Section 92-01-02-01 is repealed.

~~**92-01-02-01. Definitions.**~~

~~1. "Act" means the North Dakota Workers' Compensation Act.~~

~~2. "Organization" means workforce safety and insurance.~~

History: Amended effective August 1, 1987; January 1, 1994; April 1, 1997.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08

Section 92-01-02-02.1 is amended as follows:

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

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

~~1. Should the injured employee's postinjury earnings equal or exceed ninety percent of the injured employee's earnings at the time of the first or recurrent disability, no benefits will be paid.~~

~~2~~ 1. An injured employee may earn up to ten percent of the injured employee's average weekly wage without the organization reducing temporary total disability benefits; however, all postinjury wages, from any source, must be reported to the organization to determine whether a reduction is required.

~~3~~ 2. If an injured employee is receiving temporary partial disability benefits under North Dakota Century Code section 65-05-10, the injured employee shall submit documentation of paystubs or income earned every pay period. If the organization does not receive this documentation, the organization may not pay temporary partial disability benefits. If the organization does not receive this documentation for a period in excess of ninety days, the organization shall discontinue temporary partial disability benefits.

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

Section 92-01-02-02.3 is repealed.

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

~~1. An employer's notice of injury filed with the organization pursuant to North Dakota Century Code section 65-05-01.4 must be the first report of injury form or any other written submission which clearly contains at least the following information:~~

~~a. The injured employee's name and address.~~

~~b. The injured employee's social security number.~~

~~c. The employer's name and address.~~

~~d. The employer's workers' compensation account number.~~

~~e. A description of the nature of the injury.~~

~~f. The location where the injury occurred.~~

~~g. A description of how the injury occurred.~~

~~h. A description of the type of work done by the injured employee.~~

~~i. The name and address of the injured employee's health care provider, if known.~~

~~j. The names and addresses of any witnesses to the injury, if known.~~

~~2. Following receipt of the employer's notice of injury, the organization shall determine whether a claim has been filed by the injured employee. If no claim has been filed, the organization shall notify the injured employee by regular mail addressed to the injured employee at the address given by the employer or at the last-known address of the injured employee that the employer's notice has been received and shall inform the injured employee of the filing requirements of North Dakota Century Code section 65-05-01.~~

History: Effective January 1, 1996; amended effective July 1, 2006; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-01.4, 65-05-01.5

Section 92-01-02-02.4 is repealed.

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

~~When making findings of fact and conclusions of law in connection with an adjudicative proceeding, a hearing officer must affirm the organization's determination whether to give a treating health care provider's opinion controlling weight under North Dakota Century Code section 65-05-08.3 if a reasoning mind reasonably could have decided that the organization's determination was supported by the greater weight of the evidence from the entire record.~~

History: Effective April 1, 2012; amended effective April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-08.3

Section 92-01-02-02.5 is repealed.

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

~~As used in subparagraph 6 of subdivision a of subsection 11 of North Dakota Century Code section 65-01-02:~~

~~1. "A mental or psychological condition" must be directly caused by a physical injury. To be directly caused it must be shown with objective medical evidence that the mental or psychological condition is the physiological product of the physical injury.~~

~~2. "Other contributing causes" include emotional circumstances that generally accompany work-related injuries, such as the loss of function, loss of self-esteem, loss of financial independence, divorce, loss of career or employment position, disruption to lifestyle or family units, anxiousness, uncertainty, or compromised ability to participate in lifestyles, hobbies, or pastimes.~~

History: Effective January 1, 2018; amended effective January 1, 2022.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-01-02

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

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

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

1. The organization shall pay attorneys at ~~one hundred ninety-five~~ two hundred five dollars per hour for all actual and reasonable time other than travel time. The organization shall pay attorney travel time at ~~ninety-eight~~ one hundred three dollars per hour.

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

3. Total fees paid by the organization for all legal services in connection with a dispute regarding an administrative order is an amount equal to twenty percent of the additional amount awarded except for an order litigating the initial determination of compensability. Awards include those arrived at by a mutually agreed upon settlement. Total fees paid under an administrative order may not exceed the following:

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

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

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

d. ~~Twelve thousand six hundred fifty~~ Thirteen thousand two hundred eighty-three dollars, plus reasonable costs incurred, if the employee's North Dakota supreme court appeal is settled prior

to hearing. ~~Thirteen thousand nine hundred~~ Fourteen thousand five hundred ninety-five dollars, plus reasonable costs incurred, if the employee prevails after hearing by the supreme court.

