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

92-01-01-01. Organization and functions of workforce safety and insurance.

1. **History.** The Workmen's Compensation Act was passed in 1919 and is codi□ed as North Dakota Century Code title 65. The workers' compensation fund is an exclusive state fund which contracts with employers in this state to provide "no fault" insurance for workers injured in the course of employment.

2. **Workforce safety and insurance functions.** The ~~executive~~ director and the ~~executive~~ director's staff in the executive of□ce are responsible for the traditional management functions of planning, programming, budgeting, staf□ng, evaluating, and reviewing. Some aspects of each of these functions are delegated to ~~department directors~~ division chiefs and other ~~managers~~ department directors.

3. **Inquiries.** Inquiries regarding functions of workforce safety and insurance may be directed to the ~~executive~~ director, or to the respective department.

History: Amended effective February 1, 1982; October 1, 1983; August 1, 1987; October 1, 1987; January 1, 1992; January 1, 1994; December 1, 1996; October 1, 1997; July 1, 2004; April 1, 2012.

General Authority: NDCC 28-32-02~~.1~~
Law Implemented: NDCC 28-32-02~~.1~~

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-01-01.

Title of Section: Organization and functions of workforce safety and insurance.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-01-01.

Title of Section: Organization and functions of workforce safety and

insurance.

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

Based on our analysis of this rule there is no need to complete a Small Entity Economic Impact Statement as there is not an adverse impact. Changes to the rule only reflect a change to the functional titles within the organization.

Section 92-01-02-02.4 is created as follows:

92-01-02-02.4 Treating doctor's opinion.

North Dakota Century Code section 65-05-08.3 may not be interpreted to create a presumption in favor of a treating doctor's opinion. This section only applies to the organization's internal consideration of a treating doctor's opinion and may not be interpreted to apply to a hearing officer's consideration of an opinion. The organization's application of section 65-05-08.3 is not subject to review.

History: Effective April 1, 2012.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-08.3

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-02.4.
Title of Rule: Treating doctor's opinion.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-02.4.
Title of Rule: Treating doctor's opinion.

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

standards impacted by the change.

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

c. Five thousand three hundred dollars, plus reasonable costs incurred, if the employee prevails after ~~an evidentiary~~ the hearing is ~~held~~ called to order by the administrative law judge. If the employee prevails after ~~an evidentiary hearing~~ the hearing ~~and the organization wholly rejects the recommended decision~~, and the ~~employee~~

organization appeals ~~from~~ the ~~organization's~~ □nal order, the organization shall pay attorney's fees at a rate of one hundred twenty-□ve percent of the maximum fees speci□ed in subdivisions d and e when the employee prevails on appeal, as de□ned by North Dakota Century Code section 65-02-08, to the district court or to the supreme court. However, the organization may not pay attorney's fees if the employee prevails at the district court but the organization prevails at the supreme court in the same appeal.

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

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

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

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

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

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

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

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

7. The following costs will be reimbursed:

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

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

c. Copying charges, at eight cents per page.

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

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

8. The following costs will not be reimbursed:

a. Facsimile charges.

b. Express mail.

c. Additional copies of transcripts.

d. Costs incurred to obtain medical records.

e. On-line computer-assisted legal research.

f. Copy charges for documents provided by the organization.

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

History: Effective June 1, 1990; amended effective November 1, 1991; January 1, 1994; January 1, 1996; May 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2008; April 1, 2009; July 1, 2010; April 1, 2012.

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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

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

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

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-01-02-24, subsection 6 is amended as follows:

92-01-02-24. Rehabilitation services.

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

History: Effective November 1, 1991; amended effective January 1, 1996; April 1, 1997; February 1, 1998; May 1, 2002; July 1, 2006; July 1, 2010; April 1, 2012.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05.1

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-24.
Title of Section: Rehabilitation services
GENERAL: The following analysis is submitted in compliance with §28-32-08.1(2) of the NDCC.

