kilometers] traveled in each individual unit.

   c. The user obtains certified figures from the manufacturer of the equipment as to standard fuel consumption.

   d. The user complies with all provisions of North Dakota Century Code chapter 57-43.1 in applying for the refund.

~~4.~~ 5. Motor vehicle fuel tax imposed on fuel which was thereafter removed from this state to a state which requires payment of a tax upon the use of the fuel in that state.

~~Two cents per gallon [3.79 liters] for deposit in the agriculturally derived fuel tax fund and one cent per gallon [3.79 liters] for deposit in the township highway aid fund is deducted from refunds issued under subsections 1, 3, and 4.~~

No refund claim for less than five dollars is allowed.

History: Effective June 1, 1984; amended effective November 1, 1987; March 1, 1990; November 1, 1991.
General Authority: NDCC 57-43.1-30
Law Implemented: NDCC 54-27-19.1, 57-43.1-03, 57-43.1-03.1, 57-43.1-06, 57-43.1-08

81-06.1-03-06. ~~Assignment of tax on agricultural and industrial purchases of motor vehicle fuel~~ Motor vehicle fuel sales to persons engaged in agriculture who have a valid tax-assigned permit. ~~Any person who has purchased motor vehicle fuel on account and who is eligible for a refund may assign that person's claim for a refund to the dealer who has paid the refundable tax, provided a valid tax assignment agreement is attached to the refund claim form.~~

~~1. Dealers may take assignments on agricultural fuel sales for credit on their tax returns in April, May, June, July, August, and September. Tickets must be thirty days old before credit can be allowed on dealers' returns. Before any person is allowed to assign a motor vehicle fuel tax refund to the dealer during this period, the person must have a valid permit issued by the tax commissioner authorizing such assignment. Application forms may be obtained from the tax commissioner. There is no fee for a permit.~~

~~2. Those persons who have a valid tax assignment permit issued by the tax commissioner will be charged three and nine-fortieths cents per gallon [3.79 liters] by the dealer and that charge will be remitted to the tax commissioner by the dealer when the dealer submits the tax assigned invoices for credit. The tax of two cents per gallon [3.79 liters] will be deposited inthe agriculturally derived fuel tax fund and one cent per gallon [3.79 liters] will be deposited in the township highway aid fund and nine-fortieths of one cent will be deposited in the petroleum release compensation fund.~~

~~3. All tickets must include the following:~~

~~a. The amount of the tax.~~

~~b. The purchaser's tax assignment permit number.~~

~~c. The purchaser's address.~~

~~d. A tax assignment agreement stamp.~~

~~e. Two signatures, one as the assignor and one verifying goods received. If the signature of the assignor is missing from the ticket, the tax commissioner will send the dealer a form upon which the purchases are listed and which the dealer and the purchaser must sign verifying that those purchases were intended to be assigned. The signed certifications must be submitted to the tax commissioner by the dealer by the date specified on the form.~~

~~4. All tax assignments must meet the following conditions:~~

~~a. Custom combine tickets are not acceptable for assignment credit on monthly tax returns.~~

~~b. Assignments will be accepted on agricultural fuel only in bulk deliveries of fifty gallons [189.27 liters] or more.~~

~~c. Tickets must be tax assigned by the purchaser.~~

~~d. Sales of special fuels are not acceptable for assignment credit on the dealer's report.~~

~~e. Assignment stamps should be placed where they least interfere with other items and signatures on the ticket.~~

~~f. If more than one item appears on the ticket, the gallonage on which tax is being assigned must be clearly indicated.~~

~~g. Only original tickets will be acceptable.~~

~~5. Tickets issued to a partnership must be assigned as follows:~~

~~If issued to "Brown Brothers", the assignment agreement must be signed "Brown Brothers by John Brown, partner". If issued in individual names as "Bob and John Brown", the assignment agreement should be signed "Bob and John Brown by John Brown, partner".~~

~~6. In the case of a husband and wife, either spouse may sign the ticket even though it is issued to one spouse only, provided both parties signed the tax assignment permit application.~~

A dealer must charge the nonrefundable tax of five cents per gallon [3.79 liters] on a sale of motor vehicle fuel to a person engaged in agriculture who has a valid tax-assigned permit issued by the tax commissioner. A tax-assigned sale may be made from April first through September thirtieth. A dealer must report each sale on the dealer's tax report for the month in which the sale was made, and the dealer must attach the original sales invoice to the tax report. The sales invoice must be signed by the dealer and by the purchaser. A tax-assigned sale may not be made on a sale of less than fifty gallons [189.27 liters].

History: Effective June 1, 1984; amended effective March 1, 1990; November 1, 1991.
General Authority: NDCC 57-43.1-30
Law Implemented: NDCC 54-27-19.1, 57-43.1-03, 57-43.1-03.1, 57-43.1-11, 57-43.1-12

81-07.1-01-01. Terms and phrases. ~~Beginning July 1, 1975, and for all years thereafter, terms~~ Terms and phrases used in this article have the same meaning as those under North Dakota Century Code ~~chapter 57-37.1 and in this article have the same meaning as given to those terms and phrases in the United States Internal Revenue Code of 1954 as amended and in effect for state purposes on the date of decedent's death~~ section 57-37.1-01.

History: Effective June 1, 1984; amended effective November 1, 1991.
General Authority: NDCC 57-37.1-17
Law Implemented: NDCC 57-37.1-01

81-07.1-01-02. Taxes and interest payable. Estate taxes are due and payable upon death of a decedent and become delinquent if not paid within fifteen months from the date of death. Interest attaches to unpaid taxes beginning with the expiration of the fifteen-month period. Neither the tax commissioner, the county court, nor any other person has the authority to waive interest which has or which will accrue on unpaid estate taxes on estates of decedents who died prior to July 1, 1987.

History: Effective June 1, 1984; amended effective November 1, 1991.
General Authority: NDCC 57-37.1-17
Law Implemented: NDCC 57-37.1-02, 57-37.1-07

81-07.1-01-05. Estate tax documents. ~~It is the responsibility of the personal representative of an estate to file the proper documents required by the tax commissioner.~~

1. If the gross value of an estate meets the requirements for filing a federal estate tax return, the following documents must be submitted to the tax commissioner by the personal representative, attorney for the estate, surviving joint tenant, or other heir:

   a. One copy of ~~an application for determination of~~ a North Dakota estate tax return.

   b. ~~Duplicate certificates of estate tax determination. One copy will be returned to the personal representative or the attorney for the estate who is responsible for filing the document with the register of deeds in the appropriate county for release of any lien imposed by statute.~~

   ~~c.~~ A copy of decedent's will, if any.

~~d.~~ c. A copy of the federal estate tax return.

~~e.~~ d. If there is a North Dakota estate tax due, a duplicate situs affidavit. One copy will be filed with the state treasurer for proper distribution of taxes collected.

~~f.~~ e. If the estate includes farmland, a supplemental information form listing the assessed value.

f. Two certificates of estate tax determination must be filed if the decedent owned real property in North Dakota and died before January 1, 1991. One certificate will be returned to the person responsible for filing it with the register of deeds in the county where the real property is located.

g. ~~Such~~ Any other information as the tax commissioner may require.

2. If the decedent died before January 1, 1991, the total value of the estate is under the federal filing requirement, and the estate includes property to which a lien attached upon the death of a decedent, the following documents must be filed with the tax commissioner:

a. A verified petition for release of lien.

b. Duplicate release of lien. One copy will be returned to the personal representative or the attorney for the estate for filing with the register of deeds in the appropriate county.

3. ~~The~~ Except as otherwise provided, the documents required by this section apply to all estates of decedents who died on or after July 1, 1975. For estates of decedents who died prior to July 1, 1975, the proper forms are those required by the statutes and rules in effect on the date of death of the decedent.

History: Effective June 1, 1984; amended effective November 1, 1991.
General Authority: NDCC 57-37.1-17
Law Implemented: NDCC 57-37.1-17, 57-37.1-21

81-08-03-07. Byproducts revenue exempt from taxation. ~~Calculation of the~~ For any given month, the allowed exemption of revenue derived from the sale of byproducts ~~exempt from taxation must be accomplished by multiplying~~ may not exceed twenty percent of the sum of total gross receipts from the sale of synthetic natural gas during the month plus total gross receipts from the sale of byproducts during the month ~~for which the report is made by twenty percent~~.