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

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

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

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

6. If the organization is obligated to pay the employee's attorney's fees, the attorney shall submit to the organization a final statement upon resolution of the matter. All statements must show the name of the employee, claim number, date of the statement, the issue, date of each service or charge, itemization and a reasonable description of the legal work performed for each service or charge, time and amount billed for each item, and total time and amounts billed. The employee's attorney 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~~ ten cents per page.

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

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

8. The following costs will not be reimbursed:

a. Facsimile charges.

b. Express mail.

c. Additional copies of transcripts.

d. Costs incurred to obtain medical records.

e. Online computer-assisted legal research.

f. Copy charges for documents provided by the organization.

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

History: Effective June 1, 1990; amended effective November 1, 1991; January 1, 1994; January 1, 1996; May 1, 2000; May 1, 2002; July 1, 2004; July 1, 2006; April 1, 2008; April 1, 2009; July 1, 2010; April 1, 2012; April 1, 2014; April 1, 2016; January 1, 2018; April 1, 2020; January 1, 2022; January 1, 2024.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-08, 65-10-03

Section 92-01-02-13 is amended as follows:

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

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

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

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

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

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

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

3. **Compensation coverage.**

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

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

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

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

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

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

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

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

Subsection 7 of section 92-01-02-24 is amended as follows:

92-01-02-24. Rehabilitation services.

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

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

Section 92-01-02-27 is amended as follows:

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

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

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

Section 92-01-02-29 is amended as follows:

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

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

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

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

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

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

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

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

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

~~3. "Concurrent review" means the monitoring by the organization or the managed care vendor for medical necessity and appropriateness, throughout the period of time in which designated medical services are being provided to the claimant, of the claimant's condition, treatments, procedures, and length of stay.~~

~~4.~~ 3. "Consulting health care provider" means a licensed health care provider who examines an injured employee, or the injured employee's medical record, at the request of the primary health care provider to aid in diagnosis or treatment. A consulting health care provider, at the request of the primary health care provider, may provide specialized treatment of the compensable injury and give advice or an opinion regarding the treatment being rendered or considered for an injured employee's injury.

~~5.~~ 4. "Debilitating side effects" means an adverse effect to a treatment or medication which in and of itself precludes return to employment or participation in vocational rehabilitation services.

~~6.~~ 5. "Elective surgery" means surgery that may be required in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function, or health. Pain, of itself, does not constitute a surgical emergency.

~~7.~~ 6. "Emergency" means a medical condition that manifests itself by symptoms of sufficient severity, which may include severe pain, to cause a prudent layperson possessing an average knowledge of health and medicine to reasonably conclude that immediate medical treatment is required to avoid serious impairment of a bodily function, or serious dysfunction of any body part, or jeopardizing the person's life.

~~8.~~ 7. "Fee schedule" means the ~~publication entitled "Workforce Safety and Insurance Medical and Hospital Fees"~~ organization's rules and maximum payment amounts that govern how health care providers are reimbursed.

~~9.~~ 8. "Functional capacity evaluation" means an objective, directly observed, measurement of ~~a claimant's~~ an injured employee's ability to perform a variety of physical tasks combined with subjective analyses of abilities by the ~~claimant~~ injured employee and the evaluator. A physical tolerance screening and a Blankenship's functional evaluation are functional capacity evaluations.

~~10.~~ 9. "Improved pain control" means the effectiveness of a treatment or medication which results in at least thirty percent reduction in pain scores.

~~11.~~ 10. "Increase in function" means the effectiveness of a treatment or medication which results in either a resumption of activities of daily living, a return to employment, or participation in vocational rehabilitation services.

~~12.~~ 11. "Managed care" means services performed by the organization or a managed care vendor, including ~~utilization review,~~ prior authorization or preservice reviews, disability management services, case management services, ambulatory reviews, ~~concurrent reviews,~~ retrospective reviews, preadmission reviews, and medical bill audit.

~~13.~~ 12. "Managed care vendor" means ~~an organization~~ a vendor that is retained by the organization to provide managed care services.

