NORTH DAKOTA ADMINISTRATIVE CODE

Supplement 25

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Prepared by the Legislative Council staff
for the
Administrative Rules Committee

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TITLE 13

Banking and Financial Institutions, Department of

STAFF COMMENT:

Sections 13-02-01-08 and 13-02-01-09 were declared emergency rules and thus became effective July 21, 1980. The State Banking Board filed this statement of necessity for an early effective date:

Congress has transferred the delegated authority to regulate interest rates on deposits from the various federal agencies which used to regulate these deposits to the Depository Institutions Deregulation Committee. When this committee acts, it affects all depository institutions regulated by any federal agency. This committee has acted to adjust the interest rates on the money market certificates and small saver certificates offered by depository institutions. Consequently, credit unions and savings and loan associations within the State of North Dakota can offer the new rates without further action. Banks within the State of North Dakota cannot offer the new rates until the State Banking Board acts to change Chapter 13-02-01, North Dakota Administrative Code. The attached rule was adopted by the State Banking Board on July 21, 1980, in order to effect equality between North Dakota banks and other financial institutions.

Based upon the foregoing, the State Banking Board finds that an effective date of July 21, 1980, is necessary because of imminent peril to the public health, safety and welfare.

13-02-01-08. INTEREST ADJUSTMENTS. The state banking board hereby adopts the interest rate adjustments concerning money market certificates and small saver certificates which were promulgated by the depository institutions deregulation committee effective June 2, 1980. The board adopts the adjustments in the form ~~of the amendments to subsections (f) and (g) of section 217.7 of regulation Q of the federal reserve board, effective June 2, 1980~~ found in Volume 45, No. 110 of the Federal Register dated June 5, 1980, cited as 12 CFR Part 1204. Any provision of North Dakota Administrative Code sections 13-02-01-06 and 13-02-01-07 in conflict with the provisions of ~~federal reserve board regulation Q, section 217.7, subsections (f) and (g), as amended~~ 12 CFR Part 1204, shall be superseded by the provisions of ~~regulation Q~~ 12 CFR Part 1204 to the extent of the conflict, and all provisions of sections 13-02-01-06 and 13-02-01-07 not in conflict, shall remain effective.

History: Effective June 6, 1980; amended effective July 21, 1980.

General Authority
NDCC 6-01-04

Law Implemented
NDCC 6-03-02,
6-03-63

13-02-01-09. TEMPORARY AUTHORIZATION. The state banking board authorizes state banks to pay interest on deposits in accordance with any and all interest rate adjustments authorized by the depository institutions deregulation committee, and published in the federal register. The authority for state banks to pay such interest on deposits shall be effective from the date the depository institutions deregulation committee adjustments are effective until such time as the state banking board can consider the adjustments as proposed amendments to the North Dakota Administrative Code and act thereon. The secretary of the state banking board shall issue notice of proposed amendments, reflecting deregulation committee interest rate adjustments, as soon as information from that committee is made available to the secretary and shall set the date for consideration of the proposed amendments in accordance with this section. The state banking board shall consider the proposed amendments at its next regular or special meeting, but in no event later than sixty days after proposal of the amendments. This temporary authorization to conform to the adjustments made by the depository institutions deregulation committee shall also not extend beyond sixty days.

History: Effective July 21, 1980.

General Authority
NDCC 6-01-04

Law Implemented
NDCC 6-03-02,
6-03-63

TITLE 20

Dental Examiners, Board of

STAFF COMMENT:

Amendments to Title 20 are all new material and are therefore not underscored.

20-01-02-01. DEFINITIONS. Unless specifically stated otherwise, the following definitions are applicable throughout this title:

1. "Basic full upper and lower denture" means the replacement of all natural dentition with artificial teeth. This replacement includes satisfactory tissue adaptation, satisfactory function, and satisfactory aesthetics. Some materials used in these replacements shall be nonirritating in character and meet all the standards set by the national institute of health, and the bureau of standards and the testing agencies of the American dental association for materials to be used in or in contact with the human body.

2. "Dental assistant" means a person who functions in an auxiliary capacity and to whom a legally licensed and registered dentist may delegate certain procedures over which the dentist exercises the direct supervision and full responsibility, except those procedures which require professional judgment and skill such as diagnosis and treatment planning, cutting of hard or soft tissue, or any intraoral procedure which would lead to the fabrication of any appliance which, when worn by a patient, would come in direct contact with hard or soft tissue and which could result in tissue irritation or injury.

3. "Dental hygienist" means any person who is a graduate of a school or dental hygiene approved or provisionally approved by the council on education of the American dental association and who is registered and licensed by the North Dakota state board of dental examiners.

4. "Diagnosis" means a written opinion of items found in an examination.

5. "Examination" means the study of all the structures of the oral cavity, including the recording of the condition of all such structures and an appropriate history thereof. As a minimum, the study shall include charting of caries, identification of periodontal disease, occlusal discrepancies, and the detection of oral lesions.

6. "Prophylaxis" means the removal of all calculous deposits, accretions, and stains from exposed surfaces of the teeth and from gingival sulcus.

7. "Radiograph" means x-rays of the hard and soft oral structures to be used for purposes of diagnosis and which includes either panograph and bite wings or an intraoral x-ray review utilizing a minimum of twelve films. Any films must be adequate to provide an appropriate radiographic study of both dental arches.

8. "Simple extractions" means the removal of nonimpacted teeth and includes necessary x-rays, anaesthesia, preoperative care, and postoperative care.

9. "Treatment planning" means a written statement of treatment recommendations following an examination and diagnosis. The statement shall include a written itemized treatment recommendation and written itemized fee statement.

History: Effective September 1, 1980.

General Authority
NDCC 43-28-06

Law Implemented
NDCC 43-20-02,
43-20-12,
43-28-06

20-02-01-01. ADVERTISING.

1. Advertising by dentists is permitted in order to disseminate information for the purpose of providing the public a sufficient basis upon which to make an informed selection of dentists. In the interest of protecting the public health, safety, and welfare, advertising which is false and misleading and which does not contribute the process of rational selection of dentists is prohibited.

2. Advertising by dentists in the media is limited to advertising in newspapers in general circulation in the community in which the dentist maintains an office. Advertising on radio or television is limited to those radio or television stations located in the community in which the dentist maintains an office, or which are the prime server in the community in which the dentist maintains an office. No advertising in other media is permitted.

3. All advertising in any media must contain a name, address, and telephone number of the dentist; and the dentist's name means the use of the full name of the dentist as it appears on the dentist's license and renewal certificate.

4. In addition to the above, advertising by dentists in any media may contain the following information:

   a. A dentist engaged in general practice who wishes to announce the services available in the dentist's practice is permitted to announce the availability of those services so long as the dentist avoids using phrases that express or imply specialization. The

dentist shall also state that the services are being provided by a dentist in general practice. The phrase "practice limited to" shall be avoided.

b. A dentist who has a specialized practice may announce the dentist's specialization and limitation of practice provided that the dentist has successfully completed an educational program accredited by the commission accreditation of dental and dental auxiliary education programs, two or more years in length, as specified by the council on dental education of the American dental association, or be a diplomat of national recognized certifying board; and, the dentist's practice is limited exclusively to the special area of dental practice in which the dentist has or wishes to announce.

c. Office hours.

d. Fees charged for routing dental services as delineated in subsection 8. If the fees are contained in an advertisement, then the advertisement shall include a disclosing statement which states that the fee advertised is the minimum fee charged for these services and that the actual fee may vary depending upon the degree of complexity involved in a given case. Such disclosing statement shall be no less prominent in context of the advertisement than the fee information in the advertisement. If the fee statement is verbal, then a disclosing statement shall also be verbal and be of equal volume, quality, and duration as the fee statement. If the fee statement is written, then the disclosing statement shall be written and must be of equal size, intensity, and duration as the fee statement.

5. Advertising on radio or television may contain a person narrating the advertisement. In the case of advertisements on television, only the advertising dentist may appear and speak on camera. If the person narrating a radio or television advertisment represents oneself as a dentist, then the person must be the dentist represented.

6. No advertisement on radio or television shall use any celebrity or authority figure, nor shall advertising contain direct or implied guarantees or testimonials from patients or other persons.

7. A prerecorded copy of all advertisements on radio or television must be retained for a one-year period following the final appearance of the advertisement. The advertising dentist is responsible for retaining control of the advertisement for a period of one year following termination of the use of the advertisement and is responsible to make prerecorded copies of the advertisement available to the state board of dental examiners within five days following a request by the board.

8. Advertising of fees pursuant to subdivision d of subsection 4 is limited to the following routine dental services:

a. Examination.

b. Diagnosis.

c. Treatment planning.

d. Radiograph.

e. Basic full upper and lower denture.

f. Prophylaxis.

g. Simple extractions.

h. Any and all other services which may from time to time be approved by the board of dental examiners.

9. No dentist shall knowingly hold oneself, one's staff, one's services, or method of delivery of dental services to be superior to those of any other licensed dentist or legally recognized method of dentistry. This prohibition applies to media exposure of any nature regardless of whether it is in the form of paid advertising. No advertising in any media shall contain representations or other information contrary to the provisions of North Dakota Century Code section 43-28-18 or this section.

History: Effective September 1, 1980.

General Authority
NDCC 43-28-06

Law Implemented
NDCC 43-28-06

20-03-01-01. DUTIES. A dental assistant who is under the direct supervision of a licensed dentist may perform the following duties:

1. Take dental x-rays only if the assistant is a certified dental assistant, or has a certificate of successful completion of a course in dental assisting from a school recognized by the American dental association, or has successfully completed a course in roentgenology approved by the board.