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-01-02-25 is amended as follows:

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

1. Definitions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c. "Medical dispute" means an employee has reached maximum medical improvement in connection with a work injury and has been evaluated for permanent impairment, and there is a disagreement between doctors arising from the physical evaluation that affects the amount of the award. The dispute to be reviewed must clearly summarize the underlying medical condition. It does not include disputes regarding proper interpretation or application of the American medical association guides to the evaluation of permanent impairment, ~~fifth~~ sixth edition.

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

e. "Treating doctor" means a doctor of medicine or osteopathy, chiropractor, dentist, optometrist, podiatrist, or psychologist acting within the scope of the doctor's license who has physically examined or provided direct care or treatment to the injured employee.

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

3. The organization shall establish a list of medical specialists who have the training and experience necessary to conduct an evaluation of permanent impairment and apply the American medical association guides to the evaluation of permanent impairment, ~~fifth~~ sixth edition. When an employee requests an evaluation of impairment, the organization shall schedule an evaluation with a ~~physician~~ doctor from the list. The organization may not schedule a permanent impairment evaluation with the employee's treating doctor. The organization and employee may agree to an evaluation by a ~~physician~~ doctor not on the current list. In the event of a medical dispute, the organization will identify qualified specialists and submit all objective medical documentation regarding the dispute to specialists who have the knowledge, training, and experience in the application of the American medical association guides to the evaluation of permanent impairment, ~~fifth~~ sixth edition. To the extent more than one ~~physician~~ doctor is identified, the organization will consult with the employee before appointment of the ~~physician~~ doctor.

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

   a. Pain impairment ratings. A permanent impairment award may not be made upon a rating solely under chapter ~~18~~ 3 of the sixth edition ~~guides when there is no accompanying rating under the conventional organ and~~

~~body system ratings of impairment. In addition, no rating for pain may be awarded when the evaluating physician determines the individual being rated has low credibility, when the individual's pain is ambiguous or the diagnosis is a controversial pain syndrome. A controversial pain syndrome is a syndrome that is not widely accepted by physicians and does not have a well-defined pathophysiologic basis~~.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~5.~~ b. ~~Permanent Mental~~ Mental and behavioral disorder impairment ratings. Any evaluating ~~physician~~ doctor determining permanent mental or behavioral disorder impairment per chapter 14 of the sixth edition shall include a written summary of the mental evaluation in the evaluation report.

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

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

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

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

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

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

(b) A complete history of the impairment, associated stressors, treatment, attempts at rehabilitation, and premorbid history and a determination of apportionment.

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

c. The overall permanent impairment rating for depression or anxiety, or both, must be based upon objective psychological test results, utilizing the following accepted procedures and tests.

(1) Two or more symptom validity tests shall be conducted. If the evaluator determines good effort is not demonstrated on one or both of the symptom validity tests, no impairment rating is reported.

(2) If chronic pain is rated, the pain patient profile (P3) and either the MMPI-2 or the MMPI-2 RF may be administered.

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

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

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

~~(4) The permanent impairment report must include a written summary of the mental evaluation.~~

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

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

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

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

~~6.~~ 5. Errata sheets and guides updates. Any updates, additions, or revisions by the editors of the ~~fifth~~ sixth edition of the guides to the evaluation of permanent impairment ~~as of April 1, 2010,~~ are adopted as an update, addition, or revision by the organization.

History: Effective November 1, 1991; amended effective January 1, 1996; April 1, 1997; May 1, 1998; May 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2009; July 1, 2010; April 1, 2012.

General Authority: NDCC 65-02-08

Law Implemented: NDCC 65-05-12.2

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-25.

Title of Section: Permanent impairment evaluations and disputes.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-25.

Title of Section: Permanent impairment evaluations and disputes.

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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

92-01-02-29.1. Medical necessity.

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

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

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

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

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

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

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

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

f. Intradiscal electrothermal annuloplasty (IDET).

g. Prolotherapy (sclerotherapy)

h. Surface electromyography (surface EMG).