~~14.~~ 13. "Medical service" means a medical, surgical, chiropractic, psychological, dental, hospital, nursing, ambulance, and other related or ancillary service, including physical and occupational therapy ~~and drugs, medicine, crutches, a prosthetic appliance, braces, and supports~~ ,medications, durable medical equipment, and physical restoration and diagnostic services, or a service outlined in section 92-01-02-30.

~~15.~~ 14. "Medical service provider" means an allied health care professional, hospital, medical clinic, or vendor of medical services.

~~16.~~ 15. "Medically stationary" means the "date of maximum medical improvement" as defined in North Dakota Century Code section 65-01-02 has been reached.

~~17.~~ 16. "Notice of nonpayment" means the form by which ~~a claimant~~ an injured employee is notified of charges denied by the organization which are the ~~claimant's~~ injured employee's personal responsibility.

~~18.~~ 17. "Pharmacy services" means services rendered by a pharmacist in pharmaceutical care, selection, counseling, dispensing, use, administration, prescription monitoring, medication therapy management, disease state management, drug utilization evaluation or review, vaccination, testing, or collaborative therapy management provided in a pharmacy, clinic, hospital or medical institution.

~~19. "Physical conditioning" means an individualized, graded exercise program designed to improve the overall cardiovascular, pulmonary, and neuromuscular condition of the claimant prior to or in conjunction with the claimant's return to any level of work. Work conditioning is the same as physical conditioning.~~

~~21.~~ 18. "Primary health care provider" means a health care provider who is primarily responsible for the treatment of an injured employee's compensable injury.

~~20.~~ 19. "Prior authorization" or "~~Preservice~~ preservice review" means the evaluation by the organization or a managed care vendor of a proposed medical service for medical necessity, appropriateness, and efficiency prior to the services being performed based on medically accepted standards and an objective evaluation of the medical services.

~~22.~~ 20. "Remittance advice" means the form used by the organization to inform payees of the reasons for payment, reduction, or denial of medical services.

~~23.~~ 21. "Retrospective review" means the organization's or a managed care vendor's review of a medical service for medical necessity, appropriateness, and efficiency after treatment has occurred.

~~24.~~ 22. "Special report" means an allied health care professional's written response to a specific request from the organization for information, including information on causation, aggravation, preexisting conditions, and clarification of complex medical conditions, requiring the creation of a new document or the previously unperformed analysis of existing data. The explanatory reports required for procedures designated as "by report" under section 92-01-02-27 are not special reports.

~~25.~~ 23. "Utilization review" means ~~an evaluation of the necessity,~~ the provision of prior authorization or preservice determinations, the review of medical patterns and trends, and the analysis of the appropriateness ~~, efficiency, and quality~~ of medical services provided to ~~a claimant,~~ an injured employee based on medically accepted standards and an objective evaluation of the medical services.

~~26. "Utilization review department" means the organization's utilization review department.~~

~~27.~~ 24. "Work hardening" or "work conditioning" means an individualized, medically prescribed and monitored, work-oriented treatment process which involves the ~~claimant~~ injured employee participating in an exercise program and/or simulated or actual work tasks that are structured and graded to progressively increase physical tolerances, stamina, endurance, and productivity to return the ~~claimant~~ injured employee to any level of work or a specified job.

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

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

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

1. ~~An injured employee must obtain a primary health care provider's order of medical necessity supported by objective medical findings before the purchase of a specially equipped motor vehicle or modification of a vehicle may be approved. The primary health care provider's order must contain the following:~~ An order is required from the primary health care provider with documentation of objective medical evidence that supports the necessity for purchase of a specially equipped motor vehicle or modification of an existing motor vehicle directly due to the compensable work injury.

a. ~~Patient's name;~~ This order must be obtained and submitted to WSI prior to consideration of a purchase or modification.

b. ~~Date of patient's face-to-face examination;~~ This order must include the date of an in-person office visit that coincides with the date of the order.

~~c. Pertinent diagnosis or conditions that relate to the need for device or modification;~~

~~d. Description of what is ordered;~~

~~e. Length of need;~~

~~f. Primary health care provider's signature; and~~

~~g. Date of primary health care provider's signature.~~

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.~~ Prior to any motor vehicle adaptations or modified vehicle purchases, WSI must complete a review to determine if the most appropriate assistive device is currently being utilized by an injured employee for their functional needs. That review may require an assessment with the following criteria:

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

b. Performed by a licensed or certified occupational or physical therapist with specific training in rehabilitation mobility or functional evaluations.

c. Clear documentation of functional limits of standing and walking with an assistive device. The recommended assistive device must have documentation to support how other assistive devices were ruled out as not medically appropriate for functional needs.