2. Instruct patients in toothbrushing and flossing and other methods of oral hygiene.

3. Take and record pulse, blood pressure, and temperature.

4. Take and record preliminary dental and medical history for interpretation by the dentist.

5. Apply topical applications of drugs prescribed by the dentist except desensitizing or caustic agents.

6. Apply anticariogenic agents topically after an oral prophylaxis by a dentist or dental hygienist.

7. Receive removable dental prosthesis for cleaning or repair.

8. Take impression for study casts.

9. Remove sutures.

10. Place rubber dams.

11. Remove rubber dams.

12. Remove excess supragingival cement from coronal surfaces of teeth with hand instruments only.

13. Remove arch wires.

14. Tie in arch wires with elastic ligatures.

15. Hold impression trays in mouth.

16. Preselect orthodontic band.

17. Monitor a patient who has been inducted by a dentist into nitrosoxide relative analgesia.

History: Effective September 1, 1980.

General Authority
NDCC 43-20-10

Law Implemented
NDCC 43-20-12

20-04-01-01. DUTIES. In addition to those duties outlined in North Dakota Century Code section 43-20-03, dental hygienists who have been registered and licensed by the board and who are under the direct supervision of a licensed dentist may perform the following duties:

1. Complete prophylaxis to include removal of accumulated matter, deposits, acretions, or stains from the natural and restored surface of exposed teeth. The dental hygienist may also do root planning and soft tissue currettage upon direct order of the dentist.

2. Polish and smooth existing restorations.

3. Apply topical applications of drugs to the surface tissues of the mouth and to exposed surfaces of the teeth.

4. Take dental x-rays.

5. Take and record preliminary medical and dental histories for interpretation by the dentist.

6. Take and record pulse, blood pressure, and temperature.

7. Chart the mouth.

8. Instruct the patient in brushing and flossing and other oral hygiene matters.

9. Receive removable dental prosthesis for cleaning and repair.

10. Insert cleaned or repaired removable prostheses when directed by the dentist.

11. Place and remove celluloid or plastic strips between teeth for placement of filling by the dentist.

12. Remove ligature ties.

13. Remove rubber dam.

14. Remove sutures on direct order of the dentist.

15. Remove periodontal packs and other surgical dressings on direct order of the dentist.

16. Perform nonsurgical clinical and laboratory oral diagnosis tests for interpretation by the dentist.

17. Assist the dentist in the administration of general anaesthesia or analgesia.

18. Take impressions for study casts.

19. Place rubber dams.

20. Place temporary restorations when so ordered by the dentist.

21. Remove cement from around orthodontic bands.

22. Preset and select orthodontic bands.

23. Remove arch wire.

24. Tie in arch wire with elastic type ligatures.

History: Effective September 1, 1980.

General Authority
NDCC 43-20-10

Law Implemented
NDCC 43-20-03

TITLE 33

Health Department

33-03-09-01. RESPONSIBILITY. The applicant for a health maintenance organization must demonstrate the willingness and potential ability to assure that health care services will be provided ~~in a manner to assure both availability and accessibility of adequate personnel and facilities; and~~ in a manner enhancing availability, accessibility, and continuity of service for all persons enrolled in the plan.

1. Contents of Application. Application shall include the matters covered in this section.

   a. Disclosure in Application. Each application shall include disclosure of the following:

      (1) Any contractual or financial arrangements between members of the board of directors or principal officers and the health maintenance organization including:

         ~~(a)~~ A a description of any obligations, specified by contract or otherwise, to be met by each party in accordance with any such arrangement.

         ~~(b) A listing of the dollar amounts of any consideration to be paid each party in accordance with any such arrangements.~~

      (2) Any financial arrangements between members of the board of directors or principal officers and any provider or other person, which provider or other person also has a financial relationship with the health maintenance organization. The disclosure shall include:

         (a) A description of the obligations to be met by arrangements.

         (b) A listing of the dollar amounts of the consideration to be paid each ~~party~~ member of the board of directors or other principal officer in accordance with any such arrangements. Disclosure of dollar amounts shall be restricted to those dollar amounts only which may be expended by the health maintenance organization for such services only which are rendered by board of directors or principal officers to the health maintenance organization.

(c) A listing and description of any circumstances under which a director or principal officer is employed by or engages in a substantial commercial or professional relationship with any provider or other person.

2. Comprehensive Health Maintenance Services. All health maintenance organizations shall either provide comprehensive health maintenance services to enrollees or have provisions made through arrangement to provide comprehensive health maintenance services.

a. Comprehensive health care implies:

(1) Provisions for continuity of care.

(2) An organized health care team representing various health care professions.

b. Minimum services. Health maintenance services or arrangement for such services shall include at a minimum the following services when referred, authorized, or directed by a primary care physician except for medical emergencies. Primary care physicians shall be defined by each health maintenance organization:

(1) In-Hospital Care: All medically necessary in-patient care at a health maintenance organization contracting hospital or at an out-of-area hospital for emergencies:

(a) Room: Semiprivate (or private if medically necessary), no day limit, except for psychiatric care, ~~seventy days~~ to be determined by the health maintenance organization.

(b) Hospital services: Paid for as long as hospitalization is medically required. Services include equipment, medication, and supplies that are furnished and used in the hospital.

(c) ~~Private room and special~~ Special duty nursing when prescribed. Medically necessary operative procedures, excluding heart and bone marrow transplants, administration of anesthesia, and X-ray and radiation therapy, including operating, delivery, and recovery room, and including surgical and obstetrical physician's services.

(d) Prescribed drugs and medications.

(e) Laboratory services and diagnostic tests.

(f) ~~Blood and blood derivatives including the administration and processing costs~~ Administration of whole blood and blood components.

(g) Physical and inhalation therapy.

(h) Consultation services.---By by other physicians for a hospitalized bed patient at the request of the ~~attending physician or surgeon~~ primary care physician.

(i) Outpatient (nonbed) care: As as prescribed and ordered by the ~~attending physician or surgeon~~ primary care physician.

(j) Intensive care unit services.

(k) Emergency services, twenty-four hours a day.

(l) Other medically necessary services.

(2) In-Clinic Care: Preventive health care as well as treatment ~~in the context of~~:

(a) Injury or illness.

(b) Office visits.

(c) General and specialized medical diagnosis and treatment.

(d) Regular physical exams or screening evaluations or both at appropriate intervals as determined by the health maintenance organization.

(e) Specialist care and consultation;--~~when referred by a health maintenance organization practitioner~~.

(f) Laboratory tests and X-ray examinations.

(g) ~~Physical therapy;---occupational therapy;--speech and audiology therapy~~ Short-term therapy when medically necessary and related to the diagnosis being treated including physical therapy, radiation therapy, and inhalation therapy.

(h) Maternity care, including prenatal and postnatal care and obstetrical services.

(i) Pediatric care, including well-baby exams.

(j) Preventive immunizations and skin tests.

(k) Medications administered during visit.

(l) Minor surgical procedures.

(m) Eye and ear screening examinations ~~under~~ through age ~~eighteen~~ seventeen, to determine the need for vision and hearing correction.

~~(n)--Optometric care and prescriptions:~~

~~(o)~~ (n) Infertility and family planning services.

~~(p)--Therapy-rehabilitative-services.~~

~~(q)~~ (o) Psychiatric and mental health services, twenty visits per year.

~~(r)~~ (p) ~~Drug-and-alcohol-addiction-treatment~~ Diagnosis and medical treatment for abuse of or addiction to alcohol and drugs on either an outpatient or inpatient basis whichever is medically determined to be appropriate.

(3) Related Medical Services:

(a) ~~Emergency~~ Medical emergency care covered in full for injury or illness of an emergency nature anywhere ~~in--the world~~. A medical emergency for the purpose of this chapter shall mean the sudden, severe and unforeseen onset of illness or accidental bodily injury treated in the emergency room or outpatient department of a hospital or clinic.

~~(b)--Nervous--and--mental--health--services--provided-in-a-full service-hospital-or-on-an-outpatient-basis,-as--prescribed or---referred---by---a---health--maintenance--organization practitioner.~~

~~(c)~~ (b) Podiatrist's service for the care and treatment of the foot when prescribed by a health maintenance organization primary care physician.

~~(d)~~ (c) Out-of-area referral when approved by a health maintenance organization ~~practitioner~~ primary care physician.

~~(e)--Medical---supplies--and--equipment,--including--prosthetic devices,-as-prescribed-and-ordered-by-a-health-maintenance organization-practitioner-or-referral-physician.~~

~~(f)~~ (d) Home health care ~~as--provided--by--a--registered-nurse, preferably-a-public--health--nurse,~~ when approved by a health maintenance organization ~~practitioner~~ primary care physician.

(4) Limitations and Exclusions: Services not provided through a health maintenance organization, but which may be available through another medical assistance provider:

(a) Conditions covered by workmen's compensation or occupational disease laws.

(b) Services that are provided by any federal, state, or local government agency where the beneficiary has no legal obligation to pay for such services.

(c) Services required as a result of war or while serving in the armed forces.

(d) Services provided by a physician or hospital without the order, referral, or concurrence of a health maintenance organization primary care physician, except for care received in an emergency.

(e) Care desired by an enrollee which is not medically necessary and appropriate for either the maintenance of good health or the treatment of injury or disease.

(f) Physical examinations for a third party, school, insurance, or employer, except when such exam coincides with the periodic exam as provided by a health maintenance organization.

(g) Transportation, except medically necessary ambulance service.

(h) Cosmetic surgery, except for repair of accidental injury or correction of congenital deformities that occur while beneficiary is covered by a health maintenance organization when medically indicated.