History: Effective November 1, 1987; amended effective July 1, 1989; November 1, 1991.
General Authority: NDCC 57-60-12
Law Implemented: NDCC 57-60-01, 57-60-02, 57-60-03

TITLE 87

Veterinary Medical Examiners, Board of

87-02-01-02. Educational program attendance required. Each licenseholder, except as otherwise provided, shall be required to ~~attend an educational program~~ receive twelve hours of veterinary continuing education, approved by the board, in the twelve months preceding each renewal date. ~~However, postgraduate study or attendance at an institution or an educational session approved by the board shall be considered equivalent~~ Veterinary continuing education is defined as an educational program which will enhance the licenseholder's professional ability to serve the public and which has the prior approval of the board.

History: Amended effective November 1, 1991.
General Authority: NDCC 43-29-03
Law Implemented: NDCC 43-29-03

87-02-01-03. Educational program requirement waiver. The board shall have the authority to ~~excuse licensees, as a group or~~ waive the continuing educational requirement for an individual, ~~from the annual requirements in~~ for any of the following ~~instances~~ reasons:

1. ~~When no educational program meeting the requirements approved by the board is conducted within the state~~ Impaired health.

2. ~~Upon submission of an affidavit to the board showing that the licensee was prevented from attending an educational program at the proper time.~~

~~3. In the event of an emergency.~~

~~4.~~ For persons who have reached the age of sixty-five and are no longer actively engaged in practice.

~~5.~~ 3. For other good and sufficient reasons as presented and verified to the board at one of its regular meetings.

History: Amended effective November 1, 1991.
General Authority: NDCC 43-29-03
Law Implemented: NDCC 43-29-03

87-02-01-04. Annual educational program requirements. ~~Any of the following will fulfill the annual educational requirements for the year~~ Veterinary continuing education may consist of the following:

1. ~~Eight~~ Four hours ~~attendance of the educational program of a national, regional, or state association, anywhere in the world~~ in-house training including American veterinary medical association tapes, films, and assessment test as in the compendium.

2. ~~Eight hours attendance of a short course in veterinary medicine, anywhere in the world~~ Programs sponsored by state, regional, or national veterinary associations and other continuing educational programs or training approved by the North Dakota veterinary medical examining board.

3. ~~Eight local association meetings where a program of at least one hour of educational material is given at each meeting, anywhere in the United States or Canada~~ Wet labs or instructions, or both, taken at a college or university, the subject material of which must pertain to veterinary medicine.

Proof of attendance and verification will be necessary on request.

History: Amended effective November 1, 1991.
General Authority: NDCC 43-29-03
Law Implemented: NDCC 43-29-03

87-02-01-05. Notice of failure to comply. If a licenseholder fails to receive the amount of continuing education necessary, a written notice must be sent and a six-month grace period will be allowed to make up the requirement. If, after twelve months, the requirements have not been met, the license will be void without further action on the part of the board.

History: Amended effective November 1, 1991.
General Authority: NDCC 43-29-03
Law Implemented: NDCC 43-29-03

87-03-01-01. Definition of ~~an animal health~~ a veterinary technician. As used in this chapter, "~~animal health~~ veterinary technician" has the same meaning as "~~animal~~ veterinary technician" as defined in North Dakota Century Code section 43-29-09.

History: Effective October 1, 1981; amended effective November 1, 1991.
General Authority: NDCC 43-29-09
Law Implemented: NDCC 43-29-09

87-03-01-02. Requirements for certification as ~~an animal health~~ a veterinary technician. Certification as ~~an animal health~~ a veterinary technician requires a recommendation from a licensed veterinarian and ~~passage of~~ passing a certification examination consisting of written and practical portions.

History: Effective October 1, 1981; amended effective November 1, 1991.
General Authority: NDCC 43-29-09
Law Implemented: NDCC 43-29-09

87-03-01-03. Prerequisites for taking the certification examination. The ~~prerequisites~~ minimum prerequisite for taking the ~~certification~~ examination ~~is one of the following:~~ for certification as a veterinary technician

~~1.~~ ~~Graduation~~ is graduation from a two-year ~~animal health~~ veterinary technician training program.

~~2. Graduation from a one-year animal health technician training program, plus one year of on-the-job training.~~

History: Effective October 1, 1981; amended effective April 1, 1986; November 1, 1991.
General Authority: NDCC 43-29-09
Law Implemented: NDCC 43-29-09

87-03-01-04. Application for certification - Fees - Certificate renewal. Any person desiring certification as ~~an animal health~~ a veterinary technician shall make written application for certification to the executive secretary on forms provided for that purpose and shall pay in advance to the North Dakota board of veterinary medical examiners a fee of twenty-five dollars. Fees are not returned, except by action of the board. If the certificate is granted, the technician shall pay an annual renewal registration fee as determined by the board, based on the financial needs of the board. The renewal registration fee shall be paid by all certified technicians.

History: Effective October 1, 1981; amended effective November 1, 1991.
General Authority: NDCC 43-29-09
Law Implemented: NDCC 43-29-09

TITLE 92

Workers Compensation Bureau

92-01-02-20. Classification of employments - Premium rates. Classifications and premium rates, taking into consideration hazards and risks of different occupations, must be those classifications and premium rates contained in the ~~1990~~ 1991 edition of that publication entitled, "North Dakota Workers Compensation Bureau Rates and Classifications" which is hereby adopted by reference thereto and incorporated within this section as though set out in full herein.

Premium rates must be adjusted annually as recommended by the bureau's actuaries based upon the criteria set forth in North Dakota Century Code section 65-04-01.

The minimum premium charge for all classifications will be twenty-five dollars per year except for the following volunteer classifications:

Classification No.	
7710	Fire department, volunteer - minimum will be fifty dollars
7715	Civil defense volunteer disaster - minimum will be fifty dollars
9830	Civil air patrol, volunteer - minimum will be one hundred ten dollars
9385	Volunteer programs - minimum will be one hundred fifty dollars
9840	Vocational training and work evaluation programs, volunteer - minimum will be one hundred fifty dollars

History: Effective June 1, 1990; amended effective July 1, 1990; July 1, 1991.
General Authority: NDCC 65-02-08, 65-04-01
Law Implemented: NDCC 65-04-01

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

1. Definitions. As used in this section, "employee leasing arrangement" means an arrangement whereby an entity utilizes the services of another entity to maintain all or some of its workers. The entity providing the services must be referred to as the labor contractor. The entity receiving the services must be referred to as the client.

   Employee leasing arrangement does not include arrangements to provide temporary workers. Temporary work means a worker who is furnished to an entity to substitute for a permanent employee on leave or to meet seasonal or short-term workload conditions.

2. Coverage. For purposes of coverage under the Workers Compensation Act, the client in an employee leasing arrangement must be deemed the employer. Coverage must be provided by the client to fulfill statutory obligations to workers leased under an employee leasing arrangement.

3. Premium for leased employees - Client as policyholder.

   a. The client shall provide a complete payroll record of the employees and workers leased to it from the labor contractor. Premium on such payroll must be based on the classifications and rates which would have applied if the employees and workers leased to the client had been direct employees of the client.

   b. If the client does not supply the payroll records of the employees and workers leased to it from the labor contractor, one hundred percent of the full employee leasing arrangement price must be established as the payroll of the employees and workers leased to the client. The premium must be charged on that amount as payroll.

   c. If an experience modification has been established for the client, such experience modification must be applied to the premium developed for the leased employees and workers.

History: Effective July 1, 1991.
General Authority: NDCC 65-02-08, 65-04-17
Law Implemented: NDCC 65-04-17

92-01-02-22. Out-of-state injuries. An employee may be deemed to regularly work at or from an employment principally localized in this state as defined in North Dakota Century Code section 65-08-01 if the employee's out-of-state injury is sustained under circumstances in which the employee has worked outside this state for a period of not more than fourteen consecutive calendar days.

History: Effective July 1, 1991.
General Authority: NDCC 65-02-08, 65-08-01
Law Implemented: NDCC 65-08-01

92-01-02-11.1. Fees. Fees for legal services provided by ~~claimants'~~ employees' attorneys and legal assistants working under the direction of ~~claimants'~~ employees' attorneys will be paid following constructive denial or an order reducing or denying benefits if the matter is not submitted to binding arbitration and the employee prevails, or in all cases if the matter is submitted to binding arbitration, and when the bureau notifies the employee to be available for vocational testing, subject to the following:

1. Attorneys must be paid at the rate of seventy dollars per hour for all actual and reasonable time other than traveltime when the matter is submitted to binding arbitration and at the rate of eighty-five dollars per hour for all actual and reasonable time other than traveltime when the matter is submitted to formal administrative hearing and the employee prevails. Traveltime must be paid at the rate of forty dollars per hour.