3. Once the appropriate assistive device is determined through the mobility assessment process, WSI may begin the review for motor vehicle purchase and/or modification eligibility, if appropriate.

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

a. A primary health care provider referral for a wheelchair/seating evaluation which includes an assessment by an Assistive Technology Professional (ATP), or similarly situated professional.

b. An ATP assessment which includes an itemization of all elements needed for the manual wheelchair/power mobility device and matches the functional deficits outlined in the mobility assessment.

c. An additional assessment to determine the appropriate vehicle modifications that match the mobility needs as defined in the prior assessments after the mobility/seating/wheelchair assessment is completed.

~~3.~~ 5. If an existing vehicle cannot be repaired or modified, the organization, in its sole discretion, may approve the purchase of a specially equipped motor vehicle.

~~4.~~ 6. 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.~~ 7. Actual vehicle or modification purchase may not occur until the organization reviews the request and issues recommendations or decisions as to whether eligible for the benefit.

~~6. Cost quotes must be itemized.~~

~~7. Any available vehicle rebates or tax exemptions shall be applied back to the lifetime benefit amount as provided in subsection 5 of North Dakota Century Code section 65-05-07.~~

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

History: Effective April 1, 2009; amended effective April 1, 2012; April 1, 2014; July 1, 2017; April 1, 2020.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-05-07(5)(b)

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

92-01-02-29.4. Home modifications.

1. ~~An injured employee must obtain a primary health care provider's order of medical necessity supported by objective medical findings before the payment for home modifications can be approved. The primary health care provider's orders must contain the following:~~ An order is required from the primary health care provider with documentation of objective medical evidence that supports the necessity for home modifications directly due to the compensable work injury.

a. ~~Patient's name;~~ This order must be obtained and submitted to WSI prior to consideration of a home modification.

b. ~~Date of patient's face-to-face examination;~~ This order must include the date of an in-person office visit that coincides with the date of the order.

~~c. Pertinent diagnosis or conditions that relate to the need for device or modification;~~

~~d. Description of what is ordered;~~

~~e. Length of need;~~

~~f. Primary health care provider's signature; and~~

~~g. Date of primary health care provider's signature.~~

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.~~ Prior to any home modifications, WSI must complete a review to determine if the most appropriate assistive device is currently being utilized by an injured employee for their functional needs. That review may require an assessment with the following criteria:

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

b. Performed by a licensed or certified occupational or physical therapist with specific training in rehabilitation mobility or functional evaluations.

c. Clear documentation of functional limits of standing and walking with an assistive device. The recommended assistive device must have documentation to support how other assistive devices were ruled out as not medically appropriate for functional needs.

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

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

a. Performed by a licensed or certified occupational or physical therapist with specific training in rehabilitation mobility or functional evaluations.

b. Completed in-person. Virtual assessments are not approved unless as determined by WSI.

c. Documentation of functional limitation the modification is addressing and the medical need for that modification.

~~3~~ 5. 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~~ 6. Actual construction or modification cannot occur until the organization reviews the request and issues recommendations or decisions as to eligibility for the benefit.

~~5. Cost quotes must be itemized.~~

~~6~~ 7. Payment by the organization may not occur until the modification work is completed, or at least, completed in documented phases or at the discretion of the organization.

~~7~~ 8. The organization may request that the contractor for proposed home modification be in good standing (example: licensed in the state, bonded, etc.)

~~8~~ 9. Real estate modifications to driveways, sidewalks, or passageways may only be approved if evidence supports that those routes are needed to provide safe passageway for the injured ~~worker~~ employee.

~~9~~ 10. Any appeal of a decision under this section shall be adjudicated pursuant to North Dakota Century Code section 65-02-20.

~~10~~ 11. Modifications will only be considered upon receipt of documentation establishing injured employee's ownership of the residence to be permanently modified.

~~11~~ 12. Modifications within new construction will be considered upon receipt of the original floor plan/specifications and cost estimate, as well as the modified floor plan and cost estimate.