(i) Dental services or dental X-rays, except ~~for repair of accidental injury, oral surgery as approved by the health maintenance organization medical director, and preventive dental care as specified~~ the setting of mandibular maxillary jaw fractures or other repair of accidental injury when approved by the health maintenance organization.

(j) Private duty nursing outside a hospital or clinic.

(k) Items for personal comfort or convenience (telephone, television, etc.).

(l) Special braces, corrective appliances, hearing aids, eyeglasses, artificial limbs.

(m) Care in tuberculosis institution.

(n) Mental hospital care, except as specified "in hospital care".

~~(o) Care in an intermediate care facility, except when prescribed by a health maintenance organization physician.~~

~~(p) Care in a skilled nursing facility, except when prescribed by a health maintenance organization physician.~~

~~(q)~~ (o) Chiropractor's services, except when prescribed by a health maintenance organization primary care physician.

~~(r)~~ (p) Long-term private duty nursing services in enrollee's home.

~~(s)~~ (q) Care in Christian Science nursing home, except when prescribed by a health maintenance organization primary care physician.

~~(t)~~ (r) Food supplementation, infant formula.

~~(u)~~ (s) Psychiatric social worker, except when prescribed by health maintenance organization primary care physician.

~~(v)~~ (t) Items or services not ~~approved by a health maintenance organization practitioner or a referral physician as~~ medically necessary.

~~(w)~~ (u) Items or services provided in connection with experimental surgery or treatment, unless approved in advance by the health maintenance organization medical director.

History: Effective March 1, 1979; amended effective September 1, 1980.

General Authority
NDCC 28-32-02

Law Implemented
NDCC 26-38-05

33-03-09-03. QUALITY OF SERVICES. The state department of health shall make or arrange to have made examination of the quality ~~of care~~ of services of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements pursuant to its health care plan as often as it deems it necessary but not less frequently than once every three years. In lieu of such examination:

1. The department may accept the report from the North Dakota insurance commissioner ~~or~~, the state department of health of another state or jurisdiction~~;-or~~, the federal government, or its designee agency.

2. The department may contract with ~~the North Dakota professional services review organization~~ an outside organization to assess the quality of care ~~services~~ being provided by the health maintenance organization.

History: Effective March 1, 1979; amended effective September 1, 1980.

General Authority
NDCC 28-32-02

Law Implemented
NDCC 26-38-24

~~33-03-09-04. QUALITY EVALUATION. It shall be the health maintenance organization's responsibility to arrange for an ongoing evaluation of the quality of health care to include, but not necessarily be limited to, provisions for:~~

~~1.--Meeting the standards of quality review set forth in the Social Security Amendments of 1972 [42 U.S.C. 1320 (c)].~~

~~2.--An ongoing internal peer review system.~~

~~3.--A defined set of standards and procedures in selecting and retaining providers to serve enrollees, and as to the selection and retention of individual providers.~~

~~4.--Assuring that the quality of health care provided in satellite hospitals or clinics shall at all times be equal to the quality of health care services provided by the parent body.~~

~~5.--Maintaining a medical record system for all enrollees.~~

~~6.--A written consumer grievance procedure.~~

33-03-09-04. INTERNAL QUALITY ASSURANCE PROGRAM. Each health maintenance organization will be required to have acceptable organizational arrangements and program for assessing and improving the quality of care. This internal quality assurance program must be supervised by a physician in the health maintenance organization and involve a broad spectrum of health professionals in the health maintenance organization. While outside technical assistance may be utilized for establishing and implementing the program, the actual responsibility for review cannot be delegated to an outside party. This does not preclude such arrangements with physicians who are providing services under contract with the health maintenance organization.

The objectives of such an internal quality assurance program should be to assure that:

1. Health care services are appropriate to the patient's needs and are of acceptable quality; and

2. Health care organization and administration support the timely provision of quality care.

Each health maintenance organization shall have a written member grievance procedure.

History: Effective March 1, 1979; amended effective September 1, 1980.

General Authority
NDCC 28-32-02

Law Implemented
NDCC 26-38-24

33-03-09-05. STATISTICAL REPORTS - REPORTING REQUIREMENTS. It is the health maintenance organization's responsibility to establish procedures to develop, compile, evaluate, and report statistics relating to the cost, operations, pattern of utilization, and the availability and accessibility of its services.

~~1.--Statistics.---The--application--shall--detail--procedures-established-to develop,-compile,-evaluate,-and-report-statistics--which--shall--include the-collection-and-maintenance-of-at-least-the-following-data:~~

~~a.--Gross---utilization---aggregates,---including--hospital--discharges, surgical-hospital-discharges,-hospital-bed-days,-outpatient--visits, laboratory-tests-and-X-rays.~~

~~b.--Demographic-characteristics,-including-the-age-and-sex-of-enrollees.~~

~~c.--Disease-specific-and-age-specific-mortality-rates.~~

~~d.--Enrollment-statistics.~~

~~2.--Provider--Agreements.--The-health-maintenance-organization-shall-include copies-of-all-types-of-agreements-with-providers-through-which-enrollees will--receive--health--care-from-the-providers,-and-a-description-of-any other-relationships-with-providers-who-might--serve--enrollees--together with---a---statement---describing---the--manner--in--which--these--other relationships-assure-availability-and-accessibility-of-health-care.~~

~~3.--Other--Requirements.~~ Each health maintenance organization must also ~~include~~ provide reasonable documentation or evidence of compliance with all of the requirements of this chapter, and the state department of health may require such other information in applications for certificates of authority as it feels is necessary to make a determination on the application.

History: Effective March 1, 1979; amended effective September 1, 1980.

General Authority
NDCC 28-32-02

Law Implemented
NDCC 26-38-05

33-03-09-06. EXPENSES OF EXAMINATION. If the state department of health elects to conduct examinations pursuant to North Dakota Century Code section 26-38-24, the actual expenses as computed by the department incurred by the department in conducting such examinations shall be reimbursed by the health maintenance organization to the department. The department will prepare itemized vouchers of expenses incurred. The health maintenance organization shall make its reimbursement within ~~thirty days~~ a reasonable period of time after receipt of the vouchers.

History: Effective March 1, 1979; amended effective September 1, 1980.

General Authority
NDCC 28-32-02

Law Implemented
NDCC 26-38-24

33-03-09-08. COPAYMENTS. The health maintenance organization may impose reasonable copayments upon its members for covered services.

History: Effective September 1, 1980.

General Authority
NDCC 28-32-02

Law Implemented
NDCC 28-32-02

33-07-01-16. MEDICAL RECORD DEPARTMENT.

1. Procedure. The governing board of the hospital shall establish and implement procedures to ensure that the hospital has a medical record department with administrative responsibility for medical records. A medical record shall be maintained in accordance with accepted medical record principles, for every patient admitted for care in the hospital.

2. Maintenance. A medical record shall be maintained for every patient admitted for care in the hospital. Such records shall be kept confidential.

   a. Only authorized personnel shall have access to the record.

   b. Written consent of the patient shall be presented as authority for release of medical information.

   c. Medical records generally shall not be removed from the hospital environment except upon subpoena.

3. Preservation. Records shall be preserved, either in original or any other method of preservation, such as by microfilm for a period of twenty-five years from date of discharge. Medical records of deceased patients may be destroyed seven years following the date of death. It shall be the governing body's responsibility to determine which record has a research, legal, or medical value and to preserve such records beyond the twenty-five-year or seven-year requirement until such time in the board's determination the record no longer has a research, legal, or medical value.

4. Personnel.

   a. If a registered record administrator or accredited record technician is not in charge of medical records, a consultant registered record administrator or accredited record technician shall organize the department, train the regular personnel, and make periodic visits to the hospital to evaluate the records and the operation of the department. There shall be written job descriptions for department personnel. Medical record policies and procedures shall be developed and shall be revised as necessary and reviewed at least annually. They shall be dated to indicate the most recent revision or review.

b. Regular full-time and part-time employees shall be available so that medical record services may be provided as needed. In some hospitals this may mean around-the-clock coverage.

5. Identification and filing. A system of identification and filing to ensure the prompt location of a patient's medical record shall be maintained.

6. Centralization of reports. All clinical information pertaining to a patient's stay shall be centralized in the patient's record.

   a. The original of all reports shall be filed in the medical record.

   b. All reports or records shall be completed and filed within a period consistent with good medical practice and not longer than fifteen days following discharge.

7. Indices. Records shall be indexed according to disease, operation, and physician and shall be kept up to date. For indexing, any recognized system may be used. Indexing shall be current within six months following discharge of the patient.

8. Content. The medical records shall contain sufficient information to justify the diagnosis and warrant the treatment and end results. The medical records shall contain the following information: Identification data, chief complaint, present illness, past history, family history, physical examination, provisional diagnosis, clinical laboratory reports, X-ray reports, consultations, treatment, medical and surgical, tissue ~~report~~ reports, progress notes, final diagnosis, discharge summary, nurses' notes, and when applicable, autopsy findings. Nurses' notes shall be informative and descriptive of the nursing care given and shall include information and observations of significance so that they contribute to continuity of patient care.

   a. The chief complaint shall include a concise statement of complaints which led the patient to consult the patient's physician and the date of onset and duration of each.

   b. The physical examination statement shall include all positive and negative findings resulting from an inventory of systems.

   c. The provisional diagnosis shall be an impression (diagnosis) reflecting the examining physician's evaluation of the patient's condition based mainly on physical findings and history.

   d. A consultation report shall be a written opinion signed by the consultant, including the consultant's findings on physical examination of the patient.

   e. All diagnostic treatment procedures shall be recorded in the medical record.

   f. Tissue reports shall include a report of microscopic findings if hospital regulations require that microscopic examination be done.