2. Legal assistants and third year law students or law school graduates with a doctor of laws degree who are not licensed attorneys practicing under the North Dakota senior practice rule acting under the supervision of ~~claimants'~~ employees' attorneys must be paid at the rate of forty dollars per hour for all actual and reasonable time other than traveltime. Traveltime must be paid at the rate of twenty dollars per hour. A "legal assistant" means any person with a bachelor's degree, in a legal assistant or paralegal program, from an accredited college or university, or a legal assistant certified as such by the national association of legal assistants.

3. Subject only to ~~subsections 5 and~~ subsection 6, total fees paid by the bureau for all legal services in connection with a claim may not exceed the following:

a. No fees may be paid prior to constructive denial of a claim, issuance of a pretermination notice informing a claimant that the bureau intends to discontinue or suspend benefits, or issuance of an administrative order, except as otherwise provided by this section.

b. The sum of ~~three hundred fifty~~ four hundred twenty dollars, plus reasonable costs incurred, for legal services following issuance of a pretermination notice, if an administrative order discontinuing or suspending benefits is not subsequently issued.

c. ~~The~~ At a rate of seventy dollars per hour the sum of seven hundred dollars, plus reasonable costs incurred, for legal services in connection with an offer by the bureau to make a lump sum settlement pursuant to North Dakota Century Code section 65-05-25.

d. ~~The~~ At a rate of seventy dollars per hour the sum of ~~seven~~ eight hundred dollars, plus reasonable costs incurred, for legal services ~~in connection with a rehabilitation plan after~~ when the bureau has notified the ~~claimant to identify a rehabilitation plan~~ employee to be available for vocational testing under North Dakota Century Code section ~~65-05.1-04~~ 65-05.1-06.1.

e. The total sum of ~~fifteen~~ eighteen hundred dollars, plus reasonable costs incurred, following constructive denial of a claim, or issuance of an administrative order under North Dakota Century Code chapter 28-32 reducing or denying benefits, for services provided if the ~~dispute is resolved~~ employee prevails before an evidentiary hearing or deposition is scheduled by the bureau.

f. The total sum of three thousand six hundred dollars, plus reasonable costs incurred, if the ~~dispute is resolved~~ employee prevails after an evidentiary hearing or deposition is scheduled by the bureau or following such hearing or deposition.

g. The total sum of ~~five~~ six thousand dollars, plus reasonable costs incurred, if the ~~claimant~~ employee prevails following a district court appeal.

h. The total sum of ~~six~~ seven thousand two hundred dollars, plus reasonable costs incurred, if the ~~claimant~~ employee prevails following an appeal to the North Dakota supreme court.

i. If the bureau has awarded benefits and the employer requests a rehearing, the bureau may, in its discretion, pay the employee's attorney fees and costs in connection

with the rehearing. Total fees paid pursuant to this section may not exceed the sum of fifteen hundred dollars.

j. The total sum of two thousand dollars, plus reasonable costs incurred, for services in connection with binding arbitration.

4. When an employer has timely filed a notice of refusal to consent to arbitration, the employee's attorney fees must be paid at the rate of seventy dollars per hour, subject to subdivision j of subsection 3.

5. The maximum fees specified in subdivisions e, f, g, and h of subsection 3 include all fees paid by the bureau to one or more attorneys representing the ~~claimant~~ employee in connection with the same claim at all stages in the proceedings, including those fees paid according to subdivisions b, c, and d of subsection 3. A "claim" includes all matters affecting rights of ~~a claimant~~ an employee in connection with one or more work injuries that are or reasonably could be included in a single administrative order or application for benefits.

~~5.~~ 6. Upon application of the ~~claimant's~~ employee's attorney and a finding by the bureau that ~~a claim has clear and substantial merit and that~~ the legal or factual issues involved in the dispute are unusually complex, the bureau may approve payment of reasonable fees in excess of the maximum fees provided by subdivisions e and f of subsection 3. If the bureau approves payment of fees in excess of the maximum fees provided by subdivisions e and f of subsection 3, the bureau shall set a new maximum fee, which may not be exceeded. Upon application of the ~~claimant's~~ employee's attorney to the appellate court and a finding by the court that ~~the claim had clear and substantial merit, and that~~ the legal or factual issues involved in the appeal were unusually complex, the court may approve payment of reasonable fees in excess of the maximum fee provided by subdivisions g and h of subsection 3. All applications for additional fees in excess of the maximum fees must contain a concise statement of the reasons for the request, including a summary of the factual or legal issues, or both, justifying such request, and an explanation concerning why the issues are unusually complex. Factors that must be considered in determining whether the factual or legal issues are unusually complex include:

a. The extent of the prehearing and posthearing discovery;

b. The number of depositions;

c. The number of legal or factual issues in dispute; and

d. Whether the legal issues or relevant statutes have been previously interpreted by the North Dakota supreme court.

~~6. If the bureau has awarded benefits, and the employer requests a rehearing, the bureau may, in its discretion, pay the claimant's attorney fees and costs in connection with the rehearing. Total fees paid pursuant to this section may not exceed the sum of fifteen hundred dollars.~~

7. All time must be recorded in increments of no more than six minutes (one-tenth of an hour). Contemporaneous time records must be kept and made available to the bureau, upon request made at any time within two years of the date recorded.

8. "Minimum" billings in increments greater than six minutes (one-tenth of an hour) are not permitted.

9. ~~Monthly fee statements and~~ If the bureau is obligated to pay the employee's attorney fees, the attorney shall submit to the bureau a final statement upon resolution of the matter ~~must be submitted to the bureau~~ on forms provided by the bureau for that purpose, or on other forms acceptable to the bureau. An attorney representing an employee in a binding arbitration proceeding may submit monthly fee statements. All statements must show the name of the ~~claimant~~ employee, claim number, date of the statement, date of each service or charge, itemization and a reasonable description of each service or charge, time and amount billed for each item, and total time and amounts billed. ~~No fees for services provided more than ninety days before the date of the billing will be paid except for those approved in the sole discretion of the bureau~~ The employee's attorney must sign the fee statement. The signature of the attorney constitutes a certificate by the attorney that the attorney has not sought or obtained payment, or will seek payment of any fees or costs from the employee relative to the same services.

10. The following costs will be reimbursed:

a. Actual postage.

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

c. Copying charges, at twenty 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 bureau.

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

11. The following costs are not allowable:

a. Facsimile charges.

b. Express mail.

c. Additional copies of transcripts.

d. Costs incurred to obtain medical records.

e. Online computer-assisted legal research.

An attorney who accepts compensation from the bureau for services pursuant to North Dakota Century Code section 65-02-08 and this section agrees to binding fee arbitration of all disputes relating to payment or denial of fees.

Fees for reporters must be: The sum of twenty-five dollars per hour, for appearance at hearing or other proceeding; plus, two dollars and fifty cents per page for transcription and original transcript, and twenty cents per page for additional copies. The bureau shall also reimburse 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.
General Authority: NDCC 65-02-08~~, 65-10-03~~
Law Implemented: NDCC 65-02-08, 65-02-17, 65-10-03

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

1. For the purposes of North Dakota Century Code section 65-04-20, the interest rate is the three-year annualized rate of the total funds invested by the bureau as indicated in the bureau's March thirty-first investment measurement review. Should the March thirty-first investment measurement review not be available by July first for any reason, the most recent investment measurement review applies.

2. Premium subject to installments will be limited to the premium for the advance premium only. Prior period premium deficiencies must be paid in full within the original premium due date. Policy periods beginning on or after July 1, 1991, will be eligible for installment payments under this section. The annual interest rate for each employer will be based on the rate in effect at the start of the policy period.

3. Default on payment of any installment payment will cause the entire premium balance to be due immediately.

History: Effective November 1, 1991.
General Authority: NDCC 65-02-08, 65-04-20
Law Implemented: NDCC 65-04-20, 65-04-24

92-01-02-24. Rehabilitation services.

1. When an employment opportunity suited to an employee's educational, 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 market under subdivision c of subsection 4 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 bureau may make an award of services to move an employee's household to the locale where the employee has actually located work under subdivision f of subsection 2 of North Dakota Century Code section 65-05.1-06.1 only when the employee identifies the job he will perform, his employer, and his 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 bureau for review and approval prior to incurring the cost. The relocation award must also include per diem expenses, as set forth under subsection 2 of North Dakota Century Code section 65-05-28, for the employee only. No per diem expenses may be paid for the employee's family. Reimbursement for mileage expenses may not be paid for more than one motor vehicle.