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

Section 92-01-02-29.5 is amended as follows:

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

1. ~~An injured employee must obtain a primary health care provider's order of medical necessity supported by objective medical findings before the purchase of a power mobility device may be approved by the organization. The primary health care provider's order must contain the following:~~ An order is required from the primary health care provider with documentation of objective medical evidence that supports the necessity for a power mobility device directly due to the compensable work injury.

a. ~~Patient's name;~~ This order must be obtained and submitted to WSI prior to consideration of a purchase.

b. ~~Date of patient's face-to-face examination;~~ This order must include the date of an in-person office visit that coincides with the date of the order.

~~c. Pertinent diagnosis or conditions that relate to the need for device or modification;~~

~~d. Description of what is ordered;~~

~~e. Length of need;~~

~~f. Primary health care provider's signature; and~~

~~g. Date of primary health care provider's signature.~~

2. ~~There must be clear medical documentation of functional limits of standing and walking with an assistive device. Documentation must support reasons why a cane, walker, or manual wheelchair cannot be used to complete activities of daily living~~. Prior to any power mobility device purchase, WSI must complete a review to determine if the most appropriate assistive device is currently being utilized by an injured employee for their functional needs. That review may require an assessment with the following criteria:

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

b. Performed by a licensed or certified occupational or physical therapist with specific training in rehabilitation mobility or functional evaluations.

c. Clear documentation of functional limits of standing and walking with an assistive device. Documentation must support reasons why a cane, walker or manual wheelchair cannot be used to complete activities of daily living.

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

~~3.~~ 4. ~~A primary health care provider must make a referral for a mobility assessment and the assessment must be performed by a licensed or certified occupational therapist or physical therapist with specific training and experience in rehabilitation mobility or wheelchair evaluations. The assessment must be completed prior to the approval of a power mobility device~~. Upon completion of the mobility assessment and if a manual wheelchair, power mobility device, or both are needed, the following shall occur:

a. A primary health care provider referral for a wheelchair/seating evaluation which includes an assessment by an Assistive Technology Professional (ATP), or similarly situated professional.

b. An ATP assessment which includes an itemization of all elements needed for the manual wheelchair/power mobility device and matches the functional deficits outlined in the mobility assessment.

c. Two itemized quotes for power mobility devices, if requested by WSI.

~~4~~ 5. When the power mobility device is primarily intended for outdoor use or recreational purposes, the device is not medically necessary.

~~5~~ 6. Upgrades to a power mobility device are not considered medically necessary if the upgrade is primarily intended for luxury, outdoor, or recreational purposes. Specific items such as power tilt or recline seating will only be approved if the injured employee is at risk of additional medical complications, has issues with transfer, or an upgrade will help manage the injured employee's tone and spasticity.

~~6. An injured employee who has been approved for a power mobility device must independently qualify for a motor vehicle purchase or home modification as provided in subsection 5 of North Dakota Century Code section 65-05-07, section 92-01-02-29.3, and section 92-01-02-29.4.~~

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

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

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

(Rule 92-01-02-29.5 continued)

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

Section 92-01-02-29.6 is amended as follows:
92-01-02-29.6. Footwear.

1. ~~An injured employee shall obtain the primary health care provider's order of medical necessity supported by objective medical findings before the purchase of footwear may be approved by the organization. The primary health care provider's order must contain the following:~~ An order is required from the primary health care provider with documentation of objective medical evidence that supports the necessity for purchase of footwear directly due to the compensable work injury.

a. ~~Patient's name;~~ This order must be obtained and submitted to WSI prior to consideration of purchase.

b. ~~Date of patient's face-to-face examination;~~ This order must include the date of an in-person office visit that coincides with the date of the order.

~~c. Pertinent diagnosis or conditions that relate to the work injury and the necessity of footwear;~~

~~d.~~ c. This order must include a ~~Specific~~ specific description of the ~~type or brand or both of~~ footwear being requested~~;~~ .

~~e. Primary health care provider's signature; and~~

~~f. Date of primary health care provider's signature.~~

~~2. Medical documentation must provide the expected benefits and must explain the link to the physical injury necessitating the request.~~

~~3.~~ 2. The organization will purchase one pair of footwear per claim and only during the acute rehabilitation phase.

~~4.~~ 3. The organization shall pay a medical service provider for modifications to regular footwear purchased by an injured employee after a billing is received by the medical service provider if the modifications are due to the work injury and there is objective medical evidence to support the necessity of the modifications.