If only gross examination is warranted, a statement that the tissue has been received and a gross description shall be made by the laboratory and filed in the medical record.

g. Progress notes shall give a chronological picture of the patient's progress and shall be sufficient to delineate the course and results of treatment. The condition of the patient determines the frequency with which they are made.

h. A definitive final diagnosis shall be expressed in terminology of a recognized system of disease nomenclature.

i. The discharge summary shall be a recapitulation of the significant findings and events of the patient's hospitalization and the patient's condition on discharge.

j. Autopsy findings in a complete protocol shall be filed in the record when an autopsy is performed.

k. Complete records, both medical and dental, of each dental patient shall be a part of the hospital record.

9. Signature. Records shall be authenticated and signed by a licensed physician.

a. Every physician shall sign the entries which the physician personally makes.

b. A single signature on the face sheet of the record does not suffice to authenticate the entire record.

c. In hospitals with house staff, the attending physician shall countersign at least the history and physical examination and summary written by the house staff.

10. Promptness of record completion. Current records and those on discharged patients shall be completed promptly.

a. Current records shall be completed within forty-eight hours following admission.

b. Records of patients discharged shall be complete within fifteen days following discharge.

c. If a patient is readmitted within a month's time for the same conditions, reference to the previous history with an interval note and physical examination suffices.

History: Amended effective September 1, 1980.

General Authority
NDCC 28-32-02

Law Implemented
NDCC 28-32-02

33-07-03-13. CLINICAL RECORDS.

1. Record procedures. The governing body of the long-term care facility shall establish and implement procedures to ensure that a clinical record shall be maintained for each patient admitted, in accordance with accepted professional principles.

2. Maintenance of clinical record. The long-term care facility shall maintain a separate clinical record for each patient admitted with all entries kept current, dated, and signed. The record shall include:

   a. Identification and summary sheet or sheets including patient's name, social security number, marital status, age, sex, home address, and religion; names, addresses, and telephone numbers of referral agency (including hospital from which admitted), personal physician, dentist, and next of kin or other responsible person; admitting diagnosis, final diagnosis, conditions on discharge, and disposition.

   b. Initial medical evaluation including medical history, physical examination, diagnosis, and estimation of restoration potential.

   c. Authentication of hospital diagnosis, in the form of a hospital summary discharge sheet, a report from the physician who attended the patient in the hospital, or a transfer form used under a transfer agreement.

   d. Physician's orders, including all medication, treatments, diet, restorative, and special medical procedures required for the safety and well-being of the patient.

   e. Physician's progress notes describing significant changes in the patient's condition, written at the time of each visit.

   f. Nurses' notes containing observations made by the nursing personnel.

   g. Medication and treatment record including all medications, treatments, and special procedures performed for the safety and well-being of the patient.

   h. Laboratory and X-ray report.

   i. Consultation reports.

   j. Dental reports.

   k. Social service notes.

   l. Patient care referral reports.

3. Retention of records. All clinical records of discharged patients shall be preserved either in the original or any other method of preservation, such as by microfilm, for a period of ~~twenty-five~~ ten years from date of

discharge. Clinical records of deceased patients/residents may be destroyed seven years following the date of death. In the case of minors, clinical records shall be retained for the period of minority and ten years from date of live discharge. It shall be the governing body's responsibility to determine which record has a research, legal, or medical value and to preserve such records beyond the ~~twenty-five~~ ten-year requirement until such time in the board's determination the record no longer has a research, legal, or medical value.

4. Confidentiality of records. All information contained in the clinical records shall be treated as confidential and may be disclosed only to authorized persons.

5. Staff responsibility for records. If the long-term care facility does not have a full- or part-time medical record accredited record technician or registered record administrator, an employee of the facility shall be assigned the responsibility for assuring that records are maintained, completed, and preserved. The designated individual shall be trained in keeping with the needs of the facility, and receive consultation at least annually from an accredited record technician or registered record administrator.

History: Amended effective September 1, 1980.

General Authority
NDCC 28-32-02

Law Implemented
NDCC 28-32-02

TITLE 75

Social Service Board

AGENCY SYNOPSIS OF § 75-02-06-01:

Defines twenty-one terms used in this chapter of the regulations.

75-02-06-01. DEFINITIONS. In this chapter, unless the context or subject matter requires otherwise:

1. "Accrual basis" means the recording of revenue in the period when it is earned, regardless of when it is collected, and the recording of expenses in the period when incurred, regardless of when they are paid.

2. "Allowable cost" means the facilities actual cost after appropriate adjustments as required by medical assistance regulation are made, and also means the cost to be reimbursed under the medical assistance program.

3. "Bad debts" means those amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services.

4. "Charity allowances" means the reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

5. "Cost center" means a division, department, or subdivision thereof, group of services or employees or both, or any unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

6. "Cost finding" means the process of recasting the data derived from the accounts ordinarily kept by the provider to ascertain costs of the various types of services rendered; it is the determination of these costs by the allocation of direct costs and proration of indirect costs.

7. "Courtesy allowance" means a reduction in charges in the form of allowances to physicians, clergy, and others for services received from the provider.

8. "Consumer price index rate" means the rate which will be applied to variable costs, excluding salaries, in computing the economic condition and trend factor within the rate.

9. "Facility" means a skilled nursing or intermediate nursing care facility or distinct part thereof in a hospital.

10. "Fair market value" means value at which an asset could be sold in the open market in a transaction between unrelated parties.

11. "Generally accepted accounting principles" means the accounting principles approved by the American institute of certified public accountants.

12. "Historical cost" means those costs reported on the cost statement which were incurred and recorded on the facilities accounting records during the past fiscal year.

13. Intermediate care" means the level of care in which an intermediate care facility provides professional nursing services and personal care services to individuals requiring these services at least eight hours per day, seven days per week.

14. "Interest" means the cost incurred with the use of borrowed funds.

15. "Level of care" means the placement of patients by the level and amount of services required.

16. "Patient day" means, for cost determination purposes, all days that the facility has received payment. Hospital days, therapeutic days, and reserved bed days shall be included. The day of admission will be counted, but not the day of discharge. The day of death shall be counted.

17. "Reasonable cost" means the cost, including all necessary and proper costs, incurred in rendering the services subject to the principles related to specific items of revenue and cost. Reasonable cost takes into account both direct and indirect cost of providers of services. Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or services. Within this definition costs must be related to patient care. Patient care costs would be those costs which are necessary and proper and which are common and expected occurrences in the field of the providers activity.

18. "Related organization" means an organization with which a provider is to a significant extent associated or affiliated with or has control of, or is controlled by the organization furnishing the services, facilities, or supplies. Control may be obtained either through ownership, management, or contractual arrangements.

19. "Screening" means the method of patient review used by the social service board to determine the level of care required by individuals residing in a facility.

20. "Skilled nursing care" means a level of care in which a skilled nursing facility provides skilled nursing services and personal care services to

individuals requiring these services on a twenty-four-hour daily basis, seven days per week.

21. "Skilled and intermediate nursing service" means a service which must be furnished by or under the immediate personal supervision of licensed nursing personnel (registered nurse or licensed practical nurse) and under the general direction of the physician.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.272

AGENCY SYNOPSIS OF § 75-02-06-02:

Sets forth, in three subsections, the recordkeeping, accounting, reporting, and auditing requirements of those long-term care facilities which seek to participate in the medical assistance program.

75-02-06-02. FINANCIAL REPORTING REQUIREMENTS.

1. Records.

   a. The facility shall maintain on the premises the required census records and financial information which will be sufficient to provide for a proper audit or review. For any cost being claimed on the annual cost report, sufficient data must be available as of the audit date to fully support the report item. The accounting system shall be double entry.

   b. Where several facilities are associated with a group and their accounting and reports are centrally prepared, added information must be submitted, for those items known to be lacking support at the reporting facility, with the annual cost report or must be provided to the local facility prior to the audit or review of the facility. Accounting or financial information regarding related organizations must be readily available to substantiate cost. Home office cost reporting and cost allocation shall be in conformance with HIM-15 paragraphs 2150 and 2153.

   c. Each provider shall maintain, for a period of not less than five years following the date of submission of the cost report form to the state agency, financial and statistical records of the period covered by such cost report which are accurate and in sufficient detail to substantiate the cost data reported. Each provider shall make such records available upon demand to representatives of the state agency or to the secretary of health and human services or representatives thereof.

2. Accounting and reporting requirements.

a. The basis of accounting for reporting purposes shall be accrual. A facility may maintain its accounting records on a cash basis during the year but adjustments must be made to reflect proper accrual accounting procedures at year end and subsequently reported in the annual cost statement. Specific items to be accounted for are:

(1) Inventories.

(2) Accounts and notes receivable.

(3) Accounts and notes payable.

(4) Payroll and fringe payable.

Generally accepted accounting principles shall prevail.

b. To properly facilitate auditing, the accounting system should be maintained in such a manner that cost accounts will be grouped by cost center and be readily traceable to the reporting form 674.

c. The form for annual reporting of costs for reimbursement purposes shall be form 674. This report shall be filed with the management services division, provider audit unit, on or before the last day of the third month following the end of the facility's normal accounting year. The mailing of cost reports by registered mail, return receipt requested, will ensure documentation of the filing date. In the event a facility fails to file the required financial and statistical report on or before the due date, the medical services division shall, for the subsequent rate period, certify a rate using the following calculation:

(1) After the last day of the fourth month following the facility's accounting year, there will be a nonrefundable penalty of ten percent of any amount claimed for reimbursement to the board.