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

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

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-01-02-29.3 is amended as follows:

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

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

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

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

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

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

6. Cost quotes must be itemized.

~~4.~~ 7. Any available vehicle rebates or tax exemptions shall be applied back to the lifetime benefit of one hundred thousand dollars.

~~5.~~ 8. Any appeal of a decision under this section shall be adjudicated pursuant to North Dakota Century Code section 65-02-20.

History: Effective April 1, 2009; amended effective April 1, 2012.

General Authority: NDCC 65-02-08

Law Implemented: NDCC 65-05-07(5)(b)

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-29.3.

Title of Rule: Motor vehicle purchase or modification.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-29.3.

Title of Rule: Motor vehicle purchase or modification.

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

performance standards impacted by the change.

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

F.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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

92-01-02-29.4 Home modifications.

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

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

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

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

5. Cost quotes must be itemized.

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

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

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

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

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

F.

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-01-02-33 is amended as follows:

92-01-02-33. Utilization review and quality assurance. The organization has instituted a program of utilization review and quality assurance to monitor and control the use of health care services.

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

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

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

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

~~4.~~ 5. The organization may use the Official Disability Guidelines, the American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, Guide to Physical Therapy Practice, The Medical Disability Advisor, Diagnosis and Treatment for Physicians and Therapists Upper Extremity Rehabilitation, Treatment Guidelines of the American Society of Hand Therapists, or any other treatment and disability guidelines or standards it deems appropriate to administer claims.

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

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-33.
Title of Section: Utilization review and quality assurance.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-33.
Title of Section: Utilization review and quality assurance.

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-01-02-34 is amended as follows:

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

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

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

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

    a. Durable medical equipment.

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

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

documentation from the attending doctor that replacement or repair is needed. Prior authorization for replacements is required.

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

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

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

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

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

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

d. Telemedicine. The organization may pay for audio and video telecommunications instead of a face-to-face "hands on" appointment for the following appointments: office or other outpatient visits that fall within CPT

codes 99241 through 99275, inclusive; new and established evaluation and management visits that fall within CPT codes 99201 through 99215, inclusive; individual psychotherapy visits that fall within CPT codes 90804 through 90809, inclusive; and pharmacologic management visits that fall within CPT code 90862. As a condition of payment, the patient must be present and participating in the telemedicine appointment. The professional fee payable is equal to the fee schedule amount for the service provided. The organization may pay the originating site a facility fee, not to exceed twenty dollars.

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

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

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

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

   c. Magnetic resonance imaging, a myelogram, discogram, bonescan, arthrogram, or computed axial tomography. Tomograms are subject to

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

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

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

f. Thermography.

g. Intra-articular injection of hyaluronic acid.

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

i. Facet joint injections.

j. Sacroiliac joint injections.

k. Facet nerve blocks.

l. Epidural steroid injections.

m. Nerve root blocks.

o. Peripheral nerve blocks.

p. Botox injections.

q. Stellate ganglion blocks.

r. Cryoablation.

s. Radio frequency lesioning.

t. Facet rhizotomy.

u. Implantation of stimulators and pumps.

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

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

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

9. The organization or managed care vendor must respond to the medical service provider within ~~twenty-four hours, or the next~~ three business days~~,~~ of receiving the necessary information to complete a review and make a recommendation on the service~~, unless the organization or managed care vendor requires a review by the organization's medical director. If a review by the medical director is performed, the organization or the managed care vendor must respond to the provider's request within seventy-two hours of receiving the necessary information~~. Within the time for review, the organization or managed care vendor must recommend

approval or denial of the request, request additional information, request the claimant obtain a second opinion, or request an examination by the claimant's doctor. A recommendation to deny medical services must specify the reason for the denial.

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

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

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

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

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

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

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

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

This rule is not expected to impact the regulated community in excess of

$50,000.