~~5.~~ 4. Custom orthotic inserts and ~~custom-made~~ custom-made medical orthotic shoes must be preapproved by the organization. There must be objective medical evidence to support custom orthotic inserts and ~~custom-made~~ custom-made medical orthotic shoes are a necessity due to the work injury.

~~6.~~ 5. The organization must approve the footwear prior to purchase. If the footwear is approved, the organization shall pay the medical service provider after a billing is received. The organization may not prepay an injured employee to purchase footwear and may not place orders for footwear for an injured employee.

~~7.~~ 6. An appeal of a decision made by the organization under this section must be adjudicated pursuant to North Dakota Century Code section 65-02-20.

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

Section 92-01-02-29.7 is amended as follows:

92-01-02-29.7. ~~Prosthetics~~ Prosthetic Devices .

1. For the initial prosthesis, ~~an injured employee shall obtain the primary health care provider's order of medical necessity supported by objective medical findings before the purchase of a prosthesis may be approved by the organization. The primary health care provider's order must contain the following:~~ an order is required from the primary health care provider with documentation of objective medical evidence that supports the necessity for purchase of a prosthesis directly due to the compensable work injury.

a. ~~Patient's name;~~ This order must be obtained and submitted to WSI prior to consideration of purchase.

b. ~~Date of patient's face-to-face examination;~~ This order must include the date of an in-person office visit that coincides with the date of the order.

~~c. Pertinent diagnosis or conditions that relate to the work injury and the necessity of prosthesis;~~

~~d~~ c. This order must include a ~~Specific~~ specific description of the type of ~~prosthetic~~ prosthesis being requested~~;~~ .

~~e. Primary health care provider's signature; and~~

~~f. Date of primary health care provider's signature.~~

2. An injured employee shall undergo an evaluation and assessment by a treating provider, therapist, or prosthetist and that evaluation must contain recommendations based on medical necessity and conform to the primary health care provider's order. ~~Medical documentation must provide the expected benefits and must explain the link to the physical injury necessitating the request.~~

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

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

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

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

7. Repurchase or repair of ~~prosthetic apparatus~~ a prosthesis will be determined by the organization in its sole discretion.

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

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

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

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

Section 92-01-02-31 is amended as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

j. Pattern of submission of inaccurate or misleading bills.

k. Pattern of submission of false or erroneous diagnosis.

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Requesting prior authorization or preservice review is the responsibility of the allied health care professional who provides or prescribes a service for which prior authorization or preservice review is required.

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

a. Durable medical equipment.

(1) The organization 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 adjuster shall grant or deny authorization for reimbursement of equipment based on whether the ~~claimant~~ injured employee is eligible for coverage and whether the equipment prescribed is appropriate and medically necessary for treatment of the compensable injury. Rental extending beyond sixty days requires prior authorization from the claims adjuster. If the equipment is needed on a long-term basis, the organization may purchase the equipment. The claims adjuster shall base its decision to purchase the equipment on a comparison of the projected rental costs of the equipment to its purchase price. The organization shall purchase the equipment from the most cost-efficient source.

(2) The claims adjuster will authorize and pay for durable medical equipment, including prosthetics and orthotics, as needed by the injured employee because of a compensable work injury when substantiated by the health care provider. If those items are furnished by the medical service provider or another provider, the organization will reimburse the medical service provider pursuant to its fee schedule. Medical service providers shall supply the organization with a copy of their original invoice showing actual cost of the item upon request of the organization. Actual cost is a factor considered in determining cost-effectiveness under North Dakota Century Code section 65-02-20. The organization will repair or replace originally provided damaged, broken, or worn-out prosthetics, orthotics, or special equipment devices upon documentation from the health care provider that replacement or repair is needed. Prior authorization for replacements is required.

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

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

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

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

c. Concurrent care. In some cases, treatment by more than one medical service provider may be allowed. The claims adjuster 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 primary health care provider must provide the claims adjuster with the name, address, discipline, and specialty of all other medical service providers assisting in the treatment of the injured employee 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 health care provider~~,~~ who is responsible for prescribing all medications if the primary health care provider is authorized to prescribe medications; directing the overall treatment program; providing copies of all reports and other data received from the involved medical service providers; and, in time loss cases, providing adequate certification evidence of the injured employee's ability to perform work. The claims adjuster will approve concurrent care on a case-by-case basis. Except for emergency services, all treatments must be authorized by the injured employee's primary health care provider to be reimbursable.

d. Telehealth. The organization may pay for audio and video telecommunications instead of a face-to-face "hands on" appointment for CPT codes designated by the American medical association as teleheath codes. As a condition of payment, the ~~patient~~ injured employee must be present and participating in the telemedicine appointment. The professional fee payable is equal to the fee schedule amount for the service provided. The organization may pay the originating site a facility fee at the scheduled amount.