(2) The penalty is automatically applied each month past the deadline and continues through the month the report is received.

(3) The penalty may be waived by the director of medical services of the social service board upon a showing of good cause for a delay.

(4) Penalty appeals shall be available only through the procedures set forth in North Dakota Administrative Code chapter 75-01-03.

d. Costs reported on form 674 shall reflect allowable costs. Adjustments required by the audit unit, to attain allowable cost, though not meeting the medicaid state agency or the state medicaid investigative group criteria of fraud or abuse on their initial identification, could, if repeated on future cost filings, be considered as possible fraud or abuse. The audit unit will forward all such items identified to the appropriate medicaid investigative group.

3. Auditing. In order to properly validate the accuracy and reasonableness of cost information reported by the facilities, the state agency will provide for at least a minimum number of audits each year as follows:

   a. Annual field audits will be made on at least fifteen percent of the facilities which are deemed representative of all facilities and selected as follows:

      (1) At least five percent of participating facilities selected at random.

      (2) At least ten percent of participating facilities selected by profiles of costs or other factors established by the state agency.

   b. In all years, all cost reports, form 674, will be desk audited and exception audits will be performed as deemed necessary.

   c. The state agency will accumulate the necessary statistics and data which report the number of field audits conducted and the results thereof.

   d. The state agency will perform audits directly and retain all audit-related documents, including cost reports, working papers, and internal reports on rate calculations which are utilized and generated by audit staff in performance of audits and establishing rates. Audits will meet generally accepted audit standards.

4. Penalties for fraud. Any person who has committed a crime, including but not limited to fraud, making a false statement, or misrepresentation of a material fact in an application for reimbursement, may, upon confiction thereof, be fined not more than twenty-five thousand dollars or imprisoned for not more than five years, or both, all according to the provisions of 42 U.S.C. 1396h and North Dakota Century Code title 12.1.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 USC 1396h,
42 CFR 447.274,
42 CFR 447.275,
42 CFR 447.277

AGENCY SYNOPSIS OF § 75-02-06-03:

Sets forth, in five subsections, the methods of depreciation and amounts of depreciation which will be recognized as costs to the long-term care facility.

75-02-06-03. DEPRECIATION.

1. The principles of reimbursement for provider costs require that payment for services should include depreciation on all depreciable type assets that are used to provide covered services to medical assistance recipients. This includes assets that may have been fully (or partially) depreciated on the books of the provider but are in use at the time the provider enters the program. The useful lives of such assets are considered not to have ended and depreciation calculated on the revised extended useful life is allowable. Likewise, a depreciation allowance is permitted on assets that are used in a normal standby or emergency capacity.

2. Depreciation methods.

   a. The straight-line method of depreciation must be used. All accelerated methods of depreciation are unacceptable. The method and procedure for computing depreciation must be applied on a basis consistent from year to year and detailed schedules of individual assets shall be maintained. If the books of account reflect depreciation different than that submitted on the form 674, a reconciliation shall be prepared.

   b. The depreciable life of an asset is its expected useful life to the provider; not necessarily the inherent useful or physical life. If a difference is considered, a salvage value should be established prior to the application of the depreciation rate. The useful life is determined in the light of the provider's experience and the general nature of the asset and other pertinent data. In projecting a useful life, providers are to follow the useful life guidelines published by the American hospital association. A different useful life may be used; however, when the useful life selected differs significantly from that established by the guidelines, the deviation must be based on convincing reasons supported by adequate documentation, generally describing the realization of some unexpected event. The depreciation options made available for income tax purposes, such as those offered under the asset depreciation range system may not be used for purposes of reimbursement. A composite useful life may be used for a class or group of assets.

3. Acquisitions.

   a. If a depreciable asset has, at the time of its acquisition, an estimated useful life of at least two years and historical cost of at least three hundred dollars, or if it is acquired in quantity and the cost of the quantity is at least five hundred dollars, its cost must be capitalized and depreciated over the estimated useful life of the asset. Cost during the construction of an asset, such as architectural, consulting and legal fees, interest, etc., should be capitalized as a part of the cost of the asset.

b. Major repair costs on equipment or buildings must be capitalized if the repairs have increased the useful life of the asset by at least two years.

4. Proper records will provide accountability for the fixed assets and also provide adequate means by which depreciation can be computed and established as an allowable patient-related cost. Tagging of major equipment items is not mandatory, but alternate records must exist to satisfy audit verification of the existence and location of the assets.

5. Basis for depreciation.

a. Historical costs are those costs which are incurred by the present owner in acquiring and preparing the asset for use. This amount shall not exceed the lower of:

(1) Current reproduction costs less straight-line depreciation over the life of the asset to the time of purchase; or

(2) Fair market value at time of purchase.

In the case of a trade-in, the historical cost will consist of the sum of the book value of the trade-in plus the cash paid.

b. For depreciation purposes donated assets may be recorded and depreciated based on their fair market value. The fair market value is considered the price the asset would bring by a bona fide bargaining between the well-informed buyers and sellers at the date of acquisition. In the case where the provider's records do not contain the fair market value of the donated asset, as of the date of the donation, an appraisal must be made. The appraisal will be made by a recognized appraisal expert and will be accepted for depreciation and return on investment purposes.

c. Purchase of a facility and its depreciable assets as an ongoing operation.

(1) Determination of the cost basis of a facility and its depreciable assets of an ongoing operation depends on whether or not the transaction is a bona fide sale. Should the issue arise, the purchaser has the burden of proving that the transaction was a bona fide sale. The cost basis of a facility and its depreciable assets acquired as an ongoing operation in a bona fide sale is limited to the lowest of the following:

(a) Current reproduction cost of the assets, depreciated on a straight-line basis over its useful life to the time of the sale;

(b) Price paid by the purchaser (actual cost); or

(c) Fair market value of the facility or asset at the time of the sale.

Where the purchaser acquires the facility or assets in a sale not bona fide, the cost basis is also limited by the seller's cost basis, less accumulated depreciation, if this is lower than subparagraphs a, b, and c.

(2) The seller shall always use the sale price in computing the gain or loss on the disposition of assets.

d. Appraisal guidelines. To properly provide for costs or valuations of fixed assets, an appraisal will be required if the provider:

(1) Has no historical cost records or has incomplete records of depreciable fixed assets; or

(2) Purchases a facility without designation of purchase price for the classification of assets acquired.

Prior to having an appraisal made, the provider must inform the state that it intends to have the appraisal made. At this time the provider shall also set forth the reasons for the appraisal and will make available to the state the agreement between the provider and the appraiser. The appraisal agreement should contain the appraisal date, the estimated date of completion, the scope of the appraisal, and the statement that the appraisal will conform to the current medicare regulation on principles of reimbursement for provider cost.

e. Limitation. The state will recognize appraised value not to exceed cost basis for tax purposes. In all cases of major change, proper authority for expenditure shall be obtained.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.276

AGENCY SYNPOSIS OF § 75-02-06-04:

Sets forth, in four subsections, the types of interest expense which will be treated as costs to the long-term care provider, and establishes a method of recognizing funded depreciation in those facilities which choose to fund depreciation.

75-02-06-04. INTEREST EXPENSE.

1. General.

a. To be allowable under the program, interest must be:

(1) Supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required;

(2) Identifiable in the provider's accounting records;

(3) Related to the reporting period in which the costs are incurred; and

(4) Necessary and proper for the operation, maintenance, or acquisition of the provider's facilities used therein.

b. In such cases where it was necessary to issue bonds for financing, any bond premium or discount shall be accounted for and written off over the life of the bond issue.

2. Interest paid by the provider to partners, stockholders, or related organizations of the provider is not allowable as a cost. Where the owner uses the owner's own funds in a business, the funds are considered invested funds or capital, rather than borrowed funds.

3. Where the provider has invested funds from gifts or grants which are unrestricted as to use, and these funds are commingled with other funds, the provider's allowable interest expense is reduced by the amount of investment income earned by the fund. Any investment income in excess of interest expense will not be used to offset other operating expenses. However, if the gifts and grants are not commingled with other funds, the investment income earned by the fund does not reduce allowable interest expense.

4. Funded depreciation.

a. Funding of depreciation is the practice of setting aside cash or other liquid assets, in a fund separate from the general funds of the provider, to be used for replacement of the assets depreciated, or for other capital purposes. The deposits are, in effect, made from the cash generated by the noncash expense depreciation.

b. Deposits to the funded depreciation account are generally in an amount equal to the depreciation expense charged to costs each year. In order to qualify for all provisions of funding depreciation the minimum deposits to the account shall be fifty percent of the depreciation expensed that year. Deposits in excess of accumulated depreciation are allowable; however, the interest income generated by the "extra" deposits will be considered as a reduction of allowable interest expense. This provision is recommended as a means of conserving funds for the replacement of depreciable assets and purchase of capital assets. It is expected that the funds will be invested to earn revenues. The revenues generated by this investment will not be considered as a reduction of allowable interest expense.

c. Monthly or annual deposits representing depreciation must be in the funded depreciation account for six months or more to be considered

as valid funding transactions. Deposits of less than six months are not eligible for the benefits of a funded depreciation account. However, if deposits invested before the six-month period remain in the account after the six-month period, the investment income for the entire period will not reduce the allowable interest expensed in that period. Total funded depreciation in excess of accumulated depreciation on patient related assets will be considered as ordinary investments and the income therefrom will be used to offset interest expense.

d. Withdrawals for the acquisition of capital assets, the payment of mortgage principal on these assets and for other capital expenditures are on a first-in, first-out basis. Withdrawals for general operating purposes or for loans to the general fund are made on a last-in, first-out basis. Such loans must meet the "necessary and proper" requirements for need of the loan. Interest paid for the general fund to the funded depreciation account on the loan is an allowable cost, except as mentioned in subdivision c where the deposit has not been in the fund for the six-month period the interest paid on the loan is not an allowable cost. Loans made to the general fund shall not be made for a period or term which is longer than three years. Documentation on prevailing interest rates at the time of the loan shall be maintained on file. The necessary and proper requirements set forth in HIM-15 paragraph 202.2 and 202.3 will apply to all loans made.

e. The provider may use the funds in the funded depreciation account for purposes other than the improvement, replacement, or expansion of facilities or equipment related to patient care. However, allowable interest expenses for the period of withdrawal will be reduced to adjust for offsets not made in prior years for earnings applicable to such funds. For example, if the provider withdraws funds equal to two year's deposits, using the last-in, first-out method, any earnings applicable to these deposits during the two-year period are applied as a reduction of interest expense incurred during the period of withdrawal.

f. When money is borrowed to fund depreciation, interest paid by the provider on the money borrowed for this purpose is not an allowable cost.

g. Funded depreciation is to be used both for the replacement of existing assets and for expansion. These funds must be used for all capital outlays in excess of three hundred dollars except with regard to those assets purchased exclusively with donated funds, and cannot be restricted for a specific or future purpose. For example, restricting the account to funding depreciation for "building" would negate the intent of funding depreciation as defined by this section.