3. When the rehabilitation award is short-term or long-term training, the award must include the actual cost of books, tuition, and school supplies which are 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 bureau upon showing that such expenses are reasonable and necessary. A rehabilitation award for short-term or long-term training may include tutoring assistance to those employees who require such services to maintain a passing grade. Payment of tutoring services will only 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. A rehabilitation award for short-term or long-term training may include other expenses such as association dues or subscriptions only if such expense is a course requirement.

4. An award for short-term or long-term training which includes an additional twenty-five percent lost-time allowance to maintain two domiciles as provided in subdivision b of subsection 2 of North Dakota Century Code section 65-05.1-06.1 shall continue only for such time during which the employee is actually enrolled or participating in the training program, and is actually maintaining two domiciles.

5. An award of a specified number of weeks of training contemplates that 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.

History: Effective November 1, 1991.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05.1

92-01-02-25. Permanent impairment disputes. A dispute as to the percentage of an employee's permanent impairment must be resolved in accordance with this section.

1. Definitions. In this section:

   a. "Dispute" means an employee has reached maximum medical improvement in connection with a work injury, the employee's doctor has filed with the bureau a report of the rating of impairment of function, and the bureau fails or refuses to award permanent impairment benefits based upon that report within thirty days of receipt of the report.

   b. "Maximum medical improvement" means the level of recovery at which further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated based on reasonable medical probability and the clinical findings, determined over a period of time (usually twelve months) indicate the medical condition is stable and well-established.

   c. "Medical specialists" means those professionals who have had instruction in the use of the American medical association's "Guides to the Evaluation of Permanent Impairment" relating to the evaluation of permanent impairment, agree to have their names listed by the bureau as medical specialists, and who are:

(1) Licensed chiropractors who are board-certified chiropractic orthopedists (diplomates of the American board of chiropractic orthopedists).

(2) Licensed physicians who are board-certified medical specialists.

(3) Licensed physical therapists and licensed occupational therapists, who may conduct range of motion and strength testing under the general direction of a licensed physician. The physician must review the results of the testing and report to the bureau the rating of permanent impairment as required by North Dakota Century Code chapter 65-05.

2. An employee is entitled to payment of attorney fees pursuant to North Dakota Century Code section 65-02-08 in connection with permanent impairment benefits if, after the employee has reached maximum medical improvement, the bureau issues an administrative order reducing or denying permanent impairment benefits or the bureau fails or refuses to issue an order within ninety days of the date a report is received by the bureau which meets all the requirements of North Dakota Century Code section 65-05-12 and this section. After a formal order has been issued by the bureau, payment of attorneys' fees is governed by North Dakota Century Code sections 65-02-08, 65-02-17, and 65-10-03.

3. All permanent impairment reports must be filed on forms approved by the bureau.

4. All ratings of permanent impairment must be in accordance with the standards for the evaluation of permanent impairment as published in the latest edition of the American medical association's "Guides to the Evaluation of Permanent Impairment", unless proven otherwise by clear and convincing medical evidence. Any rating of impairment not based on the American medical association's "Guides to the Evaluation of Permanent Impairment" must include a statement explaining why those standards were not used and an explanation of the method used to evaluate impairment, along with a copy of the standards or guidelines, or both, followed in rating the impairment. The DSM III-R must be used to diagnose psychiatric or mental conditions and to assist in rating of impairments of those conditions. All reports must include the opinion of the physician or chiropractor on the cause of the impairment.

5. An employee is not entitled to an award for permanent impairment until after the employee is at maximum medical improvement. Upon receipt of a report from the employee's doctor indicating the employee has reached maximum medical improvement and evidence the employee has a permanent

impairment as a result of the work injury, the bureau shall send a form to the employee on which the employee shall identify all body parts the employee believes are permanently impaired due to the work injury. The employee must complete the form and return it to the bureau. The bureau shall then forward the report to the employee's doctor and instruct the doctor to examine the employee and report to the bureau any rating of impairment of function resulting from the work injury.

6. If the employee's doctor fails or refuses to determine permanent impairment and submit a report to the bureau as required by North Dakota Century Code section 65-05-12 and this section, the bureau shall schedule an evaluation with an appropriate medical specialist, who shall submit the required report.

7. The bureau shall establish a list or lists of all medical specialists within the state. The bureau may, in its discretion, include in the list or lists medical specialists from other states if there is an insufficient number of specialists in a particular specialty within the state who agree to be listed. In the event of a dispute, the bureau shall furnish the list or lists of appropriate specialists to the employee. The bureau and the employee, if they cannot agree on selection of an independent medical specialist, shall choose a specialist by striking names from the appropriate list or lists until a name is chosen.

8. In the event of a dispute involving an employee who resides outside of North Dakota, the bureau shall have the sole discretion to determine whether it will require the employee to return to this state for an independent evaluation. If the bureau approves an independent evaluation in another state, the bureau and the employee, if they cannot agree on a specialist, shall choose a specialist by striking names from a list of approved workers' compensation specialists in the other state, if such a list is available, or from some comparable list of appropriate medical specialists in that state.

9. Upon receipt of a report from the employee's doctor, if there is no dispute, or, in the event of a dispute, upon receipt of a report from the independent medical specialist, the bureau shall issue an order awarding or denying permanent impairment benefits.

History: Effective November 1, 1991.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-12, 65-05-12.1

92-01-02-26. Binding arbitration. Binding arbitration pursuant to North Dakota Century Code section 65-02-17 and selection and removal of binding arbitration panel members are governed by this section.

1. A request for binding arbitration may be filed with the North Dakota workers compensation bureau by an aggrieved employee no later than thirty days after notice of an administrative order has been given as required by North Dakota Century Code section 28-32-13 and in lieu of a petition for reconsideration or rehearing or an appeal filed pursuant to North Dakota Century Code chapter 28-32, or following constructive denial of a claim. The request for binding arbitration must be in writing and must include a statement of the specific grounds upon which relief is requested.

2. Upon receipt of a request for binding arbitration, the bureau shall serve notice on the employer by certified mail. In all cases relating to an injury for which the risk or payments are chargeable to an employer with an open account with the bureau, the employer has fifteen days from the date of mailing of the notice to give notice in writing to the bureau if the employer does not agree to submit to binding arbitration. The employer may notify the bureau of its consent to submit to binding arbitration prior to expiration of the fifteen days. An employer that fails to file timely notice in writing of refusal to consent to arbitration is deemed to have consented. If the employer files a timely notice of refusal to consent to arbitration, the matter is deemed submitted for reconsideration and formal rehearing and the employee is not entitled to arbitration. If the risk or payments are not chargeable to any employer, the employee is entitled to binding arbitration upon filing of the request with the bureau.

3. If the employee is self-employed or an officer, partner, or owner of all or any share of the employer's business, or if the employee or the employee's spouse is related by consanguinity within the third degree as determined by the common law, including adoptive relationships, to any person who is an officer or owner of any share of the employer's business, the employee and employer may not designate themselves as the employee and employer representatives on the arbitration panel.

4. The panel member selected from the list of persons provided by the bureau shall serve as the chair of the panel. No person may act as an arbitrator if that person has any financial or personal interest in the matter, except when the employee and employer designate themselves as the employee and employer representatives according to North Dakota Century Code section 65-02-15 and this section.