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

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

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

b. All nonemergent major surgery. When the primary health care provider or consulting health care provider believes elective surgery is needed to treat a compensable injury, the primary health care provider or the consulting health care provider~~,~~ with the approval of the primary health care provider, shall give the utilization review department actual notice at least seventy-two hours prior to the proposed surgery. Notice must give the medical information that substantiates the need for surgery, an estimate of the surgical date and the postsurgical recovery period, and the ~~hospital~~ facility where surgery is to be performed. When elective surgery is recommended, the utilization review department may require an

independent consultation with a health care provider of the organization's choice. The organization shall notify the health care provider who requested approval of the elective surgery, whether or not a consultation is desired. When requested, the consultation must be completed within thirty days after notice to the primary health care provider. Within seven days of the consultation, the organization shall notify the surgeon of the consultant's findings. If the primary health care provider and consultant disagree about the need for surgery, the organization may request a third independent opinion pursuant to North Dakota Century Code section 65-05-28. If, after reviewing the third opinion, the organization believes the proposed surgery is excessive, inappropriate, or ineffective and the organization cannot resolve the dispute with the primary health care provider, the requesting health care provider may request binding dispute resolution in accordance with section 92-01-02-46.

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

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

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

f. Thermography.

g. Intra-articular injection of hyaluronic acid.

h. Facet joint injections.

i. Sacroiliac joint injections.

j. Facet nerve blocks.

k. Epidural steroid injections.

l. Nerve root blocks.

m. Peripheral nerve blocks.

n. Botox injections.

o. Stellate ganglion blocks.

p. Cryoablation.

q. Radio frequency lesioning.

r. Facet rhizotomy.

s. Implantation of stimulators and pumps.

t. Speech therapy.

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

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

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

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

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

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

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

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

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

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

History: Effective January 1, 1994; amended effective October 1, 1998; January 1, 2000; May 1, 2002; March 1, 2003; July 1, 2004; July 1, 2006; April 1, 2008; April 1, 2009; July 1, 2010; April 1, 2012; April 1, 2014; April 1, 2016; July 1, 2017; April 1, 2020.
General Authority: NDCC 65-02-08, 65-02-20, 65-05-07
Law Implemented: NDCC 65-02-20, 65-05-07

Section 92-01-02-41 is amended as follows:

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

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

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

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

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

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

~~e. To establish when the injured employee has reached maximum medical improvement or medically stationary status.~~

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

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

~~h. To determine whether overutilization by a medical service provider has occurred.~~

~~i. To determine whether a change in medical service provider is indicated.~~

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

~~k. When the medical service provider has not provided current medical reports.~~

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

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

~~4~~ 2. The organization must provide at least fourteen days' notice to the injured employee of an independent medical examination. The organization must reimburse the claimant's expenses for attending the independent medical examination pursuant to North Dakota Century Code section 65-05-28.

~~5~~ 3. As used in subsection 3 of North Dakota Century Code section 65-05-28 regarding allied health care professionals designated or approved by the organization, "duly qualified allied health care professional" means a person chosen by the organization who is an allied health care professional who has the specialization necessary to perform an independent medical examination or an independent medical review. The organization's determination of whether an individual it has chosen is a duly qualified allied health care professional and the organization's

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

~~6~~ 4. As used in subsection 3 of North Dakota Century Code section 65-05-28, "reasonable effort" means an attempt by the organization to locate and consider individuals as possible duly qualified allied health care professionals for independent medical examinations using criteria established by the organization. These attempts need not be exhaustive and need not be on a specific case-by-case basis. An attempt may consist of a review performed by the organization from time to time of individuals in North Dakota or other states in order to form an informal group from which the organization may select an examiner. Whether the organization has undertaken reasonable effort may not be considered when determining whether an injured employee has failed to submit to, or in any way intentionally obstructed, or refused to reasonably participate in an independent medical examination. Whether the organization has undertaken reasonable effort may not be considered when weighing the opinion of the examiner who performed the independent medical examination.