History: Effective September 1, 1980

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.276

AGENCY SYNOPSIS OF § 75-02-06-05:

Describes allowable compensation for managerial, administrative, professional or other services when those services are rendered by sole proprietors, partners, and corporate employees charged with the responsibility of administration in a long-term care facility, and limits compensable travel costs.

75-02-06-05. COMPENSATION.

1. The allowance of compensation for services of sole proprietors and partners is the amount determined to be the reasonable value of the services rendered regardless of whether there is any actual distribution of the profits of the business. Subdivision b of subsection 2 shall be used in determining reasonableness.

2. Compensation in corporate facilities.

   a. For purposes of determining whether the total compensation paid is reasonable, compensation as defined herein means remuneration paid regardless of the form in which it is paid. Compensation may be included in allowable provider costs only to the extent that it represents reasonable remuneration for managerial, administrative, professional, and other services related to the operation of the facility and rendered in connection with patient care. Services rendered in connection with patient care include both direct and indirect activities in the provision and supervision of patient care, such as administration, management, and supervision of the overall institution. Compensation of this type must be documented, especially in circumstances where there is an administrator of the facility that would normally be charged with the direct and indirect activities. Services which are not related to either direct of indirect patient care are those primarily for the purpose of managing or improving the owners financial investment, and will not be recognized as an allowable cost.

   b. Reasonableness requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by

comparable institutions depending upon the facts and circumstances of each case. Reasonableness also requires that functions performed be necessary in that, had the services not been rendered, an institution would have had to employ another person to perform them. The services must be pertinent to the operation and sound conduct of the institution. The social service board shall determine reasonable administrator compensation by survey, every two years, to be the least of (1) the compensation actually paid, (2) the ninetieth percentile cost per licensed bed per year, or (3) the ninetieth percentile salary. Percentiles shall be calculated separately for facilities of less than seventy-five beds, and those of seventy-five or more beds. Reasonable compensation data will be revised at least annually to reflect changes in the consumer price index (all items - U.S. city average).

c. Items which are considered compensation and includable in the test for reasonable compensation received by an administrator include, but are not limited to, the following:

(1) Salary amounts paid for managerial, administrative, professional, and other services.

(2) Amounts paid by the institution for the personal benefits of the administrator or owner-administrator, e.g., housing allowance, flat-rate automobile allowance.

(3) The cost of assets and services which the owner-administrator or administrator receives from the institution.

(4) Deferred compensation (pension and annuities).

(5) Supplies and services for the personal use of the administrator or owner-administrator.

(6) The wages of a domestic or other employee who works in the home of the administrator or owner-administrator.

(7) Insurance premiums paid for the owner-administrator or administrator (life and health insurance).

3. Travel costs which are incurred in the course of normal operations of the nursing facility and result in providing the required transportation of the residents of the home will be considered. The cost must be patient related and reasonable. All travel costs not related to local transportation needs will require documentation to justify the cost and to indicate how the expenditure is patient related.

a. Travel costs for administrators will be allowed in order that they may attend meetings which pertain to patient care, home office visits, and board meetings for associations. Allowable travel costs shall not exceed the maximum allowed pursuant to North Dakota Century Code section 54-06-09.

b. The fees paid to members of a board of directors for meetings attended shall be allowed in an amount not to exceed fifty-two dollars per day plus travel at a rate not to exceed the maximum allowed pursuant to North Dakota Century Code section 54-06-09. Normally, no more than twenty-four meetings per fiscal year will be considered reasonable. Any exceptions to the stated number of meetings must be presented for the consideration of the auditor in charge during the onsite audit. A determination of the reasonableness of any additional meeting expenses will be made at that time.

4. All plans within the definition of deferred compensation and pension plans set forth in HIM-15 sections 2140.1 and 2142.1, respectively, shall be considered in the determination of allowable costs. No provisions of these plans may discriminate in favor of certain employees, such as employees who are officers, stockholders, supervisors, or highly paid personnel. In order to be considered an allowable cost, the payment reported must benefit all eligible employees and be based on the same payment structure.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.276

AGENCY SYNOPSIS OF § 75-02-06-06:

Establishes a profit allowance for proprietary homes which provide long-term care.

75-02-06-06. RETURN ON INVESTMENT. For a return on investment for proprietary homes, an allowance of eight and one-half percent of net investment of fixed assets relating to patient care will be established. The "net investment of fixed assets relating to patient care" means the cost, less accumulated depreciation and the balance of notes and mortgages payable, pertaining to the fixed assets relating to patient care. The allowance for the return on an investment will be made on form 674, Annual Statement of Reimbursable Cost. The allowance shall not exceed the amount allowable under section 1200 of HIM-15.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32)

AGENCY SYNOPSIS OF § 75-02-06-07:

Provides, in three subsections, for the treatment of financial operations of those facilities which are in some manner related to other facilities, or to providers of services or goods to the facility.

75-02-06-07. RELATED ORGANIZATION.

1. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere primarily in the local market. Providers must identify such related organizations and costs in the cost report. An appropriate statement of cost and allocations must be submitted with the annual cost report 674. For cost reporting purposes, management fees will be considered as administrative costs.

2. A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device controlled by one business entity. This includes not only proprietary chains but also chains operated by various religious and other charitable organizations.

3. Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to their member facilities. Although the home office of a chain is normally not a provider in itself, it may furnish to the individual provider, central administration or other services such as centralized accounting, purchasing, personnel, or management services. Only the home office's actual cost of providing such services is includable in the provider's allowable costs under the program. Any services provided by the home office which are also included in cost as payments to an outside provider will be considered a duplication of costs and not be allowed.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.276,
42 CFR 447.284

AGENCY SYNOPSIS OF § 75-02-06-08:

Provides, in two subsections, for the determination of allowable rental costs for long-term care facilities which pay rent to a related organization.

75-02-06-08. RENTAL EXPENSE PAID TO A RELATED ORGANIZATION.

1. A provider may lease a facility from a related organization within the meaning of the principles of reimbursement. In such case, the rent paid to the lessor by the provider is not allowable as cost. The provider, however, would include the cost of ownership of the facility. Generally, these would be costs such as depreciation, interest on the mortgage, real estate taxes, and other expenses attributable to the leased facility. The effect is to treat the facility as though it were owned by the provider. Therefore, the owner's equity in the leased assets is includable in the equity capital of the provider.

2. In order to be considered an allowable cost, the home office cost must be directly related to those services performed for individual providers and relate to patient care. An appropriate share of indirect costs will also be considered. Documentation as to time or services provided must be available to substantiate cost.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.276,
42 CFR 447.284

AGENCY SYNOPSIS OF § 75-02-06-09:

Provides, in two subsections, for the allowance or disallowance of various kinds of taxes as costs to the long-term care facility.

75-02-06-09. TAXES.

1. General.

   a. Taxes assessed against the provider, in accordance with the levying enactments of the several states and lower levels of government and for which the provider is liable for payment, are allowable costs. Tax expense may not include fines, penalties, or those taxes listed in subsection 2.

   b. Whenever exemptions to taxes are legally available the provider is to take advantage of them. If the provider does not take advantage of available exemptions, the expense incurred for such taxes are not recognized as allowable costs under the program.

2. Taxes not allowable as costs. The following taxes, which are levied on providers, are not allowable as costs:

   a. Federal income and excess profit taxes, including any interest or penalties paid thereon.

   b. State or local income and excess profit taxes.

   c. Taxes in connection with financing, refinancing, or refunding operation, such as taxes in the issuance of bonds, property transfers, issuance or transfers of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.

   d. Taxes from which exemptions are available to the provider.

e. Special assessments on land which represent capital improvements, such as sewers, water, and pavements, should be capitalized and may be depreciated.

f. Taxes on property which is not used in the retention of covered services.

g. Taxes, such as sales taxes, levied against the patient and collected and remitted by the provider.

h. Self-employment (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, etc.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.276

AGENCY SYNOPSIS OF § 75-02-06-10:

Provides that bad debts, charity and courtesy allowances shall not be included as allowable costs.

75-02-06-10. BAD DEBTS. Bad debts, charity, and courtesy allowances shall not be included in allowable costs.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.282,
42 CFR 447.283

AGENCY SYNOPSIS OF § 75-02-06-11:

Permits capitalized startup costs to be recognized as allowable costs when depreciated over sixty consecutive months starting with the month in which the first patient is admitted for treatment.