5. Arbitration proceedings and hearings are governed by the following rules:

a. The employee and employer shall select their panel representatives within fifteen days of the day a list of panel members is mailed to them by the bureau. The third panel member must be selected within fifteen days of selection of the first two panel members. In the event a party fails or refuses to make a selection in a timely manner, the bureau shall make the selection on that party's behalf by first selecting the person whose name appears at the top of the appropriate list and thereafter selecting persons in turn in the order their names appear on the appropriate list.

b. The chair shall schedule a prehearing conference within thirty days of selection of the arbitration panel. The conference must be conducted by telephonic conference call whenever practicable. At the prehearing conference, the parties and the bureau shall identify the issues, identify anticipated witnesses, including expert witnesses and their expected testimony, summarize the nature of evidence to be presented at hearing and identify all medical reports and records, deposition transcripts, and affidavits intended to be offered at the hearing. Deposition transcripts may not be admitted unless prior notice of the deposition and opportunity for cross-examination was provided to any interested party and the bureau.

c. The parties and the bureau may waive oral hearing before the panel and stipulate to submission to the panel based on briefs and documentary evidence. The parties and the bureau may stipulate as to the procedure. The procedures set forth in this section apply if the parties and the bureau do not stipulate to a different procedure.

d. Following the prehearing conference, the chair shall schedule a hearing, if the parties and the bureau have not waived oral hearing, and serve notice of the hearing on the parties and the bureau at least twenty days prior to the date of the hearing.

e. Any party intending to offer any medical report or record, deposition transcript, or affidavit at the hearing must provide the other party and the bureau with a copy at least ten days prior to the hearing. If the bureau intends to offer any medical report or record, deposition transcript, or affidavit at the hearing in addition to documents in the bureau's file previously disclosed to the parties, the bureau shall provide the parties with copies of the additional reports or records at least ten days prior to the hearing. Upon service of any such document,

the other party or parties or the bureau may, at any time before the day of the hearing, ask the chair in writing for permission to submit additional rebuttal documents or testimony not previously disclosed. The chair in his or her discretion, or upon agreement of the parties and the bureau, may grant any such request before the hearing, and the panel in its discretion, or upon agreement of the parties and the bureau, may allow the submission of such additional evidence at the hearing or hold the hearing record open for submission of such evidence following the hearing.

f. At the hearing, the parties may make an opening statement and shall submit their evidence and witnesses, beginning with the employee and followed by the employer and then the bureau. The procedure may be varied upon agreement of the parties and the bureau or in the discretion of the arbitration panel upon request. Following submission of all evidence, the parties may make a closing argument or may, in the discretion of the panel, be required to submit briefs or written arguments within a time specified following the hearing.

g. Only such evidence as is relevant and material to the dispute may be received. The panel is the judge of the relevance and materiality of the evidence offered, and conformity to legal rules of evidence is not required. In the discretion of the panel, the record may be held open following the hearing for the submission of additional evidence as directed by the panel.

h. Witnesses must first be sworn as required by law. The chair is authorized to subpoena witnesses or documents upon request of a party or the bureau. Witnesses must be paid a statutory fee and are entitled to reimbursement for necessary travel as provided by law. The parties and the bureau are responsible for the costs and expenses of their own witnesses, provided that if the bureau offers the opinion of an expert retained by the bureau for the purpose of refuting the opinion of the employee's doctor, the parties are entitled to an opportunity to cross-examine the bureau's expert at the expense of the bureau. The chair may in his or her discretion and for good cause order the bureau to pay statutory witness fees and expenses for a party's witness upon written application by a party.

i. Hearings must be held in the region where the employee resides or, if the employee resides out of state, in the region which is the situs of the employment. Hearings may be conducted by telephonic conference call and any witness may testify by telephonic conference call upon agreement of the parties and the bureau. Hearings need not be

recorded, but may be recorded upon agreement of the parties and the bureau or in the discretion of the panel. The party requesting the recording is responsible for the cost of recording the hearing and the cost of any transcript.

j. All decisions of the panel must be by a majority of the panel. The chair must be in the majority in order for the panel to issue a decision. If the panel is unable to reach a majority decision with the chair in the majority relative to any issue, the case must be submitted to a different panel. If the panel is able to reach a majority decision with the chair in the majority with respect to some issues but not all issues before it, the panel shall issue a written order making its decision and a statement of all benefits awarded and denied relative to those issues decided by unanimous vote. The panel shall identify those issues on which the panel is unable to reach a majority decision, and those issues must be submitted to a different panel.

k. Following the close of the hearing, the panel shall issue a written order, including a brief summary of the case and its decision and a statement of all benefits awarded or denied. The order must be based on and in accordance with applicable substantive law. The panel may not issue a lump sum payment in lieu of medical benefits or in lieu of disability or rehabilitation benefits. The order must be signed by the chair and served on the parties by certified mail.

l. Any party or the bureau may request reconsideration or correction of an order upon written application filed with the chair and served on the other party and the bureau within ten days of service of the panel's decision. The other party and the bureau may file and serve a response within five days. The panel may deny the request with or without explanation, issue an amended or corrected order, or order that the proceeding be reopened for submission of additional evidence or briefs.

6. The director may remove a member of the workers' compensation arbitration panel for cause.

a. Cause means the panel member has:

(1) Been convicted of a crime involving fraud or dishonesty or other crime that is substantially related to the qualifications, functions, and duties of a panel member;

(2) Solicited or received anything of value in connection with service as a panel member except compensation and expenses paid pursuant to this rule; or

(3) Willfully failed or refused without good cause to perform any duty or function imposed by law or this section or acted with gross negligence or incompetence or committed misconduct or malfeasance in connection with an arbitration proceeding.

b. Prior to removal of any member, the director shall serve notice of the charges or reasons for removal on the member and provide the member with an opportunity to respond to the charges.

c. Upon removal of any member, the director shall give written notice of removal, a statement of the reasons for the action and a summary of the evidence upon which the decision was made, and notice of an opportunity for a hearing before the director upon request. Upon request, the director shall schedule a hearing at which time the member must be given an opportunity to present evidence and witnesses and cross-examine adverse witnesses. Following the hearing, the director shall affirm, modify, or reverse the decision to remove the member, and issue an order stating the decision and the reasons therefore.

7. Panel members are not employees of the bureau or the state and are not entitled to compensation and may not solicit or accept any compensation or anything of value in connection with their services except as provided by this section. In addition to reimbursement for per diem and necessary travel at the rates paid state employees, additional compensation must be paid at a rate established by the bureau.

8. The panel members may not engage in any ex parte communications with any party to the proceeding.

History: Effective November 1, 1991.
General Authority: NDCC 28-32-05, 28-32-05.1, 65-02-08
Law Implemented: NDCC 65-02-15, 65-02-16, 65-02-17

92-01-02-13. ~~Transfer of coverage from selling employer to purchasing employer~~ Merger, exchange, or transfer of business.

1. Definitions. In this section:

   a. "Business entity" means any form of business organization including, but not limited to, proprietorships, partnerships, limited partnerships, cooperatives, and corporations.

   b. "Constituent business" means any 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 business entity resulting from a merger, exchange, or transfer of business assets shall retain the highest experience rating of any constituent business entity merged, exchanged, or transferred. The bureau may, in its discretion, change the experience rating of the surviving entity.

3. Compensation coverage. The compensation coverage of any ~~employer selling or transferring the employer's business to another employer who continues to operate the same business~~ constituent business may, at the discretion of the bureau, be transferred to the ~~purchaser~~ surviving entity. Any premium unearned on the seller's risk must be applied toward payment for the transferred coverage.

~~2.~~ The compensation coverage of ~~an employer, who has operated a business as an individual owner (sole proprietorship), as a~~

~~family operation, (sons, spouse, daughters), or as a partnership, selling or transferring the business~~ a constituent business sold or transferred within three months of the last actual payroll period expiration date to a ~~corporation of which the employer, as an individual owner, family member or partner, continues to be an officer or shareholder,~~ surviving entity may be transferred to the ~~purchasing corporation~~ surviving entity. Then the payroll for the three-month (or less) payroll period will be prorated on the basis of the maximum of ~~three hundred dollars~~ one-twelfth of the statutory payroll cap per month per employee for the period of time involved. If the salary paid is less than the maximum amount of ~~three hundred dollars~~ one-twelfth of the statutory payroll cap per month, the full amount is reportable, or if an employee ceased employment during the three-month period, the gross paid is to be reported up to ~~three thousand six hundred dollars~~ the payroll cap established by statute.

History: Effective June 1, 1990; amended effective January 1, 1992.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-01

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

1. Definitions. As used in this section, ~~"employee leasing arrangement" means an arrangement whereby an entity utilizes the services of another entity to maintain all or some of its workers. The entity providing the services must be referred to as the labor contractor. The entity receiving the services must be referred to as the client.~~:

   ~~Employee leasing arrangement does not include arrangements to provide temporary workers. Temporary work means a worker who is furnished to an entity to substitute for a permanent employee on leave or to meet seasonal or short-term workload conditions.~~

   a. "Client" means an entity leasing one or more employees from another entity.

   b. "Employee leasing arrangement" means an arrangement whereby an entity utilizes the services of another entity to maintain all or some of its employees. Employee leasing arrangement does not include arrangements to provide temporary employees.

   c. "Labor contractor" means an entity leasing one or more of its employees to another company.

d. "Temporary employee" means an employee who is furnished by a labor contractor to a client less than three-fourths of any three consecutive months.