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-01-02-45.1 is amended as follows:

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

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

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

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

   a. The claimant's full name and address;

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

   c. Date and nature of injury;

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

   e. Date of service;

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

   g. Name of medical service provider providing the service;

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

advanced practice registered nurse's UPIN or NPI, or both, or North Dakota state license number;

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

j. Type of service;

k. Appropriate procedure code or hospital revenue code;

l. Description of service;

m. Charge for each service;

n. Units of service;

o. If dental, tooth numbers;

p. Total bill charge;

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

r. Date of bills.

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

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

a. Laboratory and pathology reports;

b. X-ray findings;

c. Operative reports;

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

e. Consultation reports;

f. History, physical examination, and discharge summaries;

g. Special diagnostic study reports; and

h. Special or other requested narrative reports.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~15.~~14. When a medical service provider is asked to review records or reports prepared by another medical service provider, the provider shall bill review of the records using CPT code 99080 with a descriptor of "record review". The billing must include the actual time spent reviewing the records or reports and must list the medical service provider’s normal hourly rate for the review.

~~16.~~15. When there is a dispute over the amount of a bill or the necessity of services rendered, the organization shall pay the undisputed portion of the bill and provide specific reasons for nonpayment or reduction of each medical service code.

~~17.~~16. If medical documentation outlines that a non-work-related condition is being treated concurrently with the compensable injury and that condition has no effect on the compensable injury, the organization may reduce the charges submitted for treatment. In addition, the attending doctor must notify the organization immediately and submit:

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

b. A description of the treatment being rendered.

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

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

~~18.~~17. In cases of questionable liability when the organization has not rendered a decision on compensability, the provider has billed the claimant or other insurance, and the claim is subsequently allowed, the provider shall refund the claimant or other insurer in full and bill the organization for services rendered.

~~19.~~18. The organization may not pay for the cost of duplicating records when covering the treatment received by the claimant. If the organization requests records in addition to those listed in subsection 5 or records prior to the date of injury, the organization shall pay a minimum charge of five dollars for five or fewer pages and the minimum charge of five dollars for the first five pages plus thirty-five cents per page for every page after the first five pages.

~~20.~~19. The provider shall assign the correct approved billing code for the service rendered using the appropriate provider group designation. Bills received without codes will be returned to the provider.

~~21.~~20. Billing codes must be found in the most recent edition of the physician's current procedural terminology; health care financing administration common procedure coding system; code on dental procedures and nomenclature maintained by the American dental association; or any other code listed in the fee schedules.

~~22.~~21. A provider shall comply within thirty calendar days with the organization's request for copies of existing medical data concerning the services provided, the patient's condition, the plan of treatment, and other issues pertaining to the organization's

determination of compensability, medical necessity, or excessiveness or the organization may refuse payment for services provided by that provider.

~~23.~~22. A provider may not bill a claimant a fee for the difference between the maximum allowable fee set forth in the organization's fee schedule and usual and customary charges, or bill the claimant any other fee in addition to the fee paid, or to be paid, by the organization for individual treatments, equipment, and products.

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

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

C. **Consolidating or simplifying compliance or reporting requirements:** There

is no compliance or reporting issues impacted by the change.

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-01-02-49 is amended as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-49.
Title of Section: Determination of employment.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-49.
Title of Section: Determination of employment.

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-01-02-53.1 is created as follows:

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

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

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

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-53.1.
Title of Section: Vocational rehabilitation grant program.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-53.1.
Title of Section: Vocational rehabilitation grant program.

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

A. Establishing less stringent compliance or reporting requirements:

There are no reporting or compliance requirements impacted by the change.

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-01-02-56 is amended as follows:

92-01-02-56. Retrospective rating program. The organization and an employer may elect to contract for a retrospective rating program. Under a retrospective rating program, the employer's retrospective rating premium is calculated using factors including claims costs and actual standard premium and basic premium factors. The organization shall calculate basic premium factors for each level of premium and maximum employer liability.