75-02-06-11. STARTUP COSTS. In the first stages of operation, a new institution incurs certain costs in developing its ability to care for patients prior to admission of patients. Staff is obtained, organized, and other operating costs are incurred during this time of preparation which cannot be allocated to patient care during that period because there are no patients receiving services. Therefore, it is proper that such costs, commonly referred to as startup costs, be considered as deferred charges under the program and allocated over a number of periods which benefit from such costs. Where a provider has properly capitalized startup costs as a deferred charge, amortization of such costs will be recognized

as allowable costs depreciated over sixty consecutive months starting with the month in which the first patient is admitted for treatment.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.276

AGENCY SYNOPSIS OF § 75-02-06-12:

Provides, in two subsections, for the treatment of certain income items which will offset costs, and for the disallowance of certain costs not related to patient care.

75-02-06-12. ADJUSTMENT TO COST AND COST LIMITATION.

1. Income to offset cost.

   a. Several items of income to the home will be considered as offsets against various costs as recorded in the books of the facility. Any income which is received by the home for reimbursements of cost, with the exception of the basic daily rate and income from charges to private pay patients for care items which are included in the title XIX rate, will be offset against costs reported. Any reimbursement not listed below, which may be classified as an offset, must be shown as such on report form 674 and costs reduced accordingly. Items of income to offset cost include, but are not limited to, the following:

      (1) "Activities income." Income from activities department and the gift shop to the extent that it does not exceed the expenses as reported.

      (2) "Confections income." All income from the sale of pop, candy, or other items.

      (3) "Dietary income." Amounts received from or on behalf of employees, guests, or other nonpatients for lunches, meals, or snacks.

      (4) "Drugs or supplies income." All revenues received from employees, doctors, or other not admitted as patients.

      (5) "Insurance recoveries income." Any amount received from insurance for a loss incurred shall be offset against costs reported in the current year to the extent of costs allowed in prior or current year for that loss.

      (6) "Interest or investment income." Interest received on investment to the extent that it does not exceed the total interest cost for the year.

(7) "Laundry income." All amounts received for services rendered on behalf of employees, doctors, or others.

(8) "Maintenance of personnel." The cost (to be determined) of providing meals and lodging to nursing home personnel living on premises.

(9) "Nonrelated depreciation expense." All depreciation reported in costs which is not related to patient care.

(10) "Private duty nurse reimbursement." All reimbursement received for the providing of a private duty nurse if the cost is included in the reimbursement report.

(11) "Purchase discounts." All discounts received from vendors on purchases included in costs.

(12) "Rebates and refunds income." Any refund received on expense or cost item shall be offset against the appropriate cost.

(13) "Rentals of nursing home space income." Any revenues received from outside sources for the use of nursing home space and equipment.

(14) "Telegraph and telephone income." All revenues received from patients, guests, or employees.

b. Payments to a provider by its vendor will be considered as discounts, refunds, or rebates in determining allowable costs under the program even though these payments may be treated as "contributions" or "unrestricted grants" by the provider and the vendor. However, such payments may represent a true donation or grant. Examples include, but are not limited when: (1) they are made by a vendor in response to building or other fund raising campaigns in which community-wide contributions are solicited; (2) they are in addition to discounts, refunds, or rebates, which have been customarily allowed under arrangements between the provider and the vendor; (3) the volume or value of purchases is so nominal that no relationship to the contribution can be inferred; (4) the contributor is not engaged in business with the provider or a facility related to the provider.

c. Where an owner or other official of a provider directly receives from a vendor monetary payments or goods or services for the owner's or official's own personal use as a result of the provider's purchases from the vendor, the value of such payments, goods, or services constitutes a type of refund or rebate and should be applied as a reduction of the provider's costs for goods or services purchased from the vendor.

d. Where the purchasing function for a provider is performed by a central unit or organization, all discounts, allowances, refunds, and rebates should be credited to the costs of the provider in accordance with the instructions above. These should not be treated

as income of the central purchasing function or used to reduce the administrative costs of that function. Such administrative costs are, however, properly allocable to the facilities serviced by the central purchasing function.

e. Amounts paid by a supplier for the use of space or equipment in a hospital or long-term care facility will ordinarily be found to constitute a form of discount, whether paid as a percentage of charges or as a flat amount per bed or per time period. Payments made by a supplier to a provider in recognition of the fact that the supplier is relieved of the need to collect individual bills from the patients of the provider, sometimes called "accounting fees" or "collection fees", are considered a form of discount, refund, or rebate and should be used to reduce the costs of the goods or services purchased from the supplier.

f. Purchase discounts, allowances, refunds, and rebates are reductions of the cost of whatever was purchased. They are not to be considered a form of income. They should be used to reduce the specific costs to which they apply. If possible, they should accrue to the period to which they apply. If not, they will reduce expenses in the period in which they are received. The reduction to expense for supplies or services must be used to reduce the total cost of the goods or services for all patients without regard to whether the goods or supplies are designated for all patients or a specific group, e.g., medicare or nonmedicare.

(1) "Purchase discounts" include cash discounts, trade, and quantity discounts. "Cash discount" is for prepaying or paying within a certain time of receipt of invoice. "Trade discount" is a reduction of cost granted certain customers. "Quantity discounts" are reductions of price because of the size of the order.

(2) Allowances are reductions granted or accepted by the creditor for damage, delay, shortage, imperfection or other cause, excluding discounts and refunds.

(3) Refunds are amounts paid back by the vendor generally in recognition of damaged shipments, overpayments, or returned purchases.

(4) Rebates represent refunds of a part of the cost of goods or services. Rebates differ from quantity discounts in that it is based on dollar value of purchases not quantity of purchases.

(5) "Other cost related income" includes amounts generated through the sale of a previously expensed item, e.g., supplies or equipment.

2. Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in

computing reimbursable costs. They include, but are not limited to, the following:

a. Costs which are unallowable when incurred by a facility are also unallowable for a home office and cannot be allocated to facilities in a chain organization.

b. Certain corporate costs, such as stockholder servicing costs, organization costs, or reorganization costs are not related to patient care and are not allowable.

c. Costs incurred in the form of dues or contributions paid to charitable or civic organizations, i.e., the boy scouts and girl scouts, cancer foundation, league for the blind, disabled American veterans, and the lung association are not related to patient care and are not considered an allowable cost.

d. The full cost of items or services such as telephone, television, and radio which are located in patient accommodations and which are furnished solely for the personal confort of the patients are not includable in allowable costs.

e. Fund-raising costs, including salaries, advertising, promotional or publicity costs incurred for such a purpose are not includable in allowable costs.

f. Costs of advertising to the general public which seek to increase patient utilization of the provider's facilities are not allowable. Included in these unallowable costs are brochures, newspaper ads for purposes other than procurement of personnel, promotional type items such as pens and pencils, yellow page ads except those limited to the information furnished in the white page listing, advertising in journals or through radio and television or other media.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.276,
42 CFR 447.284

AGENCY SYNOPSIS OF § 75-02-06-13:

Provides, in three subsections, for the allocation of costs to identifiable cost centers and identifies the cost centers to be used unless the facility demonstrates a more reasonable method of establishing cost centers.

75-02-06-13. COST ALLOCATION.

1. Where services of the various cost centers are jointly used by any combination of facilities not related to a hospital or in the event that services are provided which result in costs that are not includable in allowable costs, the following cost allocation methods must be used. In

cases where more than one method of allocation is available within a cost center, management services shall have discretion to apply the method which, in its opinion, reflects the most reasonable cost based upon the data available at the time of audit.

a. Nursing service. Nursing salaries must be reported on actual costs. Other nursing service costs shall be allocated on patient days.

b. Dietary costs shall be allocated on the basis of meals served to patients.

c. Housekeeping costs shall be allocated on the basis of patient days or on usable square footage.

d. Laundry and linen costs shall be allocated on the basis of patient days or on pounds [kilograms] of laundry if records are maintained to reflect a study which is performed at regular intervals on an ongoing basis.

e. Plant operation costs shall be allocated on the basis of available bed days, or on the basis of usable square footage of space.

f. Property costs shall be allocated on the basis of available bed days, or on the basis of usable square footage of space.

g. Administration costs shall be allocated on the basis of percentage of total cost, other than administration, in each facility. Administrative cost shall be limited to fifteen percent of total allowable nursing home costs.

2. If certain costs within a particular cost center can be directly identified with the nursing home, then they shall not be subject to allocation procedures as previously outlined. The remaining costs within that cost center shall be allocated according to cost allocation methods as described previously. In no case shall the costs allocated by the methods above exceed those costs which are nursing home costs on the medicare report.

3. Allocation procedures for nursing homes combined with a hospital shall be those set forth in the appropriate medicare regulations. However, no cost shall be charged to the nursing home which does not directly or indirectly benefit nursing home patients, e.g., equipment leased for hospital use only.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.276

AGENCY SYNOPSIS OF § 75-02-06-14:

Provides, in two subsections, for the keeping of a daily census record at the facility, and establishes guidelines for the keeping of that census.

75-02-06-14. PATIENT CENSUS.

1. A patient day is any day that the facility has received remuneration for the available bed. The amount of remuneration has no bearing on whether a day should be counted or not. Examples of days that must be included in census, providing they have been paid for, are hospital days and therapeutic leave days. In the case where a private room has been made of a previously utilized double room and a rate has been charged that does not correspond to a normal private room rate, two patient days would be counted for this room.