2. Coverage. For purposes of coverage under the Workers Compensation Act, ~~the~~ a client ~~in~~ leasing an employee ~~leasing arrangement must~~ from a labor contractor pursuant to an employee leasing agreement must be deemed the employer of the leased employee, and the bureau may require the client to provide worker's compensation coverage for the leased employee, when the leased employee has been furnished by the labor contractor to the client at least three-fourths of any three consecutive months. A leased employee so employed may not be deemed a temporary worker. The labor contractor shall provide worker's compensation coverage for temporary employees furnished to clients. ~~Coverage must be provided by the client to fulfill statutory obligations to workers leased under an employee leasing arrangement~~.

3. Premium for leased employees - Client as policyholder.

   a. The client shall provide a complete payroll record of the employees and workers leased to it from the labor contractor. Premium on such payroll must be based on the classifications and rates which would have applied if the employees and workers leased to the client had been direct employees of the client.

   b. If the client does not supply the payroll records of the employees and workers leased to it from the labor contractor, one hundred percent of the full employee leasing arrangement price must be established as the payroll of the employees and workers leased to the client. The premium must be charged on that amount as payroll.

   c. If an experience modification has been established for the client, such experience modification must be applied to the premium developed for the leased employees and workers.

History: Effective July 1, 1991; amended effective January 1, 1992.
General Authority: NDCC 65-02-08, 65-04-17
Law Implemented: NDCC 65-04-17

92-01-02-27. Medical and hospital fees. Medical and hospital fees and rules of procedure must be those fees and procedures contained in the 1992 edition of that publication entitled "North Dakota Workers Compensation Medical and Hospital Fees", adopted by reference thereto and incorporated within this section as though set out in full herein.

Maximum allowable fees may be adjusted annually. The fees adopted in this section apply to all services rendered on or after January 1, 1992.

This section and schedules apply to all health care providers and practitioners regardless of specialty area, limitation of practice, state, or county where service is provided.

Services permitted under out-of-state workers' compensation programs, but not allowed under the North Dakota fees and procedures, may not be reimbursed. Questionable services will be addressed at the bureau's discretion at the request of a provider or practitioner.

Reimbursement for services and procedures not addressed within this section will be determined on a "by report" basis. A description of the nature, extent and need for the procedure or service, including the time, skills, equipment, and any other pertinent facts necessary to furnish the procedure or service, should be furnished the bureau, as well as the following, where appropriate:

1. Postoperative diagnosis.

2. Size, location, and number of lesions or procedures.

3. Major surgical procedure with supplementary procedures.

4. Nearest similar procedure, by code, according to the North Dakota Workers Compensation Medical and Hospital Fees publication.

5. Estimated followup.

6. Operative time.

"By report" services or procedures must be adjusted as provided in this section.

Inpatient hospital services must be paid on the basis of hospital specific per diem rates, based upon costs reported in the latest available medicare cost report for that hospital. Per diem rates will be established for the following services, if available from the hospital: medical and surgical stay; intensive care unit and coronary care unit stays; psychiatric stays; chemical dependency stays; and rehabilitation stays. Specialty services will also be allocated a per diem rate for a hospital performing that type of service (e.g., a burn unit stay). Per diem rates will be calculated by aggregating salary expenses for routine services, allocated overhead (general services) costs and expenses for ancillary services, and dividing such aggregation by related patient days. Expenses will be adjusted for each hospital to a common base of 1989, using adjustment factors specific to the regions in which hospitals are located.

Rates will be adjusted to 1992 values, using the same inflationary factors applied to adjusting North Dakota workers' compensation temporary disability payments. The maximum payable amount on an inpatient hospital charge will be computed by multiplying the eligible days or units reported on the hospital bill by the appropriate per diem rate. Where the submitted amount is less than the approved amount, payment will be based on the lesser amount. North Dakota and border states' hospitals for which recent medicare cost reports are not available will be paid at the lesser of the median of the per diem rates or the actual billed charges.

Hospital outpatient services charges, for outpatient clinic and emergency room services, will be based on a cost to charge ratio for each hospital. The cost to charge ratio will be computed by comparing the costs to charges for the hospital based on the latest available medicare audited cost report. A maximum payable amount on an outpatient hospital charge will be computed by multiplying the submitted charge by the cost to charge ratio. If a medicare cost report is not available for a hospital, the median cost to charge ratio for all eligible hospitals will be applied. The workers compensation bureau may apply additional percentage discounts from the cost to charge ratio.

History: Effective January 1, 1992.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08

TITLE 98

Office of Administrative Hearings

JANUARY 1992

STAFF COMMENT: Title 98 contains all new material but is not underscored so as to improve readability.

ARTICLE 98-01

GENERAL ADMINISTRATION

CHAPTER 98-01-01
ORGANIZATION OF OFFICE OF ADMINISTRATIVE HEARINGS

98-01-01-01. History. The office of administrative hearings was established July 1, 1991, as a result of the passage of Senate Bill No. 2234 in the fifty-second legislative assembly. See S.L. 1991, ch. 637. The office must provide independent hearing officers for state agencies, boards, and commissions that are required to use independent hearing officers to conduct their hearings, and may provide independent hearing officers for other requesting state agencies, boards, and

commissions, and units of local government, as well as for any agency to conduct a rulemaking hearing.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02.1
Law Implemented: NDCC 28-32-02.1, 54-57-03

98-01-01-02. Application of North Dakota Century Code chapter 28-32. The office of administrative hearings itself is an agency subject to chapter 28-32. It is required to conduct hearings for other agencies that are subject to chapter 28-32. When conducting hearings for agencies subject to chapter 28-32, its hearing officers must conduct those hearings in accordance with the provisions of chapter 28-32 and any rules adopted pursuant to it. The office of administrative hearings is also required to provide hearing officers for the hearings of some agencies not subject to chapter 28-32. When conducting hearings for agencies not subject to chapter 28-32, its hearing officers need not conduct the hearing according to the provisions of chapter 28-32 and rules adopted pursuant to it. Additionally, the provisions of chapter 28-32, and rules adopted pursuant to it, do no apply to any hearings conducted by the office of administrative hearings for units of local government for which the office of administrative hearings may provide a hearing officer upon request.

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02.1
Law Implemented: NDCC 28-32-02.1, 54-57-03

98-01-01-03. Inquiries. Any inquiries concerning the office of administrative hearings, the uniform rules of administrative practice and procedure adopted by it, or any of the laws relating to the office of administrative hearings or the uniform rules may be addressed to:

Director
Office of Administrative Hearings
918 East Divide Avenue
Suite 315
Bismarck, North Dakota 58501

History: Effective January 1, 1992.
General Authority: NDCC 28-32-02.1
Law Implemented: NDCC 28-32-02.1

ARTICLE 98-02

UNIFORM RULES OF ADMINISTRATIVE PRACTICE AND PROCEDURE

CHAPTER 98-02-01
DEFINITIONS

[Reserved]

CHAPTER 98-02-02
PREHEARING PRACTICE AND PROCEDURE

98-02-02-01. Contested cases - Complaint and specific-named respondent. [Reserved] See North Dakota Century Code section 28-32-05 for statutory requirements.

98-02-02-02. Proceedings other than complaint and specific-named respondent - Noncontested cases - Notice of hearing.

1. This section does not apply to proceedings pursuant to subsection 1 of North Dakota Century Code section 28-32-05, or proceedings complying with another statute or rule of practice or procedure adopted pursuant to statute by an administrative agency.

2. No hearing may be held unless all the parties have been served notice of the hearing at least fifteen days before the hearing.

3. In an emergency a hearing officer, in the hearing officer's discretion, may give notice of hearing by giving less than fifteen days' notice. Every party to an emergency hearing must be given a reasonable time to prepare for the hearing, which may be extended by the hearing officer upon good cause being shown.

4. The hearing officer shall designate the time and place for the hearing. Service of the notice must be by certified mail or personally. Service may be waived in writing by a party, and the parties may agree on a definite time and place for hearing with the consent of the agency having jurisdiction.