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

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

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

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

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

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

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

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

b. The injured employee's claim number ~~and social security number~~;

c. Date and nature of injury;

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

e. Date of service;

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

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

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

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

j. Place of service;

k. Appropriate procedure code or hospital revenue code;

l. Charge for each service;

m. Units of service;

n. If dental, tooth numbers;

o. Total bill charge.

5. All records submitted by medical service providers, including notes, except those provided by an emergency room health care provider and those on forms provided by the organization, must be typed to ensure that they are legible and reproducible. Copies of office or progress notes are required for all follow-up visits. Documentation must be authentic to the visit and may not include cloned, copied, or irrelevant documentation for purposes of up-coding a service. Office notes are not acceptable in lieu of requested narrative reports. Communications may not refer to more than one claim. Addendums and late entries to notes or reports must be signed and must include the date they were created. Addendums or late entries to notes or reports created more than sixty calendar days after the date of service may be accepted at the organization's sole discretion.

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

a. Laboratory and pathology reports;

b. X-ray findings;

c. Operative reports;

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

e. Consultation reports;

f. History, physical examination, and discharge summaries;

g. Special diagnostic study reports; and

h. Special or other requested narrative reports.

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

8. Disputes arising out of reduced or denied reimbursement are handled in accordance with section 92-01-02-46. In all cases of accepted compensable injury or illness under the jurisdiction of the workers' compensation law, a medical service provider may not pursue payment from an injured employee for treatment, equipment, or products unless an injured employee desires to

receive them and has accepted responsibility for payment, or unless the payment for the treatment was denied because:

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

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

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

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

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

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

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

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

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

13. When an allied health care professional is asked to review records or reports prepared by another allied health care professional, the allied health care professional shall bill for the review of the records using CPT code 99080 with a descriptor of "record review". ~~The billing must include the actual time spent reviewing the records or reports and must list the allied health care professional's normal hourly rate for the review~~.

14. 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.

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

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

b. A description of the treatment being rendered.

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

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

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

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

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

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

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

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

History: Effective January 1, 1994; amended effective April 1, 1996; October 1, 1998; January 1, 2000; May 1, 2002; April 1, 2008; July 1, 2010; April 1. 2012; April 1, 2014; April 1, 2016; July 1, 2017; April 1, 2020; January 1, 2022.
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

Section 92-01-02-46 is amended as follows:

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

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

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

a. The injured employee's name.

b. The claim number.

c. The date of service.

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

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

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

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

a. The injured employee's name.

b. The claim number.

c. All relevant medical information and documentation.

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

e. The specific relief sought.

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

a. The injured employee's name.

b. The claim number.

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

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

e. The specific relief sought.

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

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

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

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

Section 92-01-02-49.2 is created as follows:

92-01-02-49.2 Attorney Fee Reimbursement for Employers.

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

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

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

History:
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-02-37

Section 92-01-02-58 is created as follows:

92-01-02-58. Premium Credit for Military Members.

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

2. An applicant must be in good standing with the organization to qualify for this program.

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

History:
General Authority: NDCC 65-02-08.
Law Implemented: NDCC 65-04-19.4.

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

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

1. ~~A claimant~~ An injured employee may contact the office for assistance at any time. The ~~claimant~~ injured employed shall contact the office to request assistance with a dispute arising from an order within forty-five days of the date of service of the order. ~~A claimant~~ An injured employee must make an initial request in writing for assistance with an order.

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~~ injured employee. 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~~ an injured employee has attempted to resolve the dispute and an agreement cannot be reached, the decision review specialist shall issue a certificate of completion. The decision review specialist will ~~send~~ issue the certificate of completion to the ~~claimant~~ injured employee by regular mail or electronic means and will inform the ~~claimant~~ injured employee of the right to pursue the dispute through hearing. To pursue a formal rehearing of the claim, the ~~claimant~~ injured employee shall file a request for rehearing with the organization's legal department within forty-five days after the certificate of completion is ~~mailed~~ issued.

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

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~~ an injured employee's request for assistance. This time frame 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; January 1, 2018; January 1, 2022.
General Authority: NDCC 65-02-08
Law Implemented: NDCC 65-01-16, 65-02-27