Retrospective rating contracts may provide for the calculation of employer or organization interest credits and debits pertaining to claims payments, deposits, or premium balances.

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

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

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

   2. **Retrospective rating program.** A participating employer chooses one maximum liability limit per ~~account~~ retrospective rated period. The retrospective rating program applies to the account's entire premium period. The retrospective rating program option is based on aggregate claims costs for all claims for injury or death occurring in the contract year.

   3. **Claim payment.** The organization shall process and pay claims in accordance with North Dakota Century Code title 65. If a third-party recovery on a claim is made, the organization's subrogation interest must □rst be applied to the amounts paid on the claim by the organization. If the subrogation recovery reduces the retrospective premium, the organization shall provide a refund to the employer.

   4. **Premium payment.** Premium is due at policy inception.

   5. **Financial security.** The organization may require an employer to provide a bond, letter of credit, or other security approved by the

organization to guarantee payment of future employer obligations incurred by a retrospective rating contract. The amount of the security may not exceed the initial nonpaid portion of the maximum possible retrospective premium.

History: Effective May 1, 2000; amended effective May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2012.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-04-17.1

REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-56.
Title of Section: Retrospective rating program.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-02-56.
Title of Section: Retrospective rating program.

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-01-03-04 is amended as follows:

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

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

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

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

4. If a claimant has not attempted to resolve the dispute, the office shall

notify the claimant by letter, sent by regular mail, of the claimant's nonparticipation in the office and that no attorney's fees shall be paid by workforce safety and insurance should the claimant prevail in subsequent litigation. The decision review specialist shall inform the claimant of the right to pursue the dispute through hearing. To pursue a formal rehearing of the claim, the claimant shall file a request for rehearing with the organization's legal department within thirty days after the letter of noncompliance is mailed.

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

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

History: Effective April 1, 1996; amended effective May 1, 1998; May 1, 2000; July 1, 2004; July 1, 2006; July 1, 2010; April 1, 2012.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-27

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

Section: 92-01-03-04.

Title of Section: Procedure for dispute resolution.

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

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

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

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

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

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

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

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

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

REGULATORY ANALYSIS OF PROPOSED RULE

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

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE

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

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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

Section 92-05-02-06 is repealed:.

92-05-02-06. Safety outreach program. ~~North Dakota employers with the highest frequency and greatest severity rates and those employers in rate classi□cation industries with historically high frequency and severity rates may be selected by the organization to participate in this three year program.~~

~~1. **Calculation of discount.** The safety outreach program provides a ten percent annual premium discount for the creation and implementation of a written action plan approved by the organization. The safety outreach program provides a ten percent premium discount for a reduction of at least ten percent in frequency rate and a ten percent premium discount for a reduction of at least ten percent in severity rate. If an employer~~
~~reduces both frequency and severity rates by at least ten percent each in a premium year, that employer is entitled to an additional □ve percent premium discount. An employer's annual discount under this program may not exceed thirty-□ve percent.~~

~~2. **Ongoing eligibility.** Participation beyond the inception year is subject to the sole discretion of the organization. In no event shall an employer's participation extend beyond three consecutive years.~~ Repealed April 1, 2012.

~~**History:** Effective July 1, 2006; amended effective April 1, 2009.~~
~~**General Authority:** NDCC 65-02-08~~
~~**Law Implemented:** NDCC 65-03-04, 65-04-19.1, 65-04-19.3~~

REGULATORY ANALYSIS OF PROPOSED RULE REPEAL

Section: 92-05-02-06.
Title of Section: Safety outreach program.

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

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

SMALL ENTITY REGULATORY ANALYSIS OF PROPOSED RULE REPEAL

Section: 92-05-02-06.
Title of Section: Safety outreach program.

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

POSSIBLE WAYS TO MINIMIZE THE ADVERSE IMPACT ON SMALL ENTITIES:

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

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

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

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

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

SMALL ENTITY ECONOMIC IMPACT STATEMENT

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

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