5. The notice for hearing must state the time and place for the hearing, the name and address of the hearing officer, and shall generally inform the parties about the nature of the hearing. In lieu of, or in addition to, a general explanation about the nature of the hearing contained in the notice, the hearing officer may attach to the notice other pleadings or documents which adequately inform the parties about the nature of the hearing.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-05

98-02-02-03. Service and filing. All pleadings, notices, written motions, requests, petitions, briefs, memoranda, and correspondence relating to a proceeding must be served on all parties and filed with the agency. When a proceeding has been assigned to a hearing officer outside the agency, the agency shall inform the parties of the designated hearing officer's name and address, and filing must be with the designated hearing officer at the address of the hearing officer. Unless otherwise provided by law, filing is complete upon actual receipt by the agency or the hearing officer, if one outside the agency has been designated, or upon mailing, unless the agency or hearing officer requires actual receipt by a time certain. The date of service is the day when the document is deposited in the United States mail or is delivered in person, except that the date of service of a document

required to be served by certified mail is the date of its delivery, or of its attempted delivery, if refused. When a party has appeared by an attorney or an authorized representative, service must be upon the attorney or the duly authorized representative, unless service upon the party is ordered by the hearing officer. The serving party must be prepared to furnish satisfactory proof of service.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-05, 54-57-04

98-02-02-04. Time. In computing any period of time under this title, the time begins with the day following the act or event, and includes the last day of the period, unless the last day is a Saturday, Sunday, or state or federal holiday, in which event it includes the next following day which is not a Saturday, Sunday, or holiday. Whenever a party has the right or is required to do some act or take some proceedings within a prescribed period of time after service of a document upon the party and the document is served upon the party by mail, other than certified mail, three days must be added to the prescribed period of time.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-05, 54-57-04, 54-57-05

98-02-02-05. Appearances and representation. Any party may participate in the hearing in person, or if the party is a corporation or other artificial person, by a duly authorized representative. Regardless of whether a party is participating in person, any party may be advised and represented by an attorney licensed to practice in North Dakota or, if permitted by law, other representative. Persons acting in a representative capacity must be prepared to show proof of their authority, in law and fact, to act in such capacity.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 54-57-04, 54-57-05

98-02-02-06. Discovery.

1. **General.** Parties may obtain discovery by oral deposition, written interrogatories, production of documents or things, inspection of property or premises, physical or mental examinations, or requests for admissions. With the exception of requests for admissions, a party, except an administrative agency, seeking to undertake discovery shall first submit a written petition for approval to conduct discovery to the hearing officer. The petition must identify the type of discovery sought, must name the person to be examined, or

identify with particularity the documents or property to be inspected, as the case may be, and must explain how the information sought is relevant to the issues. If the hearing officer finds that the requesting party has demonstrated that the information sought is relevant to the the issues in dispute, is reasonable in scope, is needed for the proper presentation of the party's case, and is not for the purposes of delay, the request must be approved. The hearing officer shall recognized all privileged information or communications which are recognized by law.

2. Depositions and interrogatories. Depositions and interrogatories must be taken in the manner provided by the North Dakota Rules of Civil Procedure.

3. Discovery of documents which are public records. Requests for the production of documents which are public records will not be approved unless it is first shown that the requesting party has made diligent and good faith efforts to review such documents under the existing general law procedures for inspection of public records and access has been denied.

4. Identification of witnesses. The hearing officer may require a party to disclose the names and addresses of all witnesses that the party intends to call at the hearing. All witnesses unknown at the time of that disclosure must be disclosed as soon as they become known. Any party failing to make disclosure required by this section without good cause may, at the discretion of the hearing officer, be foreclosed from presenting evidence at the hearing through witnesses not disclosed.

5. Requests for admissions. A party may serve upon any other party a written request for the admission of the truth of relevant statements or opinions of fact, or of the application of law to fact, including the genuineness of any document. The request must be served at least fifteen days prior to the hearing and it must be answered in writing by the party to whom the request is directed within ten days of receipt of the request. The written answer must either admit or deny the truth of the matters contained in the request or must make a specific objection thereto. Failure to make a timely written answer results in the subject matter of the request being deemed admitted.

6. Failure to comply with discovery order. Upon failure of a party to reasonably comply with an administrative agency's discovery request or the hearing officer's order approving discovery, the hearing officer may take one of the following actions:

   a. Make a further order concluding that the subject matter of the order approving discovery or any other relevant facts

shall be taken as established for the purposes of the case in accordance with the claim of the party requesting the order; or

b. Make an order which recognizes the failure of the party to comply and refuse to allow that party to support or oppose designated claims or defenses, or prohibit the party from introducing designated matters into evidence.

7. **Protective orders.** Upon motion by a party or by the person from whom discovery is sought, and for good cause shown, the hearing officer may make any order which justice requires to protect a party or person from annoyance, embarrassment, oppression, or undue burden and expense. The order may provide that discovery be denied, be limited, be had only on specified conditions, or be disclosed only in a designated way.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-09

98-02-02-07. Subpoenas. The hearing officer shall issue a subpoena for the production of documentary evidence only upon the written petition of a party requesting it. The petition for a subpoena for the production of documentary evidence must specifically identify the document or other object subpoenaed. The party requesting the subpoena is responsible for its timely service, as well as payment of all fees in accordance with the North Dakota Rules of Civil Procedure. Any attorney representing a party to the proceedings may issue a subpoena to require the attendance and testimony of a witness at proceedings. Upon motion promptly made, the hearing officer may quash or modify a subpoena if it is found to be unreasonable or oppressive.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-09

98-02-02-08. Motions - Certification of motions.

1. Motions must state the relief sought, the authority relied upon, and the facts alleged. If made before the hearing they must be in writing. If made at the hearing, they may be stated orally, but the hearing officer may require that they be reduced to writing, filed, and served. Within ten days after a written motion is served, or such other period as the hearing officer may fix, any party may file a response to the motion. The hearing officer may not sustain or grant a written motion prior to expiration of the time for filing responses, but may deny the motion without awaiting response. An immediate oral response may be made to an oral motion, and

an oral motion may be ruled on immediately. Motions submitted to the administrative agency or hearing officer, and not disposed of in a separate ruling or in the findings of fact, conclusions of law, and order, will be deemed denied. When the hearing officer designated to preside at the hearing is not the final decisionmaker, the hearing officer is authorized to rule upon any motion not formally acted upon by the administrative agency prior to the assignment of the matter to the hearing officer.

2. The hearing officer, either upon the request of a party or independent of such a request, may certify a motion to the administrative agency for final ruling. In deciding which motion should be certified, the hearing officer shall consider the following:

   a. Whether the motion involves a controlling question of law as to which there is a substantial ground for difference of opinion;

   b. Whether a final determination by the agency on the motion would materially advance the ultimate termination of the hearing;

   c. Whether or not the delay between the ruling and the motion would adversely affect the prevailing party;

   d. Whether to wait until after the hearing would render the matter moot and impossible for the agency to reverse or for a reversal to have any meaning; or

   e. Whether it is necessary to promote the development of the full record and avoid remanding.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-11.1, 54-57-05

98-02-02-09. Prehearing conferences. The hearing officer may order the parties to participate in a prehearing conference. Any party may request the hearing officer to hold a prehearing conference, but the decision to conduct a prehearing conference is the hearing officer's. The hearing officer will determine the method and manner in which the prehearing conference will be conducted. The purpose of the prehearing conference is to identify and simplify the issues to be decided, to determine whether the pleadings need amendment or clarification, to set a hearing date, to identify witnesses and exhibits, to obtain stipulations in regard to foundation for testimony and exhibits, to identify and stipulate to material facts not in dispute, and to consider such other matters that may foster the orderly and expeditious resolution of the issues. The prehearing conference will be informal, but the hearing officer may record the proceeding. Agreements,

amendments, stipulations, or other matters appropriate for resolution through the prehearing conference may be reduced to writing, entered on the record, or made the subject of an order by the hearing officer. The hearing officer may require that proposed exhibits be exchanged at the prehearing conference, or otherwise prior to the hearing. Proposed exhibits not so exchanged may be denied admission as evidence.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-08.3

98-02-02-10. Prehearing briefs. The hearing officer may require the parties to file written statements of position prior to the prehearing conference, prior to the hearing, or at the time of the hearing, summarizing their positions relative to the issues, identifying material facts in dispute as well as those not in dispute, and identifying applicable statutes, regulations, policies, and case law.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-08.3, 28-32-11.1

98-02-02-11. Affidavits presented by parties. Any party intending to introduce an affidavit in evidence shall serve a copy of the affidavit upon all parties at least fifteen days prior to the hearing, unless the hearing officer fixes another time period. If, within seven days of such service, a party files and serves a written request for the opportunity to cross-examine the affiant at the hearing, the assertions may not be received in evidence unless the affiant is made available for cross-examination, or the hearing officer determines that cross-examination is not necessary for the full and true disclosure of facts referred to in the affiant's assertions, in which case the affidavit may be introduced into evidence. This procedure is not required when the parties stipulate to the admission of an affidavit.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-06, 28-32-11.1

98-02-02-12. Consolidation. The hearing officer, upon the motion of any party or upon the hearing officer's own motion, may order two or more proceedings consolidated for hearing if they present similar issues of fact and law, and if the rights of the parties or the public interest will not be substantially prejudiced.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-11.1, 54-57-04

98-02-02-13. Intervention. [Reserved] See North Dakota Century Code section 28-32-08.2 for statutory requirements.