2. A daily census record must be maintained by the facility to allow for proper audit of the census data.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.276,
42 CFR 447.277

AGENCY SYNOPSIS OF § 75-02-06-15:

Provides, in seven subsections, a list of services and items which are considered "routine" for the purpose of Medicaid cost reporting.

75-02-06-15. NURSING CARE. Routine nursing care services are those services included by the provider in a daily services charge usually referred to as the room and board charge. The following types of items and services in addition to room dietary and medical social services shall be considered to be routine for purposes of medicaid cost reporting even though they may be considered ancillary by the facility:

1. All general nursing services including but not limited to administration of oxygen and related medication, hand feeding, incontinency care, tray service, enemas, etc.

2. Items which are furnished routinely and relatively uniformly to all patients, e.g., patients gowns, water pitchers, basins, bedpans, etc.

3. Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually in small quantities, e.g., alcohol, applicators, cotton balls, bandaids, antacids, aspirins, (and other nonlegended drugs ordinarily kept on hand), suppositories, tongue depressors, paper tissues, deodorants, mouthwashes, kleenex, toothpaste, denture cleaner, etc.

4. Items which are utilized by individual patients which are reusable and expected to be available in the facility providing a skilled or intermediate level of care, e.g., ice bags, bedrails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment.

5. Items which, while not listed above, came within the definitions set forth in the personal needs guidelines of the Guidelines for Routine Drugs, Supplies, and Equipment for Skilled Nursing and Intermediate Care Facilities as issued by the medical services division for any items which may not have been covered in the above but may come within the definitions set forth in the personal needs guidelines.

6. Special dietary supplements used for tube feeding or oral feeding such as elemental high nitrogen diet, even if written as a prescription item by a physician (because these supplements have been classified by the food and drug administration as a food rather than a drug).

7. Laundry services considered necessary for the proper care and appearance of the patient.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.276,
42 CFR 447.281

AGENCY SYNPOSIS OF § 75-02-06-16:

Provides, in six subsections, the method for determining the Medicaid reimbursement rate to be established for each long-term care facility, provides for the gathering and evaluation of information to establish the rate, establishes limitations on certain costs or types of costs, and provides procedures for adjustments and appeals.

75-02-06-16. REIMBURSEMENT.

1. The method of determining the reimbursement rate per day will be through the use of the prospective ratesetting system. The system requires that the rate be established during the year in which it will be effective with retroactive adjustment to the beginning of the facility's fiscal year.

2. The determination of a prospective rate for all accommodations begins with the actual cost of the facility's operations for the previous fiscal year. Once it has been determined that the costs from the previous year are, in fact, reasonable patient-related costs, adjustments are then applied to the historical cost to determine the prospective rate. Reasonable patient-related costs will be determined with reference to health insurance manual 15 (HIM-15).

3. The historical costs combined with the adjustments take into consideration the economic conditions and trends during the period to be covered by the rate. Costs which are incurred to meet certification standards shall be allowable and included in the determination of the rate. Rate adjustments to provide appropriate compensation may be requested where major unforeseeable expenses are incurred. Such requests may be made to the director of medical services, who shall determine if the expense is patient-related and beyond the control of those responsible for the management of the facilities. The following adjustment methods will be used:

   a. Salary costs will be anticipated based upon actual data recorded in the financial records during the first two months of the current fiscal year of the facility.

   b. Property costs will be included in the rate at the historical amount unless there has been a major change in ownership or construction of the facility requiring certificate of need procedures.

   c. The other costs of the facility will be projected based upon the historical cost plus the annual percent of increase in the consumer price index as of the facility's fiscal year end. The consumer price index (CPI-U) percentage used is that considered as "all items." (United States city average.)

4. Limitations.

   a. The appropriate division of the social service board shall accumulate and analyze statistics on costs incurred by the nursing facilities. These statistics may be used to establish reasonable ceiling limitations and incentives for efficiency and economy based on reasonable determination of standards of operations necessary for efficient delivery of needed services. These limitations and incentives may be established on the basis of cost of comparable facilities and services and may be applied as ceilings on the overall costs of providing services or on specific areas of operations. It shall be the option of the social service board to implement the ceilings so mentioned at any time based upon the statistics available and under guidelines required within the regulations of title XIX. The methods used in determining limitations will be consistent for any or all classes of facilities. Approval will be received from health and human services regional office prior to implementation of additional limitations.

   b. At such time as federal regulations establish a ceiling on medical rates for skilled nursing facilities, that ceiling shall also be considered the maximum for title XIX payment.

   c. A facility is expected to maintain an average annual occupancy rate which is based upon its size. Facilities with zero to forty licensed beds should maintain an eighty-five percent occupancy rate; facilities with forty-one to sixty licensed beds should maintain a ninety percent occupancy rate; and facilities with sixty-one and more licensed beds should maintain a ninety-five percent occupancy

rate. For facilities with less than the stated percentage for the period under consideration, the number of patient days for rate computation will be computed using the required percentage instead of the lower actual percentage of occupancy. The computed patient days will apply only to the following areas:

(1) Administrative costs;

(2) Plant operation costs; and

(3) Property costs.

A reserved paid bed will be counted as an occupied bed. A waiver to the minimum bed occupancy allowance may be made for new facilities or existing facilities which add new beds under a certificate of need during the first year of operation. Consideration will be given in these circumstances to the facts available.

d. Administrative cost shall be limited to fifteen percent of total allowable nursing home costs.

e. For facilities which do not have an adequate accounting system to allocate costs to the various levels of care, the following methodology is used:

(1) In calculating nursing care cost per day, total patient days are rated at a ratio of 1.0 for total skilled care days, .67 for total intermediate care days, and .12 for total custodial care days.

(2) Costs other than nursing are prorated over total patient days. (Subject to occupancy requirement.)

5. Rate payments.

a. The rate as established shall be considered as payment for all accommodations and includes all items designated as routine services for each level of care. No payments may be solicited or received from the patient or any other person to supplement the rate as established.

b. The rate as established shall only be paid if the private pay patients rates for semiprivate accommodations equal or exceed the established rate for medical services patients. The rate being charged private pay patients at the time the services are being or were provided shall govern. In cases where private pay patients are not charged a daily rate, the daily charge will be computed by dividing the total private pay charges for each month by the private pay census for each month. At no time shall the rate paid by medical services exceed the lesser of cost or private pay charges as previously defined. If at any time the facility discounts the private pay patients rate for those periods of time that the patient is not in the facility, the discounted rate may not be lower than the rate as established for medical services patients. If the

discounting policy does create a situation in which the private rate is less, then all medical assistance patients shall be afforded a discount in the amount of the difference between the discounted private patient rate and the established medical assistance rate.

c. If the medical assistance reimbursement rate exceeds the private payment rate for a particular level of care, on any given date, the social service board shall request a refund from the provider. The refund requested shall be the difference between the private pay rate and medical assistance rate times the number of medical assistance patient days paid during the period in which the medical assistance reimbursement rate exceeded the private pay rate. It shall be the responsibility of the facility to notify medical services if the rate paid is more than that charged private pay patients.

d. Overpayments found in audits will be accounted for on the HCFA-64 report no later than the second quarter following the quarter in which found, as provided for in federal regulations.

e. Participation in the program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the rate structure.

f. Rate payments to the facility will be made on a schedule detailed as follows:

(1) During the last month of each facility's (LTC) fiscal year a letter will be mailed to them indicating the estimated amount of increase for all homes whose fiscal year ends that month. The home, by responding to this statement in writing, may indicate any amount of increase up to and including the amount specified in the letter. The amount specified in the letter will be based upon the percent of increase in rates determined from the audits of the prior six-month period ending December thirty-first or June thirtieth. In accepting the amount the facility should consider the private pay rate in the facility at that time and their best estimate of cost to be reflected in the ratesetting procedure for the next fiscal year. The rate so indicated by the facility will then be implemented effective the first of that facility's fiscal year. This rate is only an interim rate.

(2) Each facility must file an annual report 674 within three months of the end of its fiscal year. Within one month of the receipt of each form 674 it will be reviewed for completeness and accuracy. If the report is filed in a timely manner and if all information requested is present on the report, it will be used as a basis for establishing an interim rate for the facility. The rate so calculated will be based upon the costs as reported plus the percentage of increase in the consumer price index during the twelve-month period ended with the facility's fiscal year. The rate so calculated will be placed in effect as of the start of that facility's fiscal year and

shall be considered an interim rate as the result of a desk review.

(3) An onsite audit of the facility will be done as a final step in the procedure. At that time the actual rate will be established retroactive to the start of the home's fiscal year. The rate so calculated will be considered the final rate.

6. Adjustments and appeal procedures.

a. Rate adjustments may be made to correct errors subsequently determined and shall also be retroactive to the beginning of the facility's fiscal year.

b. A final adjustment shall be made for those facilities which have terminated participation in the program and have disposed of all its depreciable assets. In this case the regulations pertaining to gains and losses on disposable assets shall be effective.

c. Any requests for reconsideration of the rate should be filed with the division of management services for administrative consideration within thirty days of the date of the rate notification.

d. An appeal may be initiated by indicating a desire for an appeal hearing to the appeals referee supervisor, social service board of North Dakota, state capitol. The appeal will be governed by the provisions of chapter 75-01-03.

History: Effective September 1, 1980.

General Authority
NDCC 50-24.1-04

Law Implemented
42 USC 1396a(a)(32),
42 CFR 447.276,
42 CFR 447.279,
42 CFR 447.290,
42 CFR 447.291,
42 CFR 447.292,
42 CFR 447.293,
42 CFR 447.294,
42 CFR 447.295,
42 CFR 447.296,
42 CFR 447.301 - 306