98-02-02-14. Informal disposition. [Reserved] See North Dakota Century Code section 28-32-05.1 for statutory requirements.

98-02-02-15. Disqualification of hearing officer. [Reserved] See North Dakota Century Code section 28-32-08.1 for statutory requirements.

98-02-02-16. Default. [Reserved] See North Dakota Century Code section 28-32-08.4 for statutory requirements.

CHAPTER 98-02-03
HEARING PROCEDURE

98-02-03-01. Evidentiary purpose. An evidentiary hearing need be conducted only in cases where genuine issues of material fact must be resolved. When it appears from pleadings, admissions, stipulations, affidavits, or other documents that there are no matters of material fact in dispute, the hearing officer, upon motion of a party or upon the hearing officer's own motion, may conclude that the hearing can proceed without conducting an evidentiary hearing and enter an order so finding, vacating the hearing date if one has been set, and fixing the time for filing briefs or taking oral argument.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-11.1, 54-57-04

98-02-03-02. Authority of hearing officer. The hearing officer has the duty to conduct a hearing, and related proceedings, to take all necessary action to maintain order and avoid delay, and has all powers necessary to these ends, including, but not limited to, the authority to:

1. Arrange and issue notice of, the date, time, and place of the hearing, and related proceedings or upon due notice to the parties, to change any date, time, or place previously set.

2. Hold conferences to settle, simplify, or fix the issues in a proceeding, or to consider other matters that may aid in the expeditious disposition of the proceeding.

3. Require parties to state their position with respect to the various issues in the proceeding.

4. Administer oaths and affirmations.

5. Issue subpoenas and discovery orders.

6. Rule on motions or other procedural matters where the ruling does not result in a final determination of the proceeding.

7. Regulate the course of the hearing and conduct of the parties.

8. Examine witnesses, direct witnesses to testify, and, as may be warranted, exclude witnesses from the hearing room so that they cannot hear the testimony of other witnesses.

9. Receive, rule on, exclude, or limit evidence.

10. Fix the time for filing motions, petitions, briefs, or other items.

11. Require the parties to submit briefs, memoranda, and proposed findings of fact and conclusions of law.

These powers apply to procedural hearing officers as well as hearing officers making recommended findings and conclusions, except as they may be lawfully limited by the agency at the time of the agency's request for, or designation of, a procedural hearing officer.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-05, 28-32-05.1, 28-32-06, 28-32-08.3, 28-32-09, 28-32-11, 28-32-11.1, 54-57-04

98-02-03-03. Hearing procedure. The hearing is directed to receiving factual evidence and expert opinion testimony related to issues in dispute. Argument will not be received in evidence; rather, it must be presented in statements, memoranda, or briefs, as determined by the hearing officer. Brief opening statements, limited to stating the party's position and what it intends to prove, may be allowed, in the hearing officer's discretion. Unless the hearing officer determines otherwise, the hearing must proceed and be conducted in substantially the following manner:

1. Testimony must be preserved by electronic recording unless the agency elects to use a court reporter or stenographer. If a request is made prior to the hearing, the agency may allow a party to preserve testimony by court reporter. The requesting party shall agree to pay for the court reporter and the cost of transcript preparation. The requesting party shall make all the necessary arrangements for the court reporter. The requesting party may not delay the proceeding by use of the court reporter or in the preparation of the transcript.

2. The hearing must be conducted in the English language. The proponent of any testimony to be offered by a witness who does not speak the English language proficiently shall provide an interpreter, approved by the hearing officer, proficient in the English language and the language in which the witness shall testify. The cost of such interpreter must be paid by the party providing the interpreter, unless the proponent of such testimony identifies a prevailing requirement that the agency provide an interpreter.

3. When the agency is a party, the hearing officer may require that the agency proceed first, by making an opening statement explaining the action taken, describing the evidence upon which that action was based, and identifying the applicable statues, rules or regulations, or policy interpretations upon which the action was based.

4. All parties may present evidence and argument with respect to the issues, and cross-examine witnesses. Cross-examination of witnesses will ordinarily follow direct examination, but the sequence may be regulated by the hearing officer.

5. The party with the burden of proof shall begin the presentation of the evidence, followed by the other parties in a sequence determined by the hearing officer. In all cases the burden of presenting evidence to support a fact or position rests with the proponent of the fact or position.

6. When all parties and witnesses have been heard, opportunity must be offered to present final argument, in a sequence determined by the hearing officer. Final argument may be allowed in the form of memoranda or briefs, or oral argument, in the discretion of the hearing officer.

7. The record of the hearing must be closed upon receipt of the final memoranda or briefs, transcript, if any, or late-filed exhibits requested by the hearing officer, subject to the authority for an administrative agency to consider additional information or evidence not presented at the hearing, as provided by North Dakota Century Code section 28-32-07.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05

Law Implemented: NDCC 28-32-07, 28-32-11, 28-32-11.1, 54-57-04

98-02-03-04. Disruption of hearing. Disrespectful, disorderly, or contemptuous conduct, contumacious language, refusal to comply with directions, or continued use of dilatory tactics by any person constitutes grounds for immediate exclusion of such person from the hearing by the hearing officer.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-11.1, 54-57-04

98-02-03-05. Evidence - Official notice. [Reserved] See North Dakota Century Code section 28-32-06 for statutory requirements.

98-02-03-06. Exhibits. Evidence other than witness testimony must be submitted in the form of exhibits. Whenever possible, copies of exhibits must be furnished to all parties. In any event, all parties must be afforded an opportunity to examine the exhibit. The hearing officer may require that the parties mark exhibits in advance of the hearing. When the evidence offered through the exhibit is embodied in a book, document, or other material of such volume as to needlessly encumber the record, an authenticated copy of the relevant excerpt may be entered, or the excerpt may be read into the record, in the discretion of the hearing officer.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-06, 28-32-11.1

98-02-03-07. Continuances. A party seeking a continuance shall first contact the other parties for the purpose of obtaining a stipulated agreement. If the party seeking the continuance is unable to secure a stipulated agreement then that party shall submit a written request for continuance to the hearing officer, with copies served upon the parties of record. These requirements may be waived by the hearing officer if circumstances arise to make compliance unreasonable. The hearing officer may not approve a continuance except for good cause shown. The hearing officer may order a continuance upon the hearing officer's own motion.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-11.1, 54-57-04

98-02-03-08. Ex parte communications. [Reserved] See North Dakota Century Code section 28-32-12.1 for statutory requirements.

98-02-03-09. The record. [Reserved] See North Dakota Century Code sections 28-32-12 and 28-32-17 for statutory requirements.

CHAPTER 98-02-04
POSTHEARING PRACTICE AND PROCEDURE

98-02-04-01. Posthearing briefs and proposed findings. At the conclusion of the hearing, any party may request an opportunity to submit proposed findings of fact and conclusions of law, briefs, or memoranda. The hearing officer may direct the parties to submit proposed findings of fact and conclusions of law, briefs, or memoranda. The hearing officer shall fix the time for filing and service and the order of filing, and may direct that memoranda or briefs be filed simultaneously or sequentially. When it is ordered that proposed findings of fact and conclusions of law, briefs, or memoranda be filed and served by the party initiating the proceeding, and that party fails to comply, the hearing officer may recommend to the agency head that the proceeding be dismissed. Neither memoranda nor briefs may incorporate evidentiary materials through appendices or other attachments unless those items were received in evidence during the course of the hearing.

History: Effective January 1, 1992.
General Authority: NDCC 54-57-05
Law Implemented: NDCC 28-32-11.1, 54-57-04

98-02-04-02. Agency consideration of information not presented at formal hearing. [Reserved] See North Dakota Century Code section 28-32-07 for statutory requirements.

98-02-04-03. Findings of fact, conclusions of law, and order of agency. [Reserved] See North Dakota Century Code section 28-32-13 for statutory requirements.

98-02-04-04. Petition for reconsideration. [Reserved] See North Dakota Century Code section 28-32-14 for statutory requirements.

98-02-04-05. Effectiveness of orders. [Reserved] See North Dakota Century Code section 28-32-14.1 for statutory requirements.